Public Document Pack

NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Health Improvement Partnership Board

Notice of a Meeting of the Health Improvement Partnership Board

Thursday, 14 February 2019 at 2.00 pm

Long Room, Town Hall, Oxford

Yvonne Rees
Chief Executive

Date Not Specified

Contact Officer: ***Julieta Estremadoyro, Partnership Board Officer***
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Membership

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

Board Members:

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

Notes: ***Date of next meeting: 15 May 2019***

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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

AGENDA

1. Welcome by Chairman, District Councillor Andrew McHugh

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

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

14:05
15 minutes

To approve the Note of Decisions of the meeting held on 22nd November 2018 and to receive information arising from them.

6. Men's Health Report (Pages 9 - 66)

14:20
15 minutes

Report presented by Oxford City Utd reps.

To inform the Board about a research carried out by East Oxford United on men's health.

7. Performance Dashboard (Pages 67 - 86)

14:35
20 minutes

Report presented by Jackie Wilderspin.

To discuss and agree the draft framework for monitoring progress of the work of sub-groups of the Health Improvement Board and discuss the proposal that the outcome indicators will be reported regularly to the Health & Wellbeing Board.

8. Mental Wellbeing Working Group (Pages 87 - 102)

14:55
20 minutes

Report presented by Jannette Smith and Donna Husband.

To receive and update on progress with sign-up to the Mental Wellbeing Prevention Concordat and discuss next steps in this work.

9. Domestic Abuse (Pages 103 - 104)

15:15
10 minutes

Report presented by Sarah Carter.

To receive an update on the development of the Domestic Abuse Strategy.

10. NHS Long Term Plan (Pages 105 - 118)

15:25
30 minutes

Report presented by Val Messenger and Kiren Collison.

Information on the content of the recently published NHS Long Term Plan and discussion on the implications for the work of the Health Improvement Board.

11. Any other Business and Forward Plan (Pages 119 - 120)

15:55
5 minutes

Presented by Cllr Andrew McHugh.

The Board is asked to note the items on the Forward Plan and propose any areas for further discussion.

ITEMS FOR INFORMATION ONLY

(i) CQC Report

This report was presented to the Health & Wellbeing Board on 29th January.

(ii) Paper on Healthy Place Shaping

This report was presented to the Growth Board in November 2018.

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on 22 November 2018 commencing at 11.00 and finishing at 13.32

Present: **Board members**	Andrew McHugh, Chairman and District Councillor, Councillor Louise Upton, District City Councillor, Councillor Lawrie Stratford, Cabinet Member for Adult Social Care & Public Health, Oxfordshire City Council, Councillor Anna Badcock, South Oxfordshire District Council Councillor Monica Lovatt, (Vale of White Horse District Council Diane Hedges, Oxfordshire Clinical Commissioning Group Christine Gore, West Oxfordshire District Council Dr Jonathan McWilliam, Oxfordshire County Council Dr Kiren Collison, Clinical Chair of Oxfordshire Clinical Commissioning Group Dani Granito, District Councils liaison Richard Lohman (Lay member)
Officers:	Val Messenger, Jo Barrett, Eunan O'Neill, Sarah Carter,
Apologies:	Jackie Wilderspin, Jeanette Baker, Det Ch Inspector Clare Knibbs

ITEM	ACTION
1. Welcome Cllr McHugh welcomed everyone to the meeting.	
2. Apologies for Absence and Temporary Appointments Apologies were received from Jackie Wilderspin, Jeanette Baker.	
3. Declaration of Interest There were no declarations of interest at this meeting.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Note of Decision of Last Meeting (Minutes of previous meeting) The notes of the meeting held on September 13th were signed off as a true and accurate record. Board members asked for some administrative matters to be attended to: • Some people did not receive the email with the link to the papers for the meeting and requested that in future the papers are sent to them by post or by email. • It was noted that the pages in online agenda pack were not numbered • There was a request for microphones in future meetings	
The Joint Health and Wellbeing Strategy The draft Joint Health and Wellbeing Strategy (JHWBS) was agreed by the Health and Wellbeing Board last week and will now be the focus for wider engagement. Jonathan McWilliam outlined the structure of the document, illustrating that the priorities for the HIB are included in the Life Course Approach (A Good Start in Life, Living Well, Aging Well, Tackling Wider Issues) and in the cross cutting themes of Prevention and Tackling Health Inequalities. Board members could also see how their works fits into the bigger picture across the Health and Care system. Comments from Board members included concern that there is no specific mention of learning disabilities, including autism and dyslexia in children and in the prison population. Jonathan McWilliam and Jackie Wilderspin were given credit for an excellent report. **Action: Comments from the HIB members will be fed into the engagement process before the JHWBS is finalised and signed off by the Health and Wellbeing Board in March 2019.**	**JW**

6. Performance Framework Proposal Val Messenger presented a paper outlining proposals for future performance monitoring by the Health Improvement Board. This is designed enable the Board to monitor changes in outcomes. The Board were asked to consider adding process indicators for some new areas of work and keeping surveillance of some population level data. The Board members agreed to the approach set out in the paper. Discussion highlighted the following points for consideration and possible addition into the performance report: • It is important to continue monitoring of outcomes as a priority and this shouldn't be lost as process measures are added. • More measures on inequalities should be included if possible • Consider whether a measure on preventable admissions to hospital can be added. • Links between homelessness and hospital admissions should be explored to see if there is a measure that can be used. • School participation in the Daily Mile or "10-minute shake-ups" could be added if data is available. • Having the physical activity data broken down by age-group might be useful (though it was noted that the low numbers might make the data less robust) • Housing, homelessness and domestic abuse measures would be added with input from officers who are topic experts • It was requested that where possible the outcome targets should be expressed as both percentages and actual numbers. • The HIB needs to ensure that the performance measures that are reported here complement those reported to other Boards, e.g. the Children's Trust, and do not duplicate. In addition, there was a discussion on Human Papilloma Virus immunisations a review of evidence and guidance on HPV vaccination in boys was requested **Action: Eunan O'Neill to provide and circulate information**. In conclusion it was agreed that the new format for performance monitoring will be taken forward and suggestions for additional indicators will be followed up. **Action: A final draft version of the framework will be brought to the February meeting for agreement.**	**EON** **JW**
7. Housing and Homelessness, including Rough Sleeping Jo Barrett presented the report from the Housing Support Advisory Group. This provided an update on recent work and response to questions on rough sleeping that were raised at the HIB meeting in February.	

Some of the information that Jo highlighted included: • 280 people have moved into the homeless pathway. This includes more women and young people and over 65's than previously. • The main needs for females are mental health, drug, and alcohol issues • 60% move off the pathway after 6 – 9 months but there has been an increase in complexity in people's needs. • Social housing is becoming harder to obtain and private rental remains an option. • Future priorities centre on the observation that there are more people with complex needs in the pathway. Lack of accommodation makes it difficult to move people off the pathway and affordability is an issue. • Universal credit is less than market rent and is therefore also a factor in housing people. Discussion included the following points: • A concern was raised that rough sleeping figures in Oxford City could be high as people are drawn towards services. • A question was raised on how many rough sleepers are Veterans from the armed services. • Mental health is root cause of homelessness • There was a concern that Single homeless people who present to authorities are not considered as a priority. • Jo Barrett agreed that she and Nerys Parry would be happy to input to the performance framework on this topic area Jo and Nerys were thanked for their report and requested to bring updates to the Board twice a year. **Action: Housing Related Support Group to provide information for the performance monitoring framework and update it twice a year.**	**NP / JB**
8. Tobacco Control Alliance Eunan O'Neill attended the meeting to answer questions arising from the report on the establishment of the Tobacco Control Alliance. Discussion on the topic covered the following points: • Illicit tobacco is steered by organised crime and dealt with by Trading Standards. There are powers for local authorities to take away licenses for those selling illicit tobacco. • Collaboration on this area of work is a feature of the Tobacco Control Alliance. The emphasis has been on the criminality, but reduction in supply of illicit tobacco will also have positive health impact too. A Public Health England report will inform the work programme of the Tobacco Control Alliance by highlighting good practice.	

9. Director of Public Health Annual Report 2018 Jonathan McWilliam presented his last Director of Public Health Annual Report before he retires. Cllr McHugh presented Jonathan with some chocolates as a thank you for his service to the HIB and wished him a long and happy retirement. Jonathan outlined the content of his report which had been circulated to the Board members. He gave particular thanks to Sue Lygo and Phillipa Dent their work on the report. The Board agreed it was an excellent report and asked Jonathan for advice on how to tackle health inequalities. Jonathan responded that the Board should recognise there will always be inequalities and they need to drill down to find them in whatever topic is addressed and target work to reduce them. Jonathan remarked that the strength of this board is the breadth of the agenda and the long-term perspective on tackling issues together, with different chairmen building on different agendas.	
10. Public Health, Health Protection Forum Eunan O'Neill presented a report which summarised activity across a range of health protection issues. He remarked that, in general, the report highlighted very few concerns and illustrated that the system is working well. Discussion on the paper highlighted the following issues: • Bowel screening – is there a difference in uptake with ethnicity? Data is not available to answer this question but attempts are being made to improve uptake across the whole eligible population. • A question was raised about mumps vaccination of university students where there seems to be a 3-year cycle of mumps outbreaks. Students are encouraged to get vaccinations before starting at university. • Data on uptake of health protection / screening / immunisation services needs to be consistent with the HIB performance framework. • A question was raised on why Childhood flu vaccinations took place in December. It was noted that this is specific to Oxford Health school teams and the supply chain. • There was a request for the HIB to be part of forward planning for flu prevention in future years, learning from current practice and involving a number of different organisations. **Action: Eunan and Jackie to ensure performance monitoring is consistent.** **Action: Future planning for flu prevention to be discussed.**	**EON, JW**

11. Communications and Campaigns This item was deferred to a future meeting and districts were requested to consider if they could lead on this. **Action: Anna said she would take away and discuss at South and Vale.**	**Cllr Anna Badcock**
12. Domestic Abuse Strategy Group annual report Sarah Carter, the Domestic Abuse Coordinator, presented the Annual progress report on the recommendations set out in the strategic review. Sarah highlighted that the group is on track with all recommendations although there is a hold up on training strategy which is being commissioned. However, she was pleased to report that Multi-agency training will be in place from February. Next steps will include further development of action plans which will be presented to the HIB and will be monitored. To enable this Sarah agreed to provide targets and process indicators for the HIB performance dashboard. As mentioned in a previous meeting, the Joint Safeguarding Boards have asked HIB to report back to them on how they are monitoring the Domestic Abuse Strategic Group. The addition of outcome and process measures to the HIB Performance Framework will facilitate this reporting back, which is to be done alongside report from community safety partnerships (CSPs). Sarah will be attending CSPs to give them assurance of progress too. **Action:** **1. Sarah and Jackie to work on outcome and process measures to be included in the performance framework.** **2. Chair of the HIB to report back to safeguarding boards on the monitoring arrangements set up at the HIB to give assurance on the work of the Domestic Abuse Strategy Group.** Issues of concern that were raised in the discussion included the impact on young people living with domestic violence; professionals such as nurses who deal with secondary violence; same sex relationships and accessibility of services to everyone; the impact of non-physical abuse. It was noted that work is going on to break the generational cycle of domestic abuse through schools e.g. a touring play. It was also stated that support workers allocated to cases in the justice system bring better outcomes but often victims are reluctant to go to court without that support.	**SC / JW** **AMcH / JW**

13. Health Watch Ambassador Report Richard Lohmann presented the Healthwatch Ambassador report. He highlighted the issue of Single homelessness in the City and also the Healthwatch report on oral health in care homes. He stated that there has also been in depth work by Healthwatch on musculo-skeletal services and recent reports have shown that Child and Adolescent Mental Health services are improving.	
14. Government Letter At the last Health Overview and Scrutiny Committee meeting it was recommended that a letter be sent to the Secretary of State for Health and Social Care. A draft of this letter was presented by Cllr Lawrie Stratford for comment. There was some discussion that the letter should be supported by evidence of effectiveness for the proposals being requested. It was agreed that, with the addition of details of the evidence for why recommendations were being made on alcohol minimum pricing and reduction of fast food advertising, the letter would be signed by the Chairman and sent. It has already been approved by the Chair and Vice Chair of the Health and Wellbeing Board. **Action: Val to finalise the letter by citing evidence.**	**VM**
15. AOB The issue of Gambling addiction was raised as there is some indication that it is increasing problem with younger people. It was agreed that his could fall into the remit of the Children's Trust Board	
There being no other business, the meeting closed at 13.32	

..... in the Chair

Date of signing

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Your voice on health and social care

Men's Health

Project Report. November 2018.

Contents

Introduction

Between May and July 2018, East Oxford United worked collaboratively with Healthwatch Oxfordshire to find out what men in East Oxford thought about their health.

This report is the result of research that took place.

Who we are:

East Oxford United is a community-based grass roots sport club made up of children, young people, parents and volunteers who reflect the diverse multi-ethnic population of Cowley and the wider East Oxford area of the city.

The charity runs a range of sports-related activities including football and basketball coaching, matches and social events. In 2017 the group launched an annual 'Community Cohesion Cup' to bring together men's football teams from across the city in celebration of its diversity.

September 2018 saw the launch of a 'Diversity Football League' to continue building on the energy of the cup and boost community cohesion. This brings together teams representing more than 22 different nationalities from Oxford in their shared love of football. The focus is to welcome communities from all socio-economic backgrounds, especially those who may not have the opportunity to play in a league due to the high entry costs.

Healthwatch Oxfordshire listens to people about their experience of health and social care. It launched its Project Fund in early 2018 to enable voluntary sector groups to carry out small pieces of research with support.

East Oxford United approached Healthwatch Oxfordshire with the idea to make use of its wide community networks to find out more about men's health. Their application was successful, and the funding and support from the Project Fund has enabled this work to happen.

Aims of the study

East Oxford United saw that its links with men, particularly those from Black, Asian and minority ethnic (BAME) backgrounds was a great opportunity to ask men their views on keeping healthy. It also knew that men from this group often were low on uptake of health information and support, and in particular NHS Health Checks.

The group decided to build on its wide social networks and links in East Oxford to find out:

1) How do men maintain good health and what information and resources do they use for support?
2) What level of awareness is there amongst men from BAME and other groups about NHS Health Checks?
3) What are the barriers to men taking up healthy lifestyle advice, and NHS Checks?

139 questionnaires were completed by men, along with many more conversations with men about their health.

Main lessons

What the men we spoke to said

- Men are generally aware of health messages, and many try to live healthy lifestyles, for example by taking exercise and eating healthily
- Men are keen to have more tailor-made, targeted information about a range of health issues, including diabetes, heart disease, mental ill health among other issues
- Men have gaps in understanding of NHS Health Checks, their importance and relevance. Men of all ages want to know about NHS Health Checks, and understand why they are important once they are invited
- Men predominantly seek information and support for their health from their GP, closely followed by use of the internet and advice from friends and family
- Men face barriers to accessing health care due to time and constraints due to shift work, long working hours and

unpredictable working patterns. This has an impact on ability to take care of themselves as well as taking up on NHS Health Checks
- Other barriers included concerns about money, secure housing, cost of healthy food, exercise, and general life concerns, as well as motivational barriers. This demonstrates the importance of consideration of the underlying 'determinants of health' in addressing health inequalities and supporting men to be able to access health services from a life of security not insecurity (See Marmot, 2010).
- Men were open to health information and NHS Health Checks being delivered from wider 'community settings' in Oxford

What we learnt

- Positive collaborative working between the statutory and voluntary sector and community groups requires flexibility, ongoing communication and dialogue with specific input and allocation of appropriate resources.
- The potential for developing both 'asset-based' and 'co-produced' approaches to promoting health and wellbeing locally were positively demonstrated by the Men's Health Project. This simply means recognising and making the most of strengths within communities, at the same time as making sure communities are able to be involved in developing the services they receive (for explanation of these ways of working see: Hopkins and Rippon 2015; Realpe and Wallace 2010).
- Better Community engagement was also facilitated by the use of community volunteers whose local knowledge and diverse community access enabled a wide range of responses and feedback.
- Better information can be produced for target groups by working in partnership with community-based organisations.
- Better community engagement can be facilitated by working collaboratively with community-based organisations. e.g. A much greater impact was achieved by linking the annual national Men's Health Week campaign to local events and activities in this case - East Oxford United organising the Men's Health Cup Tournament.

What we would like to see

Given Oxfordshire's take up of NHS Health Checks is just over 50%, our research suggests that men might value opportunity for more flexible options. This could include for instance, trial of Health Checks at in a community setting where men regularly attend, working closely with community members to establish links and spread information.

It might include finding out more about time barriers of shift workers. Working with employers in this case might be a way forward.

Background and context

Men's health is a matter of concern.

According to the *Men's Health Manifesto* (2014) 'in the UK one man in five dies before he reaches 65'. 75% of men's premature deaths are from coronary heart disease. Middle-aged men are twice as likely as women to have Type 2 Diabetes. Men are less likely to engage with health services, for example seeing a GP or having NHS Health Checks and are more likely to lead unhealthy lifestyles. They are less likely to speak about their mental health.

For men from Black, Asian and minority ethnic (BAME) backgrounds, the picture can be accentuated, with these groups experiencing specific health inequalities. For example, they are less likely to seek medical help as early as the majority white population (Lipman 2014). Men from South Asian, Chinese, African and African Caribbean descent are at a higher risk of developing Type 2 Diabetes compared to those from White British backgrounds (Men's Health Forum; Diabetes UK 2018).

Many of these health conditions are preventable. Lifestyle factors, such as low levels of physical activity, and poor diet are at play. According to the latest data from *Sport England's Active Lives Adult Survey* (2017), people from lower socio-economic groups are much less likely to be active. Sport England's survey 1999/2000 showed that men from BAME backgrounds are particularly under-represented in sports (40% compared to a national average of 46%)

Men can benefit from increased uptake of NHS Health Checks, a free check-up for adults in England aged 40-74 (without a pre-diagnosed condition). The check is designed to spot early signs of stroke, kidney and heart disease, type 2 diabetes or dementia and give advice and treatment where necessary (NHS 2018). Good practice case studies nationally highlight innovative examples of community led and asset-based approaches to increasing uptake of NHS health checks, particularly among groups that do not normally attend (NHS 2018). For example, work in 2014 with Cornish fishermen who were shift workers led to NHS checks being offered within workplace settings, and in Islington in 2015, local pharmacies, community centres and places of worship were used for NHS checks as a way of reaching 'high risk' groups who were not engaging with regular NHS checks offered from GP surgeries.

The Men's Health manifesto argues for more focused attention and resources on men's health and the treatment they receive through a 'gendered' approach to prevention, information and engagement by health care professionals. They call for design of 'targeted programmes around the needs and attitudes of the highest risk men and boys' to boost men's engagement with health professionals, NHS checks, and lifestyle based preventative action (Men's Health Forum 2014).

The picture in Oxford

Overall, Oxfordshire fares well in relation to health outcomes when compared to the national average. However, pockets of ill health can be mapped, linked to both deprivation and ethnicity. For example, life expectancy by ward for Oxford city shows the gap in male life expectancy between the more affluent North ward and the relatively deprived ward of Northfield Brook has increased from 4 years in 2003-07 to 15 years in 2011-15 (Oxfordshire JSNA 2018).

In Oxfordshire as a whole, the main cause of death among adult men is from all cancers (28%) followed by heart disease (13%) Depression and diabetes are also increasingly noted by GP's as presenting conditions (Oxfordshire JSNA 2018). Many of these conditions are deemed in part 'preventable' and associated to lifestyle factors such as obesity, and low physical activity.

From numerous reports, we know that Oxford is a diverse city, with its population facing equally varied challenges when it comes to experiences of health, social care, deprivation (Oxfordshire City Council, Oxfordshire JSNA 2018).

Oxfordshire Health Inequalities Commission Report (2016) noted gaps in collection of health data of BAME populations, commenting, "during the process of consultation we found it difficult to get good data on BAME communities as well as on other disadvantaged groups". The report commented on the need to target health and preventative resources for those groups in greatest need, including focus on increasing physical activity and sport.

NHS Health Checks in Oxfordshire are commissioned by Oxfordshire County Council and delivered as a universal programme across GP surgeries. According to the *Oxfordshire County Council Health Check Equity Review* (2018) there is still improvement to be made in the uptake of NHS Health Checks. "Between quarter 1 in 2013/2014 and quarter 4 in 2017/18, 50.4% (n=95,485) of invited residents chose to take up the invitation for an NHS Health Check".

The report noted differences in those who chose to take up an invitation, "Looking at ethnicity and gender for 2016/17 data, the lowest uptake of invitation was observed for Bangladeshi (34.4%, 11/32) and Chinese men (38.0%, 35/92), compared to 60.9% uptake of invitation (5557/9133) among White British men".

The report comments on the need to encourage uptake amongst men, certain ethnic minorities, and vulnerable groups. This echoed in Oxfordshire's Director of Public Health Annual Report (2017) stating the need to 'better identify and, thus engage with high risk groups to take up the offer of a free NHS Health Check' (Oxfordshire County Council 2017).


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Our methods and approach

The process

From the start, East Oxford United wanted to work from the 'bottom up' in reaching men through building on the energy, enthusiasm and vibrant sense of community in East Oxford. Men were able to link to other men, through workplaces, friendships, families, sports groups, community centres and places of worship. The idea was to initiate interest, conversations and awareness of the importance of men's health, and to find out more about what men think about this issue.

From the outset, the *process* of 'co-design'- was as important to the group as the data collection itself. Doing the work by building on community networks, having conversations with men about health, ensured trust was built up between the men themselves, East Oxford United and Healthwatch Oxfordshire.

Healthwatch Oxfordshire held ongoing planning meetings in Costa on the Cowley Road, with members of East Oxford United, and together they developed the approach for the work. Community volunteers were involved throughout and the work developed as it went along, with ongoing reflection and adaptation as lessons were learned.

Aims of the study

As mentioned in the introduction, East Oxford United saw that their links with men, particularly those from BAME backgrounds was a great opportunity to ask men their views on keeping healthy. They also knew that men from this group often were low on uptake of health information and support, and in particular NHS Health Checks.

The group decided to build on its wide social networks and links in East Oxford to find out:

4) How do men maintain good health and what information and resources do they use for support?
5) What level of awareness is there amongst men from BAME and other groups about NHS Health Checks?

6) What are the barriers to men taking up healthy lifestyle advice, and NHS Checks?

Data Collection

A questionnaire was designed, to go out to men in paper form, and online via Survey Monkey. Draft ideas were discussed and tested with local men, and with Dr Mahamud, a London-based GP and supporter.

The questionnaire drew from Sport England, and other sources, covering questions on men's use of health information, lifestyle factors and where relevant, uptake of NHS Health Checks. The questionnaire included a description of NHS Health Checks, to raise awareness of this to men under the eligible age (See Appendix 1 for Questionnaire).

Questionnaires were in English. East Oxford United ensured that men had help interpreting and filling in questionnaires where possible, through working with community volunteers, from a range of backgrounds. All responses were anonymous, which was important to gaining confidence

When the men knew it was anonymous they were really keen to be asked (volunteer)

Due to time constraints, we decided that the data collection focus would be via questionnaire, and not through qualitative conversations and interviews, although inevitably men were keen to talk, and to share their experiences and ideas. This meant that the depth of the information collected was inevitably limited, perhaps offering opportunities for the future.

The work took place from May to June 2018, with less activity planned for the month of Ramadan; although evening gatherings in the Mosques were a great opportunity to reach men breaking fast.

Who did we approach?

Questionnaires were distributed and collected on foot by community volunteers. The questionnaire was also promoted on social media using East Oxford United's *WhatsApp* and *Facebook* links.

From the start, the idea was to use men's local networks to raise awareness of the survey. This included reaching men at their places of employment, community centres, and places of worship in the East Oxford area.

"I've been walking around in Cowley Road, Blackbird Leys, Rose Hill…didn't want to limit where it goes, teaching them about health checks, many don't know and have never heard of it."

East Oxford United's links with diverse men's football teams were another focus for questionnaire distribution. As a way of promoting the focus on Men's Health, and to link into the national Men's Health Week (11-17 June 2018) East Oxford United decided to name 2018 Community Cohesion Football Tournament, the '***Men's Health Cup***'. A total of 22 nationalities played in 25 teams on the 17th June, in a tournament which was part of Oxford's Eid Extravaganza event open to families.

Homes 4 All also had a team, which enabled us to reach men who are homeless and living on the streets, to take part in the men's health survey.

Reaching men through Unipart, BMW and bus companies as well as other employers shed interesting light on the different workforces. Whilst East Oxford United had wanted to reach mainly BAME men, they soon realised that White British men needed information just as much.

"BMW workers…we have realised a lot of white working class don't know about this either, so they are keen to fill in…realise it's a wider problem…so we are moving to focus on men generally."

They also found a difference in who they could reach with the type of employers. Agency workers at Unipart for example were anecdotally predominantly African and Asian, whereas permanent employees were mainly from White British and European backgrounds.

Men contacted during the research.

Employers	Community Centres and places of worship
Cowley Road Barber's shops, Snappy Snaps Photos, Platinum	Bangladesh Islamic Education Centre
Royal Taxis	Manzil Way Mosque (Oxford Central Mosque)
O1 Cars	Oxford Centre for Islamic Studies
BMW Unipart	Madina Masjid (Stanley Road)
Oxford City Bus Company	Asylum Welcome
Tesco	Syrian Men's Group
Burger King	Homes for All (Homeless Charity)
Oxford Express Hospital drivers	
Football Teams at the Men's Health Tournament (17 June Eid Extravaganza)	**(240 men from 22 nationalities)**
Academia Ox	KPD
Albania	Kurdish
Bengal Tigers	Nigeria
Bicester Finest	Oxford Pistols FC
Bus Company (3 teams)	Pakistan
Cowleyfornia	Portuguese
East Timor (3 teams)	Romania
Eritrea	Somalia
Homes 4 All	Syria (2 teams)
FC Beltat	
Jatt Boys	

Focus on promoting men's health

Conversations by volunteers during the data collection enabled men to speak about their health. Key to this was the opportunity to tell men about the importance of NHS Health Checks for men over 40, and to raise awareness of this for men under this age.

The Eid Extravaganza event on 17th June at Cheyney School attracted over 3000 people on the day in addition to the footballers taking part in the Men's Health Cup.

Healthwatch Oxfordshire held a stall at the event and was able to speak with men throughout the day, about their experiences of health and social care, and encourage questionnaires to be completed.

The group also invited Oxfordshire Public Health's Health Improvement Practitioner to attend the event, to give out publicity about NHS Health Checks on the day.

As part of Men's Health Week, and to build on the opportunity to reach men, Healthwatch Oxfordshire, at the request of East Oxford United, funded the purchase of 200 copies of the *Haynes Man Manual*, a booklet providing health information specifically aimed at men. These

were given out on the day of the Eid Extravaganza to both footballers and interested men. General men's health information was also given out in a range of language formats.

Limitations of the study

Looking back, some changes would have been made from the start about the way we approached the study

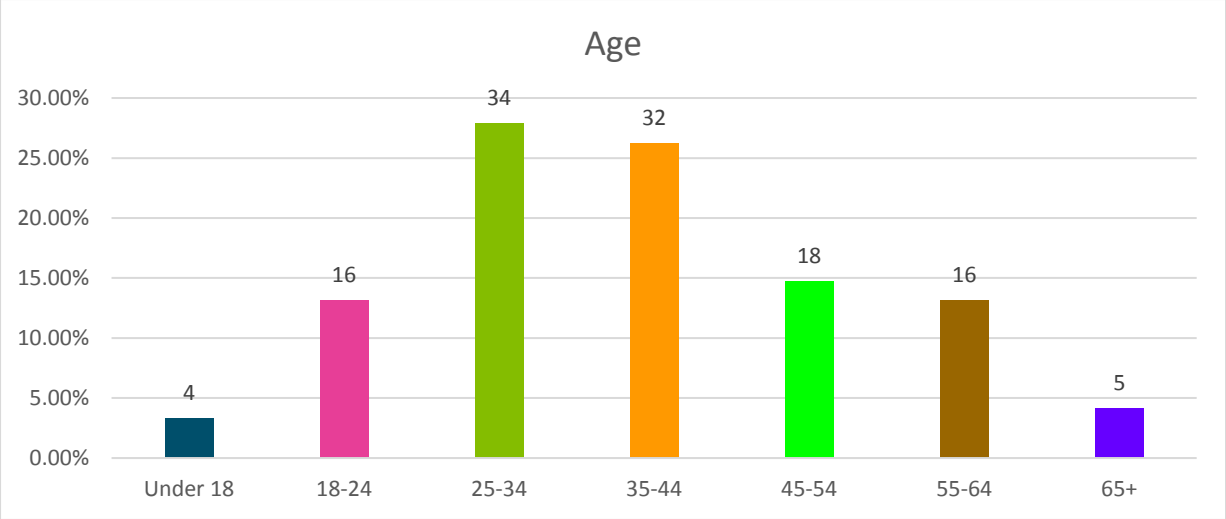
- In using standard age ranges for the questionnaire, i.e. 35-44 and 45-54, we missed the opportunity to clearly focus on understanding Men over 40 (as eligible for NHS Health Checks). However, the question about NHS Health Checks was targeted and completed by men over 40's. Embedding information about NHS Health Checks for all respondents to see did give the opportunity for ALL men to learn about their existence.
- Unfortunately, many men from workplaces completing the 'online' survey monkey question failed to click the 'submit' button, and their data did not reach us. As a result, we lost data. This was rectified half way through the data collection by clearly highlighting the need to complete the survey by pressing 'submit'. We also tried to encourage men to resubmit.
- It could be argued that there was some bias towards men already engaged in physical activity and interested in healthy lifestyles. Many of the men who completed the questionnaire were from football teams. We tried to engage men in workplaces, for example bus and taxi companies, and to reach men who were not engaged in regular sport.
- The numbers responding to the different questions about NHS Health Checks were often contradictory. Whilst this can be seen as a weakness, it can also shed light on the fact that many men seem unclear about what NHS Health Checks are, as opposed to other GP visits. There is a need for more public information so that when men come to receive a letter from their GP, they understand what it is, and how important it is. It was also important for younger men to understand what NHS Health Checks were, so they would know of its importance when an invitation arrived.

The findings: What men said

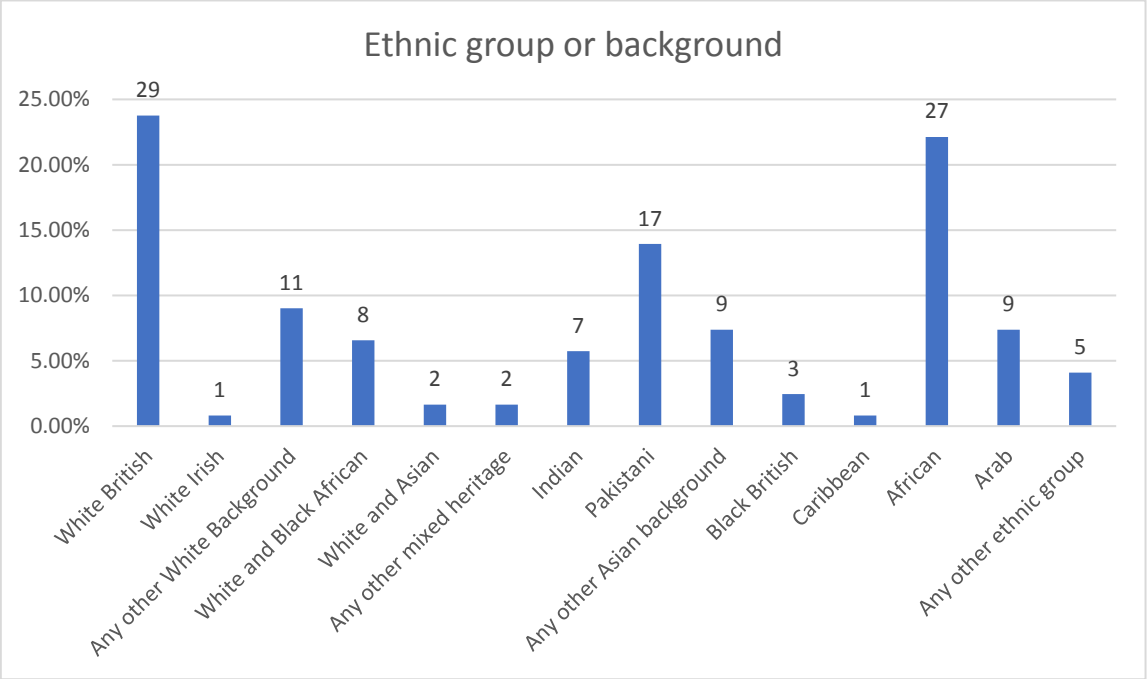
What did men say about their health? Who responded?

139 questionnaires were completed by men. We also spoke to many more men than this, at the Eid event, and during contacts within the wider community. **Appendix 2** summarises the responses to the questionnaires in graphic form.

Of the respondents to the questionnaire, men from across the age groups and ethnic backgrounds responded.



Respondents by age

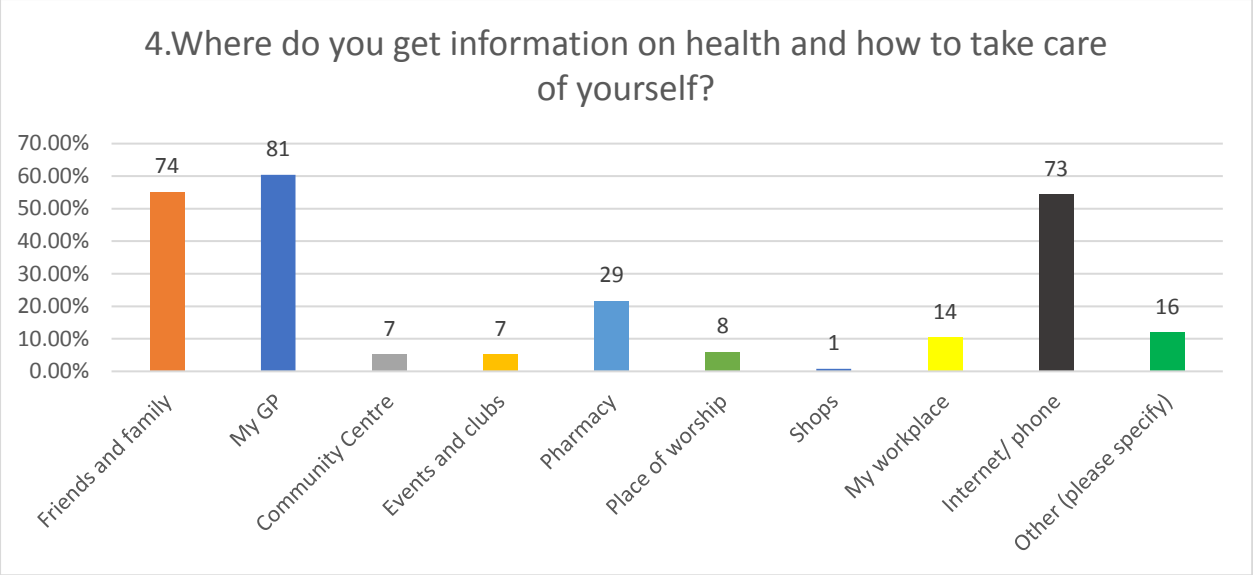


Respondents by ethnic group or background

Of these, nine considered themselves to have a disability, and eight reported as asylum seekers, with five preferring not to say.

Information for men on taking care of themselves

Questions 1-7 in the questionnaire focused on men's use of and access to health information



Sources of health information men used, was predominantly from the GP (81 respondents), followed by the internet (79) and friends and family (74). 29 people used the pharmacy for health information. Grouped together as 'community settings' (community centre, events and clubs, place of worship, shops, workplace and other) accounted for 37 responses in all. 16 responses under 'other included use of books, TV, 'New Scientist' and 'cosmology'. One commented:

"Forget about the internet, everything is set up for the internet, but many people don't have phones."

Is health information easy to understand?

When asked if this information was easy to understand answers were Yes (116), No (5) and other (9), of whom five who commented on the need for language interpretation, or more accessible information

"Ask someone else, reading and writing difficult, need someone to explain."

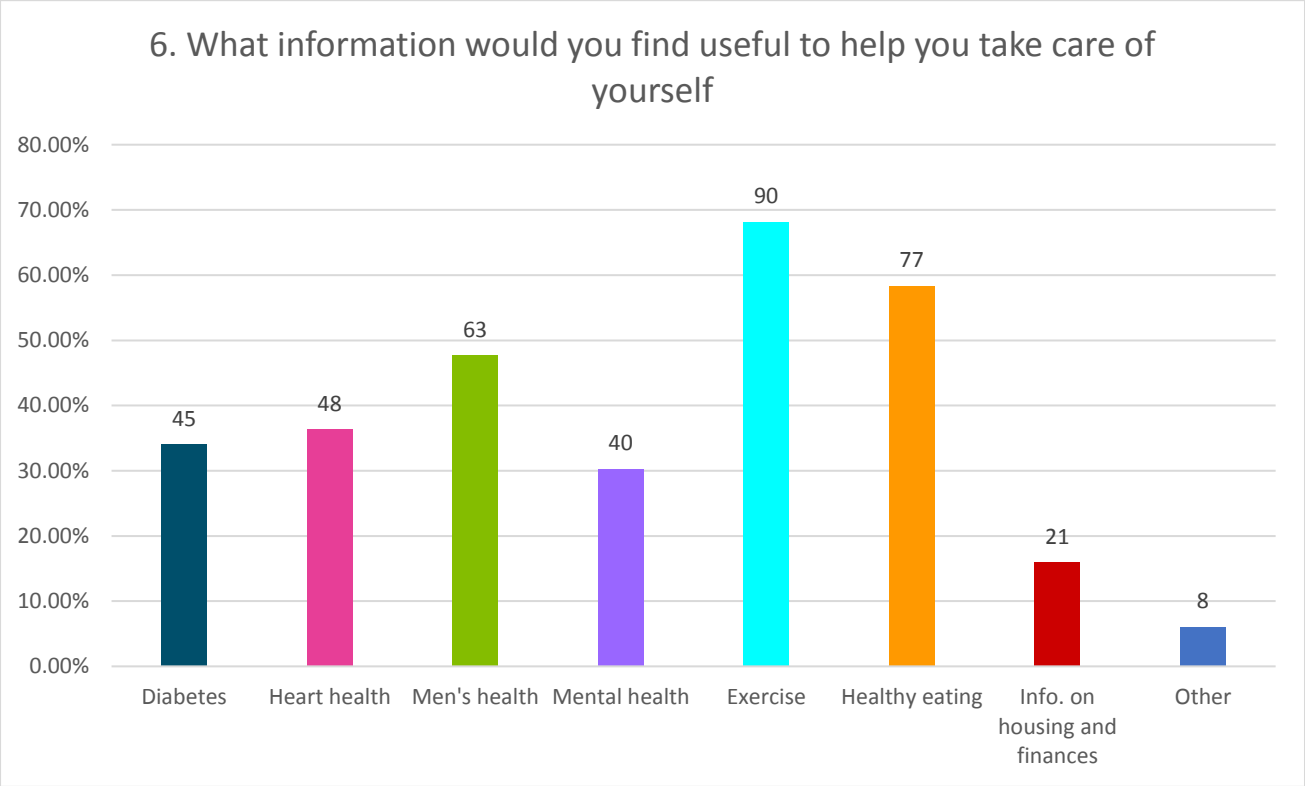
"Need English translation."

One commented on the positive role pharmacists have to play

"The way GPs have started working with pharmacies also relieve stress on GPs but also causes patients to be more relaxed...medicine info sometimes hard to understand but pharmacist now are more receptive to your enquiry and will talk you through."

What information would men find useful?

Responses by men about what information would be useful for them to help them take care of themselves are shown below.



The responses show how men are wanting support to take care of themselves across a range of themes. These include understanding prevention of health conditions such as Diabetes and Heart health, mental health, and help to tackle the underlying drivers of ill health such as housing and money, as well as information on healthy eating and exercise.

Comments in 'other' included

"Suicide."

"How not to work too much."

"Housing."

"Exercise - see what to do and how to stay active - have arthritis."

"Healthy eating- eating crap, easier living on own to eat crap takeaway."

One man met during the research commented about the need for simple information, targeted at men with little time

"I drive form Blackbird Leys to city on the daily bus…5 days a week shift work, I am tired, there is not time to look after myself…so simple tips, practical tips can really help, things that I can do easily and that fit into my life."

"Spoke to a man who is a builder, message, simple things, like knowing about diabetes, very small message but has made a big change to him."

Worth noting here, are comments received by community volunteers on the distribution of the Haynes *Man Manual*. Feedback from men contacted during this research commented on the 'explicit' and slightly 'laddish' nature of the messages and content of the book outlining men's health issues. There was a feeling that while the information was invaluable for men, aspects of the book were not sensitive to some communities' cultural or religious sensibilities.

"One community chairman came to me and said it was very helpful, but the book should be more open to other communities…Looks like nothing to us in our foreign community, messages are not what we normally see or understand….need a more culturally appropriate one."

"An Algerian said pictures are really revealing, the person who wrote the book didn't understand different cultures…not culturally viewed as normal…but personally I learnt a lot from it."

"Sometimes you think what is normal and then you realise it is not seen as normal."

"Many men in the city now come and say 'thank you for giving us the book, it is useful'."

"The book was quite interesting… a lot of men came to me and said 'that is a lot of information that is out there', and you know there were specific pictures and all that, and some of them really took them and read them all over, and said 'I was surprised it was really helpful to see this kind of information' 'where did you get it from…? It's really strong'."

Where do men want to receive health information?

Question 7 asked men where they would prefer to receive information about health and how to take care of themselves. Again, the main response (96 responses) was from the GP, and 31 from the pharmacy. Internet and phone accounted for 52 responses.

However, again if amalgamated under the category of 'community setting' (community centres, events and clubs, places of worship, shops, workplace) this would account for 81 responses, giving an indication that providing health information in a range of community settings might be of value.

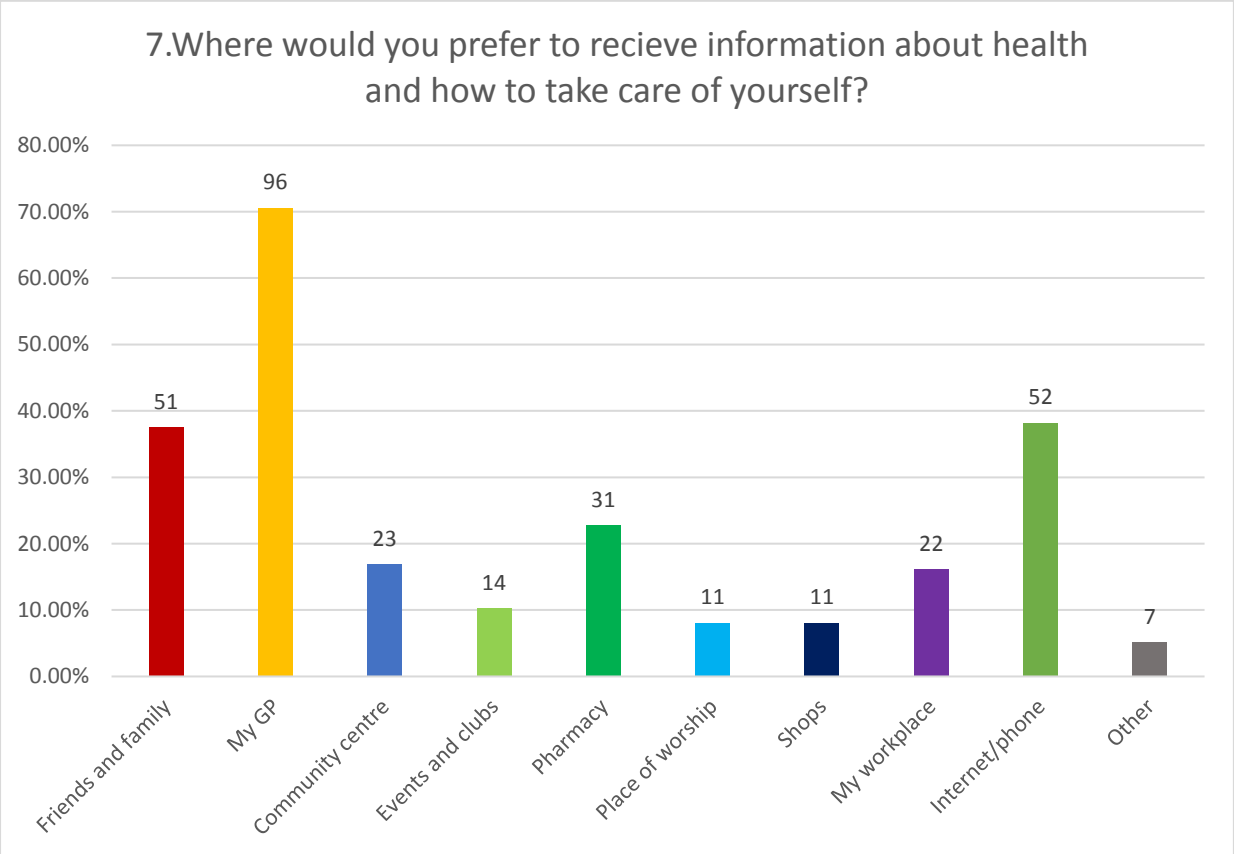
Under 'other' people commented

Instagram/ twitter

Community homeless hub

And on the difficulty seeing GP

"Doctors not easy to go and see, one quick question- rushed for time."



Men taking care of their health

Questions 2,3 and 8 asked men about their ability to 'take care of themselves', and any barriers to this. 104 men said that they 'did take care of themselves', two said they 'didn't' and 30 said they 'sometimes' took care of themselves.

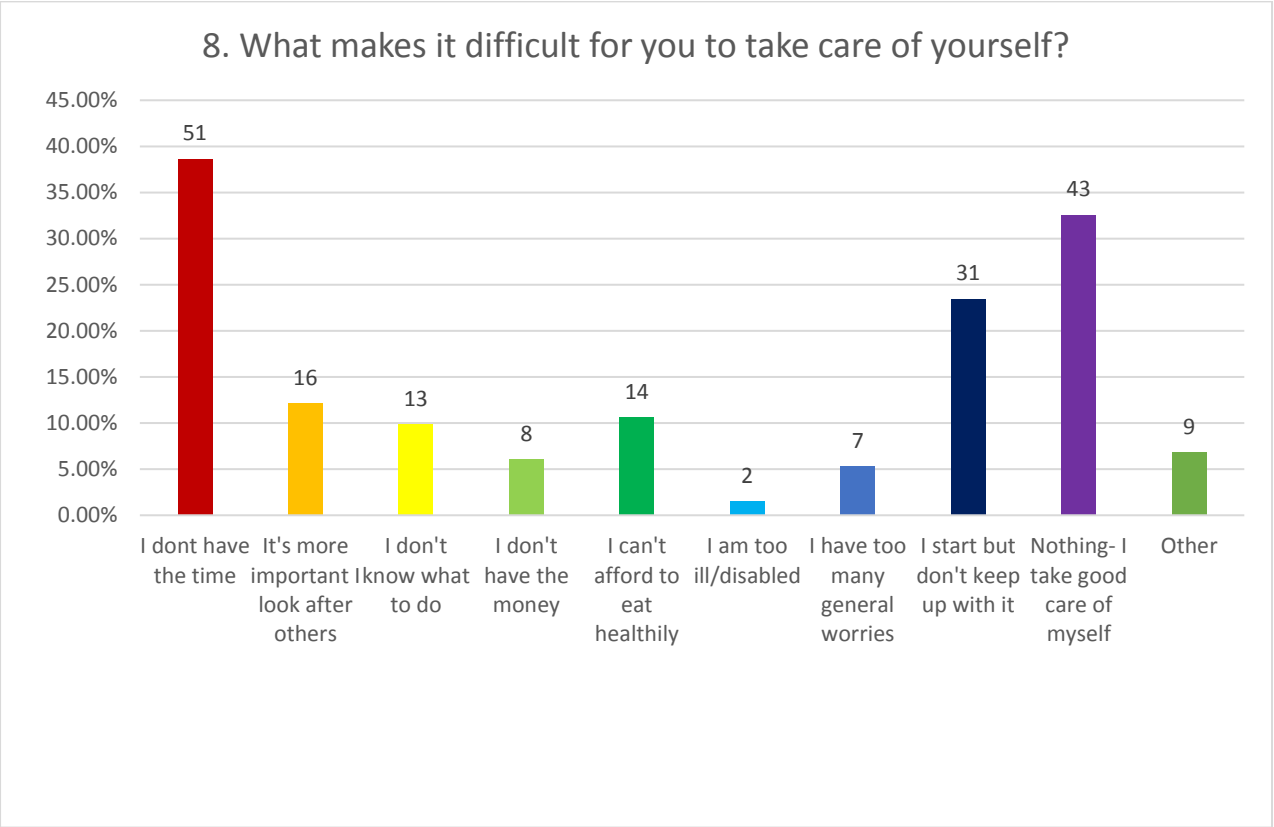
Question 2 asked men to describe *how* they took care of themselves. Overall, (influenced no doubt due to football teams taking part) men showed understanding of importance of healthy lifestyle (good diet, physical activity etc) in supporting them to take care of their health.

Generally, men who said they did take care of their health highlighted exercise as important and were engaged in a range of physical activities, including sports like football, swimming, going to the gym. Others said they got physical activity from daily activities such as gardening, walking. Having a healthy diet was also cited as important.

How do you take care of yourself? (grouped by theme)	**Number of comments**
Exercise, e.g. football, sport, gym, swimming, running, walking, cycling	57
Diet, eat healthily, food	31
work	4
Not smoking/ drinking	3
Physical job, doing work	4
GP visits, regular health checks, BP checks	4
Keeping clean/ clean clothes	3

Barriers to men taking care of themselves

Question 8 asked men about the barriers to taking care of themselves.



Of those who answered, 51 stated that they did not have time. This theme, *time* appears as a factor across future questions featuring as barriers to both men's uptake of physical activity and NHS Health Checks.

Motivation also appeared to be a factor, with 31 men saying they started to take care of themselves but don't keep up with it.

Comments included

Its hard to break inertia to start an activity, e.g. gym

Healthy eating and exercise is expensive

Working odd hours

Work doesn't give me time

I've just started working as a taxi driver and now sitting all day, it's really bad for your health

Members of the homeless community faced particular challenges

Living on the streets makes it impossible

Bottom line is a roof - if you can't think of where to go, if you have had your stuff out all night, how to keep dry, no purpose, why should I bother with my health, if it takes me it's just done sooner

Physical activity

We used the opportunity to explore men's attitudes to physical activity, as a preventive factor to ill health. Here we based questions on Sport England surveys.

When asked about levels of activity each week (compared to the recommended 150 minutes) 33 men responded that they did less than 30 minutes a week, 51 reported between 30-149 minutes a week, and 48 reported doing over 150 minutes a week.

Men's engagement with physical activity, reflected answers in Question 2 (how men take care of themselves), with men citing a wide range of sports, including football, swimming, gym, running, cycling.

Everyday activities such as 'gardening', 'walking the dog', 'daily house jobs' were also cited. Some cited hobbies and volunteering 'woodwork' and 'volunteer canal restoration' and others cited heavy manual jobs 'heavy work', 'building construction' and 'farming'.

Workplace support was valued

"…the bus company do support us with gym pass but it's down to the individual and motivation…"

One member of the homeless community commented that his physical activity came from

"Walking- get around find new places to sleep, football, or to find food services and church."

Comments from men spoken to at the Eid Extravaganza highlighted the social and mental health benefits to men of shared sports activities.

"Football is like a sign language, even people who don't want to talk together…"

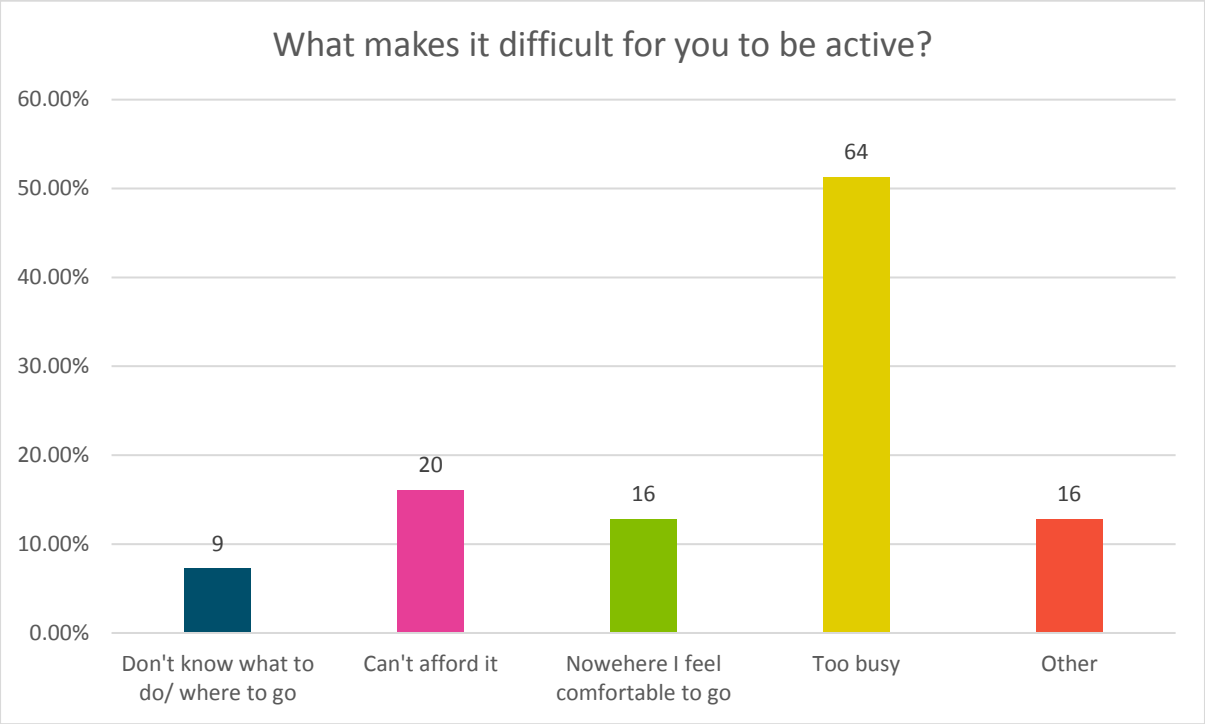
One Homes 4 All member commented

"Football event- the men have made a team in the last two weeks; bringing people together so mentoring each other, mental health

improved, really committed to coming to the practice and have now started meeting socially. There has been an excitement about joining in and being able to show that the homeless community has a lot of positive skills to bring."

Barriers to physical activity

Question 11 asked men about what made it difficult for them to be active.



The main response (reflected also in ability to take care of one's health, and take up NHS Health Checks), again was about time- 'too busy, with 64 men citing this as a barrier. Cost was also seen as a barrier to 20 men. Others commented they did not feel comfortable to go.

Comments reflected this

"Not enough time."

"I'm not a big fanboy of the gym environment."

"Peers - its easier for a man to go out with friends and have a nice drink."

"I have restricted time…its expensive living in Oxford, I have to have 2 jobs to keep the family, so I have no time...I end up going to the gym at 1 a.m."

Men's awareness of NHS Health Checks.

NHS Health Checks are available to men over 40 who have not had a previous condition diagnosed. Men receive an invitation to attend by letter from their GP.

Whilst it is essential for all men over 40 to know about and understand the benefits of NHS Health Checks, building awareness among men under this age is also important to support later uptake. Of the respondents across all ages, 77 men said that they had heard of NHS Health Checks, and 51 said they had not.

Men reported that they had heard about the checks from a variety of sources. The majority (58) as expected, had heard from GP or nurse. Others had heard via friends and family (25), workplace (10), pharmacy (3) and other (11).

Those that said 'other' commented that they had heard from sources including family members, Public Health Adverts, and via Healthwatch Oxfordshire at the event itself.

"On the Bus advert" (a number also told us they had seen this)

"Girlfriend works for NHS"

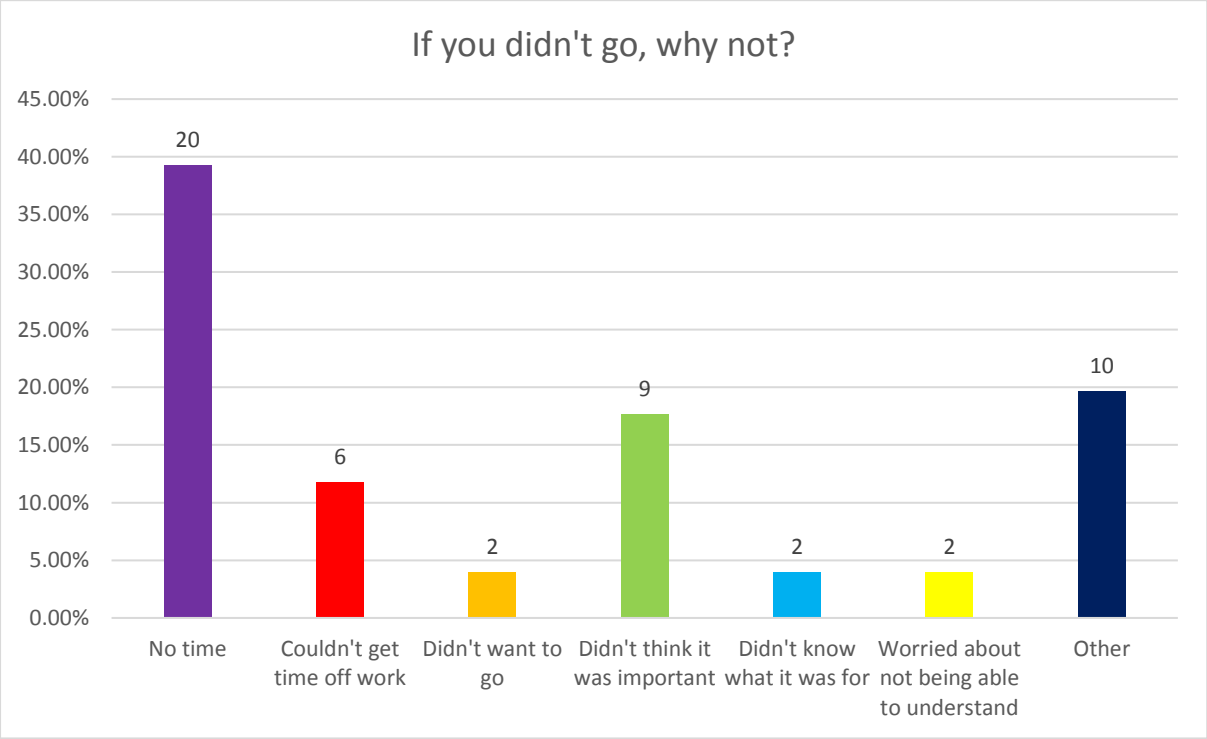
"Internet/advertisements"

Some of the answers we received about NHS Health Checks were not clear, or contradictory, with less men saying they had been invited to or had NHS Health Check (40 had been invited 60 had not) compared to those who said they had not/ had attended checks once invited (43 said they did go, 46 said they did not).

This may be due to men being unclear or confused as to what an NHS Health Check is in practice, and how they are invited. We also found this in speaking to men, many were not certain about what a Health Check was. It highlights the need for support with men to understand clearly what an NHS Health Check is and how to access it, well before they are invited.

Reasons given for not attending the NHS Health Check

Of the men who didn't go to NHS Health Check once invited, reasons given were as follows:



Again, there is some confusion, with the numbers different from those who said they had been invited.

However, reasons given for not going highlight a mix of not understanding the importance of checks (12 either didn't know what it was for or didn't think it was important), along with time and work factors (26).

Comments from speaking to men highlighted these constraints in more depth. Many men who answered the questionnaire from workplaces were shift workers, with unsocial and unpredictable hours, finding it hard to find the time to look after their health.

"I do shift working so hard to find time to get an appointment at the GP…the bus company do support us with gym pass but it's down to the individual and motivation…having health checks at work would be good but difficult also as all the men are out on the road." (bus driver)

Lack of information about Health Checks was also seen as a barrier

"There is a lack of communication of that to the community…I only went to have a health check because my friend told me."

"They could improve it by advertising and marketing it better…if no one is knowing there is a health check they won't do it."

And some commented on the environment at a GP, which they felt was not conducive to speaking about men's health issues

"Men feel it's difficult going to a GP to talk about men's issues…it's a very female dominated environment, women's health information, women's issues, women receptionists, women doctors…it's hard to feel you have a right to be there and have open conversations…it's much easier if you are a woman."

"I was called for a Health Check but the GP ended up telling me there wasn't much he could do with the funding….it was more funding for women than for men"

Others indicated that they were uncertain of the benefits of seeing a GP, or had not felt taken seriously, or religious beliefs not understood

*"He knows he needs to get checked out but he won't go…once you go to the doctors, you just end up on more and more pills and that's what puts him off." (*wife about her husband*)*

"I was sent a test tube to give a sample…the strip that comes with it has the person's name on it, to stick onto the tube...I couldn't do it as it would have been desecrating the name of the Prophet if I had…so I never returned any samples….this would be a major factor for men like me not picking up on health checks."

"I tell them about different issues, but they just say 'you will be fine'"

"Funding has had knock on effects, it always feels like they don't want to take that extra step, there is no relationship now (With GP) you notice the difference straight away funding wise it's gone down."

"Before you went in and they would make sure all was ok...I work in retail but the NHS don't take this approach of hearing what the 'customer' has to say.."

"I have lived with this problem for over two years, and the Doctor has told me 'don't keep coming back…give us a call before you come' but where do I go?"

There was an understanding that different communities perceive and use NHS services in different ways, and for some there are barriers to attending that need to be overcome

"Different communities see it in different ways, I tell my community (Pakistani) 'this is the NHS – treatment is free- go for your regular checks- don't just sit at home and try and do it yourself, solve it yourself…'"

One community volunteer commented about working with the East Timorese community (see also recent report by Butcher 2018 Oxfordshire County Council Public Health)

"East Timor the group the largest in Oxford at the moment, a lot of questionnaires came back from them. The team are using different method of healing, use traditional healers and have confidence in this and don't engage with medical world.. They use their own traditional medical things a lot in this country, they believe in different kinds of things, they tell you 'no tablets'… 'we have our own person who can come and heal us, and do this'"

Those under 40 were also keen to find out about NHS checks, as one volunteer commented on conversations

"…they were all very keen, and the youngest, the age of 19-37 when they got to the 40 NHS Check questions they were like 'why not us? When we get to 40 we will want to know' …they were really keen to answer that…"

Where to access health checks?

When asked *where* it would be most convenient to have a health check, men overwhelmingly stated at their GP. 69 men said at the GP, six at pharmacy, two at community centre, and three at work. However, 20 stated 'other' which reiterated the above along with other suggestions including;

GP	16
Pharmacy	10
Place of work	3
Local Community Centre	5
Sports Club	5
Hospital	2
Place of worship	2
Community Hub for Homeless (Homes4All Café)	1

Whilst most men said that Health Checks should be at their GP, when speaking to men, many stated that having Checks based in community settings or workplaces would be a good idea.

"I think what would help is access of it…if it was in the community, you could do it at a pharmacy…to remove the barriers."

"There is a captive audience at events like this to do things like diabetes and smoking advice…and checks."

"Go to where the people are…there are a range of activities in different community centres…you've got to walk the streets, knock on doors, use social networks that are out there already."

"Access 'mix and match' rather than just one access point- not a single access point … leisure centres in community …these places could be access points in terms on drop in NHS checks."

And for the homeless community:

"Many people don't access health services- even Luther Street. Engage through building up relationships…not in sterile places but in a café setting…"

What three things did men say would make it easier for men to look after their health?

In question 12, men were asked to comment on three things they would change to make it easier for them to look after their health. 87 men gave their suggestions, which ranged from comments about fitness, food, money, work, lifestyle, stress, and engaging with the GP. These can be summarised into themes as follows.

Theme	Number of suggestions
Healthy diet/ healthy food	39
Less shift work/ unpredictable work patterns, time off work	16
More time (e.g. with family, for life,) less stress	15
Motivation and willpower/ knowing what to do	8
More money/ affordability of e.g. healthy food and sports activities	7
GP/ Health/ regular appointments	7

Comments about healthy food reflected issues of cost, time, access and skills, and pressures of wide availability of unhealthy foods and alcohol

Generally don't eat healthily enough

More easily made meals

Time for cooking good food

Cheaper healthy food

Reduce eating unhealthy food (kebabs and junk)

Reduce fizzy drinks

Stop drinking every night

Comments about work again reflected the men finding it difficult to have time to care for themselves due to shift work, long work hours or anti- social work patterns

Less shift work- nights

Not doing night shifts

Don't work so hard

Having more time off work

Work to promote good health

Comments about money included

Better L.A. [local authority] *funded access to sports venues*

Better affordable places

Work and bills

More money

Expensive health products

Other comments included focus on the social aspects of activity, mental health benefits, and need for secure housing to be able to look after one's health

Roof over head

More understanding of the homeless

Exercise with mental health service

More fun group activities exercise with friends

What did we learn?

Working to engage men in the wider community

The group learnt a lot from this study about the process and approach.

The strength of the approach was undoubtedly the way in which we tapped into the energy, enthusiasm and interest of men themselves to spread the word and contribute to the work. There was a huge amount of interest, and the men clearly felt the issue was important and they were keen to have their say- but also be listened to.

"The question they asked was 'why did you choose the name Men's Health cup? Then when you explain Men's Health week is a national thing, some of them don't even know that…and it's a lot of when it comes to the health, with this kind of questionnaire, you have a lot of people in minority groups who really have less information, where

they women or young men, or men, and to reach them, you have to bring them activities, something they like to come out to ."

- Using trusted community volunteers to support men to fill in questionnaires worked well. This supported those who needed interpretation, or writing support, but also helped to access men
- Community leaders at places of worship, mosques and workplaces were more than happy to support us in reaching the men they serve and were keen to help men understand more about their health. This was an opportunity to build on these relationships for future health related events

"Using a simple way where the go normally like the mosque, we know all the men going in on that…an Iman would be really happy about it, they don't see any problem with it, they are there to serve their community…involvement of the community in the mosque, that is what they are there for."

Those involved in the work questioned the perception that the men in the BAME community in particular were 'difficult to engage' arguing that services needed to reach out more, and ask men what approach should be taken

"Talk to faith leaders more about what is acceptable to people and protocols for this kind of thing…providers need to have regular discussions with people about what is culturally appropriate, and update this regularly…about how to communicate with different communities."

"Hard to reach …these people are not hard to reach…has anyone asked them?"

"…providers are too stuck in their comfort zones…going to forums, that is seen as making the contact…Oxfordshire don't understand these communities…people working won't come out of their comfort zones…"

"…the group that we've got answers from it's not hard to get, it's difficult to get it, but it's a group that has been really left over and not really given information and has not been asked to be part of it- involved…"

Building up trust was important with groups reaching out to men.

"…they could be working with a group like you, who now you have an easy link with the group, as you have already done something and as you are local communities mindset, where they are thinking of the project for the broader they can see organisation that they think they could be delivered with us if they ask."

And advice to working more effectively:

"Go out and meet and talk to the people! Don't go to the same old people. I think the mosque involvement, it's not difficult at all as long as the Iman is involved, and tell him what you want information you want to give, and get out of it, but also what the mosque themselves want to get out of it, because it is information on health we are talking about, and helping people with that information. Giving people information and saving their health…we went to all the mosques and we didn't have an issue about giving our leaflet, or saying what we were doing…everyone was very supportive and said 'what you are doing is very good and please keep going, keep asking us'."

"…don't talk to the same people, go to different groups, and in different ways, don't just go with one thing, to one group and say that's all, but meet with the other groups, I think that is the key point…people are there, go and get it and meet them in the right places, communities are life, there are a lot of communities in Oxford doing things that people have never heard about."

Is it worth trying to deliver health messages and NHS Checks in community venues?

As we have seen throughout, whilst men saw the GP as their main source of information about health information and NHS checks, in conversations, they were open to possibilities of having this potentially delivered from community settings. Conversations on the topic of where men would find it easiest both to access NHS Health Checks and health information, as we have seen revealed some interest in making use of community venues. This was a way of catching men who often otherwise did not have time to get away from work, or kept irregular hours

"People are not always thinking that the hospital GP can solve the problem, people meet in social spaces, all go to church or mosque, its

part of the family, practicing religion, we have to be there, so it would be the best place for messages about health."

"…even idea in a mosque to have a place where Health Checks could be done, as they are there for public, and they serve thousands and thousands of men, and when you tell the Iman that this is relevant for the group of men you see, every Friday or every day for their lessons… there is not rejection in there, but the groups have to come up with the ways of working, the nice ways."

Appendix 1. The Men's Health Questionnaire.

healthwatch Oxfordshire Men's health

We would like to hear from you about your ideas on information and support to keep men healthy

How do you think this support can be improved? Thank you for taking time to answer these questions. We don't need to know your name or any personal details that will identify you. By helping us, it means that you are happy for us to make use of your comments to tell the organisations that support you about what men think about keeping healthy.

1. **Are you registered with a GP?**

○ Yes

○ No

2. **Do you take care of yourself?**

○ Yes

○ No

○ Sometimes

3. **If so, please tell us how you take care of yourself**

4. **Where do you get information on health and how to take care of yourself?**

- [ ] Friends and family
- [ ] My GP
- [ ] Community Centre
- [ ] Events and clubs
- [ ] Pharmacy
- [ ] Place of worship
- [ ] Shops
- [ ] My workplace
- [ ] Internet/ phone
- [ ] Other (please specify)

5. **Do you find this information easy to understand?**

- [ ] Yes
- [ ] No
- [ ] Other (please specify)

6. **What information would you find useful to help you take care of yourself?**

- [ ] Diabetes
- [ ] Heart health
- [ ] Men's health
- [ ] Mental health
- [ ] Exercise
- [ ] Healthy eating
- [ ] Information about housing and finances
- [ ] Other (please specify)

7. **Where would you prefer to receive information about health and how to take care of yourself?**

- [ ] Friends and family
- [ ] My GP
- [ ] Community centre
- [ ] Events and clubs
- [ ] Pharmacy
- [ ] Place of worship
- [ ] Shops
- [ ] My workplace
- [ ] Internet/phone
- [ ] Other (please specify)

8. **What makes it difficult for you to take care of yourself?**

- [ ] I dont have the time
- [ ] It's more important I look after others
- [ ] I don't know what to do
- [ ] I don't have the money
- [ ] I can't afford to eat healthily
- [ ] I am too ill/ disabled
- [ ] I have too many general worries
- [ ] I start but don't keep up with it
- [ ] Nothing- I take good care of myself
- [ ] Other (please specify)

9. **To stay healthy, adults are advised to do at least 150 minutes of moderate activity each week. Do you do..**

- [ ] less than 30 minutes activity each week?
- [ ] 30-149 minutes each week?
- [ ] Over 150 minutes each week?

10. **What type of activity do you do? e.g. walking, heavy work, gardening, football?**

11. **What makes it difficult for you to be active?**

- [ ] Don't know what to do/ where to go
- [ ] Can't afford it
- [ ] Nowehere I feel comfortable to go
- [ ] Too busy

Other (please specify)

12. **If you could change anything, what 3 things would make it easier for you to look after your health?**

1

2

3

13. **Have you heard of NHS Health Checks?**

- ◯ Yes
- ◯ No

14. **If yes, where did you hear?**

- [ ] Friends/ family
- [ ] GP/ nurse
- [ ] Pharmacy
- [ ] At my work
- [ ] Other (please specify)

Are you 40 and over? If so, please answer these next questions....

All adults aged 40-74 are able to have a free NHS Health Check at their GP. Your GP should contact you to invite you to this every 5 years. This helps the GP check your health and see if you are at risk of common conditions (if you have not already been diagnosed); stroke, kidney disease, heart disease, Type 2 diabetes, dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps you to find ways to lower this risk, and find out more about staying healthy.

Have you been invited to or had a NHS Health Check?

- [ ] Yes
- [ ] No

15. **Did you go to your check?**

- [ ] Yes
- [ ] No

16. **If you didn't go, why not?**

- [ ] No time
- [ ] Couldn't get time off work
- [ ] Didn't want to go
- [ ] Didn't think it was important
- [ ] Didn't know what it was for
- [ ] Worried about not being able to understand
- [ ] Other (please specify)

17. **Where would you find it most convenient to have a Health Check?**

- [ ] GP Surgery
- [ ] Pharmacy
- [ ] Local community centre
- [ ] Sports club
- [ ] Place of worship
- [ ] My place of work
- [ ] Other (please specify)

18. **If you did go, did you find it helpful? If not, why not? Please tell us**

About you....please let us know....no answers will identify who you are

19. **Tell us your age**

- [ ] Under 18
- [ ] 18-24
- [ ] 25-34
- [ ] 35-44
- [ ] 45-54
- [ ] 55-64
- [ ] 65+

20. **Do you consider yourself to have a disability?**

- ○ Yes
- ○ No

21. **How would you best describe your ethnic group or background?**

- [ ] White British
- [ ] White Irish
- [ ] Any other White Background
- [ ] White and Black Caribbean
- [ ] White and Black African
- [ ] White and Asian
- [ ] Any other mixed heritage
- [ ] Indian
- [ ] Pakistani
- [ ] Chinese
- [ ] Any other Asian background
- [ ] Black British
- [ ] Caribbean
- [ ] African
- [ ] Any other Black background
- [ ] Arab
- [ ]

Any other ethnic group

23. **Are you a refugee or asylum seeker?**

◯ Yes

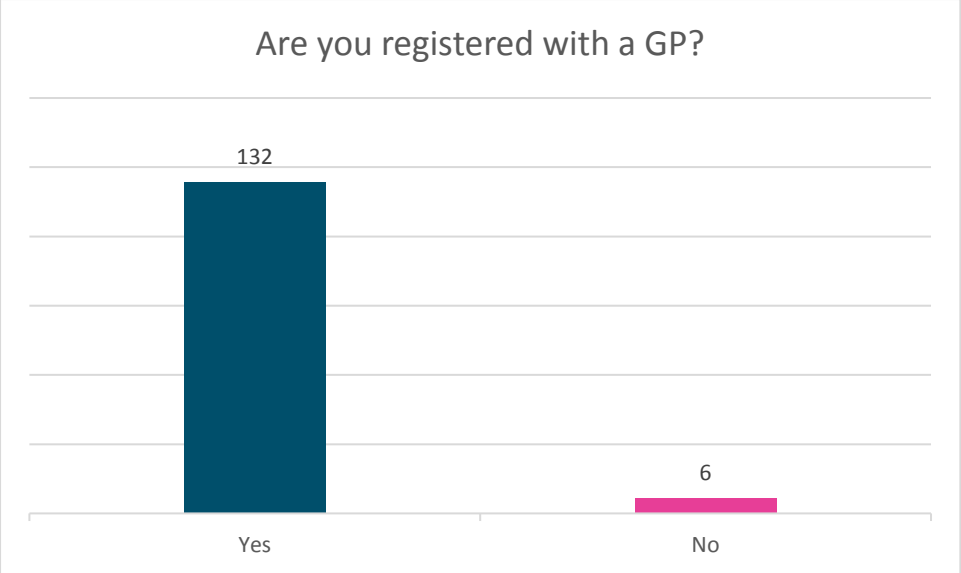
◯ No

◯ Prefer not to say

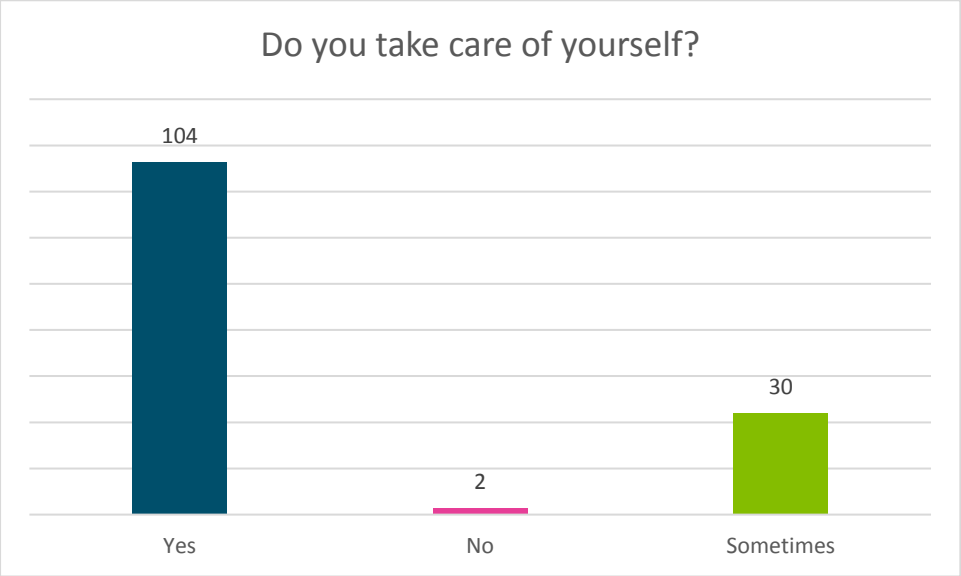
Thank you for taking part in this survey!

Appendix 2. Summary of responses.

1. Are you registered at a GP?

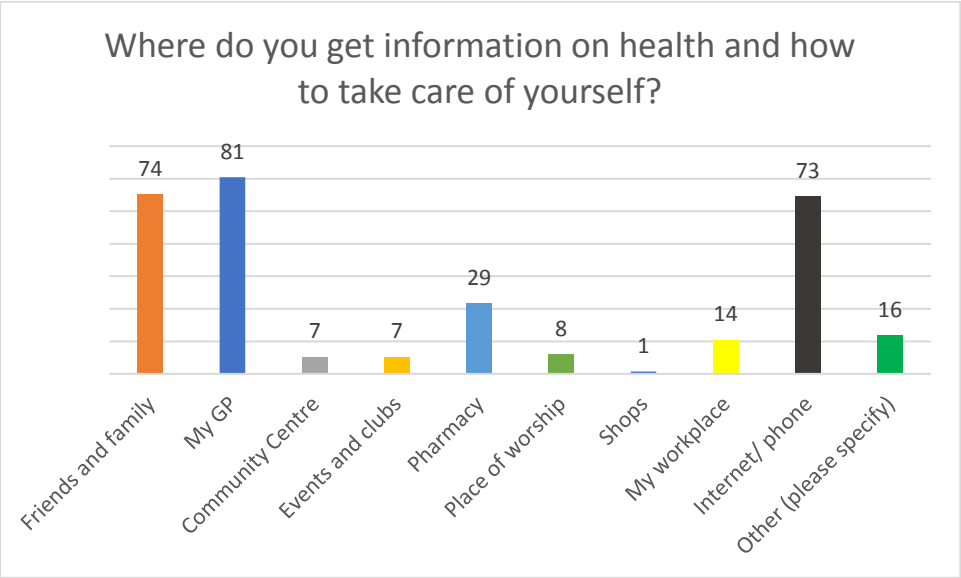


2. Do you take care of yourself?

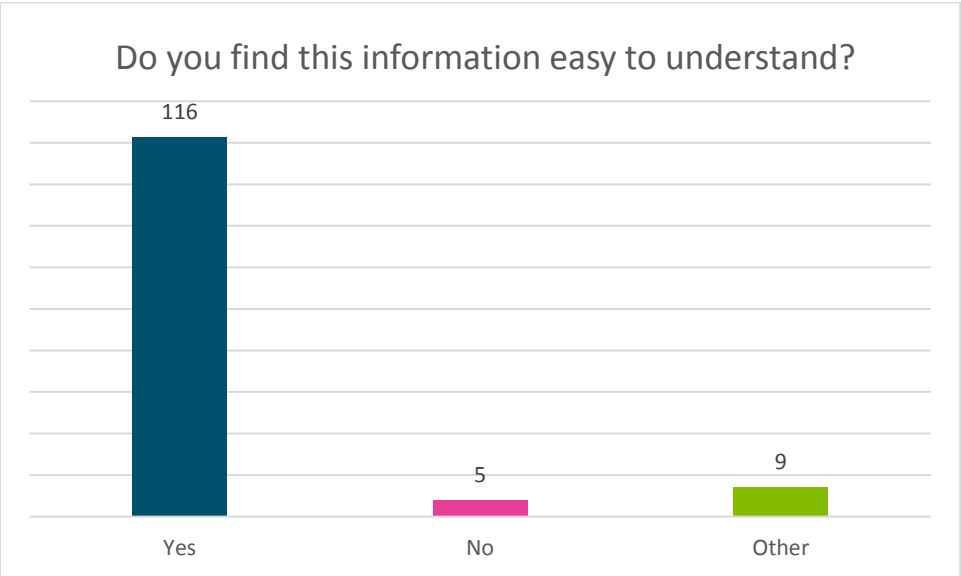


Q3. Men gave examples (see main text)

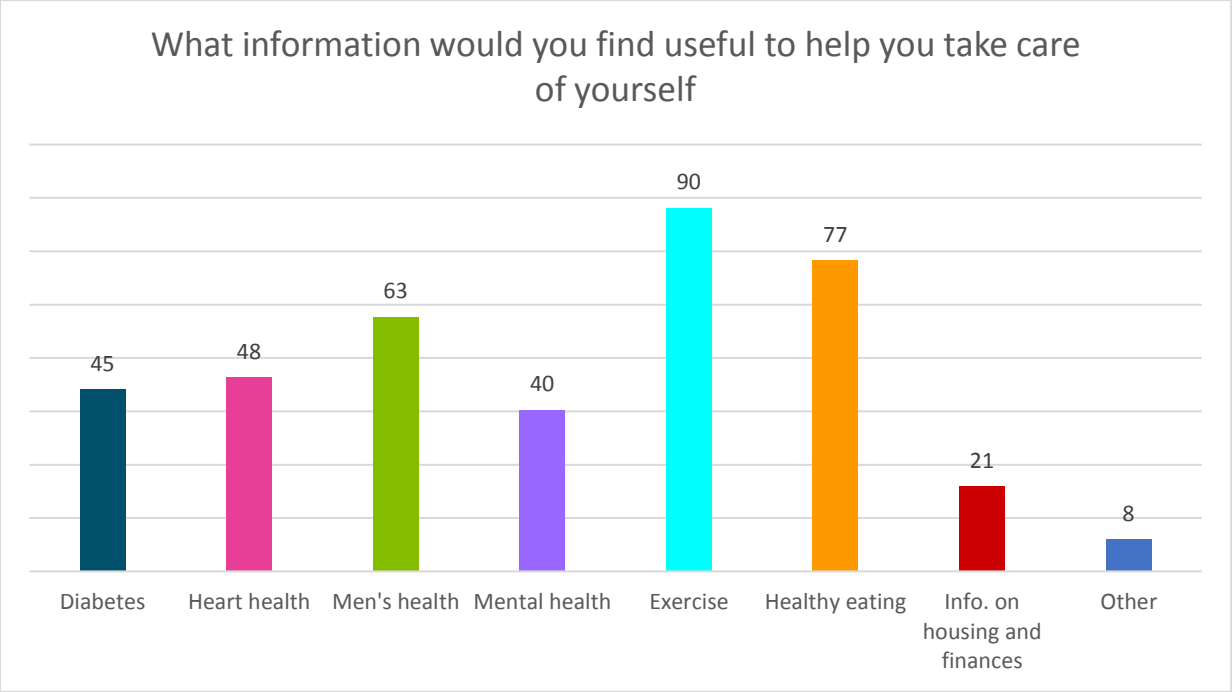
4. Where do you get information on health and how to take care of yourself?



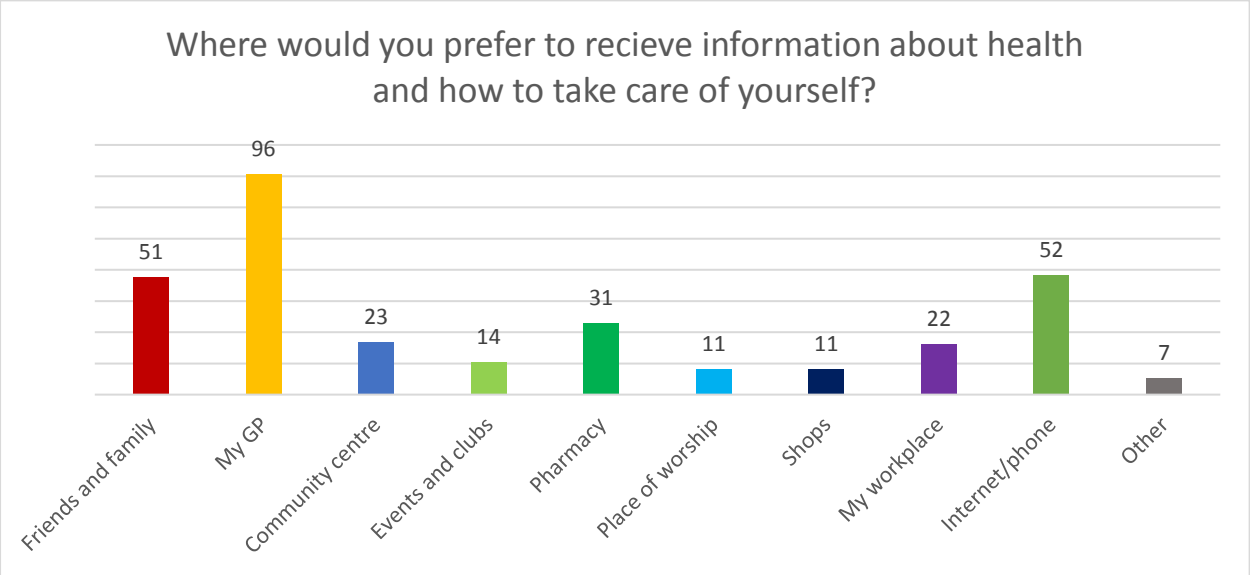
5. Do you find this information easy to understand?



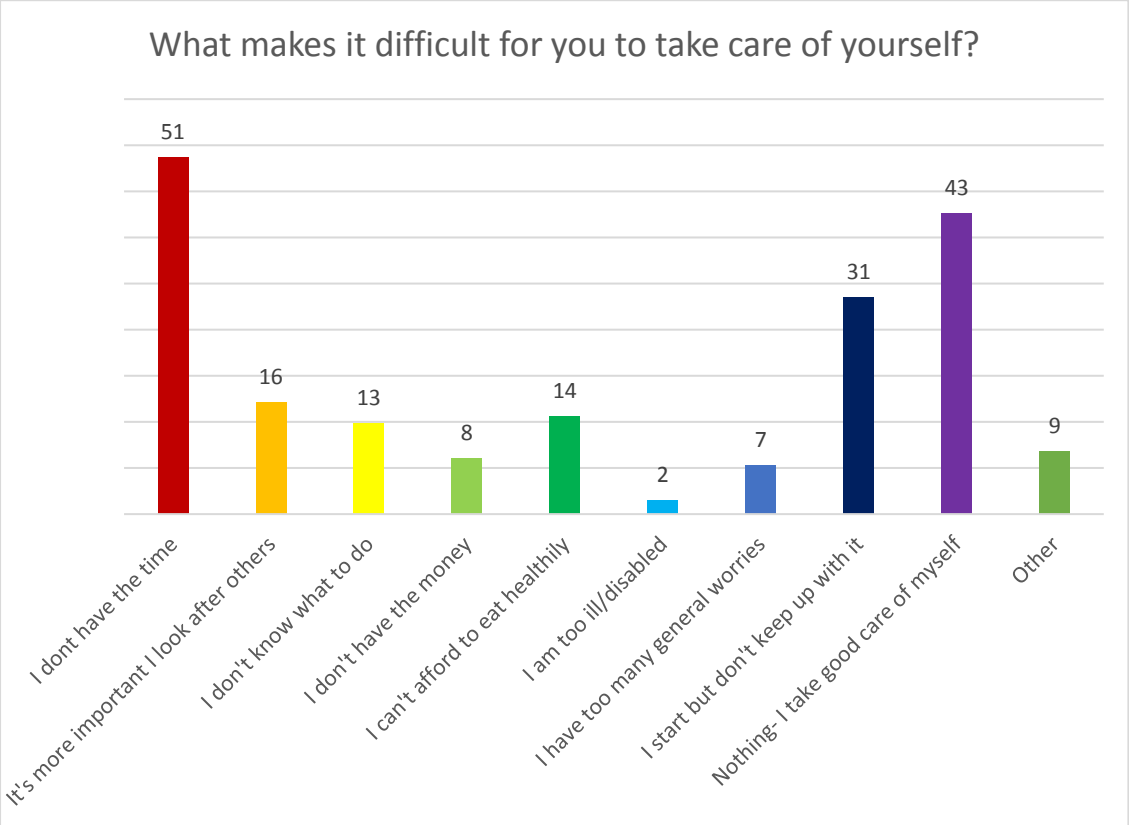
6. What information would you find useful to help you take care of yourself?



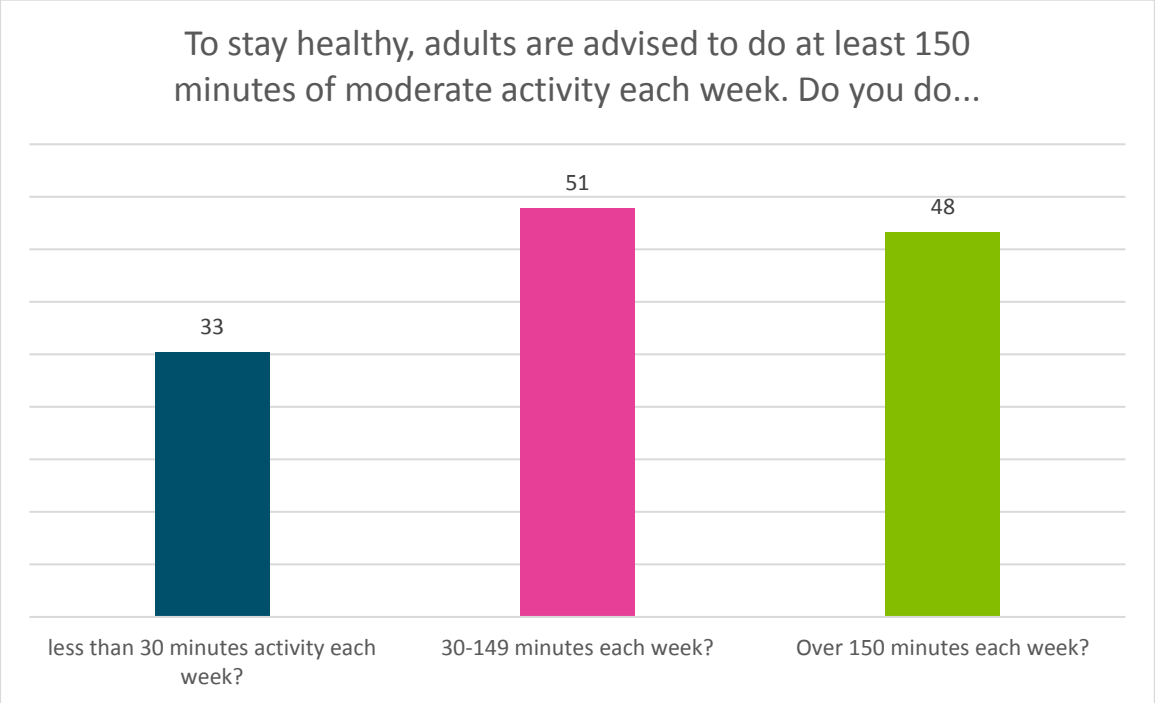
7. Where would you prefer to receive information about health and how to take care of yourself?



8.What makes it difficult for you to take care of yourself?

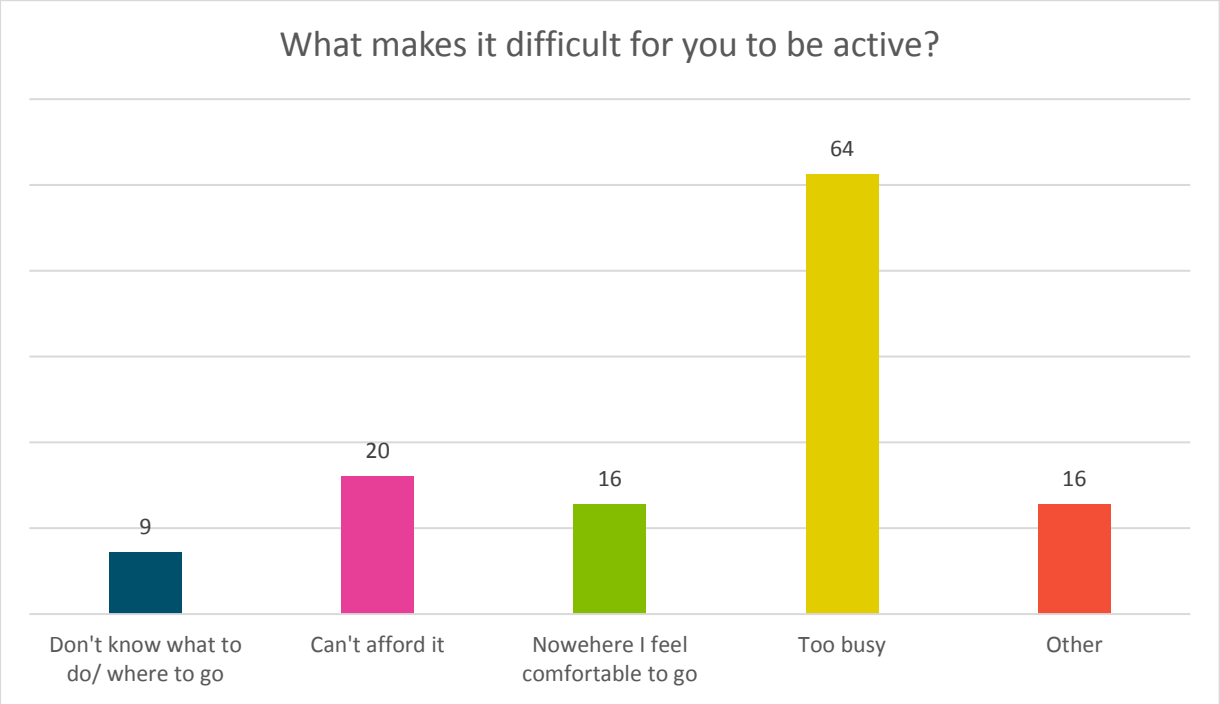


9. Do you do at least150 minutes of moderate activity a week?



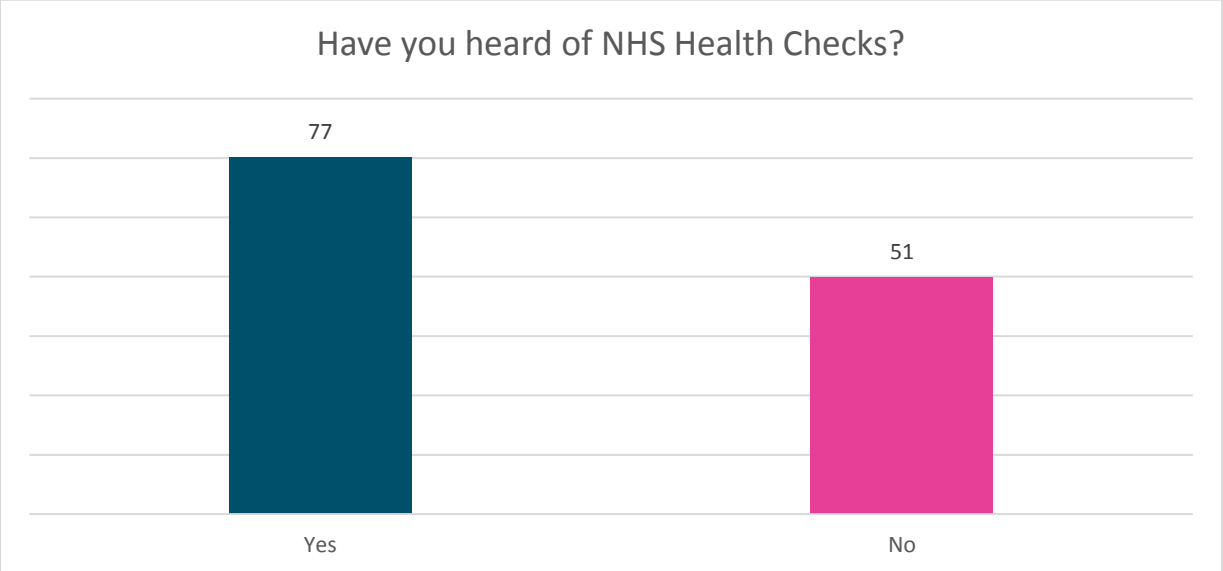
Question 10 asked men what type of activity they did (see main text)

11. What makes it difficult for you to be active?

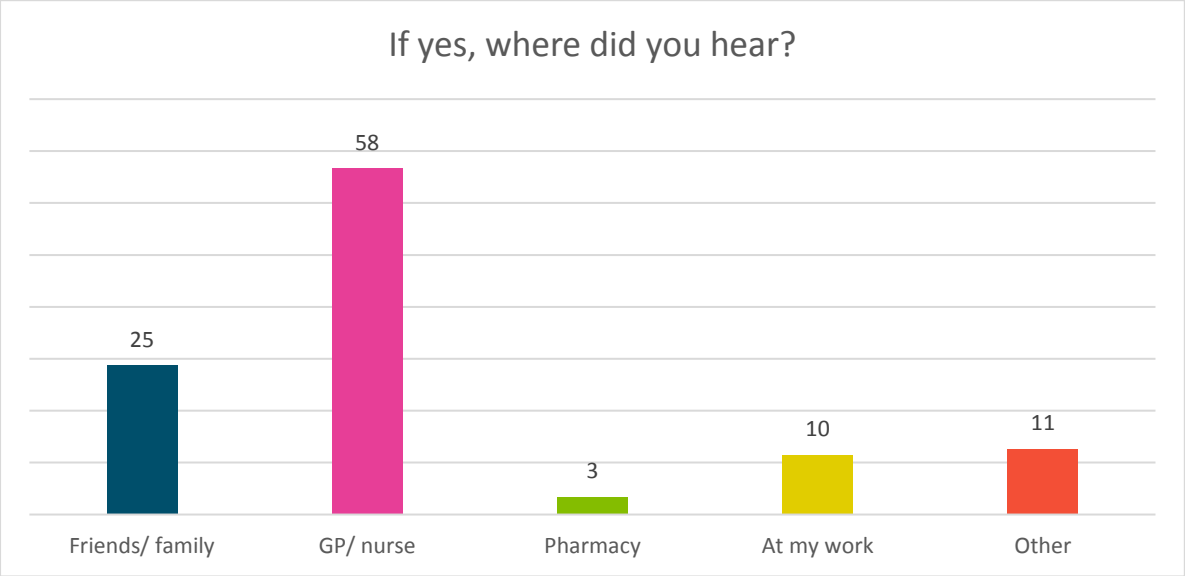


Question 12 asked men what 3 things they would change to make it easier for them to look after their health (see main text)

13. Have you heard of NHS Health Checks?

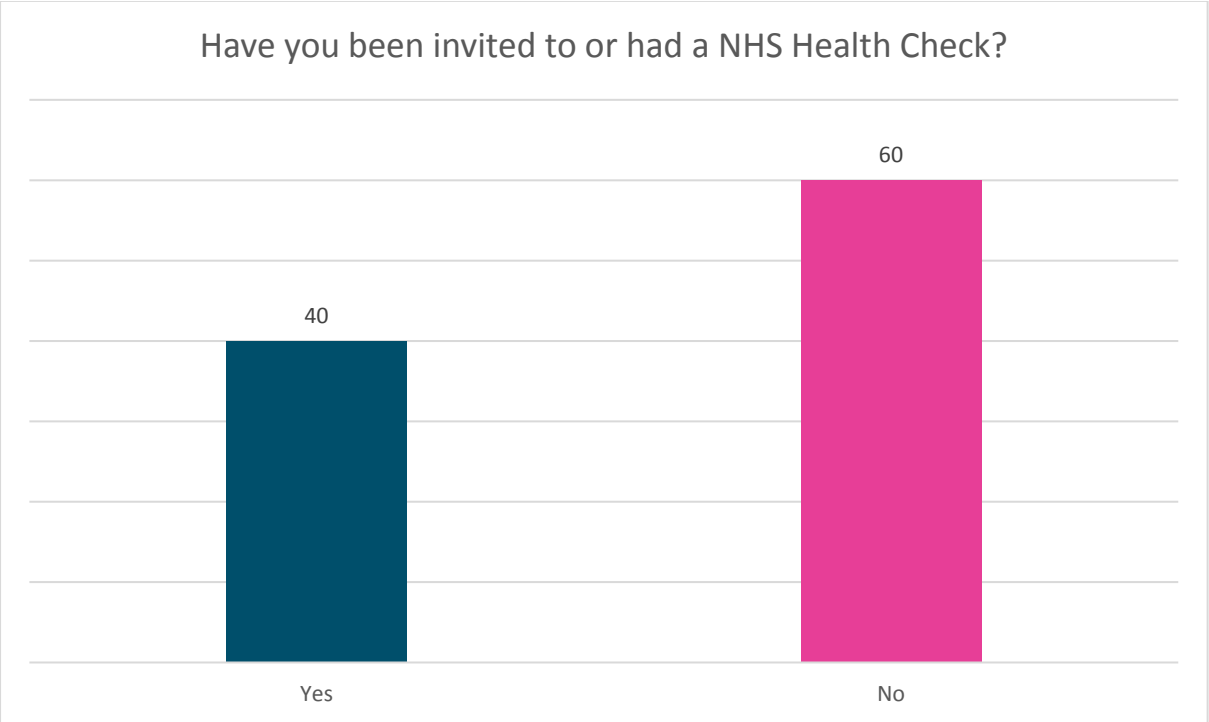


14. If yes, where did you hear?

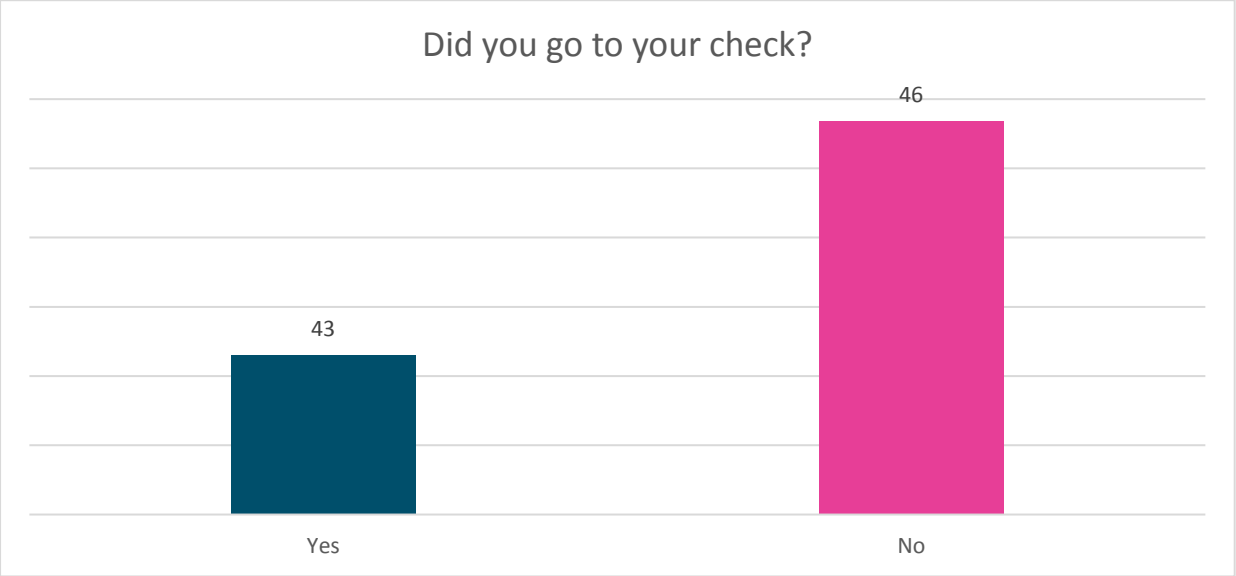


Questions 15-19 were aimed at men over 40 to respond to

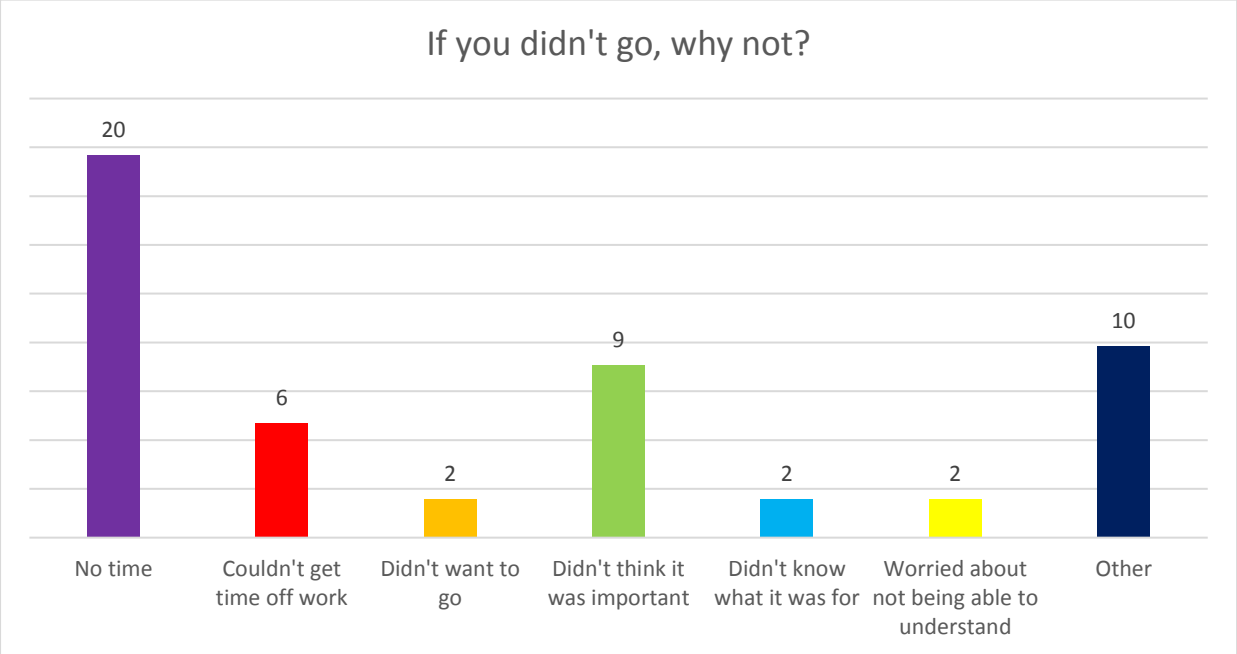
15. Have you been invited to or had an NHS Health Check?



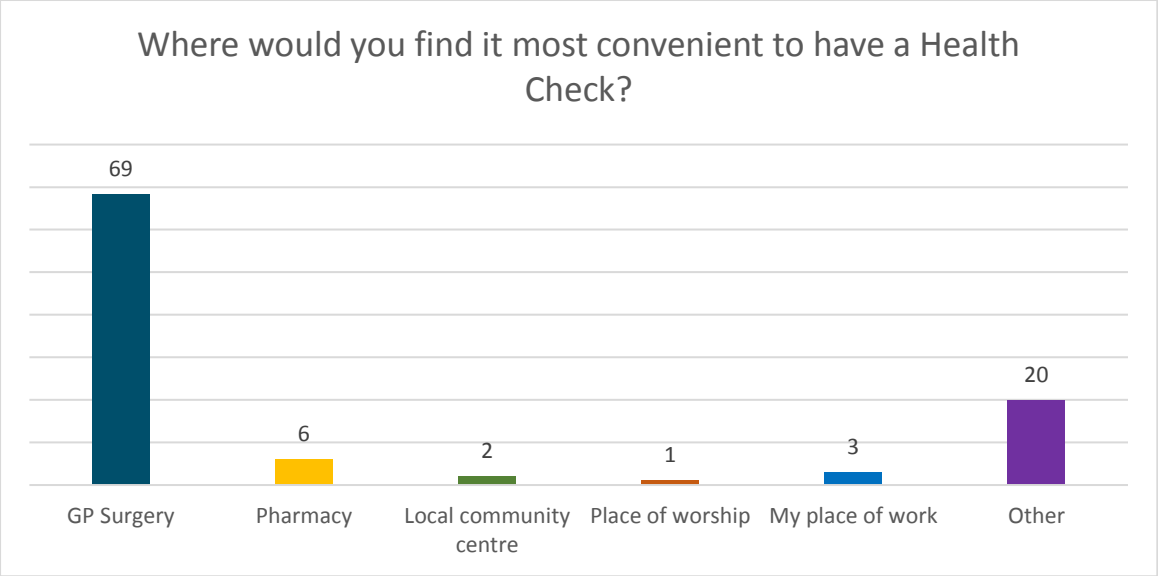
16. Did you go to your check?



17. If you didn’t go, why not?

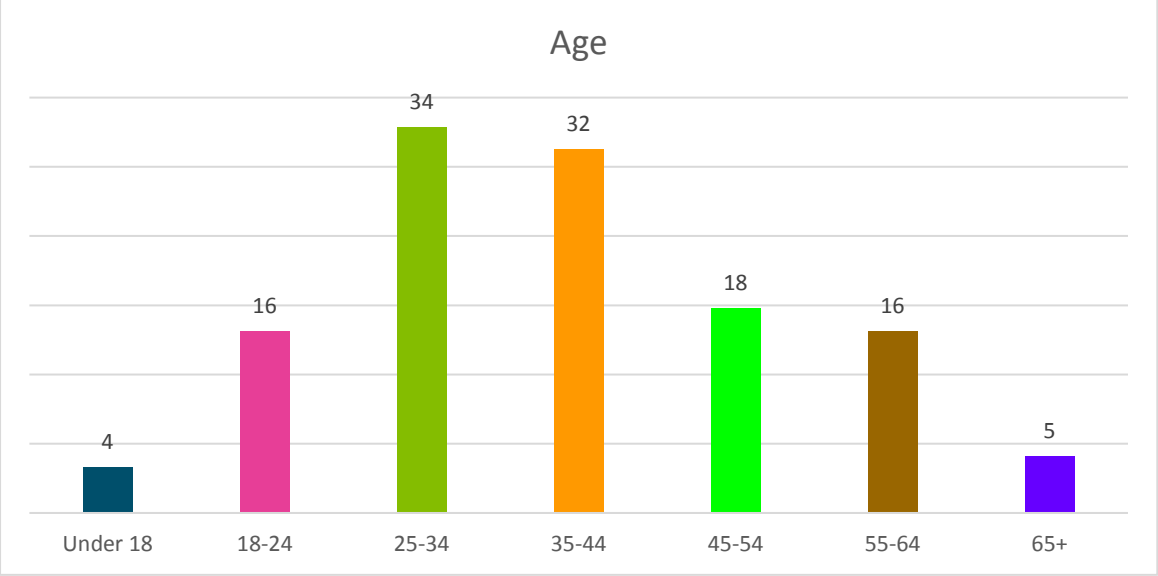


18. Where would you find it most convenient to have a Health Check?

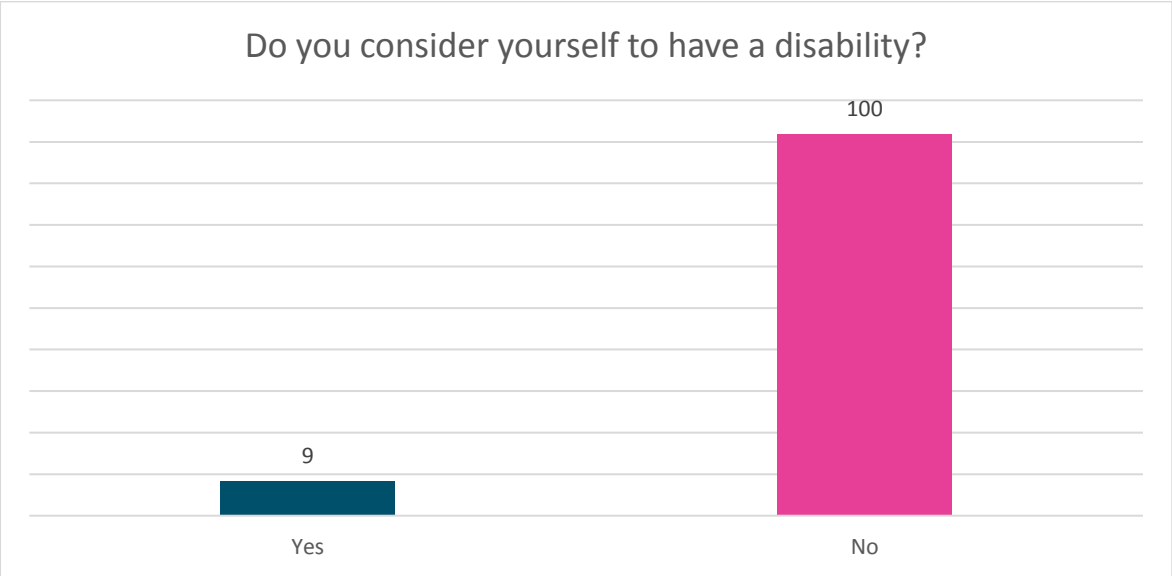


Question 19 asked men if they found the Health Check helpful (see main text)

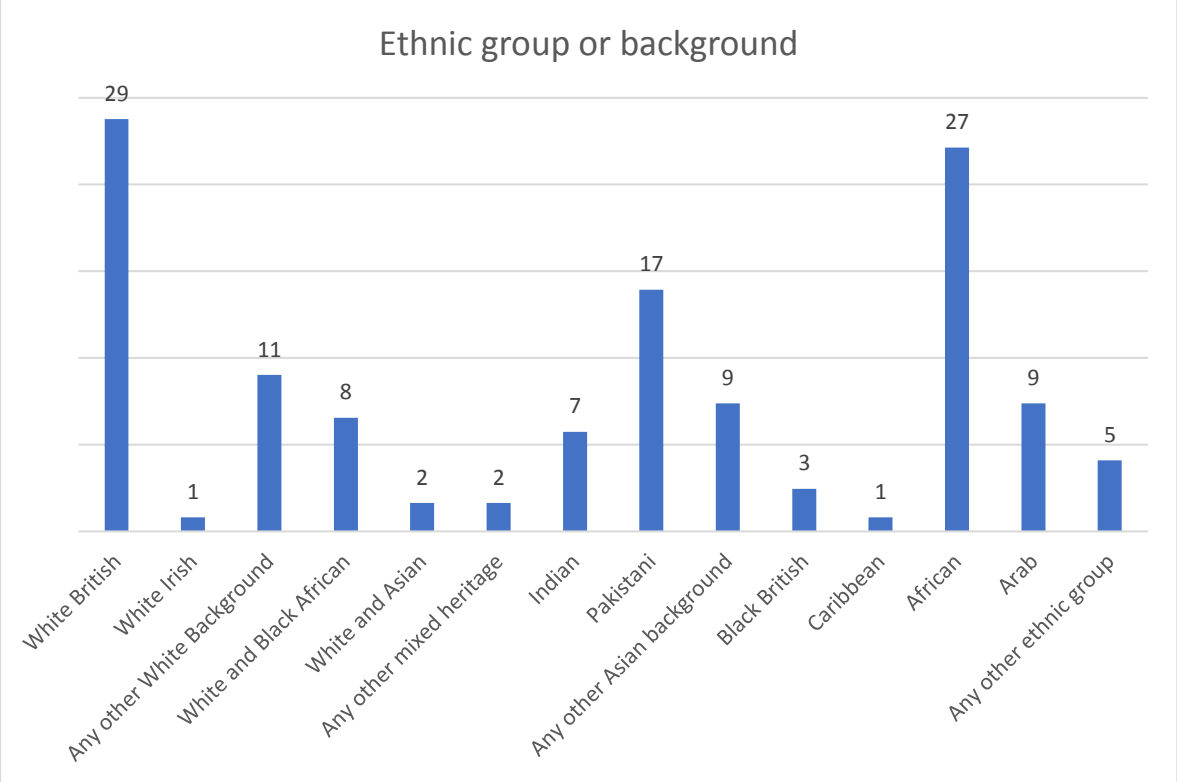
20. Your age?



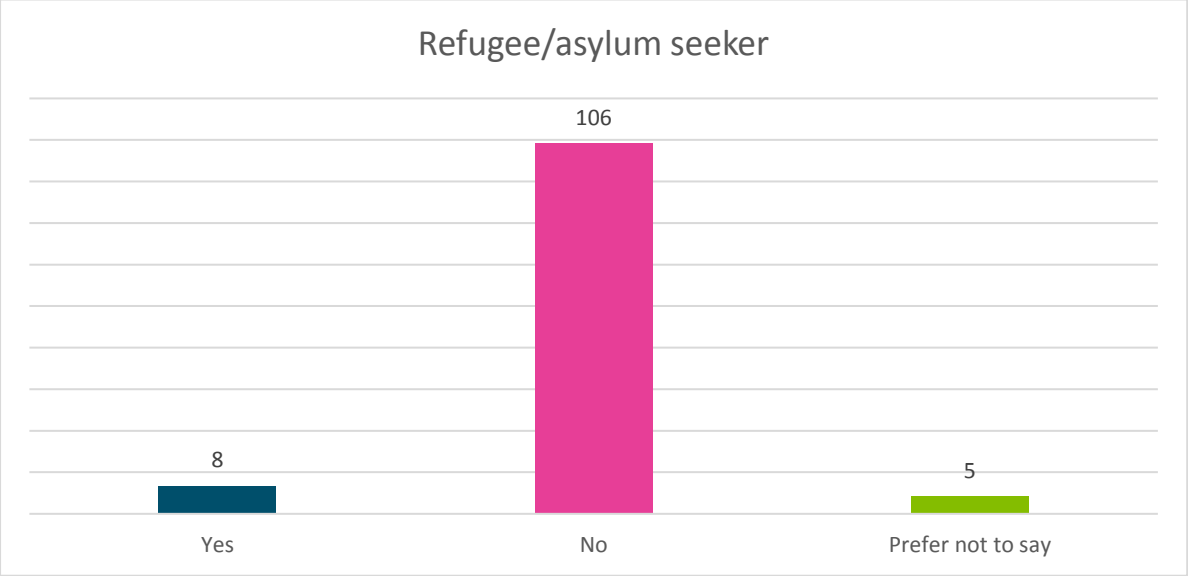
21. Do you consider yourself to have a disability?



22. Your ethnic group or background?



23. Are you a refugee/asylum seeker?



Acknowledgements

With thanks to all the men who took part in the survey and helped contribute to raising awareness of the importance of Men's Health in the city. Thanks too to all the employers and community leaders who supported the work. Thanks to the energy of East Oxford United Volunteers for making links and collecting the survey data. Hassan Sabrie and Nigel Carter for their work in imagining the project.

Photo credits: East Oxford United. Great Get Together 2018. Healthwatch Oxfordshire.

References

Butcher, F (2018) East Timorese Health Needs Assessment for Oxfordshire. Public Health Team, Oxfordshire County Council https://insight.oxfordshire.gov.uk/cms/system/files/documents/2018_East%20Timor%20HNA.pdf

Diabetes UK (2018). https://www.diabetes.org.uk

Diversity league http://diversityfootball.org/blog

East Oxford United https://www.facebook.com/EastOxfordUnited

Haynes. The Man Manual. https://www.menshealthforum.org.uk/man-manuals

Healthwatch Oxfordshire Project Fund 2018 https://healthwatchoxfordshire.co.uk/the-project-fund/

Hopkins, T., Rippon, S. (2015) Head, Hands and Heart: Asset-based Approaches in Healthcare. The Health Foundation.

Lipman, V (2014) NCIA Inquiry into the Future of Voluntary Services Working Paper 11. Inquiry into the Future of Voluntary Service Support for Black and Minority Ethnic Older People National Coalition for Independent Action. www.independentaction.net/wp-content/uploads/2014/07/BAME-paper-final.pdf

Marmot, M. (2010) Fair Society, Healthy Lives. The Marmot Review. University College London.

Men's Health Forum (2014). The Men's Health Manifesto. https://www.menshealthforum.org.uk/mens-health-manifesto

NHS. NHS Health Check https://healthcheck.nhs.uk/

NHS. NHS Health Check- case studies https://www.healthcheck.nhs.uk/commissioners_and_providers/evidence/case_studies/

Oxfordshire County Council (2018) Uptake of NHS Health Checks in Oxfordshire by ethnicity and gender/ deprivation and gender 2016-17. NHS Health Checks Programme-Equity Review. 2018.

Oxfordshire County Council (2017) Director of Public Health Annual Report for Oxfordshire. X. Johnathan McWilliam. https://www2.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/publichealth/2016-17DPHAnnualReportforHOSC.pdf

Oxford City Council. Oxford's Health https://www.oxford.gov.uk/info/20127/health/457/oxfords_health

Oxford Health Inequalities Commission (2016) Recommendation for Action on Health Inequalities in Oxfordshire. Oxford: Health Inequalities Commission http://www.oxfordshireccg.nhs.uk/key-occgpublications/oxfordshire-health-inequalities-commission-report/32180

Oxfordshire Joint Strategic Needs Assessment (2018) https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202018%20FINAL%20Apr18%20FULL.pdf

Oxford Mail. 18 June 2018. Eid Extravaganza event. http://www.oxfordmail.co.uk/news/16297366.PICTURES__Eid_extravaganza___39_is_a_celebration_for_everyone__39_/

Public Health England. Health Profile Oxford. 6 September 2016. https://insight.oxfordshire.gov.uk/cms/system/files/documents/Oxford%20PH%20profile%202016.pdf

Realpe, A., Wallace, L. (2010) What is Co-Production? The Health Foundation.

Sport England. Active Lives Adult Survey. May 2016-2017. Published October 2017. https://www.sportengland.org/media/12458/active-lives-adult-may-16-17-report.pdf

Sport England. Sports Participation and Ethnicity in England. National Survey 1999/2000. Headline Findings. https://www.sportengland.org/media/3513/sports-participation-and-ethnicity-in-england-headline-findings.pdf

This report is also available to read online at https://healthwatchoxfordshire.co.uk/the-project-fund-reports/

The research and production of the report was support through Healthwatch Oxfordshire's Project Fund 2018. The fund enables voluntary sector and self-help groups to gain funding to carry out small pieces of research with our support.

Health Improvement Board, 14th February 2019

Performance Dashboard

Introduction

At the meeting of the Health Improvement Board in November 2018 it was agreed that a 3-part Performance Framework would be drawn up to enable Board members to monitor progress on priority areas of work. This paper comprises that performance framework, setting out Outcome Measures and Process Measures for the priority areas of the Board. In addition, a surveillance dashboard has been included in the paper which gives an overview of some population health measures relevant to this work but which are not sensitive enough to be used for performance monitoring.

Recommendations

The members of the Health Improvement Board are requested to consider the proposed content of the performance framework in Tables 1 and 2 and

1. Agree the outcome and process measures to be reported at every meeting, in order to monitor progress on priority areas of work
2. Consider the proposal that Table 1 (Outcome measures) can be reported to the Health and Wellbeing Board at each of their meetings, as part of the reporting of the Joint Health and Wellbeing Strategy.
3. Comment on the content of the Surveillance Dashboard and suggest any amendments or additions.

Contents:

Performance Framework: Table 1. Health Improvement Board Outcome Measures

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

	Priority area and indicator	Oxfordshire Baseline and variation (with date)	Proposed target (by when)	Working Group and responsible organisation	Progress (with date of report)	Red / Amber / Green rating
A PREVENT						
1.1	**Physical inactivity** Active Lives Survey: Percentage of the population aged 19+ who are inactive (less than 30 mins / week moderate intensity activity)	<u>Active Lives Survey</u> 105,700 physically inactive people in Oxfordshire (May 2018) which is 19.1% of adult population of Oxfordshire (aged 19+)	An annual 0.5% reduction in inactivity across the county. Percentage of inactive people to be reduced to 18.6% by May 2019 And reduced to 18.1% by March 2020[1]	Active Oxfordshire working with all partners including Public Health and the CCG through a Physical Inactivity Task Force		
1.2		Variation • Cherwell 22.3% • Oxford City 16.3% • South Oxfordshire 18.2% • Vale of White Horse 17.4% • West Oxfordshire 22.3%	*"Stretch" target of reducing percentage of inactive people to 20% in Cherwell and 20% in West Oxon by 2020, (subject to discussion)*	Active Oxfordshire with local authorities, public Health and CCG		

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

2.1	**Smoking prevalence** Number of Smoking quitters per 100,000 adult population	Baseline is 2337 quitters / 100,000 population (2017/18)	Target is to increase this rate to more than 2337 / 100,000 by Mar 19	Tobacco Control Alliance		
2.2	Smoking in pregnancy: percentage smoking at time of delivery	Baseline is 8% women smoking at time of delivery.	Target is to reduce this by 0.5% to 7.5% by the end of 2018-19 then to 7% by the end of 2019-20	Public Health, County Council and Maternity Services		
3.1	**Housing and homelessness** Households in temporary accommodation	*Baselines to be reported and outcome targets to be tabled at the HIB meeting on 14th February.*	*Housing Support Advisory Group to advise on all baselines and outcomes for this section*	Housing Support Advisory Group District and County Councils		
3.2	Single homeless pathway and floating support clients departing services to take up independent living					
3.3	Rough sleeping					
3.4	Prevention Duty owed (threatened with homelessness)	Baseline - total number of cases where positive action was successful in preventing				

		homelessness. *tbc*				
3.5	Relief Duty Stage (already homeless)	Baseline -.total number of successful cases in relieving homelessness. *tbc*				
3.6	Total number of households eligible, homeless and in priority need but intentionally homeless	*Baseline tbc*				
4.1	**Immunisations** Measles, Mumps and Rubella dose 1	Baseline 93.5% (Q1 18-19)	95%	Public Health, Health Protection Forum. NHS England		
4.2	Measles, Mumps and Rubella dose 2	Baseline 90.1% (Q1 18-19)	95%			
4.3	Flu immunisation for at risk groups under 65 yrs	Baseline 52.4% (2017-18)	55%			
4.4	Flu immunisations for 65+	Baseline 75.6% (2017-18)	75%			
B REDUCE						
5.1	**Childhood Obesity** Children overweight or obese in Reception	Baseline: In Reception year 7% children were obese (2017-18)	Maintain at 7%	Whole System approach to obesity Working Group		

				Public Health, County Council		
5.2	Children overweight or obese in year 6	Baseline: In Year 6, 16.8% children were obese (2017-18) **Variation in Year 6 pupils:** Cherwell 18.8%; Oxford 21.3%; South Oxfordshire 12.9%; Vale of White Horse 16%; West Oxfordshire 14.7%	Target to reduce to 16% *Aim to reduce variation across the county. Details tbc*			
6.1	**NHS Health Checks** NHS Health Checks invite % (over 5 Years)	Baseline 98.8% in 2017/18	Achieve at least 97% eligible population invited by the end of 2018/19[2] Target for 19-20 tbc	Public Health, County Council		
6.2	NHS Health Checks uptake % (over 5 years)	Baseline 50.2% in 2017/18	Achieve 50.5% uptake by the end of 2018/19 Target for 19-20 tbc			
7.1	**Cancer screening**			Clinical Commissioning		

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

	Percentage of those sent bowel screening packs who will complete and return them (aged 60-74 years)	Baseline 56% (Q3, 2017-18)	National Target 60%	Group NHS England		
7.2	Cervical Screening - percentage of the eligible population (women aged 25-64) screened in the last 3.5/5.5 years	Baseline 68.2% (Q4, 2017-18)	National Target 80%			
7.3	Breast screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	Baseline 74.1% (Q4, 2017-18)	National Target 80%			

Performance Framework Table 2. Health Improvement Board Process measures

A. Prevent

8. Whole Systems Approach to Obesity

	Action	Milestones	Expected date of completion	Delivered by	Progress (to be completed for each report to HIB)
8.1	Embed the Whole Systems Approach to Obesity in Oxfordshire	1. Review the National guidance appropriate to Oxon and the NHS Long Term Plan 2. Present recommendations to stakeholders	June 2019 (following publication of guidance)	Public Health, Oxfordshire County Council	
8.2	Identify and engage stakeholders	Hold a range of participatory events	September 2019		
8.3	Establish a working group	Group identified and convened	Oct 2019		
8.4	Develop a joint action plan	Action plan with an outcome framework completed	Dec 2019	All partners	

9. Making Every Contact Count (MECC)

	Action	Milestones	Expected date of completion	Delivered by	Progress (to be completed for each report to HIB)

9.1	Transformation of Oxfordshire MECC Systems Implementation Group	• Transition from existing monthly Task and Finish group to on-going group with bi-monthly facilitated meetings • Representation from statutory and non-statutory organisations • Updated Terms of Reference agreed by group	February 2019 April 2019	All partners in Oxfordshire MECC Systems Implementation Group (Chaired and facilitated by Oxfordshire County Council and Oxfordshire Clinical Commissioning Group)	
9.2	Engagement with local/regional MECC networks to contribute updates and share learning	Participation in: • Bucks, Oxon and Berkshire STP[3] MECC overview group • PHE MECC Network	Quarterly meetings Bi-annual meetings	Oxfordshire County Council Public Health and STP Prevention Lead	
9.3	Promoting MECC approach and training within stakeholder organisations	Partners/stakeholders contributing updates to wider teams within their organisation e.g. briefings, team meetings, intranet, social media etc)	On-going	All partners in Oxfordshire MECC Systems Implementation Group	
9.4	Support BOB STP with the development and implementation of the MECC digital App	• Prototype app introduced to new trainers – scoping of required functions • Testing phase • Implementation phase • Monitoring and improvements to App	On-going	Oxfordshire MECC Systems Implementation Group	
9.5	Supporting BOB STP with IAPT training model test bed and Train the	• IAPT staff training (3 cohorts)	Cohort 1 training completion	Oxfordshire MECC Systems Implementation Group	

[3] STP – Sustainability and Transformation Partnership

	Trainer model	• Contribute to action plan for roll out of training	January 2019. Cohort 2&3 TBC March 2019		
9.6	Test/shadow BOB STP MECC Metrics	• Support the development of BOB wide MECC metrics (to include Leadership, Outputs and Outcomes) • Test and feedback on metrics • Review feasibility of adopting MECC metrics as HIB metrics for 2020/21	May 2019 December 2019 January 2020	Oxfordshire MECC Systems Implementation Group	

10. Mental Wellbeing

	Action	**Milestones**	**Expected date of completion**	**Delivered by**	**Progress (to be completed for each report to HIB)**
10.1	Sign Mental Wellbeing Prevention Concordat	• Submit application • Share outcome with partners	March 19 June 19	Public Health, Oxfordshire County Council	
10.2	Establish a working group for mental wellbeing	Group identified and convened	July 2019		
10.3	Identify wider stakeholders	Wider stakeholders engaged	September 2019	Working Group	
10.4	Develop Mental wellbeing framework	Framework developed Action plan with an outcome framework completed	March 2020	Working Group	
10.5	Suicide Prevention Multi-	Convene meeting twice a year	May &	Public Health,	

	Agency Group active		December 2019	Oxfordshire County Council	

B Reduce

11. Diabetes Transformation

	Action	Milestones	Expected date of completion	Delivered by	Progress (to be completed for each report to HIB)
11.1	National Diabetes prevention programme	• Increase uptake from baseline	March 2020	Oxfordshire GPs and NDPP Provider	
11.2	NICE treatment target achievement	• Increase percentage of patients achieving all three NICE treatment targets (HbA1c $\leq$ 58, BP $\leq$ 140/80, Chol < 5.0) from baseline	March 2020	Oxfordshire GPs, Acute and Community Diabetes Specialists	
11.3	Attendance at diabetes structured education	• Increase uptake from baseline	March 2020	Oxfordshire GPs, Acute and Community Diabetes Specialists	
11.4	Completion of the 8 care processes	• Increase percentage of patients with 8 care processes completed from baseline	March 2020	Oxfordshire GPs and Acute Diabetes Specialists	

12. Domestic Abuse ***(NB*** *these measures may change as they are to be finalised by the Domestic Abuse Strategy Group on 13.2.19. There will be an update at the HIB meeting on 14.2.19)*

	Action	Milestones	Expected date of completion	Delivered by	Progress (to be completed for each report to HIB)
12.1	Specialist services are in place to respond expertly and effectively to the needs of all people in Oxfordshire affected by domestic abuse.	• Disseminate learning from Black Asian Minority Ethnic & Refugee (BAMER) Project • Improve support for Children & Young People affected by domestic abuse • Continue to develop learning for those with complex needs domestic abuse or / Violence Against Women & Girls • Deliver on dispersed accommodation model	2019/20 2020-21 2020-21 2019-20	BAMER Strategic Lead Strategic Board for Domestic Abuse Oxfordshire Domestic Abuse service Oxfordshire Domestic Abuse Service	
12.2	Wherever possible victims and their children are supported to remain in their own home, and to sustain existing access to service (e.g. schools, work) and support networks.	• Develop countywide understanding of sanctuary provision • Refuge and dispersed accommodation well targeted	2020-21 2020-21	Strategic Board for Domestic Abuse Oxfordshire County Council Contracts Team	
12.3	Our workforces and communities are educated, informed and skilled to enable them to safely and proactively recognise and respond to people before, during and	• Multi-agency domestic abuse training • Appraise core agencies understanding of VAWG • Young People & Domestic	2019-onwards 2020-21 2019-onwards	Strategic Lead for Domestic Abuse Violence Against Women & Girls Co-ordinator Strategic Lead for Domestic Abuse	

	after experiencing abuse.	Abuse training • Communication and information strategy is developed.	2019-20	Strategic Board for Domestic Abuse	
12.4	We promote healthy, nurturing and safe relationships for children and young people living in Oxfordshire and are committed to ensuring older people and adults with disabilities are safe from abusive relationships.	• Peer audit of Domestic Abuse Pathway for Young People • Peer audit safeguarding adults and DA	2019-20 2020-21	Strategic Board for Domestic Abuse Strategic Board for Domestic Abuse	
12.5	Services with skilled and knowledgeable professionals are in place to support perpetrators to reduce offending and end abusive behaviours.	• Learning outcomes from PRP • Address gaps for young people causing harm within their relationships.	2019-20 2020-21	Strategic Board for Domestic Abuse Strategic Board for Domestic Abuse	
12.6	A multi-agency and service user focused approach is taken to learning and reviewing our joint and individual efforts to tackle domestic abuse with robust structures in place to oversee and implement change.	• Analyse and disseminate domestic Homicide review learning • Service user voice in operational and strategic decision making • Analyse and disseminate Multi-agency Risk Assessment Conference (MARAC) review data (ie review of data from high risk domestic abuse victim management processes)	2019-20 Ongoing 2019 onwards	Strategic Board for Domestic Abuse Strategic Lead for Domestic Abuse Strategic Board for Domestic Abuse	

		• Multi-agency Tasking and Co-ordination (MATAC) learning reviewed / disseminated (ie review of data from perpetrator management processes)	2020-21	Strategic Board for Domestic Abuse	

C Healthy Place Shaping and Healthy Communities

13. Healthy Place Shaping

	Action	Milestones	Expected date of completion	Delivered by	Progress (to be completed for each report to HIB)
13.1	Co-design and delivery of place based activities with local stakeholders	Examples of partnership working with evidence that stakeholder feedback has influenced the design and delivery of activities		Healthy Place Shaping Delivery Group – six monthly reports	
13.2	Healthy place shaping activities are delivering collectively agreed objectives and outcomes	Clearly defined programme aims and objectives agreed with local stakeholders and regularly reviewed with them			
13.3	Healthy place shaping is acting as a system connector	Examples of how activities involve more than one work stream with evidence of how stakeholders from different sectors are being connected by healthy place shaping initiatives			
13.4	Learning is used as a mechanism to continuously improve	Evidence that learning has been used as a feedback loop to drive adaptation of the programme and to improve the system.			

13.5	Activities increase the connectivity between local stakeholders	Evidence that time has been spent in building positive, trusting relationships			
13.6	Investment seeks to increase the capacity of the system	Evidence that funding has been used to give capacity for parts of the system to work collaboratively towards shared outcomes			
13.7	Healthy place shaping is encouraging resident engagement in activities that promote health, wellbeing and social cohesion	Evidence of resident engagement and participation in community activities which promote health and wellbeing and social cohesion			
13.8	The built environment is enabling healthy living	Annual audit of developments of 100 or more new homes to assess if they support healthy place shaping			

14. Social prescribing

	Action	**Milestones**	**Expected date of completion**	**Delivered by**	**Progress (to be completed for each report to HIB)**
14.1	Oxford City: Practice Care Navigators	• Develop measurable outcomes. • Install 'Elemental' social prescribing platform to track the patient journey	April 2019 June 2019	OxFed, Commissioned by CCG	
14.2	Cherwell & West Oxfordshire District: 'Community Connect' (Community Navigators)	• GP Practices identified and targeted for each phase of the scheme roll out. • Practices in areas of inequality identified and targeted	Nov 2019 June 2019	Citizen's Advice-North Oxfordshire and West Oxfordshire.	
14.3	South East Locality:	• All 10 Practices know the	April 2019	Age UK Oxfordshire	

	Community Navigators	Community Navigators and their role and proactively refer patients. • Proactive referrals made from the hospital discharge team to the Community Navigators	April 2019	1 year contract Dec 2018- 2019	

15. **Campaigns – process indicators to be discussed**

Table 3 Health Improvement Board Surveillance Dashboard

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

Additional reports can be brought to the Board on request.

1. Life expectancy

Indicator	Period	Oxon			Region	England	
		Recent Trend	Count	Value	Value	Value	Worst
0.1i - Healthy life expectancy at birth (Male)	2014 - 16	–	-	67.1	66.1	63.3	54.3
0.1i - Healthy life expectancy at birth (Female)	2014 - 16	–	-	68.5	66.3	63.9	54.6
0.1ii - Life expectancy at birth (Male)	2014 - 16	–	-	81.4	80.6	79.5	74.2
0.1ii - Life expectancy at birth (Female)	2014 - 16	–	-	84.6	84.0	83.1	79.4
0.1ii - Life expectancy at 65 (Male)	2014 - 16	–	-	19.7	19.3	18.8	15.8
0.1ii - Life expectancy at 65 (Female)	2014 - 16	–	-	21.9	21.7	21.1	18.7

2. Variation in Life Expectancy

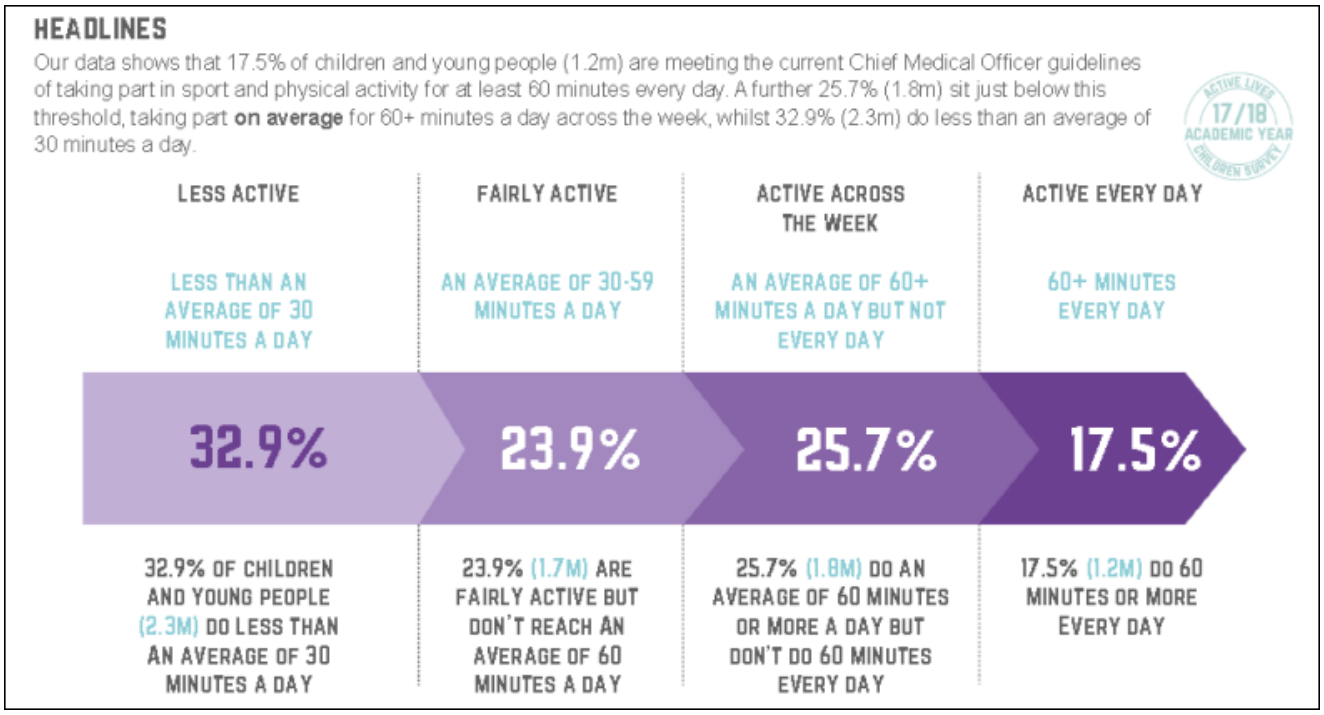
- Life expectancy by ward data for Oxford shows a significant increase in **male life expectancy** in the more affluent North ward and no change in male life expectancy in the more deprived ward of Northfield Brook. The gap in male life expectancy between these two wards has increased from 4 years in 2003-07 to 15 years in 2011-15.
- **Female life expectancy** in these wards has remained at similar levels with a gap of just over 10 years.

3. Disability Free Life Expectancy

This is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply.

- Data for the combined years 2009 to 2013 shows that for males there was a 10-year gap between the most and least deprived areas for Disability Free Life Expectancy.
- For females, the gap was just under 10 years.

4. Young People Physical Activity



5. Adult obesity, physical activity and diabetes

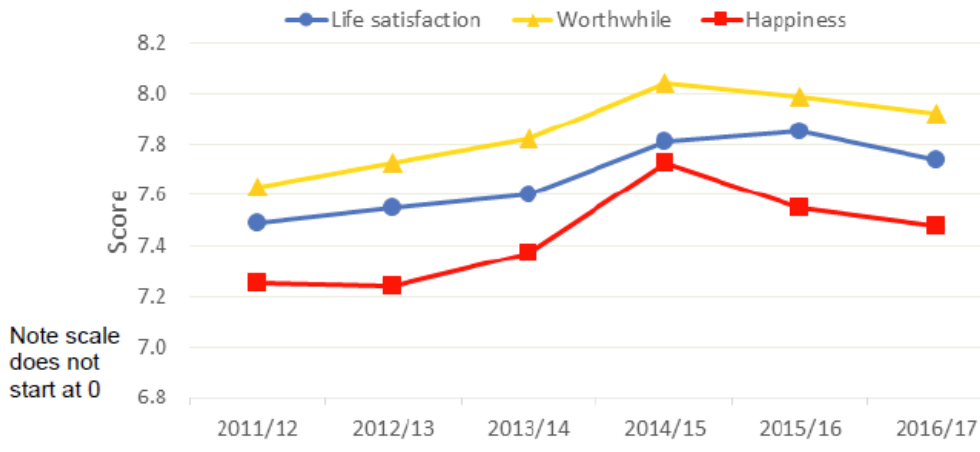
Indicator	Period	England	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
Percentage of physically active adults - current method	2016/17	66.0	70.1	64.8	74.0	67.1	73.1	71.9
Percentage of physically inactive adults - current method	2016/17	22.2	18.6	18.9	17.6	21.9	16.3	18.2
2.17 - Estimated diabetes diagnosis rate	2017	77.1	67.8	72.6	69.0	63.9	67.7	67.2

6. Premature mortality

Indicator	Period		England	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2015 - 17		101.3	71.9	78.8	88.1	61.7	66.1	67.4
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2015 - 17		45.2	32.0	35.4	47.6	25.6	30.0	25.5
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2015 - 17		45.9	31.6	38.1	39.9	24.7	29.4	27.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2015 - 17		69.2	48.6	58.4	54.6	40.9	45.1	44.1
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2015 - 17		23.9	15.6	18.5	26.0	9.7	14.4	12.7

7. Mental Wellbeing

Figure 56 Trend in average wellbeing scores in Oxfordshire for (a) life satisfaction, (b) things you do that are worthwhile and (c) happiness



Source: Office for National Statistics Personal Wellbeing released Nov17

8. **Loneliness** – data will be included here using the proposed indicators of loneliness for adults aged 16 years and over (Office of National Statistics) which are:

- How often do you feel that you lack companionship?
- How often do you feel left out?

- How often do you feel isolated from others?

Response categories: "Hardly ever or never", “Some of the time” or “Often”.

For children (aged 10 to 15 years), a modified version of the UCLA scale is proposed, using the following questions:

- How often do you feel you have no one to talk to?
- How often do you feel left out?
- How often do you feel alone?

Response categories: "Hardly ever or never", “Some of the time” or “Often”.

9. Alcohol related hospital admissions

Indicator	Period	England	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons)	2016/17	2185	1684	1826	2214	1426	1455	1618
9.01 - Admission episodes for alcohol-related conditions (Broad) (Male)	2016/17	3001	2284	2476	3050	1932	1948	2173
9.01 - Admission episodes for alcohol-related conditions (Broad) (Female)	2016/17	1485	1166	1257	1481	1007	1032	1146

10. Fuel Poverty

Using the Low Income High Costs (LIHC) indicator, a household is considered to be fuel poor if:

a. they have required fuel costs that are above average (the national median level).
b. were they to spend that amount, they would be left with a residual income below the official poverty line

Latest JSNA data for Oxfordshire shows:

- Between 2014 and 2015, an additional 1,600 households in Oxfordshire were classed as being “fuel poor” taking the total to 25,915 households in fuel poverty in the county. There was an increase in the proportion of households defined as “fuel poor” in each district of Oxfordshire
- Oxford is one of 9 (out of 67) local authority districts in the South East to be significantly worse than the national average on fuel poverty (2015).
- The greatest increase in the estimated number of fuel poor households was in Cherwell (+13%), similar to the regional average (13%)

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Progress report on the progress of the PHE Better Mental Health Prevention Concordat to the January 2019 Health Improvement Board

The Context

The Health Improvement Board (HIB) agreed in May 2018 for mental wellbeing to be a priority for Oxfordshire, after noting the results of the HIB Mental Health workshop in March 2018. This workshop was primarily focussed on services and offers to those with existing mental health conditions. Most attendees of the workshop were statutory, public sector organisations, representing the services they provided. There were some Voluntary and Community Sector representatives. It was a useful exercise to identify Mental Health service provision activity for those that attended the workshop. The recommendation was to develop and Oxfordshire Mental Wellbeing Framework.

The Prevention Concordat for Better Mental Health and the associated guidance was published by Public Health England (PHE) in August 2017.[1] The concordat aims to galvanise local cross-sector action to support the prevention of mental health problems and the promotion of good mental health across the whole system. It is structured to guide effective prevention and planning arrangements which could be achieved locally.

The consensus statements (Appendix 1) of the Prevention Concordat for Better Mental Health describe the shared commitment of partner organisations to work together via the Concordat to prevent mental health problems and promote good mental health.

The Concordat is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across:

- local authorities
- the NHS
- public, private and voluntary, community and social enterprise (VCSE) sector organisations
- educational settings
- employers

The recommendation was made to and agreed by HIB in May 2018 for Oxfordshire to sign up to the PHE Prevention Concordat for Better Mental Health.

In November 2018 the Health and Wellbeing Board (HWB) received a paper requesting sign-off of the Health Improvement Board's ambition to sign up to the Public Health England's Better Mental Health Prevention Concordat. This was approved by the HWB.

[1] https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-planning-resource

The completion of the application form has been led by Oxfordshire County Council, based on the information gathered in the March 18 workshop and subsequently commented on by key partners.

The application for the Prevention Concordat has two key sections:

1. A summary of what is currently being done at a strategic level and
2. A plan of what will be achieved over the next 12 months. The plan includes two commitments, one for the creation and adoption of an Oxfordshire Mental Wellbeing Framework and the second to generate some local publicity about the sign up to the PHE Better Mental Health Prevention Concordat.

This completed form can be found in Appendix 2.

Each member organisation of the Health and Wellbeing Board is arranging sign-off for the form by the 27th February 2019, in order to send the form, to be signed by Cllr Ian Hudspeth, to PHE for the 1st March 2019.

A provisional project plan has been drawn up by Oxfordshire County Council for the creation of the Oxfordshire Mental Wellbeing Framework, with a view to it being completed by the Winter of 2019, for sign off by the HIB at the next appropriate meeting. The HIB can then monitor the delivery of Framework through to March 2020.

Next Steps

PHE will announce the third wave of signatories to the PHE Better Mental Health Prevention Concordat and provide comment on the application in April 2019. It is anticipated some of these comments will be incorporated into the Framework, whilst others will be reported back to the Health Improvement Board to consider. It is expected that the signatories will support publicity around this announcement.

The creation of the Oxfordshire Mental Wellbeing Framework will be a collaborative piece of work by the respective signatories to the Concordat. The plan is to establish a task and finish group between the Spring and Summer of 2019. Staff time will need to be made available by the partner organisations between March 2019 to Winter 2020 to attend planning meetings, provide expert information and advice on appropriate actions, timescales and outcome measures.

The group will explore the best way to include other partner organisations in creating the Framework. Current thinking includes conducting a survey, available online and in paper format. A list of potential contacts is being drawn up and is included in Appendix 3. The intention is to include a broad cross section of individuals, organisations and interests, particularly the Voluntary, Community and Social Enterprise (VCSE) and residents with lived experience. The board is asked to pass on relevant contact details be added to the list.

Once the Framework is developed the Health Improvement Board will be asked to approve it by March 2020. The agreed actions will then be implemented across the

range of organisations who have signed up. There will be the option for other organisations to agree to adopt the Framework.

Recommendations

1. Each organisation on the Health Improvement Board is asked to identify appropriate officers who can be involved in the creation of the Oxfordshire Mental Wellbeing Framework.

2. Communications Teams from organisations signing up to the Concordat will be asked to work together to announce the result of the sign up.

Kate Eveleigh – Health Improvement Practitioner, Oxfordshire County Council.
Kate.eveleigh@oxfordshire.gov.uk

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Appendix 1

Prevention Concordat for Better Mental Health: information required from signatories to the Consensus Statement

We are delighted that you are interested in becoming a signatory to the Prevention Concordat for Better Mental Health Consensus Statement. You will be joining a number of organisations who have committed to working together to prevent mental health problems and promote good mental health through local and national action.

The Prevention Concordat registration process

Step 1. Complete the local Prevention Concordat action plan template below (Attach any supporting documents that you may want to share**)**

Step 2. Senior leader/CEO of organisation to commit and sign up to approved action plan

Step 3 e-mail your submission to publicmentalhealth@phe.gov.uk

Step 4. Confirmation of receipt

Step 5. A panel will review and approve action plans submitted within one month of submission date;

- wave 3 –Friday 14th December 2018
- wave 4 – Friday 1st March 2019

NB: the team are currently reviewing the process for approving action plans and intend to have a digital process set up moving forward. Please see below.

Registration form

Please answer the questions below:

Lead contact name	Kate Eveleigh
Lead contact details	Email:Kate.eveleigh@oxfordshire.gov.uk Telephone number: 07785453265
Job title of lead officer	Health Improvement Practitioner
Name of organisation / partnership	Oxfordshire County Council/Oxfordshire Health and Wellbeing Board/Partnership
Who are you representing? *(e.g. Individual organisation, collaboration, partnership,*	Partnership – Oxfordshire Health and Wellbeing Board,which includes Oxfordshire County Council Oxfordshire Clinical Commissioning Group

Local Authority, Clinical Commissioning Group, community group and other, please name)	Healthwatch Oxfordshire Oxford Health NHS Foundation Trust Oxford University Hospitals NHS Foundation Trust Oxford City Council Cherwell District Council South Oxfordshire District Council West Oxfordshire District Council Vale of the White Horse District Council
Please tell us more about your organisation's work (no more than 150 words)	Oxfordshire has a population of 683,200, is spread across 5 District Councils and one Clinical Commissioning Group. Two NHS Trusts operate in the area. The principles of the Health and Wellbeing board are as follows 1. Have a broad and long-term ambition to deliver measurable health and wellbeing outcomes which can be sustained within and between our organisations 2. Mobilise all the resources available for Oxfordshire, planning for the best use of the "Oxfordshire pound" and working in partnership with residents to enable them to exercise their responsibility for health and wellbeing. 3. Keep governance simple, with clear lines of accountability, transparent decision making and accessible information; 4. Strive for system- wide continuous quality improvement, developing mutual trust, honesty and shared understanding of each other's pressures and ambitions 5. Be innovative; be pro-active rather than reactive and look outside our system to learn from others about what could be done better. 6. Ensure our shared vision and values are known and aligned at all levels of our system; Communicate regularly with our system colleagues and stakeholders
What are you currently doing that promotes better mental health?	**Leadership and Direction** The Joint Health and Wellbeing Strategy for Oxfordshire includes mental health in its priorities and identifies the role of the wider determinants of health such as employment and housing. Three of the partners on the Health and Wellbeing board (HWB) are signed up to 'Time to Change' which is .., (Oxfordshire County Council, including Fire and Rescue, Oxford City Council and Oxford Health NHS Foundation Trust). The board papers endorsed by the Health and Wellbeing Board and its sub board the Health Improvement Board provide a vision for the wellbeing approach to better

mental health.

The Health Improvement Board monitors three mental wellbeing indicators and has also undertaken to review local activity and interventions that support positive mental wellbeing.

This work was informed by a workshop held in March 2018. Attached is a summary of activities for those who attended the workshop.

Mental wellbeing workshop - discussi

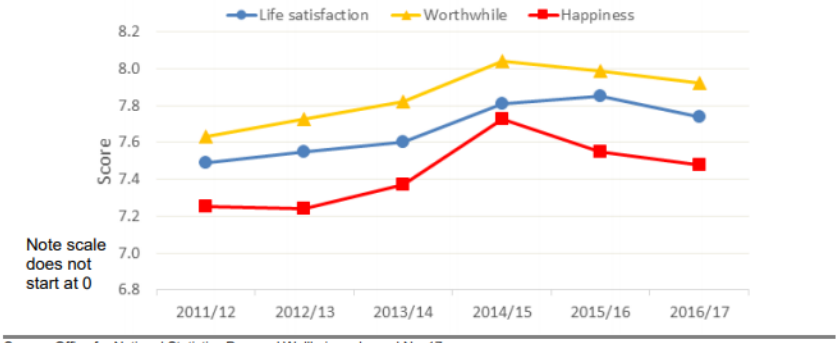
The Oxfordshire Children's and Young Peoples Plan 2018-2021, which involved children and young people in its creation, includes a priority around "Happy and Healthy" which identifies prevention and wellbeing. The Plan informs the work of the Children's Trust which is a partnership of 12 organisations. Work of the Children's Trust includes social and emotional wellbeing and mental health as one of its three priorities.

Understanding local need and assets

Oxfordshire has completed local authority led Joint Strategic Needs Assessment with a mental health prevention focus.

In Oxfordshire, the chosen indicators "feeling worthwhile, happiness and life satisfaction" scores are slightly lower in 2016-17 compared with 2015-16 and the anxiety score is higher.

Figure 15 Trend in average wellbeing scores in Oxfordshire for (a) life satisfaction, (b) things you do that are worthwhile and (c) happiness



Source: Office for National Statistics Personal Wellbeing released Nov17

[22] ONS Personal well-being in the UK: April 2016 to March 2017

In 2016-17 there were around 56,800 GP registered patients with depression, 9.7% of patients. The rate has been above the English average for the past 5 years.

During 2015-16 the number of emergency admissions for

	intentional self-harm in Oxfordshire was 1,373, this was similar to the number recorded in 2014-15 (1,387). There were 15 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2011-12 to 2015-16). Between 2014 and 2016, there was a total of 156 deaths registered as suicides in Oxfordshire. The rate of suicides was not significantly different to England. Through the Oxfordshire Mental Health partnership there is collaborative analysis of local information and intelligence sharing. Healthwatch Oxfordshire regularly gains feedback and information from members of the public across Oxfordshire. For example gathering views via targeted and geographical research, web based feedback on specific services, and participative community based inquiry. This includes people's views of mental wellbeing, underlying factors, and use of mental health and other services. The Oxfordshire County Council Public Health team leads on real time surveillance of suicide data and provides post-vention support. Exploration of capturing data on suicide attempts and serious self-harm is also underway to add further insight into where and how prevention should be targeted. There is engagement with communities to gain insight into their needs and assets. Currently the OCCG are leading on a consultation into developing the Older Peoples strategy. Young people are engaged through the Children in Care Council and Voice of Oxfordshire's Youth. People with lived experience of suicide are represented on the suicide prevention multi-agency group, following involvement with a workshop run on behalf of the National Suicide Prevention Alliance (NSPA). **Working Together** The Health and Wellbeing Board works across, Districts and City Council, the County Council, the Clinical Commissioning Group, HealthWatch Oxfordshire and local NHS trusts. The Oxfordshire Mental Health Partnership has six partners made up of local mental health charities and the local mental health NHS Trust. There is a local multi-agency group for suicide prevention which is coordinated by the County Council and includes representatives from the mental health partnerships, CCG, Coroner's, criminal justice, transport, third sector support services, employer unions The HIB also oversees the work of the Joint Management

	Group for Adults, which includes working with pooled budgets, for those adults with mental health needs. Schools can engage with Mental Health and Wellbeing in Schools network, whose aim is to provide formal and informal professional development for all school staff and governors, as well as building up a network of people who can collaborate across the area sharing best practice and ideas. The Perinatal Mental Health group is represented with a range of professionals and organizations and also includes a representative for people with lived experience. **Taking Action** GPs and Schools have received Mental Health First Aid training and some of the partners provide the training to their staff. The mental health partnership have offered and delivered Psychological Perspectives in Education and Primary (PPEP) care to colleagues across the County. Some GPs practices have received post-vention training following a suicide of a patient, and Connect 5 training has been delivered by TVP in collaboration with Papyrus to a range of front line workers in the South of Oxfordshire. The health and wellbeing boards (HWB) priority "Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential" has outcomes listed and is monitored by the Health Improvement Board. The HWB strategy identifies that resources have been pooled for mental health. The Oxfordshire Mental Health partnership pools its resources, financial, knowledge and skill based. As employers the partnership organisations have employment support which includes free counselling and mental health support. Many run awareness campaigns internally, as well awareness campaigns externally about dementia. There are local community based opportunities to engage in the arts, the natural environment, volunteering opportunities, delivered by local charities, such as OYAP, Fusion Arts, Artscape. There is a County arts and health group that promotes the role of arts in improving mental wellbeing. Local schools choose to deliver mental wellbeing interventions, such as Bladon Primary School and The Cherwell School. Active in the County is Oxfordshire Schools Mental Health and Wellbeing Network. Schools have also been offered opportunity to see a play raising awareness of self-harm and how young people can access support.

	Examples of organisations raising awareness include Oxford Health NHS Trust Stamping out Stigma campaign and Oxfordshire County Councils 5 Ways to Wellbeing campaign, which worked in partnership with Mind. **Defining Success** The Health and Wellbeing Strategy includes the following outcomes for mental health * reduce out of county placements, * improve access to crisis support, other than the Emergency Departments, * increase those with severe mental illness in employment and settled accommodation, and * increase those reporting feeling safe.
Do you have or are you intending on producing a mental health plan or a mental health needs assessment.	**Yes** ☒ **No** ☐ If yes, please specify: We have a mental health needs assessment.
The Prevention Concordat for better mental health highlights the five domain framework for local action **Please describe what are you planning to commit to in the next 12 months for your area** *(see * page 3 for examples to support completion of this section)***;**	
1. Leadership and Direction	1) Public health within Oxon CC will coordinate the production of an Oxfordshire Mental Wellbeing Framework, which will inform the work of the partner organisations and other stakeholders from 2019 onwards. 2) The Framework will involve representatives from each partner organisation which will further develop the shared vision for prevention and promotion, that all members of the Health and Wellbeing Board organisations have signed up to.
2. Understanding local need and assets	Local statistics related to mental wellbeing will be reported to the HIB alongside the life satisfaction measure, from the Office of National Statistics. The following topics will be proposed to the board. Use of green and blue spaces and engagement with volunteering and community groups. As part of the creation of the Framework existing local data will be collected and review data already available from communities which gives insights into their needs and assets. The existing Local Authority led Joint Strategic Needs Assessment with a mental health prevention focus will be refreshed to include some analysis and recommendations. The Framework project group will consider including the

	following a. Mental Health Equity Audits across the partnership b. Collaborative analysis of local information and intelligence sharing c. Shared prioritisation and resources d. Mental Health Impact Assessments to integrate mental health prevention into partnership plans and strategies
3. Working together	The framework will involve working together in collaboration across a number of organisations and will indicate agreed prevention priorities, shared plans and strategies. The Framework project group will review when and how local communities are involved as well as include those with lived experiencand co-production if plans and initiatives
4. Taking action	The Framework will be signed off by the HIB, who will then provide oversight on progress against the Framework. Delivery of relevant partnership plans and strategies.
5. Defining success	Success will be within 12 months 1) a task and finish group that involved all the key partner organisations, to produce a signed off Mental Wellbeing Framework for Oxfordshire. 2) At least one progress report on the delivery of the framework. 3) Achieving the agreed year 1 outputs and outcomes defined in the Framework across all partners 4) Additional partners signing up to the Framework, outside of the Health and Wellbeing Boards membership.
Is your organisation/ partnership happy to provide key impact headlines when contacted related to the commitment specified? Yes ☒ No ☐ *The purpose of this information is to support us to measure progress of the programme and inspire others. Information requests will not occur more than once a year.*	
Upload signature and organisation logo	

In your submission please attach any additional documents that you may want to share to support your commitments e.g. strategies, plans project outlines.

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Appendix 2 - Prevention concordat for better mental health

Consensus statement

This consensus statement describes the shared commitment of the organisations signed below to work together via the Prevention Concordat for Better Mental Health, through local and national action, to prevent mental health problems and promote good mental health.

The undersigned organisations agree that:

1. To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focussed leadership and action throughout the mental health system; and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.
2. There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equality.
3. We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.
4. We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of limited resources.
5. We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, as outlined in the Public Mental Health Leadership and Workforce Development Framework Call to Action[1].

6. We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.
7. We are committed to supporting local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers and the voluntary and community sector to adopt this Concordat and its approach.

Appendix 3 – Potential Contacts to work on the Oxfordshire Mental Wellbeing Framework

Oxford City Council – Katie Badger
West Oxfordshire District Council
South Oxfordshire District Council
Cherwell District Council
Oxfordshire Clinical Commissioning Group
Oxfordshire County Council, Public Health – Jannette Smith
Oxford Health NHS Foundation Trust
Oxfordshire Mental Health Partnership
Healthwatch Oxfordshire – Veronica Barry
Oxford University NHS Foundation Trust

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Health Improvement Board – February 2019
Domestic Abuse Paper

Update on the development of
Oxfordshire's 2019-2024 Domestic Abuse Strategy

The Domestic Abuse Strategic Board's annual report presented at the November 2018 Health Improvement Partnership Board gave a full update on work that has been delivered over the past year or more. That report specifically referenced the nine recommendations set out in the 2016 Strategic Review of Domestic Abuse for Oxfordshire.

This current report is aimed to provide further information on the Domestic Abuse Strategic Board's development of a 5-year Strategy for Oxfordshire for 2019 -2024 which was set out in recommendation 8 in the Strategic Review.

Introduction

The strategy aims to set out our local position in tackling domestic abuse, it highlights the impacts for our residents affected by domestic abuse, including current and longer-term impacts for families and the needs that they have as a result. The Strategy also sets out the ways in which this critically important area of work intersects with other policy frameworks both locally and nationally. This of course includes central Government's Violence Against Women and Girls (VAWG) Strategy as updated in 2016. In practice our local strategy will provide an opportunity for longer term planning and guide our multi-agency approach to this very complex issue. Most importantly it will assist us to work effectively in partnership to deliver the best outcomes for people living in Oxfordshire affected by domestic abuse.

What should a Domestic Abuse Strategy cover?

One of the important questions the Strategic Board will need to make in relation to this Strategy is whether the time has come to broaden focus from domestic abuse to a Violence Against Women and Girls agenda as favoured by the current Government. There are of course pros and cons to taking this approach. We must both acknowledge that domestic abuse is indeed evidenced as a seriously gendered issue but also be careful not to minimise the experiences of male victims and also the needs and experiences of the LGBT+ communities. There is arguably merit in linking domestic abuse with other strands included in the definition of Violence against Women and Girls as we know there are huge overlaps between domestic and other areas of abuse such as Sexual Violence and Child Sexual Exploitation. These and other issues such a shift would involve will need careful consideration by the Domestic Abuse Strategic Board and key partners.

The Strategy will incorporate the key principles set out in our Oxfordshire Domestic Abuse Vision Statement 2016 and explain how these are to be delivered in an appended Action Plan that will be updated annually. This action plan will directly link to the HIB Performance Indicators for Domestic Abuse. Alongside this there will be a Dashboard which will be a high-level reporting mechanism to inform key partners on progress on a six monthly or more frequent basis.

How is the Strategy being developed?

We started the process at our last Strategic Board meeting in November and agreed to develop a first draft by mid-December using

- Our Strategic Vision Statement
- A review of progress on our recommendations from the 2016 Strategic Review
- A desk top review of best practice Domestic Abuse and VAWG strategies from other areas in the UK
- Central Government's VAWG Strategy

We also agreed that we would hold an extended Strategic Board meeting in February to develop the Strategy further and incorporate feedback from other partners.

The draft Strategy document has been discussed with our Operational Board members, which includes Experts by Experience, with a focus on ensuring the document is meaningful for our delivery partners. Community Safety Partnerships have also been asked to comment on key priorities for their area to help inform the approach to reporting on delivery of the action plan and dashboard indicators.

Next steps

A second draft of the Strategy will be developed at the extended Domestic Abuse Strategic Board meeting on 13 February after which we will decide the next steps before publishing the document in early Spring 2019.

We aim to bring the completed Strategy to the next Health Improvement Partnership Board meeting for comment and sign off.

Sarah Carter
Strategic Lead for Domestic Abuse
4 February 2019

If you have any questions or comments in relation to the any of the above or a related topic please do not hesitate to contact me:

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Overview of the NHS Long Term Plan and implications for the Health Improvement Board

Discussion paper, February 14th 2019

1. Introduction

The NHS Long Term Plan was published in January 2019 and can be found here: https://www.longtermplan.nhs.uk/ A summary of the Long Term Plan is included in Annex 1 of this paper.

The opening paragraphs of the Plan sets the context and overall aim:

> **"The NHS has been marking its 70th anniversary, and the national debate this has unleashed has centred on three big truths. There's been pride in our Health Service's enduring success, and in the shared social commitment it represents. There's been concern – about funding, staffing, increasing inequalities and pressures from a growing and ageing population. But there's also been optimism – about the possibilities for continuing medical advance and better outcomes of care.**
> In looking ahead to the Health Service's 80th birthday, this NHS Long Term Plan takes all three of these realities as its starting point. So to succeed, we must keep all that's good about our health service and its place in our national life. But we must tackle head-on the pressures our staff face, while making our extra funding go as far as possible. And as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. This Plan sets out how we will do that."

2. Overview of the Long Term Plan

The plan covers the following topics:

1. Chapter One sets out how the NHS will move to **a new service model** in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

This includes
- "Digital" GP consultations being available to all patients over the next 5 years
- Redesigned hospital support to reduce the need for outpatient appointments
- Groups of GP practices working together to serve 30,00-50,000 people through integrated teams of GPs, community health and social care staff providing local services
- The expansion of Social Prescribing, personal health budgets and support for people to manage their own health.
- Urgent treatment centres

2. Chapter Two sets out new, funded, action the NHS will take to strengthen its contribution to **prevention and health inequalities**.

This includes implementing evidence based prevention programmes such as

- Improving NHS provision for smoking cessation in hospitals and maternity services
- Addressing Alcohol dependence through Alcohol Care Teams in hospital settings
- Expanding the National Diabetes Prevention Programme
- Striving to diagnose cancer in earlier stages
- Ensuring people with mental ill-health or learning disabilities have physical health checks
- Taking measures to improve air quality

This chapter includes a paragraph on the way this focus on prevention in the NHS will work in conjunction with local government:

> **"Action by the NHS is a complement to, but cannot be a substitute for, the important role for local government.** In addition to its wider responsibilities for planning, education, housing, social care and economic development, in recent years it has also become responsible for funding and commissioning preventive health services, including smoking cessation, drug and alcohol services, sexual health, and early years support for children such as school nursing and health visitors. These services are funded by central government from the public health grant, and funding and availability of these services over the next five years which will be decided in the next Spending Review directly affects demand for NHS services[20]. As many of these services are closely linked to NHS care, and in many case provided by NHS trusts, the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be." (NHS LTP p. 33)

3. Chapter Three sets the NHS's priorities for **care quality and outcomes improvement** for the decade ahead.

This includes

- Maintaining good progress and continuing to improve outcomes e.g. safe childbirth, cancer survival through earlier diagnosis
- Growth in investment in mental health services to continue at faster rate than the overall NHS budget
- Addressing unmet need and unexplained local variation in outcomes
- Extend the focus to children's health, cardiovascular and respiratory conditions, learning disability and autism
- Introducing HPV vaccination for boys aged 12 and 13.
- Selectively moving to a 0-25 service to improve transition from child to adult services

4. Chapter Four sets out how current **workforce pressures** will be tackled, and staff supported.

This includes

- NHS workforce implementation plan

- Expand nursing and undergraduate training places and develop new routes into nursing e.g. apprenticeships, nursing associates, “earn and learn” support etc.
- Expansion of clinical placements
- Improve retention of staff e.g. flexible rostering, more flexible careers, more volunteers

5. Chapter Five sets out a wide-ranging and funded programme to **upgrade technology and digitally enabled care** across the NHS.

This includes

- Investment to enable digital access to services e.g. access for patients and carers to manage their health;
- access to patient records and care plans for a range of clinicians
- Deploying population health management solutions to support ICSs to understand the areas of greatest need and match NHS services to meet them.
- Delivering Longitudinal Health and Care Records across geographies linking NHS and LA data.

6. Chapter Six sets out how the **3.4% five year NHS funding settlement** will help put the NHS back onto a sustainable financial path.

This includes

- Recognising current pressures and growth in demand along with expanding science and innovation.
- Increased rate of funding for primary care and continuing that trend for mental health services
- Increased drive for efficiency and reforms to NHS architecture, payment systems and incentives.
- System to enable systems, trusts and organisations to return to financial balance.

7. Chapter Seven explains next steps in **implementing the Long Term Plan**.

This includes

- A new operating model will set out principles of co-design and collaboration
- 2019-20 will be a transition year with each CCG and Trust setting out their organisational operating plans and contributing to a local health system-level plan.
- Funding allocations for the whole system will be set out from 2019-20 to 2023-24 which will enable local system plans to be drawn up.
- Integrated Care Systems will cover the whole country by April 2021 and will then be central to the delivery of the Long Term Plan.

- Legislative change is possible in order to enable rapid progress e.g. in enabling NHS bodies to work together to redesign care or to address the procurement processes that foster competition rather than collaboration.

3. How does the NHS Long Term Plan link with the Priorities of the Health Improvement Board?

The NHS Long Term Plan is relevant to the whole health and social care system and the range of objectives will be incorporated into the work of the Health and Wellbeing Board and all its sub-groups. This paper covers only those objectives relevant to the work of the Health Improvement Board.

The table below sets out the priorities agreed for the Health Improvement Board with relevant actions from the NHS Long Term Plan alongside.

Keeping Yourself Healthy / Prevent	
HIB Priority	**NHS Long Term Plan objective**
Reduce Physical Inactivity / Promote Physical Activity	*No specific mention in the Long Term Plan.*
Enable people to eat healthily	2.18. **The NHS will continue to take action on healthy NHS premises.** In 2016, NHS England introduced a financial incentive for hospitals to encourage healthier food options to be available for staff, limiting the proportion, placement and promotion of foods high in fat, salt and sugar (HFSS). Our action has also reduced the sale of sugar-sweetened beverages across the NHS, from 15.6% in July 2017, to 7.4% in June 2018. The next version of hospital food standards will be published in 2019, strengthening these requirements and pushing further in securing healthy food for our staff and patients. They will include substantial restrictions on HFSS foods and beverages. All trusts will be required by the NHS standard contract to deliver against these standards. (NHS LTP p. 37) 2.19. **Nutrition training, and an understanding of what is involved in achieving and maintaining a healthy weight, varies between medical schools.** Some courses have just eight hours, at most, over a five- or six-year degree. This is not about doctors becoming nutritionists or dieticians. It is about making sure staff on the frontline who are in contact with thousands of patients a year feel equipped to talk to them about nutrition and achieving a healthy weight in an informed and sensitive way. They should feel able to refer patients appropriately in cases where a nutrition support could help, if they are overweight, and have type 2 diabetes, or high blood pressure for example. Together with the professional bodies and universities we will ensure nutrition has a greater place in professional education training. (NHS LTP p. 37)
Reduce smoking prevalence	2.9. First, the NHS will therefore make a significant new contribution to making England a smoke-free society, by supporting people in contact with NHS services to quit based on a proven model implemented in Canada and Manchester. **By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.** 2.10. **Second, the model will also be adapted for expectant**

	mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments. 2.11. **Third, a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.** On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings. (NHS LTP p. 35)
Promote Mental Wellbeing	1.43. **Digital technology will provide convenient ways for patients to access advice and care.** (…) We will continue to invest in the nhs.uk platform so that everyone can find helpful advice and information regarding their conditions. As technology advances, we will also trial the use of innovative devices such as smart inhalers for better patient care and remote monitoring of conditions. We will also continue to support the development of apps and online resources to support good mental health and enable recovery. (NHS LTP p. 26) 2.38. A major factor in maintaining good mental health is stable employment. This Plan sets out how the NHS is improving access to mental health support for people in work and our commitment to supporting people with severe mental illnesses to seek and retain employment. As the largest employer in England, we are also taking action to improve the mental health and wellbeing of our workforce and setting an example to other employers.(NHS LTP p.42) 3.105. We will continue to build on this progress with the Long Term Plan, so that **reducing suicides will remain an NHS priority over the next decade.** With the support of partners in addressing this complex, system-wide challenge, we will provide full coverage across the country of the existing suicide reduction programme. Through an enhanced mental health crisis model, anyone experiencing a crisis will be able to call NHS 111 and have 24/7 access to mental health support as well as the services described earlier in this chapter. We will expand specialist perinatal mental health services so that more women who need it have access to the care they need from preconception to two years after the birth of their baby. We are investing in specialist community teams to help support children and young people with autism and their families, and integrated models of primary and community mental health care which will support adults with severe mental illnesses, and support for individuals who self-harm. (NHS LTP p. 72)
Tackle wider determinants of health • Housing and homelessness • Air Quality	2.32. The number of people sleeping rough has been increasing in recent years. People affected by homelessness die, on average, around 30 years earlier than the general population. Outside London, where people are more likely to sleep rough for longer, support needs may be higher. 31% of people affected by homelessness have complex needs, and additional financial, interpersonal and emotional needs that make engagement with mainstream services difficult. 50% of people

	sleeping rough have mental health needs, but many parts of the country with large numbers of rough sleepers do not have specialist mental health support and access to mainstream services is challenging. **We will invest up to £30 million extra on meeting the needs of rough sleepers, to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services. (NHS LTP p. 42)** 2.21. **While wider action on air pollution is for government to lead, the NHS will work to reduce air pollution from all sources. Specifically, we will cut business mileages and fleet air pollutant emissions by 20% by 2023/24.** Almost 30% of preventable deaths in England are due to non-communicable diseases specifically attributed to air pollution. More than 2,000 GP practices and 200 hospitals are in areas affected by toxic air. In 2017, 3.5% (9.5 billion miles) of all road travel in England was related to patients, visitors, staff and suppliers to the NHS. At least 90% of the NHS fleet will use low-emissions engines (including 25% Ultra Low Emissions) by 2028, and primary heating from coal and oil fuel in NHS sites will be fully phased out. Redesigned care and greater use of 'virtual' appointments as set out in Chapter One will also reduce the need for patient and staff travel. (NHS S LTP p. 38)
Immunisation	1.11. **To support this new way of working we will agree significant changes to the GP Quality and Outcomes Framework (QOF).** This will include a new Quality Improvement (QI) element, which is being developed jointly by the Royal College of GPs, NICE and the Health Foundation. The least effective indicators will be retired, and the revised QOF will also support more personalised care. In 2019 we will also undertake a fundamental review of GP vaccinations and immunisation standards, funding, and procurement. This will support the goal of improving immunisation coverage, using local coordinators to target variation and improve groups and areas with low vaccines uptake. (NHS LTP p. 15) 3.43 We will prioritise improvements in **childhood immunisation** to reach at least the base level standards in the NHS public health function agreement. The programme will also work closely with other areas of government and key programmes such as the *Healthy Child Programme*. (NHS LTP p. 54) 5.12. **In 2019/20, 100,000 women will be able to access their maternity record digitally with coverage extended to the whole country by 2023/24.** Additionally a digital version of the 'red book' will help parents record and use information about their child, including immunisation records and growth. This will be made available in a mobile format that follows the family and removes the need for a paper record. It will also help children start life with a digital Personal Health Record (PHR) that they can build on throughout their lives. (NHS LTP p. 93)

Reducing the impact of ill health (Reduce)	
Prevent chronic disease though tackling obesity • Weight management initiatives • Diabetes prevention	The NHS will therefore provide a targeted support offer and **access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+** (adjusted appropriately for ethnicity), where we know we can have a significant impact on improving health, reducing health inequalities and reducing costs. By 2022/23, we also expect to treat up to a further 1,000 children a year for severe complications related to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health. These services will prevent children needing more invasive treatment. (NHS LTP p. 37) 2.15. The NHS Diabetes Prevention Programme supports those at high risk of type 2 diabetes to reduce their risk. A joint commitment by NHS England, Public Health England (PHE) and Diabetes UK, the programme is the largest undertaking of its kind in the world and over 100,000 people have already benefited since its introduction in 2016. In many areas demand has outstripped supply, and it has proven highly effective. **We are now committing to fund a doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option** to widen patient choice and target inequality. (NHS LTP p. 37)
Screening for early awareness of risk • NHS Health Checks • Cancer screening programmes (e.g. Bowel, cervical, breast screening)	3.68. **Working with local authorities and PHE, we will improve the effectiveness of approaches such as the NHS Health Check, rapidly treating those identified with high-risk conditions.** Working with voluntary sector partners, community pharmacists and GP practices will also provide opportunities for the public to check on their health, through tests for high blood pressure and other high-risk conditions. Expanding access to genetic testing for Familial Hypercholesterolaemia (FH), which causes early heart attacks and affects at least 150,000 people in England116, will enable us to diagnose and treat those at genetic risk of sudden cardiac death. Currently only 7% of those with FH have been identified, but we will aim to improve that to at least 25% in the next five years through the NHS genomics programme. 3.69**. Where individuals are identified with high risk conditions, appropriate preventative treatments will be offered in a timely way.** We will support pharmacists and nurses in primary care networks (see Chapter One) to case find and treat people with high-risk conditions. Where 100 people with AF are identified and receive anticoagulation medication, an average of four strokes are averted, preventing serious disability or even death. The creation of a national CVD prevention audit for primary care will also support continuous clinical improvement. (NHS LTP p. 62) 3.53. **We will modernise the Bowel Cancer Screening Programme to detect more cancers, earlier.** The Faecal Immunochemical Test for haemoglobin will be easier to use for

	patients. In trials it has been shown to improve take up rates by 7%, including among groups with low participation rates such as men, people from ethnic minority backgrounds and people in more deprived areas. We will lower the starting age for screening from 60 currently to 50. 3.54. **We will implement HPV primary screening for cervical cancer across England by 2020.** This method of testing is more sensitive and more reliable than liquid-based cytology so will detect more women at risk of cervical cancer and facilitate their treatment to prevent cancer developing. 3.55. **NHS England has asked Sir Mike Richards to lead a review of the current cancer screening programmes and diagnostic capacity. (NHS LTP p. 58)**
Alcohol advice and treatment • Identification and brief advice on harmful drinking • Alcohol liaison in hospitals • Alcohol treatment services	2.20. Alcohol contributes to conditions including cardiovascular disease, cancer and liver disease, harm from accidents, violence and self-harm, and puts substantial pressure on the NHS. Hospitals in Bolton, Salford, Nottingham, Liverpool, London and Portsmouth have improved the quality of alcohol-related care, by establishing specialist Alcohol Care Teams (ACTs). ACTs significantly reduced accident and emergency (A&E) attendances, bed days, readmissions and ambulance call-outs. Over the next five years, those **hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs** using funding from their clinical commissioning groups (CCGs) health inequalities funding supplement, working in partnership with local authority commissioners of drug and alcohol services. Delivered in the 25% of worst affected hospitals, this could prevent 50,000 admissions over five years.(NHS LTP p. 38)
Community Safety impact on health outcomes / Domestic abuse	No mention in the long term plan
Shaping Healthy Places and Communities	
Healthy Environment and Housing Development • Learn from the Healthy New Towns and influence policy • Ensure our roads and housing developments enable safe walking and cycling • Ensure spatial planning	1.51. **We will continue to develop ICSs, building on the progress the NHS has made. By April 2021 ICSs will cover the whole country**, growing out of the current network of Sustainability and Transformation Partnerships (STPs). ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, for example in relation to procurement and contract award). Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long

facilitates social interaction for all generations – giving opportunities for people to meet who might not do so otherwise	Term Plan implementation. (NHS LTP p. 29) **Remove specific impediments to 'place-based' NHS commissioning.** The 2012 Act creates some barriers to ICSs being able to consider the best way of spending the total 'NHS pound'. Lifting a number of restrictions on how CCGs can collaborate with NHS England would help, as would NHS England being able to integrate Section 7A public health functions with its core Mandate functions where beneficial; (NHS LTP p. 113) 16. **Looking beyond healthcare provision, the NHS has a wider role to play in influencing the shape of local communities.** Through the Healthy New Towns programme, the NHS is playing a leading role in shaping the future of the built environment. In spring 2019 we will set out the principles and practice for *Putting Health into Place* guidelines for how local communities should plan and design a healthy built environment. These have been developed with a network of 12 housing developers who are committed to developing homes that fit these principles. This covers approximately 70,000 homes over the next five years. In 2019/20, NHS England will build on this by working with government to develop a Healthy New Towns Standard, including a Healthy Homes Quality Mark to be awarded to places that meet the high standards and principles that promote health and wellbeing. Embedding these principles within local planning guidance would ensure all future developments have a focus on design that support prevention and wellbeing.(NHS LTP p. 119)
Social Prescribing • Referral from Primary Care to non-medical schemes e.g. for physical activity, social networks, support groups	1.40. As part of this work, through **social prescribing** the range of support available to people will widen, diversify and become accessible across the country. Link workers within primary care networks will work with people to develop tailored plans and connect them to local groups and support services. Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then. (NHS LTP p. 25) 2.35. Young carers feel say they feel invisible and often in distress, with up to 40% reporting mental health problems arising from their experience of caring. Young Carers should not feel they are struggling to cope on their own. **The NHS will roll out 'top tips' for general practice which have been developed by Young Carers, which include access to preventive health and social prescribing, and timely referral to local support services.** Up to 20,000 Young Carers will benefit from this more proactive approach by 23/24.(NHS LTP p. 43)
Making Every Contact Count, Campaigns	Not mentioned

4. Conclusions

The NHS Long Term Plan has been widely welcomed as a pragmatic plan, an ambitious vision to improve NHS care and a positive shift to an increasing focus on prevention and reducing health inequalities. There have been reservations over how well it can be implemented if other parts of the system (including public health and social care) are subject to ongoing financial restraint.

It is the first time there has been such a long term plan for the NHS and it will be accompanied by announcements on indicative funding levels in order to facilitate longer term planning.

It is clear from the analysis above that many of the objectives in the Long Term Plan reflect our local priorities for Prevention. This reflects the work we have already been doing together to join up our work and agree joint priorities, but the Long Term Plan adds value through the announcement of several national initiatives and associated funding which will have a positive impact locally.

Next Steps

1. The Joint Health and Wellbeing Strategy is currently out for stakeholder engagement and a final draft will be presented to the HWB in March. This will be checked to ensure it reflects the new NHS Long Term Plan as appropriate.
2. Implementation Plans will be drawn up by all sub-groups of the HWB, including the working groups of the Health Improvement Board, and this analysis of the relevant objectives from the NHS Long Term Plan will be used in operationalising our priorities.
3. The Clinical Commissioning Group are currently drafting their Operating Plan for submission in April 2019 and this should also reflect the shared priorities for prevention in the HWB and HIB plans.
4. A draft Prevention Framework will be discussed at the Health and Wellbeing Board in March which will underpin these documents. It is currently being discussed by partners.

Recommendations

1. Members of the Health Improvement Board are asked to comment on the relevance and value of the objectives from the NHS Long Term Plan in contributing to our local priorities for prevention.
2. All partners are asked to note the common themes of the Joint HWB Strategy, the NHS Long Term Plan and the HIB priorities and ensure these are reflected in our various organisational plans e.g. the CCG Operating Plan 2019-20.
3. The Working Groups of the HIB are asked to ensure that the relevant objectives of the NHS Long Term Plan are included in their implementation plans and delivered as set out.

Kiren Collison, Oxfordshire CCG
Val Messenger, Interim Director of Public Health

Annex 1
The NHS Long Term Plan – a summary

Find out more: www.longtermplan.nhs.uk | Join the conversation: #NHSLongTermPlan

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients
These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life
- reducing stillbirths and mother and child deaths during birth by 50%
- ensuring most women can benefit from continuity of care through and beyond their pregnancy, targeted towards those who will benefit most
- providing extra support for expectant mothers at risk of premature birth
- expanding support for perinatal mental health conditions
- taking further action on childhood obesity
- increasing funding for children and young people's mental health
- bringing down waiting times for autism assessments
- providing the right care for children with a learning disability
- delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.

Delivering world-class care for major health problems
- preventing 150,000 heart attacks, strokes and dementia cases
- providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths
- saving 55,000 more lives a year by diagnosing more cancers early
- investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital
- spending at least £2.3bn more a year on mental health care
- helping 380,000 more people get therapy for depression and anxiety by 2023/24
- delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.

Supporting people to age well

- increasing funding for primary and community care by at least £4.5bn
- bringing together different professionals to coordinate care better
- helping more people to live independently at home for longer
- developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home.
- upgrading NHS staff support to people living in care homes.
- improving the recognition of carers and support they receive
- making further progress on care for people with dementia
- giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How we will deliver the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how we think we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. Doing things differently: we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. Backing our workforce: we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. Making better use of data and digital technology: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. Getting the most out of taxpayers' investment in the NHS: we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

What happens next
Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

This means that over the next few months, whether you are NHS staff, a patient or a member of the public, you will have the opportunity to help shape what the NHS Long Term Plan means for your area, and how the services you use or work in need to change and improve.

To help with this, we will work with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

Find out more
More information is available at www.longtermplan.nhs.uk , and your local NHS teams will soon be sharing details of what it may mean in your area, and how you can help shape their plans.

Health Improvement Board

Forward Plan

Meeting Date	Other papers that could be scheduled	Standing items
16th May 2019	Joint Strategic Needs Assessment Final Joint Health and Wellbeing Strategy Active Oxfordshire Update Whole System Approach to Obesity Affordable Warmth Network update Housing Support Advisory Group update Making Every Contact Count	Minutes of last meeting Performance Dashboard Forward plan Domestic Abuse update
12th September 2019	Tobacco Control Alliance Mental Wellbeing working group update Healthy Place Shaping Social Prescribing	
21st November 2019	Director of Public Health Annual Report Public Health, Health Protection Forum annual report	
February 2020 tbc		

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Oxfordshire

Local system review progress report

Health and Wellbeing Board

Date of local system review:
27 November to 1 December 2017

Date of progress review:
6 to 7 November 2018

Summary of findings from progress review

Published: January 2019

What were the key areas for improvement identified in the local system review?

Following the local system review of Oxfordshire in November 2017, we revisited the system to look at progress against the submitted action plan that was developed in response to our findings. For ease of reference, the key areas for improvement were:

Strategic priorities

- System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. While doing so, a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.
- System leaders must address and create the required culture to support service inter-agency collaboration and service integration.
- The older people's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the older people's strategy, the draft frailty pathway should be implemented and evaluated to include those under-represented in society.

- System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation, and learning should be shared with system partners to encourage continuous improvement.
- System leaders must evaluate their winter plans and pressures throughout the year to ensure lessons learned are applied when planning for periods of increased demand.
- System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly for domiciliary care, end of life care, and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.
- System leaders must implement the Strategic Transformation Partnership's joint workforce strategy and work with the full range of care providers to support a competent, capable and sustainable workforce.

Operational priorities

- System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.
- System leaders should ensure that housing support services are included within multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.
- System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure resources are used effectively.
- System leaders should review methods used to identify carers eligible for support so that they are assured that carers are receiving the necessary support and have access to services.
- System leaders should ensure that better advice, information and guidance is offered to people funding their own care.
- The trusted assessor model must continue to be embedded.

Engagement priorities

- System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.

- Engagement and partnership working with the voluntary, community and social enterprise (VCSE) sector should be reviewed to improve how the sector is used.

System leaders built their action plan around the areas for improvement identified by the Care Quality Commission (CQC)'s November 2017 local system review report for Oxfordshire. At the time of our progress review, system leaders were eight months into an 18-month action plan. We have assessed progress against the action plan and grouped this into the following themes:

- Strategic approach to meeting the needs of older people
- Culture and collaboration
- Winter planning
- Market shaping
- Workforce
- Review of pathways, points of access and services
- Housing – equipment and adaptations
- Carers
- People who fund their own care

What progress had been made following the local system review?

- System leaders had undertaken significant work to reset the culture of their organisations and develop relationships. This had enabled a sense of shared purpose and endeavour, and a willingness to take a system-based approach to resolving challenges and planning for the future.
- There was a stronger strategic approach emerging that embodied the principles of co-production. This was evident in the development of the older people's and Health and Wellbeing Board strategies. VCSE sector representatives shared that, although it was not fully developed, partnership working had strengthened and that they felt listened to by system leaders. Carers' representatives also felt that engagement had improved.
- Leaders now need to ensure this approach is embedded through the next tiers of management so that all staff understand and adopt a collaborative approach to service planning and delivery.
- The membership of the Health and Wellbeing Board had been extended to include wider partner representation such as the district councils and chief executives from the NHS foundation trusts and the clinical commissioning group (CCG). The inclusion of wider partners was considered crucial to the resolution of system-wide issues such as affordable housing, and to supporting the development of community models and local hubs.

- System leaders had undertaken evaluation and learning opportunities from the previous winter. A Winter Planning Director had been appointed and winter planning had started earlier in the year. Joint planning for winter 2018/19 was based on a system-wide collaborative approach that included engagement and involvement from the VCSE sector. Learning from the previous year had been applied to improve system capacity and anticipate risks. Confidence in the system's resilience to respond to surges in demand had increased as a result.
- In the absence of the recommended comprehensive review of pathways, work had taken place around patient flow. There had been a positive tactical response to delayed transfers of care, including improved support in primary care in relation to hospital avoidance, and planning for a wider approach to preventative services.
- We saw some practical examples where improved cross-system relationships had improved outcomes for people. For example, work had been undertaken to successfully reduce the numbers of people who remained in hospital unnecessarily.
- We found improved practice regarding the development of a workforce strategy. However, there was still a need for this activity to be aligned and a system-wide approach adopted, particularly in the adult social care and acute hospital sectors.

What improvements are still needed to be made?

- There remained a traditional and transactional approach to market management and the commissioning of services. There had been some work to develop the domiciliary care market and mental health services but this was in its early stages. The lack of capacity in the domiciliary care market meant that older people with complex needs were at a higher risk of being discharged from hospital into residential care rather than their own homes.
- There had not been a comprehensive review of all services commissioned to support pathways of care for older people. Some work had been done to evaluate the flow of people through the hospital setting, including delayed transfers of care from hospital. At the time of our progress review, analysis of our data from February 2018 to July 2018 showed that delayed transfers of care had improved but continued to be significantly higher than the England average and comparator areas ('comparator areas' are nationally determined and refer to areas of a similar geographical size and population as Oxfordshire). We found that delayed transfers of care required further work and an ongoing system-wide focus.
- The support that the VCSE sector could provide to people when they were discharged home had not been maximised. It remained a missed opportunity for improving support for older people at a vulnerable time.
- The 'discharge to assess' model was aimed at funding and supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment

outside of the hospital setting so they could then be assessed for their longer-term needs in the right place. We found that this was not fully embedded.

- For people who funded their own care, support, advice and brokerage services remained underdeveloped. This was recognised by system leaders. Work had taken place to improve access to information on the local authority's website, to help people who fund their own care. However, the planned development of a brokerage service for self-funders had not yet begun. There was an expectation that a mandate to commence this work was due to be agreed shortly after our visit.

Background to the review

Introduction and context

Between August 2017 and July 2018 CQC undertook a programme of 20 reviews of local health and social care systems at the request of the Secretaries of State of Health and Social Care and for Housing, Communities and Local Government. These reviews looked at how people move between health and social care services, including delayed transfers of care, with a focus on people aged 65 and over. The reports from these reviews and the end of programme report, *Beyond Barriers* can be found on our website.

CQC was asked by the Secretaries of State to revisit a small number of the areas that received a local system review to understand what progress had been made. This report presents the findings from our progress review of Oxfordshire in November 2018.

How we carried out the progress review

The review team included two CQC reviewers and two specialist advisors, one from a local government background and one from a health background.

This follow-up review considered system performance against the action plan developed as part of the initial local system review as well as other areas for improvement highlighted in Oxfordshire's initial local system report.

We looked at:

- performance across key indicators
- performance against the system action plan
- stakeholder reflections on progress.

This progress report highlights areas where the Oxfordshire system is performing well, and areas where there is scope for further improvement.

Prior to visiting Oxfordshire, we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local system to provide a progress update on the action plan developed following the initial review and feedback on progress through a system overview information request (SOIR). We consulted with national partners involved in supporting the system following the initial review, and we also consulted with organisations that represent people who use services, their families and carers.

The people we spoke with included:

- System leaders from the local authority, the Oxfordshire CCG, Oxford University Hospitals NHS Foundation Trust (OUHFT) and Oxford Health Foundation Trust (OHFT).
- Staff members including community nurses, occupational therapists, physiotherapist, social workers and commissioning managers.
- Local Healthwatch and VCSE services.
- Provider representatives.

Detailed findings

System progress against key indicators

When we carried out Oxfordshire's initial local system review in November 2017 we produced a local data profile containing analysis of a range of information from national data collections as well as CQC's own data. A refreshed local data profile was produced in September 2018.

For the purpose of this progress review we also analysed Oxfordshire's performance over time for six indicators:

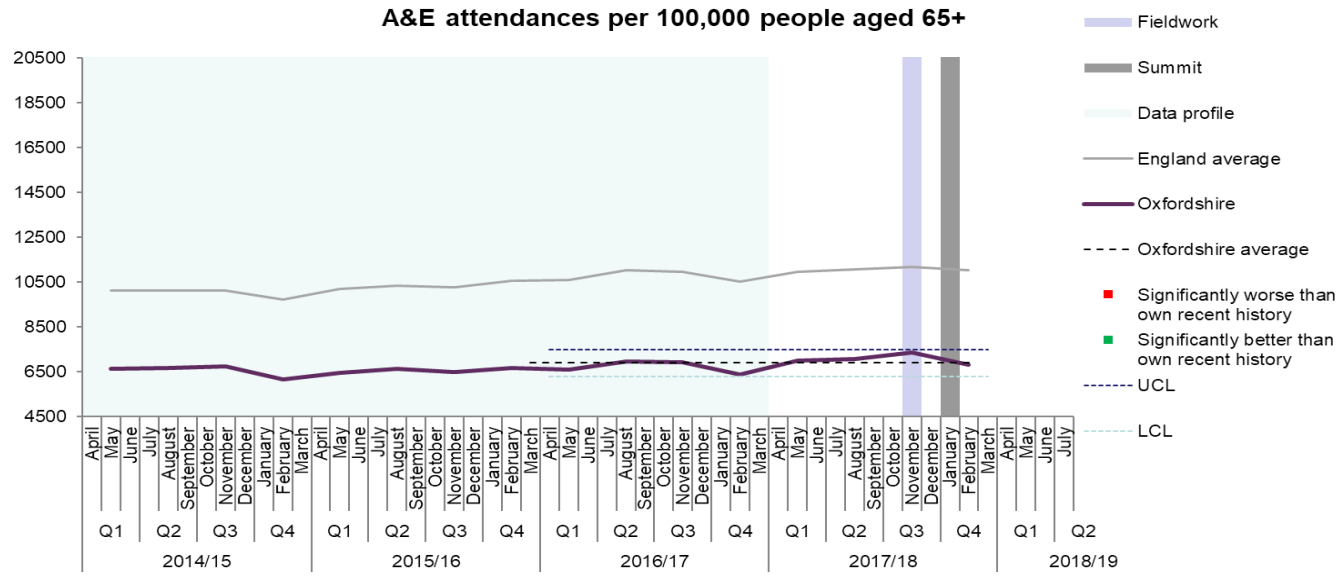
1. A&E attendance (65+)
2. emergency admissions (65+)
3. emergency admissions from care homes (65+)
4. hospital length of stay (65+)
5. delayed transfers of care (18+)
6. emergency hospital readmissions (65+).

We looked at how Oxfordshire's performance against the England average has changed since the original data profile was produced, and at how performance has changed against Oxfordshire's own history. With the exception of delayed transfers of care, the data is up to March 2018. Delayed transfers of care data is up to July 2018.

The graphs below show the performance for the six indicators. Overall our analysis shows that since we produced the original data profile, Oxfordshire has continued to perform well for A&E attendances, emergency admissions, emergency admissions from care homes and hospital length of stay over seven days. Oxfordshire has improved its performance in delayed transfers of care, but continues to perform worse than the England average, often significantly worse. It also continues to perform slightly worse for emergency readmissions within 30 days.

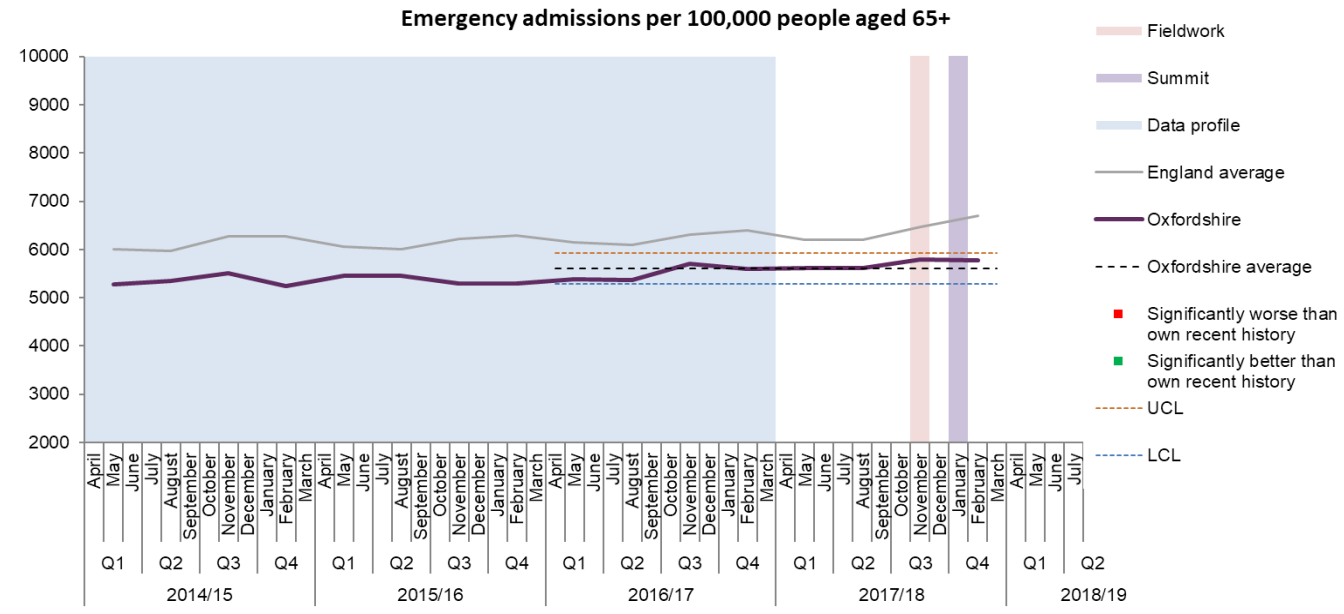
Since we produced the original data profile, Oxfordshire's performance for A&E attendances (65+) has remained consistently significantly better than the England average and has not fluctuated much from its own average.

Figure 1: A&E attendances (65+)



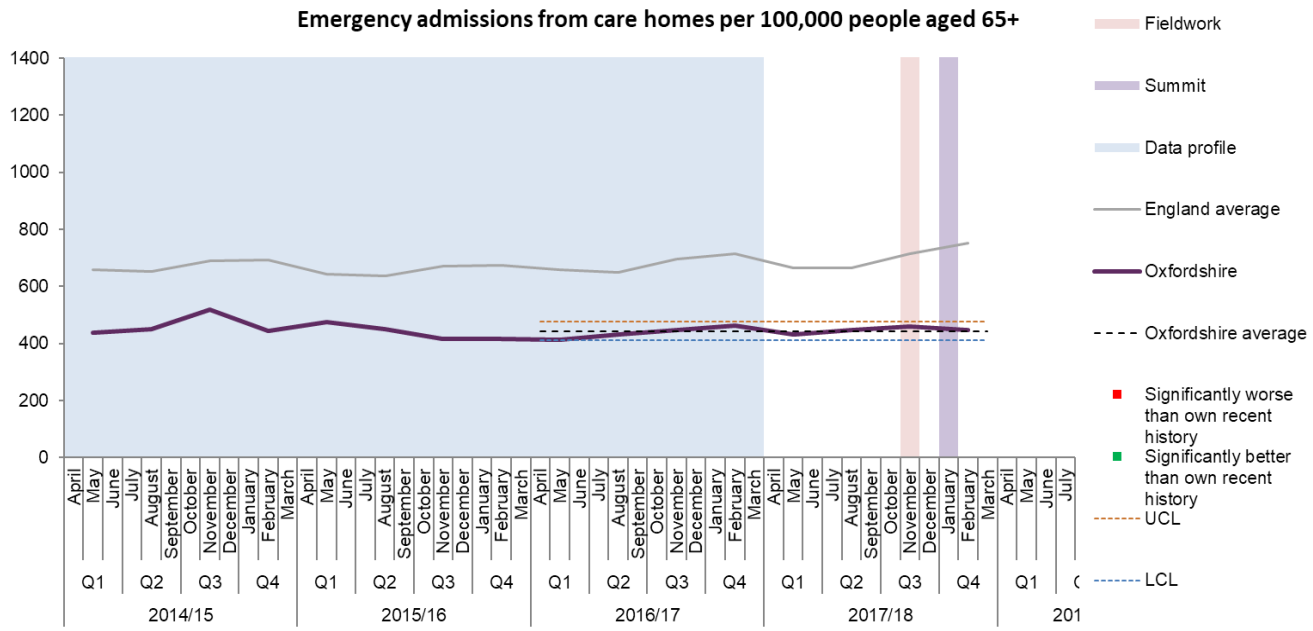
Oxfordshire's performance for emergency admissions (65+) has remained consistently better than the England average and has changed little compared to its own average.

Figure 2: Emergency admissions (65+)



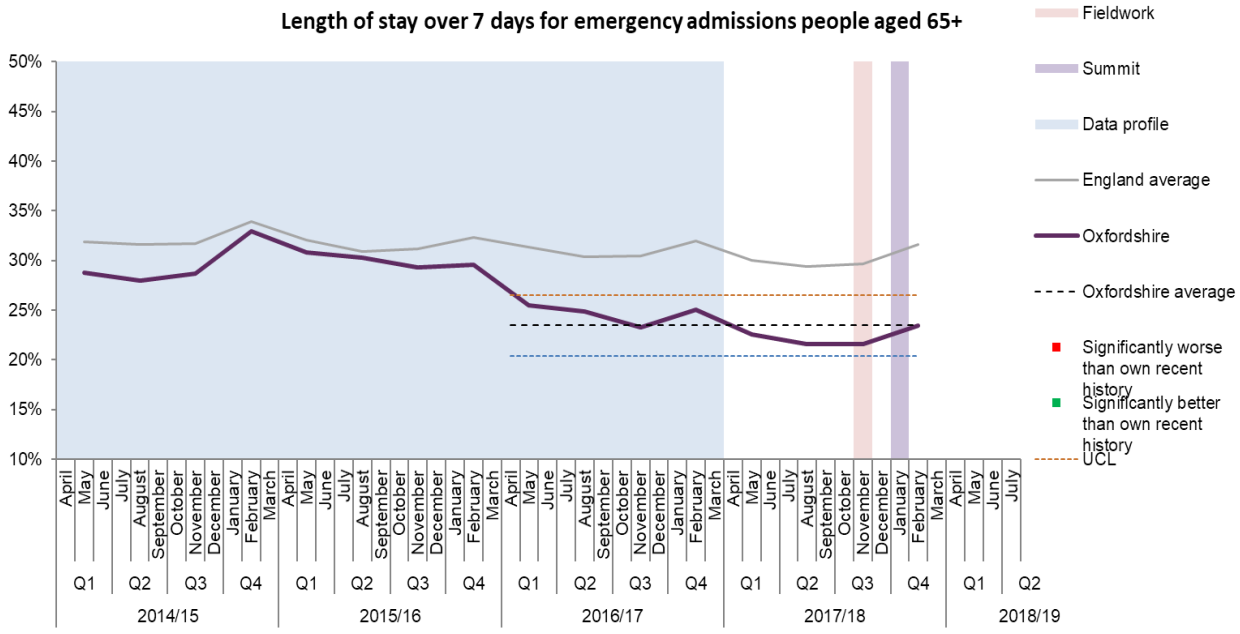
Oxfordshire's performance for emergency admissions (65+) from care homes has remained consistently better than the England average. In the last two quarters of 2017/18 it was significantly better than the England average.

Figure 3: Emergency admissions from care homes (65+)



Oxfordshire's performance for length of stay over seven days for emergency hospital admissions (65+) has remained consistently better than the England and comparator areas.

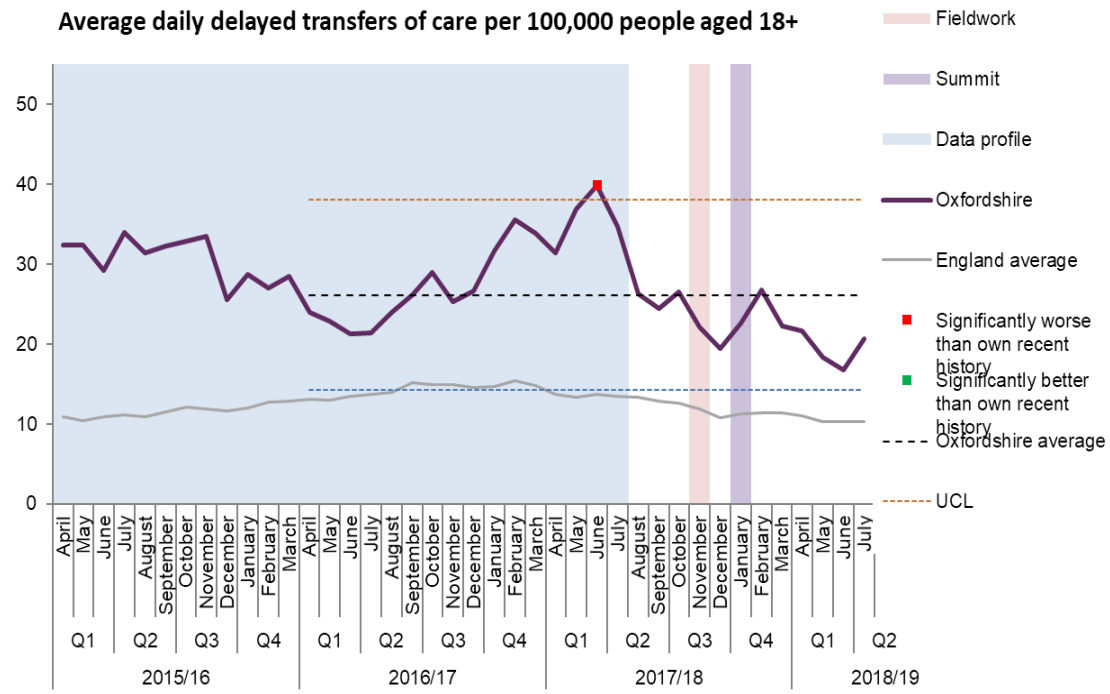
Figure 4: Length of stay (65+)



Since we produced the original data profile, Oxfordshire's rate of delayed transfers of care (18+) overall has steadily reduced from a high point in quarter 1 of 2017/18 (approximately 40 days) where it was significantly worse than its own recent history. Performance has consistently remained worse than the England average, often significantly worse. Recent activity (July 2018) highlights performance deteriorated from 16.7 to 20.6 days, which is significantly worse than the England average, 10.3 days. Updated data (October 2018)

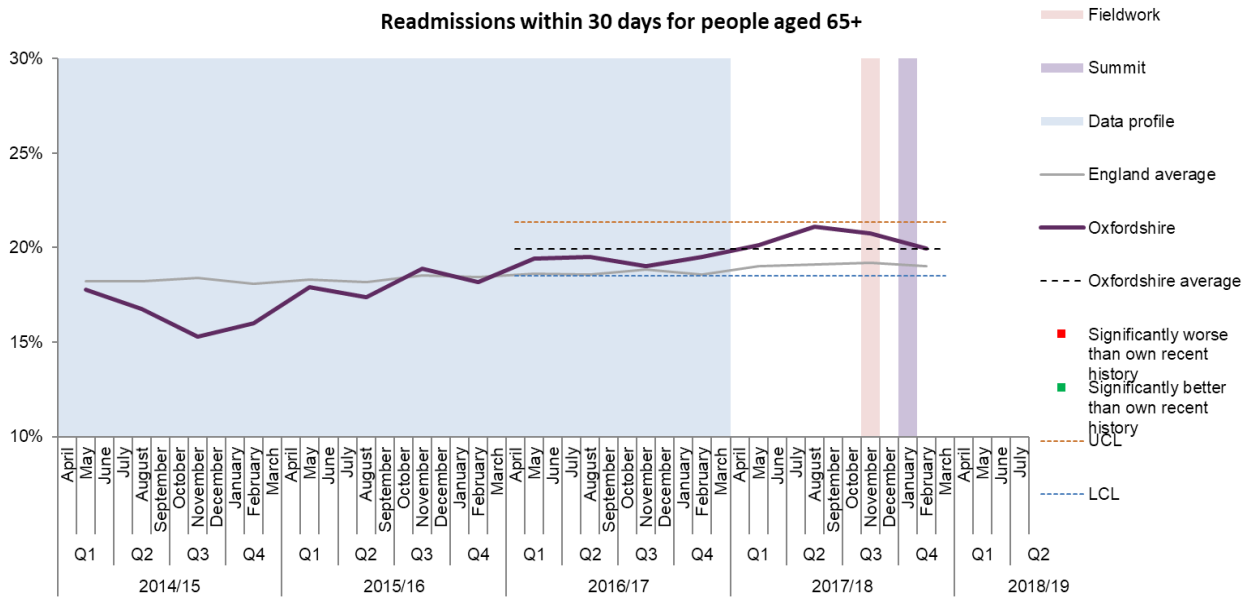
confirms that the rate has since reduced again to 16.8 days while the England average has risen slightly to 10.8 days.

Figure 5: Delayed transfers of care (18+)



Oxfordshire's rate of emergency readmissions within 30 days (65+) has remained close to 20% and slightly above the England average, 19% at quarter 4 of 2017/18.

Figure 6: Readmissions within 30 days (65+)



System progress against the action plan

What improvements have been made since the local system review?

Since our local system review in November 2017 we have noted that some progress has been made, particularly in the coming together of local leaders to begin to find local solutions to address winter pressures and pathways of care for older people. However, while the important foundations of improved culture and relationships within the system had been put in place, this did not yet fully extend to the VCSE sector and the independent provider sector.

Strategic approach to meeting the needs of older people

- Since the local system review in November 2017, we found a new drive and commitment from local leaders that had led to improved working relationships, better partnership working and a sense of shared endeavour. There was a good understanding of local population needs gained through conducting robust analysis and system-wide engagement. A draft Oxfordshire Joint Health and Wellbeing Strategy (2018 to 2023) and the draft Oxfordshire Older People's Strategy 2019 to 2024 were due to be presented to the Health and Wellbeing Board in November 2018, shortly after our progress review.
- Since our last visit, the membership of the Health and Wellbeing Board had been extended to include wider partner representation, such as the district councils and chief executives from the NHS foundation trusts, and the CCG. These were considered crucial to the resolution of system-wide issues such as affordable housing and to supporting the development of community models and local hubs.

Culture and collaboration

- At our local system review in November 2017, we identified that system leaders needed to create a culture that would support inter-agency collaboration and integration. To support our analysis, we undertook a relational audit to gather views on how relationships across the system were working. In their action plan, system leaders proactively analysed our audit results to identify key themes and issues to address. The work was built into an Organisation Development Programme facilitated through an external agency. Development workshop sessions were also held for Health and Wellbeing Board members.
- There had been changes in senior leadership across Oxfordshire County Council and Oxfordshire CCG since our local system review in 2017. Despite these changes, at our progress review, system leaders told us that relationships had improved across health and social care organisations and with elected members of the council. This had promoted more collaborative working. We heard from VCSE sector representatives that there was a more joined up approach to the development of strategy and they felt better engaged as partners, although there were further improvements to be made.

- An Integrated System Delivery Board (ISDB) had been established where system leaders met monthly to oversee the integration of the health and social care system and transformation of services. The board also had oversight of the CQC local system review action plan. At our local system review in November 2017, we found that the alignment between local plans and the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership (STP) transformation plan had contributed to delays in the development of local strategies to support older people in Oxfordshire. At our progress review, system leaders told us that the ISDB was the forum for engagement with the STP. The ISDB had agreed which components of service delivery would sit within the STP integrated care system while local delivery was addressed. This meant that wider system developments would not slow local transformation.

Winter planning

- In November 2017 our review identified concerns regarding winter planning. Some leaders and frontline staff felt that planning had been left too late and they were not confident that there was capacity in the system to cope with the anticipated winter pressures. These concerns were justified. Our analysis of performance over 2017/18 showed that although A&E attendances of people over 65 were significantly lower than the England average, there were not systems in place to manage the flow of people through hospital. The percentage of people seen at A&E within four hours was lower than the England average and although the numbers of people delayed in hospital had been reducing, these rose again in January and February 2018, and were significantly higher than the England average. System leaders addressed this in their action plan and established a dedicated Winter Team led by a Winter Planning Director with responsibility for managing flow, performance and pathways.
- The Winter Planning Director post was established in September 2018 however work on winter planning had already started in May 2018. We heard from stakeholder partners and system leaders that it had been a more collaborative approach to winter planning. They were more confident that people's journeys through hospital would be better managed in the forthcoming winter (2018/19). An evaluation of the previous winter pressures (2017/18) has been undertaken, and a series of external reviews had been commissioned to help system leaders to deliver the improvements in the winter plan. An external organisational development consultancy had been brought in to support with the design of a demand and capacity model with a dashboard to inform urgent care and Winter Team decision-making.

Market shaping

- At the local system review in November 2017, we found that there was a transactional approach to market management and the commissioning of social care services. Work to develop the domiciliary care market was in its early stages. Most delays in discharging people from hospital were caused by a lack of availability of domiciliary care packages. When we returned to Oxfordshire we found that leaders were still

struggling to shape a market that could meet people's needs at home. The provision of community support remained the largest reason for delays and was still much higher than the England and comparator averages. However, the proportion of delays caused by people waiting for a residential or nursing home placement had reduced and fewer people were delayed for this reason in Oxfordshire than the comparator and England averages.

- A Strategic Commissioning Manager for care homes had been jointly appointed by the local authority and Oxfordshire CCG. A care home strategy board had met, however the providers we spoke with told us that they had not been made aware of this or engaged with yet. A provider conference had been held the day before our progress review visit and independent social care providers had met with the new manager. The providers we spoke with were cautiously optimistic that engagement would improve despite their frustration that the work had been very slow to progress.
- The quality of the independent social care market provision had remained good in Oxfordshire which meant that the quality of provision was not a barrier to people leaving hospital. The numbers of residential, nursing home and domiciliary care services rated as good or outstanding were higher than comparators and the England average. At the time of the local system review in November 2017, there were three services rated as inadequate. When we analysed our data for this progress review, there was only one domiciliary care rated inadequate.

Workforce

- At our local system review in November 2017, there were strategic plans at organisational and STP level across Berkshire, Buckinghamshire and Oxfordshire to align the workforce to meet future demand. However, workforce challenges had resulted in heavy workloads for staff and had impacted on care delivery and integration of services. At our progress review we saw that some of the actions relating to workforce described in the action plan had been completed. There was continued attendance at the STP Local Workforce Action Board and evaluation work had been undertaken following a joint recruitment campaign.
- There were some collaborative solutions to workforce pressures being developed. The introduction of shared values-based recruitment across health and social care would ensure the right workforce to meet the needs of people as services moved towards integration. System leaders recognised that there were opportunities to use the existing workforce more creatively however this needed to be developed into a clear strategy with deliverable objectives.

Review of pathways, points of access and services

- System leaders had started to improve pathways of care for older people. They told us in their SOIR that this would be a long-term piece of work as there were 'multiple, complex pathways'. At our local system review in November 2017 we found that multiple pathways were confusing to people using services and were also a barrier to effective joint commissioning. System leaders told us that they intended to target

integration at areas where there would be the greatest impact and had started a pilot work to develop a 'frailty pathway' in three areas of Oxfordshire. The pilot was being undertaken by the GP federations, acute hospital and community services using different ways of working across organisational boundaries.

- Frontline staff we spoke with told us that they felt multidisciplinary team working had improved over the months leading up to our progress review. Staff across the local authority, acute hospital and community services had a better understanding of each other's roles which made it easier to put the person using services at the centre of their care. Community health staff had started to work with the ambulance service and staff were attending emergency callouts. This enabled staff to work together to avoid unnecessary admissions to hospital and arrange appropriate support in the community.
- There had been a lot of work focused on people who had experienced long delays in their discharge from hospital. Daily board rounds on wards had changed focus to be around determining actions rather than only providing updates. Weekly calls were taken at a higher level to discuss strategic issues that might alleviate pressures around the discharge of people who had been in hospital a long time. There were escalation processes built in so that system leaders were aware of emerging issues and could support their resolution. There was also support on the wards from the VCSE sector who helped with the liaison between hospital patients and their families.
- Discharge planning was now a part of the daily board rounds and social workers also attended. Communications with commissioning teams had also improved, supported by closer links with care sourcing placement teams. Frontline staff told us that direct payments were being routinely offered. A 'Home First' team brought together a multidisciplinary approach to enable people to be at the centre of decisions about their future care.

Housing – equipment and adaptations

- At our local system review in November 2017, we found that housing support services needed to be included within multidisciplinary working, especially in relation to admission to and discharge from hospital. Oxfordshire's updated action plan showed that the system had completed the majority of actions required to address this matter. Staff we spoke with told us that there was a 'trusted assessment' process which enabled staff to arrange equipment directly with the provider agency to save time on discharge. Waiting for aids and small adaptations was not a contributing factor to delayed discharges.

- If hospital admissions were planned, an occupational therapist could undertake advance assessments in the person's home to determine whether any equipment and adaptations would be required after their discharge. In addition, there were two 'pathway flats' where people could live for six to 10 weeks while their housing needs

were assessed and adaptations made to their properties (if necessary) or while a new place of residence, such as sheltered housing, was arranged.

- Technology was being used to support people to remain safely in their own homes. For example, some people had access to a system called 'Just Checking' which placed sensors in people's homes to monitor and analyse their activity. This meant that support could be tailored accordingly and frontline staff felt that this enabled people to stay at home and avoid residential care.

Carers

- Our review in November 2017 identified that system leaders should review methods used to identify carers eligible for support. This would ensure that carers were receiving the necessary support and services. The review also identified the need to involve carers in the review of strategies to ensure that these were co-produced. Some progress had been made in this area with carers being involved in co-producing the older people's strategy, however work is required to embed this approach in future strategy development. A meeting had been held in March 2018 with Action for Carers and Age UK to discuss plans however it was not clear how these had since developed. It was anticipated that the appointment of an independent chair for the carers group would lead to a redesign of carers support.

People who fund their own care

- At our local system review in November 2017 analysis of our data showed that 53.2% of people in Oxfordshire were funding their own nursing and residential care, compared to an England average of 38%. We identified that there needed to be better advice, information and guidance offered to people who fund their own care. System leaders told us that a Live Well Oxfordshire website had been developed in partnership with Age UK and Affinity. This was a directory of information about services that provided a range of support – from gardening and shopping, to care homes and domiciliary care agencies.

What improvements are still needed to be made?

A strategic approach to meeting the needs of older people

- Following our local system review in November 2017, system leaders identified that there was a need to improve performance reporting to support conversations with elected members of the county and district councils. There were high-level metrics to support discussions and challenge at the Health and Wellbeing Board. However, system leaders recognised that there needed to be more robust use of performance data, including timescales and outcomes. This should have a particular focus on action planning to ensure that actions were having a positive impact on local communities.

- We found that the pace of strategic development was slow. We had identified a need to review the older people's strategy and while we acknowledged that a draft strategy was due to be presented at the Health and Wellbeing Board in November 2018, a revised strategy was not expected to be agreed until the end of January 2019. This meant that it had taken more than a year to develop a strategy. Additionally, embedding a delivery plan to support the strategy had not been factored in.

Culture and collaboration

- While acknowledging the good work that has been done to ensure stronger relationships and collaborative working at system leader level, there was still a need to ensure that this work was embedded throughout all tiers of health and social care organisations. VCSE representatives we spoke with suggested that this had yet to 'trickle through' the different parts of the system. Frontline staff felt that there were still some cultural changes needed to promote better integrated working. Medical professionals and other frontline staff such as physiotherapists and occupational therapists needed to break down professional barriers so that care could be focused on supporting people to be independent at home as soon as possible.

Winter planning

- As part of the winter planning section of the local system review action plan, system leaders planned to achieve a quality premium indicator that stated that no more than 15% of continuing healthcare (CHC) assessments should take place in hospital. This had not been developed yet and the target for completion was March 2019. A CHC service specification for care homes was due to be delivered to the Better Care Fund Joint Management Group on 22 November 2018. However, the action plan did not identify further plans for consultation, rollout and delivery. We heard that there were continued delays in CHC assessments and concerns about funding arrangements with providers to manage this. There was a risk that people with complex needs could stay in hospital longer than they needed to.

Market shaping

- Although work had started to involve independent social care providers in commissioning, this area remained underdeveloped. Providers did not feel engaged and felt that there were missed opportunities to work together to shape the market. They felt that there was not a clear framework for evaluating the effectiveness of contracts and that the approach to commissioning had not changed for many years. They felt that information about increasing cost pressures was disregarded rather than discussed. Providers told us that evaluation information and data were regularly collected and shared with the local authority, however they were not assured that the data was reviewed, considered or used to inform commissioning. System leaders acknowledged that more engagement with providers was needed. Providers had not been aware that a new care home board for Oxfordshire had met. A care home

strategy had not yet been developed, however system leaders told us that they planned to cover this as part of a refresh of market position statements.

Workforce

- In November 2017 we recommended that the STP workforce strategy be implemented. A draft workforce strategy for Oxfordshire had been presented to the ISDB in October 2018, however this had not yet been agreed and implemented. While it was recognised that recruitment, particularly in the domiciliary care sector, was a challenge for Oxfordshire, we did not see evidence that the development of the workforce strategy was being progressed with a sense of urgency. The first discussions with independent social care providers had been held the day before our progress review visit at a provider conference. System leaders told us that their ambition was to build a system-wide strategic approach. However at the time of our progress review they were still mapping this. The plan was to coordinate this through the Local Workforce Action Board aligned to the STP.

- There was further work required to develop plans for the workforce in line with the action plan. A joint recruitment campaign had been evaluated and further funding was being sought to undertake an evaluation of people's access to an online recruitment portal. Analysis of our data showed that adult social care staff vacancies had increased during 2017/18 although the data was in line with the England average and lower than comparator areas. Vacancies in the independent provider sector also presented a major system challenge. Representatives from this sector sat on the Oxfordshire workforce board.

Review of pathways, points of access and services

- At our progress review, frontline staff raised concerns about the lack of domiciliary care in some parts of Oxfordshire. We heard that this had a serious impact on the work of community nurses who were required to provide support for people due to the lack of available domiciliary care. We heard that this was a problem in the previous winter and many were concerned that this might happen again in the approaching winter.

- Despite improved multiagency working to plan people's discharge from hospital, there were still barriers to the flow of people out of hospital. Frontline staff told us that discharge to assess processes weren't always effective and that this caused delays. There were jointly commissioned 'liaison hub beds' which provided step down beds, and virtual wards in care home units. However staff noted that when decisions were made in a bed-based setting, there tended to be over prescribing of care. There was still work to do to alleviate the concerns of medical staff who may tend to be risk averse.

- Staff remained frustrated by the different IT systems that had an impact on sharing information effectively. For example, in the hospitals, multidisciplinary teams were able to share information with each other but this relied on staff members being present as

they could not access each other's systems. If hospital and social care staff had different working patterns, information could not be shared.

- As part of our response to our initial review in November 2017, the action plan addressing pathways of care described a number of actions as complete, such as reviews of the Home First service and short-stay beds. A new model for discharge had been identified based on three simplified pathways of care out of hospital. It was not yet clear when these would be rolled out.

Housing – keeping people in their own home

- At our review in November 2017, we identified that housing support services should be included in multidisciplinary working to support identifying people's needs earlier so that they could be helped to live at home. There was further work to do with system leaders who managed planning and housing. For example, in one area there were a lot of new build homes intended to be lifetime homes. However, the structures did not have the strength to support some adaptions. For example, ceilings could not take track hoists. Work was underway to develop closer links between occupational therapists and district teams to address issues such as these. There was a need for a wider system understanding of the impact of changing demographics and an ageing population.

- Funding for housing adaptations was inconsistent across Oxfordshire. For example, in one part of the county, Better Care Fund support for the Disabled Facilities Grant (DFG) meant that means testing for equipment and adaptations was not required up to a certain limit, whereas in other parts of the county this was not applicable. System leaders were restricted in how they could address this as DFG allocations to local housing authorities are determined nationally.

- Frontline community and social care staff felt that there was still a tendency for hospital staff to be risk averse. There needed to be a greater understanding of the benefits of equipment and technology and the extent to which that could enable people to remain independent. Staff felt that there was an emphasis on providing care packages to meet people's needs and alternative options were not maximised.

Carers

- The action plan arising from our local system review in November 2017 described actions relating to care and support for people in caring roles. However, it did not clearly articulate how system leaders could assure themselves that carers were receiving support and had access to services. This presented a risk that people would not come into contact with services until they were in crisis. Opportunities to offer early support to enable families to stay at home together could therefore be missed. There was a carers strategy in place however system leaders acknowledged that this work was underdeveloped.

People who fund their own care

- In November 2017 we heard that 53.2% percent of people funded their own residential and nursing home care provision. This was higher than the comparator average of 44.7% and the England average of 38%. Support for people who fund their own care was not prioritised by system leaders and key actions described in the action plan, for example the creation of a brokerage service for self-funders, did not have planned delivery dates. System leaders acknowledged that their plans were underdeveloped.

- We heard from staff that there was a need to provide further support for people who fund their own care. We heard that neighbouring authorities had developed a core offer for assessment of self-funders and early work had started on this in Oxfordshire but it was not yet in place. It was recognised that a lack of routine assessment and signposting may lead to people unnecessarily opting for long-term and sometimes inappropriate residential care. Frontline staff felt that many people who were delayed in hospital were self-funders with some people choosing to move into residential care.

- System leaders recognised that this was a shortfall, however they told us that they had needed to prioritise work around organisational development and winter planning.

What are the reflections of system leaders in Oxfordshire?

- System leaders told us that there had been improved relationships and collaboration across health and social care organisations. They intended to build on this as they transformed services to realise their vision of integrated health and social care services in Oxfordshire.
- Work to co-produce strategic and operational plans with people who use services, independent providers and the VCSE sector was seen as a key enabler by leaders across the system. There was a recognition of the need to strengthen this way of working.
- There was a recognition that the pace of change was slow. They felt that the timescales in the original action plan were optimistic given the scale of change required. Now that they had made some key appointments there was an opportunity to start to plan and deliver more ambitious plans at pace.
- A number of workstreams were aligned and system leaders were active in the Buckinghamshire, Oxfordshire and Berkshire West STP. Leaders were also mindful of the need to develop strategic plans for Oxfordshire based on local needs and reflect the balance required between the STP and local plans to achieve the best outcomes for people.

Direction of travel

Areas for future focus

- The good work to develop relationships and address cultural change should continue and be embedded throughout the Oxfordshire health and social care system to improve the quality of services for older people in Oxfordshire. The older people's strategy should be agreed and implemented.
- The good work to develop relationships and address cultural change should be embedded throughout Oxfordshire's health and social care system. This should include engagement with the VCSE sector and independent providers.
- Timescales and targets for service delivery should be more ambitious to improve the pace of transformation. This includes plans such as the rollout of the CHC service specification. Reviews and evaluations of projects and pilots should be translated into decision making and wider delivery where appropriate.
- Performance metrics and reporting should be improved to support oversight and challenge with elected members of the district and county councils. These also need to be developed to provide outcome measures to test the effectiveness of plans.
- Commissioning with the independent social care market should be reviewed to move away from a transactional and traditional approach, and providers should be engaged in plans to support the development of the market.
- The draft workforce strategy for Oxfordshire should be agreed with the STP and implemented at pace, including the work with independent social care providers to support a sustainable workforce.
- The comprehensive review of pathways of care should be undertaken. Discharge to assess processes should be evaluated and streamlined to move away from bed-based assessments where possible. Housing needs, particularly equipment and adaptation needs, should be addressed as part of this review.
- Further organisation development work should take place to address the culture of frontline staff, particularly medical staff, to enable a strength-based approach to care planning.
- Support for carers and for people who fund their own care should be developed, particularly plans for the brokerage system which need to be allocated deliverable timescales.

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Oxfordshire Growth Board

Healthy Place-shaping in the Wider Growth Agenda

Introduction

There is growing evidence that significant benefits for local people can be achieved through bringing together planning for housing, infrastructure and the economy with planning for residents' health and wellbeing.

No single aspect of people's lives determines their health and wellbeing. Factors as varied as employment status, transport options, quality of housing and access to green space all affect people's health outcomes.

Making sustainable change for the better requires a local approach, aiming to change the behaviour and health status of individuals in communities. *This paper sets out how we can achieve these benefits both at scale and locally by including the concept of 'healthy place-shaping' in our strategic planning frameworks.* Combining a strategic approach with one which is locally sustainable is key to success.

This means that as we seize the growth agenda in Oxfordshire, we can simultaneously create lasting benefits for the health and wellbeing of future generations of local people. This approach also promises to improve productivity, improve efficiency and provide better value for tax-payers.

This paper builds on our local experience and sets out clear proposals for how we can bring together planning for housing, the economy and infrastructure with planning for health and wellbeing. In summary we are proposing:

1. to produce, on behalf of the Growth Board, a strategy for how healthy place-shaping can ensure that development supports the creation of healthy communities.

2. to insert the approach to healthy place-shaping into the governance structure and workstreams of the Growth Deal and Growth Board and the strategies which underpin them (the Joint Statutory Spatial Plan, the Local Industrial Strategy and the Environmental Strategy). Each of these strategies has a major role to play in taking forward healthy place-shaping and will ensure a mutual influence between these important strategic building blocks and will help to unite them as a cohesive whole.

3. to create a network of officers from across our respective organisations to take this work forward, and to appoint a lead officer to coordinate this approach.

4. to hold a countywide workshop for senior Councillors and officers on this topic as set out in the programme for the Joint Statutory Spatial Plan (JSSP) prior to its public consultation in February 2019.

Our Local Experience
The principle of bringing together planning for 'place' and planning for 'health' has been acknowledged in Oxfordshire through a variety of routes in the last two years. For example:

- Leaders of Local Authorities making a commitment to find ways to spread the learning from the Healthy New Towns initiatives in Cherwell and the City to other areas in the County at a workshop for Leaders and senior officers held in Bicester in April 2018. This learning from the 'grassroots up' is fundamental as it tells us at a micro-level the types of change we need to make to improve local people's health, increase their use of services and be actively engaged in the planning of their local communities. This learning is at the heart of healthy place-shaping.

- Discussions between Chief Officers of Local Authorities, the NHS the Local Enterprise Partnership (LEP) and the Universities over the last two years aiming to integrate health and social care planning with local planning.

- The NHS's proposals to re-design community services in various parts of the County alongside Local Authority services with the involvement of local people. This initiative is being taken forward under the auspices of the Health and Wellbeing Board.

- Improvements made to services for homeless people and victims of domestic abuse through the combined efforts of all Local Authorities, the NHS and the voluntary and community sector.

- Building the principles of active travel into our Local Transport Plan and recognising the positive impact of this on the health of local people.

- The importance to the local economy of health care and social services and the impact on these services of high house prices, workforce shortages and increasing travel times. Senior officers have long realised that no single organisation acting alone can hope to ameliorate these factors.

A unique opportunity for action
District, City and County Leaders are uniquely placed to take these issues forward because of the unique opportunities available to Oxfordshire at this point in time. These are:

- The presence of two out of the ten national Healthy New Town pilot sites and the practical learning gained from them.
- The successful conclusion of the Growth Deal with Central Government.
- The current work to create a Joint Statutory Spatial Plan a Local Industrial Strategy and a 25 Year Environment Plan.

- The potential to generalise this learning through re-framing local planning policy.
- The forthcoming Housing and Infrastructure Fund proposals
- The re-launching of the Health and Wellbeing Board, its commitment to strengthen Local Authority membership, its support for healthy place-shaping as one of its priorities and its commitment to oversee the local transformation of community services.
- The emerging UK Shared Prosperity Fund (UKSPF), the successor to EU funding, which is expected to be deployed in 2021. Social and economic inclusion, as well as skills and training opportunities are expected to feature in UKSPF. Whilst policy has yet to be finalised it's expected UKSPF will be deployed via LEPs
- Oxon 2050 as an umbrella strategy, if pursued.

This presents Leaders with a window of opportunity. Action now can crystallise these opportunities and create a unified planning framework which will benefit local people and local communities over the coming decades.

We can also secure a valuable complementarity and coordination of action between the Growth Board and the Health and Wellbeing Board. This helps to bring together the work of two of our most strategic Boards under the banner of healthy place-shaping. The concept of healthy place-shaping also includes aspects of community safety. The third strategic partnership of relevance to this agenda is therefore the Community Safety Partnership. Taking this first step, as set out in this paper, may also open the door to future discussions between the Growth Board, Health and Wellbeing Board and Community Safety Partnership seeking to unify our approaches to residents' health, wellbeing, prosperity and safety across these three strategic Boards.

Taking this approach will also maximise the spend of the 'Oxfordshire £' with District and County services working in a joined-up approach with the NHS to create healthy communities for local people.

How can this be achieved?
We can do this through taking the local learning from the Healthy New Towns and the concept of *'healthy place-shaping'* and systematically applying it to our current strategic planning through the Growth Deal mechanisms and through influencing our future local plans.

What is healthy place-shaping?
Healthy place-shaping is a practical mechanism for creating healthier communities though unified planning. It can be defined as an approach to planning as follows:

'Healthy place-shaping is a collaborative process which aims to create sustainable, well-designed communities where healthy behaviours are the norm and which provide a sense of belonging and safety, a sense of identity and a sense of community.
It is also a means of shaping local services, infrastructure and the economy through the application of knowledge about what creates good health,

improves productivity and benefits the economy, thus providing efficiencies for the tax-payer.'

Healthy place-shaping is based on 3 concepts:

1. Shaping the built environment, green spaces and infrastructure at a local level to improve health and wellbeing.
2. Working with local people and local organisations, schools etc to engage them in planning places, facilities and services through 'community activation'.
3. Re-shaping health, wellbeing and care services and the infrastructure which supports them to achieve health benefits, including health services, social care, leisure and recreation services, community centres etc.

Crucially, healthy place-shaping is not just about new developments; it applies to any geographical area experiencing significant change or growth so that all residents have the opportunity to benefit in terms of health and wellbeing.

It also applies to how we connect new developments to existing communities, as there is growing evidence showing that loneliness and social isolation (often transport related or due to commuter towns) are impacting the health of rural populations across the UK, and not just the elderly – often this involves those as little as a mile from a local centre of population as without access to transport, it may as well be 20 miles.

*Thus, healthy place-shaping is an **approach** to planning healthy communities which can be applied in many ways at many levels. In Oxfordshire it can be applied at 3 geographical levels:*

1) Level 1. Town/village/ new development level.
Healthy place-shaping applied to all new and existing developments within Districts and the City so as to create healthy communities in the broadest sense. This draws directly on application of the learning from the Healthy New Towns approach. It involves very local changes to individual's behaviour, lifestyles and engagement alongside changes to local infrastructure and services. This is fundamental as a concept and underpins the two approaches below.

2) Level 2. Locality level.
The applies to the re-design and transformation of services in localities covering larger populations (approximately 100,000-150,000). This approach considers how the services of many organisations (including NHS, Local Authority and voluntary sector organisations) and their built assets and supporting infrastructure interlock to benefit the health and wellbeing of local residents.

3) Level 3. County level and beyond.
This applies the approach to health and wellbeing issues affecting larger strategic infrastructure plans. It covers for example travel and transport planning, workforce planning, the development of the local economy and productivity issues. These factors are integral to the health and wellbeing of local residents and the development of future health and care services.
In Oxfordshire for example we have successfully supported the implementation of Community Employment Plans (CEP) through Planning Policy where major

development has taken place, this practice could be adopted more widely. The impact of this would be to create opportunities to ensure communities share the benefits of improved prosperity, associated mobility and housing choice and in so doing promote improved personal and family wellbeing.

How does this approach deliver benefits?
The approach offers much because it tackles head-on many of the current challenges society faces. The challenges and potential improvements to be made are summarised in the table below:

Challenge	Potential Improvement	Geographical Level
Lack of coordinated planning between statutory organisations	Unites organisations, services and the public behind a common purpose.	1,2,3
Separate planning systems for 'health' and 'place'	Unites all planning systems under a single banner.	1,2,3
All organisations are under financial constraints.	Assists overburdened NHS and Local Government services through shared efficiencies.	1,2,3
The growing number of cases of dementia in an ageing population.	Creating dementia friendly communities.	1,2
Reducing levels of physical activity which leads to obesity and chronic disease.	Creating cyclepaths, delineated walks, safe and attractive green spaces and walking and cycle friendly routes and pedestrian zones.	1,2
Increasing rates of chronic disease such as diabetes.	As above plus prevention-orientated health services and social prescribing such as the prescription of exercise.	1,2
Lack of social cohesion.	Community involvement in planning, planning communal spaces and facilities, improving community safety and supporting community activation.	1
Lack of community engagement in local planning.	Community activation which works to involve local people, organisations and groups in planning.	1
Lack of social contact and loneliness.	Planning communal areas and facilities. Social prescribing. Supporting community development.	1,2
Increasing rates of minor mental health problems.	Facilitating physical activity and community participation. Social prescribing. Prevention work in schools and workplaces.	1,2
Failure to engage and coordinate the activities of schools, practices, leisure centres and libraries.	Building engagement of local services into local planning methodology.	1
Getting people with health problems back into work.	Targeted approaches with local health services and support for wellbeing-at-work schemes.	1

Persistent social disadvantage and inequality.	Services targeted to meet local needs for specific areas or groups that engages with and draws on the insight of those with greatest needs.	1,2
Difficulties in engaging 'hard to reach' groups.	Services targeted to meet local needs for specific areas or groups based on local insight.	1,2
Unifying preventative services into a single 'offer' for the public.	Through closer joint working between Local Authorities, the NHS and the voluntary and community sector.	1,2,3
Reducing environmental pollution and carbon emissions. Concerns over health effects of particulates in the air.	Better planning and design of housing and transport. Promotion of and support for Active Travel.	1,2,3
Disconnected and duplicative local services from uncoordinated estate.	Incorporates the principles of 'one public estate' within the planning system.	1,2
Increasing travel times for service delivery to people's homes and home to work travel times.	Development of neighbourhood models of service provision. Consideration of travel times in strategic infrastructure planning. Considering the siting and character of businesses.	2,3
Workforce shortages for nursing and home care staff.	Delivery of affordable homes. Development of attractive communities that will encourage recruitment and retention of staff.	2,3
Flows of urgent cases to hospitals within and beyond the County	Better planning and design of housing, transport and health services. Considering these factors in strategic infrastructure planning.	3
Local skills shortages leading to future recruitment difficulties.	Consideration of these matters in forward planning with higher education providers, planning for the local economy and planning the nature and siting of local businesses	3
Planning for the health estate separate from planning for new housing.	Planning for housing growth supporting the planning for the health estate alongside other community assets.	1,2,3
Disconnection between regional hospital planning and infrastructure planning.	Closer joint working between health and planning. Consideration of these factors in strategic infrastructure planning.	3

What is the evidence that this approach would work?

The evidence exists at three levels.

1. There is emerging evidence from local and national experience with Healthy New Towns that these are constructive and powerful ways to engage local people and improve health. We have two years' practical experience of what really makes a

difference to local people through the implementation of initiatives in Barton and Bicester, and though it is too early to be precise, the results are very encouraging.

2. There is good national research evidence linking the benefits of increased active and health lifestyles to economic benefits, benefits to productivity, benefits to the workforce and a reduced need for health care services.
There is good evidence linking the benefits to an individual's health with benefits to the economy, productivity and value for money through for initiatives such as active travel and social engagement.
The health effects of factors such as air pollution are also well documented.

3. There is considerable local experience among Leaders and senior officers of the synergies and efficiencies that can be gained from better joined-up planning. Examples of this include the Growth Deal itself, multiple initiatives joining up health and social care and recent local experience with services such as domestic abuse.

However, it should be noted that we are proposing here to create a comprehensive planning *framework* for the future. The benefits gained cannot be precisely defined at this stage – that is the work of the next few years – but the opportunity to create such a framework is a unique one and the time to consider such a decision is now. Creating such a framework would enable these potential benefits to be realised. This comes down to a matter of political and managerial judgement. We believe that the managerial case is strong enough to support the proposals in this paper. We are seeking the views and approval of Leaders to proceed forward from this point.

The box below provides a selection of facts regarding the challenges we face and the benefits to be gained, drawn from national sources.

- 1 in 5 people in the UK often feel lonely which is a risk factor for poor health. (The Health Foundation) 5% often or always feel lonely (Public Health England)
- Befriending services payback £3.75 in reduced mental health service costs for every £1 spent. (King's Fund)
- Children in deprived areas are nine times less likely to have access to green spaces and places to play. (The Health Foundation)
- Increasing access to parks and open spaces could reduce NHS costs by 2Bn p.a. (King's Fund)
- Only 10% of our health and wellbeing is determined by access to health care. The rest is influenced by housing, the quality of our work, income, education and skills, the food we eat, transport, family, friends and communities. (The Health Foundation)
- Younger generations are becoming obese at earlier ages and staying obese into adulthood. Obesity is twice as common in the 10% most socially deprived children compared with the 10% least deprived. (Public Health England)
- Over half of adults are now overweight or obese. (Public Health England)
- The annual costs associated with obesity to the wider economy, NHS and social care systems are estimated to be £27 billion, £6.1 billion a year and £352 million respectively. (Public Health England)
- There are 3.8 million people in England with type 2 diabetes (obesity being a major cause). There are 200,000 new diagnoses per year. This costs just under 9% of the NHS budget. (Public Health England)
- Dementia in the UK costs 10.3Bn in social care 4.3Bn to health care and 11.6Bn on unpaid care. There are 850,000 people with dementia in the UK. By 2050 the figure will exceed 2 million. (Public Health England)
- Regular physical activity reduces the risk of dementia by 30%, mortality by 30%, type 2 diabetes by 40% and hip fractures by up to 68% (Public Health England)
- 2 in 5 people think people in their neighbourhood can be trusted (Public Health England)
- Every person moving from worklessness to work saves the economy £12,000 p.a. (public Health England)
- 1 in 3 current UK employees have a chronic medical condition. 1 in 8 have a mental health condition. (Public Health England)
- The economic cost of working age ill health is £100bn a year to the national economy, with 131m working days lost. (Public Health England)
- School-based health interventions e.g. smoking prevention can save £15 for every £1 spent. (King's Fund)
- Housing interventions to keep people warm, safe and free from cold and damp save the NHS £70 over ten years for every £1 spent (King's Fund)
- The estimated cost of poor housing to the NHS in England is 1.4Bn p.a. (Public Health England)
- Nearly 80% of car trips of less than 5 miles could be replaced by active travel. (King's Fund)
- The cost to society of transport-induced poor air quality, ill health and road accidents exceeds 40Bn per year. Getting one child to walk or cycle to school could pay back £768. (King's Fund)

What are our proposals?

The thrust of our proposals is to insert the approach to healthy place-shaping into the governance structure and workstreams of the Growth Deal and Growth Board, so

that over time, this approach becomes part of normal planning considerations, and influences the production of local plans.

We therefore propose:

1. that the Growth Board requests the production of a strategy for how healthy place shaping can ensure that development supports the creation of healthy communities. This will inform the work of the Growth Deal and Growth Board workstreams across the board.

2. that officers with a remit for healthy place-shaping are embedded into the Growth Board sub-structures including the Growth Deal Programme Board and the workstreams for the JSSP, infrastructure, housing and productivity working with the LEP.

3. that healthy place-shaping is embedded into the development of the JSSP, the local industrial strategy and the environment strategy. This will ensure influence over the strategic design and siting of local communities and local industry and will also embrace environmental concerns. This will also enable the principles of healthy place-shaping to be incorporated into the Local Plans of the future in the City and Districts.

4. to create a network of officers from across our respective organisations whose role (in addition to their other duties) will be to understand and keep up to date with the developments in the approach to healthy place-shaping and its evolving evidence-base. The intention is that healthy place-shaping becomes a routine part of planning in the County, and so the network will be drawn from officers with specialist knowledge of implementing healthy place-shaping and our various Local Authority planning departments as well as from the NHS, public health and other partners. We also propose to appoint a lead officer and CEO sponsor to coordinate this approach across the work of the Growth Board and Growth Deal.

5. to hold a countywide workshop for senior Councillors and officers on this topic as set out in programme for the Joint Statutory Spatial Plan. This will scope further the potential for this approach and will help to define how it will be included in the JSSP when it goes for public consultation in February 2019. We propose convening this jointly with the Health and Wellbeing Board which will further serve to strengthen joined-up planning across all organisations.

Recommendation
Leaders are asked to approve these proposals.

Chief Executive Officers of:
Cherwell District Council/ Oxfordshire County Council, South Oxfordshire District Council/ Vale of the White Horse District Council, Oxford City Council, West Oxfordshire District Council, Oxfordshire Clinical Commissioning Group, The Local Enterprise Partnership. 18/11/2018

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