Public Document Pack

To: Members of the Shadow Health Improvement Board

Notice of a Meeting of the Shadow Health Improvement Board

Wednesday, 20 March 2013 at 2.00 pm

Town Hall, Oxford

Peter G. Clark
County Solicitor

March 2013

Contact Officer: ***James Martin, Policy & Partnership Officer***
Tel: (01865) 323344; Email: james.martin@oxfordshire.gov.uk

Membership

Chairman – District Councillor Mark Booty
Vice Chairman - Councillor Val Smith*

Board Members:

Ian Davies	Cherwell & South Northants District Council
Peter von Eichstorff	Clinical Commissioning Group
Dave Etheridge	Chief Fire Officer & Head of Community Safety
Anita Higham	Public Involvement Network
Cllr David Nimmo Smith	Oxfordshire County Council
Dr Jonathan McWilliam	Director of Public Health
Jackie Wilderspin	Assistant Director for Public Health

* please note that Councillor Steve Curran will be substituting for Councillor Val Smith at this meeting.

Notes:

- ***Date of next meeting: 16 May 2013***

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 Rachel Dunn on (01865) 815279 or Rachel.dunn@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 Mark Booty

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 - 6)

2:10
10 mins

To approve the Note of Decisions of the meeting held on 12 September (**HIB5**) and to receive information arising from them.

A discussion on the joint response by the Alcohol Strategy Group and Community Safety Partnership and the Health Improvement Board to the national consultation on the minimum pricing of alcohol and other proposed measures from the. The response has been previously circulated.

6. Performance Monitoring (Pages 7 - 18)

2:20 mins
10 mins

Person(s) responsible: Members of the Health Improvement Board
Person giving report: Dr Jonathan McWilliam Director of Public Health

A report of the current progress against the targets of the HIB and a discussion on the latest JSNA report for the Health and Wellbeing Board

7. Housing and Health (Pages 19 - 38)

2:30
40 mins

Person(s) responsible: Members of the Health Improvement Board
Person giving reports: Jackie Wilderspin & Lesley Sherratt

A discussion on the Health Improvement Board's priority on housing and health:

1. Progress on work around fuel poverty
2. Terms of Reference for the Supported Housing Group
3. Preventing Homelessness and information on welfare changes
4. The proposed basket of indicators on housing and health to be monitored by the Health Improvement Board

8. Update from the PIN

3:10
10mins

Person(s) responsible: Members of the Health Improvement Board
Person giving report: Anita Higham OBE

A discussion of the issues being raised through the Public Involvement Network impacting on the work of the Health Improvement Board

9. Report on the joint HIB and AH&SCB workshop (Pages 39 - 46)

3:20
20 mins

Person(s) responsible: Members of the Health Improvement Board
Person giving report: Jackie Wilderspin

A review of the joint Health Improvement Board and Adult Health & Social Care Board workshop that took place in July including recommendations for next steps

10. Health Protection Forum

3:40
10 mins

Person(s) responsible: Members of the Health Improvement Board
Person giving report: Dr Jonathan McWilliam Director of Public Health

An introduction to the Health Protection Forum including the terms of reference

11. Forward Plan

3:50
10 mins

A discussion on the forward plan for the Health Improvement Board.

Meeting dates 2013/14:

- Thursday 16th May 2013

- Thursday 11th July 2013
- Thursday 26th September 2013
- Thursday 28th November 2013
- Thursday 23rd January 2013
- Thursday 27th March 2013

This page is intentionally left blank

SHADOW HEALTH IMPROVEMENT BOARD

OUTCOMES of the meeting held on Wednesday, 12 September 2012 commencing at 2.00 pm and finishing at 4.14 pm

Present:

Board Members: District Councillor Mark Booty – in the Chair

Councillor Val Smith (Vice-Chairman)
Ian Davies
Peter von Eichstorff
Anita Higham
Dr Jonathan McWilliam
Jackie Wilderspin
Councillor Jenny Hannaby (In place of Councillor Iain Brown)

Officers:

Whole of meeting — James Martin, Policy & Partnership Officer (Joint Commissioning)
Richard Webb (Trading Standards)

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact James Martin, Policy & Partnership Officer (Tel: (01865) 323344)

	ACTION
1 Welcome by Chairman, District Councillor Mark Booty	
The Chairman, Councillor Mark Booty, welcomed all to the meeting including Anita Higham attending her first Health Improvement Board meeting as a board member	
2 Apologies for Absence and Temporary Appointments	
An apology was received from Cllr Iain Brown whom sent Cllr	

Jenny Hannaby as a substitute. Apologies were also received from Dave Etheridge, Chief Fire Officer and Head of Community Safety and Val Johnson, on behalf of District Councils.	
3 Note of Decision of Last Meeting *(Agenda item 5)*	
The note of the last meeting was approved. <u>Matters Arising</u> Item 4 – The JSNA highlight report has now been presented to the Health and Wellbeing Board (HWB). Item 5 – Priority 2 – Jackie Wilderspin reported that there will not be a county wide specification for recommissioning Children's Centre and so no further update is needed. Agenda item 4 **-** Joint Health & Wellbeing Strategy and the consultation process Views expressed during the discussion included the following: • The JHWS is a remarkably concise document that sets the compass of the HWB and the direction that the partnership boards will travel; • Setting medium term targets would be helpful as the strategy is dated 2-12-16 and the targets relate to 2012-13 It was **AGREED** that: a) It will be suggested to the HWB that medium term targets are set in addition to annual targets; b) 2013-14 targets for the HIB will be set after quarter 4 of 2012-13; and c) Targets should be able to be revised or replaced to reflect priorities even within the lifetime of the strategy.	
4 The role of PIN *(Agenda item 6)*	
Anita Higham presented the paper that set out the roles and responsibilities of the PIN and also referred to the future but separate role of Local Healthwatch from April 2013. Views expressed during the discussion included the following: • The PIN is evolving and still finding its way; it will take a full year to develop but the join up of Patient Participation Groups at GP practice level with other community networks is welcome;	

• The recent consultation on the Joint H&WB Strategy was a good reflection of the work and value of the PIN in finding out what the public thinks as well as having the two-way conversation; • The task of PIN is in both informing and influencing the work of the board Dr Jonathan McWilliam asked that any questions relating to the development of the PIN and links to the Voluntary, Community and Faith sector should be directed to him or Jackie.	Jonathan McWilliam
5 Performance monitoring *(Agenda item 7)*	
A report of the current progress against the targets of the HIB and including details of the on-going surveillance of the basket of indicators Dr Jonathan McWilliam presented the performance report detailing the format and content. Performance is generally on track, with only 2 indicators marked "amber": Priority 9.1: The % of babies breastfeed at 6-8 weeks of age is currently on amber. Although local performance is much better than the national average of approximately 45%, the HIB figure of 59.8% is just shy of the target of 60%. The target is on track to be met in quarter 2. Priority 11.2: The number of children vaccinated against MMR by age 2, is currently on amber, only missing the quarter 1 target of 1925 children by 42. Discussion focussed on the fact that immunisation is a choice and although the target is testing it is achievable by continuing the joint working of PH and GPs in contacting and informing people in communities where immunisation rates are traditionally low In addition, new families coming into the area need to be contacted and action taken in partnership with GP practices to ensure levels of immunisation remain high.	
6 A report from the HIB workshop and process for action planning *(Agenda item 8)*	
Jackie Wilderspin presented a paper detailing the HIB workshop that took place in July. The paper included information on the wide range of organisations that offered a breadth of projects for affiliation with the HIB in order to achieve its targets. The next challenge for the HIB is to co-ordinate what is going on	

across these organisations and where possible make connections, combine efforts and increase effectiveness to achieve the HIB targets. In terms of a topic for the next workshop the following views were expressed: • A workshop for all 3 partnership boards was suggested to aid the delivery HIB priorities and determine how partnership boards can work together to help each other to deliver the outcomes • There is a need to involve district members and CCG localities more broadly across the HWB agenda particularly across housing and health • Raising awareness and education of preventative actions to improve health as well as the interconnectedness of lifestyle choices that can impact so negatively on health It was **AGREED** that: a) Jackie Wilderspin will develop a plan for taking this forward b) Any further suggestion for workshop topics be sent to Jackie Wilderspin	 Jackie Wilderspin All
7 Priorities within the housing agenda for HIB *(Agenda item 9)*	
Ian Davies presented the paper and noted that the HIB workshop in July confirmed that the housing priorities set are the right priorities for Oxfordshire. Ian also outlined possible working arrangements for the future, focussing on good working relationships between the Housing group being set up by the Spatial Planning and Infrastructure Partnership and successor arrangements to the Supporting People groups which will link to HWB. The discussion that followed focussed largely on governance issues for the work to support vulnerable groups in the light of changes to the Supporting People work. New arrangements are being discussed outside of this meeting. It was noted that terms of reference are being drafted for approval by Chief Executives and will have a bearing on links to HWB. Key questions need to be addressed in terms of how and where commissioning decisions are made for all of the former Supporting People budget. In addition there is a need for absolute clarity on how elements of the former Supporting People budget now under the auspices of the HIB are spent and governed.	

It was noted that new working arrangements to take forward the priority to reduce fuel poverty were more simple and could go ahead. The HIB will add better coordination to this work. The Chairman noted that District Council views should be offered to the Adult Health and Social Care Board to help understand the overall effect of the 930 Extra Care Housing places being made available by 2015. Of particular interest was the effect it may have on the subsequent level of housing availability within the existing housing stock as people move out of social or other housing and in to the ECH It was **AGREED** that: a) Jackie Wilderspin; Ian Davies; Val Johnson and Dr Jonathan McWilliam will meet to discuss and reflect on the governance and structure questions to make sure terms of reference for the working group are fit for the HIB commissioning and governance requirements: b) A basket of indicators for housing will be drawn up and should include more health related indicators than were presented in the paper; c) A coordinated approach to reducing fuel poverty is to be developed d) The HIB workshop to which members of other partnership boards will be invited should include discussion on Extra Care Housing to enable districts to express their views to the Adult H&SC Partnership.	JW, ID, VJ, JMcW VJ and JW JW and JM JW
8 Trading Standards enforcement action *(Agenda item 10)*	
A paper detailing Trading Standards enforcement action with regard to illegal sales and other health related activity Richard Webb presented a paper detailing the contribution that Trading Standards makes to promoting and supporting health and wellbeing in communities. After the presentation of the paper, discussion focussed on underage sales of alcohol across the county. The Chairman expressed his support in the underage alcohol sales spot tests that Trading Standards undertakes. The Chairman would also welcome efforts for the programme to be stepped up as it is seen as a key method to help reduce underage drinking by preventing the supply at source. Anita Higham raised the question of how HIB can influence head teachers and impact on the food available to pupils. Concern was noted regarding the new academy status of many schools and how limited any influence could be.	

Dr Jonathan McWilliam commented that Trading Standards, along with Environmental Health are unsung heroes of public health and needed to be linked together through Jackie Wilderspin to work on the priorities of the HIB	Richard Webb and Jackie Wilderspin
9 Forward Plan *(Agenda item 11)*	
See item 8 for the discussion on topics for the HIB workshop in November	

..... in the Chair

Date of signing .....

Health Improvement Board
20 March 2012

Performance Report

Background

1. The Health Improvement Board is expected to have oversight and of performance on four priorities within Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, and ensure appropriate action is taken by partner organisations to deliver the priorities and measures, on behalf of the Health and Wellbeing Board.

2. The four priorities the Board has responsibility for are:

   Priority 8: Preventing early death and improving quality of life in later years
   Priority 9: Preventing chronic disease through tackling obesity
   Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
   Priority 11: Preventing infectious disease through immunisation

Current Performance

3. A table showing the agreed measures under each priority, expected performance and current performance is attached as appendix A.

4. It is worth noting that there are a number of targets that will not be reported on a quarterly basis. This may be where data is collected or released less frequently (flu vaccinations for example), or because work this year is focused on agreeing new measures and establishing baselines (housing targets for example).

5. Current performance can be summarised as follows:

   8 indicators are Green.
   0 indicators are Amber (defined as within 5% of target).
   2 indicators are Red, although one relates to Q2 as data is not yet available for Q3.
   5 indicators were not expected to report this quarter, although one has provided Q4 data already.

6. It is also worth noting that performance against the indicator for breastfeeding (indicator 9.2) has improved from Amber to Green.

Ben Threadgold
Strategy Manager, Joint Commissioning
March 2012

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

Oxfordshire Health and Wellbeing Board
Performance Report

No.	Indicator	Q1 report Apr-Jun		Q2 report Jul-Sept		Q3 report Oct-Dec		Q4 report Jan-Mar		Notes
	Priority 8: Preventing early death and improving quality of life in later years									
8.1	100 smoking quitters above the national target (the nationally set target for Oxfordshire is 3,576)	Expected 840 **Actual 852**	G	Expected 1617 **Actual 1668**	G	Expected 2490 **Actual 2559**	G	Expected 3676 Actual		Target has been amended slightly to reflect higher national target for Oxfordshire. Achieved Q3 target
8.2	2,000 adults receiving bowel screening for the first time (meeting the challenging national target of 60% of 60-69 year olds every 2 years)	Expected 500 **Actual 406**	R	Expected 1000 **Actual 776**	R	Expected 1500 Actual		Expected 2000 Actual		Not achieved Q1 target as number of people invited fluctuates quarterly. Plans are in place to ensure the annual target is met
8.3	30,000 people invited for Health Checks for the first time (currently 25,000)	Expected 7500 **Actual 8848**	G	Expected 15000 **Actual 20707**	G	Expected 22500 **Actual 27658**	G	Expected 30000 Actual		
	Priority 9: Preventing chronic disease through tackling obesity									

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
9.1	Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2011 this was 14.9%)					Expected 14.9% or less **Actual** **15.6%**	R			Provisional data expected end of Q3 and final in Q4
9.2	60% of babies are breastfed at 6-8 weeks of age (currently 58.4%)	Expected 60% **Actual** **59.8%**	A	Expected 60% **Actual** **59.3%**	A	Expected 60% **Actual** **60.3%**	G	Expected 60% Actual		
9.3	5,000 additional physically active adults (Data available twice per year) Baseline: 125,500 Adults Annual target:130,500 Adults			Expected 128,000 Adults **Actual** **136,000 Adults**	G			Expected 130,500 Adults Actual		Numbers fluctuate as Active People Survey is based on a sample of approximately 2,500 people
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness										
10.1	A reduction in the number of households at risk of fuel poverty through use of improvement grants and enforcement activity							Expected Basket of relevant indicators to be agreed to enable monitoring and setting of		The HIB has established a working group to develop appropriate indicators and targets

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
								outcomes Actual		
10.2	Action to prevent homelessness and ensure a joint approach in times of change.							Expected Review in the light of information on best practice Actual		Report on proactive work in all districts and pilot work on direct payments in the City is being considered at the next meeting of the Health Improvement Board
10.3	New arrangements for partnership work to ensure vulnerable people are supported to remain in appropriate accommodation e.g. young people, victims of domestic violence, offenders and other adults with complex needs.							Expected New partnership arrangements to be in place Actual		New Terms of Reference for the Supporting People Core Strategy Group are being agreed
Priority 11: Preventing infectious disease through immunisation										
11.1	8,000 children immunised at 12 months, maintaining the high coverage (this means we will meet the challenging national	Expected 2000	G	Expected 4000	G	Expected 6000	G	Expected 8000		Achieved Q3 (cumulative) target

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	target of 96.5%)	**Actual** **2038**		**Actual** **4074**		**Actual** **6055**		Actual		
11.2	7,700 children vaccinated against Measles Mumps and Rubella (MMR) by age 2	Expected 1925 / **Actual** **1883**	**A**	Expected 3850 / **Actual** **3955**	**G**	Expected 5775 / **Actual** **6038**	**G**	Expected 7700 / Actual		Achieved Q3 (cumulative) target
11.3	7,300 children receiving MMR booster by age 5 (meeting the ambitious national target of 95%)	Expected 1825 / **Actual** **1857**	**G**	Expected 3650 / **Actual** **3775**	**G**	Expected 5475 / **Actual** **5684**	**G**	Expected 7300 / Actual		Achieved Q3 (cumulative) target
11.4	3,000 girls receiving Human Papilloma Virus vaccination to protect them from cervical cancer (meeting the national target of 90% of 12-13 year old girls)					Expected 3000 / **Actual** **3189**	**G**	Expected 3000 / Actual		3 doses required to achieve target - final data as at 08/10/2012 Dose 1 = 3259 Dose 2 = 3238 Dose 3 = 3189
11.5	80,000 flu vaccinations for people aged 65 or more (meeting the national target of 75% of people aged 65+)							Expected 80,000 / **Actual** **83,287**	**G**	

This page is intentionally left blank

Joint Strategic Needs Assessment
Report for Oxfordshire Health and Wellbeing Board, March 2013

Introduction

The Joint Strategic Needs Assessment (JSNA) is a shared data source which sets out the major health needs facing Oxfordshire. We are talking about health here in its broadest sense, not just about specific diseases. Producing a JSNA is a shared duty of County Councils and Clinical Commissioning Groups through their Health and Wellbeing Boards. The findings are expected to have a strong influence on the Joint Health and Wellbeing Strategy. The JSNA has been redesigned and refreshed during 2012-13 and its main findings are presented here. From this analysis it can be concluded that the current priorities set out in the Joint Health and Wellbeing Strategy should be continued.

Development of the Joint Strategic Needs Assessment in 2012-13 has resulted in a broader and more easily accessible collection of data. For the first time we have brought together a wider set of indicators for analysis, including community safety data, information on the Military Community in the county and data relating to social determinants of health such as housing, employment and skills. This information now sits alongside the health and social care data collection that has been so well used in previous JSNA reports. The data collection is also more accessible to a wide range of partners and stakeholders and they have been more engaged in the process of development.

This report covers the headlines of the JSNA. Further detail, including the raw data for further analysis, will be available through the JSNA pages of the Oxfordshire Insight website. This data should be seen as a starting point setting out major themes. All organisations will want to carry our further analysis on each issue that we have highlighted here.

Summary of Analysis for this report

Following discussions with partner organisations and the voluntary and community sector, the JSNA steering group agreed a wide range of indicators for analysis. These indicators were drawn from a wider range of sources than in previous years, including:

- Public Health
- Clinical Commissioning Group
- County Council Commissioning data
- District Councils
- Thames Valley Police
- 2011 Census
- The Office for National Statistics
- The Department for Work and Pensions

Where possible, the analysis looked at the historical trends to see whether needs had increased or decreased over the past year, and whether this was part of a sustained trend. Data was also looked at by Districts and smaller localities to see whether there were differences in health for different areas of the county.
Overall there were few statistically significant variations when compared to the previous year. This is to be expected given that health changes at the population level are slow

moving, and as such, any trends must be treated cautiously. Data from the census helped to give more information about longer term trends. Where relevant trends were observed, these have been outlined below.

The key trends are presented by theme below:

Key Findings

1. Population

- The population of Oxfordshire increased from 607,300 to 654,800 between 2001 and 2011. This is an increase of 8%.
- The number of people aged over 65 increased by 19% between 2001 and 2011. The rate of growth was much higher in the predominantly rural districts (over 20%) than Oxford City where there has been a 5% fall in the number of people over 65.
- The number of children aged 0-4 has increased by 13%. The rate of increase has been much higher in Oxford City (28%) compared to other districts (between 2% and 11%).
- The birth rate is relatively stable among UK born mothers but has increased by 37% among mothers born outside the UK.
- The proportion of black and minority ethnic groups in Oxfordshire has increased from 4% of the total population to 9% between 2001 and 2011.
- The proportion of the population who were born outside the UK increased from 10% of the population to 14% between 2001 and 2011.
- Eight wards in Oxfordshire (5 in the City and 3 in Banbury) show particularly poor outcomes across a range of indicators including child poverty, low skills, low income, poor attainment, higher crime and poor health[1].

2. Employment, economy and skills

- Whilst the percentage of people claiming the Job Seekers Allowance in Oxfordshire has remained below the national and regional level, the rate of increase was higher:
    - The number of Job Seekers Allowance Claimants increased by 115% in Oxfordshire compared to 98% in the South East during the period of February 2002 to February 2012.
    - The rate of increase for the ten year period was highest in Cherwell (141%) and West Oxfordshire (140%).
- The proportion of economically inactive people in Oxfordshire was lower (27%) than England (30%) and the South East region (28%) at the time of the Census (June 2011).
    - Oxford is the only district with an above average proportion of economically inactive people (37%) although this is primarily due to the number of economically inactive students (22% of the working age population).

[1] The wards are Blackbird Leys, Greater Leys, Littlemore, Rose Hill & Iffley, Barton and Sandhills, Banbury Ruscote, Banbury Neithrop and Grimsbury & Castle

- Oxfordshire contains a higher proportion of people (36%) with level 4 qualifications (undergraduate degree or equivalent) than England (27%) and the South East (30%).
    - The proportion is highest in Oxford City at 42% of the population.
    - Oxford City, Banbury, and Abingdon also contain wards with high proportions of people with Level 1 (1-4 GCSEs or equivalent) or no qualifications.
- The cost of housing relative to income for the poorest 25% of people is comparatively high in Oxfordshire at 9:1, representing a 33% increase from 2001 to 2011.
    - This is the fifth highest ratio of any county in the South East.
    - At district level this ratio is highest in Oxford City and South Oxfordshire at 10:1
- There have been a high number of unfilled job vacancies over the past 12 months in the Home Care/Care Assistant field.
    - This has been particularly pronounced in West Oxfordshire and Oxford City.

3. Housing and living environment

- There is a lack of affordable housing across the county and particularly in Oxford.
- The pattern of housing tenure is distinct in Oxford City with a much higher proportion of private rented housing (28%) than other districts (13% to 16%).
- There are higher rates of household overcrowding in the city (number of residents per bedroom) with 13.9% of households deemed to be overcrowded, compared to 6.9% for Oxfordshire. This may be due in large part to the high number of multiple occupancy student accommodation units.
- The number of new houses built each year has declined in recent years from 3500 in 2005/06 to 1500 in 2010/11. The number of newly built affordable houses has remained fairly constant, fluctuating between 500 and 600 over the same period.

4. Armed Forces, their families and Veterans

- There are approximately 9500 serving personnel in the county whose Primary Health Care is provided by the Defence Medical Services. The county also has approximately 1200 military family members whose Primary Health Care is also provided by military GPs and not by the NHS.
- According to longitudinal studies at the national level, outcomes are often good for veterans. However, there is an observable above-average incidence of depression/anxiety disorders and alcohol misuse for some veterans. This group is also more likely than the general population to find it difficult to seek help.
- There is currently little data available to calculate reliably the number of veterans in the local population.

5. Community safety

- The rate of police recorded offences in Oxfordshire fell from 87.2 to 57.9 per 1000 people between 2003 and 2012.

    - Oxford City had more than double the rate of offences (110.2) compared to Cherwell (55.0), South Oxfordshire (40.6), West Oxfordshire (34.4), and the Vale (36.6).
    - The Crime Survey for England and Wales suggests that the level of recorded crime does not reflect the true incidence of crime in the population. Although figures are not available for Oxfordshire, the estimated prevalence of crime for the South East region was around 83 incidents per 1000 people for the 12 months prior to 2012.
- Police recorded violent offences have been falling since 2008 across the county, from 15.9 to 11.5 per 1000 people.
- The police recorded incidence of Sexual Offences been relatively constant over the past 9 years fluctuating between 1.2 and 1.5 per 1000 people.

6. Giving Children and Young People the best start in life

- Breastfeeding rates at initiation are high in Oxfordshire at 78.7%. This is significantly higher than the national rate of 74.5%. A similar rate is found in all districts. .
- The proportion of overweight children in reception year is 7.3%. This is significantly below the national level of 9.4% Both local and national levels are rising gradually.
- The proportion of year 6 pupils considered obese is more than double the rate for reception age children at 15.5%. However it remains below the national rate for year 6 children, which is 19.20%.
- School attainment remains a mixed picture but there is improvement in performance in younger age groups. Inequalities in outcome remain.
- Teenage pregnancy rates reduced from 28.4 per 1000 females aged 15-17 (2007-2009), to 25.9 for the period 2008 to 2010. Oxford City remains significantly above the county rate at 33.6.
- The rate of referrals to children's social care increased from 389.5 to 460.7 per 10,000 under 18s from 2010/11 to 2011/12.
    - This is lower than the national rate but higher than the 'statistical neighbour' average.
    - It represents an increase of 18.3% compared to a fall of 4.2% at the national level.
- The number of repeat referrals to children's social care increased by 57% between 2009/10 and 2011/12.

7. Ensuring people live well and independently

- The percentage of residents who reported their health to be very bad or bad in the June 2011 Census was lower than the regional and national average.
- Oxfordshire contains a lower proportion of households with at least one adult with a long term health problem or disability (21.7%) than the South East region (23.6%) and the country (26.0%).
- The number of referrals to adult social care has grown at a higher rate than that which would be expected through the effects of an aging population.
- The proportion of Adult Social Care Users who report having enough control over their lives was 78.6% in 2011/12. This puts it in the top 25 % of local authorities nationwide.
- 62.2% of clients in Oxfordshire received self-directed support in 2011/12. This is the 18th highest proportion of all local authorities.

- Oxfordshire county council supports 4,500 people to provide unpaid care to another person.
    - The proportion of people who reported that they provide some form of unpaid care is much higher at 61,130.
    - There appear to be higher proportions of people providing unpaid care in rural areas compared with urban and suburban areas.
- 29% of people aged over 65 were living alone at the time of the census.
    - Across districts, it is estimated that this rate is highest in Oxford City, at 36% of the population.
- At 30.2 per 1000 people, the rate of people claiming disability living allowance in February 2012 in Oxfordshire was well below the national rate (50.4). Districts range from 25.9 in South Oxfordshire to 33.8 in Oxford City.
    - However, when only mental health related conditions (Psychosis, Psychoneurosis, Personality Disorder, Dementia) are considered, the rate for Oxford City (8.4 per 1000 people) is above the national rate (7.4)

8. Preventing chronic health problems and early death

- Life expectancy for both men and women in Oxfordshire is higher than the England average.
- Estimates for 2011/12 suggest that the number of adults participating in physical activity is higher in Oxfordshire (27.4%) than in the South East (24.7%) or England 22.9%.
- The rates of immunisation in Oxfordshire are significantly above the national rates.
- Hospital admissions for alcohol related harm are increasing, especially for men.
- Oxfordshire contains below average prevalence of most of the diseases in the quality outcomes framework. Out of 20 diseases recorded measured by General Practice the following conditions were more prevalent than the UK average in 2011/12:
    - Cancer, Depression, Asthma, Atrial Fibrillation, Chronic Liver Disease
- These figures may reflect the thoroughness of our GP services in identifying disease early rather than high disease rates in the population.
- The uptake of cervical cancer screening increased by 6% among younger women (25-49 yrs) and fell by 2% among older women (50-64 yrs) between 2007/08 and 2011/12. The rate remains higher for older women than for younger women although the gap is closing.
- The diagnosis and early recognition of dementia is increasing across the county and is particularly high in West Oxfordshire.

Conclusion

Analysis of the information available for this report leads to the conclusion that the priorities currently set out in the Joint Health and Wellbeing Strategy should be taken forward in 2013-14.

The 11 priority areas are:

Children and Young People

Priority 1: All children have a healthy start in life and stay healthy into adulthood
Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups
Priority 3: Keeping all children and young people safer
Priority 4: Raising achievement for all children and young people

Adult Health and Social Care

Priority 5: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support

Priority 7: Working together to improve quality and value for money in the Health and Social Care System

Health Improvement

Priority 8: Preventing early death and improving quality of life in later years
Priority 9: Preventing chronic disease through tackling obesity
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
Priority 11: Preventing infectious disease through immunisation

Next steps

The JSNA Steering Group will continue to develop the data collection which underpins the JSNA throughout 2013-14 in the light of feedback from commissioners and service planners. This work will include further analysis of groups with "protected characteristics" (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation).

Alexandra Bailey, Simon Grove-White. March 2013

Fuel Poverty in Oxfordshire,
Report of a meeting held on 6 December 2012 and recommendations for the Health Improvement Board

Purpose of the meeting
It was agreed that the purpose of the meeting was to

1. Note the current work of a range of organisations through the Warm Homes Healthy People project (WHHP) and the Oxfordshire Affordable Warmth Network (OAWN).
2. Take views on whether there a need to co-ordinate this work further.
3. Assess what more can be done to reduce fuel poverty in Oxfordshire.
4. Inform the Health Improvement Board of work on fuel poverty across the county and agree whether there is a potential role for the Board.

1. Fuel Poverty in Oxfordshire: Current work across the county

Affordable Warmth Network (AWN) and the Warm Homes, Healthy People (WHHP) Project:

a. Funding

Both networks are currently funded into next year but the long term sustainability of the networks is not assured. Funding for AWN is £40K and comes via Cherwell, West and South & Vale District Councils. This is secured until June 2013, beyond that there is currently no commitment in place. The City Council currently do not contribute to the running costs, though funding secured by WHHP has been used to make up a shortfall and provide a service to Oxford City residents

WHHP project is more task and finish and has a number work strands that operate over the winter period only. The project also complements and provides additional resources for the on-going work of the AWN. The project group has received a £152K grant to support the Cold Weather Plan and reduce cold related morbidity and mortality caused by cold housing in Oxfordshire. This money is to be spent by the 31st March 2013. After this the WHHP project will not have operating funds and it is not known whether future grants will be available.

b. Partners

When it was initially funded from Local Area Agreement reward money the AWN included all districts. When the LAA money ran out, all districts except the City Council funded the network to support its core activity. Although Oxford City is not part of the AWN, it is still involved in the work on fuel poverty across the county through the WHHP project and statutory enforcement activity.

Input from Oxfordshire County Council has been reduced recently; this has been exacerbated by various restructures and changes in key personnel both within districts and the county.

c. Current work

The table below provides examples of current work on fuel poverty being delivered by organisations who attended the meeting:

Organisation	Work on Fuel Poverty
Oxford City Council	Housing inspections: assessments of infrastructure such as boilers in rented accommodation, excess cold reports which mean landlords have to take action.
West Oxon DC	Enforcment, information, Home Improvement Agency providing advice, regulations and adaptation
South and Vale DC	Similar statutory function to other districts. Home energy saving promotion.
United Sustainable Energy Agency	Coordinate the Affordable Warmth Network. Home energy conservation, advice line, referrals for insulation schemes, raising awareness of fuel poverty and energy issues, training for workforce and VCS groups, web page with contact information for a range of agencies
Oxfordshire Rural Community Council	Rural Housing Enabler, bulk buying of oil, launching bulk buying of electricity in January, worked with over 500 households to improve energy efficiency. Regular surveys for public consultation
Oxfordshire Waste Partnership	Collective energy switching scheme being proposed, targeting households least likely to switch provider.
Cherwell	Enforcement activity as in other districts. Housing stock assessment. Excess cold hazard features heavily in enforcement work. Provide grants and loans to improve insulation and energy efficiency. Small repairs can include draft proofing properties.
Citizens' Advice Bureaux	Individual advice to clients, of whom the majority have questions about debt, benefits and housing. Collation of some data on enquiries is fed into national picture Financial capability training helping people to get the best deal from their energy supplier.
Oxfordshire Community Foundation	Surviving Winter Campaign - Grants to smaller voluntary groups to make payments to vulnerable people, day sessions for the elderly and other social responses. Money raised by donation of winter fuel payments or from private sector or philanthropic donors.
Age UK	Advice and information services and case work - help the frail, old, younger old people, dementia sufferers, carers access grants, newsletter to 15000 people
NHS Oxfordshire	Electric blanket testing in partnership with Trading Standards, Fire and Rescue and Age UK

d. Housing Condition Survey – agreement on working together

It was agreed that detailed discussions could take place on joint procurement of Housing Condition Surveys by all districts in the county. This was agreed in principle at the meeting as it was clear that this would cut costs for each District Council. A modelling tool could also be used to provide a picture of housing condition that also includes health outcomes and cost-health benefit outcomes via a health impact

assessment. This modelling can be completed instead of a traditional stock condition survey.

Margaret Melling has offered her time to input into and advise on the specifics of the survey should it be commissioned as part of her work for all Districts. It may be that some of the data used is already held and would not need to be purchased. ORCC have also offered to include relevant questions in their regular housing need surveys. The Housing Condition Survey contractor will be contacted so that a meeting can be held in January to discuss details of this joint approach by all districts.

The question of the usefulness of separate data was raised, as surveys need to correspond with household make up. Otherwise vulnerable households in poor quality housing cannot be identified, this is an important indicator.

3. Potential developments that would enhance the current work on fuel poverty

The following issues were identified as areas for development in order to build on current work. They could be taken forward through the AWN / WHHP group.

1. Engagement of Registered Social Landlords (RSLs) in the process of compiling Energy Conservation Reports so they can contribute to the overall picture of fuel poverty in the County.
2. RSLs, advice agencies and organisations working with vulnerable people to sign post to initiatives and opportunities to guard against or alleviate fuel poverty.
3. Shared information to enable advice giving agencies to be up to date – e.g. having the provision of a script or shared information on fuel poverty in Oxfordshire may save duplication. The USEA website will be a basis for this.
4. There is a lot of interest in the use of Energy Performance Certificate (EPC) data including at Cherwell, Oxford City and Oxfordshire Waste Partnership where it aided an energy switching programme. EPC is a tool that is used to target those households with low energy ratings. Data produced does have caveats but it can be shared with partners. Individual EPCs are available from www.epcregister.com and might be more useful for individual cases.
5. There is room for a bigger role for primary care within the WHHP project e.g. wider involvement with GPs including data sharing and using flu clinics to help identify people at risk from fuel poverty.
6. Possible opportunities for gathering information through the 'discharge to assess' procedures and offering appropriate advice or services.
7. "Cocoon insulation scheme" funding ended in September 2012, although the Green Deal will pick up elements of the scheme it will not do so to the same extent. Joined up approaches to managing this new scheme would be an advantage.
8. Several of the county's local authorities are working with USEA to establish a Green Deal Provider service that is likely to be a key focus of their energy efficiency and fuel poverty work
9. Communication will be needed around the Green Deal shortly and could be planned jointly and could include districts, OCF and other partners.

10. Several of the county's local authorities are also investigating a joint bulk switching scheme which will aim to reduce fuel prices and help mitigate fuel-poverty.

4. Possible roles of the Health Improvement Board

1. To promote sustainability and wider participation in the work of the Affordable Warmth Network to ensure the work can continue beyond the period currently funded. This may include future bids for Warm Homes Healthy People grants.
2. Monitoring progress on current work and giving it a higher profile through the H&WB. This can be achieved by including relevant indicators in the "basket of indictors for housing and health" but also by setting outcomes for 2013-14 for reduction in fuel poverty in the County.
3. Assisting with surveillance and interpretation of data to ensure efficient and effective targeting of limited resource to the areas / sectors with worst fuel poverty outcomes.

Recommendation:

The Health Improvement Board is asked to agree to take on these roles and ensure that future work on reducing fuel poverty in Oxfordshire is efficient, effective and sustainable.

Appendix: Attendees at the fuel poverty meeting on the 6th December

Name	Organisation
Jackie Wilderspin	PH
Kate King	PH
Sue Johnson	Oxford City
Cynthia Sullivan	South & Vale District Councils
Phil Measures	West Oxfordshire District Council
Jan Deacon	United Sustainable Energy Agency
Tom McCulloch	Oxfordshire Rural Community Council
Wayne Lewis	Waste Partnership
Giles Mason	Cherwell District Council
Gill Tishler	Citizens Advice Bureau
Stephanie North	Oxfordshire Community Foundation
Alice Runnicles	Age UK Oxfordshire
Maggie Dent	Oxfordshire PCT
James Martin	Oxfordshire County Council
Margaret Melling	Data lead for the districts
Ian Wright	Oxford City
Apologies	
Paul Wolf	Oxford City
Shelia Farley	Oxford City
Tim Mills	Cherwell District Council
Linda Watson	Oxfordshire Rural Community Council
Paul Cann	Age UK
Val Johnston	Oxford City
Rachel Stancliffe	Centre for Sustainable Health Care
Jayne Woodley	Oxfordshire Community Foundation

This page is intentionally left blank

Supported Housing Group: Terms of Reference

Purpose

The Oxfordshire Health and Wellbeing Board is the principal structure for Oxfordshire with responsibility for promoting the health and well being of the people of the county.

The commissioning of housing related support is a key function of the Board.

The Supported Housing Group will provide guidance and advice to the Health Improvement Board, the Adult Health and Social Care Board and the Children and Young Peoples Board in their role of supporting the Health and Wellbeing Board to fulfil its responsibilities in regard to the commissioning of housing related support, delivering service change and improved outcomes through partnership working.

The Supported Housing Group will have oversight of the commissioning of the full range of housing related support services that will enable adults, who are vulnerable for many different reasons, to live independent lives in the local community.

As well as having particular responsibility for advising on the commissioning strategy for housing related support services that are within the remit of the Health Improvement Board, the Supported Housing Group will be consulted about and advise upon all proposals to make changes to budgets and/or commissioning priorities for the provision of all other housing related support services. In this way, the implications of funding and service decisions in one part of the partnership structure can be considered across the whole structure to ensure that there are no inadvertent adverse consequences for other services.

Responsibilities

The Supported Housing Group has the following responsibilities

Strategic Overview of all Housing Related Support Services

To maintain an overview of **all** commissioning and policy development work in regard to housing related support in the county to ensure there are no gaps in service provision and to ensure that services are developed in a co-ordinated way to meet needs as effectively as possible.

To consider the findings of the Joint Strategic Needs Assessment and otherwise map emerging needs and to make recommendations accordingly with regard to how the provision of housing related support can meet the needs identified.

Supporting and advising the Health Improvement Board

To provide guidance and recommendations to the Health Improvement Board in respect of the strategic commissioning of housing related support services to meet the needs of homeless persons, offenders and those at risk of offending, persons at risk due to domestic abuse, drug and alcohol abuse.

To propose the commissioning strategy for housing related support and annual plan to the Health Improvement Board for its consideration.

To assist in the delivery of priorities, objectives and outcomes in the Health and Wellbeing Strategy with regard to the provision of housing related support and the prevention of homelessness.

Participating in the contracting of housing related support services

To advise on the content of service specifications for housing related support services.

To provide representatives to take part in the assessment of tenders and selection of service providers, when appropriate to do so.

Monitoring service performance

To receive quarterly performance indicator and service outcome reports with regard to **all** commissioned housing related support services.

To monitor expenditure against budget in respect of housing related support services that are within the remit of the Health Improvement Board and to recommend appropriate action to prevent the budget being overspent.

Expert advice to other commissioners of housing related support

To provide advice to the Adult Health and Social Care Board and relevant Joint Management Groups in respect of the strategic funding and commissioning of housing related services for older people, adults with mental health needs and adults with learning disabilities or physical disabilities

To provide advice to the Children and Young Peoples Board in respect of the strategic funding and commissioning, of housing related services for young people and teenage parents.

To provide advice and recommendations in respect of the funding, commissioning, development and delivery of housing-related support services to Oxfordshire County Council's Joint Commissioning Team.

To advise upon the likely impact of proposals to make changes to budgets and/or commissioning priorities for the provision of housing related support for adults with mental health needs, young people and teenage parents, older people and adults with learning disabilities and physical disabilities.

To have input into the commissioning strategies affecting the delivery of housing related support to any other client groups e.g. Mental Health Young People, Physical disability, Community Safety, Older People joint commissioning strategies.

Membership of the Group

The following partners to the Supported Housing programme will each send a senior representative to the Supported Housing Group:

a) Oxfordshire County Council – as administering authority
b) Cherwell District Council
c) Oxford City Council
d) South Oxfordshire District Council
e) Vale of White Horse District Council
f) West Oxfordshire District Council
g) Thames Valley Probation Service
h) Oxfordshire Clinical Commissioning Group

The following will also be invited to send representatives to the Supported Housing Group:
i) Oxfordshire County Council – Children, Education & Families
j) Oxfordshire County Council - Joint Commissioning Team (Older People)
k) Oxfordshire County Council – Safer Communities Unit
l) Oxfordshire Drug and Alcohol Action Team
m) Oxfordshire Supporting People Provider Forum (two)
n) Oxfordshire Supporting People User Group (two)

In addition, other stakeholder representatives may be asked to attend to present papers or assist the business of the meeting.

Governance

The chair of the Group will be taken on an annual basis by one of the local housing authorities.

The chair or their nominated deputy will attend meetings of the Health Improvement Board to present any papers of the Group, offer advice and to answer questions.

The chair or their nominated deputy may need to attend the Adult Health and Social Care Board and the Children and Young Peoples Board or other commissioning groups to offer advice or to represent the view of the Health Improvement Board or the Supported Housing Group.

The Group will be quorate if at least five members are present, to include representatives of not less than three of the local housing authorities.

All individual members of the Group will take joint responsibility for the overall delivery of work required to meet its responsibilities.

It is the role of each individual member to ensure that the best overall distribution of resources for the provision of housing related support is achieved for all vulnerable people in Oxfordshire.

Individual members will take responsibility for:

- Ensuring effective dissemination and communication routes exist within the organisation on behalf of whom they attend
- Taking forward any issue within their own organisation or constituency that requires action on the part of that partner

The Group aims to arrive at a consensus on all decisions but it may also make recommendations that have not achieved a consensus provided it reports the reservations expressed by members who held a minority opinion.

Meetings will usually be held quarterly on the first Wednesday of the month. Additional meetings may be called or meetings may be cancelled at the discretion of the chair.

Papers will be distributed at least five working days in advance of meetings unless prior notice has been given that papers will not be available within this timescale.

Minute taking and the distribution of papers will be undertaken by a member of the Oxfordshire County Council Joint Commissioning Team.

These terms of reference shall be reviewed at least every two years.

Report to the Health Improvement Board

Homelessness Prevention Activity in Oxfordshire

Background

The Health Improvement Board has agreed the prevention of homelessness as a key priority for housing and health inequality issues.

Local housing authorities are required by statute to periodically carry out a review of the homelessness situation in their area and to develop their strategy for reducing the incidence of homelessness and ensuring that homeless persons have the accommodation and support that they need.

This paper outlines what the key issues are across the county and describes how the issues are being addressed.

Key Issues

- Implementation of No Second Night Out in respect of rough sleepers
- Commissioning supported accommodation for homeless single people and meeting a savings target of £270k
- Mitigating the impact of welfare reform
- Prevention of homelessness of young people particularly 16 and 17 year olds
- Reducing homelessness caused by domestic abuse
- Meeting the housing needs of people leaving the Armed Forces

Main causes of homelessness

The main causes of homelessness across the county are;

- Being asked to leave by parents, other relatives or friends;
- Termination of privately rented shorthold tenancy;
- Rent or mortgage arrears
- Relationship breakdown including fleeing domestic violence or abuse;

Current trends

There remains a shortage of social housing to meet demand and access to private rented accommodation for households on modest incomes is increasingly restricted because of high general demand sustaining rent levels above Local Housing Allowance (LHA) rates set for housing benefit eligibility and a notable reluctance of landlords to offer tenancies to households who may be dependent on housing benefit.

There are a number of challenges to be met locally if a rise in the number of households being threatened with homelessness is to be successfully prevented. The impact of the current economic climate, a much reduced new build programme for affordable housing in some parts of the county, the impact of various Welfare Reform measures and continued reductions in funding for housing related support all have the potential to give rise to an increase in the incidence of homelessness.

Nationally, government figures published for quarter 3 of 2012, show that homelessness rose in England by 11% compared to quarter 3 of 2011 and that there has been an 8% annual rise in the number of households in temporary accommodation, including a 29% rise in the number in bed and breakfast.

The emerging picture locally is of an increasing number of people seeking assistance because of concerns about homelessness. (see appendix giving statistics).

Rough Sleeping

The incidence of rough sleeping is greatest in the City and data from the Oxford City Outreach service indicates that on average 2 to 3 people come onto the streets of Oxford each week. A service model of No Second Night Out was implemented in July 2012 in order to try and ensure that no rough sleeper would need to spend more than one night on the streets in Oxford. This initiative is in the process of being rolled out to the rest of the county.

No Second Night Out works on the following principles

- Providing a rapid response to new and returning rough sleepers
- Making a single service offer of suitable accommodation and support for new and returning rough sleepers, based on individual assessment
- A focus on linking people who migrate into Oxfordshire back to accommodation and services where they have a local connection
- A partnership approach of relevant agencies and services working together to achieve the aims of the model

The service model is based on verification that someone is actually sleeping rough in order to access services, a highly assertive outreach approach, the establishment of an assessment unit at O'Hanlon House in Oxford where rough sleepers can receive a rapid assessment of their needs and receive a Single Service offer with rough sleepers being prioritised for accommodation within the Oxford Homeless pathway.

Welfare Reform

A number of welfare reform measures have already been introduced. Local Housing Allowance now only covers the cost of the cheapest 30% of rental properties in the private sector rather than the average cost and single people up to the age of 34 who rent from a private landlord now have their housing benefit entitlement restricted to the cost of a room in a shared house.

From April 2013, a maximum cap will be imposed on the amount of benefits a household can claim of £500 per week for couples and lone parent families and £350 per week for single people. Also, housing benefit will be reduced for working age social housing tenants who occupy a larger property than the family needs, set at 14% of eligible rent for one extra bedroom and 25% for two or more extra bedrooms.

Further major changes are due to be made with the roll out of Universal Credit from October 2013 and the routine payment monthly in arrears of the housing element of Universal Credit direct to housing association tenants unless they are considered to be vulnerable in accordance with criteria yet to be published.

Work underway to address these issues

With regard to the prevention of homelessness of single people and particularly those who are rough sleeping, Oxfordshire and Buckinghamshire have been allocated a one off sum of £455k transitional homelessness funding to be spent on front line prevention measures. The action programme that has been agreed for the two counties has 3 strands of work which are now underway and overseen by the Buckinghamshire and Oxfordshire Single Homeless steering Group. These are:-

- Mitigation of the impact of Welfare reform by identification of those affected, raising awareness of individuals and other agencies, sharing best practice across authorities, ensuring effective housing options advice for those affected, development of incentives to private sector landlords to let properties within Local Housing Allowance rates, development of credit union services, delivering partnership work to tackle worklessness and improved access to employment and training

- Effective implementation of the No Second Night Out model across the two counties, including commissioning an outreach service for rough sleepers in the Districts, provision of additional emergency beds in homeless projects outside of the City and a personalisation of support project for rough sleepers
- Development of improved move on options from supported accommodation including assistance to access private rented accommodation

Supported accommodation for homeless single people

One of the biggest challenges facing the county is achievement of a countywide savings target of £270k to be met as part of the retendering of hostel and supported accommodation for homeless single people during 2013/14.

The majority of this provision comprises the three main hostels in Oxford City. One of the options to meet this target is to de-commission one of the hostels and invest remaining funding into move on accommodation and floating support in priority areas. Instead of pursuing this option, it has been decided to invite proposals from service providers in respect of a suite of new services that would satisfy some fundamental service parameters. This market testing exercise will get underway early in 2013 with a view to new services becoming operational in 2014.

Homelessness and Young People

A Joint Housing Team comprising representatives from the local housing authorities and the County Council's Children, Education and Families Directorate works in a collaborative way to prevent young people from becoming homeless, oversee the effectiveness of the Young People's pathway of supported accommodation and to ensure that each agency's responsibilities with regard to meeting the housing needs of potentially homeless 16 and 17 yr olds, children leaving care and other vulnerable young people are met.

In May 2009 Oxfordshire published, *"Housing and related Support for young people aged 16-24 years: Oxfordshire Joint Commissioning Strategy 2009-14."* This report set out a coherent strategy for jointly commissioning services to meet the needs of young people and young families in Oxfordshire, bringing together funding from Children's Social Care (CSC), Supporting People and the district councils.

A Young People's pathway of supported accommodation was commissioned and contracts have been in place for these services since 1 April 2010. With the exception of One Foot Forward in Oxford, all services within the Pathway need to be retendered and new contracts in place by 1st April 2015.

A review of the effectiveness of current services will inform the content of specifications for the new services going forwards.

The aim of the Young people's pathway was to change the focus of current services and set out a service model that had a clear support pathway from prevention, assessment and referral to access, progression and move-through and then into independence. It places primary importance upon preventing homelessness.

A recent review of the effectiveness of the pathway in meeting the strategic objectives was that the structure of the pathway is broadly operating well. A notable success of the Pathway has been its ability to house priority needs group, predominately 16 and 17 year olds. This has however had a number of consequences and has highlighted the need for greater countywide provision for those young people with the most complex needs and has led to a shortage of provision to meet the needs of 18 to 24 year olds needing housing related support.

In order to meet the savings target set for 2013/14, the supported lodgings provision in the pathway has had to be de-commissioned.

Homelessness as a result of domestic abuse

Homelessness of people leaving the Armed Forces

Oxfordshire has three main military bases, RAF Brize Norton, Bicester Garrison and with associated married quarters for service personnel. The county signed up to the Military Covenant in 2011. One of the commitments is to ensure that the housing needs of households leaving the forces are met satisfactorily.

This page is intentionally left blank

Health Improvement Board
Proposed Basket of Indicators for Housing and Health

Introduction
The link between poor or insecure housing and poor health is well documented, but the detail of mechanisms that have a direct effect on improving or worsening health is more difficult to define. There are no diseases or health outcomes that can be said to be a direct result of poor housing conditions. People who experience homelessness usually have complex health needs, but the fraction of this attributable to their lack of housing cannot be defined.

The Health Improvement Board has 3 major priorities which cover the strategic approach to housing related support for vulnerable people, preventing homelessness and reducing fuel poverty. It is proposed that a basket of indicators be collated to enable the Board to keep an overview of related issues in Oxfordshire. The proposed list of indicators below has been selected because the data is available regularly and is deemed to link to health issues. Outcomes to measure progress in improving health and housing will be drawn from this basket of indicators and included in the Joint Health and Wellbeing Strategy.

The Basket of Indicators

a. Taking into account the key priority areas for the health and housing issues across the County as set out in the accompanying report on homelessness prevention activity, it is proposed that the following suite of indicators that are already being collected by the local housing authorities on a quarterly basis should be reported to the Health Improvement Board as a way of monitoring trends and activity,

This information can be shown by local authority area and previously collated data is available for the purposes of establishing a trend over the last 2 years.

1	Total number of applicant households who were homeless as defined by the Housing Act 1996, comprising the following categories
1a	Eligible, unintentionally homeless and in priority need
1b	Eligible, homeless and in priority need but intentionally so
1c	Eligible, homeless and not in priority need

2	The number of applicant households who were homeless, unintentionally homeless and in priority need
2a	who were aged 16 or 17yrs old.
2b	who were aged 18 to 24 yrs old
2c	who were vulnerable because of a physical disability

2d	who were vulnerable as a result of mental illness or disability
2e	whose main reason for loss of accommodation was rent arrears

3	Number of applicant households accommodated in temporary accommodation at the end of the quarter

4	Total number of cases where positive action was successful in preventing homelessness of which
4a	homelessness was prevented by debt advice, resolving housing benefit problems or resolving rent arrears

5	Number of persons sleeping rough at the last count or estimate

b. In order to provide a context to the action being taken to prevent homelessness as a result of welfare reform measures, it would be possible to provide details of the

6a	Number of social housing tenant households whose housing benefit is reduced because they are deemed to have more bedrooms than they need for the size of the household
6b	Number of households whose overall welfare benefits entitlement (including housing benefit) is capped so that it is no more than £500 per week for couples and lone parent families and £350 per week for single people.

c. In addition, it is proposed that we also keep surveillance of Fuel Poverty data including the Excess Winter Deaths Index which is, in part, a proxy indicator for the impact of fuel poverty, especially on older people

7	The percentage of households in a geographical area that were fuel poor. A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel
8	Excess Winter Deaths (EWD) Index - the excess of deaths in winter compared with an expected number of deaths based on non-winter months expressed as a percentage.

Recommendation: The Health Improvement Board is asked to accept this list of indicators for surveillance of housing and health issues.

Next steps: The current data for each of these indicators will be collated for discussion at the next meeting and to enable selection of outcome measures for inclusion in the revised Joint Health and Wellbeing Strategy, giving outcomes expected in 2013-14.

This page is intentionally left blank

Joint Health Improvement Board and Adult Health & Social Care Board workshop

Background
On the 22 January 2013 the Adult Health & Social Care and Health Improvement Board held a joint workshop looking to explore how to take forward areas of work that overlap the two boards.

The workshop's aim was for members and wider stakeholders of the Health Improvement Partnership Board and Adult Health & Social Care Partnership Board to discuss how we will work together to achieve our outcomes for **preventing premature death and enabling healthy older age.**

Aims of the workshop
The key aims for the day were to:

- Identify gaps in how this area of overlap is being taken forward, devise plans for plugging the gaps and to ensure good working arrangements
- Consider how a wider range of partners / affiliated projects could add value to either partnership

The workshop
The workshop was well attended with over 50 participants from; service providers; CCG; the voluntary and community sector; public health; local authorities as well as members of the public.

The plenary session was introduced by Councillor Arash Fatemian, Chairman of the Adult Health & Social Care Board who gave a presentation on the Older People Commissioning Strategy and process of consultation. This was then followed by an introduction to the work on prevention undertaken by the Health Improvement Board focussing on priority 8 within the Joint Health and Wellbeing Strategy.

There was also a presentation given by Oxford University Hospital on Generation Games; a 50+ physical activity network across Oxfordshire.

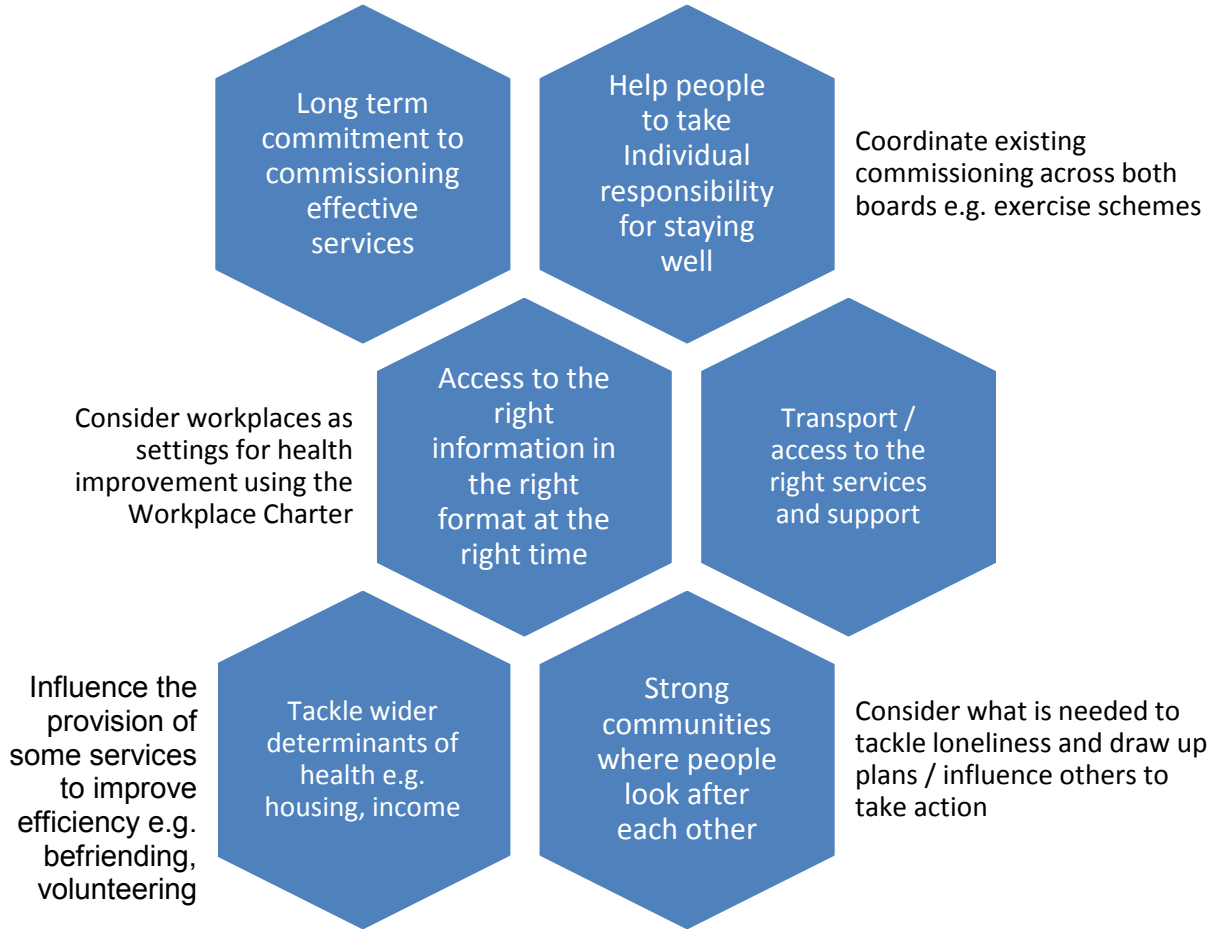
Two group discussion exercises then took place and details are given in the appendix to this paper.

Next steps for the Adult Health and Social Care Board and the Health Improvement Board

The ideas and views from participants at the workshop have been analysed and a number of themes have emerged (see the appendix for full details). Some of these can be taken forward by the Health Improvement Board (HIB) or Adult Health & Social Care Board (AH&SC). Others will need to be taken forward elsewhere. This section of the paper outlines those themes, sets out some draft principles for how the HIB and AH&SC Boards work together on taking this agenda forward and outlines some ideas for translating this work into action plans.

Themes emerging from the workshop

The diagram below shows some of the themes that have emerged from the workshop. The building blocks show broad themes. Some of these may be already in progress, may need more focus or may be the work of other partnerships. The themes which are around the edges of the diagram and not within building blocks show potential new areas of work for the HIB or AH&SC. If these ideas are taken forward then the work will be more far reaching and robust.



Recommendations:

Adult Health and Social Care Board

- Consider what contribution can be made to tackling the issue of loneliness and take action to develop work in this area
- Build on the work being undertaken through the “Futures” Programme to make information on primary prevention services accessible to the public
- Ensure that the Generation Games work develops alongside other initiatives and works together with them e.g. Go Active

- Make active links between commissioners and voluntary sector providers to align work and share strategic direction. Improve effectiveness where possible e.g. befriending schemes

Health Improvement Board

- Deliver outcomes on screening and NHS Health Checks which are in the action plans of the Older People Commissioning Strategy and share performance information
- Consider the potential for promoting health through Workplaces (in the public, private or voluntary sector) and the use of the Workplace Charter.
- Ensure that commissioners in AH&SC are aware of healthy lifestyle initiatives commissioned through the HIB
- Build on work already done to identify affiliated projects in the voluntary sector and share strategic direction. Improve effectiveness where possible.

Others

- Engage the voluntary and community sector (maybe through the Oxfordshire Stronger Communities Alliance) in prioritising health and wellbeing in community development initiatives e.g. community led planning
- Consider the use of grant funding for wellbeing initiatives in communities and work with partners to promote this, e.g. through OSCA, Community Foundation etc.

The workshop also highlighted some potential principles for how the HIB and AH&SC Board need to take this work forward:

- Prioritise primary prevention in all work streams and all commissioning
- Build on existing work e.g. don't invent a new way of getting information to members of the public
- Use the existing systems of public involvement and consultation through the PIN to develop "co production"
- Work together on commissioning prevention services to ensure they are joined up and build on what is already there.
- Have a long term view and build sustainable services
- Target the populations with worst outcomes

Next steps

1. Health Improvement Board and Adult Health & Social Care Board are to discuss the recommendations set out above and decide what actions they can take forward.
2. Action plans will be drawn up for implementation by the partnerships
3. Consideration will be given to how to influence a wider range of organisations or partnerships to contribute to this agenda.

Appendix – details of the group work undertaken at the workshop

Exercise 1: What's going on: The good, the bad, the gaps
Delegates were asked to think about what is currently going on within their own organisations, within their own lives and also elsewhere around the country that supports and enables good health and wellbeing prior to old age or conversely pushes people into poor health and wellbeing or prevents them achieving it.

Delegates were also asked to identify what gaps there currently are in helping people to attain good health and wellbeing prior to old age: what needs to be done to ensure good health and wellbeing into old age can be achieved by all?

What participants told us:

	Promotes good health and wellbeing	**Prevents good health and wellbeing**
What I do	Family and friends were overwhelmingly the top two seen as keeping individuals healthy	The key theme was around work overload, stress at work and the inability to keep up a work/life balance
What my organisation does	Importance of organisational/employer policies that promote job satisfaction and support employees	Focus on an employer/employee culture that promotes being unhealthy – sitting at a desk for long periods, not taking lunch hours and so limits time/opportunity for exercise and emotional recharging
What is going on elsewhere in the country?	Transport – links to improved access and services	
	Exercise – access to a wide range of opportunities including integrating exercise into the working day	
	Signposting, information and education – empowering people with the right knowledge to make healthy choices	
	Communities – supporting communities to support themselves	
	Dementia – engaging people with dementia and helping them stay active	
	Commissioning and contracting services – promoting staying healthy when designing service models	
What are the gaps?	Transport – inaccessible and unaffordable public transport	
	Exercise – time, cost and accessibility	
	Signposting, information and education – more effective information sharing between organisations, consistent messages, too much information only available via the web	
	Partnerships – smarter collaboration between and within organisations and better partnerships between the communities and organisations	
	Communities – investment required to build resilience and capacity	

	Promotes good health and wellbeing	Prevents good health and wellbeing
	Empowerment – supporting and promoting individual responsibility	
	Housing – decent and affordable housing for all, people in poor housing at a disadvantage	
	Health and social care – accessible GP services, more early intervention, need to prioritise ill health prevention, disincentives to poor lifestyles	
	Commissioning – the business case for procuring exercise and healthy food, the need for a comprehensive wellbeing service for older people, need for an effective lifelong and care group wide approach	
	Funding – long term and sustainable	

Exercise 2 Group discussions on action to take this work forward
Exercise 2 allowed delegates to explore the issues raised in exercise 1 in more detail and offer suggestions on how the gaps can be addressed by both boards and others, also on the back of that what can we expect to be different. The following tables provide an overview of the discussions and ideas expressed.

What can I or my organisation offer to stay healthy?

Partnerships	Working more in collaboration
The workplace	Workplace incentives for active lifestyle and wellbeing interventions
	Exercise classes at work
Signposting and Information	Better signposting and health promotion
	Be experts by experience
Volunteering	Enabling and taking part in volunteering
Community empowerment	Build better networks and infrastructure in the community
	Reach more people: the isolated and lonely people; older people
Personal responsibility	Take more control of personal health

What should HIB & AHSC do?

Funding	Partnership boards to have an overview of funding sources and encourage sustainable funding when projects are working, especially within the voluntary sector that can help to deliver strong partnerships.
	Able to provide advice on how funding can be used.
	HIB should commission an info service across partnerships
Vision and overview	Should hold the overall vision and knowledge of what is

	going on across the pathways,
	Create a shared vision including the prevention agenda to support long term planning
	Continuing to hold workshops and engage providers can help this
Influencing and co-ordinating	Adding value was a key theme especially in the form of identifying and bringing partnerships together to promote joined up working within projects (GG and Go Active).
	Influence partners to have consistent policies/approaches.
	encouragement of early intervention and help build relationship with service users
	Identify organisations and services which empower individuals and communities
	encourage employers to market the message of good health and wellbeing via active interventions
	Not to get in the way of things that are working
Intelligence	Included mapping what is going on already and developing databases and knowledge hubs so everyone can feed in what they are doing or intend to do.
	development of a co-ordinated marketing segmentation strategy to help us understand how to engage and communicate with our audience
	funding of a consultation to ask people what would persuade or help them to take action which will support health and wellbeing
Branding	Develop a brand - GPs crucial to that

Who else needs to be involved?

- Comments were received about improving the role of education and business in promoting and enabling healthy behaviours
- GPs were seen a crucial partners in this and the need for a focus HWB; noticing that things make a difference, promoting good practice
- Further engagement of the VCS and smaller community groups and organisations outside of the health & SC world working with people at a local level

Areas of unnecessary duplication or where more joined up working can take place

Better coordination / join-up	There were a number of calls for one befriending scheme rather than many
	More co-production
	Lack of long term planning
	Consolidation rather than continual change management
Funding	There is a need to have a better understanding of where and how to get funding

	Further development of pooled budgets and joint decision making
	Gap in monitoring VCS group receiving local authority funding
Communication	All parties are seeking to communicate with same hard to reach groups, can this be managed

What would we expect to be different?

Empowerment	Enable people to look after themselves
	Communities made aware of good practice
	People living longer and healthier
Equalities	Ensure what we do doesn't widen inequalities
	Better services
	More uptake of sports by BME
	A reduced variation in life expectancy across the county
Ways of working	Don't monitor contracts by numbers
	Better informed GP with information to aid long term planning
	Influencing employers to adopt good work practices
	More time spent delivering rather than planning
	Coherence of policies across all districts e.g. exercise on prescription/referral

This page is intentionally left blank