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, 28 November 2013 at 2.00 pm

Town Hall, Oxford

Peter G. Clark
County Solicitor

November 2013

Contact Officer: ***Lynda Chalcraft, Partnership & Policy Officer***
Tel: (01865) 328560; Email: lynda.chalcraft@oxfordshire.gov.uk

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Membership

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

Board Members:

Cllr Anna Badcock	South Oxfordshire District Council
Ian Davies	Cherwell & South Northants District Council
Vacancy	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
Paul McGough	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 minutes

To approve the Note of Decisions of the meeting held on 26 September 2013 (**HIB5**) and to receive information arising from them.

6. Performance Report (Pages 9 - 28)

2:10
20 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Dr Jonathan McWilliam

A report of progress against the targets of the Health Improvement Board, including report cards on Health Checks and Breastfeeding.

7. Making Every Adult Matter (Pages 29 - 30)

2:30
15 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Val Johnson, Oxford City Council

A report on the pilot to work with national partners to deliver improved outcomes and interventions for people with multiple needs.

8. Healthy Weight Strategy Development (Pages 31 - 34)

2:45
15 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin

Action required:

Discussion of paper

- Are there any issues arising in what we have outlined below regarding our proposed partnership work?
- As strategic influencers in your respective organisations, what key issues do you think we need to be discussing with your Chief Officers/relevant staff members?

9. Fuel Poverty and Excess Winter Deaths (Pages 35 - 38)

3:00
20 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin

Members of the Health Improvement Board are asked to consider what additional action they would like to take to improve fuel poverty rates and reduce excess winter deaths in the county.

10. Update from the Public Involvement Network (Pages 39 - 42)

3:20
15 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Paul McGough

An update by the Public Involvement Network representatives.

11. Welfare Reform (Pages 43 - 52)

3:35
15 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Val Johnson, Oxford City Council

The Health Improvement Board may want to consider its role in monitoring the impacts of welfare reform going forward, bearing in mind the work of other Boards and Partnerships, for example the Adult Health and Social Care Partnership Board has agreed to monitor the specific impact on vulnerable adults.

12. Forward Plan

3:50
5 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Dr Jonathan McWilliam

A discussion on the Forward Plan for the Health Improvement Board.

Items:

- Older People's Commissioning Strategy – Prevention Plans
- Oxford University Hospital NHS Trusts/Oxfordshire County Council – Public Health Strategy
- Obesity Prevention Strategy

Meeting dates:

- Thursday 23 January 2014
- Thursday 27 March 2014

13. Any Other Items

3:55
5 minutes

Items:

Disabled Facilities Grant and Transformation Fund – update from Val Johnson, Oxford City Council

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Thursday, 26 September 2013 commencing at 2.00 pm and finishing at 4:10pm.

Present:

Board Members:	District Councillor Mark Booty – in the Chair
	City Councillor Ed Turner (Vice-Chairman) Councillor Hilary Hibbert-Biles, Oxfordshire County Council Councillor Anna Badcock, South Oxfordshire District District Councillor Alison Thomson, Vale of White Horse District Council Ian Davies, Cherwell & South Northamptonshire District Councils Dr Jonathan McWilliam, Director of Public Health Jackie Wilderspin, Public Health Specialist Aziza Shafique, Public Involvement Network
Officers:	
Whole of meeting	James Martin, Oxfordshire County Council
Part of meeting	
Agenda Item	**Officer Attending**
8	Ruchi Baxi, Public Health Specialty Trainee
9	Nigel Holmes, Oxfordshire County Council

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 Lynda Chalcraft, Policy and Partnership Officer (Tel: (01865) 323860; Email: lynda.chalcraft@oxfordshire.gov.uk)

	ACTION
1 Welcome by Chairman, District Councillor Mark Booty (Agenda No. 1)	
The Chairman, Councillor Mark Booty, welcomed all to the meeting including Councillor Hibbert-Biles, Councillor Thomson,	

Councillor Badcock and Aziza Shafique attending their first meeting as members of the Health Improvement Board.	
2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Apologies have been received from Dave Etheridge, Dr Peter Von Eichstorff and Councillor George Reynolds. It was noted that this meeting would have been Peter's last as he is standing down as the Oxfordshire Clinical Commissioning Group representative on the Health Improvement Board due to his move to Devon. The chairman recognised the contribution that Peter has made and noted thanks for his work. **ACTION:** **Jackie Wilderspin will liaise with the Oxfordshire Clinical Commissioning Group about a new representative on the Health Improvement Board**	**JW**
3 Declaration of Interest - see guidance note opposite (Agenda No. 3)	
No declarations were received.	
4 Petitions and Public Address (Agenda No. 4)	
No petitions or public addresses were received.	
5 Note of Decision of Last Meeting (Agenda No. 5)	
Member's attention was drawn to the revised terms of reference for the Health Improvement Board. John Jackson updated the board on the time scales for decisions being reached on the financial aspect of the re-commissioning of the homeless pathway. The Health Improvement Board will be informed of the outcome.	

6 Performance Report (Agenda No. 6)	
Dr Jonathan McWilliam introduced and explained the performance report highlighting the measures currently rated red: 8.3 - At least 65% of those invited for NHS Health Checks will attend (ages 40-74). Dr Jonathan McWilliam pointed out that this is a very important measure and general practice must get better at chasing those invited for health checks and Oxfordshire County Council must get better at publicising health checks, using all routes possible including investigating whether social landlords could have a role. The current score of 41.9 is better than the Thames Valley average. 9.3 Breastfeeding rates at 6-8 weeks. This is under the new ambitious target of 62% The discussion that followed focussed on: The availability and appropriateness of data below County level to be informing the work of the Health Improvement Board. **ACTION:** **It was agreed that the Chairman and Vice Chairman will liaise with officers outside of the meeting to gather data and report back by exception.** **The Chairman requested that when looking at quarter one data the Board is provided with quarter four data from the previous year to provide a better visual presentation of performance.** **The Chairman also requested that in future the performance reports are printed in colour for Board Members.** **Report cards on Breastfeeding and Health Checks will be brought to the next meeting.** **At the next Health Improvement Board meeting six months of data will be available for the 'basket of indictors' on health and housing.**	**MB/ET** **JM** **JM** **JW** **JW**
7 Obesity Prevention (Agenda No. 7)	
Dr Jonathan McWilliam introduced the item highlighting that the paper is an exploratory paper looking at potential areas of work	

that could be undertaken in partnership to prevent obesity in Oxfordshire. Kate King presented the paper that detailed the challenge of maintaining a healthy weight; what is going on across the county to support people and what the future opportunities are. The discussion that followed focussed on how to use a targeted approach most effectively to reach certain groups of people identifiable by age, place and social deprivation. The importance of public health campaigns was agreed. There was consensus that any targeted approach should focus on infancy, the early years and prior to birth as benefits will be realised as children grow into adulthood. It is important that targeting is based on evidence and local data. Ian Davies commented that all those around the table including General Practice have a role to play on the obesity agenda through the communication and presentation of issues and emphasising that there is a shift in responsibility being placed onto the individual. Further to this messages need to be tailored to different audiences and should focus on the benefits of maintaining a healthy weight rather than the problems of obesity. Councillor Turner commented that the Health Improvement Board has a leadership role to drive forward this agenda in Oxfordshire. **ACTIONS AND WAY FORWARD:** In summarising the discussion Dr Jonathan McWilliam drew out a number of strands: • The role of education settings in taking forward this work is important and needs to be explored. • District Councils are responsible for leisure services and therefore have a key role. • Opportunity for exercise needs to be made available outside of the leisure centre and brought into the community. • The role of planning, travel, transport and local environment is crucial in promoting physical activity and needs to be part of the work. **Kate King will bring a more targeted strategy with formal proposals for a wide range of organisations to the next meeting.**	**KK**

8 Proposal for a Public Health strategy with Oxford University Hospital (Agenda No. 8)	
Dr Jonathan McWilliam introduced the paper and detailed the intentions of the strategy for 2014/15 which will be drafted by January 2014. A final draft will be brought to the Health Improvement Board for comment and approval in January 2014. A longer term strategy will also be developed setting out 3 and 10 year goals, all of which will be signed off at the Health Improvement Board. Both Councillor Hilary Hibbert-Biles and Ian Davies noted the positive significance of this development and the potential that is has to influence policy and improve the health of hospital employees and patients.	
9 Older People's Housing Strategy Needs Analysis (Agenda No. 9)	
John Jackson, Director of Social and Community Services gave a presentation to the Health Improvement Board that detailed progress of the Older People's Housing Strategy Needs Analysis. All district councils supported the process and principles set out in the presentation. There was also agreement that the analysis should be informed by data to be published within the Strategic Housing Market Assessment due by the end of the year. Councillor Ed Turner stated that good exchanges have taken place locally with districts and developers. Councillor Turner also highlighted that the issue is not just about ensuring new housing options are built but that existing housing options are appropriate and reach certain standards. Discussions also focussed on: • The need to have better design specifications and to have more influence on developers; • The issues are not just about the physical design of properties and regulations but about independence; assistive technology that enables; communal facilities; easier living and community **ACTION:** **John Jackson will draft a note of the concerns that are currently held in relation to ensuring that future housing needs of older people are met. This will be circulated to board members.**	**JJ/JM**

10 Update from the Public Involvement Network (Agenda No. 10)	
Aziza Shafique introduced herself as the new Public Involvement Network representative.	
11 Public Health Campaigns (Agenda No. 11)	
Councillor Hibbert-Biles detailed the Public Health campaigns that will be taking place over the next six months. Thanks were extended to Jackie Wilderspin and Rachel McQuilliam for their work in ensuring that the campaigns are planned. **ACTION:** **Jackie Wilderspin will pass details of the campaigns to district colleagues to ensure that a constant message is promoted where possible.**	**JW**
12 Forward Plan (Agenda No. 12)	
The following agenda items suggested for future meetings included: • Welfare changes • Re-commissioning of the homeless pathway update • Fuel Poverty • Making Every Adult Matter • Basket of Indicators • Obesity Plan • Older People's Commissioning Strategy • Prevention plans • Community Networks It was also noted that the board has the option not to meet in public in November. **ACTION:** **Agenda to be agreed for the board meeting on the 23 January.** **Format and agenda of the meeting on the 28 November to be agreed.**	**JJ/JM**

..... in the Chair

Date of signing .....

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Health Improvement Board

28 November 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. The four priorities the Board has responsibility for are:

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

Current Performance

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

4. It is worth noting that there are a number of targets that are not reported on a quarterly basis. This may be where data is collected or released less frequently, for example flu vaccinations.

   3 indicators are Green.
   2 indicators are Red (report cards attached)
   10 indicators were not expected to report in this quarter

5. Where performance is not meeting expectations, commentary has been included in the table and appropriate action is being taken. Commentary is sometimes included for information.

Ben Threadgold
Strategy and Performance Manager, Joint Commissioning
November 2013

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

Oxfordshire Health and Wellbeing Board
Health Improvement Board - Performance Report

	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** 20,329	G	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% (4165 of 9938)**	R	Expected 65% **Actual** **46% (9351 of 19557)**	R	Expected 65% **Actual**		Expected 65% **Actual**		Please see Report Card
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 14.9% or less **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 62.2% **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 62% **Actual** **59%**	**A**	Expected 62% **Actual** **59.5%**	**R**	Expected 62% **Actual**		Expected 62% **Actual**		Please see Report Card
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 greater than the level reported in March 2013 (baseline 216 households in Oxfordshire)							Expected 216 or less **Actual**		Measure reported annually, expected during Q4

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
10.2	At least 75% of people receiving housing related support will depart services to take up independent living	Expected 75% **Actual 85.7%**	G	Expected 75% **Actual 87.2%**	G	Expected 75% **Actual**		Expected 75% **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 80% **Actual** 82.3%	G	Expected 80% **Actual** 82%	G	Expected 80% **Actual**		Expected 80% **Actual**		As might be expected, the highest number of applicant households who were homeless as defined by the Housing Act 1996, were in Oxford City, followed by Cherwell. The lowest number was in West Oxfordshire. The highest percentage of applicants found to be eligible, unintentionally homeless and in priority need was in Vale of White Horse, where 69% applicants were in this category, compared to 51% in Cherwell, 54% in West Oxfordshire, 58% in South Oxfordshire, and 55% in Oxford City. The target of total number of cases where positive action was successful in preventing homelessness as a percentage of the number of applicants presenting as potentially homeless being 80% was met as an average across the County and all Districts were close to the target. **Next steps : Gold Standard for Homelessness** The Government has challenged Local Authorities to reach the "Gold Standard for Homelessness" meeting 10 challenges (attached as Appendix 1) The response is measured by conducting a peer review and the Oxfordshire District Councils have grouped together to begin undertaking this work. Taking up the challenge provides access to resources in the form of training and support.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
10.4	Fuel poverty outcome to be determined			Expected Outcome measure to be determined **Actual**						Work to determine current activity on reducing fuel poverty in Oxfordshire is continuing. It is important for stakeholders to identify where additional work will add value. A new outcome measure is being introduced nationally which may provide an indicator for this work.
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
11.4	At least 90% 12-13 year old girls receive all 3 doses of human									Annual data usually available Quarter 4

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	papilloma virus vaccination (currently 88.1%)									

Health Improvement Board

28 November 2013

Performance Report – Appendix 1

Gold Standard for Homelessness 10 Challenges

1. To adopt a corporate commitment to prevent homelessness which has buy in across all local authority services

2. To actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs

3. Offer a housing options prevention service, including written advice to all clients

4. To adopt a No Second Night Out model or an effective local alternative

5. To have housing pathways agreed or in development with each key partner and client group that include appropriate accommodation and support

6. To develop a suitable private rented sector offer for all client groups, including advice and support to both client and landlord

7. To actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme

8. To have a homelessness strategy which sets out a proactive approach to preventing homelessness, reviewed annually to be responsive to emerging needs

9. To not place any young person aged 16 or 17 in Bed and Breakfast accommodation

10. To not place any families in Bed and Breakfast accommodation unless in an emergency and for no longer than 6 weeks

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Additional information on performance – range of outcomes for some of the indicators

No	Priority	Data period	Overall total	Overall rate/percent	Range (Number & Rate / %)	Lowest	Highest	Notes
8.1	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)							**These data are yet to be published nationally**
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)	Q2 13/14	9,516 people aged 40-74	4.61% of the expected 5% per quarter (20% of the total population per year as 100% invitations are sent every 5 yrs)	384 to 2433 1.81 - 5.92%	CCG West Locality	CCG North East Locality	At GP practice level ranges are wider - 0.5 to 24.5%. Practices in Bicester, Banbury, Oxford had lowest proportions offered. Local analysis of last year's data shows lower uptake rate by younger age groups (40-44, 45-49 and 50-54), higher uptake rate among 55-59 and 60-64 and maximum uptake among 65+. More men invited but more women attended.
8.3	At least 65% of those invited for NHS Health Checks will attend (ages 40-74)	Q2 13/14	4,035 people aged 40-74	1.96% of the expected 3.25% per quarter (13% of the total pop per year which makes 65% over 5yrs)	262 to 943 1.25 - 2.65%	CCG West Locality	CCG North Locality	
8.4	At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)	Q1 13/14	875 adults	163 per 100,000	120 to 228 129.8 - 199.5 per 100,000	South Oxon DC	Cherwell DC	

9.1	Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2012 this was 15.6%)	2011/ 2012	858 children in year 6	15.60%	117 to 228 11.9 to 19.5%	West Oxon DC	Oxford City	Cherwell had highest number of obese children in 2011-12, Oxford City has highest percentage in 2011-12 - these are most deprived areas in county. Low-level analysis carried out by National Obesity Observatory on 2009/10 to 2011/12 data indicate 66% of variation in obesity is explained by children living in deprived areas.
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)	2012/ 2013		61.20%	Number not available 59.3 - 64.0%	Cherwell DC (59.3% Vale of White Horse (59.4%)	West Oxon DC	
9.3	62% of babies are breastfed at 6-8 weeks of age (currently 59.1%)	Q1 13/14	1,084 babies aged 6-8 weeks	58.70%	48.1 to 78.4%	Carterton/ Burford/ Chipping Norton Health visitor localities	North Oxon/ Cumnor/ Botley health visitor localities	Breastfeeding support service put in place in practices in Banbury and Oxford South East (Blackbird Leys and Donnington) localities - shows some improvement on 2012/13 figures. Elsewhere practices in Cowley and Carterton have low uptake as do some (but not all) practices in Bicester, Kidlington and Abingdon.

11.1	At least 95% children receive dose 1 of MMR by age 2 (currently 95%)	Q1 13/14	2,021 children aged 2	96.10%	92.6 - 98.8%	Oxford South East health visitor locality	Wantage/ Faringdon/ Grove health visitor locality	Oxford South East (Blackbird Leys and Donnington) shows some improvement for dose 1 but remains in lowest uptake areas for both dose 1 and dose 2. Wantage, Faringdon and Grove remains highest performing locality. Data indicate that 141 of eligible aged 5 year olds have not had their second dose of MMR at end quarter 1. Nationally it is recognised these generally fall into two groups - those who prefer not to get their child vaccinated and who may opt for single vaccines (privately) or those living in deprived areas.
11.2	At least 95% of children receive dose 2 of MMR by age 5 (currently 92.7%)	Q1 13/14	1,913 children aged 5	93.10%	90.7 to 98.5%	Iffley & Cowley health visitor locality	Wantage/ Faringdon/ Grove health visitor locality	
11.3	At least 55% of people aged under 65 in "at risk" groups receive flu vaccination (currently 51.6%)	2012/ 2013 annual		51.60%	Average 49.9 to 55.5	CCG Oxford City locality	CCG South West locality	Raw data not provided so unable to calculate actual uptake within each locality. Have used the average across each locality for comparisons. Actual ranges by practice are much wider 32.2 to 77.7%.

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DRAFT - Oxfordshire Health and Wellbeing Board
Detailed performance report

1. Details

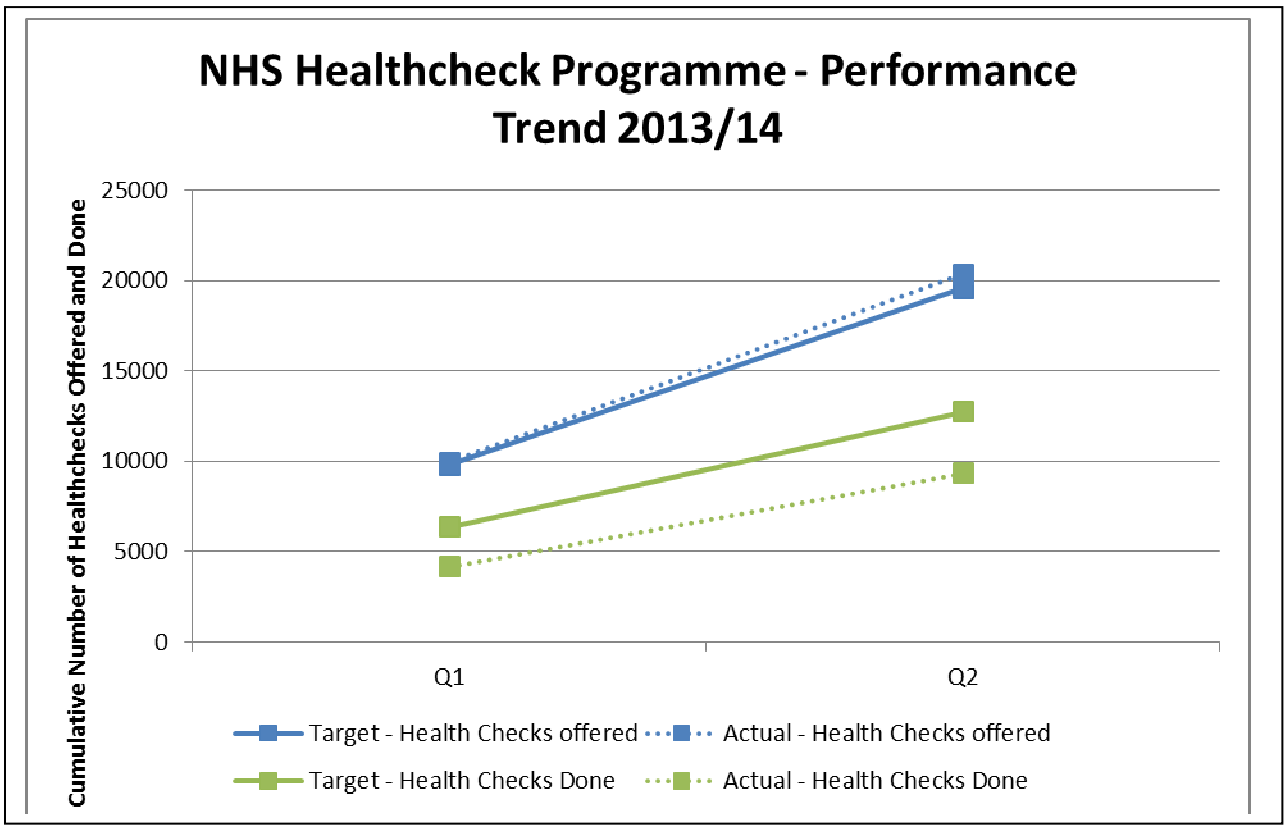
Strategic Priority: 8.3 Preventing early death and improving quality of life in later years

Strategic Lead: Nisha Sharma/Eunan O'Neill (from Dec 2013) **Last updated**: June 2012

PROGRESS MEASURE:
Health Check Offered – Q1- 9778, Q2- 19557, Q3- 29335, Q4- 39114
Health Check Done - Q1- 6355, Q2- 12713, Q3- 19068, Q4- 25424

Current indicator Rating Red
(Proportion of people taking up the Health Check Offer – Uptake)

2. Trend Data



3. What is the story behind this trend? - Analysis of Performance

Bullet points to highlight why this trend is causing concern, what factors are influencing it, what the problems or risks are…. This section is NOT for solutions, just analysis of the current situation.

- The Oxfordshire NHS Health Check programme is in its third year of full roll out.
- In 2013/14, the programme is commissioned from GP practices through local enhanced service (LES) and all 84 GP practices in Oxfordshire have signed-up to deliver the service, which means we have full programme coverage.
- All eligible people within the age range of 40-74 yrs not already on cardiovascular disease register needs to be invited for health check once every five years. We therefore have a target of inviting 20% of eligible population each year.
- **There is no national target for uptake** however local authorities are expected to seek progressive improvement in the proportion of people taking up the health check offer.
- Baseline uptake in 2012/13 was at 46% therefore an incremental target of 50% was agreed for 2013/14. **This was however increased to an aspirational target of 65% by Health Improvement Board in July 2013.**

- We are on track in terms of inviting 20% of eligible population for health checks. Cumulative total of people invited at the end of Q2 stands at 20,329 reflecting 22% coverage.
- However, of the 20,329 people invited for health checks only 9342 took up the offer giving us an uptake rate of 46%.
- Although this is an improvement from 42% uptake at the end of Q1, more work needs to be done to continuously increase the proportion of people taking up the offer of health check when invited by their GP.

4. What is being done? - Current initiatives and actions

Actions *(in brief)(add more rows if you need to)*	**Commentary** *(is this working, if not why not?)*
¤ Communicate performance trends and best practice with practices and encourage them to follow up the non-responders through second and third invite	• Health Check e-Bulletin is sent to practices with headline summary of performance trends and actions required to improve uptake. This has yielded results in terms of improved uptake from 42% in Q1 to 46% in Q2
¤ Provision of training and practical support to under-performing practices	• Bespoke training sessions are delivered to practices seeking specific training e.g. health check software training, training to new staff joining the practices etc. 3 training sessions were delivered in Q2 which were attended by 13 staff
¤ Work with Oxfordshire Clinical Commissioning Group (OCCG) and GP locality leads to drive uptake	• Practice level performance data is shared with OCCG locality leads through public health newsletter which had helped 3 practices start inviting patients in the last quarter

5. What needs to be done now? - New initiatives and actions

(this is the recovery plan. Details should show how this will get things back on track)

Action	**By Whom & By When**
¤ Continue with quarterly data analysis at practice level to identify practices with high uptake and share best practice and provide tailored support to low performing practices in order to improve uptake	Eunan O'Neil (Nov-Dec 2013 and on-going)
¤ Continue to work with OCCG locality leads to influence and encourage practices to chase the non-responders through second and third invite	Eunan O'Neill On-going
¤ Develop and deliver a sustained media campaign to increase public awareness of Health Checks and encourage them to take up the offer when invited by their GP practice	Rachel McQuilliam Nov 2013 to March 2014
¤ Develop and deliver Health Check training to primary care staff with a special focus on effective communication of risk and following up the non-responders	Eunan O'Neill Jan-March 2014

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Oxfordshire Health and Wellbeing Board
Detailed performance report

1. Details

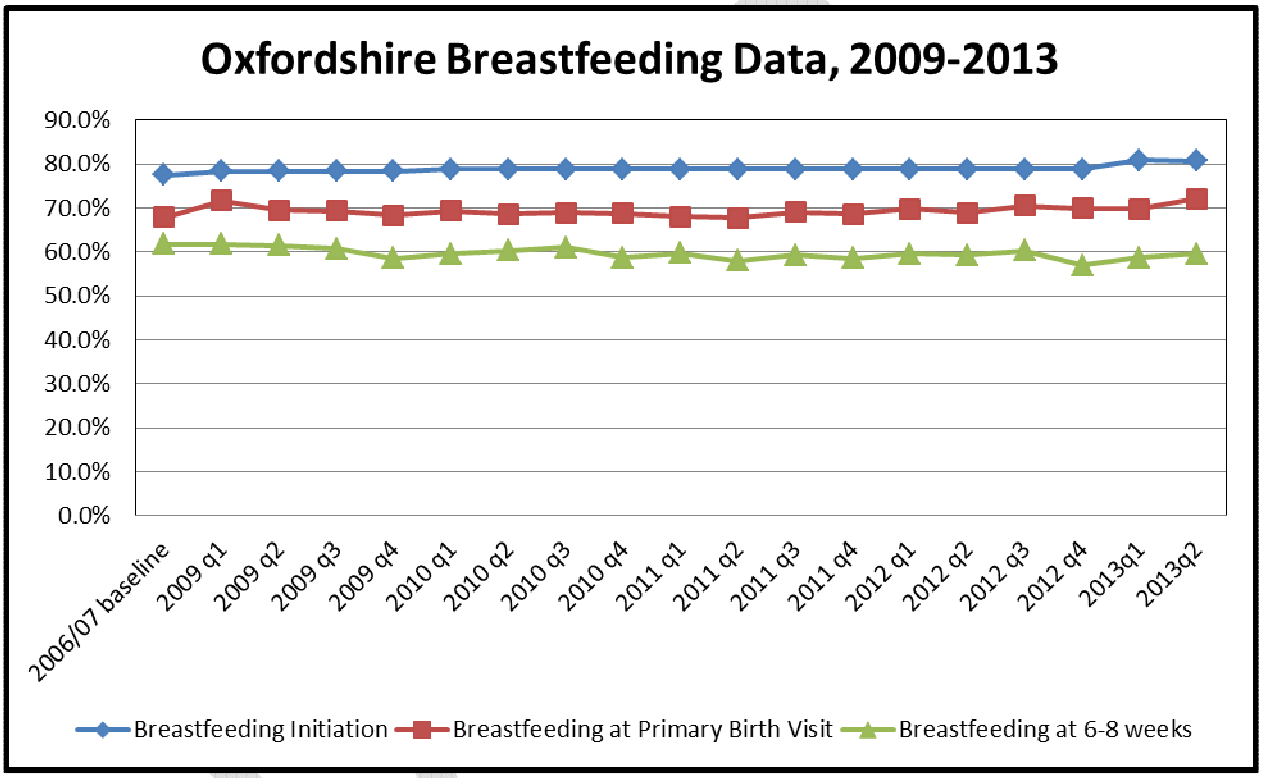
Strategic Priority: Preventing chronic disease through tackling obesity

Strategic Lead: **Last updated**: NA

PROGRESS MEASURE: 62% of babies are breastfed at 6-8 weeks of age

Current indicator RAG Rating Red

2. Trend Data



3. What is the story behind this trend? - Analysis of Performance

- In 2009, the rate of women breast feeding partially or totally at 6 – 8 weeks was around, or just above, 60%. However, since 2010 rates have fallen just below 60%.
- Over this period, rates have been consistently exceeded the national average which is currently 47.2%
- In July 2013, Oxfordshire Health's Health Visiting service was achieving 58.7% against a stretched target of 63% of women breast feeding, partially or totally, at 6 – 8 weeks. The most recent data available (q2, 2013- 2014), suggest the service is currently achieving 59.5%.
- As part of the national Health Visitor Implementation Plan, Oxford Health NHS Trust is required to increase its health visiting workforce in line with an agreed trajectory. For September 2013/14 this is 104 whole time equivalents (WTE) and the Trust has achieved 107.4 WTE and is on track to achieve its final target of 113.6 WTE for this year by March 2014. The expectation is that the additional workforce should positively affect the service's achievement of the higher targets that they are not currently achieving.

4. What is being done? - Current initiatives and actions

Actions	Commentary
1. **The national specification for Health Visiting services is being implemented in Oxfordshire** and specifies a number of initiatives to improve breastfeeding rates. For example: • *Provide breastfeeding support and information in line with UNICEF and evidence-based BFI guidance (Baby Friendly Initiative).* • *Improve links between the health visiting and maternity services to streamline information and communication across agencies.*	• Although the national specification is being implemented, breastfeeding rates have remained fairly static over the period. • The expectation is that the additional health visiting workforce should positively affect the service's achievement of the local targets.
2. **Oxford Health NHS Trust** (through the Health Visiting contract managed by the Local Area Team) **has a performance target to achieve 6-8 week breastfeeding rates of at least 60%.** Locality teams also have individual targets and the trust has an on-going breastfeeding action plan.	• The plan is reviewed quarterly to monitor performance and initiatives to maintain and improve breastfeeding rates.
3. Oxford University Hospitals Trust (OUHT) has employed a **new lead for Infant Feeding Coordinator** and has launched an internal **Infant Feeding Strategy Group**. The trust intends to implement a long-term programme working towards full BFI accreditation by 2020.	▪ OUHT recognises that breastfeeding advice and support is inconsistent and does not meet *UNICEF and evidence-based BFI guidance.* However, service improvements will have to be made within the current financial envelope.
4. Oxfordshire County Council (Public Health) **additional community breastfeeding support in Oxford and Banbury where breastfeeding rates are lower.** This service is also provided by Oxford Health NHS Trust.	• A recent analysis suggests this investment not had a significant positive impact on breastfeeding rates in Oxford and Banbury, although there have been improvements in specific areas of Oxford City. However, there is insufficient data available to fully understand why this is the case.
5. Childrens Centres are required to promote breastfeeding and support mother to breastfeed e.g. by hosting breastfeeding cafes, providing advice etc. Children's centres currently have a shared KPI, with Oxford health, to achieve 60% breastfeeding at 6-8 weeks.	▪ 5 Children's centres in Oxford have achieved level 2, BFI accreditation, with the support of local HV teams. ▪ There is uncertainty and risk to community breastfeeding support arising from the review of Children Centre provision in Oxfordshire.

5. What needs to be done now? - New initiatives and actions

	Action	By Whom & By When
¤	Health Visiting (Oxford Health) will **increase its coverage of the ante natal visits** in line with the new, national, Health Visiting service model, which is an opportunity to promote breastfeeding and address any issues proactively.	OH by Q3 2013/14
¤	**Pilot '5 day' project in one Oxfordshire locality**. Health Visitors are leading in a 5 day telephone contact to breastfeeding mothers with an aim to reduce drop off rates between birth and 6-8 weeks. The project is being delivered in Bicester and is based on a similar project in East Sussex.	OH by Q3 2013/14
¤	**Closer working** and **collaboration between Health Visiting and Midwifery colleagues**. This has already led to the development of infant feeding pages for the 'Red Book' to be used by Health Visitors, Midwifery and lay supporters in the community and it is envisaged there will joint, multi-disciplinary training programmes for midwifery and health visiting staff in the future.	OH and OUHT, On-going
¤	**Breastfeeding Champions** - continue to meet quarterly. This includes on-going networking, and sharing of good practice initiatives. Champions across the county planned and supported a range of events during the month of June 2013 to raise awareness and promote breast feeding.	OH, On-going
¤	**Locality Audits** – plans are in place to commence locality audits, to assess local practice, using a modified version of the UNICEF audit tool. Audits will take place in Iffley /Cowley, Witney, Wantage & Faringdon.	OH by Q4 2013/14
¤	• Oxford Health endeavouring to **achieve Baby Friendly Initiative (BFI) accreditation.** Via the Local Area Team, they are requesting to bid for £20k national transformational funding to take this forward in 2014-15.	

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Health Improvement Board

28 November, 2013

Report on "Making Every Adult Matter"

Introduction

Making Every Adult Matter (MEAM) is a coalition of four national charities – Clinks, DrugScope, Homeless Link and Mind – formed to influence policy and services for adults facing multiple needs and exclusions.

Adults with multiple and complex needs often:-

- **experience several problems** at the same time, such as mental ill health, homelessness, drug and alcohol misuse, offending and family breakdown. They may have one main need complicated by others, or a combination of lower level issues which together are a cause for concern. These problems often develop after traumatic experiences such as abuse or bereavement.
- **have ineffective contact with services.** People facing multiple needs usually look for help, but most services are designed to deal with one problem at a time and to support people with single, severe conditions. As a result, people with multiple needs are often seen as 'hard to reach' or 'not my problem'.
- **live chaotic lives.** Facing multiple problems that exacerbate each other, and lacking effective support from services, people easily end up in a downward spiral of mental ill health, drug and alcohol problems, crime and homelessness. They become trapped, living chaotic lives where escape seems impossible, with no one offering a way out.

Making Every Adult Matter - Oxford

Oxford City Council with partners across a wide range of statutory and voluntary sector partners submitted an Expression of Interest to the MEAM coalition in early 2013 to become a pilot area for the South East and was chosen as one of nine local authority areas to work with the national partners to deliver improved outcomes and interventions for people with multiple needs.

Oxford City Council will be the lead agency for this work. Partners include the following organisations:-

- Oxfordshire County Council (including Mental Health, Housing Related Support and Young People's Commissioning, Drug and Alcohol Action Team and Vulnerable Adults Teams)
- Oxfordshire Clinical Commissioning Group - mental health commissioning
- Oxford Health - statutory mental health
- Thames Valley Probation
- Thames Valley Police
- Voluntary sector representatives including those working with people with mental health problems, homeless and complex needs.
- Homeless Link (Local Network Team from national coalition)
- Mind (Local Network Team from national coalition)

Although this initial pilot phase will be focussed on the City, learning, good practice and implications can be shared both across the County.

The MEAM approach

The MEAM approach provides a non-prescriptive framework for developing a coordinated approach in our local area. It does not bring extra resources into an area but seeks to organise current resources in a more effective way to help meet the needs of this group of vulnerable people.

The MEAM approach is broadly as follows:-

- **Partnership and Audit**
- **Consistency in Client Identification**
- Coordination for Clients and Services
- Flexible Responses from Services
- Service Improvement and Gap Filling
- Measurement of Success
- Sustainability and Systems Change

Partnership

Oxford is at the planning phase and is currently in the process of establishing its governance group as well as a broader partnership of interested parties.

The governance group will be made up of senior managers who will be responsible for developing MEAM and brokering the necessary partnerships as well as reporting to the HIB periodically. The partnership will be a wider group of organisations all of which will have an interest in the agenda

Audit and Client Identification

Having agreed on the definition of the client group, we are looking to carry out an audit of need in order to establish how many clients with these complex and multiple needs we believe there are in the City so that we can tailor our response. A small working group has been established to carry out this work.

Having established the need we will then be able to progress to the next steps of the process and begin to co-ordinate our response.

It is worth noting that MEAM does not necessarily look to establish new services for this client group although in time it may be appropriate to appoint a co-ordinator to pull together client work and approaches to various agencies. In fact, its essence is in looking at mainstream services and helping them where necessary and with a co-ordinated approach to flex their approach and service to meet the needs of this client group at the earliest opportunity.

In order to achieve this, buy-in at a senior level is essential to give the authority for this flexibility.

Health Improvement Board Briefing

28 November 2013

Healthy Weight Strategy Development - Update and moving plans forward

For Action at November 2013 HIB

- Discussion of paper – Are there any issues arising in what we have outlined below regarding our proposed partnership work?
- Discussion of paper – As strategic influencers in your respective organisations, what key issues do you think we need to be discussing with your Chief Officers/relevant staff members?
- Please ensure that you have responded to our email request regarding a meeting with your Chief Officers/relevant staff members

The Health Improvement team in the Public Health Directorate are developing a healthy weight strategy that will come into effect in April 2014

This strategy will dovetail other areas of public health work, including reducing inequalities and mental health and wellbeing.

We will work in partnership with the Local Authority, OCCG, Public Health England and third sector colleagues in order to address the multiple dimensions of ensuring healthy weight in a population.

The strategy will broadly look to address four areas (see diagram below):

	The Interior (Subjective) World	**The Exterior (Objective) World**
Individual Level	How individuals think and understand themselves Individual values and ethics/morals *(E.g. I'm overweight and have been since I was a child, I'm happy with my size and see no reason to change)*	An individual's physical body and brain. This physical world can be objectively studied and produce scientific evidence *(E.g. The more calories that an individual consumes, the more exercise they will have to do to use them up)*
Collective (Population) Level	Our culture A society's beliefs and values *(E.g. Our society does not think that an obese population is a good thing to aspire to, but neither does it want to discriminate against people who are obese)*	The environment in which we live The economy, social structures, government policies, the world of business etc. *(E.g. The factors that make up an obesogenic environment)*

This approach considers healthy weight across the population. However, as weight management issues often manifest at an early age, the strategy will particularly focus on addressing overweight and obesity in early years and childhood. Current data show that obesity rates double between 6 year olds and 11 year olds, and this strategy will emphasize the need to work particularly closely with schools and parents to ensure we understand the most effective approaches to reversing this trend.

In our current approach, we have put particular emphasis on addressing issues in the top right hand quadrant, i.e. exterior issues for an individual. Many of our services work with individuals to achieve and manage a healthy weight through a combination of diet and exercise. These services also go some way to addressing interior issues for an individual (top left hand quadrant), offering psychological support as an adjunct to education on healthy eating and exercise.

Primary prevention, identification & and early intervention in a health care setting is an effective way to influence and educate individuals on the best choices for their wellbeing. We will continue to work closely with CCG colleagues, to develop and improve opportunities for prevention in a healthcare setting.

The bottom left hand quadrant is an area that our obesity strategy has not considered in great detail previously. We have been involved and supportive of National campaigns such as Change 4 Life, which aims to impact our understanding of risk and how to achieve and maintain a healthy lifestyle. We will continue to work with National campaigns and explore how we might further work in this area at a local level.

Of particular interest for the members of the Health Improvement Board is the work associated with the bottom right quadrant. Exterior issues at a collective, or population, level relate to issues in our environment that promote or dissuade healthy living and wellbeing. The term obesogenic environment refers to a set of circumstances that are extremely conducive to obesity. For example a lack of opportunity to exercise (no green spaces, no availability of safe cycling lanes, lack of leisure services etc); high availability of food with a high fat and sugar content (more fast food businesses than healthy options, local shops stocking processed food rather than fresh produce etc.); a work-life balance that does not allow time for food preparation, leisure activities etc.

The Health Improvement Team propose to work with members of the Health Improvement Board and their respective colleagues in District Councils to plan a comprehensive approach to reducing the obesogenic aspects of the local environment. To this end, we have sent a request to all District Councils, asking to meet with the Chief Officers responsible for:

- Spatial planning
- Leisure
- Environmental Health

At these meetings, we aim to map out what is currently underway to address the obesogenic environment and how we can work together to build on and improve existing work. Examples of this might include:

- Health and wellbeing considerations for new planning developments
- Improving access and provision of leisure services for hard to reach groups
- Including an assessment of population health needs when considering granting of planning permission for new local businesses or street traders (e.g. food establishments)
- A healthy workplace approach – encouraging employees to adopt healthy lifestyles through promoting an active transport policy, healthy eating at work and regular exercise as part of the working day

Next Steps

- Following our meetings with District Council Chief Officers, we will draft a joint working plan and present it for approval at the January 2014 HIB

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Health Improvement Board

28 November 2013

Briefing on Fuel Poverty and Excess Winter Deaths

Background

The Health Improvement Board has agreed to tackle fuel poverty as part of the priority to tackle the broader determinants of health through better housing and preventing homelessness (Joint H&WB Strategy priority 10). No outcome measure has yet been agreed for this measure. This paper sets out information to enable the Board to define clear aims and areas of work on this topic.

There are 2 current definitions of fuel poverty:

1. **"10% definition":** A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel to maintain an adequate level of warmth (usually defined as 21 degrees for the main living area, and 18 degrees for other occupied rooms)

2. **"Low Income High Cost" (LIHC) definition** –A household is fuel poor if:

- Their income is below the poverty line (taking into account energy costs); and
- Their energy costs are higher than is typical for their household type.

This measure will not fluctuate with fuel costs to the same extent as the 10% definition. Local data is not yet available on this measure.

There are 3 variables which affect fuel poverty:

1. Household income
2. The price of fuel
3. The energy efficiency of the home.

Efforts to reduce levels of fuel poverty have largely focussed on energy efficiency of homes, though there are also some local schemes for bulk buying fuel or switching to cheaper providers.

Current work in Oxfordshire

This issue is multi-faceted and is being tackled by a range of organisations. The reasons an organisation may give for their involvement can be expressed differently, but all result in similar outcomes. Aims may be expressed as:

- Improving energy efficiency of buildings
- Reducing carbon emissions
- Reducing excess winter deaths (this is a health perspective which comes from the link between a cold environment and susceptibility to illness, especially for vulnerable people)

Current work to deliver this includes:

1. **Oxfordshire Affordable Warmth Network** (AWN). Four out of five district councils (excluding the City) pay an agency to provide information to residents through a helpline, website and events. In West, Vale, South and Cherwell this information is given through, for example, flu clinics and community events , raising the profile of keeping warm and well and the energy efficiency schemes available. It provides an advice line to refer those residents on to relevant services as well as provide some basic advice.

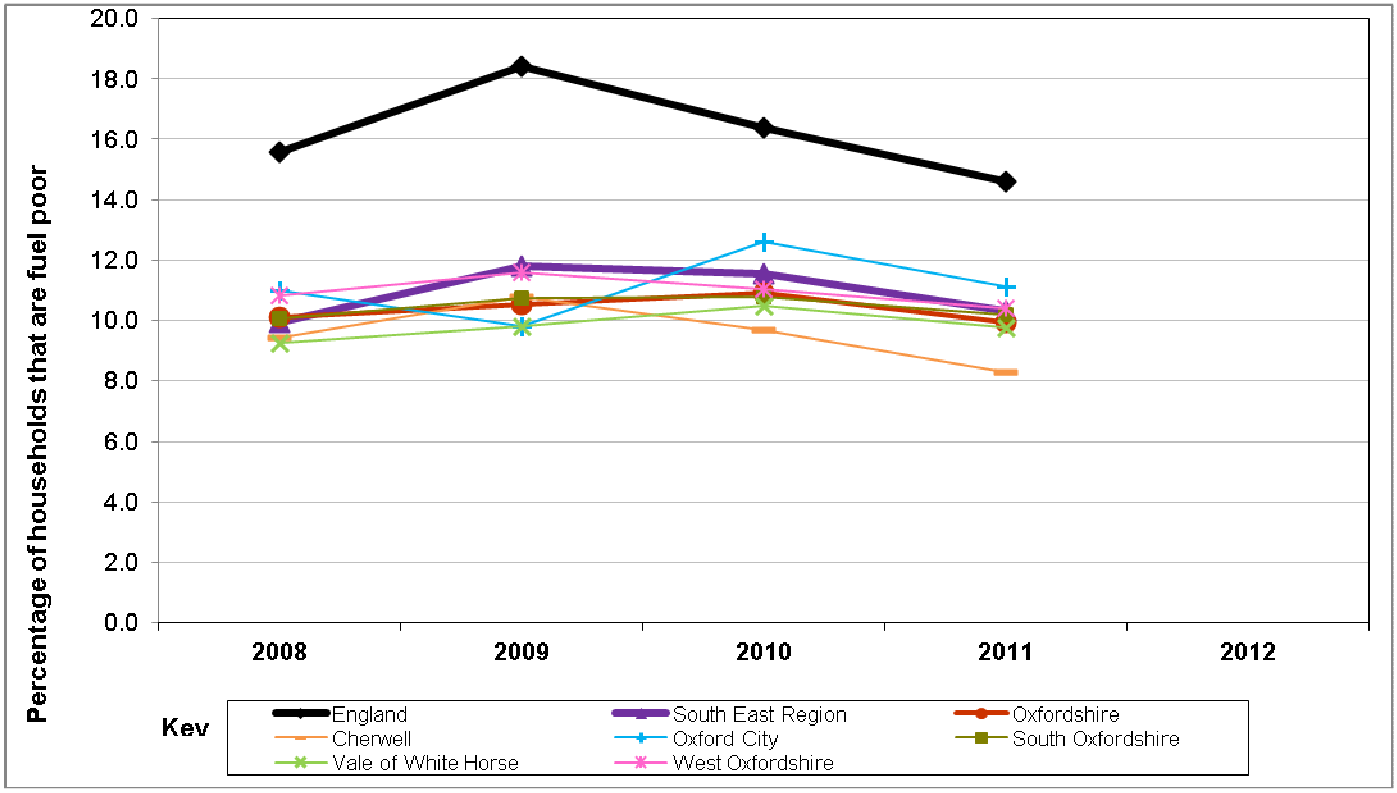
2. Green Deal and **Energy Commitment Obligation** (ECO).

Energy companies are obliged to invest in energy saving measures and this funding is accessed through partnerships. Four of the Oxfordshire District Councils have chosen to join the USEA Community Interest Company (CIC) to access and deliver the available funds. Oxford City Council are working with Low Carbon Hub and Insulation NE. The money is available to carry out energy surveys and subsequent retrofitting of energy efficiency measures, if residents are eligible.

3. Public Health England Cold Weather Plan has been updated this year at a national level. It calls for local efforts to ensure a local, joined up programme is in place to support improved housing, heating and insulation, including uptake of low carbon solutions. It also outlines the importance of signposting vulnerable clients to that help.

The current situation in Oxfordshire

1. Percentage of households that are fuel poor (i.e. spending more than 10% of income on fuel) - 2008 to 2011 (calendar years)



2. Excess Winter deaths

Excess Winter Deaths (EWD) Index measures the excess of deaths in winter compared with an expected number of deaths based on non-winter months

expressed as a percentage. Data for the year runs from August to July. Winter months are December to March. Non-winter months are August to November and April to July.

- In the winter of 2010/2011 there were 24,442 excess winter deaths (EWD) in England.
- In Oxfordshire there were 351 Excess Winter Deaths.
- In addition there is the increased incidence of heart attacks, stroke, respiratory disease, influenza and falls during the colder months.

Discussion:

Members of the Health Improvement Board are asked to consider what additional action they would like to take to improve fuel poverty rates and reduce excess winter deaths in the county.

The diagram in Appendix 1 suggests which Oxfordshire organisations and partnerships could be involved and the various activities they can / could carry out to achieve this aim.

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Health Improvement Partnership Board

This sheet must be completed and attached to the front of all papers to the Health Improvement Partnership Board so that the paper is submitted is one continuous document.

Date of meeting: Thursday 28th November 2013

Title of report: Public Involvement Network Report

Is this paper for:	Discussion	Decision	**Information x**

Purpose of Report:

To update the Health Improvement Board on main areas of focus, highlight key issues and messages from the public to inform the board and to identify forward activity.

Action Required:

As above.

Impact on Public:

Authors:

Aziza Shafique and Paul McGough
HIB PIN lay representatives

Overview

- Paul and Aziza have produced a HIB PIN plan – available to view mid Dec.
- Two main HIB PIN themes – one targeting Asian Community and the other focusing on Oxford University Hospital Trust Public Health (the joint strategy)
- Attended PIN Core Group Bubbling up session in Banbury plus North East Locality Public and Patient Health Forum - Bicester - plus other Ad hoc PPI engagement activity.
- Core questions have been drafted to encourage consistency and robustness.

Main areas of focus:

Theme – Asian Community – Key messages (Aziza Shafique)

- **Exercise:** Visits to Oxford Temple Cowley Leisure Centre women-only session – this is proving very popular especially with Asian Muslim Women. Offers swimming sessions, fitness classes and women-only gym sessions. **Key messages:** Muslim women really value women only swimming sessions and we need more facilities like this. **Comments**: Access to be further encouraged to take account of cultural and gender specific needs (especially women only sessions) with child care support. The Leisure Centre also provides a good opportunity and venue to promote healthier eating and lifestyle advice.
- **Childcare:** Rose Hill Wellbeing Project is going well
  Key messages: Availability of child care makes it easier for mothers of young children to take part. Practical things need to be taken in consideration such as childcare and the locality.
- **Breastfeeding:** I am picking up concerns around the challenges for mothers in Asian Community to breast feed, particularly new mothers.
  Comments: Muslim women to be encouraged to breastfeed for up to 2 years.

Forward activity:

- Started working with Kate King and Rebecca Cooper to gather information on breastfeeding and weaning for Asian Families
- Also working with Annie Davey of Healthwatch to gather information around health services
- I will get involved with OUH on aspects related to Asian Community with Paul

Theme: Oxford University Hospitals NHS Trust Public Health (Joint strategy) (Paul McGough)

- **Meeting held** with OUH; Andrew Stevens Director of Planning and Information & Public Health Physicians; Dr Adam Briggs, Dr Louise Marshall & Dr Ruchi Baxi. Agreed it will be possible to consult with OUH members (6700) to seek views in HIB - OUH priority areas on key themes. Next meeting in December to advance plan and clarify areas of focus for PIN. **Comment:** Public communication issue identified: How to talk about "Clinical risk" with Public – using more easily understood language.

- **Outcome Based Commissioning Maternity Services Public Engagement Survey** – Sara Price report 15th November contains a full evaluation. (With OUH support) Paul contacted 500 OUH members with declared interest in women's services and childcare – this was complementary to the main OBC Maternity Services survey.

- **Key messages** – Reinforced importance of postnatal breastfeeding support – recognising difficulties of early stages, anxieties and stress - especially for new parents.

- **Public and patient involvement meetings attended:** Banbury - PIN Bubbling up and Core Group meeting. Health Experiences Institute international seminar on shared decision making in healthcare. Bicester - North East Locality Public & Patient Health Forum.

Forward activity:

- OUH Public Health
- Nov – January OUH - Peer Review Programme: to seek views of patients and staff re Medical Rehabilitation Cardiac Services – focus groups and ward visits.
- Nov 21st Oxford Biomedical Research Centre: Bringing research to life through public talks - Involving Patients in Medical Research
- Jan 2014 - Substance Misuse Service User feedback meeting

Bubbling up issues: fed back and ongoing

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Health Improvement Board

Date of Meeting: 28 November 2013

Title of Report: Welfare Reform - Update

Is this paper for:	**Discussion**	**Decision**	**Information**
			x

Purpose of Report: To update the Board on the two projects linked to the introduction of Universal Credit that Oxford City Council are running, together with details of work being undertaken to support those affected by them. The paper also touches on the work the county council is doing around the broader impacts of welfare reform and how those impacts are being monitored by other Boards and Partnerships in the county.

Action Required: The Health Improvement Board may want to consider its role in monitoring the impacts of welfare reform going forward, bearing in mind the work of other Boards and Partnerships, for example the Adult Health and Social Care Partnership Board has agreed to monitor the specific impact on vulnerable adults.

Impact on users and carers: n/a

Author/s:

Paul Wilding, Revenues & Benefits Programme Manager, Oxford City Council
Alison Yates, Senior Policy Officer, Oxfordshire County Council

(The paper will be presented at the meeting by Val Johnson, Partnership Development Manager, Oxford City Council and Alison Yates, Senior Policy Officer, Oxfordshire County Council)

Health Improvement Board

28 November 2013

Welfare Reform - Update

Background

The paper focuses on Oxford City Council as they are running two projects linked to the introduction of Universal Credit. It provides an insight into the impact of those changes, together with details of work being undertaken to support those affected by them. The paper also touches on the work the county council is doing around the broader impacts of welfare reform and how those impacts are being monitored by other Boards and Partnerships in the county.

This report also went to the Adult Health and Social Care Partnership Board on 10 October 2013 as a result of a discussion at its November 2012 meeting. Concerns were raised at that meeting by the Public Involvement Network Board Member on the impact of the reforms.

As many of the reforms were not introduced until April 2013 it was agreed that the October and November Board meetings would be the most appropriate at which to provide an update.

Introduction

Since 2010 the government have been carrying out a significant reform of the welfare system. There have been many changes to existing benefits, and preparation is ongoing for the introduction of Universal Credit which will see the six main means tested benefits rolled into a single system.

Underoccupancy Rules in Social Sector

New rules pertaining to the occupation of socially rented properties were introduced on 1 April 2013. This has become known colloquially as the “Bedroom Tax”. These rules give an allowance for the number of bedrooms for which Housing Benefit can be paid based on the age and make-up of the household. If there is a spare bedroom then the maximum amount of benefit which can be paid is reduced by 14%. If there is more than one spare bedroom the reduction is 25%.

The typical profile of people affected by this change is individuals and couples who are over 45, and have had children who have left home. At the start of the year there were 956 households in Oxford City affected by these changes, of which 668 were Council tenants. This represented an annual loss in Housing Benefit of £534,000. However by the start of September, this number had reduced to 795. The reasons for this reduction are not known, and difficult to ascertain as there is continual change occurring within the benefit caseload. There are approximately 4 changes per year for each claim in Oxford.

The Welfare Reform Team at Oxford City have been providing advice to people affected by this measure and helping people to downsize where that is possible. Additionally households may have seen additional people move in. This could be where an adult child has moved back to the property, or where a lodger has been taken in. In 138 cases a Discretionary Housing Payment has been made to meet the Housing Benefit shortfall to give the claimant time to find a permanent solution. However the most common response from people affected by this change has been to say they will pay it themselves and cut spending elsewhere.

Benefit Cap

Over the summer a Benefit Cap has been introduced. This limits the total amount of benefit a household can receive to £500 per week for families or single parents, or £350 per week for individuals. The cap is applied by reducing a person's Housing Benefit award by the amount they exceed the Cap. There are two main exemptions to the Cap. One is where a member of the household is in receipt of qualifying disability benefits (such as Disability Living Allowance or PIP). The other is where the claimant, their partner, or both people combined, are working sufficient hours to entitle them to working tax credits.

In May it was expected that 166 households would be affected by the Cap in Oxford, 90 from the private rented sector and 76 from the social rented sector. This was based on data provided by the Department of Work & Pensions(DWP). The estimated loss of Housing Benefit annually was £1 million. However so far, only 99 households have been capped. The DWP are currently carrying out a review of cases to be capped, so it is possible that additional cases will be capped in October.

Of those cases that have been capped, the impact is as follows:

- 11 are losing over £200 per week in Housing Benefit
- 19 are losing between £100 and £200
- 24 are losing between £50 and £100
- 44 are losing under £50

The typical profile of people affected by the cap is a single parent with four or more children. It is the number of children which drive the higher levels of benefit which mean that such households are in receipt of more than £500 per week in benefits. The details of the work being carried out to support people affected by the cap is provided below.

Direct Payments Project
Oxford has been one of six sites participating in the Direct Payments Demonstration Projects which began in the summer of 2012. This is a DWP led project assessing the impact of paying social tenants their housing benefit. The project is being undertaken because Universal Credit will see most claimants receiving their benefit payment themselves, inclusive of housing support costs. Currently, nearly all social tenants have their Housing Benefit paid to their rent account.

The aim of the project is to inform the final design of Universal Credit, particularly the process of making payment to the claimant. The project will determine which categories of people might require a different arrangement for payment of their housing support and also what kind of assistance might be needed to help people manage direct payment of their housing support.

The projects have been extended by six months in order to assess how the welfare reforms introduced this year impact on people's ability to manage payment of their rent. In the first year of the project we paid 1,371 tenants their Housing Benefit directly. In the last two months payments have been made to a further 400 tenants following the project extension.

The impact on overall rent arrears of the direct payments project can be seen by comparing the arrears at the end of the last two years. For 2011/12 rent arrears were 1.7% of the rent roll. This increased to 2.6% for 2012/13. For those cases which had received a direct payment, arrears stood at 3.1% at the end of 2012/13. This year there has been a continuing reduction in arrears until the start of the extension period of the project. Following the introduction of direct payment for the 400 new cases there has been a small increase in arrears again.

It is interesting to note the impact of the under occupancy rules on people in the direct payments project. They seem to be coping with this change better than the other tenants who are affected. There are approximately 650 city council tenants affected by the under occupancy rules. A third of these are involved in the direct payments project. Those in the project have seen a 15% increase in arrears since the start of April. However for the 650 as a whole, arrears have increased by 25%. This would suggest that the financial capability of those subject to direct payment, has improved as a result of their participation in the project. There may be other factors at play though, so this will be monitored on an ongoing basis.

LA led pilot
Oxford is one of 12 LA led pilots in the country, each looking at how people claiming Universal Credit may need to be supported locally. The Oxford pilot is focussing on how people can be supported into work with a focus on those people affected by the Benefit Cap and the Under Occupancy rules in the social sector.

A team of five people was established to do this work, a project manager and four caseworkers. Although the aim of the pilot is to move people into work,

we are also considering other options for people such as moving to more affordable accommodation, or reducing expenditure so they can meet the shortfall in their rent.

An in depth interview is held when a claimant first engages with the team. The caseworker assigned to them then becomes their sole point of contact at the Council. The interview aims to establish any and all their barriers to work, and to work out a way forward for them to break down those barriers and undertake any other activity so they are able to sustain their tenancy or find a new one which is sustainable.

We are working with a number of partners to carry out the specialist work which is required to help someone into work, or resolve any barriers to work. Initially this was just Jobcentre Plus, Oxford CAB and Skills Training UK (who offer a mentoring program to help people into work). However this has been extended during the project to include Crisis Skylight, Aspire, Oxford & Cherwell Valley College and the Thriving Families programme.

To encourage people to work with the pilot, the team has been given responsibility for making Discretionary Housing Payment awards to those people in the pilot's scope. The Council's DHP policy has been amended this year and conditionality has been introduced to any award made. This means that a DHP award is conditional on certain activity being undertaken such as engaging with our partners to prepare for work, looking for alternative accommodation or reducing expenditure. If someone does not want to undertake this activity then they will not be awarded a DHP. This has proven very useful in getting people engaged with the work of the pilot. It has also helped change the culture of DHP payments in that they can no longer be seen as an ongoing solution to a shortfall in Housing Benefit. They are very much an interim solution to give people time to find a long term fix.

Up until the end of August, the pilot had engaged with 545 people of which 140 had been assigned a case worker and are working with the team on an ongoing basis. Of these 22 have secured employment have assessed 247 applications for Discretionary Housing Payment and made 160 awards. In addition in 395 cases housing or work related advice has been provided.

Local Support Services Framework

In February 2013, the DWP produced the Local Support Services Framework (LSSF). This was an offer to local authorities to help provide required services to support the front end of the Universal Credit application process. Services will be required to help people with the process of making an application, to ensure people are able to manage the single monthly payment (including housing costs), to help people access services digitally and to support people into work. The DWP intends that these services are provided by a local partnership including Jobcentre Plus, local authorities and any other organisation who are well placed to help provide some of the required services.

Following the delay in the rollout of Universal Credit, these services will not be required in Oxfordshire until April 2015 at the earliest. A second version of the LSSF is due to be published in November 2013, with a final version due in autumn 2014. These documents will help facilitate the formation of a local partnership to deliver the required services.

Activity at Oxfordshire County Council
In addition to the under occupancy rules in the social sector and the benefit cap, there are a number of other reforms that have been introduced, and are to be introduced, in Oxfordshire. These are listed in Annex 1.

The county council has established a group of lead officers from each directorate to monitor and plan for the impacts of the reforms. This ensures that directorates have the latest information on the changes and that feedback on the impact of the reforms from operational teams is shared.

Relevant teams are also working closely with partners, including district councils, to share information and knowledge. For example: the Children's Management Team is part of the Universal Credit Project Board chaired by Oxford City Council, receiving updates on the project's progress; both the Children's Management Team and the Thriving Families team are receiving data on families affected by City's pilots to ensure proper oversight; the Economy and Skills team, the Oxfordshire Skills and Learning Service, and the Library Service attend the 'Back to Work' group which is chaired by Job Centre Plus and directs funds received from the Skills Reward Grant.

Localisation of the Social Fund
From 01 April 2013, the discretionary elements of the Social Fund – which had been administered by DWP - were abolished. Oxfordshire County Council introduced a new scheme, run by Auriga Services Limited, to provide local welfare assistance to vulnerable people living in Oxfordshire.

The Fund supports vulnerable people living in Oxfordshire by helping to meet basic needs in a timely way. Assistance is mainly given through the provision of goods and services, although cash payments are available where goods and services are not appropriate.

The priority groups for assistance are: people establishing themselves in the community e.g. moving out of institutional or residential care; people who need help to remain in the community; and people who are facing exceptional pressure, particularly in the event of an emergency or a disaster.

Monitoring the impacts of welfare reform
The Health Improvement Board is monitoring the reforms as part of its responsibility for tackling the broader determinants of health through better housing and preventing homelessness. It is tracking indicators including the number of households homeless due to rent arrears, and the percentage of households that suffer from fuel poverty.

The Learning Disability Partnership Board has discussed the impacts of welfare reform, particularly around the roll out of Personal Independence Payments (which replaces Disability Living Allowance). They have also raised concerns around the reductions in local area housing benefits and exemptions for supported housing providers.

The Better Mental Health Oxfordshire Commissioning Programme Board has also raised the issues faced by people with mental illness. Patrick Taylor from MIND has outlined the main three key issues affecting people with mental health problems in light of welfare reform. This is attached in Annex 2.

At its meeting on 10 October the Adult Health and Social Care Partnership Board has agreed to monitor the specific impact of the reforms on vulnerable adults.

Annex 1

The following key reforms have been introduced in Oxfordshire to date:

Reform	**Date of introduction**	**Group most affected**	**Numbers affected (approx.)**	**Estimated annual loss by 2015/16 (£m)[1]**
Incapacity Benefits restricted[2]	01 April 2012	Sick or disabled former workers; young disabled (16-19yrs)	n/a	22.1
Size eligibility criteria ('bedroom tax') extended to social housing	01 April 2013	Social sector renters with spare rooms – esp. older people and disabled people	3,100	2.5
Uprating of many working-age benefits restricted to 1%	01 April 2013	All working age claimants (excl. disabled and carers)	n/a	22.3
Non-dependent deductions increased	01 April 2013	Renters – private and social sector	n/a	2.2
Council Tax Benefit (CTB) replaced by local reduction schemes	01 April 2013	n/a	35,560	2.6 (in 2013/14) This 'loss' was not passed onto claimants.
Social Fund abolished and replaced by the	01 April 2013	n/a	n/a	0.08*

[1] Source: FT Austerity Audit April 2013

[2] e.g. People on Incapacity Benefit and Severe Disablement Allowance are being moved to Employment Support Allowance (ESA), but only if they have matched the criteria of a revised, tougher, medical test. Certain elements of ESA are also being restricted.

'Oxfordshire Support Fund'				
Personal Independence Payment (PIP) replaced Disability Living Allowance (DLA) for new working age claimants	June 2013 (Existing claimants are unlikely to be affected until October 2015 at the earliest)	People with disabilities making a new claim. Incl. disabled children turning 16 or anyone with changed circumstances.	500-800 per year	n/a (The budget for PIP will be 20% lower than that of DLA)
Benefit cap introduced	Roll out complete by Sept 2013	Large families and those in high rent areas.	300	1.7

Reforms in the process of being rolled out:

Reform	**Date of implementation**	**Numbers affected**	**Estimated loss in year 2015/16(£m)**
Universal Credit -replacing six working-age benefits	Not yet known – an announcement on roll-out plans is expected in the Autumn of 2013.[3]	n/a	n/a

Annex 2

mind
for better mental health

Welfare Reform Report to Oxfordshire Health Improvement Board

Submission from Oxfordshire Mind:
Welfare reform and the impact on people with mental health problems

The welfare reform changes being introduced over the next few years will present a significant barrier to those with mental health problems in accessing their benefit entitlement. The changes are principally aimed at encouraging those who can return to work; as a result those who are unable to work due to mental health issues are being caught up in a system that ignores their needs and puts up barriers to their accessing their benefit entitlement. It also reduces

[3] Four 'pathfinders' are running in north-west England, with a further six beginning between October 2013 and spring 2014 – none of these are in Oxfordshire.

their potential entitlement through onerous assessments and has brought confusion to this vulnerable group.

Having seen over 3,000 people with mental health conditions over the last few years, Oxfordshire Mind's Benefits for Better Mental Health project has seen at close hand the impact that these changes are having.

We have been asked to say what we see as the main three issues affecting people with mental health problems.

These are as follows;

1. The end of Disability Living Allowance

With the abolition of Disability Living Allowance (DLA) and its replacement with Personal Independent Payments (PIP), we expect to see over 20% of those currently entitled to DLA being unable to claim PIP. The criteria for PIP has been designed to cut entitlement to the benefit by 20%, but we believe that those with mental health issues will be hardest hit as they will no longer be able to claim the lowest rate of care – as they reach a level of stability in their recovery they will cease to be able to claim this important benefit which currently allows them to manage financially.

The introduction of PIP also brings with it the need for applicants to attend a face to face assessment. This already causes great anxiety and fear amongst those with mental health issues as the assessment focuses on their 'functionality'. As those with mental health conditions can vary their 'functionality' also varies and this is frequently overlooked during the assessment. The result of this is that people are forced to go though the long and arduous appeal process whilst poor and inaccurate decisions are challenged. The volume of appeals has the knock on effect of leaving them without their entitlement for often over a year at a time. This makes it all the more important that people get the right help to complete their claims as well as support to appeal.

2. Changes to the Appeals System

We are also very concerned by the changes to the appeal system itself. Over the last five years, Benefits for Better Mental Health have represented on several hundred appeals averaging a 95% success rate. We have seen an increasing range and number of decisions challenged and anticipate that as a result of dual benefit systems running parallel, we are likely to see more appeal requests than ever before.

Dealing with these additional appeals will become far more demanding from October 2013, as each decision which needs to be challenged will face a mandatory reassessment of undetermined time. Even those challenging Employment Support Allowance decisions will be without any income during this period unless they are able to claim Job Seekers Allowance – which they cannot

do if they are unfit for work – and so are likely to be caught in a 'Catch 22' position.

The changes have also resulted in an increase in the number of ways that appeals are made, so that whilst we have to date had one appeal channel, from October there will be five appeal channels which will cause confusion and further distress unless the person is able to access appropriate help at the right time.

3. Introduction of Universal Credit

The third issue may prove to the most significant of all - and that is the introduction of Universal Credit (UC) to replace all income related benefits.

UC is designed to be part of the governments 'Digital by Default' programme and so will require that claimants make and maintain their claim on-line, there will be no special assistance for those not seeking employment from Job Centre Plus and so we anticipate that there will be significant difficulties for those with mental health issues in making and updating their claims – even when they have access to good IT.

The other most concerning issue regarding the introduction of UC will be that payments will now be made to only one household account one month in arrears. Housing benefit payments will be included with all other benefit payments as a lump sum and claimants will start the process already in arrears. The financial impact of this could be very worrying indeed. We know that trials some areas resulted in over 30% of those on the trial being removed from it as they immediately started building up arrears and facing financial problems.

The combination of these changes will affect those most vulnerable though their mental health conditions and place further barriers in accessing and maintaining their benefit entitlement and we believe that it is essential that they are able to receive the help and support they need by informing then of the changes in a timely manner and in assisting them in getting their legal entitlement

Oxfordshire Mind
September 2013