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 ≤ 58, BP ≤ 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

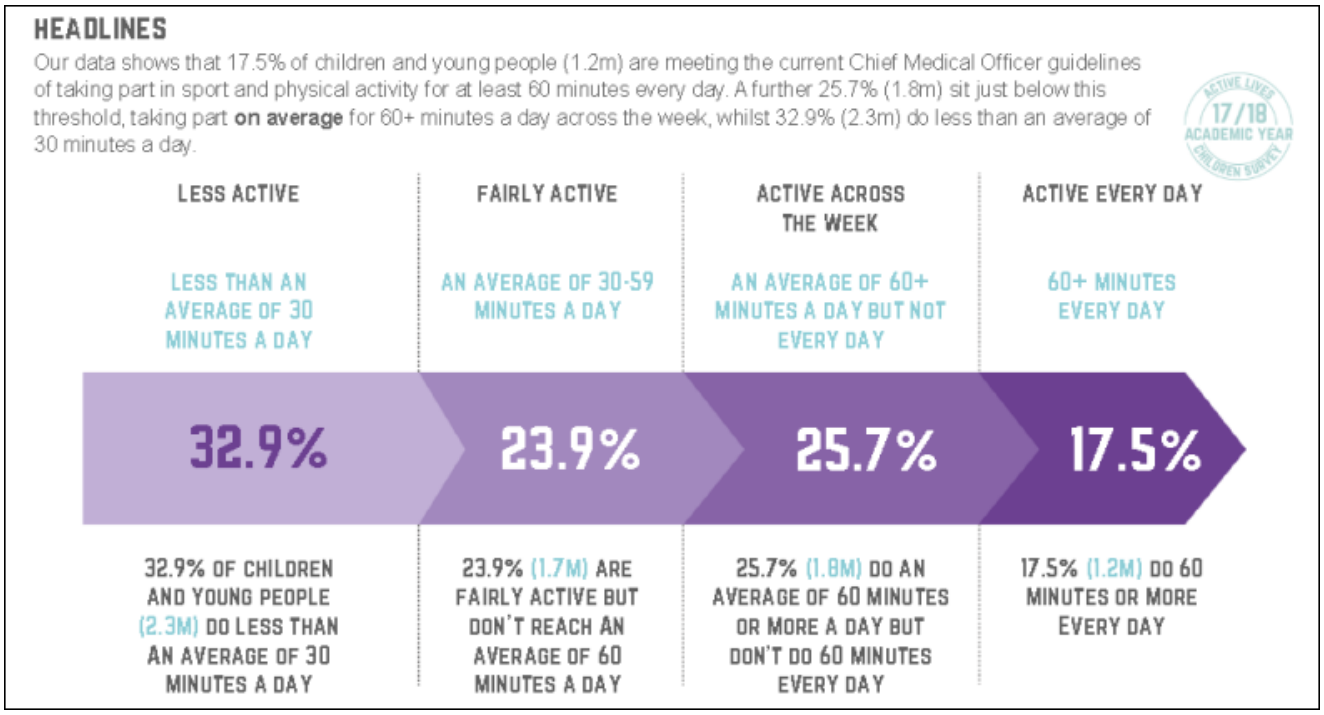
- Life expectancy by ward data for Oxford shows a significant increase in **male life expectancy** in the more affluent North ward and no change in male life expectancy in the more deprived ward of Northfield Brook. The gap in male life expectancy between these two wards has increased from 4 years in 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

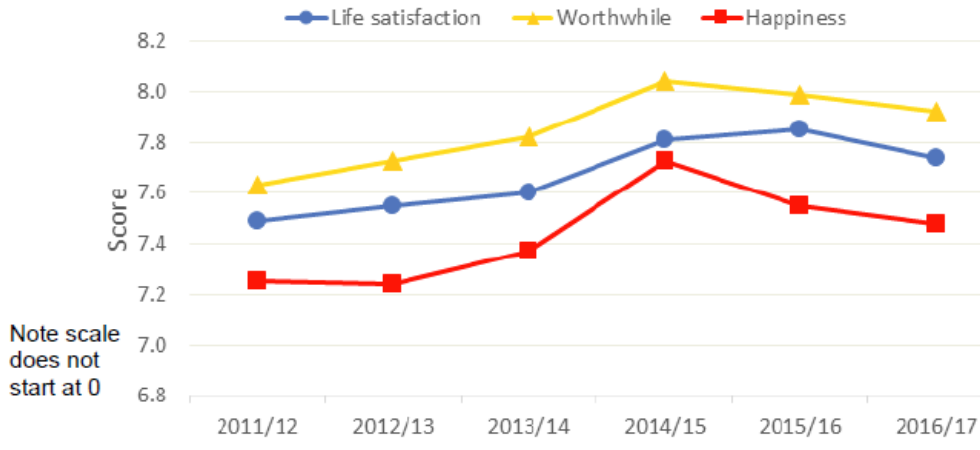
Indicator	Period	England	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
Percentage of physically active adults - current method	2016/17	66.0	70.1	64.8	74.0	67.1	73.1	71.9
Percentage of physically inactive adults - current method	2016/17	22.2	18.6	18.9	17.6	21.9	16.3	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%)