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NHS Oxfordshire Clinical Commissioning Group | OXFORDSHIRE COUNTY COUNCIL | healthwatch Oxfordshire

**To: Members of the Health Improvement Partnership Board**

# *Notice of a Meeting of the Health Improvement Partnership Board*

**Thursday, 26 September 2013 at 2.00 pm**

Peter G. Clark
County Solicitor


September 2013


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


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## Membership

Chairman – District Councillor Mark Booty
Vice Chairman - City Councillor Ed Turner

*Board Members:*

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| Cllr Anna Badcock | South Oxfordshire District Council |
| Ian Davies | Cherwell & South Northants District Council |
| Peter von Eichstorff | Clinical Commissioning Group |
| Dave Etheridge | Chief Fire Officer & Head of Community Safety |
| Cllr Hilary Hibbert-Biles | OCC – Cabinet Member for Public Health & Voluntary Sector |
| Cllr G.A. Reynolds | Cherwell District Council |
| Aziza Shafique | Public Involvement Network |
| Cllr Alison Thomson | Vale of White Horse District Council |
| Dr Jonathan McWilliam | Director of Public Health |
| Jackie Wilderspin | Assistant Director for Public Health |

***Notes:***

- ***Date of next meeting: 23 January 2014***

## 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 - 8)

   **2:05**
   **5 mins**

   To approve the Note of Decisions of the meeting held on Thursday 16 May and to receive information arising from them.

6. **Performance Report** (Pages 9 - 66)

   **2:10**
   **15 mins**

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

   A report of the current progress against the targets of the HIB

7. **Obesity Prevention** (Pages 67 - 88)

   **2:25**
   **50 mins**

   Person(s) responsible: Members of the Health Improvement Board
   Person giving report: Kate King

   A review of current activity across the county and a discussion on the opportunities

## 8. Proposal for a Public Health strategy with Oxford University Hospital (Pages 89 - 104)

**3:15**
**10 mins**

Person(s) responsible: Members of the Health Improvement Board
Person giving report: Andrew Stevens and Dr Jonathan McWilliam

A joint paper from Public Health and Oxford University Hospital setting out a statement of intent for a joint strategy

## 9. Older People's Housing Strategy Needs Analysis

**3:25**
**20 mins**

Person(s) responsible: Members of the Health Improvement Board
Person giving report: John Jackson and Ann Nursey

A paper presenting progress to date in developing a needs analysis to inform housing plans

**Report to follow**

## 10. Update from the Public Involvement Network (Pages 105 - 106)

**3:45**
**5 mins**

Person(s) responsible: Members of the Health Improvement Board
Person giving report: Aziza Shafique

An update from the Public Involvement Network including introducing the new representatives on the Health Improvement Board

## 11. Public Health Campaigns (Pages 107 - 108)

**3:50**
**5 mins**

Person(s) responsible: Members of the Health Improvement Board
Person giving report: Councilor Hilary Hibbert Biles

Information about the Public Health campaigns for the next six months

## 12. Forward Plan

**3:55**
**5 mins**

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

A discussion on the forward plan for the Health Improvement Board

Meeting dates:

- Thursday 28th November 2013
- Thursday 23rd January 2014 – Board Meeting
- Thursday 27th March 2014

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## SHADOW HEALTH IMPROVEMENT BOARD

**OUTCOMES** of the meeting held on Thursday, 16 May 2013 commencing at 2.00 pm and finishing at 3.53 pm

**Present:**

**Board Members:** District Councillor Mark Booty – in the Chair

Edward Owen Turner (Vice-Chairman)
Dr Jonathan McWilliam
Jackie Wilderspin
Ian Davies
Peter von Eichstorff
Steven Curran

**By Invitation:** Councillor Roger Cox
Councillor Anna Badcock
Councillor Scott Seamons

**Officers:**

Whole of meeting Lesley Sherratt
James Martin

*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; Email: james.martin@oxfordshire.gov.uk)*

| | ACTION |
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| **21 Welcome by Chairman, District Councillor Mark Booty**<br>(Agenda No. 1) | |
| The Chairman, Councillor Mark Booty, welcomed all to the meeting including Councillor Ed Turner in his role as Vice Chairman. It was noted that Councillor Val Smith has stood down from her role in the Executive of the City Council. Thanks for her | |

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| role in the Health Improvement Board from its inception were noted.<br><br>Councillor Roger Cox, Councillor Scott Seamons and Councillor Anna Badcock were welcomed as guests of the Chairman. | |
| **22 Apologies for Absence and Temporary Appointments**<br>(Agenda No. 2) | |
| Apologies have been received from Councillor David Nimmo-Smith, Val Johnson, Anita Higham, Dave Etheridge and Councillor Pickford.<br><br>Lesley Sherratt is deputising on behalf of Val Johnson. | |
| **23 Declaration of Interest - see guidance note opposite**<br>(Agenda No. 3) | |
| No declarations were received. | |
| **24 Petitions and Public Address**<br>(Agenda No. 4) | |
| No petitions were received. | |
| **25 Note of Decision of Last Meeting**<br>(Agenda No. 5) | |
| Matter arising:<br><br>Access to Academies is done on an individual basis through Heads or through a Governing Body rather than collectively.<br><br>The Housing Support Advisory Group terms of reference will be circulated to the Adults and Children Boards, next time they meet.<br><br>The note of the last meeting was approved. | |
| **26 Re-commissioning of Homeless Pathway**<br>(Agenda No. 6) | |
| Clare Rowntree presented the paper that detailed the process and principles of the framework for re-commissioning of the | |

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| homeless pathway in Oxfordshire that has a budget of £4million per annum.<br><br>Dr Jonathan McWilliam stated that homelessness is an important issue to the Health Improvement Board and is a serious issue for public health. This work shows how we can all work together to address the issues.<br><br>The discussion that followed focussed on the following points:<br><br>• **The timetable for the re-commissioning**<br>Procurement rules mean that new contracts must be in place by 1 February 2015. In order ensure adequate time to make any alterations to the properties from which services are delivered, the aim is to complete the procurement process by January 2014, giving a 12 month transition period before the new contracts commence.<br><br>The length of contracts will be 3 years with an option to extend for a further 2 years.<br><br>• **Future funding and sustainability**<br>The re-commissioning of the homeless pathway must make a saving of £270K, possible options will need to take account of this. Councillor Turner expressed caution about the commissioning of services that future changes to funding or the welfare benefits system may make unsustainable.<br><br>The response from Ann Nursey, Lead Commissioner for Adult Services was that future savings that may be required are, at this point, unknown. The review of the total homeless pathway and not just a number of services within it will provide the best opportunity for stability during the length of the contracts.<br><br>Councillor Seamons suggested that there may also be a need to review the use of buildings currently in use to deliver services. This is because building based service are an essential component of homeless services. This was agreed and work is currently being done looking at the suitability and possible options of existing buildings and services.<br><br>• **Links with MH**<br>Ian Davies welcomed the report and praised the collaborative efforts across the county. Ian Davies also stressed the importance of getting right the commissioning of services to deal with Mental Health issues and acknowledged the difficultly in producing an accurate and conclusive needs analysis. This was agreed as was the importance of preventative work that will continue. It was also highlighted that the commissioning of Mental Health services is going through a review similar to the | |

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| homeless pathway.<br><br>• **Future meeting with elected members**<br>Cllr Mark Booty proposed that the next scheduled meeting of the Health Improvement Board should be brought forward to June and take the format of a working meeting to progress this agenda with lead officers and members to look at future options for the homeless pathway. This was seconded by Cllr Ed Turner and agreed as an **action**.<br><br>Clare Rowntree was thanked for her paper. | JW / JM |
| **27 Performance Monitoring**<br>(Agenda No. 7) | |
| Jonathan McWilliam presented the monitoring report noting the indicators that are rated red and detailing the reasons for this:<br><br>**<u>Indicator 8.2: 2,000 adults receiving bowel screening for the first time</u>**<br><br>The programme is going well. Figures are however below the expected levels due to how data is collected through the national system that causes delays receiving the data locally.<br><br>**<u>Indicator 9.1: Ensure that the obesity level in Year 6 children is held at no more than 15%</u>**<br><br>Although the figure is currently 15.6%, Oxfordshire is performing well given the national figure of 19%. Work is on-going to reduce childhood obesity across Oxfordshire through many different agencies. When setting targets for next year the Health Improvement Board will need to look at what it wants to achieve.<br><br>Discussion focussed on the issues that are causing childhood obesity and the work going on across the county and opportunities there might be. These included:<br><br>• The current very good involvement of the County Council in regards to nutrition at schools<br>• Further opportunities for physical activity both in a school setting and beyond<br>• Primary prevention: increased education and support at the weaning stage to tackle overfeeding, obesity and the need for intervention in later childhood and into adulthood<br><br>**<u>Indicator 9.2: 60% of babies are breastfed at 6-8 weeks of age</u>** | |

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| Although this indicator is red, Oxfordshire is doing well nationally, out-performing the England average. The benefits of breastfeeding were highlighted and the Health Improvement Board was encouraged to keep this indicator high on the agenda next year.<br><br>Discussion focussed on what services there are currently within the county to promote breastfeeding and actively work with mothers to learn and develop techniques that work for them and their babies.<br><br>Dr Peter von Eichstorff detailed the work of GPs in this area that includes the personalisation of services and active dialogue to encourage and support breastfeeding. Resources are targeted geographically at areas that have traditionally lower levels of breastfeeding such as Cherwell.<br><br>Dr Jonathan McWilliam pointed out that there many agencies across the county looking that the work associated with indicators 9.1 and 9.2 that would be helpful context for the Health Improvement Board. It was **agreed** that a report or information detailing this work will be brought to a future Health Improvement Board meeting.<br><br>Cllr Turner suggested that it would be helpful to have the data sets broken down to district level or even smaller areas to get a better understanding of need and possible responses. This reporting could be done by exception to prevent the presentation of too much data.<br><br>Dr Jonathan McWilliam agreed that this would be helpful and depending on how the Health Improvement Board develops this approach may be appropriate for certain indicators. | JMcW |
| **28 Review of the Joint Health and Wellbeing Strategy**<br>(Agenda No. 8) | |
| Jackie Wilderspin presented the paper that detailed the review of the Joint Health and Wellbeing Strategy. The revised strategy is to be agreed by the Health and Wellbeing Board in July following public consultation in June.<br><br>The four priorities of the Health and Improvement Board have been agreed at a previous meeting, the current focus is the developing and agreement of indicators and outcomes.<br><br>The following suggestion were raised in the discussion that followed: | |

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| **Priority 8: Preventing early death and improving quality of life in later years**<br>• Bowel screening and NHS Health Checks indicators could be extended to include uptake as well as the number of invitations issued<br>• 'Increased healthy life expectancy / reduced differences in healthy life expectancy between communities' may be better placed as a recommended indicator rather than a surveillance indicator to help regional differences, though it was acknowledged that changes in this measure take several years to accrue.<br><br>**Priority 9: Preventing chronic disease by tackling obesity**<br>• It was noted that the nature of this work is to bring long term gradual change which will make it difficult to select indicators that show progress in the short term.<br>• There is a need to target areas or groups with worst outcomes and concentrate on primary prevention and early years (0-5).<br><br>**Priority 10: Tackling the broader determinants of health through better housing and prevent homelessness**<br>• Number of households in temporary accommodation needs to be an indicator<br>• Preventing homelessness, possibly adding a new surveillance indicator for how many people are housed out of district or county.<br><br>**Priority 11: Preventing infectious Disease through immunisation**<br>• Extending the flu vaccination to at risk groups under 65 yrs chimes with the current priorities of the CCG. The indicator will need to be thought about carefully as many people in this group do not come forward to receive the flu jab.<br><br>Ian Davies noted that preventing ill health is a key undertaking of the Board; working with the CCG to get the basics right upstream for long term sustainable improvement. Due to this a number of the indicators are about behavioural change, change that will not be seen immediately, but in the long term.<br><br>Further work will take place in the next 2 weeks to reach an agreement of the indictors to propose to the Health and Wellbeing Board. | JW |
| **29 The basket of indicators for health and housing** | |

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| (Agenda No. 9) | |
| Lesley Sherratt introduced the paper that presented the basket of indicators for housing and health including the latest data available for each indicator.<br><br>An amendment to the paper was noted: Paragraph 5 on page 2 of the paper should read:<br><br>'This affects households where none of the tenants are of retirement age or fall within one of the exception categories and they are assessed as having one or more bedrooms than they require according to the following formula of one bedroom for'<br><br>The discussion that followed focussed on the following points:<br><br>• Performance is good and it is improving in most cases<br>• Could the prevention activity be expanded into categories to get a better understanding of what the action might be<br>• Housing Related Support data can still be reported into sustainable housing<br>• The Health Improvement Board is a good place to present this data, it provides a good clear overview and allows the board to take action<br><br>It was **agreed** that updates of some indicators would be received quarterly and others annually to be reported to the Board. Outcome indicators for 2013-14 would be selected based on the data reported at this meeting. | LS / JM |
| **30 Update from the PIN**<br>(Agenda No. 10) | |
| Cllr Mark Booty introduced the paper on behalf of Anita Higham in her absence. A number of the issues raised are already known to OCCG and its work continues to address these. Other issues will be forwarded to relevant Boards | JW |
| **31 The Health Protection Forum**<br>(Agenda No. 11) | |
| Dr Jonathan McWilliam introduced the Health Protection Forum's terms of reference and noted that there had been some concern amongst City Council Environmental Health Officers about the role this forum. In response to this and to clarify the role of the | |

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| group it will be known as the Public Health Protection Forum.<br><br>Dr Jonathan McWilliam offered to meet Environmental Health colleagues in the City to discuss this further should they want to | <br><br>JMcW |
| **32 Forward Plan**<br>(Agenda No. 12) | |
| • The workshop planned for July will be brought forward and used to progress the re-commissioning of the homeless pathway.<br><br>• The next Board meeting is the 26 September and will have focus on obesity. | |
| **33 District action on public health**<br>(Agenda No. 13) | |
| Ian Davies introduced the District Councils' Network publication highlighting the clarity that it provides in detailing the contribution that district councils have to public health and explaining the relevance of services to the Health and Wellbeing structure. | |
| **34 Oxfordshire Affordable Warmth Network**<br>(Agenda No. 14) | |
| Jackie Wilderspin introduced two draft reports:<br><br>• Oxfordshire Affordable Warmth Network end of year report 2012/13<br>• Warm Homes Healthy People Evaluation Report<br><br>The discussion that followed focussed on understanding the wider picture of fuel poverty and where the Affordable Warmth Network sits within it. It was **agreed** that a paper will be brought to a future meeting so that Health Improvement Board members are informed and can make appropriate recommendations to how the issue should be addressed. | JW |

……………………………………………………………………… in the Chair

Date of signing ………………………………………………………

**Health Improvement Board**
**26 May 2013**

**Performance Report**

## Background

1. The Health Improvement Board is expected to have oversight 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. This is the first reporting period since the refresh of the strategy for 2013-14. Although the four priorities of the Board remain unchanged, there have been changes to a number of the outcomes measures.

3. 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

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

5. It is worth noting that there are a number of targets that are not reported on a quarterly basis. This may be where data is collected or released less frequently (flu vaccinations for example), or because work is currently underway to agree new measures and establishing baselines (fuel poverty target for example).

6. Current performance can be summarised as follows:

   **5** indicators are Green.
   **2** indicators are Amber (defined as within 5% of target).
   **1** indicator is Red
   **1** indicator was expected to report this quarter but does not yet have information available.
   5 indicators were not expected to report in this quarter

7. Where performance is not meeting expectations, commentary has been included in the table and appropriate action is being taken.

Ben Threadgold
Strategy and Performance Manager, Joint Commissioning
September 2013

# Oxfordshire Health and Wellbeing Board
## Health Improvement Board - Performance Report

| No. | Indicator | Q1 report Apr-Jun | RAG | Q2 report Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Priority 8: Preventing early death and improving quality of life in later years** | | | | | | | | | |
| 8.1 | At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years) | Expected 60% **Actual** | | Expected 60% **Actual** | | Expected 60% **Actual** | | Expected 60% **Actual** | | Bowel cancer screening data is released at least 4-5 months in arrears |
| 8.2 | Number of invitations sent out for NHS Health Checks to reach the target of 39,114 people aged 40-74 in 2013-14 (Invitations sent in 2012-13 = 40914 as more people were eligible in 2012-13) | Expected 9,778 **Actual** 9,938 | G | Expected 19,557 **Actual** | | Expected 29,335 **Actual** | | Expected 39,114 Actual | | NHS Health Check data is usually available a month after quarter end |
| 8.3 | At least 65% of those invited for NHS Health Checks will attend (ages 40-74) | Expected 65% **Actual** **41.9%** | R | Expected 65% **Actual** | | Expected 65% **Actual** | | Expected 65% **Actual** | | Between Aril and June 2013, the Oxfordshire programme invited 9938 people of which 4165 took up the offer, giving us an uptake rate of 41.9% which is better than Thames Valley uptake rate of 41.5% there has been a technical issue with reporting in Q1 which means that the Oxfordshire figure is an underestimate. |
| 8.4 | At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703) | Expected 851 **Actual** | G | Expected 1639 **Actual** | | Expected 2523 **Actual** | | Expected 3800 **Actual** | | Smoking quitters data is at least 2-3 months in arrears because people need to quit for 4 weeks to be considered as having quit smoking |

| No. | Indicator | Q1 report Apr-Jun | RAG | Q2 report Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **875** | | | | | | | | |
| **Priority 9: Preventing chronic disease through tackling obesity** | | | | | | | | | | |
| **9.1** | Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2012 this was 15.6%) | | | | | Expected<br>14.9% or less<br>**Actual** | | | | Childhood obesity data is an annual data return that follows the school year instead of financial year cycle |
| **9.2** | Increase to 62.2% the percentage of adults who do at least 150 minutes of physical activity a week . (Baseline for Oxfordshire 61.2% 2011-12) | | | | | | | Expected<br>62.2%<br>**Actual** | | This is reported annually from the Active People Survey monitored / managed by the Oxfordshire Sports Partnership |
| **9.3** | 62% of babies are breastfed at 6-8 weeks of age (currently 59.1%) | Expected<br>62%<br>**Actual**<br>**59%** | **A** | Expected<br>62%<br>**Actual** | | Expected<br>62%<br>**Actual** | | Expected<br>62%<br>**Actual** | | Although the expected level was not reached in quarter 1, the figure represents an improvement on quarter 4 (56.9%) in 2012/13.<br><br>A request has been made to Oxford Health to produce a recovery plan detailing work towards improving rates of breastfeeding |
| **Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness** | | | | | | | | | | |
| **10.1** | The number of households in temporary accommodation as at 31 March 2014 should be no | | | | | | | Expected<br>216 or less | | Measure reported annually, expected during Q4 |

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| No. | Indicator | Q1 report Apr-Jun | RAG | Q2 report Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | greater than the level reported in March 2013 (baseline 216 households in Oxfordshire) | | | | | | | **Actual** | | |
| **10.2** | At least 75% of people receiving housing related support will depart services to take up independent living | Expected<br>75%<br>**Actual**<br>**85.7%** | G | Expected<br>75%<br>**Actual** | | Expected<br>75%<br>**Actual** | | Expected<br>75%<br>**Actual** | | |
| **10.3** | At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 2012- 2013 when there were 2468 households known to services, of which 1992 households were prevented from becoming homeless. 1992/2468 = 80.7%) | Expected<br>80%<br>**Actual**<br>82.3% | G | Expected<br>80%<br>**Actual** | | Expected<br>80%<br>**Actual** | | Expected<br>80%<br>**Actual** | | |
| **10.4** | Fuel poverty outcome to be determined | | | Expected<br>Outcome measure to be determined<br>**Actual** | | | | | | |

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| No. | Indicator | Q1 report Apr-Jun | RAG | Q2 report Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Priority 11**: **Preventing infectious disease through immunisation** | | | | | | | | | | |
| **11.1** | At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95%) | Expected 95% **Actual 96.2%** | **G** | Expected 95% **Actual** | | Expected 95% **Actual** | | Expected 95% **Actual** | | Childhood immunisations data is usually available 1-2 months after the quarter end |
| **11.2** | At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.7%) | Expected 95% **Actual 92.4%** | **A** | Expected 95% **Actual** | | Expected 95% **Actual** | | Expected 95% **Actual** | | Childhood immunisations data is usually available 1-2 months after the quarter end. Oxfordshire County Council has recently run a campaign encouraging parents to ensure their children are immunised before returning to school. |
| **11.3** | At least 55% of people aged under 65 in "risk groups" receive flu vaccination (currently 51.6%) | | | | | | | Expected 55% **Actual** | | Seasonal flu is annual data usually available in Quarter 4 |

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**Oxfordshire Health and Wellbeing Board**
**25 July 2013**

# Performance Reporting

## Current Performance

1. A table showing the agreed measures under each priority in the Joint Health and Wellbeing Strategy, expected performance and current performance is attached as appendix A.

2. End of year performance can be summarised as follows:

   **34** indicators are Green
   **4** indicators are Amber (defined as within 5% of target)
   **11** indicators are Red
   **4** indicators expected to report in Q4 do not have information available – explanation is included in the notes column in the appendix.

3. Current performance is generally good, with many targets being met and exceeded for the year. Appropriate action is being taken where performance did not meet expected levels to improve this. This has been summarised in the notes column of the appendix.

4. It is worth noting that performance on the indicators for teenage pregnancy (indicator 2.1) has dropped from Green to Amber, and the indicator for young people not in education, employment and training (indicator 4.5) has dropped from Green to Red.

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

6. End of year performance information is not available for four indicators – support for people with long term conditions (5.5), health checks for people with severe mental illness and for people with learning disability (indicators 5.4 and 5.5), and bowel screening (indicator 8.2). Due to changes in the health structures at the start of April this information has taken longer than normal to release, and is expected within the next month. If it is available by the time of the meeting this will be updated verbally.

## Action Planning

7. Each of the priorities and measures in the Joint Health and Wellbeing Strategy has a clear owner, an organisation or partnership that is responsible for reporting progress.

8. However, it is important to capture the wide range of activity happening across the county that contributes to each of them. The workshops are proving to be important in understanding the work of partner organisations,

how this contributes to meeting the priorities and measures in the strategy, and the opportunities they present for further joint working.

9. The Children and Young People's Board hosted four workshops in 2012/13, focused on key priorities within the strategy: mental health transitions, children's safeguarding, raising achievement and a child and families journey through health and social care services.

10. The Adult Health and Social Care Board hosted three workshops in 2012/13, focused on key priorities within the strategy: the Older People's Commissioning Strategy and the Staying Healthy workshop held jointly with the Health Improvement Board. There was also a workshop on the new carers strategy in June 2013.

11. The Health Improvement Board hosted workshops in 2012/13 focused on housing and action planning.

12. Further workshops over the coming months will focus on learning disability and obesity.

Ben Threadgold
Strategy Manager, Joint Commissioning, Tel: (01865) 328219

July 2013

## Oxfordshire Health and Wellbeing Board
## Performance Report

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| | **Priority 1: All children have a healthy start in life and stay healthy into adulthood** | | | | | | | | | |
| 1.1 | Reduce emergency admissions to hospital for episodes of self-harm by 5% year on year. This means reducing admissions by 8 young people in 2012/13 (currently 155) | Expected<br>37 admissions<br>**Actual**<br>**35 admissions** | G | Expected<br>74 admissions<br>**Actual**<br>**66 admissions** | G | Expected<br>111 admissions<br>**Actual**<br>**96 admissions** | G | Expected<br>148 admissions<br>**Actual**<br>**134 admissions** | G | |
| 1.2 | Reduce emergency admissions to hospital with infections by 10% year on year. This means reducing emergency admissions by 145 in 2012/13 | Expected<br>417 admissions<br>**Actual**<br>**512 admissions** | R | Expected<br>834 admissions<br>**Actual**<br>**993 admissions** | R | Expected<br>1251 admissions<br>**Actual**<br>**1870 admissions** | R | Expected<br>1668 admissions<br>**Actual**<br>**2486 admissions** | R | This is a challenging target set against a national trend of increased admissions.<br><br>The original baseline for 2011/12 has been increased from 1450 to 1853, meaning the quarterly targets and overall reduction have also been amended.<br><br>This increase in numbers is not matched by an increase in rate of admissions and relates primarily to the change in demographics in Oxford City. |
| 1.3 | Review and redesign transition services for young people with mental health problems. This would mean there would be a new service in place from 1st April 2013 | | | | | | | Expected<br>New service to be in place<br>**Actual**<br>Review is | G | Project completed. Implementation of new service underway. New service will go live on 1st October 2013. |

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| | | | | | | | | completed and service will be in place from October 2013 | | |
| | **Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups** | | | | | | | | | |
| 2.1 | Maintain the recently improved rate of teenage conceptions (currently at 22 women aged 15-17 per 1000 - in 2010 this was 251 conceptions) | Expected<br>62<br>**Actual**<br>**62** | G | Expected<br>125<br>**Actual**<br>**123** | G | Expected<br>187<br>**Actual**<br>**182** | G | **Expected**<br>**251**<br>**Actual**<br>**254** | A | 2011 Calendar Year (Q4). Latest data Sept-Dec 2011. Revised data published March 2013.<br><br>Although the actual number of conceptions rose slightly in Q4, the overall rate of conceptions (the national measure) remained constant; 22 in 2010 and 22.4 in 2011 the 0.4 increase actually isn't statistically significant and there has been a steady downward trend over the last five years which is excellent news. |
| 2.2 | The 'Thriving Families' project will have begun work with the first 100 families by April 2013 | | | | | | | Expected<br>100 families<br>**Actual**<br>**83 families** | R | 663 families have been identified who meet the Thriving Family criteria with an additional 43 families identified and worked with that are not included within these figures as they are receiving funding via The European Social Fund within Oxfordshire.<br><br>Of the 663 identified families, 338 currently have a worker from a network of partnership targeted services and 83 families are being seen by Thriving Family workers.<br><br>The target of working with 100 families was not met for operational reasons in |

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| | | | | | | | | | | order to ensure a safe and appropriate start for families. This included not all Thriving Family worker posts filled and Senior Practitioners jointly working with other workers at the start as very complex cases were undertaken. In some instances it has been more appropriate for Thriving Family workers to work jointly with Early Intervention Hub or Children's Social Care staff which reduced the number of families solely worked with by Thriving Family workers. |
| 2.3 | Reduce persistent absence (15% lost school days or more) from school for children looked after to 4.9% for 2011/12 academic year (currently 11.7%) | | | Expected 4.9% **Actual** **Figure Suppressed** | G | | | | | This figure is for those children continually looked after for at least 12 months as of 31 March 2012. The figure is suppressed under data protection legislation as it relates to less than 6 individuals, but performance is below target and below the national average.<br><br>We are currently receiving real-time data from Welfare Call which will be looked at by the Deputy Director within the County Council to identify any actions required; an Intervention Manager starting in Sep 2013 will coordinate, support and challenge via schools and Hubs . 6-weekly meetings with a multi-agency team are ongoing. |
| | **Priority 3: Keeping all children and young people safer** | | | | | | | | | |
| 3.1 | Collect information to establish a baseline of prevalence and trends of child sexual exploitation in Oxfordshire by March 2013 | | | | | | | Expected Baseline established and targets | G | This work was led by the Child Sexual Exploitation (CSE) sub group of the Safeguarding Children's Board. (OSCB) Although the national data collection model has still not been confirmed, a |

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| | | | | | | | | set<br>**Actual**<br>**There is a clear baseline and multi-agency strategy to prevent and detect Child sexual exploitation** | | local data collection model has been developed based on the University of Bedfordshire model, including some local indicators, It is being applied to all known cases. A baseline and target will be established as a result and reported to the next meeting of the Board.<br><br>However, there are some issues with the new reporting system which need to be resolved before the local data collection can be complete.<br><br>A Thames Valley Police prevalence report of local 'hotspots' of Child Sexual Exploitation in Oxfordshire has been submitted to the Office of the Children's Commissioner and has gone to the CSE subgroup of the OSCB |
| | Reduce the number of children who need a subsequent Child Protection Plan (following a previous completed plan) to no more than 15%, which will require full multi-agency commitment (in 2011/12 15.3%) | Expected<br>15% rolling year<br>15% year to date<br>**Actual**<br>**11.5% rolling year**<br>**2.6% year to date** | G | Expected<br>15% rolling year<br>15% year to date<br>**Actual**<br>**10.3% rolling year (44/429)**<br>**10.2% year to date (22/216)** | G | Expected<br>15% rolling year<br>15% year to date<br>**Actual**<br>**12.3% rolling year (55/446)**<br>**13.2% year to date (44/333)** | G | Expected<br>15% rolling year<br>15% year to date<br>**Actual**<br>**13.5% (60/444)** | G | The measure is the proportion of children who became subject to a child protection plan who had previously been subject to a plan (the national definition is within 2 years, this report is all children) |

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| 3.3 | A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire's Safeguarding Children Board covering the following agencies: children's social care; youth offending service; education services; children and adult health services; early intervention services; services provided by the police. Over 50% of these audits will show a positive overall impact (baseline to be confirmed in 2012/13) | | | | | | | Expected<br>Programme of audits in place and baseline established<br>**Actual**<br>**Programme of audits is in place and baseline established** | G | In 2012/13 through audit, the quality of practice is being measured against the key interagency tasks: referral, assessment, decision making, planning, review and outcomes. Grade descriptors and outcomes are based on the London safeguarding Board guidance on practice audits.<br>Adjustment to the quality assurance audit target (50%) is being determined by the outcome of the 2012/13 baseline exercise, and is being set at a higher percentage than the attainment in 2012/13. This baseline will be reported on the 24 October meeting of the CYPB together with the first performance report . |
| **Priority 4:** | **Raising achievement for all children and young people** | | | | | | | | | |
| 4.1 | 76% (5,000) children achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2011/12 (currently 74.3% for the academic year 2010/11) | | | Expected<br>76%<br>**Actual**<br>**78%** | G | | | | | Performance is now above national average (76%). Oxfordshire still ranks below its statistical neighbour average |
| 4.2 | 80% (4,880) of children achieve Level 4 or above in English and Maths at the end of Key Stage 2 of the academic year 2011/12 (currently 75% for the academic year 2010/11) | | | Expected<br>80%<br>**Actual**<br>**82%** | G | | | | | Oxfordshire now performs above national average (80%) and above the statistical neighbour average (81%). Only 1 primary school is below floor standard compared with 18 in 2011. |
| 4.3 | 59% (3,500 out of 6,000) of young people achieve 5 GCSEs at A*-C including English and Maths at | | | Expected<br>59% | | | | | | In the key performance measure of pupils achieving 5+A*-C inc English and maths Oxfordshire has increased slightly |

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| | the end of the academic year 2011/12 (currently 57.4% for the academic year 2010/11) | | | **Actual**<br><br>**57.9%** | R | | | | | to 57.9%. However, in this measure Oxfordshire is performing below the Statistical Neighbour and National averages and is ranked 8th out of Statistical Neighbours |
| **4.4** | 66% (153) primary schools and 70% (24) secondary schools will be judged by Ofsted to be good or outstanding in 2012/13 (currently 61% (142) of primary schools and 65% (21) of secondary schools) | Expected<br><br>62% (Primary) 66% (Secondary)<br><br>Actual<br><br>**60% primary 65% secondary** | A | Expected<br><br>63% (Primary) 67% (Secondary)<br><br>**Actual**<br><br>**62% primary 65% secondary** | A | Expected<br><br>64% (Primary) 68% (Secondary)<br><br>**Actual**<br><br>**65% primary 71% secondary** | G | Expected<br><br>66% (Primary) 70% (Secondary)<br><br>**Actual**<br><br>**71% (165) Primary 77% (26) secondary** | G | The proportion of both primary and secondary schools judged as Good or Outstanding continues to rise. |
| **4.5** | Reduce the number of young people not in education, employment or training to 5% or 864 young people (currently 5.7% in the financial year 2012/13) | Expected<br><br>5.6%<br><br>Actual<br><br>**5.2%** | G | Expected<br><br>8.3% (NB figures always peak in September)<br><br>**Actual**<br><br>**8.4%** | A | Expected<br><br>6.6%<br><br>**Actual**<br><br>**6.1%** | G | Expected<br><br>5.0%<br><br>**Actual**<br><br>**5.4% (937)** | R | The proportion of young people that are not in education, employment or training continues to reduce from the seasonally high figure reported in September. This reduction is due to confirmation from schools and colleges about the activity of young people post-16. The proportion of "Not Knowns" is 34%, one of the highest in the country. Measures are in place to address this such as the recruitment of a casual tracking team and the commissioning of Welfare Call to provide an intensive follow up service |
| | **Priority 5: Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential** | | | | | | | | | |

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| 5.1 | 75% of working age adults who use adult social care say that they find information very or fairly easy to find (currently 71.3%) | | | | | | | Expected 75%<br>**Actual**<br>**69%** | R | Overall the proportion of people who use adult social care who said they found information very or fairly easy to find rose from 71.5% to 73.5%.<br><br>However for working age adults the figure fell from 71.3% to 69.4%. This represents 129 adults of working age who use adult social care who said information was very of fairly easy to find out of 186 who had tried to access information in the year.<br><br>The council is developing an information strategy which will look at both the information that is provided and the ways in which it is provided |
| 5.2 | 15% of adults on the care programme approach receiving secondary mental health services will be in paid employment at the time of their most recent assessment / review (currently 10.7%) | Expected 11.8%<br>**Actual**<br>**11%** | A | Expected 12.9%<br>**Actual**<br>**13.4%** | G | Expected 13.9%<br>**Actual**<br>**13.6%** | A | Expected 15%<br>**Actual**<br>**13%** | R | The wording of this indicator has been changed slightly to more accurately reflect the targeted individuals, although the baseline and targets remain the same<br><br>In 2014-15 it is proposed to move to a different measure based more on the relative severity of people's illness. The range of expectation for people in work will vary from 2 to 25%, meaning the global figure used in 2012/13 has masked this and it is unclear whether 15% would have been a "good" or a "poor" result. |
| 5.3 | 86% of people with a long-term condition feel supported to manage their condition (currently 84%) | | | | | | | Expected 86%<br>**Actual** | G | This target and baseline was set using the GP Patient annual survey 2012, and performance this year is taken from the 2013 survey.<br><br>Performance compares favourably with |

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| | | | | | | | | **88%** | | the Area Team figure of 85%, South of England figure of 86% and the national figure of 84% |
| **5.4** | 95% of people living with severe mental illness will have an annual physical health check by their GP (currently 93.7%) | | | | | | | Expected 95%<br>Actual | | It has not been possible to report on this as the indicator was removed from the Quality Outcomes Framework and there is no suitable alternative indicator to use. However, this is still considered to be a priority locally, and it is proposed to include an indicator for 2013/14 that focuses on supporting all patients with schizophrenia to undertake a physical health assessment |
| **5.5** | 50% of people with learning disabilities will have an annual physical health check by their GP (currently 45%) | | | | | | | Expected 50%<br>**Actual**<br>**43.7%** | **R** | Performance reflects that this is a challenging target, and does not reflect the amount of work that has been done this year across agencies to increase the number of people having a health check.<br><br>Many people with learning disabilities are in regular contact with their GP, and so visits are not necessarily recorded as being specifically for an annual health check.<br><br>It is proposed to add a measure for 2013/14 that reports the contact people have with their GP, to give a more rounded picture of the support they are receiving. |
| | **Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support** | | | | | | | | | |

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| 6.1 | A reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter (current ranking is 151/151) | Expected 146<br>**Actual 151** | R | Expected 103<br>**Actual 144** | R | Expected 72<br>**Actual 104** | R | Expected 72<br>**Actual 182** | R | The figure reported is the actual number of delays. Delays rose in the final quarter of the year and remain the worst of any authority nationally (151/151).<br><br>However this needs to be seen in the context of an increasing pressure on hospital admissions - with a 10% rise in non-elective admissions in 2012/13 compared to 2011/12.<br><br>The pathway through hospitals is currently being revised to ensure people are seen in the most appropriate place and are given a greater chance of returning home |
| 6.2 | No more than 400 older people per year to be permanently admitted to a care home from October 2012 (currently 546) | | | | | Expected 100<br>**Actual 136** | R | Expected 100<br>**Actual 105** | A | A reduced number of people were placed permanently in care homes in the final quarter. An additional 40 people were placed in a short term assessment bed, but now need a permanent placement in a care home |
| 6.3 | 50% of the expected population with dementia will have a recorded diagnosis (currently 37.8%) | | | Expected 43.9%<br>**Actual 46.7%** | G | Expected 46.95%<br>**Actual 47.4%** | G | Expected 50%<br>**Actual 49.6%**<br>**3516 diagnosed 7086 expected** | A | There has been a significant increase in diagnosis rates this year, from 37.8% to 49.6%.<br><br>A new calculator is being introduced, but has not yet been finalised and distributed. Indications are that this is more stringent and if applied to current performance the figures for Q4 would be lower at 44.6% (creating a new baseline for 13-14). |
| 6.4 | 3,140 people will receive a reablement service (currently 1,812) | Expected 654 | R | Expected 1526 | R | Expected 2420 | R | Expected 3140 | R | The number of people starting reablement increased in the year and by over 20% on last year's level, but is |

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| | | **Actual**<br>**492** | | **Actual**<br>**1020** | | **Actual**<br>**1566** | | **Actual**<br>**2197** | | below the contract level.<br><br>Work is in hand to ensure appropriate capacity from the service and timely and complete referrals. |
| **6.5** | Maintain the current high standard of supporting people at home with dignity as measured by people themselves (currently 91.6%). | | | | | | | Expected<br>91.6%<br>**Actual**<br>**89.9%** | **A** | Figures are taken from the annual adult social care user survey run in February 2013.<br><br>246 out of 274 older people who use social care reported that the way they were helped and treated either made them feel better about themselves or did not affect the way they felt about themselves. |
| **6.6** | By the end of March 2013, commission an additional 130 Extra Care Housing places, bringing the total to 407 and by the end of March 2015 an additional 523 places, bringing the total number of places to 930 | | | Expected<br>130<br>**Actual**<br>**130** | **G** | | | | | Target for this year has been achieved – 40 new ECH places have opened at Thame, 70 at Banbury (Stanbridge) and 20 at Bicester. |
| **6.7** | 75% of older people who use adult social care say that they find information very or fairly easy to find (currently 71.6%) | | | | | | | Expected<br>75%<br>**Actual**<br>**77.7%** | **G** | This is taken from the annual adult social care user survey in February 2013.<br><br>Of the 188 older people who responded and indicated they had tried to find some information about social care, 146 reported that they found information very or fairly easy to find. This is a significant increase from 2011/12. |

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| **6.8** | Review transport in the community to understand the best way of meeting community needs by June 2013 | | | | | | | Expected<br><br>Review complete by June 2013<br>**Actual**<br><br>**Review will report in 2013/14** | **G** | |
| | **Priority 7: Working together to improve quality and value for money in the Health and Social Care System** | | | | | | | | | |
| **7.1** | Deliver a joint single point of access to health and social care community services, provided by Oxford Health and Oxfordshire County Council by the 1st December 2012 | | | | | Expected<br><br>Single point of access in place<br>Actual<br><br>An integrated health and social care Single Point of Access has been established and operational since the 3rd December 2012 | **G** | | | The single point of access has staff from both organisations co-located, and is adopting a multi-agency/multi-professional approach towards ensuring the delivery of seamless integrated care. |
| **7.2** | Deliver fully functioning, locality based and integrated health and | | | | | | | Expected | **G** | OHFT and OCC have been working in partnership to deliver integrated |

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| | social care services by March 2013 | | | | | | | Integrated health and social care services operational in localities<br>**Actual**<br>**Good progress has been made, a plan for further integration being implemented in 2013/14** | | community services throughout 2012/13 with significant progress being made with the development of the integrated Single Point of Access and the implementation of the Oxfordshire Discharge to Assess Policy.<br><br>A detailed plan for fully integrated health (community and older adult's mental health) and social care services has been jointly developed by Oxford Health Foundation Trust and Oxfordshire County Council and will be fully implemented during 2013/14 |
| 7.3 | A single Section 75 agreement to cover all the pooled budget arrangements by April 2013 | | | | | | | Expected<br>Single section 75 agreement in place<br>**Actual**<br>**Agreement in place** | G | The agreement was approved in March and formally signed in April by both parties. |
| **7.4** | A joint older people's commissioning strategy covering both health and social care by April 2013 | | | | | | | Expected<br>Joint strategy agreed and delivery plans in place | G | The draft strategy has been developed by a multi-agency working group, and consultation took place between Dec – Feb. The strategy has now been amended to reflect the outcomes of consultation, and the strategy and action plans were formally signed off by the |

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| | | | | | | | | **Actual**<br><br>**Strategy and Action Plan in place** | | County Council Cabinet and Clinical Commissioning Group Executive Board in June |
| 7.5 | Oxfordshire's Clinical Commissioning Group will be authorised by April 2013 | | | | | | | Expected<br><br>CCG to be authorised<br><br>**Actual**<br><br>**CCG Authorised** | G | Oxfordshire Clinical Commissioning Group has been formally authorised to take on commissioning responsibilities for Oxfordshire from 1 April 2013. |
| 7.6 | More than 60% of people who use social care services in Oxfordshire will say they are very satisfied with their care and support (currently 61.7%) | | | | | | | Expected<br><br>60%<br><br>**Actual**<br><br>**64.0%** | G | This is measured through the annual adult social care user survey in February 2013.<br><br>Overall satisfaction has increased for the third successive year.<br><br>324 people who used social care out of 507 people who responded (64%) reported that they were extremely or very satisfied with services. 476 people (94%) reported they were satisfied. |
| 7.7 | Achieve above the national average of people satisfied with their experience of hospital care (when the nationally sourced information for Oxfordshire is available) | | | | | Expected<br><br>Above national average<br><br>England 2011/12 = 75.6% | G | | | Published as NHS National Outcomes Framework 4b. Since it is for experience of hospital care the data is given for individual hospitals, performance is then averaged to give an overall figure. NOC and OUHT were separate in 2011/12 and so they are reported individually. The values are reported as values out of 100. |

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| | | | | | | **Actual**<br>**78.7%** | | | | OUHT 75.1/100<br>NOC 82.3 / 100<br>Oxford Mental Health Trust is not included. |
| 7.8 | Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (when the nationally sourced information for Oxfordshire is available). | | | | | | | Expected<br>Above national average<br>**Actual**<br>**Above national average (Oxfordshire 90.1% England 87.6%)** | G | Data for this indicator comes from the GP Patient Survey. 2011/12 data for the survey was collected in two waves. (NHS National Outcomes indicator 4a)<br>1st wave published (July-Sept) – 88.28%<br>2nd wave published March 2013 - 90.1% of respondents 'very satisfied' (10,551 of 11,713) compared to 87.6% nationally (837,852 of 956,509)<br>. |
| 7.9 | Establish a baseline for measuring carer satisfaction of services by May 2013 | | | | | | | Expected<br>Baseline established and targets set<br>**Actual**<br>**Baseline established and targets set** | G | Carer survey completed and baseline established. Current levels of satisfaction are 39% - this is significantly lower than levels of service user satisfaction, but a similar picture is appearing nationally.<br>39% reflects 185 out of 472 carers who reported to being extremely or very satisfied. 360 carers (76%) are satisfied.<br>An action plan to address this is being put in place as part of the carers strategy<br>The baseline and targets form part of the proposed outcomes for 2013/14 |
| 7.10 | 800 carers' breaks jointly funded and accessed via GPs | Expected<br>200 | G | Expected<br>400 | G | Expected<br>600 | A | Expected<br>800 | G | Achieved |

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| | | Actual<br>213 | | Actual<br>427 | | Actual<br>594 | | Actual<br>881 | | |
| | **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<br>840<br>**Actual**<br>**852** | G | Expected<br>1617<br>**Actual**<br>**1668** | G | Expected<br>2490<br>**Actual**<br>**2559** | G | Expected<br>3676<br>**Actual**<br>**3703** | G | Target has been amended slightly to reflect higher national target for Oxfordshire. |
| 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<br>500<br>**Actual**<br>**406** | R | Expected<br>1000<br>**Actual**<br>**776** | R | Expected<br>1500<br>**Actual**<br>**1260** | R | Expected<br>2000<br>Actual | | Delay in age-extension has negatively affected the performance. Programme now age-extended (March 2013) and the media campaign to increase up-take has also been delivered therefore improved performance is expected in 2013/14.<br><br>Bowel cancer screening data is usually available 3 months in arrears, however due to changes in the health structures it had taken longer for data release. Q4 data is not expected until end July early Aug. |
| 8.3 | 30,000 people invited for Health Checks for the first time (currently 25,000) | Expected<br>7500<br>**Actual**<br>**8848** | G | Expected<br>15000<br>**Actual**<br>**20707** | G | Expected<br>22500<br>**Actual**<br>**27658** | G | Expected<br>30000<br>**Actual**<br>**40914** | G | Achieved Q4 and 2012/13 target |

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| **Priority 9: Preventing chronic disease through tackling obesity** | | | | | | | | | | |
| **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<br>**Actual** **15.6%** | R | | | |
| **9.2** | 60% of babies are breastfed at 6-8 weeks of age (currently 58.4%) | Expected 60%<br>**Actual** **59.8%** | A | Expected 60%<br>**Actual** **59.3%** | A | Expected 60%<br>**Actual** **60.3%** | G | Expected 60%<br>**Actual** **56.9%** | R | Although there is a dip in quarter 4 performance, the average performance throughout the year (2012/13) is 59.1%, which does represent an improvement on 2011/12. |
| **9.3** | 5,000 additional physically active adults (Data available twice per year)<br><br>Baseline: 125,500 Adults<br>Annual target:130,500 Adults | | | Expected 128,000 Adults<br>**Actual** **136,000 Adults** | G | | | Expected 130,500 Adults<br>**Actual** **145,646 Adults** | G | 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 | | | | | | | Expected<br>Basket of relevant indicators to | | The HIB has established a working group to develop appropriate indicators and targets.<br><br>A group of indicators has been |

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| No. | Indicator | Q1 report Apr-Jun | RAG | Q2 report Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | grants and enforcement activity | | | | | | | be agreed to enable monitoring and setting of outcomes<br>**Actual**<br>**Basket of relevant indicators is agreed to enable monitoring and setting of outcomes** | G | established that includes measures on fuel poverty and excess winter deaths |
| 10.2 | Action to prevent homelessness and ensure a joint approach in times of change. | | | | | | | Expected<br>Review in the light of information on best practice<br>**Actual**<br>**Basket of relevant indicators is agreed to enable monitoring and setting of outcomes** | G | Report on proactive work in all districts and pilot work on direct payments in the City has been presented to the Health Improvement Board and a basket of indicators has been agreed |
| 10.3 | New arrangements for partnership work to ensure vulnerable people are supported to remain in appropriate accommodation e.g. | | | | | | | Expected<br>New partnership arrangements | | New Terms of Reference for the Housing Support Advisory Group are agreed including the new name for the group and the group is meeting regularly |

| No. | Indicator | Q1 report Apr-Jun | RAG | Q2 report Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | young people, victims of domestic violence, offenders and other adults with complex needs. | | | | | | | to be in place<br>**Actual**<br>**New partnership arrangements have been agreed and are in place** | G | |
| **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 target of 96.5%) | Expected 2000<br>**Actual 2038** | G | Expected 4000<br>**Actual 4074** | G | Expected 6000<br>**Actual 6055** | G | Expected 8000<br>**Actual 8042** | G | Achieved Q4 (cumulative) and 2012/13 target |
| **11.2** | 7,700 children vaccinated against Measles Mumps and Rubella (MMR) by age 2 | Expected 1925<br>**Actual 1883** | A | Expected 3850<br>**Actual 3955** | G | Expected 5775<br>**Actual 6038** | G | Expected 7700<br>**Actual 7990** | G | Achieved Q4 (cumulative) and 2012/13 target |
| **11.3** | 7,300 children receiving MMR booster by age 5 (meeting the ambitious national target of 95%) | Expected 1825<br>**Actual 1857** | G | Expected 3650<br>**Actual 3775** | G | Expected 5475<br>**Actual 5684** | G | Expected 7300<br>**Actual 7610** | G | Achieved Q4 (cumulative) and 2012/13 target |

| No. | Indicator | Q1 report Apr-Jun | RAG | Q2 report Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| 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<br>3000<br>**Actual**<br>**3189** | G | | | 3 doses required to achieve target - final data as at 08/10/2012<br><br>Dose 1 = 3259<br>Dose 2 = 3238<br>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<br>80,000<br>**Actual**<br>**83287** | G | |

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# Oxfordshire's Joint Health & Wellbeing Strategy

# 2012 - 2016

**Final Version July 2012, Amended July 2013**

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## 1. Foreword to the Revised Version of this strategy, July 2013

The Oxfordshire Health and Wellbeing Board has made the transition from being a “shadow” board to taking on statutory status as a sub-committee of Oxfordshire County Council. We used our existence as a shadow board to establish good working practices and to develop the ways we work together across organisations. This was all encapsulated in the Joint Health and Wellbeing Strategy which was finalised and adopted a year ago.

We made great progress in 2012-13. We believe Oxfordshire is unique in setting outcomes for all our Health and Wellbeing priorities and for receiving updates on performance each time we meet. This has enabled us to keep our focus on the issues that matter and to drive improvement. It was a year of great change in the health service and the Board provided a forum for discussion and development of working relationships with the new NHS organisations. We are now able to build on this success.

We have made progress on several issues during the year, including

- Fewer children and young people were admitted to hospital for self harm, better transitions to adult mental health services were introduced, teenage pregnancy rates continued to fall and the “Thriving Families” programme was established
- High numbers of people said they were happy with health and social care services in the county, we took more steps forward in establishing integrated, patient-centred services and we worked together on an older people commissioning strategy which is now being implemented.
- There was good take up of screening and immunisation programmes, especially the winter flu immunisations for older people. We saw even higher percentages of people who are physically active, who breastfeed their babies and who succeed in quitting smoking.
- The Public Involvement Network has established good two-way communication and has a wide range of people participating in consultation and making their views known.

However, there is still a lot to do. This revised strategy sets out our renewed intentions for the year ahead. We have proposed and consulted on outcome measures so that we can continue to monitor improvements in 2013-14. We will hold each other to account, expect good results and continue to strive for good quality in all health and social care services.

**Cllr Ian Hudspeth**, **Chairman of the Board**
Leader of Oxfordshire County Council

**Dr Stephen Richards, Vice Chairman of the Board**
Chief Executive of the Oxfordshire Clinical Commissioning Group

## 2. Introduction

A Health and Wellbeing Board has been set up in Oxfordshire to make a measurable difference to the health and wellbeing of its people. Oxfordshire has a rich history of partnership working which strives to improve the health of Oxfordshire’s people and the care

they are offered. This Board is, therefore, very much the next logical step for Oxfordshire to take, and through it we also fulfil a key requirement of the Government's new Health and Social Care Act.

The Health and Wellbeing Board is the principal structure in Oxfordshire responsible for improving the health and wellbeing of the people of the County through partnership working.

The Board is a partnership between Local Government, the NHS and the people of Oxfordshire. Members include local GPs, Councillors, Health Watch Oxfordshire and senior officers from Local Government.

Early tasks for the board have been to look at the biggest challenges facing the wellbeing of Oxfordshire's people and to set out the Board's initial ideas in this strategy for improving the situation.

This strategy is the main focus of the Health and Wellbeing Board's work. We strive to make this a ‘living document’. As priorities change, our focus for action will need to change with it. It is for this reason that, at the end of the first full year of operation as a shadow Board, we have reviewed our performance, assessed local need and are proposing revised outcomes for the year ahead. We want to make sure that our planning stays ‘alive’ and in touch with the changing needs of Oxfordshire’s people.

## 3. Vision

The vision of the Health and Wellbeing Board is outlined below. This sets out our aspiration in broad terms. It is fleshed out in the priorities which follow and the action plans that are now in progress.

By 2016 in Oxfordshire:

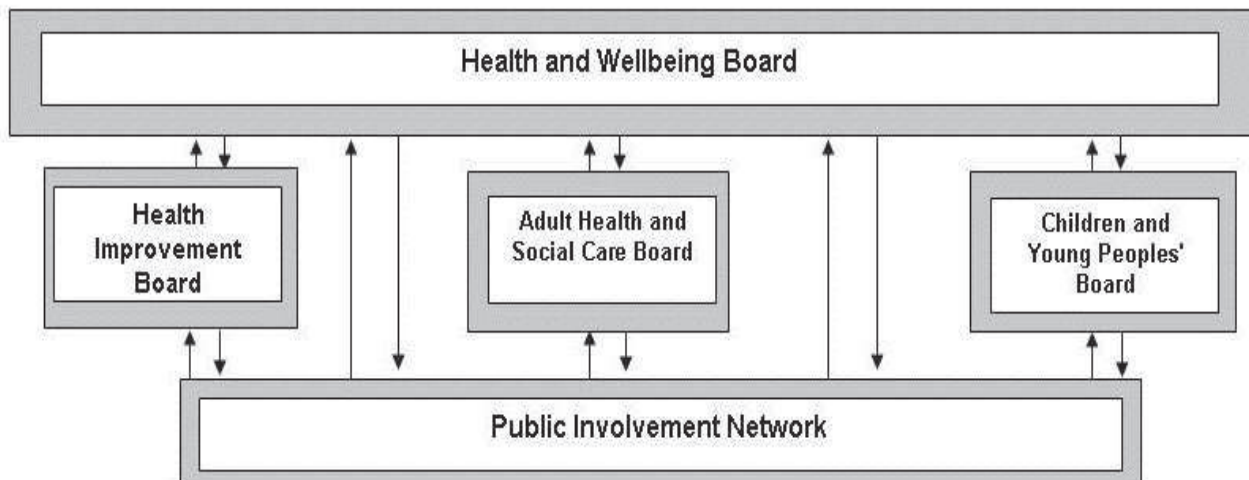
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services;
- everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs;
- the best possible services will be provided within the resources we have, giving excellent value for the public.

The priorities set out in this document put flesh on these themes. The priorities are intended to run to 2016 while the measures and targets set out within each priority are for the financial year 2012/13.

## 4. The structure of the Health and Wellbeing Board

### 4.1 What does the Health and Wellbeing Board look like?

The Health and Wellbeing Board has three Partnership Boards reporting to it and a Public Involvement Network; each with responsibilities as outlined below:




The purpose of each of the Partnership Boards and the Network are outlined below:

**Adult Health and Social Care Board**
To improve outcomes and to support adults to live independently with dignity by accessing support and services they need while achieving better value for money, especially through oversight of our pooled budgets.

**Children and Young People's Board**
To keep all children and young people safe; raise achievement for all children and young people and improve the life chances for our most disadvantaged and vulnerable groups

**Health Improvement Board**
To add life to years and years to life, focusing on the factors underpinning wellbeing, while levelling up differences in the health of different groups in the County

**Public Involvement Network**
To ensure that the genuine opinions and experiences of people in Oxfordshire underpin the work of the Health and Wellbeing Board.

### 4.2 How do decisions get made?

The Health and Wellbeing Board is ultimately responsible for setting a direction for the County in partnership. Its members are committed to working with its three Partnership Boards and its Public Involvement Network to agree that direction. They are also accountable to their constituent organisations – the Oxfordshire Clinical Commissioning Group, County, District and City Councils and HealthWatch Oxfordshire.

In turn, the Partnership Boards are committed to working with a wide range of health and social care providers, voluntary agencies, carers, faith groups, members of the public and advocacy groups. We invite these partners to formal meetings as 'expert witnesses' and to workshops during the year as a means of engagement. In this way, the decisions of the Health and Wellbeing Board aim to be truly inclusive.

The Health and Wellbeing Board meets in public three times a year. Each of the three Partnership Boards also meet in public at least once each year and will also host workshops which will include many more service providers, partners, informal/ volunteer carers, faith groups, voluntary sector representatives, the public and advocacy groups.

While the Health and Wellbeing Board listens carefully to the views of many groups of stakeholders and of the public as a whole, it has to be acknowledged that:

a) they want to take careful account of the evidence base provided by the Joint Strategic Needs Assessment and scientific research, and
b) given that there will never be enough resources to meet all of people's needs, it is the duty of the Health & Wellbeing Board to balance needs carefully and to influence its constituent organisations to make difficult decisions about priorities.

Details of the Health and Wellbeing Board, including membership, be found through the link below-
http://www.oxfordshire.gov.uk/cms/content/about-health-and-wellbeing-board

**4.3 The Work of Other Partnerships and Cross-Cutting themes**

The Health and Wellbeing Board is not the only group of its type in Oxfordshire.
Public consultation suggested including topics which are already covered by other groups and strategies. We do not want to duplicate effort and the work of these groups therefore has a key role to play. Other key partnerships and plans include:

- Better Mental Health in Oxfordshire
- Carers Strategy Oxfordshire
- Child Poverty Strategy
- Urgent Care Programme Board that covers the A&E Recovery Plan
- Civilian Military Partnership
- Corporate Parenting Panel
- Dementia Plan for Oxfordshire
- Drug and Alcohol Treatment Services Joint Commissioning Group
- Education Transformation Board
- End of Life Care Strategy
- Joint Management Groups
- Oxfordshire Children's and Adults Safeguarding Boards
- Oxfordshire Domestic Violence Strategy Group
- Oxfordshire Safer Communities Partnership
- Oxfordshire Stronger Communities Alliance
- Oxfordshire Sports Partnership
- Partnership Boards and joint strategies for Physical Disability, Learning Disability, Older People, Mental Health and Autism
- Young People's Lifestyles and Behaviours Steering Group
- Thriving Families Steering Group
- Young Carers' Strategy Oxfordshire
- Youth Offending Service Board

A number of issues were identified in the major consultation in 2012 as ones that are of cross cutting interest to the adults, children's and health improvement boards. These were - safeguarding, carers, housing, poverty, mental health, drug and alcohol dependency, offender health, long term conditions, end of life care, co-ordination of good quality support and making a successful transition from children's to adult services. The action plans to deliver the improvements needed will take account of the cross cutting nature of these issues wherever possible.

Three of these cross-cutting issues are so fundamental and public support for them so strong, that the Health and Wellbeing Board will require that the implementation of this strategy across all priorities takes account of:

**1) Social disadvantage**
The aim here is to level up health and wellbeing across the County by targeting disadvantaged and vulnerable groups. This will vary from topic to topic but will include: Rural and urban disadvantaged communities, black and ethnic minority groups, people with mental health problems, members of the armed forces, their families and veterans and carers of all ages.

**2) Helping communities and individuals to help themselves**
As the public purse tightens, we need to find new ways of supporting people to help themselves. It is early days for this approach, but recent examples have included direct payments to people to buy their own care and the County Council's use of the 'Big Society Fund'.

**3) Locality working**
Local problems often need local solutions and Oxfordshire is a diverse County. The Clinical Commissioning Group, County Council and District councils all support locality working and we should expect to see locality approaches to the priorities in this County when they are the best way to make improvements.

## 5. A strategic focus on Quality

Discussion at the Health and Wellbeing Board in 2012-13 has further fuelled our intention to build a strategic focus on quality issues. The role of the Health and Wellbeing Board is to set strategic concerns for the whole system and to receive assurance of good practice. For the last year we have been monitoring a range of quality outcomes measures and see a fairly good picture overall, but believe there is more to do. We consulted on a process for developing this area of our work and the responses received were supportive but called for specific action.

The Board is concerned that the issues uncovered by the Francis Report on the Mid Staffordshire NHS Trust should not be repeated in Oxfordshire and that the learning that is arising from the Child Sexual Exploitation cases locally will be implemented. In addition, the Joint Strategic Needs Assessment (JSNA), Director of Public Health Annual Reports and feedback of concerns from representatives of the public also indicate gaps in quality which need to be addressed.

The intention is to ensure that governance and assurance systems are joined up between organisations across the County. Performance measures which show patient and public satisfaction or dissatisfaction with services will be embedded in our performance framework again. The development of Healthwatch Oxfordshire will bring independent and informed views to the Board. We will seek assurance on quality at all our public meetings.

Process for setting additional outcomes for 2013-14

- It is proposed that a range of patient reported outcome measures will continue to be monitored, as in 2012-13. These are listed under the relevant priorities.
- In addition there will be a joint review of current systems of quality assurance across partner organisations. These systems are set up for recognising, monitoring,

reporting and acting upon concerns about quality of services. This review will be completed by September 2013.
- Additional proposals for continual quality improvement in Oxfordshire will be discussed and approved by the Health and Wellbeing Board in November 2013.

## 6. The Bedrock of our Decision-making: Oxfordshire's Joint Strategic Needs Assessment

### 6.1 What is the Oxfordshire Joint Strategic Needs Assessment (JSNA)?

The Oxfordshire Joint Strategic Needs Assessment is a report that includes a huge wealth of information and intelligence from a number of different sources that cover the health and wellbeing of the population in its broadest terms. This information is shared between the NHS locally and Local Authorities and is available to the public. When added to local knowledge of services, it gives Oxfordshire a common and consistent evidence-base which allows us to pinpoint gaps and target improvements.

This analysis is the scientific bedrock on which this strategy rests. During 2012-13 the data collection was improved and made more accessible. A summary report was accepted by the Board in March 2013. It can be found here:
http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

The JSNA highlights the following challenges which need to be met which are summarised in the following section:

### 6.2 What are the specific challenges?

1. **Demographic pressures** in the population, especially the increasing number and proportion of older people, many of whom need care and may be isolated or lonely. This is markedly higher in our more **rural districts** than in the City.
2. The **proportion of older people** in the population also continues to increase which means that every pound spent from the public purse has further to go.
3. There are a growing number of people with **dementia** in the County who require access to new emerging treatments.
4. The persistence of small geographical areas of **social disadvantage containing high levels of child poverty**, especially in Banbury and Oxford but also in parts of our market towns. These areas are also the most culturally diverse in the County **containing ethnic minority groups who have specific needs.**
5. The increase in **'unhealthy' lifestyles which leads to preventable disease**.
6. The need to ensure that services for the **mentally ill and those with learning disabilities and physical disabilities** are prioritised.
7. **Increasing demand** for services.
8. The need to support **families and carers of all ages to care.**
9. The need to encourage **volunteering**.
10. An awareness that the **'supply side'** of what we provide does not 'mesh' together as smoothly as we would like - (e.g. hospital beds, discharge arrangements, care at home and nursing home care).
11. The recent **tightening of the public purse** which has knock-on effects for voluntary organisations.
12. The need to work with and through a **wide patchwork of organisations** to have any chance of making a real difference in Oxfordshire.

13. The changing face and **roles of public sector organisations.**

### 6.3 What are the overarching themes required to meet these challenges?

A number of overarching themes required to improve health in Oxfordshire have been identified as follows –

- The need to shift services towards the prevention of ill health.
- The need to reduce inequalities, break the cycle of deprivation and protect the vulnerable.
- The need to give children a better start in life.
- The need to reduce unnecessary demand for services.
- To help people and communities help themselves.
- The need to make the patient's journey through all services smoother and more efficient.
- The need to improve the quality and safety of services.
- The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

These themes will be overseen by the Health and Wellbeing Board and will be tackled by all of the three partnership boards.

### 6.4 What criteria have been followed in selecting priorities?

The priorities are based on the challenges and themes set out previously. We have also used the following criteria to help us focus our priorities:

a) Is it a major issue for the long term health of the County?
b) Are there some critical gaps to which we need to give more attention?
c) What are we most concerned about with regard to the quality of services?
d) On what topics can the NHS, Local Government and the public come together and make life better for local people?
e) Which issues are most important following consultation with the public?

## 7. What are the priorities for Oxfordshire's Health and Wellbeing Strategy?

A summary of the priorities can be found in Annex 1

Each of the priorities set out in this strategy has associated outcomes to be achieved in the current year. The Board examines progress against all of these outcomes at each meeting. At the end of each year of operation the Board reviews successes, analyses on-going need as identified in the Joint Strategic Needs Assessment and proposes revised outcomes to be achieved in the year ahead.

The section below examines each priority in turn. Building on the original rationale for agreeing each, we have updated this strategy to illustrate why this issue is still a priority and the areas of focus going forward. In addition to this narrative the Board considers specific

outcomes for each priority and consults the public and stakeholders on their proposals. The agreed outcomes for the year ahead become the performance framework and progress is reported at every Board meeting.

## A. Priorities for Children and Young People:

Delivery of these priorities is the responsibility of the Children and Young People's Partnership Board

### Priority 1: All children have a healthy start in life and stay healthy into adulthood

A healthy start in life begins at conception, runs through pregnancy and on into the first few years of life. Where problems occur, we aim to provide the wide range of services that parents need to support them.

There is increasing evidence that demonstrates that outcomes across health, education and social care are determined from very early on in life. For this reason we will monitor two new areas that focus on a healthy pregnancy and progress up to the age of 2 years.

The number of children in Oxfordshire aged 4 and under has grown by 13% since the last census in 2001 whilst the Oxfordshire population as a whole has only increased by 8%. We know there is a year on year increase in the proportion of children and young people admitted to hospital in an emergency. The most common causes of emergency admission to hospital for young children (under 5) are respiratory tract infections, viral infections and gastroenteritis. We therefore need to continue to prioritise these children as a focus for our services in the community.

Young people tell us that there is much more we could do to improve the transition between young people's services and younger adults' services. This is particularly relevant to young people with mental health needs. We are determined to act on this.

This priority should be read together with priorities 9 and 11 in the Health and Wellbeing Strategy which proposes the promotion of breastfeeding and improved immunisation for children as further priorities.

**Where are we now?**

- Although there are more children being admitted to hospital for infections, the rate of admission is stable. Numbers have increased in proportion with the increase in population of under 5's. There is also evidence that the length of time spent in hospital is beginning to decrease but we need to maintain a focus on this issue.
- There were 20 less young people admitted to hospital for self-harm in 2012/13
- From September 2013 up to 20 of the most vulnerable young people with mental health problems will be managed throughout the transition via Children and Adolescent Mental Health Services until they recover.
- Oxfordshire continues to perform well against a range of indicators important for a healthy start in life monitored by the Health Improvement Board. This includes breastfeeding and immunisation. The increasing level of obesity in Year 6 children remains a cause for concern.

**Outcomes for 2013-14**

1.1 Increase percentage of women who have seen a midwife or maternity health care professional by 13 weeks of pregnancy from 90% to 92% by end March 2014.
1.2 Ensure that at least 90% of children aged 2-2.5 years old receive a Health Visitor review (currently 90%)
1.3 Reduce the rate of emergency admissions to hospital with infections for under 18's from 177.5 per 10,000 to 159.8 per 10,000
1.4 By March 2014 we will have developed a joint measure(s) that will demonstrate the impact of services on the mental health and wellbeing of school age children.

**Priority 2:** **Narrowing the gap for our most disadvantaged and vulnerable groups**

Oxfordshire is overall a very 'healthy and wealthy' county but there are significant differences in outcomes across health, education and social care for some specific groups. We know that outcomes for children and families from vulnerable groups and disadvantaged communities can be worse than for their peers and is variable across the County.

Poverty and disadvantage are known to be strongly linked to poor outcomes and so work focused on reducing the gap between the most disadvantaged and most advantaged groups starting in 'early years' is seen as a key way of improving outcomes for children and families. We will therefore monitor the take up of free early education places for 2 year olds and continue to monitor the rate of teenage conceptions (as reducing the number of teenage pregnancies has proven to be an effective way of improving outcomes for young people).

There is a national focus on helping the most disadvantaged and challenged families to turn their lives around. The "Thriving Families" programme work with these families to reduce worklessness, antisocial behaviour, crime and school exclusions and to increase school attendance. The key focus is on our most resource intensive and vulnerable families with the aim of reducing the numbers needing the type of support offered by social care. This continues to be a vital strand in the on-going work locally to 'narrow the gap'.

There are attainment gaps for many 'vulnerable groups' of pupils at all key stages. Persistent absence from school is a key factor impacting on educational attainment of the most vulnerable groups of children and young people. Persistent absence rates in secondary schools are higher than the national average. The attainment gap at all key stages of education and the number of school exclusions are greater for specific pupil groups so there is a particular need to focus on specialist groups of vulnerable learners, in particular, children and young people eligible for free school meals; children and young people with autistic spectrum disorder and children and young people 'looked after' by the County.

**Where are we now?**

- The Joint Teenage Pregnancy Strategy has led to significant reductions in the teenage pregnancy and conception rates in Oxfordshire so we would like to continue to monitor this to maintain progress.
- The Thriving Families workers are on track to meet their target of working with 100 families. In Year 2 of the programme there will be a much greater focus on outcomes and the effectiveness of the family intervention model. The plan is to evaluate locally and nationally the difference to families by family intervention work.
- Persistent absence rates from school vary across the county but generally improved from 2010/11. Rates in primary schools are lower than the national average but in secondary schools Oxfordshire is higher than the national average.
- The proportion of 'looked after children' who are persistently absent is below the

national figure but remains a priority.

- Fixed term exclusions tend to be higher than the national average but the number of fixed term exclusions for terms 1-3 in the current academic year is slightly lower than the corresponding term last academic year, despite being higher in previous terms
- Permanent exclusion rates in Oxfordshire are below the national figure

**Outcomes for 2013-14**

2.1 Increase the take up of free early education for eligible 2 year olds in 2013/14 to 1080 (from 1050 in 12/13)
2.2 Increase the take up of free early education for 2 year-old Looked After children to 80% (currently at 8% - 2/24)
2.3 Maintain the improved rate of teenage conceptions (currently at 23.3 women aged 15-17 per 1000 - in quarter 1 of 2012 this was 65 conceptions)
2.4 Maintain the current low level of persistent absence from school for looked after children (2012 persistent absence figures were supressed by the Department for Education, however they indicated that the number of children was small, i.e. less than 4%).
2.5 Maintain the number of looked after children permanently excluded from school at zero.
2.6 Establish a baseline of all children in need who are persistently absent from school
2.7 Establish a baseline of children and young people on the autistic spectrum who have had an exclusion from school (over a school year) and work to reduce this number in future years.
2.8 Identify, track and measure the outcomes of all 810 families in Oxfordshire meeting the national Troubled Families criteria (improve attendance and behaviour in school; reduce anti-social behaviour and youth offending; increase adults entering work)
2.9 Improve the free school meals attainment gap at all key stages and aim to be in line with the national average by 2014 KS2: 16.8% points; KS4 26% points (currently the free school meal attainment gap in Oxfordshire is in line or above the gap nationally in all key stages)

**Priority 3: <u>Keeping all children and young people safe</u>**

Keeping all children and young people safe is a key Oxfordshire priority. Children need to feel safe and secure if they are to reach their full potential in life. “If we don’t feel safe we can’t learn”.

Safeguarding is everyone’s business and many different agencies work together to achieve it. The aim is to make the child’s journey from needing help to receiving help as quick and easy as possible.

In Oxfordshire we have done a great deal of work together – County Council, Police, Health, District Councils and other organisations to prevent child sexual exploitation and to protect and support its victims. This includes setting up the multi-agency dedicated Kingfisher team and increasing capacity by recruiting additional social workers. Nationally and locally there is growing awareness about young people who are victims of sexual exploitation. There is a need to concentrate even greater emphasis on better recognition and prevention of such exploitation. We need to do more in Oxfordshire and work together as agencies to prevent this type of crime happening.

We know that going missing is a key indicator that a child might be in great danger and they are at very serious risk of physical and sexual abuse and sexual exploitation. Nationally 10,000 children are estimated to go missing from care in a year (UK Missing Persons Bureau 2012). The number of looked after children reported missing from Oxfordshire care homes fell significantly between 2011 and 2012 from 155 episodes to 63 episodes.

The safeguarding of children affected by domestic abuse is a core element of child protection. Domestic abuse affects children's resilience, emotional wellbeing, educational attainment, behaviour and longer term life chances. Domestic abuse is a factor in the majority of Safeguarding Children Board serious case reviews of child death or injury.

Quality assurance audits look at the quality of the casework that agencies deliver to reduce the risk of abuse and neglect of children and young people. In 2012/13 a baseline has been established by working with independent auditors to grade the multi-agency audits. These grades will make up the baseline performance on which future progress in 2013/14 will be measured.

Keeping children safe is a key priority for all agencies.

**Where are we now?**

- The Oxfordshire Safeguarding Children Board has overseen a number of multiagency audits of practice that demonstrate a step change in the way professional practice is delivered.
- Adjustment to the quality assurance audit target (50%) will be determined by the outcome of the 2012/13 baseline exercise, but will be set at a higher percentage than the attainment in 2012/13.
- The prevention of child sexual exploitation continues to be a key priority in Oxfordshire.
- There is a much greater focus on children who go missing from home
- In Oxfordshire we have a low level of repeat child protection plans which is now better than the national average. This will continue to be monitored by social care teams but given the level of improvement it is proposed that it is no longer a monitoring priority for the Health and Wellbeing Board.

**Outcomes for 2013-14**

3.1 Maintain the reduction in risk for victims of domestic abuse considered to be high risk to medium or low through Multi-Agency Risk Assessment Conferences (currently 85% for 2012/13 based on a single-agency assessment by the Independent Domestic Violence Advisory Service)

3.2 Every child considered likely to be at risk of Child Sexual Exploitation (identified using the CSE screening tool) will have a multi-agency plan in place

3.3 Reduce prevalence of Child Sexual Exploitation in Oxfordshire through quarterly reporting on victims and perpetrators to the Child Sexual Exploitation sub group of the Oxfordshire Safeguarding Children's Board.

3.4 Reduce the proportion of children who go missing from home 3 or more times in a 12 month period to 12% (currently 12.2%, 77 of 630 who went missing at least once).

3.5 A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire's Safeguarding Children Board covering the following agencies: children's

social care; youth offending service; education services; children and adult health services; early intervention services; services provided by the police. Over 50% of these audits will show a positive overall impact.

**Priority 4:** **Raising achievement for all children and young people**

The Health and Wellbeing Board aspires to see every single child being successful and reaching their potential, thriving in an outstanding learning environment throughout their education, wherever they live across the county, and to see the gap reduced between the lowest and the highest achievers. We aim for every single school to be rated at least as 'good' and to be moving towards 'outstanding'.

Early Years and primary school results are better than the national average and this can be built upon. There have been some signs of improvement in some subject areas at Key Stage 4 and we need to continue to improve with a particular focus on building on the achievements of specific groups. We know that specific pupil groups in Oxfordshire do not do as well as their peers in similar Local Authorities. This includes children receiving free school meals, children from some Black and Minority Ethnic Groups and those with special education needs.

In 2011/12 there have been improvements in inspection outcomes and significant improvements in the performance of some schools though Oxfordshire has a greater proportion of schools judged by Ofsted as requiring improvement. Overall, the picture shows gradual improvement but there is inconsistency across Oxfordshire and for certain groups of children.

There is still a need to focus on young people Not in Education, Employment and Training (NEET) so we can continue to work with specific vulnerable groups and track young people in Oxfordshire moving between education, training providers and/or employers (referred to as 'not known').

**Where are we now?**

- There has been significant improvement in reading at Key Stage 1 and achievement at Key Stage 2 maths.
- A higher percentage of pupils in Oxfordshire made expected progress in Key Stage 2 English and maths than nationally
- Pupils achieving 5 or more A*-C GCSEs including English and Maths Oxfordshire has increased slightly in 2011/12 to 57.9%. However, in this measure Oxfordshire is performing below the statistical neighbour and national averages. Overall GCSE results fell below the national average in 2011/12.
- There has been a 0.7% decrease in overall absence levels in both primary and secondary schools in Oxfordshire for the academic year 2011/12. Persistent absence rates from school vary across the council but generally improved from 2010/11. Rates in primary schools are lower than the national average but in secondary schools Oxfordshire is higher than the national average.
- The number of schools falling below the accepted standard fell from 18 to 1
- The percentage of children taught in good/ outstanding primary schools has increased from 59% to 67%
- The proportion of year 12-14s who are Not in Education, Employment and Training is lower than that nationally but we still need to focus on the young people who are 'not known'.

**Outcomes for 2013-14**

4.1 Increase the number of funded 2-4 year olds attending good and outstanding early years settings to 83% or 8870 children (currently 80.5% or 8600 children)

4.2 80% (5700) of children will achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2012/13 (currently 78% or 5,382 children for the academic year 2011/12)

4.3 80% (4800) of children at the end of Key Stage 2 will achieve Level 4 or above in reading, writing and maths (currently 78% or 4800 children)

4.4 61% (3840 children) of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2012/13 (currently 57.9% or 3474 children)

4.5 At least 70% (4400 children) ) of young people will make the expected 3 levels of progress between key stages 2-4 in English and 72%(4525 children) in Maths (currently 65% or 3800 young people for English and 71% or 4170 young people for Maths)

4.6 Increase the proportion of pupils attending good or outstanding primary schools from 59% (29,160) to 70% (34,590) and the proportion attending good or outstanding secondary schools from 74% (26,920) to 76% (27,640) (currently 67% primary and 74% secondary).

4.7 Of those pupils at School Action Plus, increase the proportion achieving 5 A* - C including English and Maths to 17% (70 children) (currently 7% or 30 children)

4.8 Reduce the persistent absence rates in primary schools to 2.6% (1070 children) and secondary schools to 7.2% (2250 children) by the end of 2012/13 academic year. (The current rates are 3.0% or 1233 children for primary schools and 8.0% or 2500 children for secondary schools)

4.9 Reduce the number of young people not in education, employment or training to 5% (870 children) (currently 5.4% or 937 young people)

## B. Priorities for Adult Health and Social Care

Delivery of these priorities is the responsibility of the Adult Health and Social Care Partnership Board

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

Adults living with a physical disability, learning disability, severe mental illness or another long term condition consistently tell us that they want to be independent and to have choice and control so they are able to live "ordinary lives" as fully participating members of the wider community. This priority aims to support the increasing number of adults with long term conditions to meet their full potential.

Both nationally and locally, people tell us that living ordinary lives means:

- Having improved access to information that supports choice and control
- Having improved access to housing and support
- Having improved access to employment, study, meaningful activity and involvement in the community and wider public life
- Having access to responsive, coherent services that help people manage their own care

- Having improved support for carers, to help them to help the people they care for to live as independently as possible

We will continue to monitor how easy people find it to access information and the quality of support offered to people with a long term condition. We recognise the importance of supporting people with mental health needs to find and stay in employment, and will develop a measure during this year that will help demonstrate how effectively we are in doing this.

Access to good health care is an area for improvement in Oxfordshire for people with learning disabilities and for people with mental health needs. The physical health check target we set, of at least 50% for adults with learning disabilities was seen as a step in the right direction towards at least 60% by the end of 2013/14. There is a specific focus this year on improving access to health care for people with schizophrenia.

**Where are we now?**

- Overall the proportion of people who use adult social care who said they found information very or fairly easy to find rose from 71.5% to 73.5%. However for working age adults the figure fell from 71.3% to 69.4%.
- The current measures for people with a severe mental illness receiving a health check are not part of national outcome frameworks and have been difficult to measure, and do not necessarily provide the best indicators of improved outcomes.
- The number of people with learning disabilities who had physical health check only increased slightly, from 45% to 45.7%.

**Outcomes for 2013-14**

5.1 75% of working age adults who use adult social care say that they find information very or fairly easy to find (currently 69%, 129 of 186 responses)

5.2 Maintain the proportion of people with a long-term condition who feel supported to manage their condition at 85%.

5.3 100% patients with schizophrenia are supported to undertake a physical health assessment during 2013/14 (this is a new indicator and the baseline will be established this year)

5.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP (currently 45.7%)

5.5 Maintain the high number of people with a learning disability who say they have seen their GP in the last 12 months at over 90% (currently 93%, 223 of 241 respondents for 2012/13)

5.6 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (baseline rate of 1012.6 per 100,000)

5.7 Reduce unplanned hospitalisation for chronic conditions that can be actively managed (such as congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension) for people of all ages (baseline rate of 490.5 per 100,000)

5.8 Provide autism awareness training for an additional 500 front line health and social care workers in Oxfordshire (1000 have been trained since 2011/12)

5.9 Develop a measure of how effectively people with mental health needs are supported to find and stay in employment by March 2014, based on the relative severity of people's illness.

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

We know that living at home with dignity is key to the quality of life that older people want to enjoy and that older people and their carers require access to good quality information and advice.

In Oxfordshire we know that the proportion of older people in the population continues to increase and that the number of referrals for support are also increasing along with the cost of caring for older people which increases markedly with age. This is true for both health and social care.

In 2012/13 Oxfordshire had the highest level of delayed transfers of care from hospital in the country. All organisations continue to be committed to improving the situation and one of the best ways of doing this is to provide services which help people to learn or re-learn the skills they need to live more independently and to prevent ill health. These services are called "reablement services". We are committed to offer these to more people.

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. To achieve this we are focusing together on better use of reablement; reducing emergency admissions to hospital for acute conditions; reducing the number of people permanently admitted to care homes; developing more integrated community services; improved diagnosis of people with dementia; providing additional extra-care housing units as well as ensuring there is a range of housing options for older people and that people can find the information they need. We believe we should also continue to set a challenging target for reducing the number of people admitted to a care home, because this is the ultimate test of whether these alternative services and options are working.

Loneliness and social isolation are increasingly acknowledged as root causes of poor health and wellbeing and we know they influence people's choices about staying at home. More local information is needed to identify the key issues in this area for Oxfordshire.

Another key issue is the increase in the number of people with dementia who need access to newly emerging treatments. To enable us to develop high quality care for people with dementia we need to diagnose it earlier. Currently only 38% of people with dementia in Oxfordshire have a diagnosis. This is below the national average of 42% (within a national range of 27% - 59%). In Oxfordshire our ambition is for 60% of the expected population to have a diagnosis by 2014 but we need a staged approach to get there. This year we are therefore aiming for a step increase in performance to 50% of people with dementia in Oxfordshire to have a recorded diagnosis.

**Where are we now?**

- 77.7% of older people who use adult social care say that information is very or fairly easy to find
- 582 people were placed permanently in care homes in 2012/13, although the number placed each quarter reduced from October 2012 onwards.
- 40 new Extra Care Housing places have opened at Thame, 70 at Banbury (Stanbridge) and 20 at Bicester.
- The number of people starting reablement increased in the year and by over 20% on last year's level, but is below the expected level.
- Delayed transfers of care remain high and Oxfordshire is still the worst of any authority nationally.

- 89.9% of people living at home consider they are treated with dignity, down slightly on 2011/12 (91.6%).

**Outcomes for 2013-14**

6.1 Reduce the number of patients delayed for transfer or discharge from hospital so that Oxfordshire's performance is out of the bottom quartile (current ranking is 151/151)
6.2 Reduce the average number of days that a patient is delayed for discharge from hospital (baseline and target to be confirmed following audit in summer 2013)
6.3 Reduce the number of emergency admissions to hospital for older people aged 60+ (from 25,538 in 2012/13)
6.4 Develop a model for matching capacity to demand for health and social care, to support smooth discharge from hospital, by September 2013
6.5 No more than 400 older people per year to be permanently admitted to a care home (currently 582)
6.6 By September 2013, review and redesign the range of community services that support people to live independently at home, receive good quality local support of their choice when needed and to help avoid getting into a crisis situation, and implement a way of monitoring waiting times for health and social care services at home that provide support in an emergency.
6.7 Increase the proportion of older people with an ongoing care package supported to live at home from 60% to 63% (currently 2122 of 2537 clients)
6.8 60% of the expected population (4251 of 7086 people) with dementia will have a recorded diagnosis (currently 49.6% or 3516 people)
6.9 Set up a network of dignity and dementia champions in care homes so that by March 2014 90% of care homes (95 of 105) in the county have a champion (baseline zero as this is a new initiative)
6.10 3500 people will receive a reablement service (currently 2197)
6.11 Increase proportion of people who complete reablement who need no on-going care from 50% to 55% (was 426 of 858 Oct to March, would be 1484 of 2698 based on current numbers)
6.12 Maintain the current high standard of supporting people at home with dignity as measured by people themselves (currently 89.9%, 246 of 274 respondents).
6.13 Increase the proportion of older people who use social care who reported that they have adequate social contact or as much social contact as they would like to 81.2% (currently 80.4%, 229 of 285 respondents).
6.14 Ensure an additional 523 Extra Care Housing places by the end of March 2015, bringing the total number of places to 930
6.15 Produce an analysis of demand for alternative housing options for older people within Oxfordshire to inform future targets and planning by September 2013
6.16 Maintain the high number of older people who use adult social care and say that they find information very or fairly easy to find (currently 77.7%, 146 of 188 respondents for adult social care)
6.17 Bereaved carers' views on the quality of care the person they cared for received in the last 3 months of life (baseline and target to be confirmed as awaiting national figures – these are due in September 2013)
6.18 Increase the proportion of adults who use social care that say they receive their care and support in a timely way to 85% (currently 214 of 259 – 83%)

**Priority 7: <u>Working together to improve quality and value for money in the Health and Social Care System</u>**

Integrating the health and social care systems has been a goal of public policy for the past 40 years. The successful integration of health and social care offers important benefits e.g.

- Improved access to, experience of, and satisfaction with, health and social care services that place people at the centre of support.
- Development of different ways of working, including new roles for workers who work across health and social care.
- Ensuring that all health and social care providers deliver high quality safe services which ensure that those receiving their services are treated with dignity and respect
- Ensuring people receive the right quality care, in the right place at the right time and achieve more efficient use of existing resources and a reduction in the demand on expensive health and social care services.

The integration of services has progressed in Oxfordshire over the last year with the introduction of a joint single point of access to health and social care community services for health and social care staff. The next step is to integrate health and social care services in GP localities.

The County Council and Oxfordshire Clinical Commissioning Group are committed to working together to raise the quality and improve the value of health and social care services for both service users and for carers. This is what the people of Oxfordshire have said they want. Integrating health and social care is a priority because it gives us the chance to improve services, make better use of resources and meet the stated desires of the public.

**Where are we now?**

- Oxfordshire Clinical Commissioning Group, Oxford Health Foundation Trust, Oxford University Hospital Trust and the County Council have been working in partnership to deliver integrated community services throughout 2012/13 with significant progress being made with the development of an integrated Single Point of Access and the implementation of the Oxfordshire Discharge Pathway.
- A single Section 75 agreement is in place covering all the pooled budget arrangements between the County Council and Clinical Commissioning Group
- The Older People's Joint Commissioning Strategy has been developed by a multi-agency working group, and following public consultation will be reported to County Council Cabinet and Clinical Commissioning Group Executive Board in June 2013.
- Oxfordshire Clinical Commissioning Group has been formally authorised to take on commissioning responsibilities for Oxfordshire from 1 April 2013.
- 61.7% of people who use social care services in Oxfordshire say they are very satisfied with their care and support, an increase in overall satisfaction for the third successive year.
- Achieved above the national average of people satisfied with their experience of hospital care (78.7%), and above the national average of people 'very satisfied' with their experience of their GP surgery (90.1%)
- 881 carers' breaks have been jointly funded and accessed via GPs, but carers' satisfaction with services (39%) is significantly lower than service users levels of satisfaction. However, a similar picture is emerging nationally.

**Outcomes for 2013-14**

7.1 Implement a joint plan for fully integrated health (community and older adult's mental health) and social care services in GP locality areas by March 2014, leading to improved outcomes for individuals.

7.2 Agree an expanded and genuinely pooled budget for older people by July 2013
7.3 Achieve above the national average of people very satisfied with the care and support they receive from adult social care (currently 62.4% against a national figure of 63.7% for 2012/13)
7.4 Achieve above the national average of people satisfied with their experience of hospital care (currently 78.7% against national figure of 75.6% for 2012/13)
7.5 Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (currently 91% against national figure of 87% for 2012/13)
7.6 Increase the number of carers known and supported by adult social care by 10% to 15,265 (currently 13,877 are known so this would represent an additional 1,388)
7.7 880 carers breaks jointly funded and accessed via GPs (currently 881)

**C. Priorities for Health Improvement**

Delivery of these priorities is the responsibility of the Health Improvement Partnership Board

**Priority 8: Preventing early death and improving quality of life in later years**

This priority aims to add years to life and life to years – something we all aspire to.
The biggest killers are heart disease, stroke and cancers. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services but we can encourage healthier lifestyles and prevent disease through early detection and screening.

A gap in life expectancy still remains within Oxfordshire, with women likely to live longer than men and those in more deprived areas likely to die sooner and be ill or disabled for longer before death.

Promoting healthy lifestyles and access to screening programmes is a cost effective way of reducing the risk of chronic disease and premature death

The following priorities for action will continue to be the priorities in the year ahead:

- To reduce levels of smoking in the county by encouraging more people to quit as smoking remains a major cause of heart disease and cancer.
- To boost our cancer screening programmes so that more people are protected, focusing on the bowel cancer screening programme.
- To promote the 'Health Checks' programme which offer adults a full health 'MOT' and looks at many lifestyle factors such as obesity, exercise, smoking, blood cholesterol levels ,diabetes, blood pressure and alcohol consumption.
- Reversing the rise in the consumption of alcohol is another priority of the Health and Wellbeing Board. It is being taken forward by the Oxfordshire Community Safety Partnership and progress will be monitored by the Health Improvement Board.

In addition to this, our work must be even more focused on those who are most at risk. The Joint Strategic Needs Assessment shows that there are differences between different groups of people and different places in the County, with some faring better than others both in terms of their life expectancy and in their chances of living healthy lives into old age.

A programme of public awareness campaigns will support this work by raising awareness of prevention and early intervention services.

| **Where are we now?** |
| --- |

- Over 2500 people in Oxfordshire had quit smoking for at least 4 weeks by the end of Q3
- The number of 40-74 year olds invited for NHS Health Checks was on target
- Bowel screening rates were below target at the end of Q3

**Outcomes for 2013-14**

8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)

8.2 Number of invitations sent out for NHS Health Checks to reach the target of 39,114 people aged 40-74 in 2013-14 (Invitations sent in 2012-13 = 40914 as more people were eligible in 2012-13)

8.3 At least 65% of those invited for NHS Health Checks will attend (ages 40-74)

8.4 At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)

**Priority 9: Preventing chronic disease through tackling obesity**

After smoking, obesity is the biggest underlying cause of ill health. It can lead to high blood pressure, heart disease, stroke, diabetes, cancer and early death. It also increases immobility and makes any other disability more severe than it would otherwise be.

Surveillance of these issues in the last year show that

- Rates of obesity in the county continue to rise. Data from surveys show a cause for concern.
- The percentage of people diagnosed with diabetes by their GP continues to rise across the county.
- The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire. These higher rates need to be maintained.
- Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates, but show over 15% obesity at year 6. These are year on year snap shot measures so trends cannot be identified.

To tackle obesity we propose to keep our focus in the following areas:

**Promoting breastfeeding**

Breastfeeding gives the best start to life and has been proven to lead to fewer overweight children and adults. Increasing the number of breastfed babies is still the foundation of an obesity strategy for the County. The national figure for breastfeeding prevalence at 6-8 weeks is 47% but in Oxfordshire we want to keep the stretching target of 60% and will only achieve this if we focus on the areas where rates are low.

**Halting the increase in childhood obesity**

Children in Reception class and Year 6 are weighed and measured every year and results show that around 8% of reception year and 15% of Year 6 children are obese. This feeds through into ever increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to. Healthy eating initiatives are part of the approach. Levels of obesity are also linked to social deprivation, with more deprived

parts of the County showing higher rates of obesity, so some targeting of effort is called for here too.

**Promoting physical activity in adults**
Physical activity is an important component of maintaining a healthy weight for all ages and there is local encouragement here, with Oxfordshire still doing well according to the 'Active People' survey. The survey showed that 27% of the population participate in regular activity each week. Maintaining this position will be critical to good health in the County. Regular participation in physical activity will also have an impact on mental wellbeing.

**Where are we now?**
- The ambitious target of halting the rise in childhood obesity was not met, though the Oxfordshire rate is still lower that the national rate.
- Breastfeeding rates for babies aged 6-8 weeks showed good progress but dipped at the end of the year.
- The rates of adults undertaking the recommended level of physical activity continued to increase.

**Outcomes for 2013-14**
9.1 Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2012 this was 15.6%)
9.2 Increase to 62.2% the percentage of adults who do at least 150 minutes of physical activity a week. (Baseline for Oxfordshire 61.2% 2011-12)
9.3 65% of babies are breastfed at 6-8 weeks of age (currently 59.1%)

**Priority 10: <u>Tackling the broader determinants of health through better housing and preventing homelessness</u>**

Housing and health are intimately connected and inextricably linked. Having a home, living in good housing conditions and in a good neighbourhood with the right kind of support, are vital ingredients to health and well-being.

There are several ways in which housing issues impact on health, including the following:

- 'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses
- Homeless people die earlier and suffer worse health than people with a stable home. The threat and experience of homelessness also has an impact on mental wellbeing.
- Safe, secure housing contributes to improving health outcomes. Some vulnerable people need support to maintain their tenancies and live ordinary lives as fully participating members of the wider community. This is an essential ingredient for preventing ill health and homelessness.

These housing issues all have to be tackled in partnership.

Surveillance and sharing of good practice over the last year through the Health Improvement Board has already seen a higher profile for this area of work. Concerns remain including

- Changes to the welfare benefit system have potential to put more households at risk of homelessness
- New ways of working to provide Housing Related Support need time to develop
- Fuel poverty is still a risk for a large number of households. New systems for improving energy efficiency of homes have been introduced and need to be established.
- Fuel Poverty work is not funded sustainably.

**Where are we now?**
- Scoping work and local pilot projects to understand and agree actions to reduce the risk of homelessness are now complete.
- The Housing Related Support Group has been established and several services will have to be re-procured in 2013-14
- The annual report from the Affordable Warmth Network for 2012-13 shows that there has been good take-up of information and advice services. Some energy efficiency improvements were made in 363 households across the county. 400 referrals were made to Warm Front resulting in improvements in 105 households

**Outcomes for 2013-14**
1. The number of households in temporary accommodation on 31 March 2014 should be no greater than the level reported in March 2013 (baseline 216 households in Oxfordshire)
2. At least 75% of people receiving housing related support will depart services to take up independent living.
3. At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 2012- 2013 when there were 2468 households known to services, of which 1992 households were prevented from becoming homeless. 1992/2468 = 80.7%)
4. Fuel poverty outcome to be determined in Sept 2013

**Priority 11**: **Preventing infectious disease through immunisation**

Immunisation is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire continue to improve but it is imperative that this is maintained. Constant vigilance is needed to make sure that individual children have access to immunisation. This means working closely with GPs, community nurses and individual families.

It is important that immunisation rates remain high throughout the population to maintain "herd immunity". Responsibility for commissioning immunisation services has been taken on by NHS England. This is done locally through the Thames Valley Area Team. High levels of coverage need to be maintained through this transition to new organisations within the NHS in order to continue to achieve the goal of protection for the population.

The recent increase in cases of measles in other parts of the UK and increased prevalence of whooping cough has caused concern at a national level.

New immunisations are to be introduced in the next year.  From July 2013, a rotavirus vaccination will be offered at 2 months and at 3 months, flu immunisation will be given to children aged 2 and 3 and Shingles vaccinations to people aged 70 and 79..

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met and there are early signs that our high rates have begun to slip a little. The leadership for these services will change profoundly during the next year and maintaining our current position will be a real challenge.

We are proposing priorities for improving immunisation levels across the board, focussing on childhood immunisation, immunisation of teenage girls to protect against cervical cancer and flu vaccinations in the elderly and vulnerable.

**Where are we now?**

- High coverage rates for most childhood immunisations were achieved across the county.
- Follow up of some families with incomplete immunisation records meant that they were successfully immunised.
- Over 80,000 people aged over 65 received their flu immunisations in 2012-13
- Rates of flu immunisations for people aged under 65 who are at risk of illness are not meeting targets.

**Outcomes for 2013-14**

11.1 At least 95% children receive dose 1 of MMR vaccination by age 2 (currently 95%)
11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.7%)
11.3 At least 55% of people aged under 65 in “risk groups” receive flu vaccination (currently 51.6%)
11.4 At least 90% 12-13 year old girls receive all 3 doses of human papilloma virus vaccination (currently 88.1%).

## Annex 1: Summary of Priorities for the Oxfordshire Health and Wellbeing Strategy

**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 safe
**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

## Annex 2: Glossary of Key Terms

**Terms**

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|---|---|
| **Carer** | Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment. |
| **Child Poverty** | Children are said to be living in relative income poverty if their household's income is less than 60 per cent of the median national income. |
| **Child Protection Plan** | The plan details how a child will be protected and their health and development promoted. |
| **Commissioning** | The process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased. |
| **Delayed Transfer of Care** | The national definition of a delayed transfer of care is that it occurs when a patient is medically fit for transfer from a hospital bed, but is still occupying a hospital bed. |
| **Director of Public Health Annual Report** | http://www.oxfordshirepct.nhs.uk/about-us/publications/public-health-annual-report.aspx |
| **Extra Care Housing** | A self-contained housing option for older people that has care support on site 24 hours a day. |
| **Fuel Poverty** | Households are considered by the Government to be in 'fuel poverty' if they would have to spend more than 10% of their household income on fuel to maintain an adequate level of warmth. |
| **Healthwatch Oxfordshire** | Healthwatch is the new independent 'Consumer Champion' for health and social care for people of all ages |
| **Joint Health and Wellbeing Strategy** | The strategy is the way of addressing the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for action. |
| **Joint Strategic Needs Assessment (JSNA)** | A tool to identify the health and wellbeing needs and inequalities of the local population to create a shared evidence base for planning. |
| **Not in Education, Employment or** | Young people aged 16 to 18 who are not in |

| | |
|---|---|
| **Training (NEET)** | education, employment or training are referred to as NEETs. |
| **Oxfordshire Clinical Commissioning Group** | The Oxfordshire Clinical Commissioning Group is the new organisation in Oxfordshire that has the responsibility to plan and buy (commission) health care services for the people in the County. It is currently in shadow form until it takes over from Oxfordshire Primary Care Trust in April 2013. |
| **Oxfordshire's Safeguarding Children Board** | Representatives from the main statutory agencies who ensure there are suitable robust arrangements for protecting children in Oxfordshire. |
| **Pooled budget** | A mechanism by which the partners to the agreement bring money to form a discrete 'fund'. The purpose and scope of the fund is agreed at the outset and then used to pay for the services and activities for the relevant client group. |
| **Quality Assurance Audit** | A process that helps to ensure an organisation's systems are in place and are being followed. |
| **Reablement** | A service for people to learn or relearn the skills necessary for daily living. |
| **Secondary Mental Health Service** | Services for adults with more severe mental health problems and needs requiring the specialist skills and facilities of mental health services. |
| **Section 75 agreement** | An agreement made under section 75 of National Health Services Act 2006 between a local authority and PCT(s), NHS trusts or NHS foundation trusts. This can include arrangements for pooling resources and delegating certain functions to the other partners if it would lead to an improvement in the way those functions are exercised. |
| **Thriving Families Programme** | A national programme which aims to turn around the lives of 'Troubled' families by 2015. |
| **Transition** | This is the process through which a person with special needs transfers from children's services to adults services. |

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**Oxfordshire Health and Wellbeing Board**

# Health Improvement Partnership Board

## Terms of Reference

**Purpose:**

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

The Health Improvement Partnership Board exists to support the Health and Wellbeing Board in this purpose by delivering service change and improved outcomes through partnership working.

**Responsibilities:**

To achieve its purpose, the Health Improvement Partnership Board has the following responsibilities:

- To demonstrate effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources
- To deliver the priorities and objectives arising from the Joint Health and Wellbeing Needs Assessment (JSNA) for Oxfordshire,
- In particular to
    - *Bring a coordinated and coherent approach to influencing a broad range of determinants of health to bring about health improvement*
    - *Work together to recommend priority areas to improve health in order to make a real and measurable difference to outcomes*
    - *Recommend actions and responsibilities to make that improvement a reality*
    - *Hold each other to account for making the agreed change and for reporting progress*
- To meet the performance measures agreed by the Health and Wellbeing Board.

**Membership**

The core membership of the Health Improvement Partnership Board is:
- Five district/city councillors – one of whom will be Chairman and another Vice-Chairman
- County Council Cabinet Member for Public Health and Voluntary Sector
- Clinical Commissioning Group representative
- Director of Public Health for Oxfordshire
- Assistant Director of Public Health
- Public Health Specialist
- District Council officer representative

- Public Involvement Board representative

In attendance
- Oxfordshire's Chief Fire Officer in his role as Chairman of the Safer Communities Business Group

It is proposed that a wide range of stakeholders can be invited to Board meetings at the discretion of the Chairman. They may attend as expert witnesses and to report on implementation of plans.

Governance

The meetings of the Health Improvement Partnership Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and the Access to Information Procedure Rules, insofar as these are applicable to the Partnership Board.

The Health Improvement Partnership Board will also be subject to existing scrutiny arrangements with the Oxfordshire Joint Health Overview and Scrutiny Committee providing the lead role.

Members of the Group will be subject to the Code of Conduct applicable to the body which they represent.

The Partnership Board will meet at least once a year in public. Dates, times and places of meeting will be determined by the Chairman of the Partnership Board.

The County Council's Joint Commissioning Team will service meetings of the Partnership Board including the preparation and circulation of agendas and minutes.

The Health and Wellbeing Board will agree terms of reference and membership for the Partnership Board. It will also agree its priorities, proposed outcomes and performance measures. The Partnership Board will review the terms of reference on an annual basis.

Peter Clark

County Solicitor and Monitoring Officer

July 2013

## Tackling Obesity: The challenge of maintaining a healthy weight

### 1. Introduction

The aim of this paper is to:

- Review the issue and extent of the problem in Oxfordshire; and outline the progress that has been made since 2009.
- Discuss some of the promising initiatives, the gaps and what more could be done.
- Ask the Health Improvement Board to consider approaches to preventing obesity, building on work that is already underway.

### 1.1 Why is it is a priority

Obesity is a condition of excess body fat and in adults is defined as a body mass index (BMI) of 30 or more. The number of obese individuals in England has tripled since the 1980s and it is estimated that approximately 31 million adults or two thirds of the UK population are either overweight or obese. If current trends continue it is estimated that nearly 60% of the UK population could be obese by 2050.

Being obese reduces life expectancy by an average of nine years and is attributable to many more years of ill health. It causes long-term chronic diseases such as diabetes, stroke and heart disease and the risk of disease gets worse the more overweight people become. Obesity can severely affect mobility and general deteriorations in physical health and mental well-being are common in very obese individuals. Once established, obesity can be difficult to treat so prevention and early intervention are extremely important.

### 1.2 What do we know about the problem in Oxfordshire?

The National Childhood Measurement Programme (NCMP) provides annual data on the number and proportion of underweight, overweight and obese children in Reception and Year 6. The programme has been in place since 2006/2007. The NCMP surveillance data (Figures 1 and 2) tells us that:

- Oxfordshire continues to have rates of obesity which are lower than the national average.
- Children in year 6 have a higher prevalence of obesity than those in Reception year (15.6% and 7% respectively) indicating intervention should start in the early years by promoting breastfeeding, healthy weaning and healthy lifestyles in children & families.
- Oxfordshire obesity rates have remained fairly stable over this period (fluctuating between 15.1% and 15.8%) but do not show signs of declining. Although the rate dropped to 15.1% in 2009/10 and 2010/11 it has now risen to 15.6%.
- Higher rates of obesity in Oxford City (19.5%) and Cherwell (17.2%) are a particular cause for concern and are likely to reflect a population with more social disadvantage and more ethnic minority groups.

**Figure 1.**

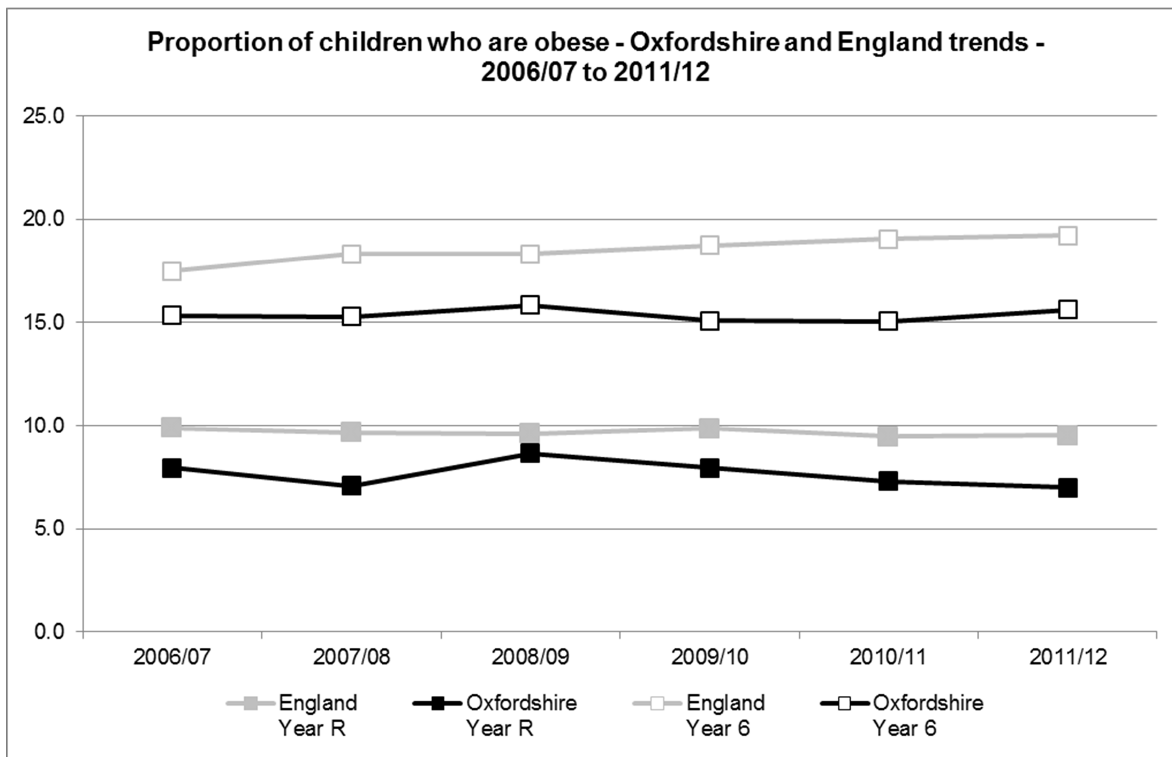
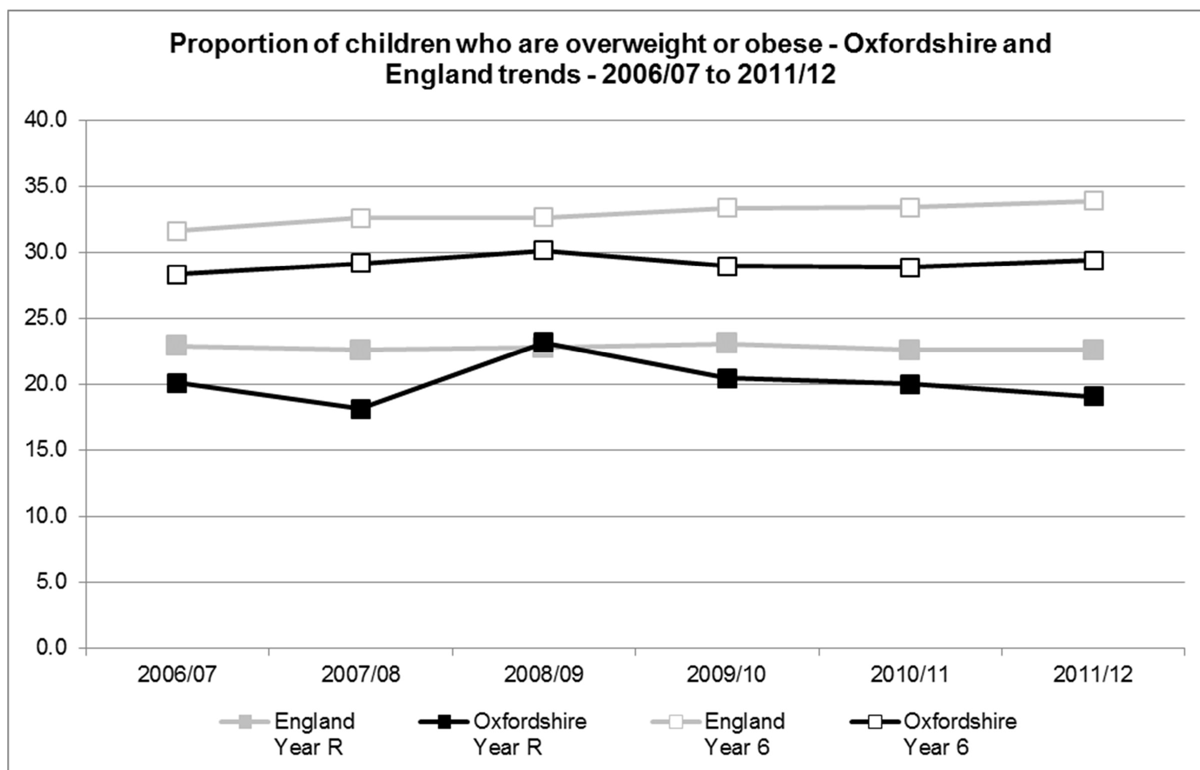



**Figure 2.**




There is no effective way of monitoring adult obesity at a local level. Health Survey England (HSE) data, which is used to monitor national rates, relies on small sample size which these can make the data unreliable. The most recent HSE suggests that 29 % of adults in Oxfordshire are obese compared to the England figure of 25%. Recent data from the national Health Checks programme suggest that up to 60 % of 40 – 64 year olds in Oxfordshire are overweight or obese, reflecting the national picture.

### 1.3 National and local approaches to the problem

In 2009 we launched the first Public Health Strategy for Commissioning Obesity Services within Oxfordshire. We established a multiagency 'Healthy Weight Network' which contributes to and monitors the countywide 'Healthy Weight Delivery Plan'. Since 2009, we have commissioned a range of universal services and targeted initiatives which help to prevent overweight and obesity. We have an adult care pathway and a range of adult weight management (treatment) services which are accessible through GP practices. We are also piloting a children and families service in Oxford and Banbury which will be commissioned across the county from April 2014. Appendix 1 provides a list of local services and initiatives.

In the meantime, the new national Obesity strategy, Healthy Lives, Healthy People: A call to action on obesity in England launched October 2011, the key points of which are:

- For government, local government and key partners to act to change the environment thus supporting individuals to change their behaviour
- Cradle to Grave approach, which also addresses inequalities
- Issuing two new national ambitions (targets)

    1. Sustained downward trend in childhood obesity by 2020

    2. A downward trend in average weight across all adults by 2020

The general approach of the national strategy is national and local multiagency approach to:

- Helping People to make healthy food and drink choices
- Helping people to become more active
- Transforming the environment, especially within workplaces.

### 1.4 Current Challenges

The energy imbalance, which causes obesity, is driven by a complex, multifaceted system of determinates and no one cause is dominant. Therefore finding ways to tackle the root causes of the problem and intervene successfully is not straightforward and requires a long term, multifaceted approach.

Austerity and policy changes since 2010 have impacted on some of our local preventative services and ambitions. For example, there have been cuts to the nationally funded School Sport Partnerships and Healthy School programmes and local leisure, transport and children's services have also been squeezed. Nevertheless, we need to remain focused on enabling people to maintain a healthy weight. Obesity adds £1 million **every year** to the cost of the NHS services in Oxfordshire alone; we need to take action to, in the first instance halt the year on year rise of obesity and then reduce these levels in a sustainable way. This ambition requires a long term strategy that is focused on prevention.

To achieve this we need to make a shift change in our approach and engage with a broader church of local organisations. There are opportunities to be gained from the public health function returning to the local authority; for example, by linking public health priorities more closely to the strategic objectives planning, transport and community services. However, this influence also needs to extend to district and town councils, the private and voluntary sectors.

This paper will now discuss some of the promising initiatives, the gaps and what more could be done. As the issue is complex, the discussion is broken down by early years, children and young people, adults and cross cutting themes.

## 2. Early years

Preventing obesity begins in the pre-school years, perhaps even before a child is conceived. In Oxfordshire, nearly 1 in 5 children are already overweight or obese when they begin school and evidence is now emerging that an overweight or obese mother in pregnancy is an indicator of a child's future weight. In addition, eating and physical activity behaviours in adulthood have their roots in the early years and association between parent's lifestyle and their children's has been demonstrated.

### 2.1 What are we doing now?

- Universal Health Visiting services, children's centres and breastfeeding cafés provide advice to parents on parenting, weaning and breastfeeding.
- Providers are being challenged to increase rates of breastfeeding to 60% or more as breast milk is highly nutritious and helps to protect against a variety of child and adult diseases including obesity.
- We commission HENRY (Health Exercise Nutrition for the Really Young) training which enables practitioners to provide 1-2-1 and group based support and expertise that empowers parent and families to make healthier choices
- The Healthy Child Programme is being implemented across Oxfordshire.

However there is more that can be done, particularly to address inequalities. For example, despite additional support, breastfeeding rates in our most deprived wards remain 20% lower than our least deprived and 10% lower than the average for Oxfordshire.

### 2.2 What else can be done?

Oxfordshire Clinical Commissioners, Oxfordshire County Council and the Local Area Team should ensure that primary prevention is fully integrated into the core offer of providers and closely monitored as part of the following contracts:

- Midwifery
- Heath Visiting
- Community paediatricians
- School Nursing
- Children Centres/Early Years Settings

Examples could include:

- Lead professionals to develop & implement service plans for healthy weight including proportional universalism of breastfeeding, weaning and parenting support.
- Mandatory training of primary care practitioners and community midwives to be aware of risk factors that will predispose children to be obese and take action accordingly.
- Paediatricians to provide clear and consistent advice to parents of children identified as overweight or obese and refer to relevant community service.
- Early years settings to provide healthy promoting environments for families and children and develop and implement service plans for healthy weight.

- Addressing the barriers faced by staff including knowledge, confidence and their own weight management issues (links to workplace health).

All partners regularly review their strategies, plans and services against National Institute of Clinical Excellence (NICE) guidance and provide regular updates to the board as part of the healthy weight plan. We should concentrate on the following areas:

- Publically owned facilities, including health provider settings, to be health promoting environments for adults, children & families.
- Increase accessibility of parks and green spaces to families and strategies that support active play.
- Publically owned buildings with facilities which ensure mums can breastfeed and policies to encourage shops and restaurants to be 'Breastfeeding Friendly'.

**3. Children and Young People**

3/10 children are entering secondary schools in Oxfordshire will be overweight or obese. Overweight children are more likely to become overweight adults; the younger that children become obese, the longer they are likely to be living with a risk factor such as coronary heart disease, stroke, type 2 diabetes and cancers. Children and young people who are obese will have lower levels of physical fitness, suffer from discrimination, and have low self-esteem and a lower quality of life.

**3.1 What are we doing now?**

- Oxfordshire Play Partnership has been successful in creating and promoting opportunities for children to enjoy active play
- Oxfordshire County Council (OCC) successfully commissions the NCMP programme, providing robust data and proactive feedback to parents and carers about their child's weight status.
- Responsibility for commissioning School Nursing has transferred to OCC and the Council will ensure that healthy weight management is embedded into the service specification and monitored from March 2014.
- District councils and school sport coordinators are supporting schools to make best use of the Pupil Premium for Sport & Physical Education (PE)

In 2010, 90% of schools had reached Healthy School Standard and 45% of children were doing at least 3 hours of high quality PE and out of hour's school sport in a typical week. However, as previously ring fenced funding for School Sport Partnerships and Healthy Schools has now transferred directly to schools and we do not have a clear picture of what local schools offer in or outside school hours. Schools are becoming independent of the local authority and universal prevention initiatives for school age children will be more challenging to fund and implement in the future.

**3.2 What more could be done?**

- Headmasters and school governor's to maintain and report status of the Healthy School Standard.
- Headmasters and school governor's to work with school health nurses to develop an annual healthy school plan and promote the national Change4Life initiative in discussions with children & parents.
- Schools should play particular attention to improving their physical activity offer, particularly to girls and other groups who are less likely to participate.

All partners regularly review their strategies, plans and services against NICE guidance and provide regular updates to the board as part of the healthy weight plan. We should concentrate on the following areas:

- Publically owned facilities, including schools & colleges, to be health promoting environments for children and young people
- Consult with children & young people to increase accessibility of leisure facilities, parks and green spaces
- Councils use saturation orders to prevent more fast food outlets being opened or trading near schools and colleges
- Use NCMP data more creatively to influence schools and local councils to improve the current offer of healthy food, physical activity, sport and active recreation to children and young people.

## 4. Adults

In Oxfordshire, 61.2% of adults reach Government recommendations for physical activity and we are the most active county in England. However, 22.2% of people do less than 30 minutes of activity a week and approximately 1 in 4 adults in Oxfordshire are obese, similar to the national average. Obesity increases with age, is strongly related to social deprivation and there are differences in the levels of prevalence across ethnic groups.

### 4.1 What are we doing now?

- We have a comprehensive care pathway for obese adults including a weight management referral hub and a range of treatment services
- All 40-74 year olds in Oxfordshire (who are not excluded from the programme) should be offered a Health Check by their GP every 5 years
- We have a range of community based physical activity initiatives, such as Go Active and Active Women in addition to the offer from leisure services

### 4.2 **What more could be done?**

- Men, older people and certain ethnic groups do not routinely access the services. We should continue efforts to support adults to maintain a healthy weight but respond more flexibly to differences in age, sex, social & ethnic background
- We could do more to promote or direct people to self-care and/or new online technologies to help adults manage their weight

However, as obesity is so difficult to treat and because children of obese parents are at greater risk of becoming obese themselves, we need to refocus our efforts on babies, children and families to prevent the cycle of obesity from repeating itself

## 5. Cross cutting themes including communications, local communities and workplaces

Local communities, workplaces and schools are where people live, work and spend most of their leisure time. Many of the services and initiatives discussed above are provided in these settings but there is more that could be done to:

- Engage local communities, workplaces and schools in the ambition to build health promoting environments and the development of local physical activity and healthy eating initiatives.

- Communicate clear and consistent messages about the importance of healthy weight management in addition to improving the marketing of existing programmes.
- Build the capacity of local communities, workplaces and schools to understand the importance of this agenda and support it in local plans and day to day activities.

**Examples to consider**:

- ➢ Developing a countywide communications plan for healthy weight including a set of key messages, a local brand and website information that all partners can align to.
- ➢ Continue to develop affordable active play opportunities, ensuring that there is sufficient space for children and young people to use, both indoor and outdoor.
- ➢ Encouraging schools to address their catering (including vending machines) and the food and drink children bring into school and healthy food policies encouraged by the National Healthy Schools Programme.
- ➢ Influencing transport planning, town planning and urban design to encourage more walking and cycling opportunities and easy access to affordable healthy foods.
- ➢ Ensuring that leisure facilities, parks and green spaces are accessible to all, offering a wide range of activities that are affordable and appeal to many different young people.
- ➢ Engaging with our own workforces to reduce obesity. For example, public sector workers account for nearly 1/3rd of the local workforce - tackling the obesity issue within this population would have a significant effect on our trends.
- ➢ Engage more with local communities to support the development of community initiatives such as “jog leaders” and “sport makers” and “learn to cook” sessions.
- ➢ Ensure that there is physical activity and healthy eating opportunities for all groups including those who are vulnerable, have long term conditions or have learning or physical disabilities.

## 6. Next steps

The aim of this paper has been to describe the current picture of obesity in Oxfordshire and to ask the Health Improvement Board to consider approaches to preventing obesity, building on work that is already underway. Our approach should prevent obesity, rather than treat it, as this will ultimately lead to a healthier population. This prevention approach will apply to the general population, but with a greater focus on babies and young children (primary school age) as this is when patterns of healthy eating and physical activity are formed. It is therefore an ideal age to introduce healthy behaviours that will last into adulthood.

The following table (Table 1) considers some of the key areas to be addressed in preventing obesity and some of the services that already have obesity prevention in their mandate. We ask that the Health Improvement Board use this table as a starting point to discuss how obesity prevention in Oxfordshire can best be taken forward, ensuring that all key stakeholders are engaged. An overarching framework will then be developed, to ensure that work is aligned across the sectors and that deliverables are achieved.

| **Table 1.** | **Healthy Eating** | **Physical Activity** | **Environment** |
|---|---|---|---|
| **General Population** | • Communications and media strategy to promote healthy eating and physical activity<br>• Linking to National campaigns<br>• Healthy Workforce strategies<br>• Planning – new developments and redevelopment, "Healthy Town" approach<br>• Leisure facilities, parks and green spaces | | |
| | • Primary Care prevention approach<br>• Healthy Hospitals and care settings | | |
| | Promotion and support of business selling local healthy produce over fast food chains | Green spaces in new and existing developments (particularly for psychosocial wellbeing) | |
| | Healthy eating strategy in workplaces | Creating a walkable environment | |
| | Engaging with local groups and training volunteers to deliver healthy eating/cooking sessions | Making cycling safer and more attractive (e.g. Cycle Lanes, 20mph limits, filtered permeability, priority at lights) | |
| | | Transport (e.g. more public transport to facilitate walking, alternatives to using the car) | |
| | | Living Streets (E.g. Summertown) | |
| | | Active travel strategy | Mixed use development (people can walk to shops, leisure centre, schools and work) |
| | | Engaging with local civic society groups e.g. Oxford Pedestrians Association and Oxford Cycle Campaign | |

<table>
<tr><th><u>Table 1.</u></th><th>Healthy Eating</th><th>Physical Activity</th><th>Environment</th></tr>
<tr><td rowspan="5">Children (Babies, Under 5’s and Primary School)</td><td colspan="3">• Communications and media targeted at children to counteract advertising from manufacturers of high calorie products<br>• “Healthy Schools” concept – pilot school(s) to implement innovative ways of addressing obesity</td></tr>
<tr><td colspan="2">• Midwives – preventing & managing obesity in pregnancy<br>• Health visitors – breastfeeding & early years interventions<br>• School Nurses – healthy schools<br>• Community paediatricians – primary care prevention approach<br>• Children’s Centres<br>• Early Years Hubs and Intervention Services</td><td></td></tr>
<tr><td>Limiting availability of fast food options for children at school and around school)<br>No vending machines with sugary drinks in school</td><td>Sports Clubs</td><td>Playgrounds/Activity areas for children</td></tr>
<tr><td>Restrictions on sponsorship by Big Food of children’s sporting events</td><td></td><td>Cycle lanes on school routes (backed up by safe cycle storage, cycle training at schools etc)</td></tr>
<tr><td></td><td>Active travel strategy for schools: i.e. public transport, walking and cycling to school</td><td></td></tr>
</table>

**Appendix 1**

**Healthy Weight Service Mapping: September 2013**

| Age | Service/Intervention | Type | Description/Size of programme | Partners | Type |
|---|---|---|---|---|---|
| Generic work across all age groups | Increase participation in physical activity, sport & active recreation | Prevention Exercise | Receive & distribute national lottery funding from Sport England – whole Oxon pop | Oxfordshire Sports Partnership | Partnership |
| | Encourage active travel through transport strategy | Prevention Activity | Cycling, walking use of public transport – whole Oxon pop | OCC | Partnership |
| | Health Weight Network | All | Provide overarching steer by co-ordinating work – whole Oxon pop | ALL | Partnership |
| | Change4Life campaigns | Prevention Exercise Eating | National Campaigns and initiatives – whole Oxon pop | PHE/LPH | Partnership |
| Pregnant women | Silver star specialist care for obese mothers | Treatment All | Specialist maternity care - approx. 800 preg women per year | OUHT | OCCG Commission |
| | Antenatal classes | Prevention Eating Exercise | Breastfeeding advice healthy eating in preg - approx 8000 preg women per year | OH/LPH | LAT Commission |
| Prenatal to 5 | Maternity Service | Prevention All | Maternity care includes supporting women to start & continue breastfeeding - approx. 640 per year | OH/LPH | OCCG Commission |
| | Health Visiting services | Prevention All | Parenting advice, weaning, breastfeeding advice and support to all - approx. 8000 families per year | OH/Children /LPH | LAT Commission |
| Birth to 18 years old | Community Breast feeding Support service in areas of deprivation | Prevention Eating | Specialist support to women in areas of deprivation – 900 babies per year | OH/LAT/ Children | OCC/LPH Commission |
| | Early Intervention Service and Social Care | Prevention All | Provides support to children at greater risk – unknown | Districts/ OCC/OH | OCC Provider |
| 1 – 3 years | HENRY Parenting Programme Programme | Prevention Eating | Healthy Eating & Nutrition in really young - approx 8000 families per year | OCC/LPH/ OH | LPH Commission |
| 1 – 3 years | Breastfeeding support, healthy eating policy, parenting programmes | Prevention All | Children Centres as healthy living champions | OCC | Commission/ Provider |
| 5 – 11 years | NCMP | Monitoring awareness | National Childhood measurement programme – 16,000 children per year | OH/Schools | OCC/ LPH Commission |
| 5 – 16 years old | School based PE & Sport offer | Prevention All | Exercise in schools provision all school children 5 – 16 | Schools/ Sports part | Partnership |
| | Pupil Premium for Sport & PE | Prevention All | National ring-fenced funding for primary schools | Sports part | Partnership |
| | School Health Nursing Services | Prevention Treatment All | Parenting advice, Healthy Eating & Exercise - all school children 5 – 16 | OH/Children /OCC | OCC/LPH Commission |
| | Reach4Health Programme | Treatment | Intensive programme to improve eating & exercise behaviours in families – approx. 150 – 200 families per year | OH/Children /OCC | OCC/LPH Commission |
| 5 – 16 years old | Free swimming for Children in Oxford City | Prevention Exercise | Offered during certain time periods, all children in Oxford City | District Councils | Commission |
| 3-16 years old | Oxfordshire Play Partnership | Prevention Exercise | Increasing opportunities for children & young people to enjoy active play | ALL | Partnership |
| 16+ | Bariatric Surgery | Treatment All | Surgical treatments for obesity Approx. 30 patients per year | OUH/RBFT/ More Life | NCB Commission |
| | Adult Weight Management Service | Treatment All | Intensive programmes to support weight loss –2000 patients per year | More Life | OCC/LPH Commission |
| | Dietetics Services | Treatment All | Individual referral from GP for those with LTC/Obesity | OH/More Life | OCCG Commission |
| | Exercise on referral | Treatment Activity | GP referrals to leisure providers | GP's/Sports part/District | Partnership |

| Age | Service/Intervention | Type | Description/Size of programme | Partners | Type |
|---|---|---|---|---|---|
| 16+ | GO Active | Prevention Exercise | Exercise programme which co-ordinates activity – whole Oxon population | Sports partnerships Districts | Commission |
| | Active Women | Prevention Exercise | Exercise programme which co-ordinates activity for women – whole female Oxon population | Sports partnerships Districts | Commission |
| | GO Active, Get Healthy | Prevention Exercise | Experimental exercise programme and motivational interviewing with focus on sedentary population. | Sports partnership LPH/ Brookes University | Commission |
| | Health Walks | Prevention Treatment Exercise | Walking initiatives to encourage non walkers to walk – whole adult population | Sports partnership Districts | Partnership |
| | Green Gyms | Prevention Treatment Exercise | Gardening initiatives – WODC, SODC areas | District Councils Vol | Partnership |
| | Health checks/Disease registers | Monitoring awareness | GP identification of obesity and treatment – Oxon GP registered population | OCCG/GP's /LPH | OCC/NCB Commission |
| 16 – 18 year olds | College Nursing Service for those in mainstream school | Prevention Treatment All | Personal advice and weight management advice – 16 – 18 yr olds at OCVC | OH/Children /LPH | OCC/LPH Commission |
| 65+ | Generation Games | Prevention Treatment All | Co-ordinating and development of older peoples physical activity Over 65 population of Oxon | Age UK/Leisure Providers/ Vol | OCCG Commission |
| | Leisure Services for Older Adults | Prevention Treatment Exercise | Exercise for the older person | Leisure Providers | District Commission |

**Key**

OCCG- Oxfordshire Clinical Commissioning Group

OCC- Oxfordshire County Council

GP's – Primary Care General Practitioners

PHE – Public Health England

LAT – Local Area Team of the NHS National Commissioning Board

LPH – Local Public Health in Oxfordshire County Council

OUHT- Oxford University Hospitals NHS Trust

OH – Oxford Health NHS Trust

RBFT – Royal Berkshire Foundation Trust

Vol – Voluntary Sector

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# Childhood Obesity Sounding Board Public Involvement Network (PIN) August 2013


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## Background

On behalf of Public Health, the Engagement Team asked parents and children their views about healthy eating; physical exercise; and what was helpful to them locally. We talked to parents at four Children's Centres and a Play Day, and got feedback from Asian women via Sunrise Centre in Banbury. Overall 73 women and 7 men took part – 23 were from Black and Minority Ethnic groups, and 12 were from families in the armed forces. We conducted an online survey of children and young people and received 100 replies, and engaged 13 children in discussion aged between 7 and 13 years from mixed minority ethnic backgrounds.

## Main Themes

### Healthy Eating:

- Generally there was a high level of awareness about the benefits of breast feeding
- Affordability featured strongly, with a perception that healthy food was more expensive and is more effort to prepare, and convenience food being fast and cheap
- Some people are lacking basic cooking skills and knowledge in nutrition
- Lack of time to cook healthy food and shop was an issue for working parents
- There is lack of information about portion sizes for young children
- Lack of availability of fresh food in disadvantaged areas
- Schools were thought to be very influential
- Make healthy eating messages 'cool' to change behaviours.

### Physical Activity:

- People want to be able to access local information about activities
- Lack of access to affordable indoor activities in winter
- More open access to clubs and activities to allow for budgeting
- Local parks were mentioned across the groups and well utilized
- Other physical activity e.g. dance should be available not just sport.

### Local support:

- Some people cited a lot of examples of groups and activities for children
- Some people were aware of groups and networks in their communities
- Children's Centres were seen as a strong source of support and advice
- Access to information and support was important for fathers too.

## Main Messages

### 1. Breastfeeding

Many women we interviewed breastfed their child, and a very small number just didn't want to do it and found bottle feeding more convenient. Obstacles included pain/baby unable to latch on. Some felt unsupported to manage bottle feeding. *"I feel guilty around not breastfeeding but there wasn't enough good support and information". "It's hard to get advice about bottle feeding if you are unable to breastfeed."*

- **Weaning:** Increased budgeting for food was a consideration. A positive aspect was bottle feeding means dads can be involved. Many women mentioned the Annabelle Carmen website for giving good ideas as a starting point for weaning. *"The amount of my food shopping has doubled since weaning started and lots of fruit and veg are expensive."*

- **Baby cafés**: Children's Centres hosted these and they were mentioned a lot, were much appreciated and seen as a good resource.

- **Children's Centres**: Children's Centres mentioned very often as a source of support and advice, either by offering Peer Training and support for breastfeeding, or trained staff to offer support.

- **Health visitors:** Some women said health visitors were helpful, but a high number of mothers we spoke to didn't feel supported by their health visitor to breastfeed. Inconsistency of staff meant they couldn't build a relationship with them and feel confident, and there was inconsistency of advice from different health visitors. Several women said they felt unsupported and were told to "just keep trying". *"As a young parent I didn't get any help from Health Visitors and I didn't have the confidence to try it." "The Health visitor just hands out leaflets."*

- **Hospitals:** Although some women felt unsupported at hospital, many women said there was not enough support or encouragement and the maternity ward was rushed and midwives didn't have enough time. *"I wanted to breastfeed but had no support in or out of hospital." "When I was in hospital staff didn't have the time to show me how to breastfeed".*

## 2. Early Years

### 2.1 Healthy Eating

Many people were motivated to want to try to give their children a healthier diet, but barriers such as knowledge, cost and availability made it difficult for some. *"Most people know what's healthy – it's easier not to, and there are cost implications."*

- **Knowledge**

  People reported there is lack of information about portion sizes for children, and parental anxiety about children who are fussy eaters was common. *"I wouldn't know about a healthy target weight if I didn't have a childcare background." "Media give the problems but not the solutions e.g. we need pictures of what they should be eating at certain ages."* The Annabelle Carmen website was frequently mentioned which produces healthy convenience baby food ideas and cook books for toddler/baby food. HENRY courses run out of the Children's Centres were frequently mentioned as *helpful "HENRY course was very informative in raising awareness about ingredients."* The Children's Centres were particularly helpful resources for information and support, and knowing the staff at the Children's Centres is important, as it feels very comfortable to ask questions and seek advice.

  Health Visitors are a good source of advice. Healthy Start Vouchers were useful and provide recipes and advice. There was general agreement that children eating healthily depends on what children see parents eat and what they get used to, and that pre-school parents have good level of control over what food their children eat.

- **Cost**
  There was a widespread perception that healthy food is more expensive than convenience food. People use frozen vegetables as fresh are too expensive.
  *"All my money goes on childcare and food." "Fresh fruit is more expensive."*

- **Availability**
  Lack of variety of fresh food in local shops, especially in deprived areas, leads to people shopping at stores that stock unhealthy food but will deliver a large shopping order. They said unhealthy food/junk food is always on promotion in supermarkets - not fresh or healthy food.

### 2.2 Physical Activity

Some parents of young children did not feel physical activity was an issue as their children are already really active and *"always on the go".* Those parents who were already active tended to think family exercise was very important e.g. games, walks, swimming. Soft play centres were important especially in winter, and small community groups e.g. Twinkle Toes dance sessions in Barton. There often was not a shared knowledge of what was available in the local communities; some people did not use the community centres and therefore did not read the notice boards, or use the internet. *"Should have information up in Tesco's or Boots rather than GP surgeries. Not everyone goes to the doctors - especially dads"*

Many said there is not enough information about activities for the under 4's. Peer support groups were valued such as Slummy Mummies in Witney an informal support group doing affordable activities together. Also mentioned was an International group *that* *"is very friendly, more so than other groups, and the women are more open."*

## 3. School Age

### 3.1 Healthy Eating

***Parent's responses***

- **Convenience**
  Many people thought if parents are faddy eaters, then the children are more likely to be *"It's so much easier to use convenience food." "Some children graze all day on crisps and then don't eat a healthy meal in the evening."*

- **Cost**
  Many people said they believed healthy food costs more than junk food, and they couldn't afford it *"Fresh fruit and vegetable are more expensive". "Financially it's very difficult to provide fresh veg and fruit, I do try but not so easy even though I know I should, and I try when I can, like apples sometimes."*

- **Knowledge**
  A family culture of home cooking was said to be very helpful as this knowledge and skills gave people the confidence to experiment to get children to eat healthily *"You have to be creative and make the food attractive or blend it (even roast dinners)."* Quite a few people said they lacked the basic cookery skills *"Not everyone knows how to cook healthy food from scratch."* Others said *"We get mixed messages about what is good, like dairy: it used to be good, but now it's fattening."* More help with reading and understanding food labels, and information in different mediums and languages was mentioned by British Pakistani women. Some women who spoke English as a second language were not aware of information sent via schools; did not access the internet or know the nutritional values of their traditional food.

- **Schools**
  Many parents agreed that peer pressure is a factor from their children's' friends at school. They thought schools are very influential and said:
  - Fizzy drinks shouldn't be allowed in schools
  - When children get to secondary school the food rules are much more relaxed, they should do more
  - "One treat" lunchbox policy was very helpful
  - The Healthy Schools Initiative and Healthy Schools Team were good, and involved children
  - Schools could run sports clubs for children and parents at weekends and evenings.

- **Control over choices**
  When eating *out "Kids meals in (especially family) restaurants are fast food, like chicken nuggets and chips - could do with mashed veg or veg sticks as options".*
  For separated parents there is lack of knowledge/control about what the other parent is feeding the child.

- **Temptation**
  *"There is too much food and choice"* in shops and the junk food is promoted more than the healthy food. Junk mail about fast food through the letter box makes it hard for parents to resist "pester power" and this is especially difficult for single parents.

***Children and Young People's responses:***

Children and young people said parents, grandparents and friends help them to eat healthily, and they eat unhealthy food as snacks when they are hungry. Most said their area could be improved by having healthy foods to choose from in the local shops. Some said the media does influence by advertising unhealthy food on TV and in magazines.

- **Choices**
  The majority said they ate healthy food because it is good for them and they like the taste. They said they ate junk food because they like the taste and it is cheap and accessible. Nearly a half said they only have it sometimes as a treat.

- **Influences**
  **Who**
  - Examples of ill health linked to obesity in the family
  - Influence of parents, especially mothers either because they were dieting themselves, or they strongly promoted healthy diet
  - brothers and sisters influence what they eat because it is hard to stick to a diet when other people are eating something different like junk food
  - Schools - health days
    - learning about it in science lessons
    - food pyramid
    - tutorial information
  - Other adults – doctors/people at the gym. Only a few said youth clubs and other clubs for young people.
  - Friends

  **What**
  - Cost - A third of comments were about the cost of healthy food. *"Didcot Girls School make all the unhealthy nicer food more expensive, so I can only buy healthy food".*

  **How**
  - Knowledge gained from someone at home or the school, and a third from the internet. They also cited personal development nurses at school, TV and health magazines, doctors, and people from the gym.
  - Availability depended on what food parents chose to buy
  - Taste - *"if they made it cheaper, and made it taste better and look more appealing".* Even those who eat healthy meals said they eat unhealthy snacks when they are hungry.

- **Ideas (Children and Young People)**
  Designing a game to teach about healthy eating; posting messages about healthy eating on social media; the after school club selling healthy food; school providing more vegetables and salads; cooking more often at home and school; make a healthy eating page with pictures on Facebook; have a fun day and give out free food like fruit. Some said have more opportunities to learn about healthy food and how easy it actually is to prep and cook.

### 3.2 Physical Activity

***Parents Responses***

- **Resources**
  Local parks and play areas were mentioned across the board and well utilized, as were swimming pools although some people thought the learner pools are too small for the population. Leisure centres clubs and cycling were popular.

- **Cost**
  People said Leisure Centres are seen as expensive, and they would prefer that clubs are open access, to allow drop in when they can afford it. Parents don't want to pay for terms, and do want more ad hoc sports and activities for kids to just turn up and play.
  *"Tasters in sports and activities would be good so you don't have to commit to a whole term and then decide they don't like it."*
  Swimming was very popular, and many people suggested free swimming lessons should be on offer. *"After school fitness clubs would be good."*

- ***TV/screen time***
  An extremely common theme was that children don't want to leave the TV/electronic devices to go outdoors and play, and a lot of persuasion from parents is needed. Some parents' restricted time spent watching the screen, others found it a struggle.

- ***Seasonality***
  Very many people said there is a lack of indoor free activities in winter to keep the children active as it is too cold and wet to be outdoors a lot. They would welcome the equivalent of summer play schemes in winter. Affordability of indoor activities was an issue for many, especially large families.

- **Alternatives to sport**
  Some children do not like doing sport, and sometimes finding any other sort of physical activity for them is difficult locally and costly.

***Children and Young People Responses***

Approximately half said they spent between 30-60 minutes being active per day. About a quarter did less, and about a quarter did more. 22 people did not answer.

**Who Influences**

A social element to activity is important for motivation for many. *"If my friend goes out for a jog I will as well, but I wouldn't go out on my own."*

- A major influence on the amount of physical activity was friends. Family including parents also had an influence, especially where the family did activities together.
- Schools especially through sports clubs. *"Stricter PE teachers, more clubs."* Also walking to school.
- National schemes such as Duke of Edinburgh Award

**What Influences**

- Events - sports, fun, play and activity
- Knowledge – what different sports and events are available, and alternatives to sport e.g. dancing
- Facilities such as public parks, skate parks, leisure centres.
- Cost of gym, swimming etc. can be prohibitive

**Where**
Half said local activities and clubs helped and half said they didn't. People wanted to use facilities nearby.

- Local clubs: school & after-school clubs, sports clubs and Brownies.
- Informal community or friendship activities. *“Football with friends, dancing, acting and singing and swimming with mum sometimes.”*

**How**

- Websites
- Posters advertising events and giving advice
- Social media: Only a third said the social networking sites affected exercise or healthy eating

**Ideas for improvements**

- Social networking- games e.g. for club penguin; videos including age appropriate workout routine; recipes e.g. for healthy snack; ads for fun days or free sports trials. Pop up ads e.g. showing how sitting at computer is unhealthy. *“Making it cool”*
- Free taster classes.

**Media influence**
Ten people found the Change 4 Life website helpful. Very few people said social media had any influence on them. Some parents remarked that the media affects young people's image of themselves as they see famous people very slim and want to be like them, and they are self-conscious about their bodies so they don’t want to go swimming or do other activities.

## 4. Adults

This engagement exercise was in the context of how adults help and influence children to be healthier rather than focusing on adults themselves.

### 4.1 Healthy eating

- **Lack of time**
  This featured strongly for working parents who say they don't have the time, and it’s difficult for working parents to produce quick healthy food. Many working women said they are too tired after work and then driving the children to their clubs which after which there is no time to shop and cook.

- **Knowledge**
  Frequent comments were made on the need for a central place to find the up-to-date information people need to support a healthy lifestyle.

- **Ideas**

People put forward suggestions they thought would help:

- Ideas of simple meals that take a short time to prepare or prepare in advance
- Kid’s cookery club. Parents cooking with their children and inspiring them
- An award to pubs that serve healthy children’s food
- Demonstration cooking and classes to help those who have never cooked

- Cooking classes in local areas for Asian and Western food
- Demonstrate to parents how to make food fun e.g. sandwich shapes
- Advice on planning menu's ahead of time and on shopping
- Advice on buying on offer and bulk freezing
- *"Don't talk at people"* – you need interactive sessions and to be able to try or experience stuff e.g. strawberries as a pudding or dessert

### 4.2 Physical Activity

- People generally agreed that children were influenced by the level of enthusiasm for exercise and physical activity undertaken by their parents
- Active families encouraged their children to do a range of activities
- Many of the less well-off parents only mentioned walking as their activity and no other form of activity. It was suggested that lack of confidence to carry on an activity after an organised course, and being self-conscious were factors that prevented people sustaining activity
- The British Pakistani women said they did very little physical activity and the men in the family did more activities with the children.

- **Knowledge**
  Information about local activities was not thought to be easy to find out about, some people knew of small activity clubs that only advertised by word of mouth. People said there was a need for some way in which communities could find out what was available locally.

- **Ideas**

Schools could run sports clubs for children and parents at weekends and evenings

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Oxford University Hospitals NHS
NHS Trust

**Trust Board Meeting: Wednesday 11 September 2013**

**TB2013.110**

| **Title** | **Development of a Public Health Strategy for OUH NHS Trust** |
|---|---|

| **Status** | For approval |
|---|---|
| **History** | 22 Aug 2013: Paper to Trust Management Executive meeting |

| **Board Lead(s)** | Andrew Stevens, Director of Planning and Information | | | |
|---|---|---|---|---|
| **Key purpose** | **Strategy** | Assurance | Policy | Performance |

## Executive Summary

1. Oxford University Hospitals NHS Trust (OUH) is the primary provider of acute health care services to the population of Oxfordshire, but it has the ability to play a much wider role in improving the health of this population.

2. The purpose of this paper is to seek the approval of the Trust Board to develop a public health strategy for 2014/15 for OUH, jointly with Oxfordshire County Council (OCC) – the responsible body for public health in the County.

3. OUH employs over 11,000 staff and has around 1 million patient contacts every year. The Trust is therefore ideally placed to promote healthy lifestyles and improve health at a population level.

   OUH is committed to working with partners to shift care out of hospital settings where appropriate. However, the economic climate and demographic change dictate that the growing demand for health care services is addressed.

   A public health strategy for OUH would demonstrate innovative commitment to improving the health of the population of the county and thereby also to reducing the demand on local health services through the prevention of ill health. It will strengthen links with OCC and build on strands of public health work already happening at OUH.

**Recommendation**

The Trust Board is asked to consider and approve this proposal to develop a 1 year public health strategy for OUH, jointly with OCC, for 2014/15. Also to approve the submission of the suggested Statement of Intent to OCC Health Improvement Board.

**Development of a public health strategy for Oxford University Hospitals NHS Trust**

## 1. Purpose

1.1. The purpose of this paper is to seek the approval of the Board to develop a public health strategy for 2014/15 for Oxford University Hospitals NHS Trust (OUH), jointly with Oxfordshire County Council (OCC) - the responsible body for public health in Oxfordshire. Also to approve the submission of a Statement of Intent to develop this strategy to the OCC Health Improvement Board (the suggested statement is included as Appendix A to this paper).

## 2. Background

2.1. OUH is the primary provider of acute health care services in Oxfordshire, but it has the potential to play a much broader role in improving the health of this population.

2.2. Financial pressures on the NHS are predicted to grow at around 4% a year over the next decade, due to rising demand for health care to meet the needs of a growing and ageing population that is experiencing more chronic disease, and to the increasing costs of providing health care[1]. The economic climate dictates that a new approach is needed if the NHS is to remain sustainable, providing high quality health care free at the point of delivery.

2.3. In line with national policy ambitions, OUH is committed to working with partners to shift care out of hospital and into the community where this is appropriate for patients. However, the Trust also has an important role to play in addressing overall demand on the local health care system through the prevention of ill health. Increasing numbers of people are admitted to hospital with chronic diseases, which are in large part preventable through healthy lifestyles and behaviours.

2.4. With more than 11,000 staff and around 1 million patient contacts each year, OUH is ideally placed to promote healthy behaviours and improve health at the population level, and consultation on the Trust's strategy in its Integrated Business Plan stressed the organisation's role in the wider public health agenda.

2.5. The Department of Health has stated that hospitals have a responsibility to promote healthy behaviours, and are encouraging them to sign up to their Responsibility Deal, thereby committing to actions to improve public health.

## 3. Main paper content

3.1. The health challenges facing Oxfordshire, which are increasing demand for health care locally, are consistent with national patterns:

- an ageing population needing support to maintain their health and independence;
- inequalities in health, with discrepancies in life expectancy between the least and most deprived areas of 6 years in males and 3 years in females[2]; and
- a large burden of preventable disease, attributable to obesity, poor diets, low levels of physical activity, alcohol misuse, and smoking.

3.2. The OUH workforce is exposed to the same preventable risk factors for disease as the rest of the population, and if representative of the national population, around 7,000 staff will be overweight or obese, and more than 2,000 will be smokers. Priority

[1] Roberts et al (2012) A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22. London: The Nuffield Trust.
[2] Association of Public Health Observatories (2012) *Health Profile 2012, Oxfordshire.* Public Health England.

health needs identified through the OUH staff survey include mental health and musculoskeletal health.

3.3. A healthy workforce is essential to a successful hospital, through reduced sick leave and also more broadly. Staff health affects patient experience, patient safety, and clinical outcomes[3]. Improving staff health thereby also improves patients' health. Helping staff improve their own health behaviour will also enable and empower them to deliver health improvement messages to patients and visitors.

3.4. In many cases, the quality of treatment provided is only one among many determinants of the outcome of that treatment. Improved health behaviours in patients will maximise the long-term outcomes of their treatment and can contribute to preventing them from returning to hospital.

3.5. The Trust's reach for promoting healthy behaviours and preventing ill health is very wide, extending to the families of staff, patients, and visitors, plus the local community, in which it has a prominent position. The potential for an impact on the health of the community is therefore high.

<u>Developments to date</u>

3.6. Various strands of public health activity, described below, are currently on-going at OUH. An overarching public health strategy for the Trust would help to draw these together where appropriate and ensure activities are complementary and synergistic. The various groups would all be involved in the development of the strategy and in its delivery. OUH currently has a small team of public health registrars on placement, working under the Director for Planning and Information.

3.7. OUH has engaged with OCC on public health, and contributed to the development of their County-wide Health and Wellbeing Strategy. OUH shares OCC's strategic objective of improved health and wellbeing for the people of Oxfordshire, and is committed to partnership working across the county. Jointly producing a public health strategy for OUH with OCC will ensure that the strategy is complementary to ongoing public health programmes throughout the county.

3.8. OUH has an internal Health and Wellbeing Board (HWB) and a Centre for Occupational Health and Wellbeing which have a health and wellbeing strategy for staff. We are proposing to develop a broader OUH public health strategy, which encompasses staff, patients, visitors, as well as the wider community over the longer-term. The HWB will be key to the delivery of this overarching strategy and will be closely involved throughout its development.

3.9. OUH is currently piloting Making Every Contact Counts (MECC) schemes at the Nuffield Orthopaedic Centre musculoskeletal unit and the Horton maternity unit. MECC is a national initiative to train frontline staff to deliver brief interventions to patients and visitors to promote healthy behaviour change and signpost to appropriate local services. In doing this, the scheme also empowers staff to make positive changes to their own behaviour.

3.10. The Health for Healthcare (H4H) group is a bottom-up organisation of junior doctors, physiotherapists and nursing staff, currently engaged in stand-alone activities aimed at improving health for staff, patients and visitors. The Deputy Medical Director is the senior representative for this group.

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[3] Department of Health (2009) *NHS Health and Well-being. Final Report*. London: DH.

Proposed next steps

3.11. With the approval of the Board, we will take forward the development of a 1 year public health strategy for OUH. We would aim to produce an initial strategy for 2014/15 which builds on much of the work already underway at OUH. Once in place, we propose to develop a long-term strategy with mid- and long-term objectives. This long-term strategy will be developed through wide consultation with stakeholders during 2014/15.

3.12. Following approval of the Board, the next steps in the development of the 2014/15 OUH public health strategy will be:

| | |
|---|---|
| Sep 2013 | Submission of a Statement of Intent to develop an OUH public health strategy to both the OCC Health Improvement Board (part of the OCC HWB) and the OUH HWB, to formalise initial discussions, and gain the commitment of OCC to jointly develop and implement the strategy. The proposed Statement is included as Appendix A to this paper for the Board's approval. |
| Sep 2013 | Development of a draft OUH public health strategy for 2014/15 that builds on on-going work at the Trust. This will be informed by scoping work already completed, and by initial discussions with partners to date. |
| Sep-Oct 2013 | Consultation and development with key internal and external partners, including: OUH HWB, OCC Department of Public Health, OUH Trust Management Executive Team, plus wider interested hospital/ health groups. |
| Jan 2013 | Submission of the proposed 2014/15 strategy to the OUH Board for consideration. |
| 23 Jan 2013 | If approved by the Board, submission of the proposed 2014/15 strategy to the OCC Health Improvement Board. |
| Jan-Mar 2014 | Planning and implementation, including development of an evaluation plan and baseline data collection. |
| Apr 2014 | Commencement of OUH public health strategy |

3.13. One objective of the 2014/15 strategy will be the development of a longer-term public health strategy for OUH. This will be a 12 month process, involving identification, with key partners, of a long-list of potential priorities and aims for 2015/16, the mid-term (3-5 year), and long-term (10 year). This will then be taken through an extensive consultation process including key internal and external partners listed above, plus wide public consultation through patient groups, community groups, OUH members and the OUH website. A comprehensive list of the types of themes and interventions that a public health strategy could incorporate is included as Appendix B.

Risks

3.14. Although OUH currently has public health registrars on placement, this resource is not guaranteed over the longer-term. Producing the strategy jointly with OCC will ensure external support through the Director of Public Health for Oxfordshire and their team, but internal resource with the appropriate specialist skills will need to be developed over the coming 12 months to ensure the delivery, evaluation, and long-term sustainability of the strategy.

3.15. While the OUH Health and Wellbeing team will be key to the delivery of the staff-facing aspects of the strategy, the structure for delivery of public and patient aspects will have to be determined and developed. An internal public health resource will be key to this.

## 4. Conclusion

4.1. OUH has an important role to play in the improving the health of the population of Oxfordshire, which is broader than provision of acute health care services. A public health strategy for OUH would demonstrate innovative commitment to improving the health of the population of the county and thereby also to reducing demand on local health services.

4.2. In jointly developing and owning the strategy with OCC, links between the two organisations will be strengthened. Joint ownership will also provide external support and help ensure that the OUH public health strategy complements the wider health and wellbeing strategy for Oxfordshire.

4.3. Several areas of public health activity are already happening in OUH. An overarching public health strategy for the Trust would build on and provide a link for these strands of work.

4.4. This paper recommends that the Board considers and approves the proposal to develop a 1 year 2014/15 public health strategy for OUH, and submission of a Statement of Intent to do this to OCC Health Improvement Board (suggested statement included as Appendix A to this paper).

## 5. Recommendation

5.1 The Trust Board is asked to approve this proposal to develop a 1 year public health strategy for OUH, jointly with OCC, for 2014/15 and to approve the submission of the suggested Statement of Intent to OCC Health Improvement Board.

**Andrew Stevens**
**Director of Planning and Information**

**Paper authors:**
**Dr Adam Briggs and Dr Louise Marshall, Specialty Registrars in Public Health**

**14 August 2013**

**Appendices:**

A. Draft Statement of Intent to develop a public strategy for OUH

Proposed for submission to OUH and OCC Health and Wellbeing Boards

B. Public Health Framework

A list of potential themes and interventions which a long-term public health strategy for OUH could include

## APPENDIX A: Draft Statement of Intent to develop a public strategy for OUH

### Development and implementation of a Joint Public Health Strategy between Oxford University Hospitals NHS Trust and Oxfordshire County Council

*Statement of intent for discussion at Oxfordshire County Council Health Improvement Board*

The Oxford University Hospitals NHS Trust (OUH) is the primary provider of acute clinical services to the population of Oxfordshire. OUH employs over 11,000 people, the majority of whom live in the county, and it has approximately one million contacts with patients every year.

OUH seek to develop a Joint Public Health Strategy with Oxfordshire County Council (OCC) to improve the health of OUH employees and the health of the patients, families and communities they serve. OUH wish for the development and implementation of this joint strategy to be accountable to the OCC Health Improvement Board, to whom OUH and OCC will periodically report performance against pre-set targets.

It is intended that the Joint Public Health Strategy for 2014/15 will be written and agreed by January 2014, and one objective of this will be to jointly develop a longer-term strategy from 2015/16 which will include short-term (1 year), medium-term (3-5 year), and long-term (10 year) goals.

*Oxford University Hospitals NHS Trust, August 2013*

## APPENDIX B: Public Health Framework

### Wider potential scope of public health in an acute trust

A living document consisting of a comprehensive contents list of interventions that may improve the health of acute hospital trust staff and the population they serve (tailored to OUH). From this, specific locally relevant objectives for an OUH public health strategy can be developed and agreed. This list is not-exhaustive and can be progressively added to.

Internal facing interventions predominantly affect the staff of the trust, and external facing interventions affect patients, visitors, and the wider community.

### Key documents

Implementing NICE PH guidance for the workplace – NICE, 2012
Workplace Wellbeing Charter – Dame Carol Black, 2011
NHS Health and Well-being. Final Report – Steve Boorman, 2009
Working for a healthier tomorrow – Dame Carol Black, 2008
Standards for Health Promotion in Hospitals – WHO Europe, 2004

### Abbreviations

OH Centre for Occupational Health and Wellbeing
H4H Health for Healthcare
*Bottom-up organisation consisting of junior doctors, physiotherapists, and nursing staff. Currently engaged in stand-alone activities relating to improving health for staff, patients and visitors.*

### Coding for internal facing policy:

Underlined: Initiatives currently/historically in place (OUH/H4H/other (OUH unless stated otherwise) – these do not imply anything re sustainability or degree of implementation/ effectiveness of the intervention)

*Italics*: Other potential initiatives (from NICE recommendations or examples from other organisations – unknown if in place at OUH)

## 1. Internal

### 1.1 Health protection

1.12 Vaccinations

Influenza, Hep B, others as required

1.13 EPP and BBVs

1.14 Infection control for staff, personal protective equipment

1.15 Staff sickness policy

1.16 Needle-stick policy

1.17 Other occupational hazards policy (eg dermatitis)

### 1.2 Health promotion

1.21 Health behaviours/ multi-theme

Development of H&WB Champions

Training people in brief interventions for alcohol, smoking, nutrition, physical activity (e.g. RSPH qualifications in *Understanding Health Improvement* and *Brief Interventions*)
Education and promotion – posters, induction, newsletter, e-newsletter, trust website, intranet
Employee health checks
Healthy Hospital Day (OUH, H4H)
Annual generic health promotion events

1.21 Mental health

Stress and mental wellbeing policy
Staff awareness of rights/expectations
Identification of mental ill-health/awareness training
Stress management/risk workshops (aimed initially at managers)
Counselling training (OUHT staff have access to counselling)
Managerial training and support for mental ill-health
*Flexible working*
*Equality of opportunity (part time staff, shift workers, migrant workers)*

1.22 Musculoskeletal health

Fast track physiotherapy service
Manual handling training
Workplace ergonomic aids

1.23 Obesity

External weight management programme
OUH referral to dietician
*Estates and building design*

1.24 Nutrition

Catering operation group to oversee the management of catering in the trust
Sign up to Healthy Food Mark
Free fruit available on the ward to staff and patients (H4H)
Healthy eating options in staff canteen/vending machines
Restaurant user group
*Catering facilities, vending machines, hospital canteens/shops offering healthy choices as the 'norm' at affordable prices (health product, prominent placement, affordable price, health promotion)*
*Pricing policy on fruit and veg*

1.25 Physical activity

Annual rounders competition, plus rounders equipment available to borrow
Installation of outdoor table tennis tables outside OHWB department
Lunchtime walking clubs
Workplace cycle purchase schemes
Swimming classes for beginners
OCC bike hire
Footpaths/cycle lanes
Power walking
On site Pilates
Health walks
OUHT travel plan and access to parking permits to encourage PA

Provide sufficient staff showers and lockers
*Staff gym/discounts for OUH staff for local gyms*
*Access to bike maintenance (free labour for staff)*
*Fitness trails in hospital grounds*
*Incentives for active travel through travel expenses*

1.26 Alcohol

Workplace staff drug and alcohol policy
*In-hours alcohol services and signposting,*

1.27 Smoking

In-hours staff smoking cessation services and signposting
Commitment to smoke-free hospital site

1.28 Sexual health

*Signposting to sexual health services*
*Access to condoms*

1.29 Flexible work/NHS T&Cs

Childcare vouchers, on-site crèche, flexible working

**1.3 Health surveillance and health intelligence**

1.31 Staff surveys

NHS staff survey and needs assessment based on this
OHWB department designed staff survey
*Counselling reports*

1.32 Sickness absence

Support for long-term sickness absence, rehabilitation, staggered return
Hot-spot analysis of staff sickness absence

1.33 Cost data

1.34 NHS smartcard

*For storing electronic staff record data (NHS Lincolnshire example)*

1.35 Facilities use

*Audit of canteen purchases*
*Audit of active travel/stair use*
*Audit of use of OH services*
*Evaluation of uptake of brief intervention courses*

1.36 Other internal and external assessment

Bi-annual NICE public health workplace guidance audit
*Workplace Wellbeing Charter Self-Assessment Standards*

**1.4 Cross sector themes and ideas**

1.41 Research

*Utilise link with Universities - research into physical activity/ nutrition/ public health/ behaviour change*

1.42 Transport infrastructure

*Organisation travel plan with public health as a driving theme*

1.43 Sustainability

Link with transport policies
Ward based recycling
*Make recycling the default for all trust areas*
*Promotion of reducing electricity use (turning off computers/ screens/ lights/ reduce printing etc)*
*Teleconference/Skype where possible to avoid unnecessary travel*
*Promote working from home for staff groups where this is possible*

1.44 Organisational values

*Make link in organisational values between patient outcomes and staff H&WB*
*H&WB of staff in induction and job plan of all managerial staff/staff appraisals, including discussion of health champions*

1.45 Other trust sector areas for benefit – recruitment and retention, quality and productivity, capacity and capability of the workforce, efficiency savings

## 2. External

### 2.1 Health protection

2.12 Infection control, policies surrounding outbreaks etc.

2.13 Advice to visitors surrounding infectious diseases

2.14 Notify statutorily notifiable infections to Thames Valley Public Health England Centre in order to carry out public health actions

2.25 OUH provision of screening services

2.26 OUH provision of sexual health services

### 2.2 Health promotion

Health promotion days (OUH/H4H), with links to external national events (e.g. No Smoking Day, Alcohol Awareness Week etc…)
MECC and brief intervention training (2.24)

2.21 Obesity

Brief interventions in all clinical areas

2.22 Physical activity

Information/education for patients and visitors
Estates/infrastructure designed around active travel/PA
Highlighting use of stairs rather than lifts

2.23 Nutrition

As per internal facing regarding canteens/shops and vending machines
Encourage labelling of healthy food
Appropriate nutrition to patients
Free fruit on wards (H4H)
Breastfeeding promotion

2.24 MECC/brief interventions

Staff training in brief interventions inc. train the trainer models for sustainability

2.25 Alcohol

Alcohol advisor in A&E
Signposting to alcohol services

2.26 Smoking

NRT prescribing to patients
Enforcement and example setting for no-smoking hospital sites
Brief interventions and signposting to smoking cessation services

**2.3 Health surveillance and health intelligence**

2.31 Evaluation of MECC/brief interventions

Process and outcome framework being developed/in place

2.32 ICT/outbreak surveillance

2.33 Facilities use

Audit of food purchasing at canteens
Audit of stairs use/active travel

**2.4 Cross sector themes and ideas**

2.41 Transport and environment

Development of active travel routes
Cycle parking
Bus connections
OCC cycle hire scheme
Access to green space

2.42 Sustainability

Recycling facilities in all areas
Reducing unnecessary patient journeys
Reduce printing
Sustainability and public health in all capital/estates projects

2.43 Research

Improve links between University research units investigating public health and patients/visitors

2.44 Employment generation

Encourage local people to work at trust
Youth access/apprenticeship schemes
Skills development with links to local educational institutions

2.45 Local education

Using staff to outreach to local schools and communities for health promotion activities and to enable access to careers in the NHS
Share Trust public health knowledge locally, regionally, and nationally

2.46 Goods and services procurement

Source supplies locally from businesses that pay staff a living wage to promote local employment and reduce carbon through small transport distances

2.47 Partnership working with Oxford Health and Oxfordshire County Council

Particularly demonstrate how OUH can link with Joint Health and Wellbeing Strategy priorities. Specific priorities which strongly tie-in are - priority 1: all children have a healthy start in life and stay healthy into adulthood; priority 5: living and working well; priority 6: support for older people; priority 7: improving quality and value for money in the Health and Social Care system; priorities 8-10: health improvement

2.48 Partnership working with Oxford Universities – students, academics, teachers

2.49 Promotion of strategy and demonstrable commitment on website, newsletter, posters etc.

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**Development and implementation of a Joint Public Health Strategy between Oxford University Hospitals NHS Trust and Oxfordshire County Council**

*Statement of intent for discussion at Oxfordshire County Council Health Improvement Board*

The Oxford University Hospitals NHS Trust (OUH) is the primary provider of acute clinical services to the population of Oxfordshire. OUH employs over 11,000 people, the majority of whom live in the county, and it has approximately one million contacts with patients every year.

OUH seek to develop a Joint Public Health Strategy with Oxfordshire County Council (OCC) to improve the health of OUH employees and the health of the patients, families and communities they serve. OUH wish for the development and implementation of this joint strategy to be accountable to the OCC Health Improvement Board, to whom OUH and OCC will periodically report performance against pre-set targets.

It is intended that the Joint Public Health Strategy for 2014/15 will be written and agreed by January 2014, and one objective of this will be to jointly develop a longer-term strategy from 2015/16 which will include short-term (1 year), medium-term (3-5 year), and long-term (10 year) goals.

*Oxford University Hospitals NHS Trust, August 2013*

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**Public Involvement Network Report for the Health Improvement Board**

**New Representatives**
An application and interview process took place and there was an excellent response. Following the recommendation of the PIN Review, two new reps were selected for each of the partnership boards. For this board the reps are Paul McGough and Aziza Shafique.

Introducing Paul McGough:
Paul has a biosciences and healthcare background (BSc honours degree in nutrition from London University - followed by a main career in marketing and communications). Paul has worked in industry in both strategic and operational roles - In recent years he has increasingly got involved on a voluntary basis in patient advocacy and public and patient involvement and engagement consultations with Oxford University Hospitals NHS Trust and workshops within the Oxford Academic Health Science Network. In his new role as PIN lay representative he's looking forward to focusing on health and wellbeing in the wider community setting. He knows it's important to ask the right questions, in the right way, to be approachable so that people feel comfortable to express their views, concerns and ideas... and for him as one of the PIN lay reps to capture the feedback. Paul feels the HIB will be a fertile ground for him to put his experience and life's healthcare passion to good use. He believes strongly in the value of "a big public voice" particularly when shaping health improvement strategy. He says the exciting challenge is to find new ways of get the public to buy into and take greater personal ownership of their health - motivating everyone to stay active (physically and mentally) and shift attitudes and lifestyle behaviour where possible - he's really looking forward to working with new colleagues and partners in Oxfordshire across many of these areas.

Introducing Aziza Shafique:
I am interested in Health Improvement Board because of both personal and professional experiences. I am a carer for my son who has rare genetic disorder called Galactosemia and my mother in law who has Alzheimer's disease and a regular user of Health services in Oxford. As a Youth and Community Development worker for 26 years I have a wide range of experiences in working as a volunteer and paid work. I feel that the ethnic minority communities are underrepresented and face many social issues such as, poverty, low educational attainment levels and social deprivation. Poverty and low socio-economic status have a profound effect on both adult's children's physical and mental health which has a detrimental effect on family circumstances. In my current role is that of a Project Co-ordinator for the Oxfordshire Cultural Parenting project with Core Assets Childrens Services.
I am passionate about making a positive and lasting difference to families and my involvement Health Improvement Board will give me the opportunity to represent the opinions and experiences ethnic minority communities and to improve their health to give them and their children better quality of life.

**Engagement Activities:** The Engagement Team conducted a Sounding Board with parents and children about childhood obesity, the resulting report is for information in the papers of this board.

**Bubbling Up Issues:** Nothing to report at this time.

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**Public Health Campaigns**

**Report for the Health Improvement Partnership Board, September 2013**

The Public Health Directorate in Oxfordshire County Council has set out a forward plan for campaigns and communications on a range of Health Improvement Issues. Priority has been given to topics which are overseen by the Health Improvement Partnership Board.

All of the campaigns target the local population in Oxfordshire with relevant information and events designed to promote health improvement. Some are run at the same time as national campaigns and aim to bring a local focus, such as Stoptober. A few are fairly short lived and give messages relevant for that time, for example promoting the uptake of flu immunisations. Others are long term and build on work in communities and with particular target audiences to ensure that people are informed and able to make healthy choices. All of the campaign topics give an opportunity for public health to work with a range of partners to ensure we promote health together.

**Proposed Forward Plan for 2013-14**

| Campaign | Aim | When |
|---|---|---|
| Eat Well, Move More | To promote healthy eating and physical activity. Target - families with young children | July – Sept 2013 |
| Measles, Mumps and Rubella immunisation catch-up campaign | To encourage attendance for Measles, Mumps and Rubella vaccination (especially second dose for 10 - 16 year olds) before the start of the new school year. | Aug – Sept 2013 |
| Stoptober | To encourage smokers to quit smoking for the month and provide general information to the public on support services available | October 2013 |
| Flu Immunisations | To promote the uptake of flu immunisations for all groups (over 65, under 65 with pre-existing conditions, pregnant women, children aged 2-3) and also inform of the introduction of the Shingles vaccinations for people aged 70 and 79 | Oct – Dec 2013 |
| Health Checks | To promote uptake of NHS Health Checks when invited to attend by GP. Target 40-74 year olds (who will be invited every 5 years) and particularly men aged 40-50 yrs | Nov 2103 and ongoing |
| Alcohol Awareness | To give appropriate information on alcohol related harm and promote Dry January. Target groups: people drinking at parties; adults who drink at home | Nov 2103 – Dec 2014 |
| Immunisation birthday cards | To send reminders of immunisation schedules as birthday cards. Potential targets:, 3 and 4 year olds | From Jan 2014 |
| Sexual Health | Aim: to promote safe sex using Valentine's day as a focus, to reduce sexually transmitted infection. Target 16-24 year olds | February 2014 |

**Recommendations:**

1. It is recommended that members of the Health Improvement Board work together with the Public Health team to maximise the impact of these campaigns for long term health improvement.

2. It is proposed that a forward plan for campaigns in 2014-15 will be brought to the Health Improvement Board for information and so that appropriate joint work can be planned in advance for next year to support our shared priorities.

Jackie Wilderspin