Health Inequalities Commission
Update on implementing the recommendations

Report to the Oxfordshire Health and Wellbeing Board, March 2017

Background

The independent Health Inequalities Commission for Oxfordshire carried out its work throughout 2016. The report of the Commission was presented by the Chair, Professor Sian Griffiths, to the Health and Wellbeing Board in November 2016 and at a launch event on 1st December, chaired by the Leader of the County Council, attended by a very wide range of stakeholders.

Professor Griffiths will also present the findings of the Commission to the Growth Board on 29th March 2017.

The Health Inequalities Commissioners were independent members selected from public and voluntary sector organisations and academia. They received written submissions and verbal presentations from a wide range of people and organisations at four public meetings held around Oxfordshire in the winter and spring of 2016. Local data and information on health inequalities were also presented to the Commissioners supported by access to a wide range of local and national documents, including the Director of Public Health Annual Reports, the Joint Strategic Needs Assessment and data from Public Health England.

The 60 recommendations in the report which are arranged in a set of themes:

- Five Common Principles
- Cross cutting themes of access to services, housing and homelessness, rurality
- Promoting Healthy Lifestyles
- Life course approach, focussing on Beginning Well, Living Well and Ageing Well.

The Health and Wellbeing Board has received the report and agreed to oversee the next steps of dissemination, implementation of recommendations and evaluation of the impact on health inequalities.

The full report and Headline report can be found here:
http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/health-inequalities-commission/health-inequalities-findings/

This paper outlines the process underway to implement recommendations from the report and sets out some proposals for next steps.

The role of the Health and Wellbeing Board in overseeing implementation

The Health and Wellbeing Board has a non-executive role in overseeing the operationalization of the recommendations from the Health Inequalities Commission and ensuring that progress is measured and reported.

The Health Inequalities Commission set out their advice on which organisation should lead on implementation for each of the recommendations. This designation of recommendations is included in Annex A.

However, although there is a named lead organisation or partnership for each recommendation, most of this work cannot be done by one organisation alone. Other partners are expected to engage in taking each recommendation forward. An Implementation Workshop will take place in April 2017 and it is hoped that more details and action plans will result from the discussions there.

The Health and Wellbeing Board is asked to consider and discuss the proposals set out in this report, agree the process for implementing recommendations in the Health Inequalities Commission Report and ensure that progress can be measured and will be reported.

Setting out a process and making progress

1. Widespread dissemination of the report

Since its publication the report has been discussed by a wide range of groups and partnerships and has been accessible to individuals via the CCG website.

The report has been on the agenda for the meetings listed below, though it should be noted this is unlikely to be an exhaustive list. Discussion at each meeting is likely to have resulted in action for the organisation concerned, though this cannot all be reported here.

- Oxfordshire Clinical Commissioning Group (OCCG) Executive, OCCG Board, OCCG Board workshop, OCCG Locality meeting
- Oxfordshire Health and Wellbeing Board
- The Children's Trust
- The Health Improvement Board (workshop)
- Joint Management Group for Older People
- Local health partnerships in Wood Farm, Rose Hill
- Oxford University Hospitals Trust Management Executive
- Oxford University Hospitals Trust Public Health Steering Group
- Stronger Communities partnership
- Cherwell Local Strategic Partnership
- Oxford Health Foundation Trust Board
- Oxford City Scrutiny Committee
- A seminar at Oxford University Hospitals Foundation Trust

One example of a new approach from the CCG Board is the appointment of an Inequalities Champion who will ensure that a renewed focus on inequalities issues is taken at the highest strategic level.

2. Implementation

The recommendations will be implemented by including them within existing work programmes. This will include:

a. Adapting and developing existing systems and processes

There is a consensus that work to implement the recommendations should be embedded in existing systems and processes. Partners are reluctant to set up new structures or write separate action plans but want to include action in their mainstream plans. The report highlights one way to do this is to take the Health in All Policies approach . All partners have welcomed the opportunity to renew and further develop their focus on health equality of outcomes across the population.
Ideas for making sure that services address identified health inequalities of access and outcome include:

- **Equality impact assessments** – commissioners can make better use of population level data to identify health inequalities and ensure services are available and appropriate for those who experience worse outcomes.
- **Equity audits** – service managers can use information on who accesses their services to make sure there are no barriers to particular groups who will have worse outcomes as a result.
- **Better reporting** – for example including more reports of variation in outcomes in the JSNA and in needs assessments for commissioning.
- **Setting targets to reduce variation** – for example through the Joint Health and Wellbeing Strategy where targets for improving the worst outcomes are added to ambition for overall improvement for the whole population.
- **Shift the focus** – either by looking at the needs of people in particular places or for specific groups rather than assuming a universal service will meet all needs.
- **Using the levers of Contract management** – for example to gather evidence of “reasonable adjustment” for people with additional needs.

b. Furthering the Prevention agenda

Partners have already reported that there are opportunities to further the prevention agenda locally. There is also an appetite to continue with current work and learn from the findings of the Health Inequalities Commission in developing existing programmes. This includes

- **Sustainability and Transformation Plans in the NHS**. The Five Year Forward View for the NHS sets out a clear agenda for a shift to prevention in all health services.
- **Making Every Contact Count** – professionals in health and other settings can raise the subject of healthy lifestyles with their clients. This should continue to develop to include a holistic approach to mental wellbeing and physical health.
- **Oxfordshire Sport and Physical Activity** bid to Sport England
- **Health in All Policies** adopted by all partners.

- **NHS Healthy New Towns** – Barton and Bicester. Developing new housing provision with healthy outcomes in mind and disseminating the learning to other areas.

c. Building on Existing Projects

It is clear that there is an abundance of work already underway to address inequalities in Oxfordshire. However, it is also clear through the work of the Commission that there is more to be done. This is likely to include

- **A focus on inequalities in bids for funding** and development of programmes – such as recent work with care leavers, asylum seekers, preventing homelessness.
- **Refreshing plans for existing programmes** – such as Stronger Communities in the City and Brighter Futures in Banbury
- **Targeting initiatives at groups with poor outcomes** – using data to ensure that services are well targeted and not "one-size-fits-all". For example the CCG are piloting new initiatives in small areas or specific groups of people such as social prescribing in Barton, a rapid access clinical unit in Henley, setting up talking therapies for people who may struggle to manage their long term conditions.

d. Preliminary discussion about setting up an Innovation Fund

The Health Improvement Board held a workshop to discuss the detail of the Health Inequalities Report in December 2016. One area of discussion was the potential for setting up and using an Innovation Fund to take forward this work. This idea will be discussed with the Growth Board.

3. Developing a Basket of indicators

It is essential that the work of implementing recommendations results in measurable improvements in population health, especially for those who are currently experiencing the worst outcomes.

Recommendation 3 states: "Local indicators on progress towards reducing inequalities should be developed, with regular reporting to the Health and Wellbeing Board. This should be in place by the end of 2017"

It is proposed that Public Health lead on this work and there will be discussion on details with partners at the Implementation Group.

A proposal to monitor the trends and variation for a range of indicators affecting children's life chances have already been made in the Director of Public Health Annual Report published in 2016. An extract from that report is included below, and it is suggested that they should form the basis for compiling the basket of indicators, with others being added to give wider set. For example, a set of national Marmot indicators is available from Public Health England and could be used locally.

Director of Public Health Annual Report for Oxfordshire
Report IX, May 2016 Jonathan McWilliam

Breaking The Cycle Of Disadvantage Part III: A Basket of indicators for Disadvantaged Children

Given the proposed changes to children's services in the County, I am keen to monitor the trends in children's life chances using reliable indicators so that we can assess any overall future impact.
The dilemma here is that the data we can rely on tends to come at County level, or District level at best. It will be important to find ways to dig into this data in future years to look more closely at these issues more locally - this is work that the Children's Trust might take on. As we look more locally the numbers will be smaller and will tend to vary, so data from service performance and informed opinion will come into play too. That said, it is important to establish a good baseline now, and that is what I am trying to do here.
The point of setting a baseline now is to draw a line in the sand that can be used to see if things are getting better or worse in future reports.
The indicators I have chosen look at outcome measures that together try to give a picture of children's life-chances in Oxfordshire.

1. Percentage of children (under 16 years) in Low-Income Families
2. Under 18 conception rate per 1,000 female population aged 15-17 years
3. Teenage mothers (ie teenage conceptions which do not result in termination)
4. Percentage of Infants aged 6-8 weeks who are being breastfed
5. Percentage of 2 year olds who have received one MMR vaccination
6. School Readiness: the percentage of children achieving a good level of development at the end of reception
7. Percentage of pupils achieving 5+ A-C grades at GCSE, including English and Maths*
8. 16-18 year olds not in education employment or training
9. Percentage of children in Reception Year (4-5 year olds) who are obese
10.Percentage of Year 6 children (10-11 years) who are obese
11.Households accepted as homeless
12.Households in temporary accommodation

The Health Inequalities Commission acknowledged that there are some limitations in reporting inequalities because of missing data. This includes details of protected characteristics such as ethnicity or sexuality in some instances. This means that there are gaps in knowledge about whether some vulnerable or disadvantaged groups are accessing services. The data may be missing because better recording is needed or it may be as a result of individuals preferring not to have personal details recorded. Work to understand and make improvements in data recording needs to continue. This includes what data can be shared between different agencies

4. Next steps

- An Implementation Workshop is being arranged for April 2017, supported by the CGG. This will provide an opportunity for a wide range of partners to discuss practical details of implementing recommendations (some of which have been outlined above).

- The Chairman of the Health Improvement Board and the Clinical Chair of the CCG will be attending the Growth Board at the end of March 2017. They will seek the commitment of all members of the Board in working together to address health inequalities as described above

- The Basket of Indicators will be drawn up and baseline data reported. This will enable regular reviews of progress to illustrate the impact of work being undertaken.

- The revision of the Joint Health and Wellbeing Strategy and development of all strategic plans of partners in the Health and Wellbeing Board will need to demonstrate how they are implementing the recommendations of the Health Inequalities Commission.

- Further reports to the Health and Wellbeing Board will be made to keep members up to date on progress.

The members of the Health and Wellbeing Board are asked to consider and discuss the proposals set out in this report and note the next steps for implementing recommendations in the Health Inequalities Commission Report.

Jackie Wilderspin

Appendix A Health Inequalities Commission recommendations by theme

Recommendations		Responsibility
Principle 1. The profound influence and impact of poverty on health needs to be widely recognised		
1.	Statutory funding bodies need to do more to demonstrate their commitment to reducing inequalities. Their policies and plans should be scrutinized by HWB on an annual basis .	**HWB**
2.	Monitoring of the process of commissioning/service design to ensure it has taken inequalities into account in the design of new models of care and innovations such as vanguards needs to be undertaken regularly.	**CCG/OCC**
3.	Local indicators on progress towards reducing inequalities should be developed, with regular reporting to the Health and Wellbeing Board. This should be in place by the end of 2017	**HWB**
Principle 2. Commitment to prevention needs to be reflected in policies, resources and prioritisation		
4.	Greater investment is needed in prevention, innovation and service design both across the health and social care system and more widely to mitigate the impact of poverty and health inequalities. • All NHS partners should state clearly their investment in prevention. • The current level of spending on public health services through the ring fenced budget should be maintained • The HWB should track increased spending on prevention, and annually report to the public on progress made and outcomes achieved	***CCG*** ***NHS*** ***HWB/OCC*** ***HWB***
5.	The needs of disadvantaged groups should be monitored to ensure preventive programmes do not increase the inequalities gap, and that programmes delivered to all raise the health of all, including those who are most disadvantaged	***HWB/CCG***
6.	Core preventative services such as Health Visiting, Family Nurse Partnership, School Health Nurses and the Public Health agenda should be maintained and developed	***PH/OCC***
Principle 3. Resource reallocation will be needed to reduce inequalities		
7.	Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities. • The CCG should actively consider targeting investment at GP surgeries and primary care to provide better support to deprived groups, to support better access in higher need areas, and specifically address the needs of vulnerable populations. • The CCG should conduct an audit of NHS spend, mapping health spend generally and prevention activity particularly	***CCG*** ***CCG***

	against higher need areas and groups, setting incremental increasing targets and monitoring progress against agreed outcomes. • The ring fenced funding pot for targeted prevention should be expanded in higher need communities, using a systemwide panel of stakeholders to assess evidence and effectiveness, with ongoing independent evaluation of impact, including quantification of impact on other health spend. • An Innovation fund/Community development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations.	***CCG/STP*** ***CCG***
Principle 4. Statutory and Voluntary agencies need to be better coordinated to work effectively in partnership organisations using the Health In All Policies approach.		
8.	The Health in All Policies approach should be formally adopted and reported on across NHS and Local Authority organizations, engaging with voluntary and business sectors, to ensure the whole community is engaged in promoting health and tackling inequalities. Regular review of progress should be undertaken by HWB	***All statutory organisations*** ***HWB***
9.	The presence of the NHS and of the voluntary sector should be strengthened on the Health and Well Being Board	***HWB***
Principle 5. Data collection and utilization needs to be improved for effective monitoring of health inequalities		
10	The data on health inequalities available through PHE/NHS and other routine sources should be regularly reported to all statutory organisations and made available to the public.	**PH Dept**
11	Gaps in data collection on the health of BME communities, those with learning difficulties and other vulnerable groups at greater risk of poor health should be addressed and data used to inform resource allocation decisions. This includes encouraging all public sector organisations and organisations who do work on behalf of these organisations to be fully Equality Act compliant.	**HWB**
Access		
12.	Benefits Advice should be available in all health settings, including GPs networked into local areas to support CABs	***CCG/NHS Partners***
13	A sub group working on income maximization should be established, and asked to report back to the HWB/CCG within a year	***HWB***

14.	District Councils should be approached to seek matched funding, dependent on existing contribution	***Districts***
15	Indicators in the wider NHS performance framework should be utilized as part of routine monitoring for NHS organisations to yield useful, if limited, insights into inequalities and provide a metric that can be measured to assess progress in addressing inequalities.	***NHS organisations***
Health and Housing		
16.	Public agencies, universities and health partners should work together to develop new models of funding and delivery of affordable homes for a range of tenures to meet the needs of vulnerable people and key workers. Specifically, public agencies should work together to maximise the potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing by undertaking a strategic review of public assets underutilized or lying vacant .	***Public agencies, districts, universities and health partners*** ***Public agencies***
17.	Consideration should given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, addressing health inequalities in particular, and learning from other areas .	***HWB/CCG***
18	In 2014 9.1% of households were fuel poor . This should be reduced in line with the targets set by the Fuel Poverty Regulations of 2014.	***HWB***
Homelessness		
19.	All public authorities are encouraged to continue their collaboration and invest in supporting rough sleepers into settled accommodation, analysing the best way of investing funding in the future. Homelessness pathways should be adequately resourced and no cut in resources made with all partners at the very least maintaining in real terms the level of dedicated annual budget for housing support.	***HWB***
20.	The numbers of people sleeping rough in Oxfordshire should be actively monitored and reduced.	***HWB/Districts***
Rurality		
21.	An integrated community transport strategy should be developed	***District and County Councils***
22.	A digital inclusion strategy, which explicitly targets older people living in	***CCG***

	rural communities should be developed and the % of older people over 65 with access to on line support regularly reported	
23.	Reports of isolation and loneliness in older people/people suffering from dementia in rural areas should be collated and monitored on an annual basis with a reduction achieved year on year utilizing advice in http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation .	***CCG/OCC***
24.	The recommendations from the DPH annual report should be implemented and monitored.	***All Agencies***
Supporting Vulnerable Populations		
25.	Funding for locally enhanced services for refugees and asylum-seekers should be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers.	***CCG***
26.	Outreach work in communities with high numbers of refugees, asylum seekers and migrants, should be actively supported and resources maintained, if not increased, especially to the voluntary sector, to improve access to the NHS, face to face interpretation /advocacy and awareness raising amongst health care professionals	***HWB***
27	Robust pathways to community services for community rehabilitation (including Community Rehabilitation Companies) on release, particularly for short term offenders, need to be developed	***NHS/ Community Safety Partnership***
Lifestyles – physical activity, smoking, alcohol, drugs		
28.	A set of Oxfordshire-grounded targets for increasing activity should be developed, targeting people living in deprived areas, older people, and vulnerable groups .	***Districts***
29.	Continuing investment and coordination of existing initiatives should be maintained supported by social marketing and awareness-raising of the benefits of physical activity to targeted populations.	***PH Dept***
30.	The county should : • monitor and increase the number of disabled people participating in regular physical activity • achieve a measurable decrease in inactivity and in parallel an increase in mental well-being measures, measured using the Active People Survey and Health Survey for England datasets • demonstrate and increase a narrowing of the gap between the less socioeconomically privileged groups and the norm .	***Districts***
31.	Better data should be collected on smoking rates in different population groups including pregnant women, people with mental health problems, people in manual or routine occupations and other	***PH Dept CCG/GPs***

	vulnerable groups to ensure that ,in addition to lowering the overall rates of smoking ,the inequalities gap between these groups and others is reduced.	
32.	An alcohol liaison service should be developed in the OUHT	***NHS***
33.	A targeted project should be developed which aims to reduce drinking in middle aged people living in deprived areas	***PH Dept***
34.	Building on experience from Wantage, Community Alcohol Partnerships should be established across the county to address the problems of teenage drinking, particularly in Banbury as A&E data shows high numbers of under 18s attending the Horton ED for alcohol related reasons. [The partnership model brings retailers, schools, youth and other services together to reduce under age sales and drinking.]	***Community Safety partnership***
35.	Support and develop schools interventions including support given to school health nurses as well as services such as those run by The Training Effect to increase capacity of young people to choose not to misuse substances.	***PH OCC***
36	Resources in the public health budget should be maintained to provide services and support for drug misusers and their families	***OCC***
37.	School based initiatives should be promoted for all age groups	***OCC***
38.	Policy and action should be targeted to continue to address - the rates of successful completion of drug treatment in non opiate users - the rate of parents in drug treatment - the rate of people in substance abuse programmes who inject drugs who have received a hep C vaccination - the rate of children facing a fixed period of exclusion due to drugs/alcohol use - NPS use	***OCC***
Mental Health		
39	The under provision of resources for Mental health services should urgently be addressed	***CCG***
40	The implementation of the Five Year Forward Strategic View of mental health services for the county should explicitly state how it is addressing health inequalities and how additional resources have been allocated to reduce them.	***CCG***

Lifecourse approach – Beginning Well		
41.	Perinatal mental health should be a priority with appropriate investment to improve access to perinatal mental health services across Oxfordshire	***CCG***
42.	Use of food banks needs to be carefully monitored and reported to HWB	***Districts***
43	Child Health Profiles and other relevant routine data should routinely be reported from the perspective of addressing factors which could reduce health inequalities	***OCC***
44	New and creative ways to work with schools, such as Oxford Academy, should be explored and initiatives funded and evaluated through the proposed CCG fund	***CCG***
45	The current plans for closures of Children's Centres should be reviewed by March 2017 to ensure prioritization of effective evidence-based investment and good practice in early intervention for children and to ensure that the change of investment and resource allocation to young children and their families does not disadvantage their opportunities especially for those children & families from deprived areas and identified disadvantaged groups	***OCC***
Lifecourse approach – Living Well		
46	Resources should be committed to ensure that prevention and lifestyle advice are embedded in all contacts with statutory service providers and the opportunity taken to include advice about healthier lifestyles and signpost support .	***CCG/NHS***
47.	Promoting the health of those in work should be a priority and examples of good practice shared by establishing a county wide network .	***All employers***
48	The NHS workforce should engage in equity audit and race equality standards should be routinely reported	***NHS***
49	The needs of adults with learning disabilities within the County should be reviewed in 2017 and targets set to reduce their health inequalities .	***NHS/HWB***
Lifecourse Approach – Ageing Well		
50.	Health and social care systems should work together to agree how best to bring together local services to produce a more coherent transition between sectors when addressing inequalities, recognising that co-morbidities are common in this age group, and that many older people are acting as carers for their partners and family members.	***NHS/OCC***
51.	Shared budgets for integrated care should be considered and how this	***CCG/OCC***

	fits with the broader care packages available to older people. For example, looking at how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers	
52	Support for carers , including their needs for respite care and short breaks , should be supported with resources by all agencies	***NHS/OCC***
53	The recommendations from the 2016 DPH annual report are endorsed and the Commission wishes to ensure they are targeted to reduce health inequalities and progress reviewed by HWB in 2017	***NHS/OCC***
54.	Support for services and stimulation should be provided to older people, especially those living on their own to avoid isolation and loneliness especially amongst those with dementia and in rural areas	***CCG/OCC***
55.	Strategic action should be taken to oversee increased access to support for older people in disadvantaged and remote situations: ○ physically through a better coordinated approach to transport across NHS, local authority and voluntary/community sectors ○ digitally through a determined programme to enable the older old in disadvantaged situations to get online ○ financially, through support to ensure older people, who are often unaware of their financial entitlements, are helped to access the benefits they are entitled to claim.	***HWB/CCG/Districts***
56	Building on existing experience , support the further development of Alzheimer's friendly environments	***HWB/Districts***
57.	The current gap in provision of support for older people with mental health needs other than dementia needs to be addressed urgently.	***NHS/OCC***
58.	Promoting general health and wellbeing through a linked all ages approach to physical activity, targeting an increase in activity levels in the over 50s, especially in deprived areas, using innovative motivational approaches such as 'Good Gym' and Generation Games	***HWB/CCG***
Conclusion – overall recommendations		
59.	The suggested actions should be considered by relevant parties and prioritized, with a report on progress to the HWB by mid 2017	***HWB***
60.	The resources produced by PHE to support local action should be used as part of the formal review process.	***HWB/all partners***