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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, 27 March 2014 at 2.00 pm

Old Library, Oxford Town Hall, Oxford

Peter G. Clark
County Solicitor

Published: 19th March 2014

Contact Officer: ***Sophie Kendall, Partnership & Policy Officer***
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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
Dave Etheridge	Chief Fire Officer & Head of Community Safety
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Voluntary Sector
Paul McGough	Public Involvement Network
Dr Jonathan McWilliam	Director of Public Health
Dr Paul Park	Oxfordshire Clinical Commissioning Group
Cllr G.A. Reynolds	Cherwell District Council
Aziza Shafique	Public Involvement Network
Cllr Alison Thomson	Vale of White Horse District Council
Jackie Wilderspin	Assistant Director for Public Health

Notes:

- ***Date of next meeting: Thursday 29th May 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 September Meeting (Pages 1 - 6)

To approve the amended Note of Decisions of the meeting held on 26 September 2013.

6. Note of Decision of Last Meeting (Pages 7 - 14)

2.05
5 Minutes

To approve the Note of Decisions of the meeting held on 28 November 2013 and to receive information arising from them.

7. Joint Strategic Needs Assessment Annual Report (Pages 15 - 50)

2:10
20 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin, Oxfordshire County Council

The draft annual Joint Strategic Needs Assessment report to the Health and Wellbeing Board, reporting on trends in local data.

8. Performance Report (Pages 51 - 56)

2:30
20 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jonathan McWilliam, Oxfordshire County Council

A report of progress against the targets of the Health Improvement Board.

9. Healthy Weight Strategy (Pages 57 - 84)

2:50
20 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Rebecca Cooper, Oxfordshire County Council

The draft Healthy Weight Strategy 2014-17, which aims to tackle obesity and promote healthy weight for the people of Oxfordshire.

The Health Improvement Board are recommended to:

- Approve the Strategy
- Agree that the draft action plan for the Strategy is developed further, in conjunction with stakeholders during the consultation process, and is returned to the Health Improvement Board for final approval

10. Oxford University Hospitals Trust and Oxfordshire County Council Joint Public Health Strategy (Pages 85 - 96)

3:10
20 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Louise Marshall, Oxfordshire County Council and Adam Briggs, Oxford University Hospitals Trust

The purpose of this paper is to seek the approval of the Board for this public health strategy for Oxford University Hospitals Trust, with priorities for 2014/15.

This strategy will be jointly owned by Oxford University Hospitals Trust and Oxfordshire County Council, and has been approved by the Oxford University Hospitals Trust Board.

11. Public Involvement Network Update (Pages 97 - 102)

3:30
10 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Paul McGough, Public Involvement Network Representative

A paper to update the Health Improvement Board on the Public Involvement Network

Representatives' main areas of focus and to highlight key issues and messages from the public to inform forward activity.

12. Public Health Protection Forum Report (Pages 103 - 106)

3:40
15 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Eunan O'Neill, Oxfordshire County Council

A report on the activity of the Public Health Protection Forum over 2013-14, performance and forward plan for 2014-15.

13. Forward Plan (Pages 107 - 108)

3:55
5 minutes

People responsible: Members of the Health Improvement Board

Presented by: Councillor Mark Booty, Chairman

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

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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

INFORMAL HEALTH IMPROVEMENT BOARD

OUTCOMES of the meeting held on Thursday 26 September 2013 commencing at 2.00 pm and finishing at 4.10 pm.

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

By Invitation:

Officers:

Whole of meeting: James Martin, Oxfordshire County Council

Part of meeting

Agenda Item	**Officer Attending**
Agenda item 8	Ruchi Baxi, Public Health Specialty Trainee
Agenda item 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 James Martin (Tel 01865 32 3344: Email:James.Martin@Oxfordshire.gov.uk)

	ACTION
1. Welcome 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 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 No declarations were received	
4. Petitions and Public Address No petitions or public addresses were received	
5. Note of Decision of Last Meeting 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 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 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 that 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 on the 23rd January 2014**	**KK**
8. Proposal for a Public Health strategy with Oxford University Hospital 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 health of hospital employees and patients.	
9. Older People's Housing Strategy Needs Analysis 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. **However concern was raised about the ability of District Planning**	

Authorities to influence precisely the extra care housing numbers identified. Districts/City councils are not commissioners of such housing and there are many housing type and other development matters which need to be considered in relation to this particular requirement. In addition, the dynamics of the housing market are such that planning authorities cannot determine the timescale for delivery of what is agreed despite their best endeavours to encourage new housing where appropriate. 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 PIN Aziza Shafique introduced herself as the new Public Involvement Network representative.	
11. Public Health Campaigns Councillor Hibbert-Biles detailed the Public Health campaigns that will be taking place over the next six months. Thanks were noted 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 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 agreed**	 **JW / JM** **JW / JM**
The meeting closed at 4:10 pm.	

..... in the Chair

Date of signing .....

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Thursday 28 November 2013 commencing at 2.00 pm and finishing at 4.30 pm.

Present:

Board Members:	West Oxfordshire District Councillor Mark Booty – in the Chair
	Oxford City Councillor Ed Turner (Vice-Chairman)
	Councillor Alison Thomson, Vale of White Horse District Council
	Councillor Anna Badcock, South Oxfordshire District Council
	Ian Davies, Strategic Director, Cherwell & South Northamptonshire District Councils
	Councillor George Reynolds, Cherwell District Council
	Dr Jonathan McWilliam, Director of Public Health
	Paul Park, Oxfordshire Clinical Commissioning Group
	Jackie Wilderspin, Public Health Specialist
	Paul McGough, Public Involvement Network
	Aziza Shafique, Public Involvement Network

Officers:

Whole of meeting	Val Johnson, Oxford City Council
	Lynda Chalcraft, Oxfordshire County Council
	Sophie Kendall, Oxfordshire County Council

Agenda Item	**Officer Attending**
6	Eunan O'Neill, Oxfordshire County Council
	Becky Cooper, Oxfordshire County Council
11	Dave Lansley, Oxford City Council
9	Alison Yates, Oxfordshire County Council
	Jan Deacon, Oxfordshire Affordable Warmth Network
	Ian Wright, Oxford City 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 Sophie Kendall (Tel: 01865 32 8530; Email: Sophie.Kendall@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 Paul McGough and Paul Park 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 and Councillor Hilary Hibbert-Biles. The Board was informed that Dr Jonathan McWilliam and Paul Park would be joining later, owing to a Clinical Commissioning Group meeting.	
3 Declaration of Interest (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) The Board was informed that due to the budget process the decision on the financial aspect of the re-commissioning of the homeless pathway is not available at the moment. A draft will go out for consultation within the next two weeks. Jackie Wilderspin proposed that the board offers itself as a place for discussion on options for the future. It was noted that the Supported Housing Officers' Group will be doing the work on the implications and agreed that the Board would revisit the issue in the January meeting. Councillor Anna Badcock expressed concern that the draft minutes do not accurately reflect the discussion that was had on housing for older people. Whilst there was agreement on Extra Care Housing, it was also emphasised that it needs to be kept in balance with other types. It was agreed that these minutes would be amended and brought to the Board for approval at the next meeting. The Board was also informed that John Jackson is awaiting the completion of the strategic market assessment before drafting a note of the concerns that are currently held in relation to ensuring that future housing needs of older people are met.	

ACTION: **The Vice Chairman asked for a timetable to be circulated re budget decisions and work to commission the homeless pathway.**	**JJ**
The draft minutes from the 26th September meeting will be amended and brought to the Board for approval at the next meeting.	**VJ / ID**
The Homeless Pathway and Older People's Housing Strategy Needs Analysis will be held as future agenda items.	**JW**
6 Performance Report (Agenda No. 6) Jackie Wilderspin introduced and explained the performance report, presenting an additional document which provided a breakdown on the range of outcomes for some of the indicators. It was acknowledged that the range across localities revealed by this more detailed presentation of data raises some important questions. . It was agreed that this format will be adopted going forward and other opportunities to present even more detailed data will be sought, down to ward level when possible and showing trends. Report cards were presented on the two measures currently rated red: 8.3 – At least 65% of those invited for NHS Health Checks will attend (ages 40-74). This report card was presented by Eunan O'Neill. The discussion that followed focused on how GP practices notify patients of health checks and whether follow-up reminders are sent. It was suggested that text messages and emails might be effective. The possible use of community settings for delivering health checks was suggested. A possible role for the business sector in promoting health checks for employees was also mooted. Other suggestions included working with social landlords and promoting health checks at events. The Vice Chairman asked for data on take-up by ethnicity. 9.3 – 62% of babies are breastfed at 6-8 weeks of age (currently 59.1%) This report card was presented by Becky Cooper. There was concern about the availability of breastfeeding support to mothers within the first ten days of giving birth, as it is likely to determine longer-term breastfeeding rates. It was acknowledged that owing to the many agencies involved, this indicator is challenging to monitor. Data on specific locations and communities would be helpful. There was discussion about what the role of the Board can be, with suggestions of promoting campaigns and commissioning specific services alongside	

setting direction and monitoring progress. **ACTION:** **The Vice Chairman requested a breakdown by ethnicity for indicators 8.2 and 8.3.** **Reports on 11.2 (MMR vaccinations) and 11.3 (flu vaccinations) will be brought to a future meeting as part of the Public Health Protection Forum report.** **Becky Cooper to provide link to Unicef's Baby-friendly initiative: http://www.unicef.org.uk/babyfriendly/**	 **EO** **EO** **BC**
7 Making Every Adult Matter (Agenda No. 7) Val Johnson introduced the paper about the pilot, which aims to bring a range of organisations together to improve services for people with complex needs and chaotic lives. It was agreed that this was a good initiative. **ACTION:** **In response to Ian Davies' suggestion, Val Johnson will ensure there are links with the Thriving Families Programme.** **The outcomes will be reported back to the Board in one year.**	 **VJ** **VJ**
8 Healthy Weight Strategy Development (Agenda No. 8) Becky Cooper introduced a paper explaining the four areas the healthy weight strategy will cover. The Board was informed that meetings are being set up with chief officers in the District Councils and responses are awaited from the Vale of White Horse, South Oxfordshire and West Oxfordshire. Councillor Anna Badcock welcomed the approach and suggested a priority area should be addressing the insufficient amount of sports provision in schools. The Vice Chairman suggested working with young people on cooking and diet as another priority, highlighting the positive impact of the cookery project in Rose Hill. Ian Davies emphasised a focus on 'healthy weight' rather than obesity. Aziza Shafique drew attention to the bigger picture of deprivation, as well as targeted sporting activities such as popular women-only swimming sessions. Overall, there was consensus that district councils have an important role to play in addressing the issue.	

ACTION: **Becky Cooper will contact Councillor Anna Badcock, Councillor Alison Thompson and Councillor Mark Booty, who will follow up with their respective officers.** **The draft Healthy Weight Strategy will be presented to the Board in early 2014.**	**BC/ AB/ AT/ MB** **BC**
9 Fuel Poverty and Excess Winter Deaths (Agenda No. 9) Jackie Wilderspin introduced a briefing on fuel poverty and excess winter deaths and asked the members of the Board what more their organisations could be doing to address the issues raised. It was agreed that there is cause for concern in Oxfordshire because of the health implications of fuel poverty, even though rates are lower than national averages. It was agreed that there is a need to build on existing work and improve coordination. Jan Deacon was invited to outline the work of the Affordable Warmth Network: • Improving the energy efficiency of households • Providing advice and signposting on benefit checks • Checking tariffs across providers • Providing additional support to those with health conditions The main discussion was about the role the Health Improvement Board can and should play. Dr Jonathan McWilliam emphasised the importance of having a measure on fuel poverty, as it is at the interface of issues related to housing, health and older people. Ian Davies emphasised the leadership role that needs to be taken by District Councils and the challenge for future funding.. Councillor Anna Badcock proposed an audit of what is currently available, including potential funding sources. The Chairman proposed the Board may need to think about both broadening and better targeting existing initiatives and asked for more information from the Affordable Homes Network. **ACTION:** **The Vice Chairman will email round an update note from Oxford City Council on fuel poverty.** **Val Johnson will work with Jan Deacon of the Affordable Warmth Network and make proposals on how to move forward. A future report will also include ideas on how to identify households in fuel poverty and a review of available funding.**	**ET** **VJ**
10 Update from the Public Involvement Network (Agenda No. 10) Paul McGough introduced a report of the work he and Aziza Shafique are	

undertaking to develop core questions and the key messages from recent public engagement events. It was agreed that Paul and Aziza have made outstanding start the Board was reminded ask them to consult on particular issues as they arise. **ACTION:** **The Chairman suggested Paul and Aziza attend Oxfordshire Clinical Commissioning Group's Call to Action workshops.**	**PG/ AS**
11 Welfare Reform (Agenda No. 11) Valerie Johnson introduced a report on welfare reform. Dave Lansley (Oxford City Council Welfare Reform team) and Alison Yates (Senior Policy Officer at Oxfordshire County Council) were also introduced. A number of projects and pilots are underway in Oxfordshire, although the introduction of Universal Credit has now been delayed to 2015. The Chairman concluded it is too early to consider what role the Board might play and in the meantime developments should be closely monitored. **ACTION:** **Jackie Wilderspin will work with Alison Yates and Val Johnson to update the Board on future developments.**	**JW**
12 Forward Plan (Agenda No. 12) **ACTION:** **Jackie Wilderspin and Val Johnson will consider what has been discussed and circulate a proposal for the January (23rd, 2-4pm) and March (27th, 2-4pm) meetings.** **In future 40 minutes will be scheduled for the Performance Report.**	**JW/ VJ** **SK**
13 Any Other Items (Agenda No. 13) **ACTION:** **Val Johnson will provide an update on the Disabled Facilities Grant at the next Board meeting.**	**VJ**
The meeting closed at 4:30pm.	

..... in the Chair

Date of signing .....

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Joint Strategic Needs Assessment Annual Report 2014

The Joint Strategic Needs Assessment (JSNA) monitors trends in the health and wellbeing of the Oxfordshire population and assesses changing patterns of need and demand for services across the county. This year's JSNA looks at a wide range of data across the topics of:

- Population
- Groups with protected characteristics
- Wider determinants of health
- Mortality and morbidity
- Healthy Lifestyles and Behaviour
- Service Demand
- Quality of services

New to this update of the Oxfordshire JSNA are locally-produced datasets and analysis including:

- Oxfordshire County Council, Housing Led Population Forecasts
- FACE Needs Profile Database – a database of the social care needs of people on Self-Directed Support;
- Service user feedback from consultation events and complaints teams;
- Operational data from the Central Southern Commissioning Support Unit
- Recent 2011 Census releases.

Finding out more:

For a detailed look at the data which informs this report, go to http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment. The website includes interactive dashboards showing key datasets, single issue reports and needs analyses (detailed links follow at the end of this document).

Executive Summary

The analysis presents a picture of an increasingly diverse county, which is, in the most part, a relatively healthy and prosperous place to live. However, it is clear that certain areas of the county experience less benign conditions which are associated with poorer health and wellbeing outcomes. These areas tend to be in the more economically deprived parts of South East Oxford and Banbury but include parts of Abingdon, Berinsfield, and Didcot.

The county's population is growing. This is due to increased inward migration, particularly in the urban hubs of Oxford and Banbury, and the increasing life expectancy of the existing population, particularly in the rural areas of the county. The mini baby boom of the past ten years, which has seen numbers of children increasing year on year, is forecast to level off, stabilising demand for early years

provision and schools over the next ten years following a further increase in the immediate future.

The proportion of older people is likely to continue increasing and this will have implications for service demand. Recently, demand for both Children's and Adult Social care has been increasing at a faster rate than even that which would be expected by population growth, suggesting that previously unmet need is coming forward.

Disability free life expectancy is increasing at a faster rate than life expectancy, meaning that not only are people living longer, in the future they might be expected (at the population level) to be living in good health and free of disability for longer towards the end of their lives. This is particularly true for the male population but will need further monitoring to see if it is a sustained trend, and if so what the implications are.

Data on mortality and morbidity suggest that Oxfordshire residents are less likely than those of the wider region to die early from cancers and circulatory diseases but that the identification of cancers is above the regional rate.

Assessment data for older people accessing Self-Directed Support gives a picture of the kinds of needs and disabilities people have at the point when they access care. Analysis has shown that close to one third of older people on Self-Directed Support have dementia, with the proportion being highest among people in the 80-94 age band. For service users over the age of 95 the most common disabling condition was arthritis.

In line with the growing population, as well as shifts in the way people are accessing them, some services are seeing significant challenges in meeting demand. This can be seen in the increasing demand around delayed transfers of care, the proportion of A&E waits which take more than 4 hours, and the increasing demand for adult and children's social care.

Feedback from service users has emphasised the importance of giving clients control over their daily lives including their care choices. Consultation feedback has also highlighted the difficulties people find in accessing up to date information and advice on the care options available.

<u>Limitations of the data and areas for future development</u>

The identified trends in life expectancy and disability free life expectancy are two of a number of factors which should be considered when projecting who will use services in the future. The analysis of rising demand in social care for older people suggests that a large proportion of the people who might be eligible for social care do not currently access services, but that this picture may be changing. Any estimates of population level demand must consider the fact that previously unmet need may come forward creating further pressures on services. Work is already underway with

the London School of Economics to develop a more textured model of future demand for adult social care.

Much of the available data does not allow detailed analysis of health outcomes by particular client characteristics – e.g. age, ethnicity, or local level geographies. This makes it difficult to identify areas where inequalities of outcome exist. In addition, the separate nature of health and social care records limits the ability to analyse patient pathways and understand complex needs in the service user population.

Section 1 – Population

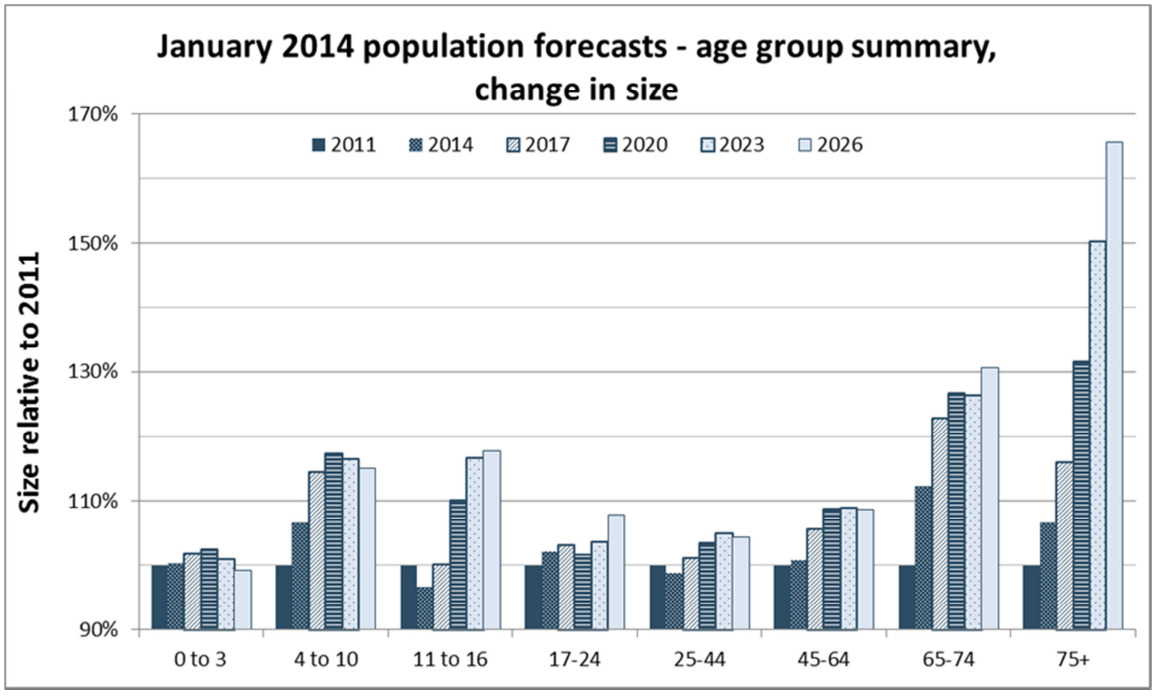
Population change

Unless otherwise stated, this section discusses the outputs of the January 2014 population forecasts produced by Oxfordshire County Council: unlike ONS Population Projections, these forecasts take into account housing supply growth trajectories (some 45,000 extra homes in 2026 vs. 2011) as set out by district planning authorities, giving a more complete picture of future population change.

Oxfordshire's population has aged since the 2001 Census, due to older age groups experiencing greater growth than younger groups. The 65-and-over population grew by 18% from 2001 to 2011, while the number of people aged 85 and over increased by 30%. The number of people in their 30s in the County declined by 12% whilst the number of children aged 4 and under has grown by 13%[1].

Over the next 15 years, Oxfordshire's total population is forecast to grow by 93,000 (14%), from 655,000 residents in 2011, to 748,000 in 2026. This growth will be because the number of births is forecast to exceed the number of deaths by 45,000, and 50,000 more people are forecast to move into Oxfordshire than to move out.

Oxfordshire's population is forecast to continue aging. The proportion of the population that is above the current retirement age (65) is forecast to increase from 16% in 2011 to over 20% by 2026, whilst the proportion that is of working age is forecast to fall.



Source: 2014 Housing led Population Forecasts, Research and Intelligence Team

[1] Figures from ONS, 2001 Census and 2011 Census

Forecast increases are most dramatic in the oldest groups: 66% growth in the 75+ group (from 50,000 in 2011 to 82,000 by 2026) and 69% growth for the 85+ group (up from 15,000 in 2011 to 25,000 in 2026). This is due to a combination of falling death rates, and baby-boomers entering this age range. The rate of growth among these age groups is predicted to be highest in rural areas of the county, with numbers remaining relatively constant in Oxford City.

For the 4-16 age group, the latest forecasts are for growth from a total of 97,000 in 2011 to 127,000 in 2026 (16% growth). Whilst the 4-10 group will peak in 2020, the 11-16 group will peak in 2026. The 0-3 age group will not change significantly over the period.

Fertility rates (the average number of children born to a woman over a whole lifetime) rose across England throughout the 2000s and early 2010s and are expected to reach a forty-year high-point in 2013. International migration into Oxfordshire was shown by the 2011 Census to have been higher than previously expected, which increased the number of women of childbearing age. These two factors have caused a recent "baby-boom" in Oxfordshire which is expected to level off over the next 10 years.

At birth, numbers of people in England recorded as male at birth slightly out-number females, but in the overall population, recorded numbers of females slightly out-number males. This is primarily a result of the fact that mortality rates for men are generally higher than for women.

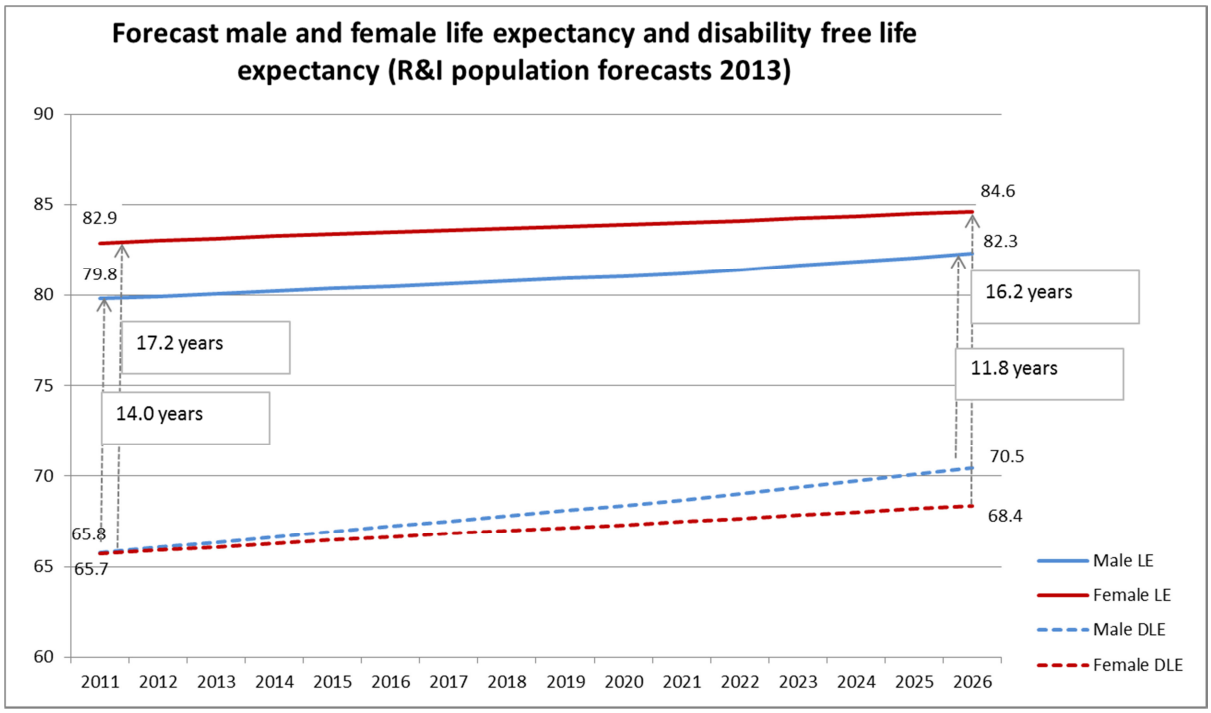
Life expectancy

Life expectancy at birth predicts the average number of years a person born today could expect to live if they were to experience that area's age specific mortality rates. In line with falling mortality rates, life expectancy has been increasing for some time. In Oxfordshire life expectancy for a person born in 2013 was above the national average at 80.3 for males and 84.1 for females[2].

In 2011, female life expectancy in Oxfordshire was higher than male life expectancy by 3.1 years. This gap has reduced in recent years with male life expectancy increasing at a faster rate. If current trends continue the gap in male and female life expectancy will reduce to 2.3 years by the year 2026.

Disability-free life expectancy (DLE) estimates the number of years a person will live before they are affected by a disabling condition. Currently disability free life expectancy is 65.7 for males and 65.8 for females. This is relevant because it predicts the age at which people are likely to need some level of support in their activities of daily living, whether through informal arrangements or formal care through their local authority.

[2] 2013 - Health Profiles, Public Health England http://www.apho.org.uk/default.aspx?RID=49802



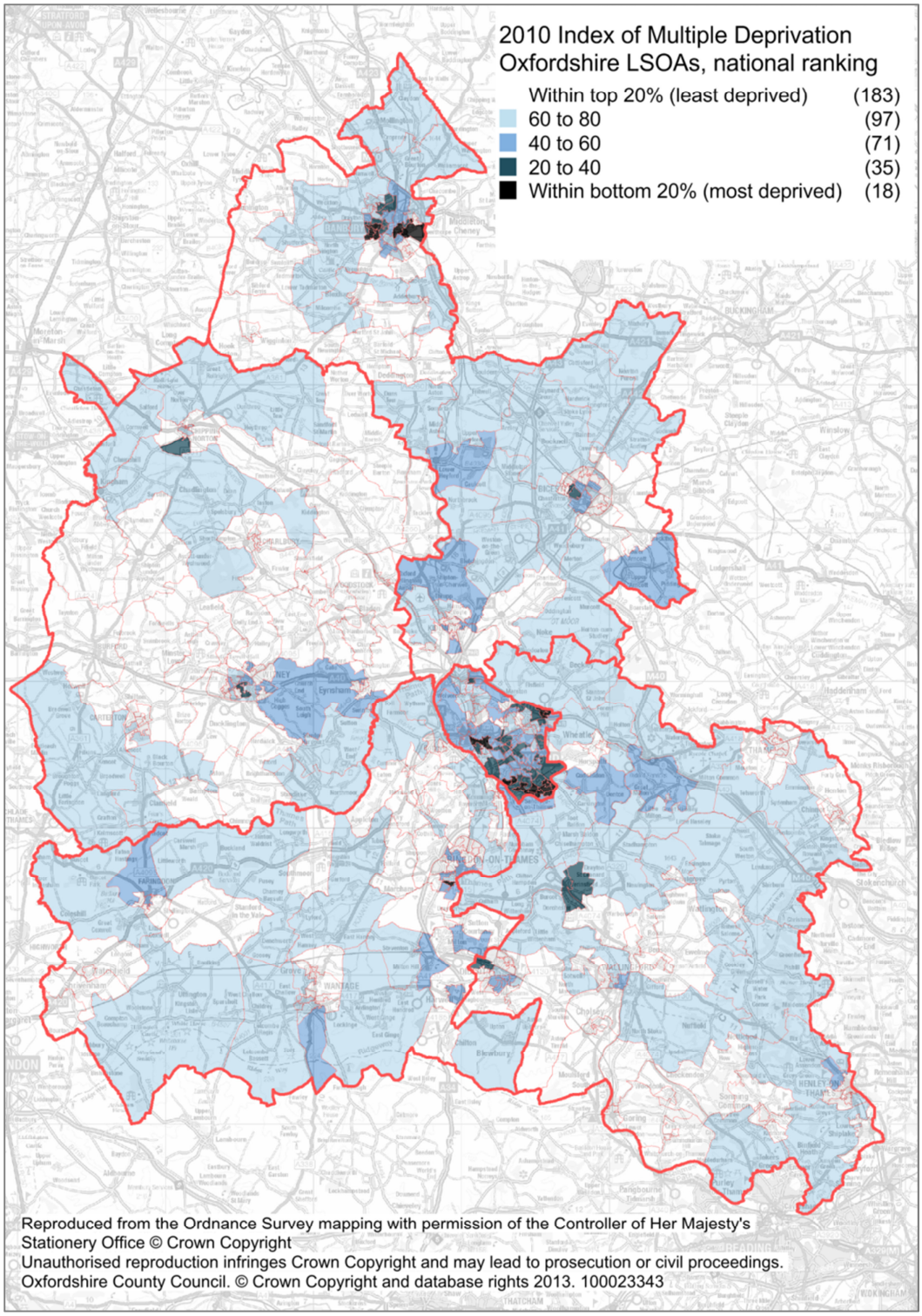
Source: ONS 2011 Mid Year Population Estimates, ONS death data, and ONS mortality assumptions for future years (taken from 2011 SNPPs)

ONS have also produced historic data on the relationship between total life expectancy and disability free life expectancy, which shows that DLE is increasing at a faster rate that LE. Assuming that this historic trend observed 2001 to 2010 continues to apply over the period 2011 to 2026, the gap between life expectancy and disability free life expectancy will reduce for both females (from 17.2 to 16.2 years by 2026) and males (from 14 to 11.8 years by 2026). Assuming the trend continues, by 2026 DLE would be 70.5 years for males and 68.4 years for females.

Deprivation

According to the 2010 Index of Multiple Deprivation, Oxfordshire ranks as the 12th least deprived upper tier local authority in the country. However, 18 Oxfordshire neighbourhoods (Lower Super Output Areas – LSOAs) rank among the 20% most deprived in England. These areas experience significantly poorer outcomes in terms of health, education, income and employment, and include a number of areas of South East Oxford, Abingdon, and Banbury[3]. These areas are shaded in dark blue on the following map:

[3] LSOAs in the following wards - Northfield Brook, Rose Hill and Iffley, Blackbird Leys, Barton and Sandhills, Banbury Ruscote, Banbury Grimsbury and Castle, Littlemore, Holywell, Abingdon Caldecott,



Source: Oxfordshire Insight, data taken from 2010 Index of Multiple Deprivation, DCLG.

It is notable that Oxfordshire contains relatively high levels of deprivation on the geographic barriers index, which assesses the average road distance to key services such as hospitals and schools. 139 of the 404 neighbourhoods in the county are among the 20% most deprived nationwide in this respect. The majority of these areas are in Cherwell, South Oxfordshire, Vale of White Horse, and West Oxfordshire and are predominantly rural.

Further Information

Population dashboard showing population forecasts at district level by single year of age. Download district level forecast data by user defined age bands, and compare population pyramids for different years and districts:

http://insight.oxfordshire.gov.uk/cms/population-forecasts-dashboard

Life expectancy dashboard – Includes data on male and female life expectancy at birth and male and female life expectancy at age 65 by district, county and region:

http://insight.oxfordshire.gov.uk/cms/health

Index of Multiple Deprivation Dashboard - maps and ward profiles for the 2010 Index of Multiple Deprivation:

http://insight.oxfordshire.gov.uk/cms/index-multiple-deprivation-dashboard

Section 2 – Protected Characteristics

All public bodies are required under the equalities act to consider the needs of people with protected characteristics – ethnicity, sexual orientation, and religion (age and gender are described in the population section above). This section gives the latest available data on the numbers of people in these groups, and, where relevant, their geographic distribution.

For the most part it is not currently possible to analyse health outcomes for people in these different groups (available data have been referenced in the Mortality and Morbidity and Lifestyle sections).

Ethnicity

The ethnic composition of Oxfordshire has changed since the 2001 Census. All of the county's black or minority ethnic communities have grown, and now account for 9.2% of the population, just under double the 2001 figure of 4.9% (Census 2011 table: KS201EW).

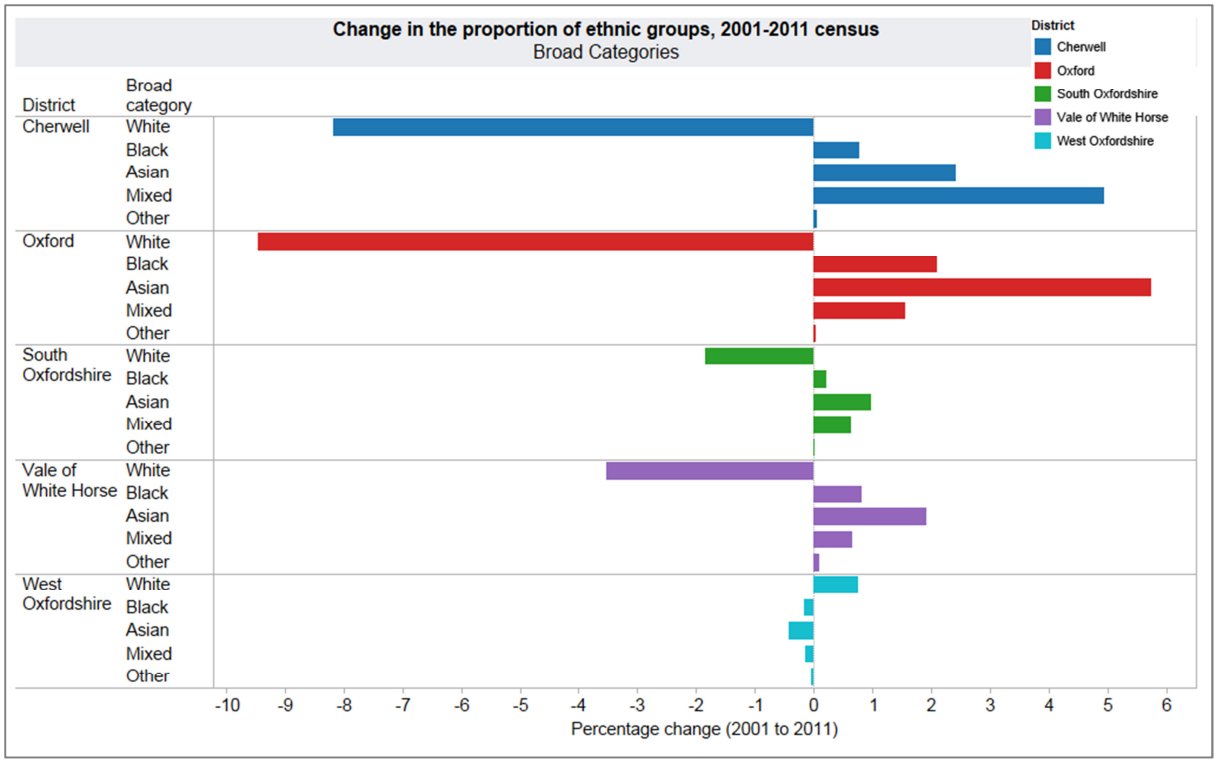
There has been a growth in people from White backgrounds other than British or Irish, who now account for 6.3% of the population (up from 4% in 2001). Much of this increase is explained by a movement of people from the countries which joined the EU in 2004 and 2007. In 2011, 13,000 residents in Oxfordshire were born in these countries, with more than half born in Poland (7,500 people, 2,700 resident in Oxford and 2,300 in Banbury).

People from White Gypsy or Irish Traveller backgrounds make up 0.1% of the county, and this is the same proportion across all the districts aside from West Oxfordshire, where 0.2% of the population classify themselves as such.

4.8% of the population are from Asian backgrounds, twice the 2001 figure of 2.4%. People from Asian communities form the largest minority ethnic group in the county, and most come from Indian or Pakistani backgrounds (2.45%).

The proportion from all Black backgrounds has more than doubled, from 0.8% to 1.75% of the county's population. People from mixed ethnic backgrounds account for 2% of the population (up from 1.2% in 2001).

The change in ethnicity across each district is shown in the chart below. Oxford City and Cherwell have seen the largest increases since the last census, as shown below.



Source: Oxfordshire Insight, taken from Census table KS201EW

Oxford City has seen a 5.8% increase in people of Asian ethnicity, the largest increase of any broad category. There has been a 4.9% increase in the proportion of people of mixed ethnicity in Cherwell. West Oxfordshire is the only district where there has been a reduction in the proportion of people from BME communities since the 2001 census.

Religion

60% of the county's population are Christian, whilst 28% do not have any religion. The county's Muslims make up 2.4% of the populace. The proportion of Hindus in Oxfordshire in 2011 was 0.6%. The size of the county's Jewish population is 0.3%. The growth and size of county's Buddhist population (0.5%) is in line with the regional and national figures.

Sexual Orientation

Reliable figures on the number of lesbian, gay, or bisexual people in the county are still difficult to obtain. The Census did not include a question on sexual identity or sexual orientation, and using the number of people in a civil partnership will not capture those who are either in a relationship but are not registered or those who are single.

Experimental statistics from the ONS's 2012 'Integrated Household Survey' suggested that the proportion of people identifying as gay, lesbian, bisexual, or other was 1.6% in the South East, against a figure for England of 1.9%.

Disability

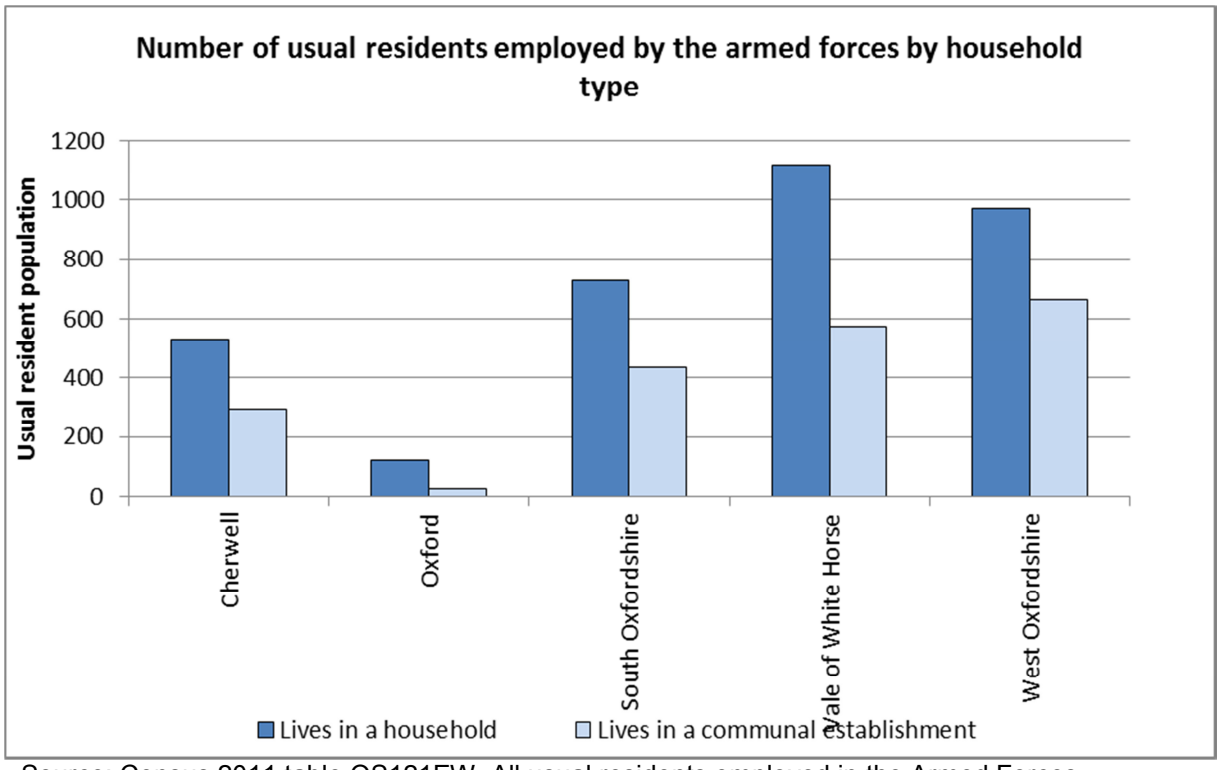
90,000 people countywide are limited in their daily activities by a long term health problem or disability. This equates to 14% of the population. A smaller proportion (8%) reported that their activities were 'limited a lot' by their condition. These proportions are broadly similar across the districts. However, there is some variation in the rates for specific age groups across districts, with Oxford (24.7%) and Cherwell (23.2%) containing higher rates among people over 65 than the county average (21.6%).

12,400 people aged 85 and over in households are living with day-to-day activities significantly limited by a health problem or disability. This is equivalent to 49% of the total resident population aged 85 in households. Cherwell, Oxford and Vale of White Horse Districts are above the regional average on this measure.

Other population groups

Armed forces personnel

At the time of the 2011 census Oxfordshire was home to 5470 armed forces personnel, of whom 33% lived in communal establishments. The remaining 67% live in households.



Source: Census 2011 table QS121EW. All usual residents employed in the Armed Forces

31% of armed forces personnel in the county live in Vale of White Horse, with a further 30% in West Oxfordshire.

Carers

The 2011 Census suggests that 9.4% of the Oxfordshire population provide some level of informal care to a relative or friend. This equates to approximately 60,000 people, of whom 72% provided between 1 and 19 hours of care per week, 10% provided between 20 and 49 hours, and 18% provided more than 50 hours.

2% of people under 25 and 9% of people aged 25 to 49 provide some unpaid care, compared to 14% for people aged 65 and over. The group most likely to provide unpaid care was people aged 50-64, with 20% providing some level of care.

Feedback from county council surveys has suggested that being an informal carer is very demanding, with many carers caring for long hours. 61% responding to the Carers Survey said they were satisfied with services. This was lower than satisfaction levels among users of adult social care services which follows the national trend (see section 7 - Quality of Service). Most carers wanted more time to do what they wanted, more control, support and social contact; and to be fully involved in decisions about those they care for.

Carers also stated that they find it hard to access the information they want, though when they find it they are usually satisfied.

Further Information

Compare changes in ethnicity in Oxfordshire's population between 2001 and 2011:

http://insight.oxfordshire.gov.uk/cms/ethnicity-dashboard

View charts and tables on Disability, Caring, and Health by age from the 2011 Census:

http://insight.oxfordshire.gov.uk/cms/health

Section 3 - Wider determinants of health

The Marmot review 'Fair Society, Healthy Lives'[4] highlighted the fact that health inequalities arise from a complex interaction of a range of social and environmental factors - housing, income, education, social isolation, and exposure, or perceived exposure, to crime - all of which are strongly affected by one's economic and social status. This section looks at recent trends across these domains, identifying geographic areas in Oxfordshire where outcomes tend to be below the regional and national averages.

Housing and homelessness

The pattern of housing tenure differs in Oxford City compared to other districts, with a much higher proportion of people in local authority social housing (13.4%) and private rented housing (26.1%) than the county average (4.6% and 15.2% respectively).

Close to 280,000 people in Oxfordshire live in households with more than 1 person per bedroom. This includes 76,000 people who live in households with more than 1.5 people per bedroom, equating to 12% of the population.

There are 22 neighbourhoods (Lower Super Output Areas) in the county where the proportion of people in households with more than 1 person per bedroom is greater than 50%. 12 of these areas are in South East Oxford, 4 are in Banbury, with the remainder in Berinsfield, Didcot All Saints, Abingdon Caldecott, Benson, and Marcham and Shippon (Source: Census table QS414EW).

Education

The percentage of people over 16 in Oxfordshire with at least a bachelor's degree (census category - level 4 and above) has risen to 35.7 per cent (up from 27.7% in 2001). This is similar to the national increase. All Oxfordshire districts contain above the national average, with Oxford City containing the highest proportion of people with level 4 and above qualifications.

16.7% of Oxfordshire's population lack any qualification, down from 18.6% per cent in 2001 and below the average for England (22.5%). Except for Cherwell, the proportion of Oxfordshire's population without a qualification is higher than the national and South East averages. Oxford City contains the lowest proportion of people with no qualifications at 13.6% of the population.

[4] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

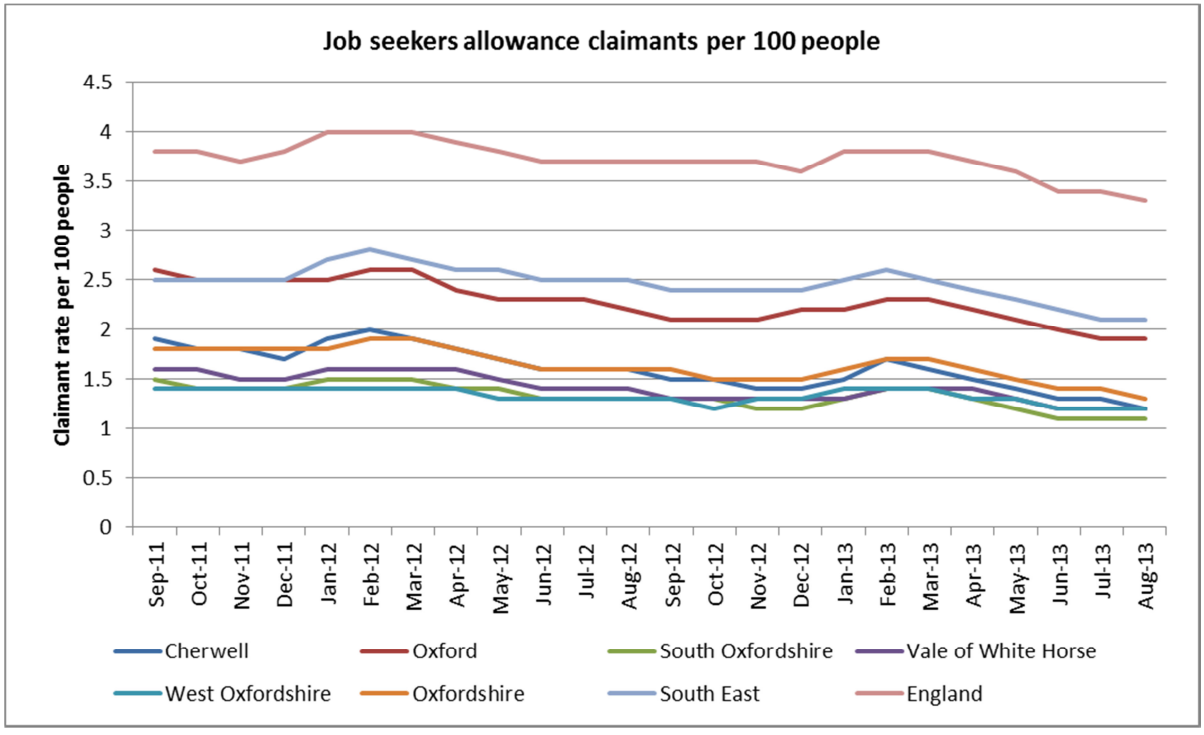
The wards with the highest proportion of people with level 1[5] or no academic or professional qualifications are Blackbird Leys (54.9%), Northfield Brook (46.3%), Banbury Ruscote (55.2%), Barton and Sandhills (37.4%), and Littlemore (37.8%).

Employment

In June 2013, there were 427,800 people aged between 16-64 (this is classed as the working aged population) in Oxfordshire. There are a total of 342,600 working aged people in employment, which equates to 77.1%. This compares with 74.7% for the South East and 71.1% for Great Britain.

In June 2013 the unemployment rate was 6.3% which equates to 23,000 people, compared with 6.2% for the South East and 7.8% for Great Britain.

In August 2013 1.3% of working aged people in Oxfordshire people claimed Job Seekers Allowance (JSA), compared with 2.1% for the South East and 3.3% for Great Britain. Oxford City had a higher rate than the county at 1.9% of the population but remained below the regional average.



Source: Nomis, Official Labour Market Statistics

11 wards had a higher JSA claimant rate than that of the South East region, namely Blackbird Leys, Northfield Brook, Rose Hill and Iffley, Banbury Ruscote, Barton and Sandhills, Cowley, Iffley Fields, Banbury Grimsbury and Castle, Abingdon Abbey and Barton, Witney Central, Littlemore, and Didcot Northbourne.

[5] Level 1 qualifications: 1-4 O Levels/CSE/GCSEs (any grades), Entry Level, Foundation Diploma, NVQ level 1, Foundation GNVQ, Basic/Essential Skills

In May 2013, 32,530 people in Oxfordshire were claiming Key Out of Work Benefits (Job Seekers, ESA and Incapacity Benefits, Lone Parents and Others on Income Related Benefits). This is higher than the number of unemployed as it includes a number of people who are in work, but claim income related benefits. The Oxfordshire Rate of 7.6% was lower than the South East (10.1%) and almost half that of Great Britain (13.9%).

Crime

In the 12 month period ending December 2013, there were 10,397 Anti-social behaviour incidents across the county. This represents a fall of 11.2% compared to the previous 12 month period. The areas with the highest rates of antisocial behaviour were Oxford East, Wheatley/Chalgrove, and Banbury Rural (Thames Valley police area classifications).

After a reduction up to April 2012, Violent Crime has remained at the same rate for the last 12 months. Violent Crime is lower in Oxfordshire compared with the regional and national rates. The summer months have higher proportions of crime compared with the monthly average. Violence with injury has reduced by 15.2% (298 crimes) over the last 12 months, whereas violence without injury has increased by 6.7% (293). The Oxford district rates are higher than the Country and Thames Valley Police rates, whilst Cherwell district rates are higher that the County rates.

Hate Crime has fallen by 13.0% between April 2013 - December 2013 and the corresponding period in 2012. The most common type of hate crime incidents were racist, accounting for 75% of the 662 incidents between September 2010 and August 2013. These were predominantly classified as public order offences (55%). A further 31% of racist incidents were classified as violent.

The number of domestic abuse incidents (non-recordable crime) increased from April to December 2013. This does not indicate that domestic abuse is more prevalent but demonstrates that victims are reporting abuse earlier and that reporting is increasing. This suggests that the preventative approach in Oxfordshire is working. In 2012/13, 2,829 victims of DA accessed dedicated support services. For the period April-September 2013 1,601 victims of DA accessed dedicated support services.

The prevalence of Child Sexual Exploitation has been an emerging national issue of concern over recent years. Operation Bullfinch was a joint surveillance operation by Police and Social Workers within Oxfordshire which commenced in 2010 due to growing concerns about possible street grooming of vulnerable girls by a gang of men acting together. This resulted in the successful prosecution and conviction of 7 men for a range of serious sexual offences against these girls and young women.

The Oxfordshire Safeguarding Children Board has instigated a Serious Case Review into this matter and commissioned a special task group to identify and action improvements into how agencies can better work together in combatting this horrific form of abuse. A formal strategy to address this abuse has been agreed by all statutory agencies, procedures reviewed and training undertaken for key professionals involved in this area.

The Kingfisher team has been established as a multi-agency professional group charged with the responsibility of investigating all referrals where Child Sexual Exploitation is suspected. The Team has handled over 90 referrals in the last 12 months, as a result of work by all agencies to pro-actively identify children who present risk factors for CSE using the CSE screening tool. Following referral these children receive preventative support, protection and further investigation as appropriate to their individual circumstances. All these children have multi-agency plans in place to ensure all risks are assessed and addressed.

In the last 12 months 13 women have been identified by GPs, Community Midwives and the Hospital Consultant Obstetrician as having been subjected to FGM; all are believed to have undergone FGM abroad prior to coming to this country. There is currently no reliable data on the extent of Female Genital Mutilation (FGM) in Oxfordshire or even the United Kingdom. It is estimated that in 2001 nearly 66,000 women with FGM were living in England and Wales with an additional 5,000-8,000 girls who may possibly be affected in the future. The Oxfordshire Safeguarding Children Board (OSCB) has for some years had a clear procedure in place but is taking a more pro-active approach on this to ensure that there is better awareness of this form of physical abuse and strengthen the co-ordinated approach with partners.

Isolation

Feedback from service users and communities has suggested that isolation, loneliness and social contact are crucial ingredients for health and wellbeing for carers, users, and people in rural areas. Engagement events have highlighted the role that local groups, volunteers, and the faith and community sectors play in providing local supports.

At the time of the last census 28.7% of Oxfordshire residents aged over 65 lived alone. Though this does not directly equate to loneliness, these people are significantly more likely to be socially isolated which may lead to experiences of loneliness.

Further Information

Education and Skills Dashboard – charts on highest levels of qualification by areas

http://insight.oxfordshire.gov.uk/cms/education-and-skills-dashboard

Community safety dashboard – time series charts on the number of recorded crimes by type and by geographic area:

http://insight.oxfordshire.gov.uk/cms/community-safety-dashboard

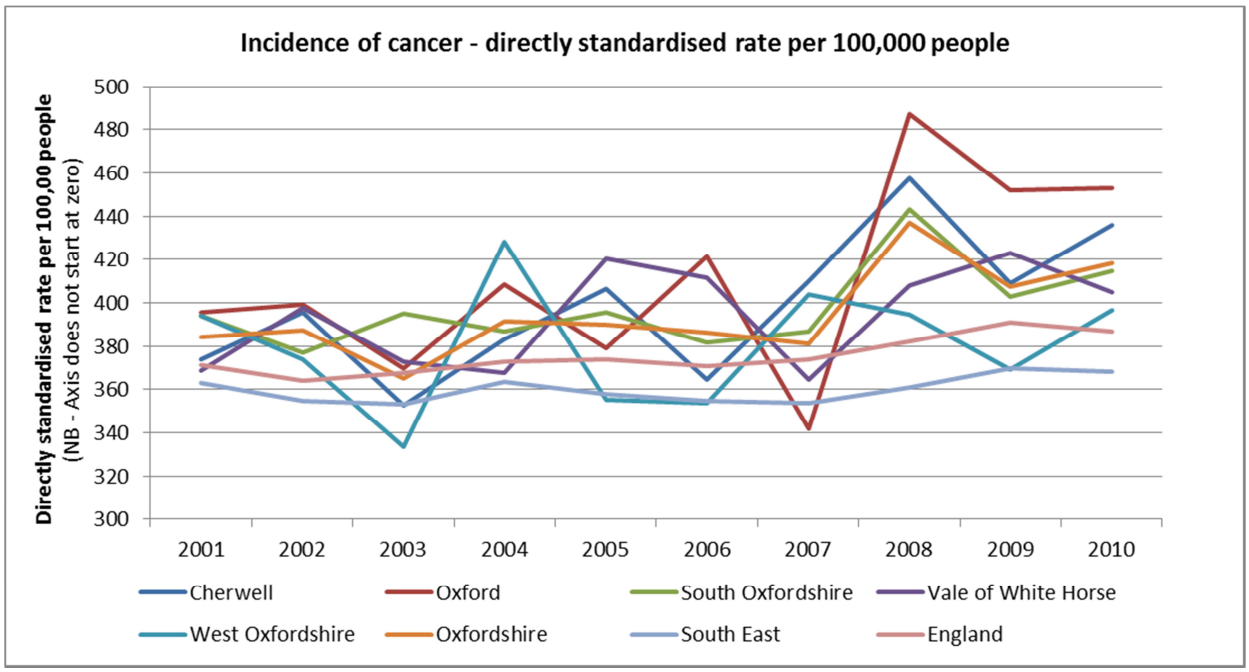
Section 4 - Morbidity

Diabetes

There are over 26,000 people aged 17 years and over diagnosed with Diabetes registered in Oxfordshire GP practices, representing almost 5% of that age group. This gives some indication of the prevalence of the disease and the majority are likely to have Type 2 Diabetes. Overall Oxfordshire percentages are lower than England and this may be due to lower prevalence.

Cancer

The incidence of cancers has been steadily increasing across all areas in men and women under the age of 75. The latest data (2008-10) shows Oxfordshire has a significantly higher rate of incidence than England in both men and women. The higher rate may in part be explained by better ascertainment i.e. local health services may be better than other areas at diagnosing cancer or the local population may be more aware of the signs and symptoms of cancer and seek medical advice early resulting in a prompt diagnosis.



Source: Health and Social Care Information Centre, Indicator Portal

Circulatory diseases

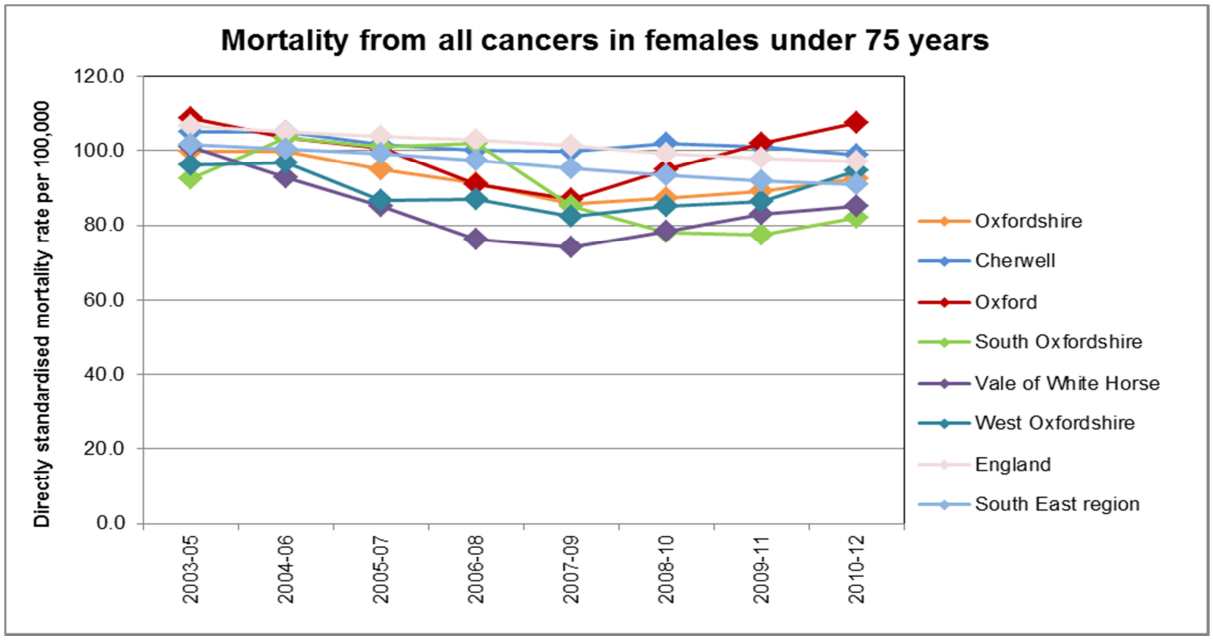
The estimated prevalence of stroke and coronary heart disease can be taken from GP-recorded information. These data do not reflect true levels as they are based on general practice recording. Nevertheless general practice in Oxfordshire is of high quality and so it is reasonable to assume that these give us a good estimate. Of Oxfordshire's GP-registered population 1.6% are recorded as having had a stroke or TIA (transient ischaemic attack) and 2.6% has a recorded diagnosis of coronary

heart disease (CHD) in 2012/13. These are both significantly lower than the national average. GP practices within Oxford City have a significantly lower recorded diagnosis of both stroke and CHD (than Oxfordshire) – with a younger population profile than the rest of the county this may account for the lower prevalence.

Mortality

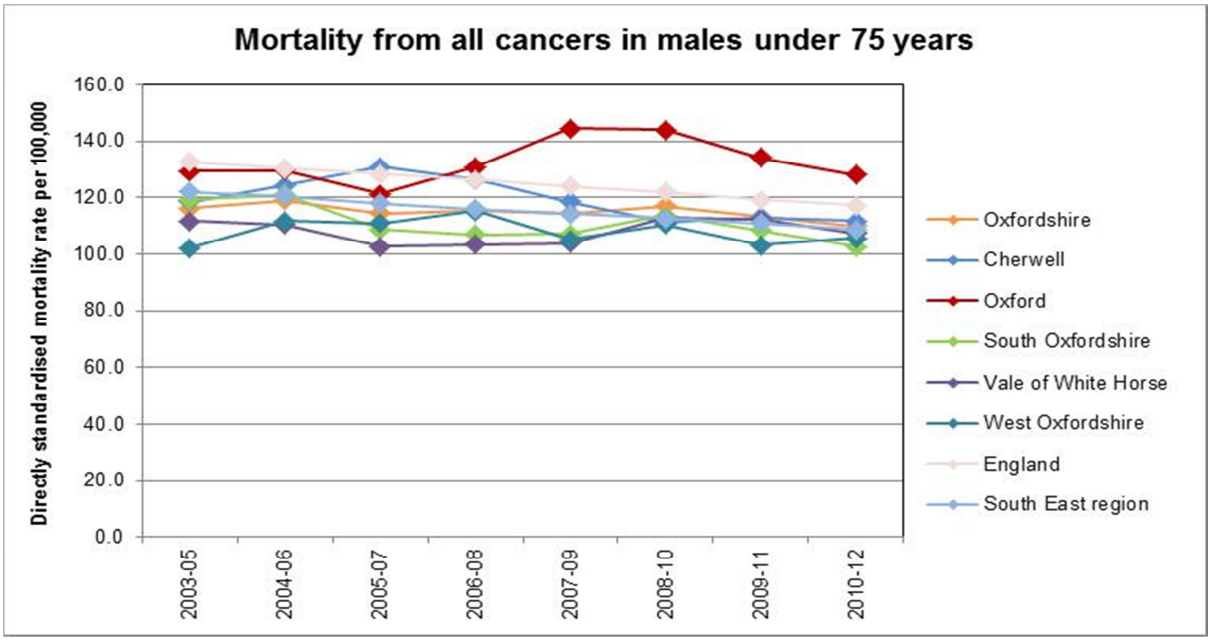
Cancer

Cancer is the biggest cause of mortality in males and females under the age of 75 in England and Oxfordshire. Cancer mortality accounts for approximately 700 deaths per year in Oxfordshire. Both nationally and locally the mortality rate from all cancers is significantly lower in women than men, although the gap is closing as the rate in men has been decreasing at a more rapid rate.



Source: Health & Social Care Information Centre Indicator Portal

Male cancer mortality in Oxfordshire remains significantly lower than the England average however this is no longer the case for females in 2010-12.



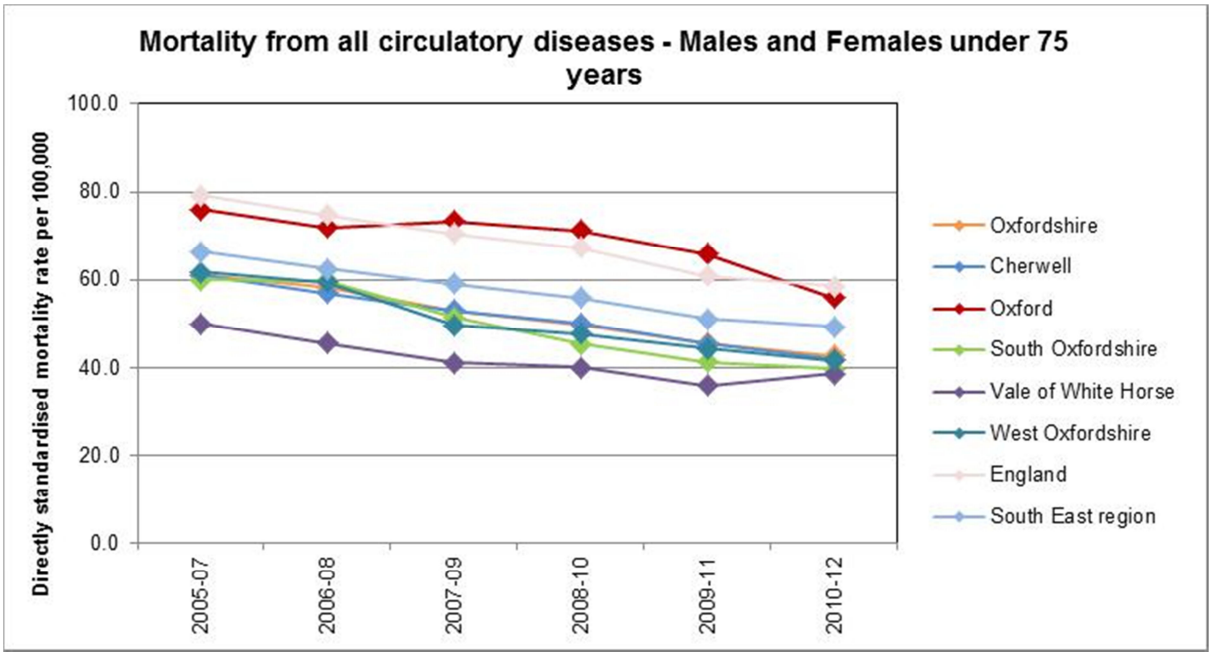
Source: Health & Social Care Information Centre Indicator Portal

There are many causes of cancer; smoking remains the biggest single cause. Lung cancer is the most common cause of death from cancer for men, responsible for nearly a quarter (22%) of cancer deaths in males in Oxfordshire. Colorectal cancer accounts for a further 11% and prostate cancer 8%. In women 17% of cancer deaths are from lung cancer whilst breast cancer accounts for 19% and colorectal cancer 9% (figures are based on numbers for 2010-12 three years combined).

Screening programmes were introduced for early detection of bowel, breast and cervical cancer and late detection is almost certainly a major contributor to poor survival.

Circulatory diseases

Circulatory diseases such as heart disease and stroke also contribute to the main causes of mortality. Trends indicate a decline in mortality rates in people under 75 years. There is some fluctuation at a district level but this will be due in part to the low numbers involved. Although still a leading cause of death, Oxfordshire has a significantly lower level of mortality from circulatory diseases than the national and regional averages for both males and females.



Source: Health & Social Care Information Centre Indicator Portal

Nationally heart diseases are a leading cause of death for men aged 50 and over, and for women aged 65 to 79 years. These diseases are usually caused by the build-up of fatty deposits on the walls of the arteries around the heart. Lifestyle choices (such as smoking and diet), and other conditions such as high cholesterol, high blood pressure and diabetes, can also lead to heart disease.

Further Information

Mortality dashboard – charts and tables on the causes of death and standardised mortality ratios at district level. Burden of ill-health dashboard – Charts on incidence of cancer:

http://insight.oxfordshire.gov.uk/cms/health

Public Health Outcomes Framework data tool:

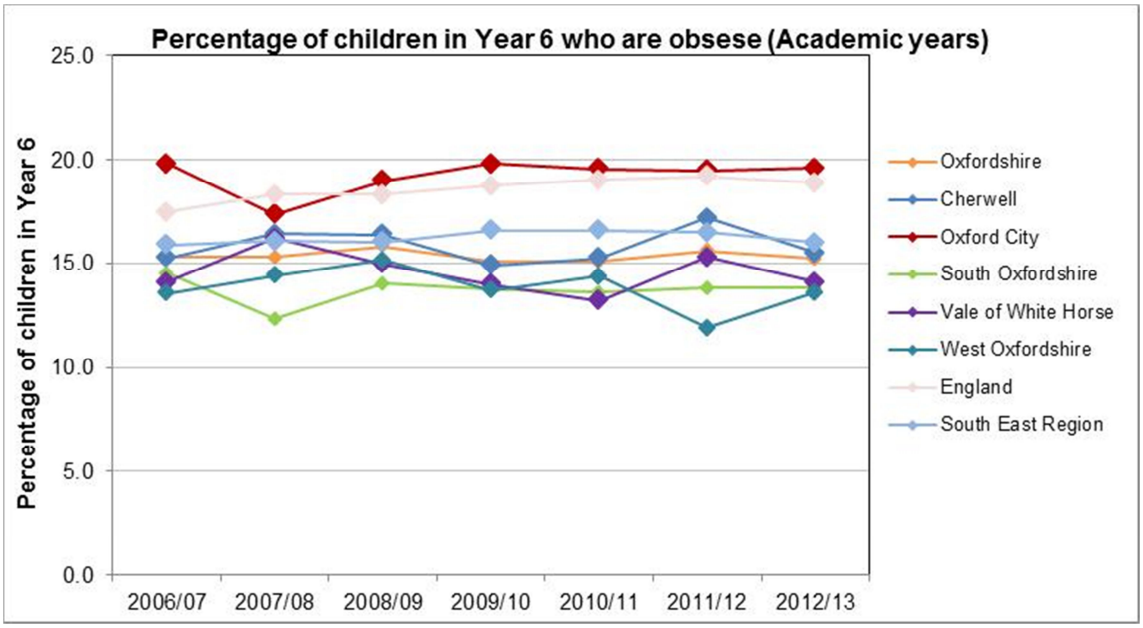
http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000008/are/E10000025

Section 5 – Lifestyles

Obesity

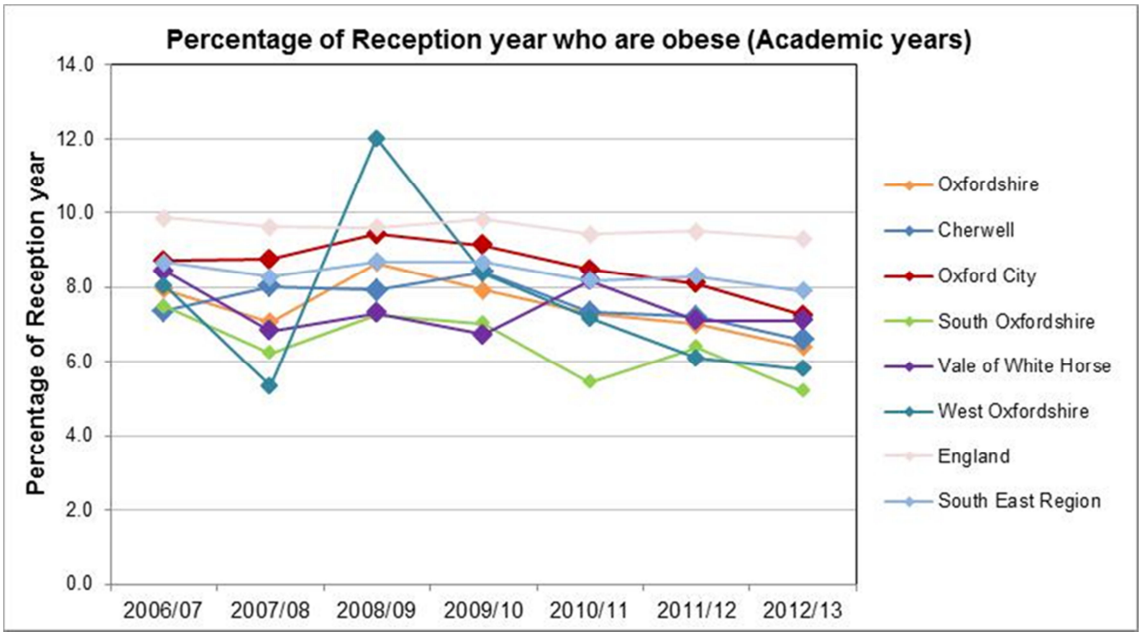
The rise in obesity both nationally and locally has caused concern. There is little robust data at a local level - latest data from Health Survey for England indicates that obesity could be as high as 29% in people aged 16 years and over in Oxfordshire. However GP-recorded cases of obesity show a much lower proportion (10%) which is likely to underestimate as not all people will have had their BMI recorded.

For children there is a more robust source of obesity data as Reception year and Year 6 have been measured in schools since 2006/7 which gives us some good trend data. Oxfordshire remains significantly lower than the national average.



Source: Health & Social Care Information Centre Indicator Portal

Children in year 6 have a higher prevalence of obesity than those in Reception year. Once established, obesity is difficult to treat so prevention and early intervention are important. Being obese or overweight can increase the risk of developing a range of serious diseases in later life. There is a strong relationship between deprivation and childhood obesity. Analysis of data from the National Child Measurement Programme (NCMP) for 2012/13 shows that obesity prevalence among children in both Reception and Year 6 increases with increased socioeconomic deprivation (measured by 2010 Index of Multiple Deprivation (IMD) score). The NCMP also reveals substantial variation in childhood obesity prevalence between ethnic groups at a national level.



Source: Health & Social Care Information Centre Indicator Portal

A consultation in August 2013 involving nearly 200 parents, children and young people about Childhood Obesity highlighted a number of challenges for families:

- Benefits of breastfeeding are well known, but parents had mixed experiences of support
- Affordability and availability of healthy food in some areas
- Time it takes to buy and prepare fresh food compared to fast convenience food, for working mothers with families
- Lack of basic cooking skills and knowledge in nutrition
- Healthy eating messages need to be 'cool'
- Affordability of exercise classes/activities, especially in winter
- Schools and Children's Centres seen as core and influential hubs for information in communities

Physical activity

Of the adult population (16+ years) in Oxfordshire, 61.2% partake in moderate equivalent physical activity for at least 150 minutes per week. These data are based on survey results conducted by Sport England and weighted to represent the demographic population of each geographic area. Oxfordshire has a significantly higher proportion than the national average. This indicator has changed so there are no trend data available.

Smoking

The most up to date data available for smoking prevalence is for 2011/12. These figures are taken from a national survey but are the only data available for smoking prevalence. They indicate that approximately 17% of the adult population (18+ years) in Oxfordshire are smokers. This is significantly lower than the national average.

Further Information

Children's bodyweight dashboards Smoking, drinking, and drugs dashboard – charts on prevalence rates for overweight children in year 6 and reception years:

http://insight.oxfordshire.gov.uk/cms/health

Public Health Outcomes Framework data tool:

http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000008/are/E10000025

Section 6 – Service Demand

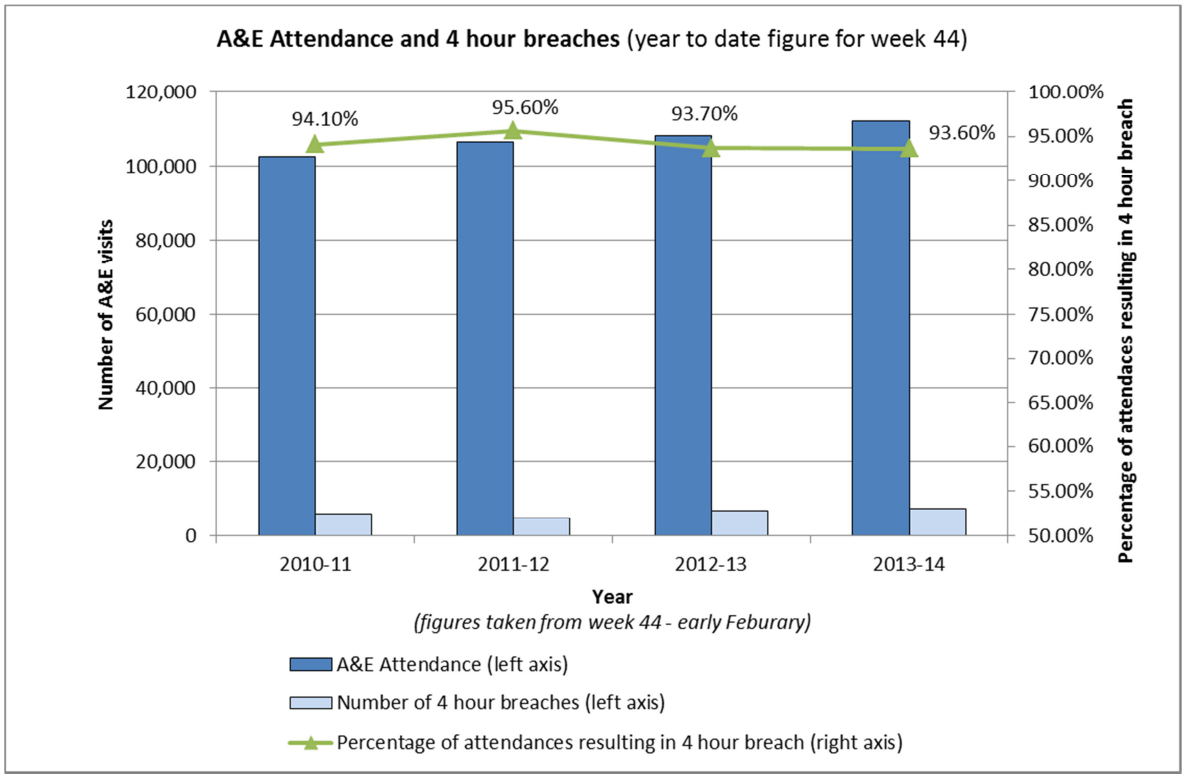
GP Practice population

There were 698604 people registered with Oxfordshire GPs in 2013. This has increased by 4% since 2010. The number of people registered with GPs has increased by 15% in the South East Locality over the same period.

The number of people registered with a GP does not necessarily reflect the actual number of people using GP services, and is likely to include the records of people who remain registered despite leaving the area, as well as people who live in neighbouring counties but are registered with GPs in Oxfordshire. This explains the fact that the GP registered population is higher than the county population.

A&E attendance and breaches

The number of people attending accident and emergency has increased steadily over the past four years.



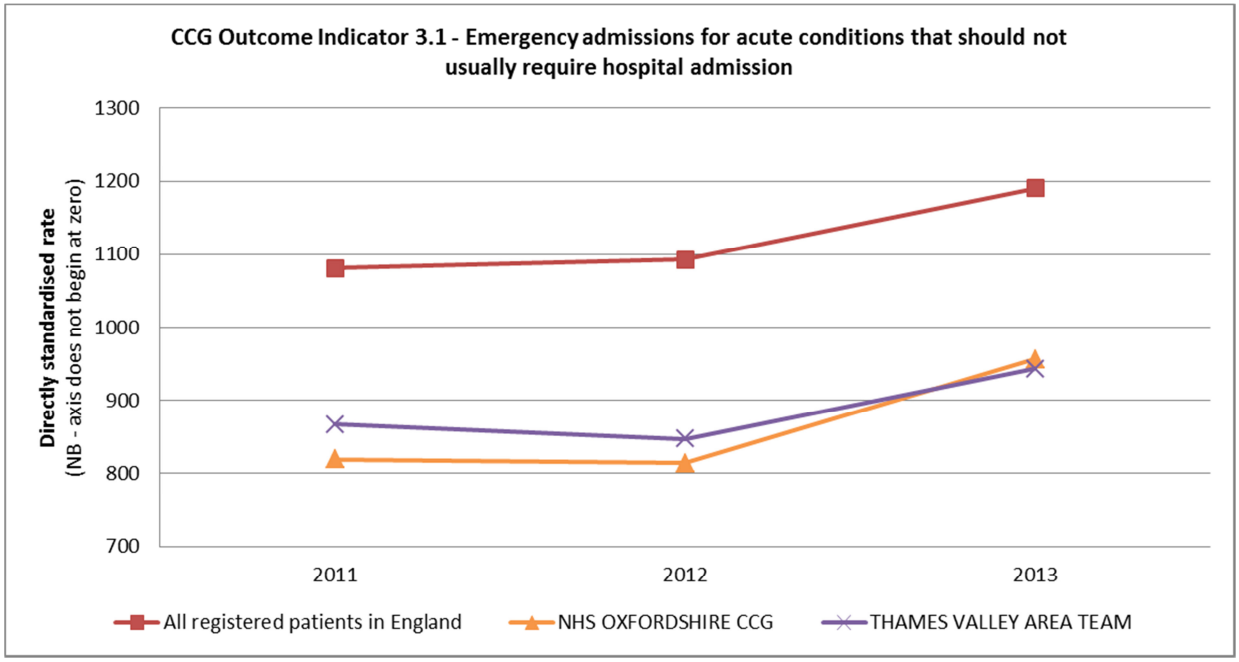
Source: Central Southern Commissioning Support Unit

Over the same period the proportion of people attending who were seen within 4 hours has reduced (episodes exceeding this are known as A&E Breaches) to 93.6%, as shown in line on the above chart[6].

[6] 4 hour breach figures for 2011/12 are estimated. Data was not collected during the final 4 months of the year.

Emergency Admissions for Acute conditions that should not usually require Hospital Admission

The past year has seen an increase in the number of emergency admissions for acute conditions that should not usually require hospital admission. The directly standardised rate has risen from 814.1 to 956.2, taking it above the Thames Valley figure of 943.3 (CCG Outcomes Framework 3.1).



Source: CCG Outcomes Framework, Health and Social Care Information System

Data from the Southern Central Commissioning Support Unit suggests that this increase is mostly attributable to increases in admissions for Skin Infections and Dental & Other Mouth Problems. Convulsions (many of which will be related to Epilepsy) and Gastrointestinal Infections have also shown increases. There has been a reduction in the number of emergency admissions for genitourinary system infections over the same period.

Delayed Transfers of Care (DTOC)

Although delayed transfers of care have fallen in recent months from a high of 166 in September 2013 to 133 in December, Oxfordshire continues to have the highest number of delays nationwide.

Aggregation of the reasons for delays as at week ending 23rd February 2014 suggests that the most common category of delays were people awaiting community hospital beds which accounted for 27% of delays. Further common categories/subdivisions were people waiting for a care home placement (21%); people awaiting a re-ablement care package (15%) and patient and family choice (18%).

Social Care – Older People

The number of users of adult social care is growing at a faster rate than that which could be attributed to population growth alone. In 2012/13 the number of older people receiving long term support from the County Council rose by 4.8% and by a further 7.9% to a figure of 4,037 by September 2013. By contrast the population of older people is estimated to have grown by around 3% each year since the 2011 Census.

The average number of hours of care provided per week rose by 9.2% and 1.7% over the same period, suggesting that the levels of need among people entering the system may also be increasing.

This suggests that demand is rising due to pre-existing unmet need in the population which is now presenting to social care. The table below uses service data and figures from the 2011 census to estimate the potential scale of 'unmet need' in Oxfordshire:

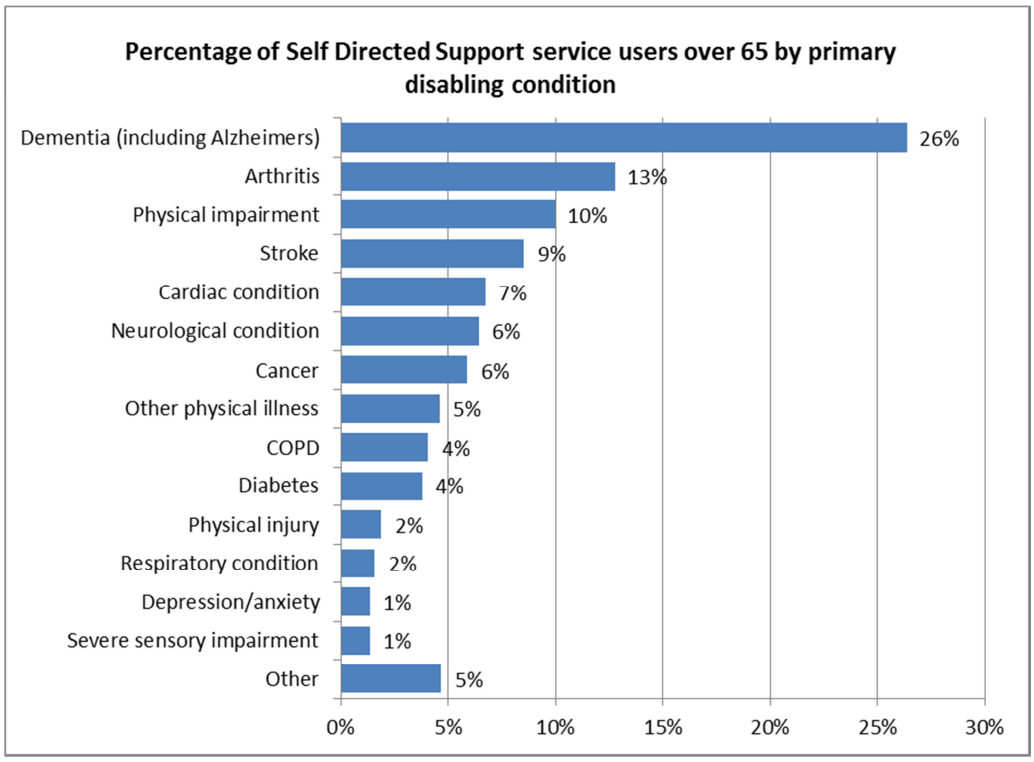
Estimate of needs and services in Oxfordshire

Category of Need	**Number**
Older People whose activity of daily living are limited a lot	24,000
People receiving long term support managed by the local authority	4,000
Estimate of older people receiving intensive (50 hours plus) informal care from a family or friend	5,700
Older People self-funding care home placements	2,100
Older People self-funding care at home	3,400
Needs currently met (local authority; informal; private)	15,200 (63%)
Potential unmet need which could come forward	**37% (8,800)**

In the current population, there are at least 8,800 older people who have serious difficulties in their activities of daily living but do not currently meet these needs through private care, social care, or informal care. The care bill is likely to create additional incentives for people to access formal care, ultimately increasing the

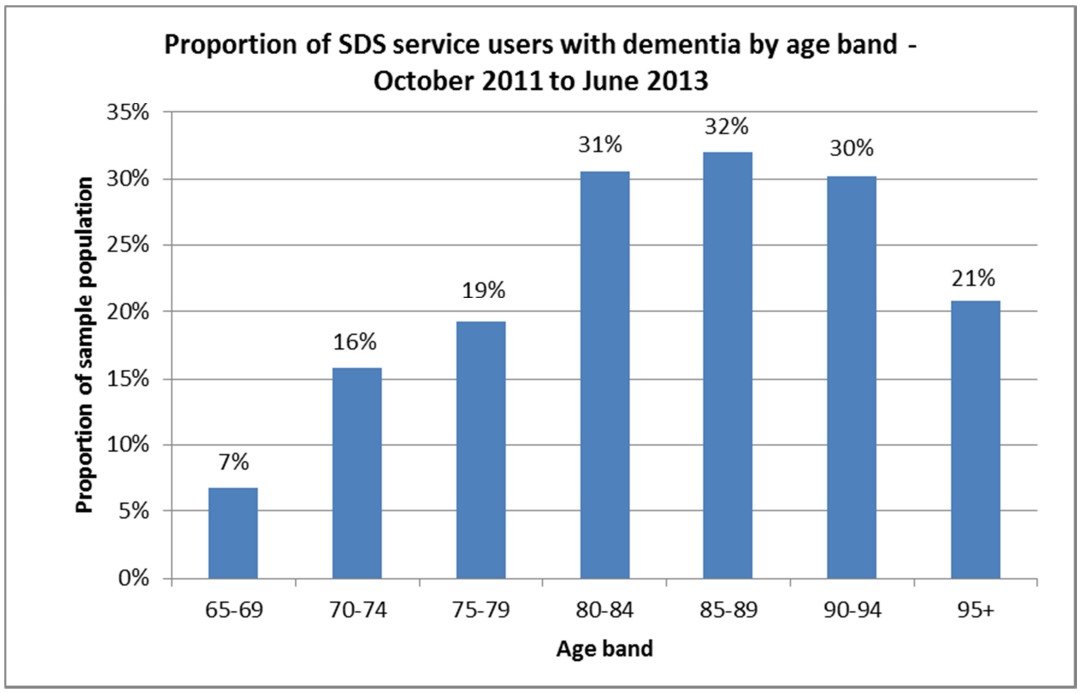
proportion of needs met through Local Authority managed care. Whilst this is on the surface a positive development for the service user, it will present serious challenges for the capacity of the social care system as currently constituted.

Analysis of assessment data offers further texture to the types of needs people have when entering the social care system. A sample of assessment forms for 1500 Self Directed Support service users over the period of October 2011 to July 2013 suggests that the condition most affecting the activities of daily living for older people presenting to social services is dementia, which affected 26% of the sample (a further 6% recorded dementia as their secondary condition). Other common conditions included Arthritis (12%), Physical impairment (10%), Stroke (9%), Cardiac conditions (7%), Neurological conditions (6%), and Cancers (6%).



Source: FACE Needs Profile Database, Oxfordshire County Council

The same data suggest that the likelihood of a client presenting with dementia increases with age, with 7% of people aged 65 to 69 presenting with dementia as a primary disabling condition, compared to 32% for people aged 85 to 89, as shown in the following chart.



Source: FACE Needs Profile Database, Oxfordshire County Council.

For those over the age of 95, the most common condition affecting activities of daily living was arthritis, which affected 26% of this age group.

Feedback from older people in Oxfordshire cited three key things as contributors to quality of life: health, control over daily living, and social contact.

Service users have highlighted the fact that good, up-to-date, accessible information and advice underpins people's ability to be more independent, have more control and make better choices. It needs to be jargon free, accessible in a variety of formats and channels, up-to-date and simple.

Learning Disabilities

National prevalence rates[7] suggest that there are likely to be around 9,000 adults with some level of learning disability in the county. In September 2013, 1923 people with learning disabilities were known to social services. This equates to 21% of the estimated total which matches the national rate.

National estimates predict that demand for services will increase at a rate between 0.6% and 4% per year between 2009 and 2026[8]. Although there has been a steady increase in the number of people open to learning disability teams in recent years (from 1792 in March 2012 to 1923 in September 2013), the number of people in

[7] http://www.improvinghealthandlives.org.uk/uploads/doc/vid_9244_IHAL2011-02PWLD2010.pdf
[8] http://eprints.lancs.ac.uk/21049/1/CeDR_2008-6_Estimating_Future_Needs_for_Adult_Social_Care_Services_for_People_with_Learning_Disabilities_in_England.pdf

supported living and care homes increased between 2011/12 and 2012/13 but fell in the first 6 months of 2013/14.

Physical Disabilities

In Sept 2013, Oxfordshire County Council supported 591 adults (aged 18-64) with a Physical Disability. A large majority of this group (86%) receive either home care or direct payments with the rest supported in care homes. The latter group has remained largely unchanged since March 2012 whilst the former grew by 29% from March 2012 to September 2013.

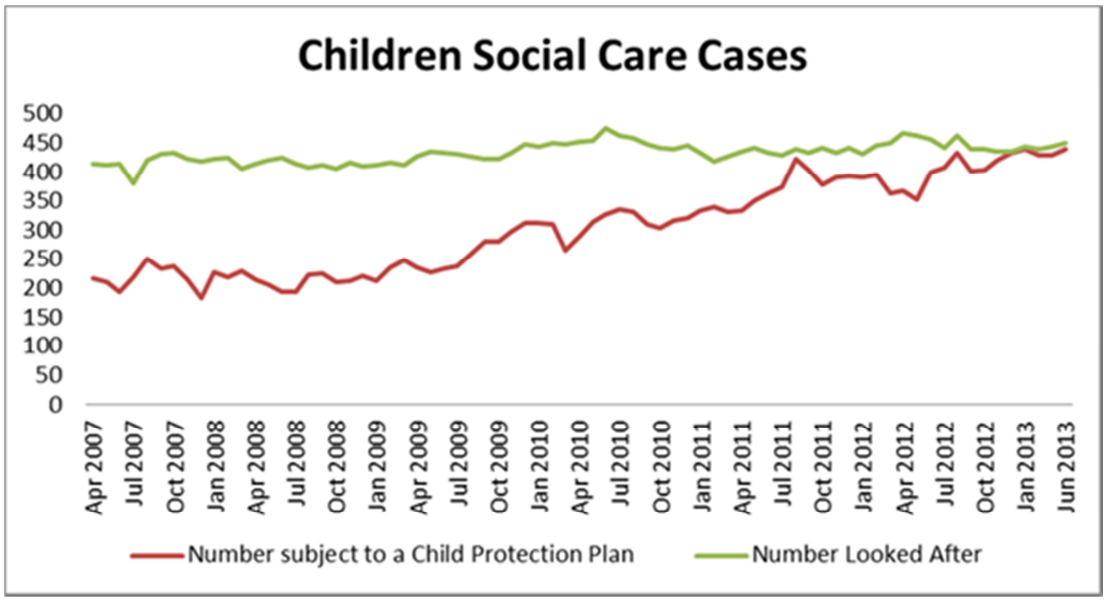
Consultation on the PD strategy in April 2012, involving 274 people suggested the strategy should find ways to measure social integration, quality of life and overall well-being among people with a physical disability, rather than relying too heavily on indicators such as employment and the receipt of direct payments which were viewed as somewhat crude proxies for independence.

Children's Social Care

Activity levels in Children's Social Care are higher than would be expected based on relative measures of need in the population, and are increasing at a faster rate than the national trend.

Whilst there is no single predictive measure of need for children's services, the level of income deprivation affecting children (IDACI index) is a nationally used proxy for understanding the proportion of a population who might be referred to social care.

At the end of 2012/13, Oxfordshire had a rate of 30.9 children on a child protection plan for every 10,000 children and young people countywide. Whilst this is lower than the national rate of 37.9, when it is weighted for the number of income deprived children/young people, Oxfordshire has a higher rate than would be expected. Nationally, for every 60 deprived children/young people, there is one on a child protection plan. In Oxfordshire the ratio is one child on a plan for every 40 deprived children/young people.



Source: Joint Commissioning, Oxfordshire County Council

The chart shows that the number of children on child protection plans has more than doubled over the past five years, whilst the number of looked after children has remained relatively stable. The most recent national statistical returns showed that between 2011/12 and 2012/13 the number of children on a plan in Oxfordshire increased by 17% compared to 0.3% nationally.

There is reason to believe that the upward trend is attributable to more effective screening and referral processes, resulting in greater numbers of children being put on plans, and remaining on plans, than was previously the case. Although this represents positive performance relative to the national picture, it does present challenges for the capacity of the service.

Alternative hypotheses might be that the overall level of need has increased at the population level, or that the application of eligibility criteria is being applied more stringently than it had been in the past. However, it is unlikely that population level needs have increased given the scale of the change – a twofold increase in the number of children on plans over a five year period. Furthermore, the pattern is visible in Oxfordshire but not at the national level, which would be expected if the increase were a consequence of the economic recession. Audits of case files by senior social work managers have found that threshold criteria at key points have been consistently applied over the period.

In a Survey of Looked After Children in Dec 2013, 85% stated that they were happy with their social workers. Further feedback from children and young people has suggested that transition planning and management at key transition points is not always smooth, particularly between children and adults social care and health services, at admission/discharge from hospital, and from primary to secondary school. It was emphasised that communication between professionals and across organisations at transition points is key.

Further Information

Adult Social Care Outcomes Framework Dashboard – view Oxfordshire's relative scores on ASCOF outcomes framework indicators for past three years:

http://insight.oxfordshire.gov.uk/cms/adult-social-care-outcomes-framework

National Adult Social Care Information System (NASCIS):

https://nascis.hscic.gov.uk/Portal/Tools.aspx (requires registration)

Section 7 – Quality of Services

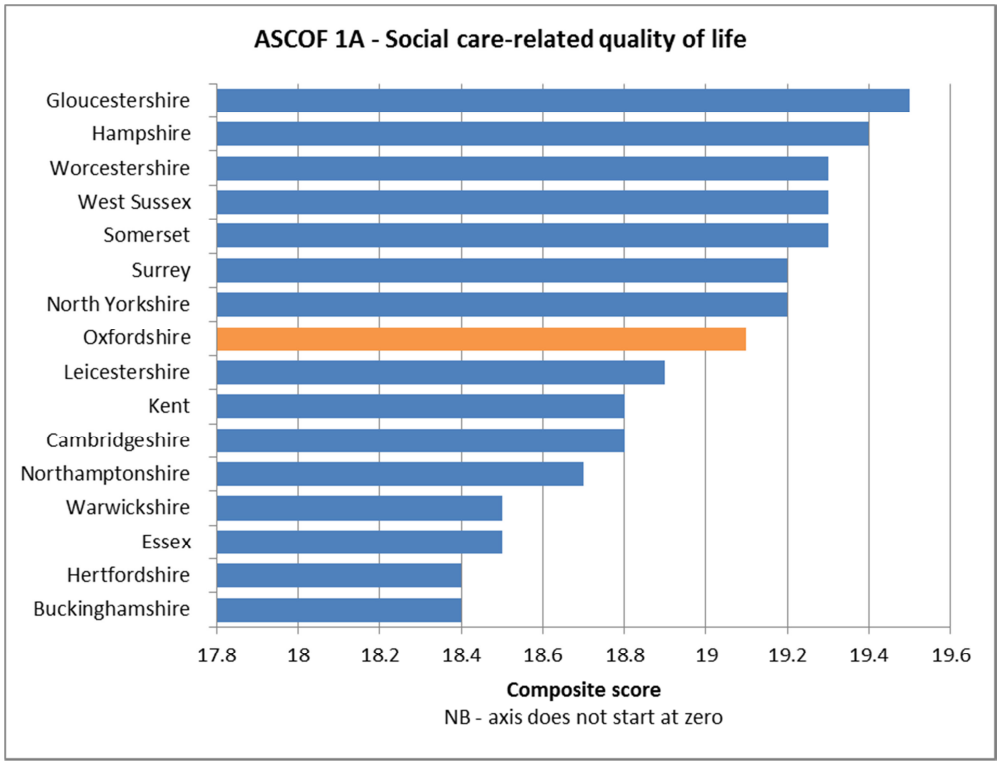
GP Survey

For the most part, Oxfordshire service users have above average satisfaction levels for most measures in the GP survey. The last set of data from the CCG outcomes framework suggests a fall in patient satisfaction of out-of-hours health services, down from 76.3% to 72.7% for the period July 2012 to March 2013. This puts the Oxfordshire figure below that of the Thames Valley area team (73%). It is too early to say whether this is the start of a sustained trend or a statistical anomaly.

Adult Social Care User survey

The Personal Social Services Adult Social Care Survey (ASCS) for England is an annual survey and took place for the third time in 2012-13. The survey is designed to cover all service users aged 18 and over receiving services funded wholly or in part by Social Services during 2012-13, and aims to learn more about whether or not the services are helping them to live safely and independently in their own home and the impact on their quality of life.

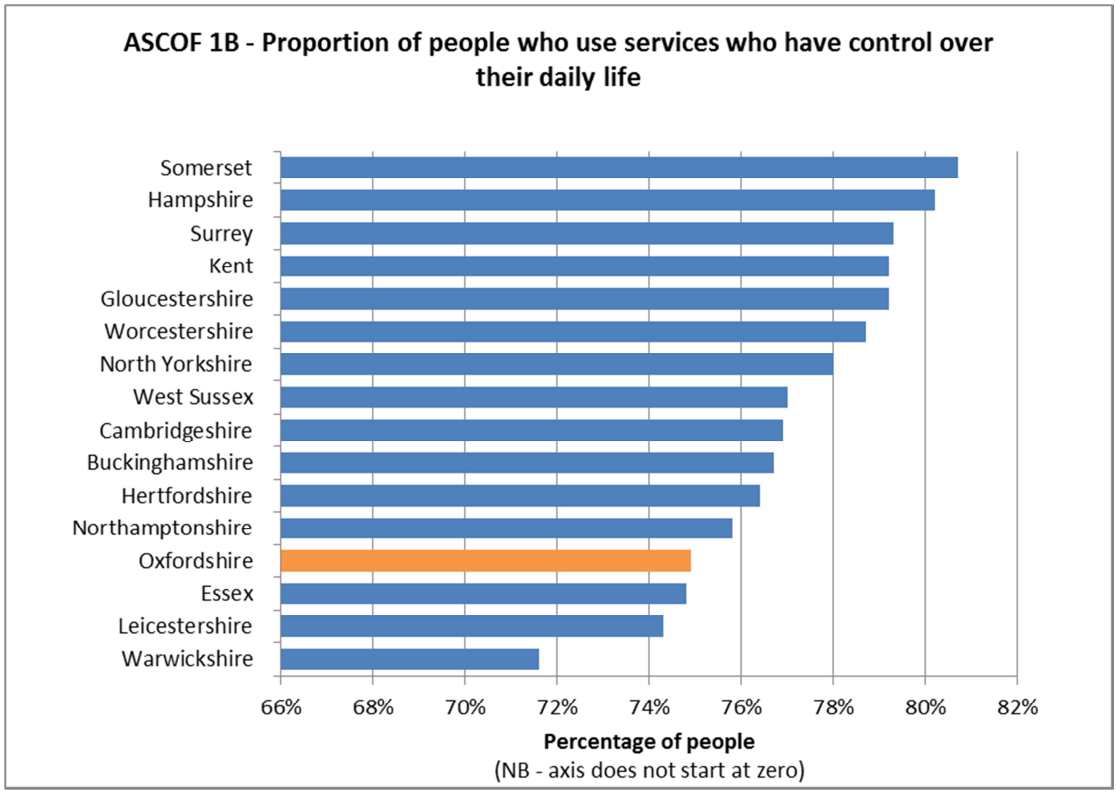
The headline measure in the Adult Social Care Outcome Framework is social care related quality of life. This is a composite of 8 different outcome domains. Oxfordshire ranked 8 out of a cohort of 15 local authorities of a similar socio-economic profile with a score of above 19.1 which puts it above the national average of 18.8.



Source: Oxfordshire Insight, data from NASCIS Online Analytical Processor

93% people reported positive experience of care which is above the national average of 90%. 93% of respondents said that social care services improved their quality of life and over two thirds of adult social care users felt as safe as they want to. Where they do not feel as safe as they want to, the major concern is falls, particularly in the home.

Feedback from service users has emphasised the importance of giving them control over their care and, although Oxfordshire has a high proportion of clients on personal budgets, the level of control service users said they have over their lives ranked 12 out of 15 comparator authorities in 2012/13.



Source: Oxfordshire Insight, data from NASCIS Online Analytical Processor

In the previous two years Oxfordshire ranked 4 out of 15 on the same measure so further investigation may be needed to understand whether this is a sustained trend or a statistical anomaly.

Friends and Family Survey

The recently introduced friends and family feedback survey gives an indication of user satisfaction with secondary care services. Patients are asked a single question: "How likely are you to recommend our ward/A&E department/maternity service to friends and family if they needed similar care or treatment?" Responses are given on a six point scale and a single score is calculated for the organisation.

Currently the friends and family test applies to all accident and emergency attendances, in patients and more recently addition of maternity services.

The first sight of the data for A&E services at the Oxford University Hospitals Trust suggests levels of satisfaction above the Thames Valley average of 45but below the England average of 56. The most recent results show a score of 49 for December 2013., Inpatient satisfaction levels are higher than those for A&E at 70 in December 2013. This was comparable with the England score of 71 and Thames Valley score of 69.

Further Information

Adult Social Care Outcomes Framework Dashboard:

http://insight.oxfordshire.gov.uk/cms/adult-social-care-outcomes-framework

National Adult Social Care Information System (NASCIS):

https://nascis.hscic.gov.uk/Portal/Tools.aspx (requires registration)

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Health Improvement Board
27 March 2014

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 (awaiting data on two indicators that were green in Q2)
   3 indicators are Amber
   1 indicator is Red (report card circulated in November 2013)
   8 indicators were not expected to report in this quarter

5. Data for 10.4 (fuel poverty) has been received but has not been RAG rated until more information becomes available

6. 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.

Alison Wallis
Performance & Information Manager, Joint Commissioning
March 2014

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** 56.6%	**A**	**Expected** 60% **Actual** nya		**Expected** 60% **Actual** nya		**Expected** 60% **Actual**		Bowel cancer screening data is released at least 4-5 months in arrears and is not yet available. During Q1 56.6% of individuals (aged 60-69 years) who were sent invitation letters that were adequately FOBt (Faecal Occult Blood test) screened. Across the Thames Valley the average is 56.5% and Oxfordshire ranks 2nd out of the 4 Public Health teams within this area.
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** **30,206**	**G**	**Expected** 39,114 Actual		NHS Health Check data is usually available a month after quarter end. 30,206 invitations had been sent out between Q1 and the end of Q3. This represents 13.7% of the eligible population. This remains above the national average of 13.2% and equal to that of the Thames Valley average; ranking Oxfordshire 4th out of the 8 local authorities within Thames Valley.
8.3	At least 65% of those invited for NHS Health Checks will attend (ages 40-74)	**Expected** 65%	**R**	**Expected** 65%	**R**	**Expected** 65%	**R**	**Expected** 65%		Report Card was circulated in Nov 2013. Although this indicator remains below the target uptake continues to steadily improve. Compared

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
		Actual 41.9% (4165 of 9938)		**Actual** 46.0% (9351 of 20,329)		**Actual** 46.5% (14148 of 30206)		**Actual**		across Thames Valley (43.6% average) the county performs well and is currently ranked 3rd out of the 8 authorities. This is a progression from 5th at the end of Q1 and 4th at the end of Q3, evidencing a continued improvement. Nationally the uptake rate is running at 48.1%. Campaigns are being planned to target groups in the population who are less likely to take up the offer of a health check.
8.4	At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)	**Expected** 851 **Actual** 909	G	**Expected** 1639 **Actual** 1735	G	**Expected** 2523 **Actual** **2672**	G	**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.
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** 15.2%	A					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							**Expected** 62.2%		This is reported annually from the Active People Survey monitored / managed by the Oxfordshire Sports

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	week. (Baseline for Oxfordshire 61.2% 2011-12)							**Actual**		Partnership. This is a new indicator. The 2012 baseline figure shows that Oxfordshire has the highest proportion out of the 7 authorities in the South East.
9.3	62% of babies are breastfed at 6-8 weeks of age (currently 59.1%)	**Expected** 62% **Actual** 58.7%	A	**Expected** 62% **Actual** 59.5%	A	**Expected** 62% **Actual** **60.4%**	**A**	**Expected** 62% **Actual**		Report card was circulated in Nov 2013. The recovery plan by Oxford Health is resulting in some gradual improvement.
	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.
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** nya		**Expected** 75% **Actual**		
10.3	At least 80% of households presenting at risk of being homeless and known to District	**Expected** 80%	G	**Expected** 80%	G	**Expected** 80%		**Expected** 80%		

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	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%)	**Actual** 82.3%		**Actual** 82%		**Actual** nya		**Actual**		
10.4	Fuel poverty outcome to be determined							**Expected** **Actual** **Oxfordshire 8.7% are fuel poor according to the Low Income, High Cost definition**		A new national indicator has been introduced and this reports levels of fuel poverty in Oxfordshire of 8.7%. In England the rate is 11%. Under this new Low Income High Cost definition a household is considered to be fuel poor when: • they have required fuel costs that are above average (the national median level) • were they to spend that amount, they would be left with a residual income below the official poverty line. Plans are being drawn up by the Affordable Warmth Network for 2014-15 to target action to reduce fuel poverty. It is suggested that this indicator is not RAG rated as more information is still needed.
Priority 11: **Preventing infectious disease through immunisation**										

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** 95.0%	G	**Expected** 95% **Actual** **95.8%**	G	**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** 92.4%	A	**Expected** 95% **Actual** **93.7%**	A	**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 papilloma virus vaccination (currently 88.1%).							**Expected** 90% **Actual**		Annual data usually available Quarter 4

OXFORDSHIRE COUNTY COUNCIL

Healthy Weight Strategy (Draft) 2014 - 2017

Authors
Rebecca Cooper, Kate King, Kate Eveleigh (Public Health Directorate, Oxfordshire County Council)

Aim of Strategy
To tackle obesity and promote healthy weight for the people of Oxfordshire using a holistic, multidisciplinary framework

The Public Health Directorate requests that the Health Improvement Board make the following recommendations:

- That the draft healthy weight strategy be approved
- That the draft action plan for the healthy weight strategy be developed further, in conjunction with stakeholders during the consultation process, and returned to the HIB for final approval

Table of Contents

1. Introduction

Ensuring a healthy weight across the population is a National and International priority. In England, there has been a marked increase in obesity rates over the past eight years. In 1993, 13% of men and 16% of women were obese – in 2011 this rose to 24% for men and 26% for women.
For children attending reception class (aged 4-5 years) during 2011-12, 9.5% were obese.[1]

In Oxfordshire, self-reported data collected as part of the annual Active People Survey[2] suggests that:

- Nearly 61% (95% CI 58.6 - 62.8) of adults (16+) are either overweight or obese compared with 63.8% nationally.
- 20.2% (95% CI 18.5 – 21.9) of adults (16+) are obese
- Oxford City has the lowest percentage of overweight or obese adults, 55.9% (95% CI 51.3 - 60.6). Although the difference is not statistically significant from Oxfordshire or the four Districts, Oxford City has a significantly lower percentage than the England average.

The National Childhood Measurement Programme (NCMP)[3] provides robust annual data on the number and proportion of underweight, overweight and obese children in Reception and Year 6.

NCMP data from 2012/13 tells us that[4]:

- Oxfordshire continues to have rates of childhood obesity which are lower than the national average.
- Reflecting the national trends, children in year 6 have a higher prevalence of obesity than those in Reception year 15.2% (95% CI 14.2-16.2) and 6.4% (95% CI 5.8-7) respectively.
- Statistically higher rates of childhood obesity (Yr. 6) in Oxford City, 19.6% (95% CI 17 – 22.2) are a particular cause for concern and are likely to reflect a population with more social disadvantage and more ethnic minority groups.

Being overweight and obese has adverse health outcomes. In 2011, 53% of obese men and 44% of obese women were found to have high blood pressure. During 2011-12 there were 11,736 hospital admissions due to obesity – this is over 11 times higher than during 2001-02.[1]

Inequalities in obesity rates are marked between different socio-economic groups. Nationally, among children in reception and year 6, the prevalence of obesity in the 10% most deprived groups is approximately double that in the 10% least deprived.[1]

[1] Healthy and Social Care Information Centre, Statistics on Obesity, Physical Activity and Diet, England 2013 http://www.hscic.gov.uk/catalogue/PUB10364
[2] Active People Survey, Sport England.2012. Data available at http://www.phoutcomes.info/ or http://www.noo.org.uk/visualisation
[3] National Obesity Observatory http://www.noo.org.uk/NCMP
[4] Healthy and Social Care Information Centre, National Child Measurement Programme http://www.hscic.gov.uk/ncmp

Why a healthy weight strategy?

Achieving a population with a healthy weight has all too often been described simply in terms of reducing obesity rates. Whilst this is important for obese individuals and doubtless has consequences for the local healthcare budget, the longer term goal of public health is to work toward a healthy living agenda (one aim of which is to ensure that the population achieves and maintains a healthy weight). A healthy living agenda is one which looks at population needs holistically and acknowledges that to address poor health, it is not possible to ignore the many and complicated factors often referred to as the wider determinants of health (education, employment, the environment in which we live, housing etc.). If, for example, we were to choose to place all our resources and expertise in to addressing the health problems of overweight and obese individuals, we would fail to address the universal need of a population that is currently living in an obesogenic environment and has potentially very little resilience against the choices that ultimately lead to an unhealthy weight and associated health problems. The broader determinants of health are therefore of paramount importance and can be significantly influenced by how local authorities deliver their core roles and functions.[5]

This strategy is for the population of Oxfordshire and will be led by the Public Health Directorate in Oxfordshire County Council. The strategic direction therefore has a focus on localism and what local authorities, businesses and communities can do to promote healthy living and achieve a healthy weight for the population. However, the people of Oxfordshire do not operate within a bubble and there are National and International influences that will have an impact on whether or not the population can achieve a healthy weight. Where possible, the Public Health Directorate will add its voice as an advocate for change in these areas, either directly or through its partners.

Rationale for refreshing the strategy at this juncture

This strategy has been developed as a result of the relocation Public Health from the NHS to the County Council. This new location for Public Health has enabled us to develop closer links with colleagues in Local Authority departments, many of which directly influence the wider determinants of health. Addressing these wider determinants, as will be discussed in greater detail below, is essential to enabling a population to engage in healthy living and as a result of this, to achieve a healthy weight.

Developing the Strategy

The development of this strategy is occurring in three stages:

1. Initial Development (November 2013 – March 2014)
    - The health improvement team (Oxfordshire public health directorate) assemble evidence on current National policy, best practice and effective measures to achieve and maintain a healthy population weight
    - The health improvement team hold initial discussions with colleagues in key departments in County and District Councils
    - The evidence base and results of initial discussions are written up in a draft strategy.
    - The draft strategy is signed off by the Public Health Directorate and the Health Improvement Board. It will then move in to a consultation phase

[5] Marmot Review – Fair Society, Healthy Lives. 2010

2. Consultation (April-June 2014)
   - All key stakeholders will be consulted on the content of the strategy. This will happen both electronically and through a series of workshops. The electronic consultation will focus on feedback for the content of the strategy and the workshops will focus on input for the associated action plan[6]
   - Following consultation with key stakeholders, the consultation will then go out to public consultation (format of which to be decided)

3. Consolidation and Implementation
   - The result of the consultations will then be consolidated and the strategy and action plan will be finalised
   - The final document will be presented to the Health Improvement Board for approval
   - The strategy and action plan will be implemented and will be subject to annual review

Aim of strategy
   - To tackle obesity and promote healthy weight for the people of Oxfordshire using a holistic, multidisciplinary framework

2. Background

History of Oxfordshire Public Health Directorate work in the area of healthy weight
Under the previous 'Commissioning Strategy for Overweight and Obesity in Oxfordshire' there was an emphasis on developing pathways of care for individuals who are already overweight and obese (this trend is discussed further in cultural norms and social values below). From this strategy, we have commissioned an adult care pathway, an adult weight management hub and a range of adult services which are accessible through GP practices. We have also piloted the children, families and young people's service which will be commissioned across the county from April 2014. These services are part of the on-going work with Primary Care to effectively address the rising tide of obesity.

The previous strategy aimed to prevent overweight and obesity in children by providing advice and group support to parents on parenting, weaning and breastfeeding. We commissioned 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.

Finally, working predominately through the Oxfordshire Sports Partnership (OSP), the strategy also focused on increasing physical activity levels in the adult population (16+). This partnership brings together public health, district councils, voluntary sector and providers of leisure services, physical activity and sport and is a powerful advocate for increasing participation across Oxfordshire. It has two main mechanisms of working:

1. Through its funding from Sport England, it works to engage more people in grass roots organised sport and active recreation

[6] The key stakeholder consultation will include a piece of work undertaken by the County Council engagement team that will gather views on healthy eating and influencing food choices, from children in Reception year and Year 6

2. Funding and in-kind contributions from the Public Health directorate and district councils allows it to develop programmes that seek to increase physical activity in people's everyday lives

A summary of the current work programmes is illustrated in Appendix 1. The new strategy will strengthen partnerships already well established, such as those with the Oxfordshire Sports Partnership and Health Care and will build new partnerships within and between the Local Authorities, Health and Public Health to bring innovation to our work in this area and to complement established programmes.

Ways in which this strategy will broaden work undertaken in the area of healthy weight

This strategy has three key focus areas:

1. Influencing choice and changing social norms and cultural values
2. Working with partners in the Local Authorities
3. Ensuring that healthy weight is embedded in to the wider public health objective of improving and maintaining general health and wellbeing for the population

We have chosen these three areas as they are complimentary and reflect not only public health's new home in the local authority, but also the evolving thinking on the most effective ways to achieve and maintain a healthy weight across the population. In 2007, the Foresight Report concluded that whilst achieving and maintaining calorie balance is a consequence of individual decisions about diet and activity, our environment (and particularly the availability of calorie-rich food) now makes it much harder for individuals to maintain healthy lifestyles.[7] Subsequent government white papers, such as Healthy Lives, Healthy People[8], have built on this evidence and there is now a growing movement to consider the norms and values which shape our society and how this affects the choices that we make. This is an essential part of ensuring a healthy weight for our population, but potentially the most difficult in terms of pragmatic interventions, particularly at a local level. This strategy uses the tools of behavioural economics to create a framework, within which we can begin to address the norms and values that are currently acting as a barrier to achieving a healthy weight for the population.

Working with the local authority at both District and Council level is the lynchpin of this strategy, allowing us to more effectively consider and influence the environment in which we live. Local authorities are under new obligations to demonstrate that they are delivering "social value"[9] – that is, they have considered the social, environmental and economic impacts of their commissioning decisions.[10] We have begun to develop good working relationships with colleagues in the departments of planning, transport, leisure and environmental health and will continue to build on these networks.

Public Health has a broad agenda and the Oxfordshire Public Health Directorate has many programmes that work across different sections of the population. Achieving a healthy weight is an integral part of many of the programmes that are working in the context of a

[7] The Foresight Report 2007 http://www.bis.gov.uk/assets/foresight/docs/obesity/17.pdf
[8] Healthy Lives Healthy People – A call to action on obesity in England Department of Health 2011
[9] Public Services (Social Value) Act 2012
[10] Improving the Public's Health – The King's Fund

healthy living agenda. These programmes involve many different partners and the third section of the strategy therefore makes explicit reference to this work. There are some programmes which are directly associated with ensuring a healthy weight in the population, such as increasing the rate of breastfeeding, whereas others, such as improving mental health, may need more explicit reference to capitalise on the links between the two areas.

These key areas will need to be considered as part of a life-course approach. That is to say, achieving and maintaining a healthy weight must be integrated in to programmes that address all people of all ages.

3. Key Focus Areas

3.1 Influencing choice, addressing social norms and cultural values

Background

In designing our preventative, healthy weight interventions or when commissioning obesity treatment services we have traditionally used modes of intervention which use established models of behaviour change. These 'cognitive' or 'rational' models attempt to isolate the key controlling factors, processes or causes of behaviour and most of these theories originate from within the fields of psychology and sociology.

For example, the ***Theory of Planned Behaviour*** [11]suggests that the intention to act and the action itself, for example - doing more minutes of physical activity per week, is an outcome of a combination of attitudes towards doing more physical activity.

These models of behaviour change have led us to implement programmes which aim to address the key controlling factors for individuals. In addition, they have tended to drive us towards interventions or services primarily directed at higher risk individuals with pre-existing issues e.g. people who are identified as inactive, overweight or with health problems, rather than community or population level approaches to address less healthy behaviours before they become embedded and start to cause problems.

For example:

1. We often use campaigns and deliver health education messages to advise people about the potential threats to their health. We positively promote physical activity and healthy eating as a way to maintain a healthy weight, look good, feel good, prevent disease etc. In doing so we are aiming to influence how individuals evaluate their own behaviour and the potential outcomes of changing their behaviour. This is also a core aspect of the ***Health Belief Model***.[12]
2. We use group based support and buddy schemes e.g. Health Walks, Go Active activities, weight management classes, to deliver health education messages, but also to utilise professional and peer support to try and influence or change the

[11] Ajzen, I (1991).The theory of planned behavior. *Organizational Behavior and Human Decision Processes.* 50 (2): 179–211.

[12] Stretcher V and Rosenstock I (1997).The health belief model. In Andrew Baum. *Cambridge handbook of psychology, health and medicine*. Cambridge University Press.113–117.

negative subjective norms that people may have adopted from their close friends, family, workmates etc.

3. Finally, we try to make the intended behaviour more accessible, removing barriers such as cost and making it easier for the individual to participate.

Put simply, by using tools such as incentives, information and support we have aimed to change people's behaviour by 'changing their minds'. We assume that people will weigh up the revised costs and benefits of their actions and respond accordingly. However, although these efforts to influence the key controlling factors are still valid, they are not sufficient to affect all of human behaviour. In fact, some experts have argued that these models of behaviour change can only predict as little as 10% – 30% of human behaviour. Unfortunately for us, much of human behaviour is not entirely rational.

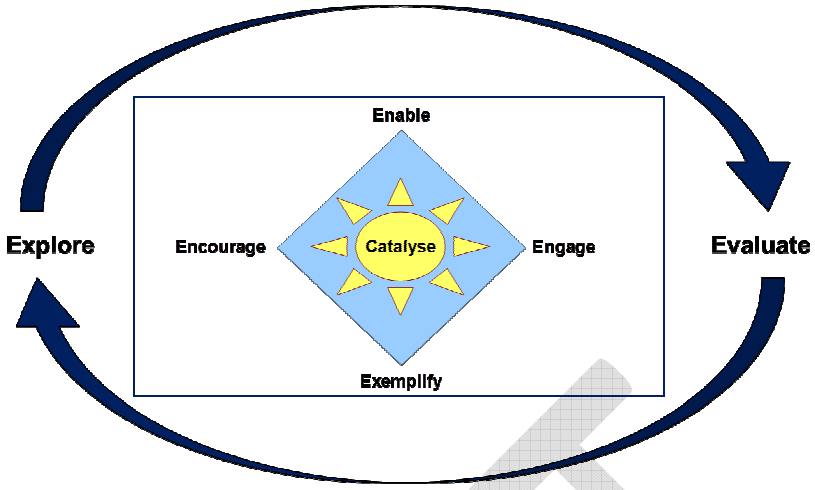
Behavioral Economics

The complexity of behaviour and behaviour change has led to attempts to develop integrated frameworks to inform policy and intervention designs, and assist non-experts in understanding behaviours and how they might engage with them. Known as 'Behavioral Economists' these experts suggest that behavioural approaches based on "changing contexts" (i.e. Adapting the wider environment within which humans frequently use the automatic system to respond to cues) could bring about significant changes in behaviour at little cost.

To support new innovations and complement existing policy the Behavioral Insights Team, previously based at the Cabinet Office has developed MINDSPACE[13]. A set of tools for changing behaviour, MINDSPACE can be used in conjunction with the 6E's policy framework of Explore, Enable, Encourage, Engage, Exemplify and Evaluate (Figures 1 & 2).

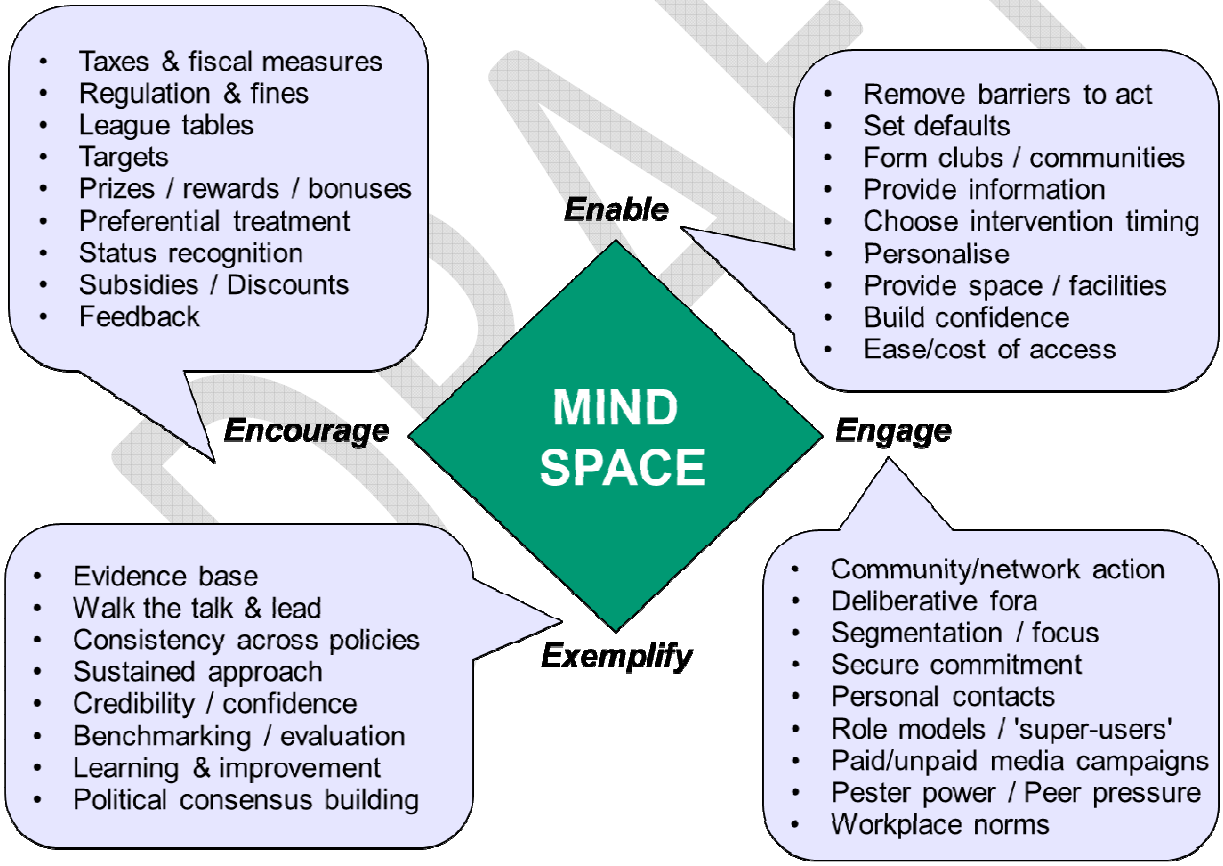
[13] Cabinet Office (2010) Applying behavioural insight to health. Available at https://www.gov.uk/government/publications/applying-behavioural-insight-to-health-behavioural-insights-team-paper

Figure 1.The 6Es policy framework



Source: Clive Bates, Director General, Sustainable Futures, Welsh Assembly Government

Figure 2: Approaches to behaviour change



The MINDSPACE report suggests we should always consider the following tools when considering our chosen approaches to behaviour change:

Messenger - we are heavily influenced by who communicates information
Incentives - our responses to incentives are shaped by predictable mental shortcuts such as strongly avoiding losses
Norms - we are strongly influenced by what others do
Defaults – we "go with the flow" of pre-set options
Salience - our attention is drawn to what is novel and seems relevant to us
Priming - our acts are often influenced by sub-conscious cues
Affect - our emotional associations can powerfully shape our actions
Commitments - we seek to be consistent with our public promises, and reciprocate acts
Ego - we act in ways that make us feel better about ourselves

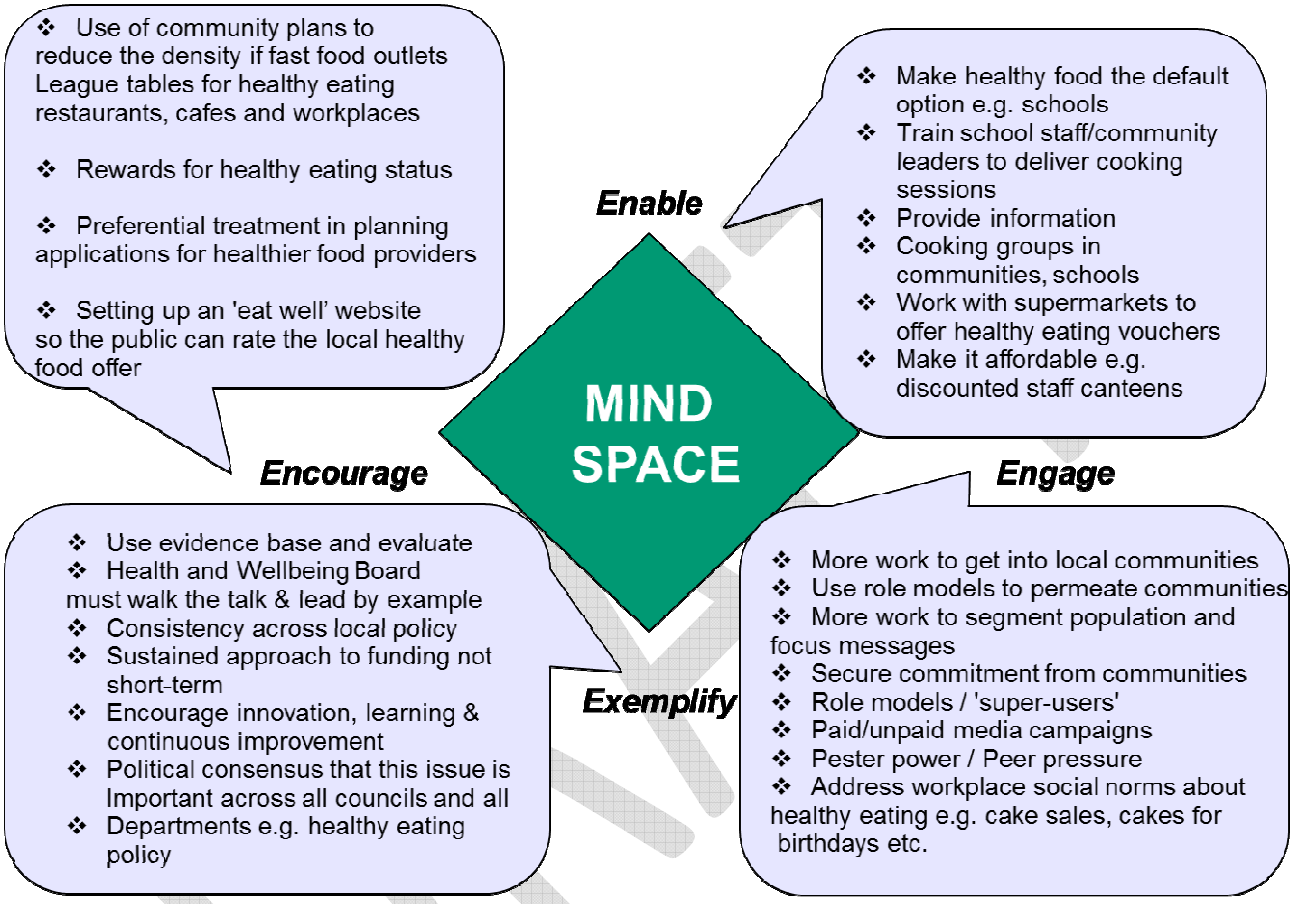
Implications for current and future work programmes

In considering how we apply behavioural economics to our refresh of the healthy weight strategy, first, we need to broadly consider and agree which behaviours we wish to encourage or discourage in the local population. We then need to agree if and where we should focus our efforts. Many of the population groups and behaviours we may wish to influence are outlined in the table below.

Age or Group	Encourage	Discourage
Pregnant women	Healthier food choices Regular exercise	"Eating for two" As below for adults
Parents of young children and families • Parents • Pre-schools, nurseries and child care providers • Children Centres	Exclusive breastfeeding Infant led weaning Healthy eating for young children 60 minutes of physical activity a day Family meal times Cooking from scratch Leading by example	Screen time High sugar, high fat snacks Sedentary behaviour Poor sleep patterns Using food as reward or for emotional comfort
Children and young people • Parents • Schools • Colleges	60 minutes of physical activity a day Try more sports and active recreation Make healthier food choices Active travel to school or college Leading by example	Screen time High sugar, high fat snacks Sedentary behaviour Poor sleep patterns Using food as reward or for emotional comfort
Working Age Adults • Communities • Workplaces	150 minutes of physical activity a week Make healthier food choices Active travel to work Leading by example	Screen time High sugar, high fat snacks Disordered eating Sedentary behaviour
Older Adults • Communities	Active living Make healthier food choices	Sedentary behaviour

Figure 3, uses the Enable, Encourage, Engage and Exemplify frame work approach to suggest where we could do more locally to encourage adults to eat more healthily. We then go on to use the framework to examine a local partnership initiative, GO Active Get Healthy and consider the interventions within the context of MINDSPACE.

Figure 3. Approaches to behaviour change, Healthy Eating



Go Active, Get Healthy is a local partnership initiative, partially funded by the Sport England, Get Healthy Get into Sport Fund. The main focus of the intervention is to engage, encourage and enable inactive individual to become more active.

- **Engage:** Providers such as GP's working in local communities are being 'signed up' as refers GO Active sessions are offered in local communities
- **Encourage**: Inactive individuals who take part receive motivational phone calls and earn rewards e.g. free passes, for taking part in physical activity. Organisations that refer inactive individuals to the programme, who become active, are rewarded.
- **Enable:** Information is provided on websites, social media, and press releases and given out by refers Free or discounted sessions GO Active sessions are offered over the county.

Example: Go Active, Get Healthy

Go Active, Get Healthy is an evolution of the GO Active programme. The programme aims to work with inactive adults to help them become more physically active by connecting them with a range of local activities and opportunities, whilst offering additional support including motivational coaching and subsidised activities. Following a referral or self- referral, all participants receive information about activities in their area. Inactive participants will also be offered:

- *Motivational coaching with a trained professional to identify suitable activities and provide support.*
- *Up to £100 of subsidy towards activities at their local leisure centre.*
- *Up to a further £60 of incentives for completing the follow-up assessments (sports equipment vouchers or a charity donation)*

- **Exemplify**: The project is being evaluated by Oxford Brookes University and results will support learning & continuous improvement.

Examining the Go Active Get Healthy intervention in the context of MINDSPACE adds some other dimensions to the project that may not have been fully considered:

Mess**enge**r – The Oxfordshire Sports Partnership and referrers (such as GPs) are passing on the information. Are these the right messengers to engage inactive individuals? Do we know? Have we asked?

Incentives - the project makes good use of incentives for participants and referrers. Are these incentives strong enough to outweigh other mental shortcuts? Are they the right incentives for the target population? Have we asked?

Norms - we are strongly influenced by what others do. 22% of adults in Oxfordshire do no physical activity but the norm is NOT being inactive. 78% of people do some physical activity per week (even is if not as much as we would like it to be). Does the project do enough to promote this message? Does the project do enough to use role models to promote the 'being active is normal 'message?

Defaults – if we "go with the flow" of pre-set options the default for the target population will be a menu of sedentary behaviours. What is the project doing to address these e.g. in the motivational interviews, in addition to trying to support people to take up an activity?

Salience - this is a new and novel programme but is it relevant to the target audience? Have we asked them? Have they been involved in the design?

Priming – we have designed an intervention we think will work but are the subconscious cue's to be inactive still the same for the individual? How can we help to change them?

Affect - our emotional associations, perhaps derived from a bad experience in the past, can powerfully shape our actions. Are these emotional associations and experiences being explored during motivational interviewing?

Commitments - are participants signing up to join the programme? Have they made a public commitment?

Ego - the programme provides rewards in the form of incentives for participants. What other goals or objectives could be used to help participants feel good about themselves for taking part? For example, raising money for charity or spending quality family time with the children etc.

This is one just one example of how MINDSPACE could be applied to a local initiative and the Cabinet Office Report gives further examples of how MINDSPACE has been successfully used in the UK and other countries in a number of behavioural contexts including diet and physical activity.

3.2 Working with partners in the Local Authority

Background

In recent years, evidence has accumulated which demonstrates just how important the physical, social and economic environment in which we live and work is for our health. Health and environmental inequalities are inexorably linked and poor environments contribute significantly to poor health and health inequalities. In their Steps to Healthy Planning, the Spatial Planning and Health Group state that the following issues impact on physical and mental health[14]:

- The location, density and mix of land uses
- Street layout and connectivity
- Access to public services, employment, local fresh food and other services
- Safety and security
- Open and green space
- Affordable and energy efficient housing
- Air quality and noise
- Extreme weather events and a changing climate
- Community interaction
- Transport

These broad health issues will directly impact on achieving and maintaining a healthy weight across the population. Many of these issues are areas where the public health directorate will need to work closely with colleagues in local authorities. The Public Health Directorate has previously worked with the local authorities in the area of healthy weight, predominantly focussing on the work of Leisure Departments and sport and leisure providers, with several successful partnerships and sport and physical activity programmes.

[14] Spatial Planning and Health Group, Steps to Healthy Planning: Proposals for Action 2011

The contracting out of leisure provision has enabled some Districts to specifically contract terms which include healthy weight initiatives and approaches.

Other initiatives such as Healthy Heart campaigns, where cafes and restaurants are encouraged to provide healthy options on their menus, have been run by Environmental Health or Health Promotion departments. With budget pressures increasing year on year over the past ten years, these initiatives have been cut back. Some District Councils however, such as South and Vale have been able to sustain these schemes.

Planning departments, through the changing planning development policies have had opportunities to influence healthy weight promoting environments, when building new developments. This has often been as a result of policies surrounding Sustainable Development which have resulted in developments encouraging the use of sustainable public transport.

Working with District Councils

> *With public sector resources shrinking, demand growing and health inequalities widening, Health and Wellbeing Boards must acknowledge the multifaceted role of districts and integrate this into a 'whole-system' focus on preventative public health policy. In two-tier areas, achieving improvements across the Public Health Outcomes Framework Indicators will be dependent upon the delivery of district frontline statutory and discretionary services, innovative use of its public assets and utilisation of its local partnerships*
>
> *District Councils Network*[15]

The Healthy Weight, Healthy Lives toolkit [15] identifies the need for a multi-agency approach. NICE Guidance on physical activity [16] identifies the need to include all local authority departments when increasing physical activity levels. Any successful physical activity initiatives the County may choose to adopt will rely on the engagement of the District Council and their services to ensure success.

NICE Public Health Guidance on Obesity [17] focuses on community engagement, of which District Councils are a key delivery mechanism. It makes reference to local policies which may have indirect impacts, such as the removal of park wardens from local parks, a District

[15] District Action on Public Health (Feb 2013) How district councils contribute towards the new health and wellbeing agenda in local government (District Council Network) Available at http://districtcouncils.info/files/2013/02/District-Action-on-Public-Health.pdf

[16] Healthy weight, healthy lives: A toolkit for developing local strategies (Oct 2008) Dr Kerry Swanton for the National Heart Forum/Cross- Government Obesity Unit/Faculty of Public Health Available at http://www.fph.org.uk/uploads/full_obesity_toolkit-1.pdf

[17] NICE (2012) PH42 Obesity – working with local communities. NICE. Available at http://guidance.nice.org.uk/PH42

Council function. The Local Government Association [18] also highlight the need to include all levels, from strategy to delivery, to tackle obesity.

District services can provide assets and officers in leisure, environmental services, parks and public places as well as planning. There are opportunities to build on existing partnerships and networks to use district services and officer expertise as a potential source of place shaping, public health delivery, commissioning and intelligence gathering, which is needed to deliver a comprehensive Healthy Weight Strategy.

Working with the Districts is a key part of the strategy for two main reasons. First, the specific work they do that is mandated by legislation. Secondly, the resource they can bring to working together on the strategy through an expert workforce, different professional perspectives and a greater depth and variety of tacit knowledge.

District Councils have duties and powers under various pieces of legislation, alongside wider influences on healthy lifestyles that can help to create places where people are supported to maintain a healthy weight. The specific departments in District Councils have discreet actions that will contribute to achieving and maintaining a healthy weight for the population, alongside multidisciplinary programmes of work that will need departments to work together, alongside colleagues from the County Council and other partners.

Planning

Planning authorities can influence the built environment to prioritise the need to be physically active, as a routine part of daily life.[19] They can do this through their Regional Spatial Strategy, the Local Development Framework and local planning policy guidance.

The National Planning Policy Framework (NPPF) requires that local planning authorities (LPAs) have a responsibility to promote healthy communities. Local plans should "take account of and support local strategies to improve health, social and cultural wellbeing for all"[20].

Planners have a significant contribution to make through changes in local planning policy, to make a difference now - to peoples environment and the ease of the choices they can make. Due to the relative permanency of developments, they can have a generational impact through the design of new developments, by designing in a healthy choice and making that choice the easier option. They are also an important link to transport policy, which can create incidental physical activity opportunities. When it comes to building design they have relationships with architects who can also affect the internal space of buildings, for example making stairs a more obvious and even preferable option, whilst still making the space accessible for all.

[18] Tackling obesity Local government's new public health role LGA (Feb 2013) Available at http://www.local.gov.uk/c/document_library/get_file?uuid=dc226049-df94-487e-be70-96bdcb4a9115&groupId=10180

[19] NICE (2008) NICE PH8 – Physical Activity and the Environment. NICE, Available at http://guidance.nice.org.uk/PH8

[20] The role of local authorities in health issues Available at http://www.publications.parliament.uk/pa/cm201213/cmselect/cmcomloc/writev/694/m21.htm

Both Planning and Environmental Health Departments would be crucial in delivering an initiative, such as controlling the development or expansion of fast food outlets, as outlined in the LGA/PHE/CIEH guidance[21].

Environmental Health

Environmental health and licensing can contribute to the strategy by influencing policies for which they are responsible, by recommending a particular course of action to Councillors. They have a database and relationships with a variety of food related businesses. They are also the main body of a Districts workforce who have been trained in Public Health principals. NICE PH42[22] specifically identifies Environmental Health departments and their role in promoting corporate responsibility to local food businesses.

Building a bridge between public health, environmental health and planning, through commenting on and championing relevant applications, means there may be enhanced opportunity to influence for healthy weight e.g. regulate the sale of fast food where there is a strong argument to do so[23]. Whilst Environmental Health primarily focus on the safety of food they have a cross cutting understanding of the businesses in the area, who may either need to be educated or who can be easily brought on board. This saves time when trying to influence the 'local food offer' by using existing professional relationships and local knowledge.

Leisure Services

Leisure services have historically been the more obvious partners in Districts and have tended to be more involved over a more sustained period of time. All of the Council funded leisure centres are part of the Oxfordshire Exercise on Referral scheme and leisure providers contribute to local initiatives and countywide programmes led by the Oxfordshire Sports Partnership. They remain key partners, in terms of the local physical activity offer and services they provide and making sure they contribute to both a more active population and support initiatives to help encourage healthy eating behaviours.

Working with the County Council

The Public Health Directorate's new home in the County Council has allowed us to develop and improve relationships with colleagues in directorates that directly or indirectly, influence the ability of the Oxfordshire population to achieve and maintain a healthy weight. Key directorates include transport, education and trading standards.

Transport

Encouraging Active Transport is an important element in a healthy weight strategy. It seeks to create an environment where people, rather than using their car – particularly for short journeys - are encouraged to use alternative modes of transport such as cycling, walking or

[21] Healthy people, healthy places briefing. Obesity and the environment: regulating the growth of fast food outlets. LGA/PHE/CIEH November 2013 Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/264914/Briefing-OBESITY-FASTFOOD-FINAL.pdf

[22] Obesity - working with local communities (PH42) - Guidance

[23] Takeaways Toolkit. Tools, interventions and case studies to help local authorities develop a response to the health impacts of fast food takeaways (GLA) November 2012 Available at https://www.london.gov.uk/sites/default/files/TakeawaysToolkit_0.pdf

public transport (where people are likely to walk to public transport hubs). In order for active transport to be successful in Oxfordshire, infrastructure must be in place to allow people easy access to public transport, safe cycle paths and walking routes. These routes must link people to their home, schools, places of work, shops, leisure bases etc.

Public health can work with the transport department to promote active transport by:

- Providing input in to the Local Transport Plan
- Providing evidence to make the business case for active travel (financial savings for health service, attracting business to the County etc.)
- Working with transport colleagues to consider new infrastructure proposals for development (E.g. inclusion of 20mph zones in built up areas, cycle paths included in new housing developments)

Education

A healthy start is vital to ensuring a healthy approach to eating and physical activity. As schools move from LEA to Academy status, the public health directorate will be seeking new ways of working with young people to ensure that a public health agenda is prioritised in an educational setting. The new model of school health nursing (described in more detail below) will ensure that from September 2014, a programme of public health initiatives is available in every secondary school in Oxfordshire. As this model evolves, we will continue to develop our public health engagement with all young people.

Trading Standards

The core business of testing and making food safe is an important part of delivering a healthy diet and physical activity.

Some examples of best practice include Oxfordshire Trading standards carrying out a sampling program to test “healthy soup” claims. Other Trading Standards authorities, such as Stoke on Trent have undertaken projects to work with Fish and Chip shops to change the oil they fry in to reduce saturated fats.

Examples of Best Practice in Local Authorities

- Nationally, there have been several Healthy Eating initiatives (including a local example in South and Vale), focusing on food establishments such as cafes and restaurants specifically providing a “Healthy Option” on their menu, as well as guiding customers to healthier options more generally.
- Several Local Authorities have introduced planning policies on restricting takeaways close to schools
- Blackburn and Darwen made leisure activities free. The scheme has helped drive up participation in physical activity. Rates have risen by more than 50% with one in four adults now active for 30 minutes, three times a week.
- Walks to local parks to make them attractive and useable have been done locally in Cowley Marsh, Oxford
- An EU funded and evaluated project worked with schools and local community in towns in France to reduce overweight and obesity levels through education and co-ordinated community events
- Bristol City Council launched a scheme “Cooking from Scratch”. The scheme was targeted at teaching people in disadvantaged areas about how to cook simple, healthy

food on a budget. It now trains key community workers to spread the messages to a wider audience

- Wealden District Council worked with lunch clubs to offer training and other support in both food hygiene and nutrition. The council worked closely with Action in rural Sussex and a number of representatives from various lunch clubs.

3.3 Ensuring that healthy weight is embedded in to the wider public health objective of improving and maintaining general health and wellbeing for the population

Taking a life course approach and embedding healthy weight into the strategies and plans of partner organisations will create a golden thread of healthy weight from pre-term to later 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. The transfer of School Nursing and Health Visiting services to the County Council (Health Visiting from the autumn of 2015) presents an exciting opportunity to address this agenda more holistically, through the collaborative delivery of the Healthy Child Programme.

Let's get Healthy with HENRY *is an 8 week course that offers parents a chance to share ideas and gain new skills and tools to address lifestyle issues in a supportive and fun environment. The course adopts a holistic approach and focuses on:*

- *practical and authoritative **parenting skills** for a healthy lifestyle*
- *increasing self-esteem and **emotional well-being** of parents and children*
- *helping families change old habits and adopt a **healthier lifestyle***
- *practical information that will help the whole family to **eat more healthily** and become **more active**.*

Source: HENRY

Early Years

Health professionals, early year's staff and trained volunteers have opportunities to engage with mothers before and during pregnancy, to identify and address risk factors that will predispose children to be overweight or obese. Encouraging healthy weight maintenance, the uptake of breastfeeding and access to parenting courses such as HENRY (Health Exercise and Nutrition for the Really Young) can make a real difference. Working with mothers to tackle smoking in pregnancy through the provision of trained midwives and advisors, also provides an opportunity to influence a healthier mind-set.

Between birth and 2-3 years is crucial in establishing an informed approach to infant feeding. Universal maternity services, health visiting services, children's centres and breastfeeding cafés already provide advice to parents on parenting, weaning and breastfeeding. A community breast feeding service gives additional support to breastfeeding mothers who live in wards which are particularly deprived. Parents are also able to access the 8-week HENRY programme which gives them the skills and confidence to address family lifestyle issues.

School Age Children
During early childhood, and when children start making decisions for themselves, organisations such as Oxfordshire Play Association help to create and promote more opportunities for children to enjoy active play. Initiatives provided in local communities and schools such as walking buses and cycle training promote cycling and walking as a means of transportation, whilst also ensuring children's safety from accidents.

From September 2014, all children in Reception, Year 1 and Year 2 will be able to access a free cooked meal at school and the introduction of the Whole School Food Plan will present more opportunities to improve the standards and provision of food in primary and secondary schools. Finally, the new school nursing service, commissioned by Oxfordshire County Council, In addition to core safeguarding activities and providing early help, advice and on-going support for more vulnerable children, will now provide public health leadership and interventions for every secondary school in Oxfordshire. Public health interventions will include:

- The development and implementation of a healthy school policy
- Ensuring schools are a health promoting and health protecting environment
- Building capacity to promote emotional health and wellbeing, healthy eating and physical activity, positive relationships and sex education

For more vulnerable families, the Early Intervention Service can deliver important public health messages, targeted interventions and parenting support which complement the universal work of schools and school health nurses. Where a child is identified as overweight or obese the Children, Families and Young People Healthy Weight service can help them with additional support to return to a healthy weight. Once a healthy weight is firmly embedded, opportunities within and outside of school need to be available to help them maintain their weight. Outside of school the Oxfordshire Sports Partnership continues to provide and support opportunities for children and young people to engage in sport and physical activity in their local community.

As children reach adolescence, issues relating to mental health such as body image, confidence and risky behaviours come to the fore. Other public health services which also work with young people, such as sexual health and substance misuse, can help to embed healthy weight messages through ensuring that mental health and physical health are always linked. At this point in the life course, positive and/or diversionary activities such as multi-sports, street dance and others provided by the Youth Ambition programme in Oxford City can help young people to live healthier lives in addition improving their educational achievement and overall life chances.

As a young person approaches adulthood, they may decide to attend one of our further education colleges. Similar to secondary schools, the college nursing service will be on hand to provide early help, advice and on-going support for more vulnerable young people, in additional to public health leadership and onsite interventions. If a young adult goes straight into work, initiatives to encourage local businesses to adopt a healthy workplace policy will contribute to opportunities to make healthy choices, in terms of active transport and healthy food in the workplace.

Adults

Unhealthy choices such as high fat, high sugar foods and excessive use of alcohol can affect both weight gain through excessive calorie consumption as well as a decline in mental health and wellbeing. The promotion of the national Change4Life "Swaps" campaign highlights the benefits of reducing empty calories through alcohol[24]. The work around public dental health can also be linked to healthy weight by the focus on reducing sugary drinks and medicines.

Leisure services, sport clubs and targeted initiatives provided in the community such as GO Active Get Healthy and Exercise on Referral can support young adults to maintain a more active lifestyle. However, being more physically active does not necessarily require accessing structured sports and exercise sessions. Incidental activity, such as active transport, encouraging the use of green space and volunteering increases the likelihood of maintaining a healthy weight while also improving mental health and wellbeing.

As people age they have increased demands for primary and secondary health care services. The work the PH directorate does with Oxfordshire CCG, Public Health England and their providers is important to ensure that people keep themselves well and return to an independent and healthy lifestyle as soon as possible after a period of illness and recovery.

The role of the national health checks programme, for those between 40 and 74, is paramount in helping people to maintain a healthy weight. Besides the identification and communication risks of being overweight or obese, it is important that there is a clear pathway to local support through commissioned weight management services, local exercise schemes such as Exercise on Referral and GO Active Get Healthy or signposting to more informal sources of support.

As people reach older age, projects such as Generation Games can connect people with appropriate local opportunities remain active and socially connected, whether that's through a local health walk, Exercise to Music Class or DVD. The work done through reducing Excess Winter Death initiatives can also help keep them independent and mobile through advice and support to eat well, remain physically active and protect their wellbeing.

[24] https://smartswaps.change4life.co.uk/

4. High level Action Plan

This strategic approach to ensuring that our population achieves and maintains a healthy weight can only be realised if we work closely with our key partners, enabling them to build a healthy weight approach in to their everyday work. We will offer public health expertise and support where we are able and learn from partners' often first-hand experience as to what is actually making the difference to people's lifestyle choices. Our partners include, but are not limited to: Local Authority; education; healthcare – including primary health care (health visitors, GPs etc.), mental health care, hospitals; local employers and the third sector.

Public Health is already working collaboratively with these partners through many of the programmes described above. However, in order to realise the vision of achieving and maintaining a healthy weight for the people of Oxfordshire, we will ask each of these partners to reconsider their role and contribution to this strategy. Through consultation and a mutually agreed action plan, we will ensure that all partners are optimising their potential to influence and improve the lifestyles of the people of Oxfordshire, which will contribute to the achievement and maintenance of a healthy weight across the population.

As with all public health work, we will continue to ensure that all work we undertake will reduce inequalities across the population. We will ensure that there is a focus on population sub-groups where it is difficult to make healthy weight choices. Being aware of groups who have been harder to engage, such as young Asian women is important and the creativity to adopt novel measures to report on the success of various public health initiatives.

This action plan is intended as a starting point for discussions with partners as to the most effective ways to transform our strategic direction in to programmes and projects in the County of Oxfordshire. It is anticipated that as a result of the consultation process, these actions will undergo significant amendments and additions.

Draft Action Plan for Oxfordshire Healthy Weight Strategy

Influencing choice, addressing social norms and cultural values	The Oxfordshire Healthy Weight Network and other partnership forums to adopt the "6Es" policy framework of Explore, Enable, Encourage, Engage, Exemplify and Evaluate and use of MINDSPACE in the design and implementation of healthy weight interventions.
	Oxfordshire County Council – Public Health to lead the way with more innovative public health programmes and services such as "Be a Star" social marketing campaign[25]
	Oxfordshire County Council – Public Health to work alongside colleagues in Public Health England (Thames Valley PHE Centre and the National Behavioural Insights Team) to implement good practice from other areas and to develop and evaluate local behavioural interventions.
Local Authority: Planning	Named Public Health contact to be known to strategic managers and relevant front line officers
	Planning departments to request input from Public Health for Local Development Plans
	Planning department to request input from public health on major planning applications (Health Impact Assessments where appropriate)
	Training for public health and planning colleagues in the use of the HEAT tool for walking and cycling (to estimate the value of different scenarios of increasing walking and cycling levels)
	Jointly held training to understand each other's skill sets, develop opportunities to work together and keep informed of latest evidence and publications
	Annual meeting to scan ahead for projects, initiatives and policies in planning that can be complimented by public health objectives
Local Authority: Environmental Health	Named Public Health contact to be known to Strategic Managers and relevant front line officers
	Develop a "Charter" on policies and initiatives that can be run, associated with local food businesses in the area
	Review existing policies to assess if there is scope to adopt healthy weight principals
	Consider if additional policies are needed to address healthy weight policy and practice.
	Jointly held training to understand each other's skill sets, develop opportunities to work together and keep informed of latest evidence and publications
	Annual meeting to scan ahead for projects, initiatives and policies in planning that can be complimented by public health objectives
Local Authority: Leisure	Named Public Health contact to be known to Strategic Managers and relevant front line officers. Identify what is needed for them to develop and deliver joint projects
	Review existing policies to assess if there is scope to adopt healthy weight principals.

[25] http://www.beastar.org.uk/

	Consider if additional policies are needed to address healthy weight policy and practice
	Jointly held training to understand each other's skill sets, develop opportunities to work together and keep informed of latest evidence and publications
	Annual meeting to scan ahead for projects, initiatives and policies in planning that can be complimented by public health objectives
Local Authority: Transport	Named Public Health contact to be known to Strategic Managers and relevant front line officers
	Transport to request input from Public Health for the Local Transport Plan
	Transport to work with Public health to make the business case for active travel
	Review existing policies to assess if there is scope to adopt healthy weight principals
	Consider if additional policies are needed to address healthy weight policy and practice
	Jointly held training to understand each other's skill sets, develop opportunities to work together and keep informed of latest evidence and publications
	Annual meeting to scan ahead for projects, initiatives and policies in planning that can be complimented by public health objectives
Embedding healthy weight in to the wider public health objective of improving and maintaining general health and wellbeing for the population	Public health, with and through their partners, will ensure that healthy weight is embedded in to relevant programmes and projects that are implemented throughout the life course
	Continue to commission healthy weight services, from prevention through to treatment

Appendix 1 – Healthy Weight Service Mapping March 2014

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/LP Commission
	Reach4Health Programme	Treatment	Intensive programme to improve eating & exercise behaviours in families	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. 80 - 100 patients per year	OUHT/ RBFT	NCB Commission
	Adult Weight Management Service	Treatment All	Intensive programmes to support weight loss –2000 patients per year	More Life SW and WW	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	Partnership
	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	Prevention Treatment	Personal advice and weight management advice – 16 – 18 yr olds	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

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Project Plan for Obesity Project March to June 2014

Aim of Project

- To understand the perspective / views of local children on healthy weight and associated topics (activity, healthy foods, less healthy foods etc.)

Target Groups

- Age group: children in reception year and Year 6 (with ages in between if feasible)
- Rationale for age groups: National Children's Measurement Programme (NCMP) measurements are taken in reception and year 6 classes
- Background information: obesity rates double between reception and year 6
- Demographic areas identified by Dr Rebecca Cooper and specific primary schools chosen from those schools who participate in the National Child Measurement Programme

Consultation Objective

- Following on from Obesity Sounding Board and previous consultation work with parents and families, additional qualitative data is required to inform the Healthy Weight Strategy.
- It is expected that the data will provide valuable insights as to how children's knowledge, attitudes and beliefs about eating and exercise change and develop as they get older.
- This will aid the public health work in planning appropriate programmes to positively influence eating and exercise habits.

Time Scale

- Preparation and scoping work from March to April 2014
- Consultation work in schools, potentially from middle of April to June 2014
- Report – end June 2014

Engagement Team Officers

- Sally Latham and Lynn Smith (supported by Emily Chaundy for primary schools work)

Methodology (national research and guidance taken into account)

- Link with schools to determine the most appropriate approach
- We envisage using a variety of activities and interactive methods to glean the information
- Recording methods will include officers' observations and noting of children's answers / comments re: simple questions and conversations.

Budget

- If practical resources are needed for interactive sessions, the officers will investigate the resources held by the Oxfordshire NHS Health Promotion Unit (HPU) in the first instance
- All possible costs to be checked out with Dr Rebecca Cooper prior to commitment

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Oxfordshire Health Improvement Board: Thursday 27th March 2014

Paper: A Joint Public Health Strategy for Oxford University Hospitals NHS Trust: 2014/15

For discussion and approval by the Board

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. This ability has been recognised by the Health Improvement Board (the Board) in approving the development of a public health strategy for OUH, to be developed jointly between OUH and Oxfordshire County Council (OCC, the responsible body for public health in the County).
2. The purpose of this paper is to seek the approval of the Board for this public health strategy for OUH, with priorities for 2014/15. This strategy will be jointly owned by OUH and OCC, and has been approved by the OUH Trust Board.
3. OUH employs over 11,000 staff and has around 1 million patient contacts every year, plus many more visitors. The Trust is therefore ideally placed to promote healthy lifestyles and improve health at the 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. This public health strategy for OUH will demonstrate innovative commitment from OUH 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 between OUH and OCC, and build on strands of public health work already happening at OUH. This strategy proposes public health priorities for 2014/15 that will build capacity to promote healthy lifestyles, create a more health promoting environment, and embed public health approaches within OUH.
4. Recommendation: The Board is asked to consider and approve this joint public health strategy for OUH for 2014/15.

A Joint Public Health Strategy for Oxford University Hospitals NHS Trust: 2014/15

1. Purpose

1.1. The purpose of this paper is to seek the approval of the Health Improvement Board (the Board) for the proposed joint public health strategy for 2014/15 for Oxford University Hospitals NHS Trust (OUH).

1.2. This is a joint strategy between OUH and Oxfordshire County Council (OCC), the responsible body for public health in Oxfordshire, thereby ensuring that it is aligned with county-wide public health programmes and priorities. This strategy has been approved by the OUH Trust Board.

1.3. In September 2013, both the OUH Trust Board and the Oxfordshire Health Improvement Board approved the development of this joint strategy for 2014/15, to include consultation on longer-term public health priorities for OUH.

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. This role for OUH in the wider public health agenda was stressed in the public consultation on the Trust's strategy, presented in the 2013 Integrated Business Plan.

2.2. Rising demand and financial pressures on the NHS are predicted to continue over the next decade, driven by the needs of a growing and ageing population that is experiencing more chronic disease, and increasing costs of providing health care.

2.3. Tackling behavioural risk factors such as smoking, obesity, poor diets, low-levels of physical activity, and alcohol misuse, can achieve major health benefits across the life-course: from better outcomes during pregnancy and childbirth, through to a better quality of life in older age. Furthermore, some of the leading causes of ill health and premature death can be prevented, such as heart disease, stroke, diabetes, and cancer. This will have the added benefit of reducing demand on local health care services.

2.4. With more than 11,000 staff and around 1 million patient contacts each year, plus many more visitors, OUH is ideally placed to promote healthy lifestyles and behaviours, and improve health at the population level. The Trust's potential health promoting influence also extends to the families of staff, patients and visitors, and to the wider local community in which it holds a prominent and respected position.

2.5. This public health strategy recognises the important role that OUH can play in improving the health of the population of Oxfordshire. It demonstrates innovative commitment to improving the health of this population, and thereby also to reducing demand on local health services. It is aligned with the view of the Department of Health that hospitals have a responsibility to promote healthy behaviours, and with OUH's mission: "The *improvement of health* and alleviation of pain, suffering and sickness for the people it serves", to be achieved by "providing high quality, cost-effective and integrated health care, and through… the development of its workforce".

2.6. This strategy will reinforce how OUH operates as a valued member of the community it serves, and from which it employs so many people. It is jointly owned by OUH and OCC, ensuring that the OUH public health strategy and the wider Oxfordshire health

and wellbeing strategy are aligned. Joint ownership of this strategy will also strengthen links between the two organisations.

Public health need

2.7. Oxfordshire health services are facing unprecedented and rising demand. The major needs of the county's population are:

- reducing the burden of preventable disease – that which is attributable to smoking, obesity, poor diets, low levels of physical activity, and alcohol misuse;
- supporting an ageing population to maintain their health and independence; and
- reducing inequalities in health – within Oxfordshire, men living in the least compared with the most deprived areas live, on average, an extra 6 years, and women an extra 3 years.[1]

2.8. In addition to preventing ill health in the first place, improved health behaviours in patients will maximise long-term treatment outcomes, and can contribute to preventing readmissions to hospital.

2.9. A healthy workforce is essential to a successful hospital. Staff health not only reduces absenteeism, but also influences patient experience, patient safety, and clinical outcomes.[2] If OUH staff are typical of the population of Oxfordshire, as many as 2,300 are likely to be obese, 7,500 may not be eating healthily, and 9,500 not getting enough physical activity.[1] The OUH staff survey identified mental health and musculoskeletal health as priorities for staff members.

2.10. Online consultation for this 2014/15 public health strategy received 900 responses, the majority (804) of which were from OUH staff members. The top two public health priorities among respondents were to improve staff mental health and wellbeing, and to support and enable healthy choices through changes to the hospital environment. In addition, more than two-fifths of 'free-text' suggestions concerned the food provision at OUH, ranging from calls to increase the availability of healthy choices, to removing unhealthy options entirely.

3. The OUH Public Health Strategy 2014/15

Approach

3.1. This strategy sets out public health priorities for 2014/15 for OUH. These have been identified through consultation with staff and key partners, assessment of current public health activity at OUH, and analysis of need and gaps. They are aligned with public health priorities for the county, and consistent with NICE public health guidance.

3.2. This overarching public health strategy will draw together current public health activity at OUH where appropriate, and help ensure activities are consistent, complementary, and synergistic. The various groups leading these activities have been consulted on and closely involved in the development of this strategy.

3.3. Creating a health promoting hospital requires embedding public health at all levels, and across the breadth of activities, at OUH. In addition to the overarching Trust-wide priorities outlined in this strategy, the five divisions are being asked to identify their own public health objectives, for inclusion in their business plans for the first time in 2014/15.

3.4. This strategy aims to:

(i) Build capacity to promote healthy lifestyles to patients, visitors, and staff at all opportunities;

(ii) Develop a hospital environment that enables and promotes healthy behaviours;

(iii) Embed public health approaches within OUH.

3.5. This strategy sets out priorities in each of these areas for 2014/15. The accompanying action plan outlines specific initial actions and milestones for 2014/15 (see appendix). This action plan is a working draft that will be further developed within this strategic framework through a multi-agency, multi-disciplinary public health steering group that will be formed to oversee the delivery of this strategy.

3.6. Cross-cutting themes of equity and sustainability of resources will apply to all actions associated with this public health strategy.

(i) Building capacity to promote healthy lifestyles to all patients, visitors, and staff

Why is this important?

3.7. Behavioural risk factors can be improved through brief interventions delivered in health care settings, such as giving advice or signposting to relevant services.

3.8. Delivering brief interventions and advice in a secondary care setting may also help to address inequalities in health and in access to preventive care. People with lower socioeconomic status are more likely to access emergency acute health care, less likely to access primary preventive services, and are more likely to undertake unhealthy lifestyle behaviours.

3.9. Helping staff to improve their own health behaviours will enable and empower them to deliver health improvement messages to patients and visitors.

What is currently happening at OUH?

3.10. OUH staff members are being trained to deliver brief health improvement advice and interventions through several separate initiatives: (i) Two departments are involved in the Thames Valley 'Making Every Contact Count' (MECC) pilot programme, delivering brief advice to patients and visitors on topics such as smoking and healthy eating. (ii) The OUH Occupational Health and Wellbeing Specialist is recruiting and training staff to deliver brief opportunistic health promotion advice to OUH colleagues, with the aim of developing a network of 'Health Champions' across the Trust. (iii) Junior doctors are delivering brief intervention training to colleagues in delivering patient advice on diet and exercise through the national 'Move Eat Treat' campaign.

3.11. Oxfordshire Smoking Advice Service support patients and staff who wish to quit smoking across all hospital sites in Oxfordshire as well as training frontline staff to deliver direct smoking cessation support for patients.

3.12. A Community Safety Practitioner has been recruited to provide brief interventions relating to alcohol consumption in the emergency department (ED), including referral to specialist services as required. The ED Psychiatric Service also take referrals of patients with alcohol dependence.

2014/15 Public Health Strategy priorities

3.13. The 2014/15 strategy will consolidate and expand the provision of brief health promotion advice and interventions at OUH to patients, visitors and staff.

3.14. This ambition will require the development of a brief intervention training strategy for the whole trust, provision of appropriate and consistent training, staff capacity for training, and an information resource for health promotion and local services. Examples of issues that will be addressed include diet, physical activity, excess weight, smoking, alcohol and other substance misuse, plus mental wellbeing.

3.15. Delivery of this priority will include the recognition of OUH as a training centre for health promotion, the introduction of a dedicated health improvement clinic, and expansion of alcohol and smoking cessation services to patients.

(ii) Developing a health promoting environment

Why is this important?

3.17 As a health care provider, large employer, and member of the wider community, OUH has a responsibility to make the healthy choice the easy choice for all patients, visitors, and staff whilst at the hospital sites.

3.18 The hospital environment not only impacts on behavioural choices within that setting, but also on longer-term health beliefs of people exposed to that environment.[3] The OUH public health consultation highlighted that making the hospital environment a healthy environment is a high priority among respondents.

3.19 Both the staff survey and the public health consultation have revealed staff mental health and wellbeing to be a major priority for OUH.

What is currently happening at OUH?

3.20 Physical activity: promotion of physical activity to staff is on-going through an employer cycle purchase scheme, availability of subsidised gym membership, and onsite fitness classes. However, barriers to accessing these, including lack of awareness, were identified through the consultation.

3.21 Food provision: a healthier eating working group involving food providers, facilities management, clinical staff, public health, and occupational health and wellbeing are exploring ways of achieving healthier food provision at OUH sites. A recent staff survey on food provision and healthier eating at OUH received over 2000 responses.

3.22 Tobacco control: OUH is currently reviewing its 2012 smoke-free policy, aspects of which are not currently operational or enforced.

3.23 Staff mental health: OUH operates a staff mental health policy which outlines procedures for the identification of mental health problems, plus support and referral.

2014/15 Public Health Strategy priorities

3.24 The 2014/15 strategy will work to better understand the hospital environment and the barriers and enablers of healthy lifestyle choices within that setting.

3.25 Following this, actions will be identified and taken to improve the ability of the hospital environment to promote healthy behaviours for patients, visitors, and staff.

(iii) Embedding public health approaches within OUH

Why is this important?

3.26 Public health needs to become a priority for all at OUH, and a public health approach must be embedded within the wide activity of the Trust. Dedicated staffing and governance structures are needed to drive and monitor the delivery of this strategy, coordinating and managing current and future activity, and building on progress to date. A sustainable, professional public health presence within OUH will be key to this.

3.27 This public health strategy for 2014/15 needs to evolve into long-term public health objectives for OUH, which are embedded in all Trust activity, and included in the Trust's Business Plan.

3.28 Specialist public health skills can contribute to numerous aspects of Trust activity both by using a population approach and by acknowledging the individual perspective. Areas where specialist public health skills can add value include audit, service planning, needs assessment, data interpretation, evidence synthesis, peer review, evaluation, and inter-organisational work.

What is currently happening at OUH?

3.29 In response to the 2009 Boorman review of NHS Health and Wellbeing,[2] OUH developed a staff health and wellbeing strategy, and a health and wellbeing strategy group was set up in 2011 to implement this. The Trust has an active Occupational Health and Wellbeing Department which employs a Health and Wellbeing Promotion Specialist who leads work on staff health and wellbeing promotion.

3.30 Three Public Health Specialty Registrars from the Oxford Deanery have been placed at OUH during 2013/14, working under the Director for Information and Planning. Amongst wider work on audit, data interpretation, and service planning, this team have led the development of this strategy.

3.31 A group of OUH junior doctors, nurses, and allied health professionals have set up a group called *Health 4 Healthcare* who work to promote healthy living among staff and patients through directly engaging with front line staff, including organising a 'Healthy Hospital Day'.

3.32 Public health objectives now form part of the Trust's annual business plan.

2014/15 Public Health Strategy priorities

3.33 The 2014/15 strategy will work to embed public health approaches within the Trust, and build sustainable public health leadership to drive forward, monitor, and expand the delivery of public health work across the Trust.

3.34 Delivering this priority will include the development of a multi-agency, multi-disciplinary public health steering group, plus definition of governance structures within OUH and OCC; inclusion of public health objectives in the Trust business plan; increased awareness of and support for public health approaches throughout the Trust and the local community; and development of a business case for the future of public health at OUH.

3.35 Extensive consultation among staff, patients, visitors, and the wider community and partners will be carried out to inform longer-term public health priorities for OUH through to 2019/20.

4. Conclusion

4.1 OUH has the potential to significantly improve the health of the population it serves and from where it employs its staff. This Public Health Strategy offers a mechanism to consolidate public health related activities currently operating within the trust, and to expand this activity to address the health priorities of trust staff, patients, and visitors. It also demonstrates innovative commitment from OUH to improve the health of the population and reduce demand on local health services.

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

4.3 Achievement of the priorities outlined in this strategy will be measured against the identified actions and outcome milestones, and reported ultimately to the OUH Trust Board and Oxfordshire Health Improvement Board, and more widely communicated to all OUH staff, partner organisations, and the wider local community,

5. Recommendation to the board

5.1 The Board are asked to approve this OUH joint public health strategy for 2014/15.

Appendix: Working draft OUH public health strategy 2014/15 action plan

This is a working draft and the action plan will be further developed across organisations through the OUH public health steering group, once established.

References

[1] Association of Public Health Observatories (2012) Health Profile 2012, Oxfordshire. Public Health England.

[2] Boorman S (2009) NHS Health and Wellbeing. Final Report. London: Department of Health

[3] Sahud et al (2006) Marketing Fast Food: Impact of fast food restaurants in children's hospitals. Pediatrics 118(6): 2290-2297

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Appendix 1: Oxford University Hospitals Trust (OUH) and Oxfordshire County Council (OCC) Joint Public Health Strategy 2014/15 Action Plan

Objective		Key actions			Risks to delivery	Milestones/measures	Accountable Lead
(i) Build capacity to promote healthy lifestyles to patients, visitors and staff at all opportunities							
1	Develop a brief advice and intervention plan for health behaviour change at OUH	1.a	Review evaluation of Making Every Contact Count (MECC) pilots			Identification of evaluation outcomes and input into action 1.c	
		1.b	Evaluate implementation of health champions programme			Development of evaluation plan, evidence of evaluation	
		1.c	Following evaluations, adapt or expand MECC and Health Champions programmes as appropriate, and align their objectives to benefit both patients and staff			Development of action plan based on 1.c	
		1.d	Identify staff and trust capacity for training in brief interventions, this may include:	1.d.i	Become an accredited RSPH Level 2 Understanding Health Improvement training provider	Evidence of accreditation	
				1.d.ii	Development of online training module in behaviour change	Development of module	
2	Provide information and support for patients, staff, and visitors on improving health	2.a	Implement health improvement clinic pilot	2.a.i	Appoint staff members to clinic	Evidence of appointment	
				2.a.ii	Develop clinic materials	Evidence of materials	
				2.a.iii	Promote clinic	Use of local newsletters/ meetings/ posters/ wider press to promote clinic	
				2.a.iv	Evaluate pilot at 3, 6, 9, and 12 months	Write process and outcome evaluation criteria; link to threshold for continuation of clinic; evidence of evaluation	
				2.a.v	Submit business case/apply for funding for continuation and expansion based on 2.a.iv	Evidence of business case/funding applications, ascertainment of funds	
		2.b	Use on-going educational vehicles such as the Oxford Biomedical Research Centre series of public talks to promote public health and health improvement			Record of educational activities	
3	Expand alcohol and smoking cessation services for patients	3.a	Develop business case for OUH patient alcohol liaison function			Evidence of business case	
		3.b	Work through MECC, health champions, and the health improvement clinic to increase delivery of brief interventions for smoking cessation to patients			Evidence of MECC and Health Champion expansion	
		3.c	Develop and expand smoking cessation services for patients and staff			Evidence of increased services (i.e. NRT prescribing, quit rates)	
		3.d	Work towards implementation of NICE Guidance on smoking cessation			Evidence of action against NICE guidance	
4	Estimate baseline burden of unhealthy behaviour within staff, patients, and visitors to OUH	4.a	Use routine data to estimate buden of unhealthy behaviour in patient, staff, and visitor populations at OUH			Evidence of estimation using both burden in Oxfordshire and identifying feasibility of measuring burden within OUH	
		4.b	Work to make collection and recording of data on behaviour risk factors of patients routine (i.e. smoking status, alcohol intake)			Relevant boxes included on EPR	

(ii) Develop a health promoting environment						
5	Work to enable healthy food choices for staff, patients, and visitors	5.a	Better understand the current food environment for staff, patients, and visitors	5.a.i	Evaluation of provision and promotion of foods at outlets and on wards	Create evaluation plan, evidence of evaluation
				5.a.ii	Analyse staff survey data on current food provision	Evidence of staff survey analysis
		5.b	Understand staff demand for healthier food provision through analysis of staff survey			Evidence of staff survey analysis
		5.c	Work with internal and external partners to enable a healthier food environment at OUH following results of 5.a and 5.b. This includes working with the Healthier Eating Working Group and Patient Food Forum			Development of action plan on improving the food environment at OUH from these meetings
		5.d	Explore contractual levers to changing the food environment			Development of action plan on improving the food environment at OUH
6	Work to improve the OUH environment to encourage physical activity	6.a	Assess the OUH physical activity environment and opportunities for change e.g. through responses to the public health consultation and comparison with identified standards			Evidence of consultation analysis and indentification of employment standards for a physical activity promoting workplace
		6.b	Work with Health and Welbeing Strategy Group to identify and implement interventions to increase physical activity at OUH			Development and implementation of physical activity action plan, including potential development of OUH obesity strategy
		6.c	Evaluate changes to the OUH environment in terms of physical activity			Development of evaluation criteria and evidence of evaluation outcomes
7	Improve staff mental wellbeing	7.a	Use responses to the NHS Staff Survey and the public health consultation to identify need and mechanisms to improve staff mental health			Evidence of consideration of survey and consultation responses
		7.b	Work with the Health and Wellbeing Strategy Group to review and update changes to the OUH staff mental health policy			Evidence of policy review
8	Reduce exposure to secondhand smoke	8.a	Provide public health input to the review of the OUH 2012 smoke-free policy			Evidence of policy review
		8.b	Work towards implementation of NICE Guidance on smoking cessation			Evidence of action against NICE guidance
(iii) Embed public health approaches within OUH						
9	Determine the public health resource requirements to embed a sustainable public health function at OUH	9.a	Determine core public health functions, roles, and responsibilities through discussions with Health and Wellbeing Strategy Group, OUH Senior Management, and wider internal and external stakeholders			Document of core public health functions
		9.b	Develop business case for sustainable OUH public health function based on 9.a			Evidence of business case
10	Determine the governance structure of public health within OUH	10.a	Embed public health within OUH overall and divisional business plans			Evidence from business plans
		10.b	Establish multi-organisation and multi-disciplinary Public Health Steering Group to oversee the Public Health strategy implementation and 2015-2020 consultation			Implementation of steering group and agreement of terms of reference

		10.c	Maintain accountability for the Public Health Strategy to the OUH Trust Board and to the Oxfordshire Health Improvement Board	Steering group to report periodically (at least annually) on progress to these boards
11	Promote links between OUH and partner organisations	11.a	Continue to establish and develop relationships between OUH and its internal and external stakeholders	Evidence of ongoing relationships
12	Implement a consultation process for 2015-2020 public health strategy priorities	12.a	Determine a consultation plan for 2015-2020 public health strategy including email, phone, and face-to-face consultations with staff, patients, visitors, and wider stakeholder groups	Initiation of consultation including writing of consultation document and survey, and identifying key stakeholders
		12.b	Include within 2015-2020 consultation explicit questions regarding 2014-2015 public health priorities, as well as environmental sustainability and community engagement	Evidence of items within consultation document and survey
13	Increase awareness and support for public health within OUH	13.a	Promote the public health strategy and public health function with OUH	Evaluate against staff and patient awareness of public health function and activity within OUH
		13.b	Identify public health champions at all levels of OUH organisational structure	Develop database of champions
(iv) Cross-cutting themes of equity and sustainability of resources				
14	Ensure equity is considered in all aspects of the public health strategy	14.a	Ensure equity is considered within all actions of the 2014-2015 public health strategy	Evidence of consideration of equity including through discussions with OUH Equality and Diversity Officer
15	Ensure the consideration of resource sustainability through all aspect of the public health strategy	15.a	Show evidence of consideration of sustainable resources through all actions	Evidence of consideration of sustainability of resources

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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 27th March 2014

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:

Impact on Public:

Authors: Aziza Shafique and Paul McGough Health Improvement Board Public Involvement Network (PIN) lay representatives

Overview:

- Asian Community Women's Group Research – 3 projects – Commissioned by Healthwatch Oxfordshire: PIN Lead Aziza Shafique + Annie Davey Healthwatch Oxfordshire

    1. GP access
    2. Mental Health
    3. Domiciliary Care

- Focus on Public Health PIN lead by Paul McGough (in consultation with Jackie Wilderspin & Eunan O'Neill)

    1. Oxford University Hospitals Trust and Oxfordshire County Council Public Health strategy consultation
    2. GP preventive health – NHS Health Checks (Minority Ethnic focus)

- Focus on patient experience & service quality – PIN Lead Paul McGough

    1. GP Patient Participation Group Forum – (Oxford City) views on Care Quality Commission inspections
    2. Oxford University Hospitals Trust Pre-Care Quality commission peer review inspection (Dec – Jan)
    3. Oxford University Hospitals Trust Infection theme research (reduce antibiotic use in hospital research)

- Attended Oxfordshire Clinical Commissioning Group strategy consultation + PIN Core Group Carer Forum Bubbling up session in Abingdon, Minority Ethnic Consultative Forum
  + Polish focus group

Asian Community Women's Group Research – Aziza Shafique (in partnership with Annie Davey Healthwatch Oxfordshire)

- This Asian women's group project was commissioned by Healthwatch Oxfordshire to gather information, views and opinions from Asian women on the three main priorities of Healthwatch:-

    - **GP access**
    - **Mental Health**
    - **Domiciliary care**

- **Approach:** a mix of questionnaires, focus groups and face to face interviews

- **Research findings:** these are currently being analysed and the final report

will be published by Healthwatch in due course. Report to be written jointly by PIN & Healthwatch Oxfordshire (The research is separate & complementary to the main Healthwatch Oxfordshire + Patients Association GPs survey)

Oxford University Hospitals Trust and Oxfordshire County Council Joint Public Health Strategy

- **Consultations on development of strategy and Public Involvement component** – Meeting held Dec 10th with Oxford University Hospitals Trust; Andrew Stevens Director of Planning and Information & Public Health Physicians; Dr Adam Briggs, Dr Louise Marshall & Dr Ruchi Baxi. **Plus ongoing Ad hoc consultations.**

- **PIN welcome Oxford University Hospitals Trust plans for more public facing consultation** – (PIN reps have offered to contribute to this) – Plus a Public Health Steering Committee is to be set up

- **PIN reps Paul & Aziza are fully supportive of the Joint Public Health strategy** – There is ongoing proactive involvement

GP preventive health – NHS Health Check (Minority Ethnic focus)

- **Minority Ethnic Consultative Forum attended meeting** (19th Feb) – Very helpful engagement with Khalid Mehmood (Chairman) and Forum participants – especially Polish Saturday School Head Teacher Marzena Henry as a result arranged...

- **Polish focus group** (on Sat 8th March) GP preventive health – NHS Health Check – 40 – 74 age range (attendees mainly in 40 - 50+) Summary to be sent separately to Public Health & Healthwatch Oxfordshire and Health Improvement Board

GP Patient Participation Group (PPG) Forum – (Oxford City 20th Feb)

- **Views on Care Quality Commission inspections:** GP Patient Participation Group experiences were shared at meeting. There was discussion on the balance between inspection and shared learning approaches to quality improvement.

Oxford University Hospitals Trust Pre-Care Quality Commission inspection (Dec 13 – Jan 14) **Peer review approach:**

- **Hospital wide Staff-Patient representative review process.** It started with team training, analysis of data, staff and patient focus groups, **K**ey **L**ines **o**f **E**nquiry (KLOE), followed by unannounced visits of inspection team - in pairs to in outpatient / day case wards – (daytime, evenings, and weekend.) Observational plus face to face staff + patient interviews – to capture patient & staff experience and views, feedback quickly any safety & staff issues as appropriate, collate findings & analyse. Data was triangulated, individual Divisional reports presented. (Staff reviewers covered other divisions)

- **Patient Representative Reviewer in Medicine, Rehabilitation and Cardiac Division Peer review**. Visits as per Care Quality Commission focus on safety, efficiency, responsiveness, care and leadership. Divisional reports published. A very positive experience for participants, learning, improvement and best practice.

- **Local Public Listening Event Care Quality Commission Pre-inspection**. Attended Oxford Town Hall meeting 24th Feb – issues end of life care awareness poor, Non- internet user communication concerns – how access information (65+ age group)

- **Full main Oxford University Hospitals Trust Care Quality Commission visit 25th – 26th February** – Care Quality Commission report imminent

- **Follow up conference is scheduled for on 24th April to share what was learnt** from the Peer review programme (& Care Quality Commission Inspection), findings, good practice identified and areas that require improvement. From a public patient perspective - improvement process is robust, learning orientated and reacts quickly to quality issues - I heard many positives from staff too (staff reviewers review different areas).

- **Public Representative on Oxford University Hospitals Trust Infection theme research - to reduce antibiotic use in hospital** (Paul has Ongoing involvement)

  - **Research aim is to reduce the incidence of serious infections** caused by antibiotic-resistant micro-organisms in the future, by substantially and safely reducing antibiotic use in hospitals

  - **Primary care (GP) antibiotic prescribing** is **not** included in this study (due to hospital prescribing accounts for ~67% of broad-spectrum antibiotic use: these antibiotics have the greatest potential to drive future resistance)

Forward activity:

- **Asian Community Women's Group + Asian men Public engagement research** (Lead Aziza + Paul, in liaison with Healthwatch Oxfordshire)

- **GP preventive health – NHS Health Check** (Minority ethnic focus) Asian,

plus liaise Minority Ethnic Consultative Forum and with other support groups

- **PIN Preventive Health questionnaire** – being used - further developed?

- **Contribution & Scrutiny of Housing related support proposals – review, options & next steps** (ongoing – to be discussed at closed Health Improvement Board meeting, date to be confirmed)

- **Await Substance Misuse Service review – PIN User views feedback?**

- **Participation in Public/Patient Group – Infection Research Theme**

- **Other PIN & Oxfordshire Clinical Commissioning Group Public Patient Involvement meetings attended:** Abingdon - PIN Bubbling up and Core Group Carer meeting, Public Participation Groups Oxford City: Issues: fed back already

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The Public Health Health Protection Forum

A report to the Health Improvement Board

Eunan O'Neill
Consultant in Public Health

Introduction

Local authorities (and the director of public health (DPH) who acts on behalf of the local authority) have a critical role in protecting the health of their population, both in terms of planning to prevent threats arising, and in ensuring appropriate responses when things go wrong. The DPH has a duty to prepare for and lead the local authority's response that present a threat to the public's health. The local leadership of DPH, on behalf of local authorities, is critical to ensuring that the local authority and local partners are implementing preventative strategies to tackle key threats to the local population.

The establishment of the Public Health Health Protection forum facilitates the DPH in fulfilling the statutory function of protecting the health of the population of Oxfordshire.

Role of the Health Protection Forum

The group report on the following issues

- Prevention
- Planning and preparedness
- Relationships and accountabilities
- Monitoring of local data
- Reporting of local issues which may affect the health of the local population

Membership

Membership of the forum includes;

- Director of Public Health, Oxfordshire County Council (Chair)
- Oxfordshire County Council Portfolio Holder for Public Health
- Director of Public Health England Centre – Thames Valley (or nominated deputy)
- District representation of Environmental Health colleagues
- Associate Director Medicines Management, Quality and Innovation, Oxfordshire Clinical Commissioning Group
- Head of Public Health Commissioning, NHS England Thames Valley
- Consultant in Public Health Screening and Immunisation, NHS England Thames Valley
- Consultant in Health Protection/CCDC with responsibility for Health Protection in Oxfordshire – Public Health England

- Consultant in Public Health/Public Health Medicine with responsibility for Public Health Protection/emergency planning – Oxfordshire (Deputy Chair)
- Specialist advisors will be invited as necessary

Meetings

The forum meets three times a year and extraordinary meetings will be held in the event of an emergency.
The group has met twice since April 2013 and is next due to meet 20 March 2013. These meeting have agreed the terms of reference for the group and established the format and regular topics reported to the group.

Recent reporting of activity to the forum includes;

Plans for Flu campaign and achieving 75% coverage

Children's vaccinations

Latest sentinel data
2 year old children in Oxfordshire vaccinated 47.1% (Thames Valley 43.7%)
3 year old children in Oxfordshire vaccinated 43.2% (Thames Valley 41.3%)

The offer of immunisations to children aged 2-4 will continue in the next flu season.

Adult vaccinations

Latest data (as of 8/12/13)
Adults aged >65 in Oxfordshire vaccinated 72.7% (Thames Valley 71.2%)
Adults aged < 65 at risk in Oxfordshire vaccinated 50.2% (Thames Valley 49.7%)
Pregnant Women in Oxfordshire vaccinated 44.3% (TV 39.8%).
Maternity services in JR and Horton have delivered 933 vaccinations to pregnant women.

Measles
There has been a slight uptake in MMR vaccine in children aged under 5 years. Oxfordshire is just short of the 95% target but only by a very small margin. There has been a loss of momentum at a National and local level.

Bowel Screening
The performance levels are on target to meet activity levels despite the Q1 activity. The screening programme will be addressed over the next couple of months when the AT increase their workforce resources.

Breast Screening
Current activity is meeting minimum standards but is amber. The number of women attending for appointment within 3 weeks of screening activity could likely have been affected by seasonal variations (summer holidays). It is anticipated that the activity should improve in Q3.

Antenatal and new born screening

Programme activity is meeting targets, except for avoidable repeats for blood spot test. The provider is investigating to see if this is a training issue. Wider Thames Valley stakeholders are meeting to develop a new blood spot pathway.

Cervical Screening

Activity was recorded as green in Q2. Current data shows a sustained level of activity. Action plan to address the City Locality of the CCG is to be discussed

Future Reports to the Forum include:

- Environmental issues including air and water pollution
- Healthcare acquired infection activity
- Improving uptake of immunisation programmes
- Improving uptake of screening programmes
- Blood borne virus activity
- HIV and sexually transmitted infections

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Health Improvement Partnership Board
Forward Plan 2014-15

Date	Item
Meeting: *11-1pm, 29th May 2014 (tbc)* 2-4pm, 29th May 2014 Oxford Town Hall, Long Room	• *Closed meeting on housing related support proposals* • Joint Health and Wellbeing Strategy refresh – proposals
Workshop: Summer	• Promoting Healthy Weight (Joint with Children and Young People Partnership Board)
Meeting: 2-4pm, 31st July 2014 Oxford Town Hall, Long Room	
Meeting: 2-4pm, 25th September 2014 Kings Centre	
Meeting: 2-4pm, 27th November 2014 Oxford Town Hall, Old Library	
Meeting: 2-4pm, 22nd January 2015 Oxford Town Hall, Old Library	
Meeting: March 2015 TBC	

Forward plan suggestions:
• Re-commissioning of the homeless pathway • Older People's Housing Strategy Needs analysis • Welfare reform update • Fuel Poverty/Affordable Warmth Network • Making Every Adult Matter • Basket of Indicators • Healthy Weight Strategy • Older People's Commissioning Strategy • Community Information Networks • Health impact of changes to children's centres and supporting people budget

Sophie Kendall
Policy and Partnership Officer, Joint Commissioning
March 2014

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