

Oxfordshire Health Improvement Board Healthy New Town Programme Update

Introduction

Over the past year Barton in Oxford and Bicester have been testing out healthy place making as two of ten demonstrator sites for NHS England's Healthy New Town programme. The NHS has provided three years of funding for these sites to test out innovative ways of shaping communities to promote health and wellbeing, prevent illness and rethink the way that health and care services are provided. Both projects have taken a partnership approach to improving health and wellbeing in their communities as described below.

Barton Healthy New Town

Barton is an area on the western outskirts of Oxford, just outside the ring road and only 3.5 miles from Oxford City Centre. . Built in 1946, the estate was originally developed to provide social housing for residents of Oxford. The population of the Barton and Sandhills ward has grown by 9% since 2006 and now stands at 7,411. With a further 885 new homes planned at Barton Park (delivered by Barton Oxford LLP a joint venture between Oxford City Council and Grosvenor) in the next 7 years, a further 3,000 new people are likely to move into the area as a result of the new development.

*The Barton Healthy New Town programme is being delivered through a partnership between Oxford City Council, which is the lead delivery partner, Grosvenor Developments Ltd, Oxfordshire County Council's Public Health team and Oxfordshire Clinical Commissioning Group. The project aim was set early on in year one for **'All Barton residents (Barton and Barton Park) to have an equal opportunity to good physical and mental health and good health outcomes.'***

Bicester Healthy New Town

Bicester is a market town located within Cherwell District Council's administrative area in North Oxfordshire. The town currently has approximately 13,000 dwellings and a population of about 30,000 people. Over the next 20-30 years a further 13,000 homes are planned to be built which will effectively double the size of the population. Bicester was designated as a Garden Town in 2014 under the government's Garden Cities initiative and is a strategic location for growth within the Oxfordshire Strategic Economic Plan.

The Bicester Healthy New Town programme is a partnership initiative led by Cherwell District Council, Oxfordshire Clinical Commissioning Group, Oxford Academic Health Science Network, A2 Dominion developer of the ecotown Elmsbrook at North West Bicester, and supported by a further 25 different community organisations, health and care providers and Bicester schools and businesses. In Bicester the two key priorities are:

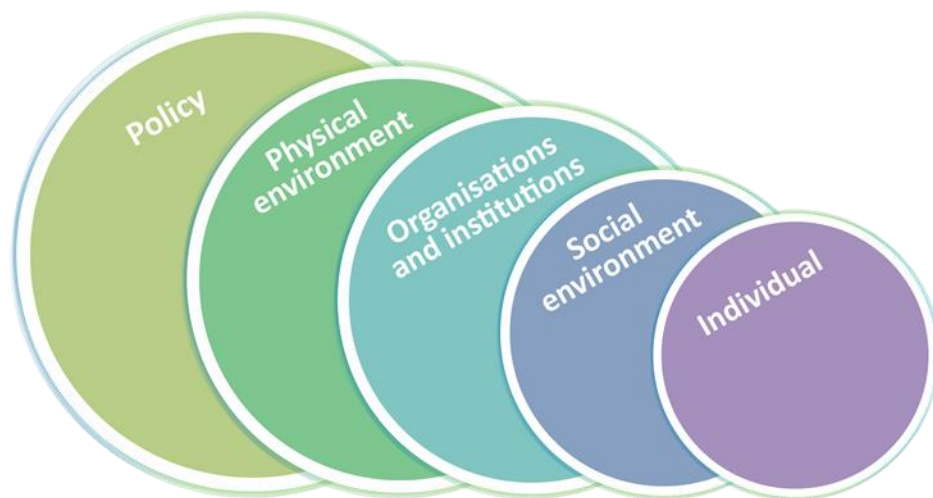
- To increase the number of children and adults who are physically active and a healthy weight.*
- To reduce the number of people who feel socially isolated or lonely in order to improve their mental wellbeing*

Healthy place making is not just about new developments; it applies to any place experiencing significant housing growth and is a mechanism for integrating new estates with existing communities so that all residents have the opportunity to benefit in terms of health and wellbeing.

In Barton and Bicester the three years of NHS England funding is delivering projects within three key work streams:

- **The Built Environment:** making best use of Bicester's built environment and green spaces to encourage healthy living and in Barton delivering a health hub which triples primary care for existing and new residents.
- **Community Activation:** helping local people to live healthier lives with the support of community groups, schools, and employers. Encouraging innovation, collaboration and strengthening links between existing community assets.
- **New Models of Care:** delivering new approaches to care closer to home and minimising hospital-based care, including a proactive population health model.

The programmes have been co-designed with residents and local stakeholders, using their insight and lived experience to identify effective interventions for promoting healthier behaviours. It has adopted a systems based approach to delivering change, identifying how the policy and built environment can support healthy living and how organisations and social networks can encourage people to adopt healthier behaviour.



In this update we focus on two examples of how a system approach can support new models of care that enable people to better manage their health conditions and reduce their need for more acute services in the future.

Bicester's New Model of Care for People with Diabetes

In Oxfordshire 4.92% of the Oxfordshire GP-registered population is on practice diabetes registers (age 17+) with the actual number equalling 29,461 (2016/17). There is a clear need to improve the care of patients with diabetes given that:

- Compared to other CCGs in England, Oxfordshire is in the highest quintile for additional risk of mortality among people with Type 1 and Type 2 diabetes compared with the general population
- Achievement of the three NICE treatment targets (HbA1c \leq 58mmol/mol, blood pressure < 140/80 and cholesterol <4mmol/l) for Type 2 diabetes patients across Oxfordshire is 40.2%, which is worse than the national average of 40.4%.
- In delivery of the 8 care processes for both Type 1 and Type 2 diabetes patients, Oxfordshire is worse than the national average and local/similar CCGs.

In Bicester and the rest of the North East GGC locality we have been testing an integrated care model and population health outcomes approach to improve care for diabetes patients. Integrated care aims to provide continuous and coordinated care that puts the patient perspective at its heart, reshaping traditional 'silo' working and enabling the planned and efficient delivery of care both within – and beyond- the NHS.

The model includes:

- Practice multidisciplinary meetings
- A diabetic dashboard
- Virtual Skype outpatient clinic appointments
- An alliance of providers including local GPs, Oxford University Hospital Foundation Trust, Oxford Health Foundation Trust and Diabetes UK
- A strategy for diabetes prevention
- Engagement of community assets

This new model of care seeks to engage partners in the community to support people with diabetes. This is exemplified by an educational evening to encourage patients to become more physically active to manage their diabetes. This event was organised by Montgomery House Surgery in partnership with Active Oxfordshire (OxSPA), Legacy Leisure who provide services at Bicester Leisure Centre, the Health Walks Team from Cherwell District Council, Achieve weight management services, Citizens Advice North Oxfordshire and Bicester Healthy New Town Programme.

Being more physically active is an important part of managing diabetes but often patients are intimidated by the thought of going to the gym. Active Oxfordshire has been commissioned by Oxfordshire CCG to lead the GO Active (with diabetes) Programme to offer motivational pathways for patients and to provide affordable, accessible community classes. This service helps to identify local community groups that offer exercise opportunities that are more closely aligned to an individual's interests, such as social cycling or the green gym which helps you get active by doing outdoor conservation work.

Fifty-six patients attended the evening educational meeting where they heard from their practice GP about the benefits of exercise, were taken through a seated exercise session by a trainer from Legacy Leisure and were encouraged to sign up

for the motivational coaching service. They also heard about some of the exercise opportunities in the community such as the Health Walks programme and Bicester's 'Blue Lines', circular 5K health routes marked in residential neighbourhoods to promote walking/running, as well as services to support weight loss run by Achieve Oxfordshire.

As a result of the meeting: -

- 7 patients joined GO Active during event
- 4 patients joined GO Active post event
- 2 joined Achieve
- 2 signed up as patient volunteer drivers for Citizens Advice
- 1 joined Bicester Health Walk

Comments on the event included:

"An inspirational evening - it was packed out! You could feel the infectious enthusiasm empowering patients to take control of their health"

Dr Ellen Fallows

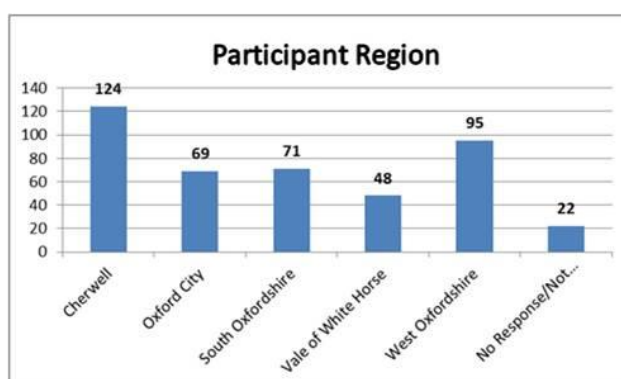
'I didn't know all of these were available and there are activities I can join just down the road from where I live.'

Bicester Resident



Further educational events are planned with the other practices in Bicester and Montgomery House are organising a follow-up event focused on healthy eating for people with diabetes.

As a result of the partnership working between GP practices, health commissioners, community services and district councils that the Healthy New Town Programme has promoted to increase support for patients with diabetes, Cherwell has achieved significantly higher referrals to Active Oxfordshire, see Figure below.



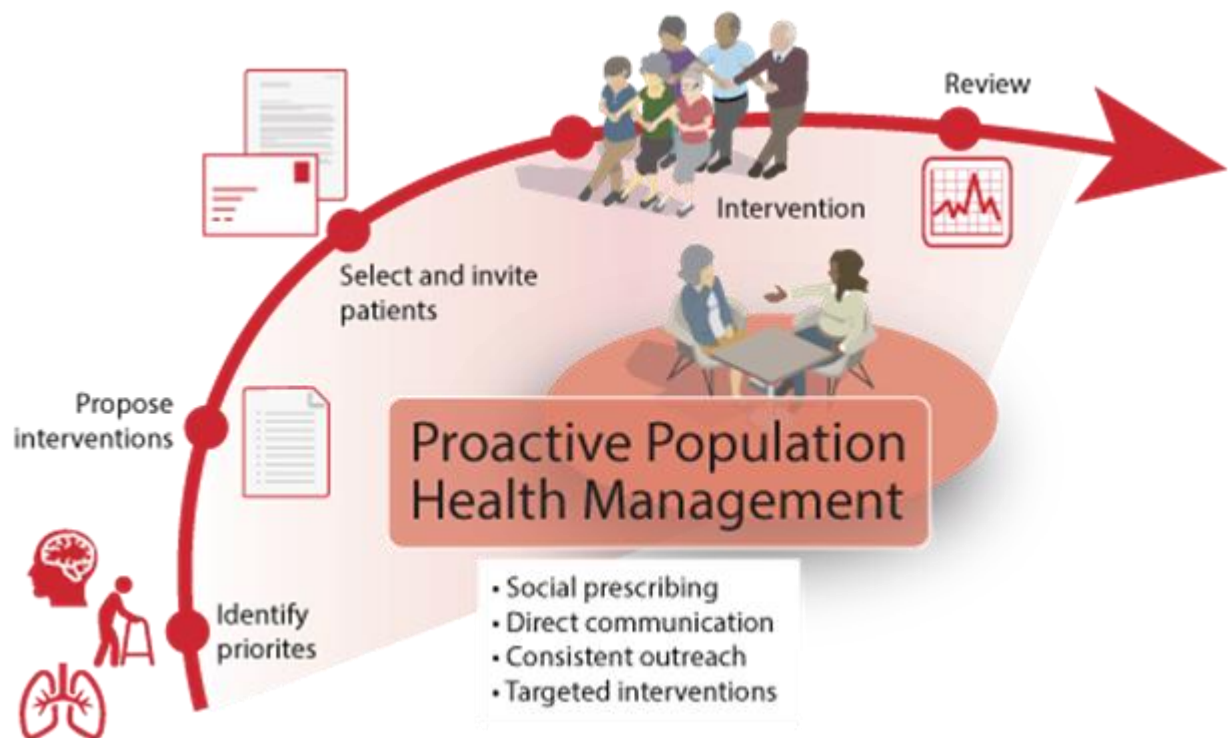
Most importantly, although it is still early in the implementation of the new model of care, there are indications that care is improving with a 7.43% increase in all 8 care processes being provided by practices in the North East. Even such small improvements in diabetic care will result in lower healthcare costs in the future.

Barton’s Proactive Population Management Model

The health priorities for Barton were developed using the Barton Health Plan (developed in collaboration with Barton Health and Wellbeing Partnership) and from baseline health research undertaken in 2017 identifying significant health inequalities around life expectancy, long term conditions, food poverty, mental health issues and social isolation.

Under the New Models of Care work stream, the Barton project team developed a proactive population health management model with Hedena Health and Manor GP surgeries proactively contacting patients with long term conditions, promoting the specific benefits to their health conditions of attending community-based preventative and early intervention activities.

Undertaking an asset based approach the project mapped out current physical and social assets as well as current provision, participation levels and service gaps. By matching these gaps to the health inequalities a range of new commissioned services started in January 2018 to address the identified health needs and to fill those gaps.



To demonstrate the impact of the proactive invitations from GP surgeries, a falls prevention programme was initially promoted only through traditional means, but only one resident attended in week one. In week two, after the invitations sent by the GP practice, 20 people attended and after 12 weeks there was still regular attendance by 15 people. In comparison, when the same programme ran in another area of deprivation in the county, it took a full three months to get to 12 people regularly attending. In the three months this pilot ran, 53 patients with long term conditions took part with 29 patients sustaining participation. This approach is now being scoped for replication in other Oxford localities, as part of a Health Inequalities Commission joint project between Oxford City Council and Oxfordshire Clinical Commissioning Group.

The project also commissioned service provided by a local mental health charity which offered coaching to 12 unemployed people experiencing mental health issues to support them back to employment.

One person supported by this service was Mrs A, a carer for her husband, who engaged for several sessions before starting to become involved in community activities and joining a Recovery Group. She is now actively seeking paid employment and has arranged regular care/respice care for her partner to free up her time to pursue her own wellbeing.

However, one particular intervention, a class to support people with pain management and anxiety, wasn't as successful. The reflection on this poorer performance was that this was a more specialist intervention and therefore identifying the relevant patients in the first place was more difficult.

The development of this model has demonstrated that the voluntary sector supporting health can increase capacity in primary care through initiatives such as social prescribing and better use of community resources. For example, the social prescribing co-ordinator in Barton Surgery was able to refer patients directly to the activities due to her knowledge of the patients. She also trained a member of staff at the other surgery serving Barton to develop social prescribing there.

In year three, Barton HNT is developing and delivering a 'Team Around the Patient' (TAP) model for high users of health and public services, linking in with a city wide health inequalities project. GPs will work with the local Accident and Emergency Department, Ambulance Service, Social Housing providers and other partners to identify individuals who place the highest demand on services, convene a TAP meeting to identify the root causes of their high use and then provide a support package to address these root causes, which may be more social than clinical.

This model will evaluate the impact and usage levels on primary care, acute services and local authority services, as well as the wellbeing of the patients involved to report back to NHS England and shared with local partners. This model will also look to develop an 'early warning system' to identify signs before patients become high users of services.

Spreading the Learning and Scaling Healthy Place making across Oxfordshire

With one year of funding remaining for the demonstrator sites a workshop was held with representatives from all the District Councils, County Councils and Oxfordshire CCG. At that meeting Barton and Bicester shared the key learning from the pilots,

identifying some key 'ingredients' that are fundamental to healthy place making, Irrespective of size of community:

Principles of Healthy Place making

- **A whole population approach** is required which involves existing residents and people moving into new developments. Growth is often seen as a challenge by existing residents but the place making process could help turn this into an opportunity to improve the quality of life for all.
- **A built environment that promotes health is key to healthy place making.** Developing a built environment that promotes health is central to healthy place making. It needs to ensure that housing meets the needs of the whole population including all generations, and that healthy lifestyles can be supported through the built environment. This includes making provision for social spaces, access to open space for recreation and natural areas and positively planning for active travel. In addition homes that are warm and comfortable and of sufficient size to accommodate activities such as shared meals. The growth deal offers a window of opportunity for system leaders to ensure that Oxfordshire develops healthy communities that benefit existing as well as new residents, rather than simply creating new housing estates.
- **Partnership working is fundamental to effective healthy place making.** Healthy place making is not just about planning and the built environment and community development which fall within the remit of district councils. It involves the participation of services delivered at a County level such as highways and education as well as public health, social care, and children's services. Close working with the local voluntary sector and community groups, health and care services and other public services is key to activating the community, in order to increase social capital, community cohesion and a sense of belonging. The NHS, both commissioners and providers, have a key role in shifting the focus to proactive prevention. Healthy place making will only work if system leaders agree that it is a strategic priority and actively commit to work together to deliver it.
- **Healthy place making only works when it is undertaken alongside and in partnership with local people.** They are able to articulate the existing sense of place, the assets present in the community and the gaps that place making may be able to help them to address. Place making needs to build on and add value to existing activities, taking an assets based approach to community development. Only by engaging honestly and working closely with local stakeholders and residents will council services and place making projects be welcomed and valued by local residents and enable healthy communities to be sustainable.

These principles have been noted by NHS England who are developing a publication *Putting Health into Place* due for publication in March 2019 which will draw on the experience and learning from all ten demonstrator sites.

Within Oxfordshire leaders from across the County are considering how best to sustain these initiatives in Barton and Bicester and spread them across the County.

Recommendations

- The Health Improvement Board is asked to note the progress that Barton and Bicester Healthy New Town programmes have achieved.
- The Health Improvement Board is asked to agree that it is important to sustain and spread healthy place making across Oxfordshire and to make a request of the Health & Wellbeing Board that this becomes one of its strategic priorities.
- It is proposed to develop and promote *Oxfordshire's Principles of Good Practice for Healthy Place Making* which can build on the work of Community First Oxfordshire and integrate the national guidance on healthy place making due for publication by NHS England in March 2019. This publication will be brought to the Health Improvement Board for approval.
- The Health Improvement Board is asked to consider what resources could be mobilised to support the spread of healthy place making across Oxfordshire.