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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, 29 May 2014 at 2.00 pm

Town Hall, Oxford

Peter G. Clark
County Solicitor

Contact Officer: ***Sophie Kendall, Policy & Partnership Officer***
Tel: (01865) 328530; Email: sophie.kendall@oxfordshire.gov.uk

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Membership

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

Board Members:

Cllr Anna Badcock	South Oxfordshire District Council
Ian Davies	Cherwell & South Northants District Council
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	Public Health Specialist

Notes:

- ***Date of next meeting: 31 July 2014 (TBC)***

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned….."*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chairman, District Councillor Mark Booty

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decision of Last Meeting (Pages 1 - 6)

2.05
10 Minutes

To approve the Note of Decisions of the meeting held on 27th March 2014 and to receive information arising from them.

6. Performance Report (Pages 7 - 26)

2:15
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, including:

1. The regular Performance Report
2. Additional information on performance – range of outcomes
3. Additional information on Indicator 8.3 - take up of GP health checks by ethnic background
4. The annual report on the basket of indicators for housing and health, 2013-14

7. Alcohol and Drugs Partnership (Pages 27 - 32)

2:35
10 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin, Oxfordshire County Council

A paper setting out the proposal to establish an Alcohol and Drugs Partnership, to facilitate joint-working to reduce the harm associated with the misuse of alcohol and

drugs, including health, wellbeing, social and community safety issues.

The Health Improvement Board are recommended to:

- Approve the proposal to establish an Alcohol and Drugs Partnership, which will be overseen by the Health Improvement Partnership Board

8. Health Improvement Board Priorities for 2014-15 (Pages 33 - 48)

2:45
30 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin, Oxfordshire County Council

A discussion paper to set the context for deciding the Health Improvement Board priorities for 2014-15.

9. Public Involvement Network Report (Pages 49 - 54)

3:15
10 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Paul McGough and Aziza Shafique, Public Involvement Network Representatives

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.

10. Health Inequalities Commission (Pages 55 - 60)

3:25
10 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Dr Paul Park and Rachel Coney, Oxfordshire Clinical Commissioning Group

A short briefing paper to inform Health Improvement Board members of Oxfordshire Clinical Commissioning Group's approach to tackling health inequalities in Oxfordshire (particularly the establishment of a Health Inequalities Commission).

11. Health and Housing Roundtable Report (Pages 61 - 70)

3:35
10 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Councillor Ed Turner and Val Johnson, Oxfordshire City Council

A report on the outcome of the Housing and Health Working Together Round Table event held in February, including the resulting action plan for Oxford City Council and partner organisations.

12. Affordable Warmth Network Report (Pages 71 - 76)

3:45
10 minutes

People responsible: Members of the Health Improvement Board

Report presented by:

A report to inform Health Improvement Board members of the proposed outcome measure for fuel poverty and the associated action plan for 2014/15.

The Board is recommended to:

- adopt the proposed outcome and endorse the proposed actions in the plan for 2014/2015

13. Forward Plan (Pages 77 - 78)

3:55
5 minutes

People responsible: Members of the Health Improvement Board

Presented by: Councillor Mark Booty, Chairman

To agree the Forward Plan for the Health Improvement Board.

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HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Thursday 27 March 2014 commencing at 2.00 pm and finishing at 3.50 pm.

Present:

Board Members:

City Councillor Ed Turner (Vice Chairman)
District Councillor Alison Thomson, Vale of White Horse District Council
Ian Davies, Cherwell & South Northamptonshire District Councils
Paul McGough, Public Involvement Network Representative
Dr Jonathan McWilliam, Director of Public Health
Dr Paul Park, Oxfordshire Clinical Commissioning Group
Jackie Wilderspin, Public Health Specialist

By Invitation:

Officers:

Whole of meeting	Val Johnson, Oxford City Council Sophie Kendall, Oxfordshire County Council Phil Ealey, South Oxfordshire District Council
Part of meeting	
Agenda Item	**Officer Attending**
Agenda item 9	Rebecca Cooper, Oxfordshire County Council
Agenda item 10	Louise Marshall, Oxfordshire County Council Adam Briggs, Oxford University Hospitals Trust
Agenda item 11	Eunan O'Neill, 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 Sophie Kendall (Tel 01865 32 8530; Email: sophie.kendall@oxfordshire.gov.uk)

	ACTION
1. Welcome The Vice-Chairman, Councillor Ed Turner, welcomed all to the meeting.	

2. Apologies for Absence and Temporary Appointments Apologies have been received from Councillor Mark Booty, Councillor Anna Badcock, Dave Etheridge, Councillor Hilary Hibbert-Biles, Councillor George Reynolds and Aziza Shafique. The Board was informed that Dr Paul Park and Val Johnson would be joining later, owing to other meetings.	
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 September Meeting The Board approved the amendment to the September minutes. **ACTION:** **Concerns regarding the record of discussions in the minutes were raised and it was agreed that going forward they will be used to record actions rather than discussion.**	**SK**
6. Note of Decision of Last Meeting The minutes of the November meeting were approved. Outstanding actions were followed up as follows: **ACTION:** **A breakdown by ethnicity for indicators 8.2 and 8.3 will be brought to the next meeting.** **The report outlining an approach for addressing fuel poverty will be brought to the next Health Improvement Board meeting for discussion.** **An update on welfare reform will be brought to the next Health Improvement Board meeting. The Vice-Chairman asked that it include crisis loan arrangements.**	**EO** **JW** **JW**
7. Joint Strategic Needs Assessment Annual Report Jackie Wilderspin introduced the draft Joint Strategic Needs Assessment Annual Report, which will be amended following discussions at the Health and Wellbeing Board on 13th March 2014. Key changes include more	

data on mental health and at local levels. The equal responsibility of the Clinical Commissioning Group and Oxfordshire County Council, this work will be guided by the JSNA steering group, which includes Districts representation. Areas discussed included: delayed transfers of care; access to services in rural areas; cancer diagnoses; obtaining accurate data on inequality and multiple deprivation; satisfaction with in-hours GP services; and loneliness. How the Health Improvement Board should use the Joint Strategic Needs Assessment going forward was also raised. **ACTION:** **Suggestions made in the discussion will be followed up in the work to revise the Joint Health and Wellbeing Strategy and set the Board's priorities in July.** **The Healthwatch report on patient experiences of GP services will be brought to a future meeting.**	 **JW** **JW**
8. Performance Report Jonathan McWilliam introduced and explained the performance report, highlighting the measures currently rated red. **ACTION:** **The Vice-Chairman requested a breakdown for each indicator at future meetings, to show groups experiencing worst outcomes.** **It was agreed that discussion on setting performance targets for the coming year would begin by email in advance of the next meeting.**	 **JM/SK** **ALL/JW**
9. Healthy Weight Strategy Becky Cooper outlined the draft Healthy Weight Strategy and approach, inviting the Board to consider and approve it. Members welcomed and approved the strategy and approach, making some further suggestions. These included: engaging workplaces; regulating the food industry; highlighting what the benefits will be, for example to employers; prioritising areas of greatest benefit. **ACTION:** **The Vice-Chairman proposed approaching Board members to help in securing engagement with the District and City Councils if this has not already been achieved.** **Suggestions will be followed up in developing the strategy and action plan.**	 **BC** **BC**

It was agreed that a Joint workshop (with the Children and Young People Partnership Board) on obesity would be helpful, ideally between April and June when the strategy will be consulted on.	**BC/SK**
The strategy and action plan will be brought back to the Health Improvement Board at a future date.	**BC**
10. Oxford University Hospitals Trust and Oxfordshire County Council Joint Public Health Strategy Louise Marshall and Adam Briggs outlined the draft Oxford University Hospitals Trust and Oxfordshire County Council Joint Public Health Strategy, inviting the Board to consider and approve it. Members welcomed the strategy and approach, making some further suggestions. These included: including Districts/City representation on the steering group and involving District/City Councils and primary care partners in signposting. Dr Paul Park suggested constructing a database of available services to help with this and proposed that, in the longer term, confederations of practices will allow for increasingly coordinated approaches. **ACTION:**	
Suggestions will be followed up in developing the strategy and action plan.	**LM/AB**
District council representation for the steering group will be found.	**ID/VJ**
The Board will be updated on developments on the strategy and action plan.	**JW**
11. Public Involvement Network Update Paul McGough introduced a report of the work he and Aziza Shafique are undertaking, to gather public opinion on key areas of health improvement. Members acknowledged how valuable Paul and Aziza's work is to the Board. They also offered help in linking to forums/contacts. **ACTION:**	
Board Members are invited to let Paul know any areas of interest/discussion points they would like him to ask about when consulting the public.	**All**
Jackie Wilderspin will liaise with Becky Cooper for whether Aziza could help in the consultation phase of the Health Weight Strategy.	**JW**

12. Public Health Protection Forum Report Eunan O'Neill outlined the Public Health Protection Forum Report, an update on the activity of the Public Health Protection Forum over 2013-14, performance and the forward plan for 2014-15. **ACTION:** **Jackie Wilderspin will consult the Forum to ensure relevant measures are included when priorities and performance reporting are agreed for the upcoming year.**	**JW**
13. Forward Plan It was agreed to hold the workshop on obesity in summer 2014. The housing-related support proposals are scheduled to be discussed at a workshop on 29th May 2014.	
The meeting closed at 3:50 pm.	

..... in the Chair

Date of signing .....

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Health Improvement Board
29 May 2014

Performance Reporting

The performance reporting for the 29th May meeting includes:

1. The regular Performance Report
2. Additional information on performance – range of outcomes
3. Additional information on Indicator 8.3 - take up of GP health checks by ethnic background
4. The annual report on the basket of indicators for housing and health, 2013-14

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Health Improvement Board
29 May 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. Since the last HIB performance report data has been received for five indicators. Four of these are Green and one is Amber. The remaining Q4 data is expected early in June and will be reported in the next performance report.

5. Data was received for two indicators that only report annually (the number of households in temporary accommodation and the proportion of under 65s in "risk groups" receiving a flu vaccination) and both met their set targets.

6. The current situation for the set of indicators is:

   7 indicators are Green
   4 indicators are Amber
   1 indicator is Red (report card circulated in November 2013)
   3 indicators do not yet have data to allow a rating.

7. 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.

8. A separate report is attached providing a geographical breakdown of indicators where appropriate. This will allow the board to see the variations between different areas of the county.

9. A further report showing the takeup of health screening checks by ethnic background is also attached as requested.

Alison Wallis
Performance & Information Manager, Joint Commissioning
May 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** 58.1%	**A**	**Expected** 60% **Actual** nya		**Expected** 60% **Actual** nya		This data is released at least 4-5 months in arrears and so Q2 data has just been released. Oxfordshire now is ranked top of the 4 Public Health teams within the Thames Valley region.
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 Nya		NHS Health Check data is usually available a month after quarter end.
8.3	At least 65% of those invited for NHS Health Checks will attend (ages 40-74)	**Expected** 65% **Actual** 41.9% (4165 of 9938)	**R**	**Expected** 65% **Actual** 46.0% (9351 of 20,329)	**R**	**Expected** 65% **Actual** 46.5% (14148 of 30206)	**R**	**Expected** 65% **Actual** nya		Q4 data available in June

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** **nya**		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 week. (Baseline for Oxfordshire 61.2% 2011-12)							**Expected** 62.2% **Actual** **nya**		This is reported annually from the Active People Survey monitored / managed by the Oxfordshire Sports Partnership.
9.3	62% of babies are breastfed at 6-8 weeks of age (currently 59.1%)	**Expected** 62% **Actual** 58.7%	A	**Expected** 62% **Actual** 59.5%	A	**Expected** 62% **Actual** **60.4%**	A	**Expected** 62% **Actual** nya		Report card was circulated in Nov 2013. The recovery plan by Oxford Health is resulting in some gradual improvement.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	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** **197**	G	The majority (57%) are in Oxford City.
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** 83.9%	G	**Expected** 75% **Actual** **93.1%**	G	This figure does not include information from mental health services.
10.3	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 2012- 2013 when there were 2468 households known to services, of which 1992 households were prevented from becoming homeless. 1992/2468 = 80.7%)	**Expected** 80% **Actual** 82.3%	G	**Expected** 80% **Actual** 82%	G	**Expected** 80% **Actual** nya		**Expected** 80% **Actual** **81%**	G	The number of households known to services increased this year (from 2468 to 2837). Positive action covers securing accommodation with a housing association or in the private rented sector as well as a result of the provision of advice, support or other intervention.
10.4	Fuel poverty outcome to be determined							**Expected** **Actual**		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

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
								Oxfordshire 8.7% are fuel poor according to the Low Income, High Cost definition		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**										
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** **nya**		Data available June
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** **nya**		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.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
11.3	At least 55% of people aged under 65 in “risk groups” receive flu vaccination (currently 51.6%)							**Expected** 55% **Actual** **55%**	**G**	
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** Nya		Annual data available June

Additional information on performance – range of outcomes **Updated 13/05/14**

No	Priority	Data period	Overall total	Overall rate/ percent	Range (Number & Rate / %)	Lowest	Highest	Notes
Priority 8: Preventing early death and improving quality of life in later years								
8.1	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	Q2 13/14		Age 60-69 Age 70-74	58.1% 56.1%			Data is not published below county level. Data is available by two age bands which have been included in this report
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	Q3 13/14	30,206 people aged 40-74	**13.7**% of the expected 15% per quarter (20% of the total popln per year as 100% invitations are sent every 5 yrs)	10.4% – 17.6%	Oxford City (CCG Locality)	South West (CCG Locality)	At GP practice level ranges vary more widely. Practices in Bicester, Banbury and Oxford had lowest proportion of invitations in the eligible population, but all localities have practices that have a low proportion offered. A breakdown by ethnicity is provided as a separate report.
8.3	At least 65% of those invited for NHS Health Checks will attend (ages 40-74)	Q3 13/14	14,048 people aged 40-74	**46.5**%	41.7% - 59.9%	Oxford City (CCG Locality)	North Oxfordshire (CCG Locality)	
8.4	At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)	Q3 13/14	865 adults (during the quarter)	**161.1** per 100,000 population (aged 16+)	105 - 280 92.0 – 221.4 per 100,000 population	South Oxon DC	Oxford City	Of the 865 quitters in Q3, 52 had no associated postcode and hence not allocated to a local district. These data represent those who have quit via the NHS Stop Smoking Services (not those who have quit via Solutions for Health). The cumulative data to 9 May 2014 indicate 3348 quitters (year end 30 May). In Q1 Cherwell has the highest proportion of quitters whereas it is now Oxford City. South Oxfordshire has consistently the lowest proportion

No	Priority	Data period	Overall total	Overall rate/ percent	Range (Number & Rate / %)	Lowest	Highest	Notes
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%)	2012/ 2013	815 children in year 6	15.2%	136 to 178 13.6% - 19.6%	West Oxon DC	Oxford City	Cherwell has the highest number of obese children. Oxford City has the highest proportion. These two districts are the most deprived in the county. Data at MSOA/Ward level was due in May via the National Obesity Observatory website but this has been delayed due to national data-sharing protocols.
9.3	62% of babies are breastfed at 6-8 weeks of age (currently 59.1%)	Q3 13/14	1,179 babies aged 6-8 weeks	60.4%	45.1% - 84.3%	Banbury Health Visitor Locality	North Oxon/ Cumnor/ Botley Health Visitor Locality	Updated Feb 2014 (Q4 data due end May 2014) Practices in Banbury, Kidlington and Bicester remain low as do some practices in Wantage, Faringdon, Grove, Witney and Didcot. Carterton showed some improvement in Q2 but has dropped in Q3. Some practices in Oxford City remain low but there has been improvement in breastfeeding prevalence in Oxford South East practices.
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)	13/14	197	na	14 – 113	West Oxon District Council	Oxford City	Over half the households (57%) in temporary accommodation are in Oxford City. Numbers are lower than 12/13 in Oxford, Vale and Cherwell District Councils. In particular in Cherwell numbers reduced from 43 to 28. Numbers increased in both South Oxfordshire and West Oxfordshire.

No	Priority	Data period	Overall total	Overall rate/ percent	Range (Number & Rate / %)	Lowest	Highest	Notes
10.2	At least 75% of people receiving housing related support will depart services to take up independent living	13/14	2298	87.6% (whole year)	75.2% - 96.8%	Oxford City	South Oxfordshire	These figures relate to the whole year. Data in performance report is for individual quarters. Lowest numbers are in Vale of White Horse (21) and West Oxfordshire (41).
10.3	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless	13/14	2298	81%	256 - 916	VOWH	Oxford City	
Priority 11: Preventing infectious disease through immunisation								
11.1	At least 95% children receive dose 1 of MMR by age 2 (currently 95%)	Q3 13/14	1,932 children aged 2	95.8%	192 – 523 93.3% - 98.5%	Oxford City CCG Locality	South East CCG Locality	These data is now supplied at CCG locality rather than Health Visitor locality as previously. Ranges at GP practice level for the second dose of MMR are much wider - 75% to 100%. Practices with the lowest uptake are spread across the county but more fall within Oxford City and North Oxfordshire than the other localities. Data indicate that 116 eligible 5-year olds in Oxfordshire had not had their second dose of MMR at the end of quarter 3.
11.2	At least 95% of children receive dose 2 of MMR by age 5 (currently 92.7%)	Q3 13/14	1,732 children aged 5	93.7%	204 - 410 91.1 to 95.1%	Oxford City CCG Locality	West Oxon CCG Locality	
11.3	At least 55% of people aged under 65 in "at risk" groups receive flu vaccination (currently 51.6%)	13/14 annual	34,119	54.5%	4214 – 8138 49.6% - 60.1%	Oxford City CCG Locality	West Oxon CCG Locality	Summary as at end Jan 2014. The ranges across GP practices are much wider - 33.5% to 74.8%. Half of the practices in Oxfordshire (41) have an uptake lower than 55%. Practices with the lowest uptake are spread across the county. However the majority are within Oxford City and North Oxfordshire localities.

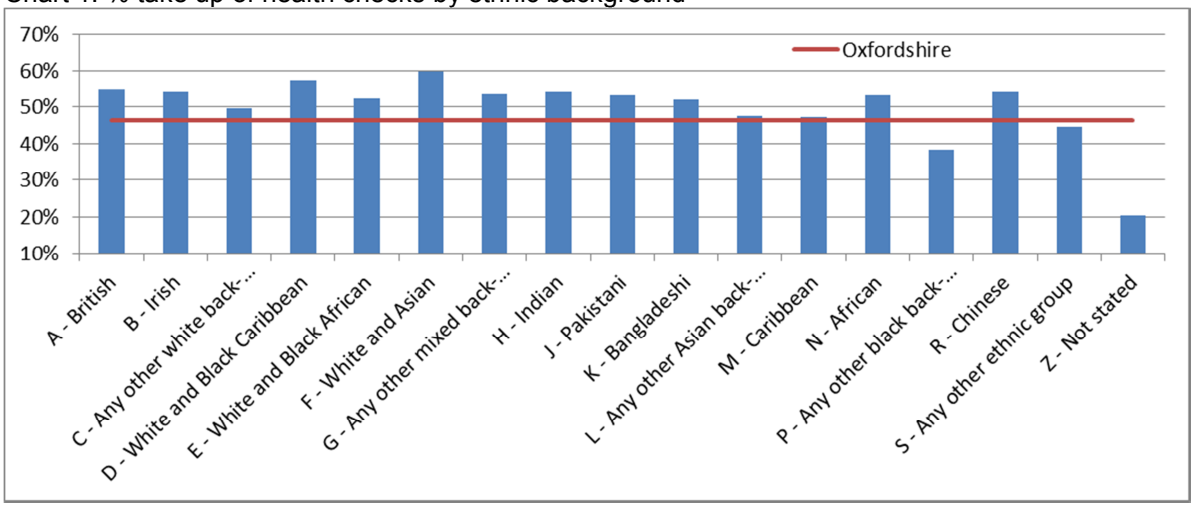
HWB Board Priority 8.3
At least 65% of those invited for an NHS Health Check with attend.

Across Oxfordshire this figure has increased from 41.9% at the end of Quarter 1 to 46.5% at the end of Quarter 3 but still remains below target.
The average across the Thames Valley is 40.6% and Oxfordshire ranks 4th out of 8.

Take up by ethnic background
Table 1: take up of health checks by ethnic background

	A - British	B - Irish	C - Any other white background	D - White and Black Caribbean	E - White and Black African	F - White and Asian	G - Any other mixed background	H - Indian	J - Pakistani	K - Bangladeshi	L - Any other Asian background	M - Caribbean	N - African	P - Any other black background	R - Chinese	S - Any other ethnic group	Z - Not stated
Number Invited	26387	233	3299	40	86	87	142	249	176	46	285	91	156	47	192	244	1499
% Uptake	**55.2%**	**54.1%**	**49.6%**	**57.5%**	**52.3%**	**59.8%**	**53.5%**	**54.2%**	**53.4%**	**52.2%**	**47.7%**	**47.3%**	**53.2%**	**38.3%**	**54.2%**	**44.7%**	**20.3%**

Chart 1: % take up of health checks by ethnic background



- Take up varies from 59.8% of people from White & Asian backgrounds to 38.3% of people from Other Black backgrounds. Both of these have small cohorts.
- Of the two largest cohorts, the take up of White British backgrounds (55.2%) is the third highest in the county but the take up of those from Other White backgrounds (49.6%) is just above the county average.
- A significant proportion of people did not state their ethnicity.

NB This data is for the full 2013/14 year and is still provisional. This is the first time that the ethnicity breakdown has been extracted and will be used for the future planning of the programme.

May 2014

Health Improvement Board
Basket of Indicators for Housing and Health
Annual report 2013-14

One of the four Joint Health and Wellbeing Strategy priorities the Health Improvement Board has responsibility for is:

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness

At the May 2013 Health Improvement Board meeting it was agreed that the following 'basket of housing indicators' would be reported annually to the Board.

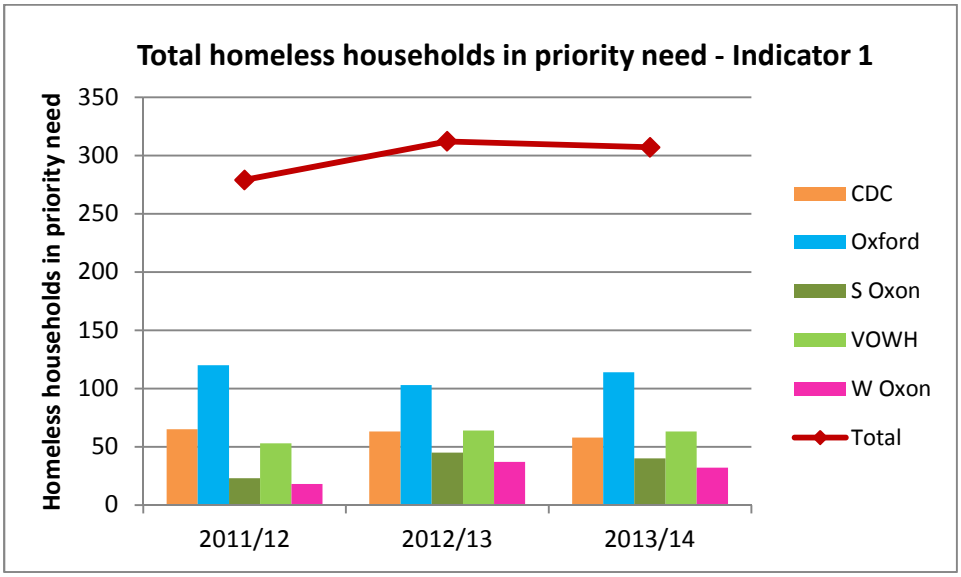
The statistics for 2013-14 show the following (see page 6 for full table):-

Key

CDC	Cherwell District Council
Oxford	Oxford City Council
S Oxon	South Oxfordshire District Council
VOWH	Vale of White Horse District Council
W Oxon	West Oxfordshire District Council

Homelessness presentations (Indicator 1)
There has been an overall increase in people presenting as homeless, over the County as a whole, from 457 in 2011/12, 476 in 2012/13 compared to 517 in 2013/14.

There has been an increase in people who are presenting as homelessness and are in **priority need** in the County since 2011/12.



The numbers of people found to be **intentionally homeless** has risen also since 2011/12.

The numbers of people presenting as homeless but **not in priority need*** are relatively low. Over the County as a whole, the numbers have increased from 50 in 2011/12 to 51 in 2012/13 and 69 in 2013/14. There are considerable variations between the Districts with 24

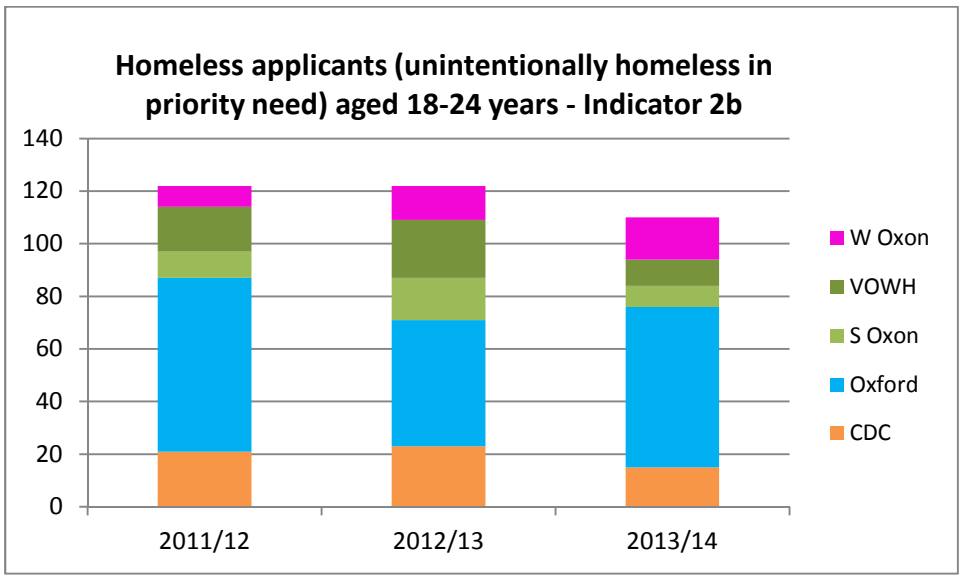
in CDC, 23 in Oxford, 11 in both South Oxfordshire and Vale of White Horse and none in West Oxfordshire.

**Local housing authorities have a duty to secure accommodation for households who are in priority need under homelessness legislation. Categories of priority need are pregnancy, dependent children, vulnerable as a result of old age, mental illness or handicap, or physical disability or other special reason, homeless as a result of an emergency such as fire or flood, a child aged 16 or 17, vulnerable as a result of having been looked after, accommodated or fostered, as a result of serving in the armed forces or having been imprisoned or ceasing to occupy accommodation because of actual or threatened violence.*

People found to be homeless expressed as a percentage of the number of people of cases where positive action was successful in preventing homelessness was 81% (target (10.3) is at least 80%).

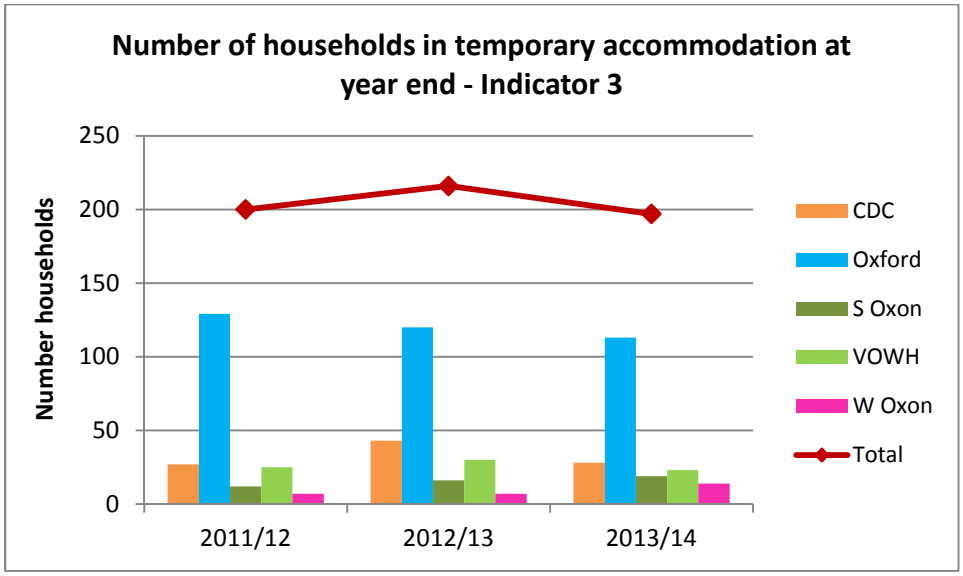
Homeless applicants who were unintentionally homeless and in priority need (Indicator 2)

- 116 people age 16 -24 became homeless in Oxfordshire. There were 6 aged 16 or 17 and 110 between 18 and 24 years.
- The number of households who are in priority need because of physical disability or mental illness is moderately low. In 2012/13, there were 15 homeless households where a member had a physical disability and 18 because of mental health.
- An increased number of households have become homeless with the main reason being due to rent arrears, though this number remains low. There were 19 households in 2012/13.



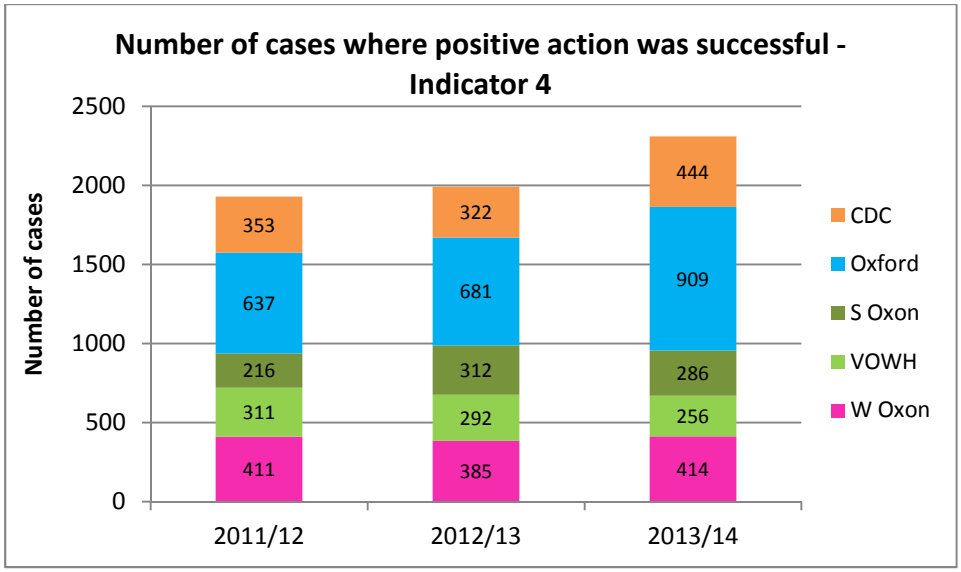
Number of households in Temporary Accommodation (Indicator 3)

There were 197 people in temporary accommodation at the end of the financial year 2013/14, a reduction on the previous year's figure of 216 (exceeding target 10.1).



Positive action preventing homelessness (Indicator 4)

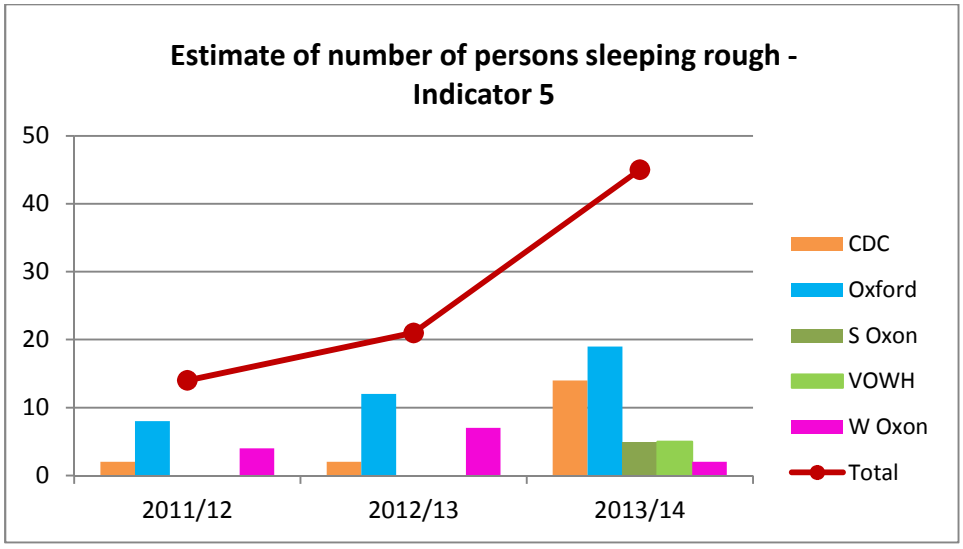
There were 2298 cases recorded where positive action prevented homelessness, compared to 1992 in 2012/13. Positive action covers securing accommodation with a housing association or in the private rented sector as well as a result of the provision of advice, support or other intervention.



Rough-Sleeping (Indicator 5)

The estimated number of people rough sleeping is 45 compared to 21 in 2012/13. Oxford City Council carry out street counts quarterly in order to monitor the level of rough sleeping in the city. The nature of the other districts means that a count is not practicable and an estimate is made by the Council using intelligence from partner agencies. The count and estimates are reported to Central Government.

The estimate has risen in Cherwell, South Oxfordshire and Vale of White Horse, which has been attributed to better information arising from the commissioning of an Outreach team.



Removal of Spare Room Subsidy

Full data on the number of Housing association and Council tenancies affected by the Removal of Spare Room Subsidy** is not available. 2084 have been reported in the County excluding West Oxfordshire. These households have found that their housing benefit has been reduced because of the introduction of the Social Sector size criteria.

***This affects households where the tenants are of working age and do not fall within one of the exception categories and they are assessed as having one or more bedrooms than they require according to the following formula of one bedroom for*

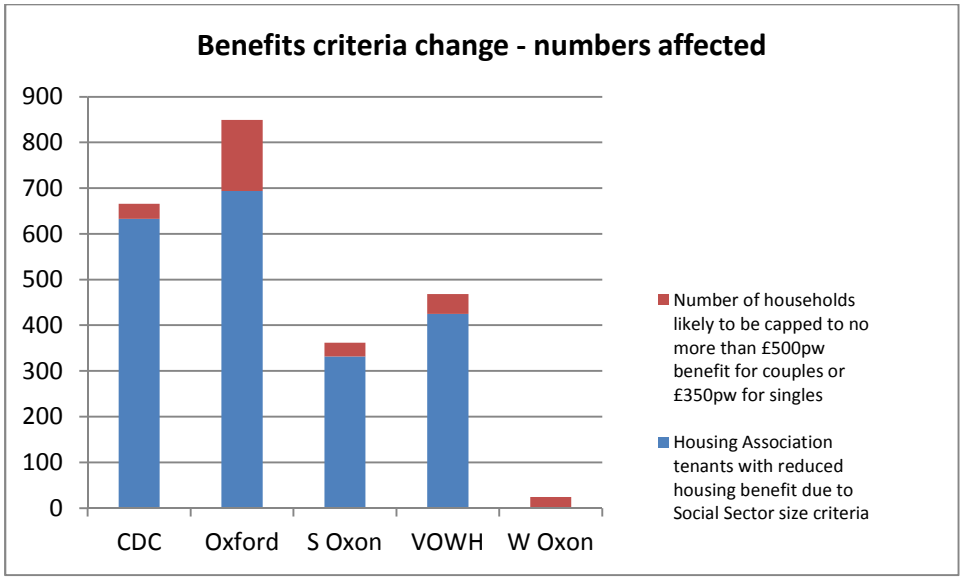
- *each adult couple*
- *any other person aged 16 or over*
- *two children of the same sex under the age of 16*
- *two children under the age of 10 regardless of their sex*
- *any other child*
- *a carer (who does not normally live with the tenant) if the tenant or their partner needs overnight care.*

Tenants who are under occupying by one bedroom, have their benefit reduced by 14% of eligible rent, and tenants who are under occupying by two or more bedrooms have their benefit reduced by 25% of eligible rent.

Benefit Cap

255 households in the County excluding West Oxfordshire are affected by the benefit cap***.

****£350 per week maximum of benefits covered for single adults who don't have children or whose children don't live with them and £500 per week maximum for couples (with or without children living with them) and £500 a week for single parents whose children live with them.*



Going Forward:-

Opportunities for joint working

On 12th May, the Housing Minister Kris Hopkins wrote to all Local Authority Leaders urging them to work through Health and Wellbeing Boards to cooperate with Health and Care services saying:-

"Often, unsuitable or poor quality housing and housing support can have as much of an impact on health and wellbeing as illness. Homeless people and rough sleepers often have the highest health needs and can require greater levels of access to health services compared to the general population. The ageing population means that there is an increasing number of older people, and people with disabilities, living in properties that they consider unsuitable for their needs, or requiring support to continue to live independently and avoid the need for more costly care…The development of the Better Care Fund will offer further opportunities for joint work by housing, health and care services… This summer, the Homes and Communities Agency and the Greater London Authority will be publishing a prospectus inviting organisations to bid for £40m Department of Health funding for homelessness hostel refurbishment and shared accommodation for vulnerable young people. The move of hostels funding to the Department of Health recognises that homelessness and housing are tightly bound to issues of healthy living, primary care and hospital admission."

Recommendations for indicators 2014-2015

It is recommended that the existing indicators are retained with the following clarifications:-

- **Number of rough sleeper to be the November count or estimate figure submitted to Department for Communities and Local Government**
- **Number of households in Bed and Breakfast accommodation to be separated out from number of households in temporary accommodation**
- **Report on Indicator 3 (number of households in temporary accommodation, performance target 10.1) six-monthly instead of annually**

	2011/12						2012/13						2013/14					
Indicator 1 Homeless households																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
(1a) in priority need	65	120	23	53	18	279	63	103	45	64	37	312	58	114	40	63	32	307
(1b) intentionally	27	71	8	11	11	128	30	46	13	15	9	113	34	67	13	14	13	141
1c) no priority need	10	29	1	4	6	50	11	26	7	6	1	51	24	23	11	11	0	69
	102	220	32	68	35	457	104	175	65	85	47	476	116	204	64	88	45	517
Indicator 2 Homeless applicants who were unintentionally homeless and in priority need who were/had																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
(2a) aged 16/17yrs	1	0	0	0	1	2	2	0	0	1	3	6	0	0	0	1	5	6
(2b) aged 18 to 24	21	66	10	17	8	122	23	48	16	22	13	122	15	61	8	10	16	110
(2c) physical disability	4	4	1	4	0	13	3	3	3	1	3	13	3	3	2	6	1	15
(2d) mental illness	2	7	1	6	2	18	2	4	5	6	2	19	1	5	7	5	0	18
(2e) rent arrears	5	2	1	0	0	8	1	3	2	2	0	8	0	15	0	2	2	19
Indicator 3 Number of households in temporary accommodation at end of year																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
Indicator 3	27	129	12	25	7	200	43	120	16	30	7	216	28	113	19	23	14	197
Indicator 4 Number of households where positive action was successful in preventing homelessness																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
Indicator 4	353	637	216	311	411	1928	322	681	312	292	385	1992	444	916	268	256	414	2298
Indicator 5 Rough Sleeping																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
Estimate/count of persons sleeping rough	2	8*	0	0	4	14	2	12*	0	0	7	21	14	19*	5	5	2	45
Impact of Welfare Reform																		
Council and RP tenants with reduced HB due to RSRS													633	694	332	425	Not available	2084
Number of households capped to £500/£350 per week													33	155 *	30	43	24	255

*Count rather than estimate ** (47 social housing, 108 private rented)

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 29th May 2014

Title of report: Alcohol and Drugs Partnership

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

Purpose of Report:

To set out the proposal of establishing an Alcohol and Drugs Partnership, to facilitate joint-working to reduce the harm associated with the misuse of alcohol and drugs, including health, wellbeing, social and community safety issues.

Action Required:

The Board is recommended to adopt the proposal to establish an Alcohol and Drugs Partnership, which will be overseen by the Health Improvement Partnership Board.

Impact on Public:

Authors:

Jackie Wilderspin, Oxfordshire County Council

Alcohol and Drugs Partnership

Proposals for working together in Oxfordshire from April 2014

Aim
To work together to reduce the harm associated with the misuse of alcohol and drugs, including health, wellbeing, social and community safety issues.

Objectives
1. To enable people to make informed choices about alcohol and drugs by providing relevant, accessible information and support for sustaining healthy lifestyles.
2. To ensure early intervention and appropriate support for people whose use of alcohol and drugs may become problematic.
3. To improve outcomes for people entering treatment for alcohol or drug use so that a higher proportion will achieve long term abstinence / recovery.
4. To commission effective services for people with complex health and/or social problems which include alcohol or drug misuse.
5. To tackle community safety issues which are caused or affected by alcohol and drug use

Working arrangements
It is envisaged that the work of an Alcohol and Drugs Partnership could cover any aspect of alcohol and drug use by individuals or population groups. Appendix A sets out a description of all the services and interventions along a pathway from preventing problems to treating the consequences.

Not all of these areas need to be addressed through a partnership approach as some are clearly within the remit of an individual organisation. It is assumed that these areas of work can be considered "business as usual" and will be set out in the plans of the relevant organisation (e.g. commissioning drug treatment services by the Public Health Team; the offer from Mutual Aid organisations like Alcoholics Anonymous; the work of schools in teaching about substance misuse etc.) These organisations may be open to influence and should consult partners on their approaches but will be individually responsible for delivery.

This proposal will address the areas of work that need the attention of several organisations and can therefore be classed as "partnership work". These areas of work need to be prioritised and several organisations may need to express their commitment to work together on each issue and to take joint responsibility for delivery. They may not be the same organisations for each issue.

It is likely that the priority areas of work that will be addressed in 2014-15 will include:
- Commissioning services for people with complex needs (mental health/ substance misuse/ vulnerable housing etc). Links with Making Every Adult Matter (MEAM) initiative in the City as appropriate.
- Risky Behaviours – reducing the likelihood of young people starting to misuse alcohol and drugs

- Reducing demand and supply of so-called “Legal Highs”
- Alcohol harm reduction campaigns including Alcohol Awareness Week, Christmas / New Year campaigns etc
- Improving recovery from substance misuse for offenders
- Licensing initiatives e.g. super strength lager campaign

Given the wide range of issues to be addressed it is proposed that working groups made up of the relevant organisations will take each issue forward. This will enable efficient approaches to the work. Some organisations will be involved in several areas of work, others in just one. Wherever possible the work should be undertaken on a “task and finish” basis. Leadership and coordination can be provided through the Public Health Directorate.

Strategy development
There is a statutory requirement for each Community Safety Partnership to have a Drugs and Alcohol Strategy (Crime and Disorder Act, 1998; Police Reform Act 2002). Until now this requirement has been met by the DAAT Strategy and the Alcohol Strategy produced by the Alcohol Tactical Business Group. It is now proposed that these 2 groups be disbanded. New arrangements for setting out strategic intentions are needed.

It is proposed that;
- The Public Health team oversees preparation and publication of an annual Alcohol and Drugs strategy, based on priorities agreed by all partners. This should include only those areas of work which are seen as “partnership work” and not include the “business as usual” of individual organisations.
- This strategy should link to the business plan of the Safer Communities Partnership and illustrate how the work enables reduction in crime and promotion of community safety.
- The strategy should be based on assessment of need and current performance as outlined in the Joint Strategic Needs Assessment and the Strategic Intelligence Assessment.
- The strategy should influence the priorities set out in the Joint Health and Wellbeing Strategy.

Accountability / Governance
It is clear that the work to reduce alcohol and drug related harm is both a health issue and a community safety issue. It seems important that this work should be influenced by both the Health and Wellbeing Board and the Community Safety Partnership. However, it is also important not to duplicate time and effort.

It is proposed that the governance for this work should be through the Health Improvement Board – a partnership board linked to the Health and Wellbeing Board. However, working links with the Safer Communities Partnership are still needed and it is proposed that this should be through the Safer Communities Partnership Business Group. This will insure that actions will deliver the business of required by the Safer Communities Partnership. It is planned that single reports on work can be produced which will go to both groups.

It is proposed that suitable outcome indicators are included in performance management frameworks of both partnerships. These may be different from each other.

Meetings

1. Task and Finish Groups or working groups will set their own patterns of meeting to ensure delivery of work. They may function as project management groups if that is appropriate
2. The Alcohol and Drug Partnership will meet twice a year to gain an overview of progress and propose priority areas for future work. Terms of reference are to be agreed.
3. Membership of the partnership needs further discussion but may include
    a. Convenors of all the working groups
    b. Members of the working groups
    c. Representatives of key organisations such as local authorities, Clinical Commissioning Group, police, probation, provider organisations, voluntary sector etc.

Next steps

1. Further discussion on the proposals set out in this paper (which are summarised in Appendix B)
2. Set up of working groups as listed above
3. Addition of more working groups if appropriate
4. Discussion on terms of reference for the Partnership, including membership, purpose and frequency of meeting.

Appendix A
The Alcohol and Drugs services pathway
The whole pathway runs from primary prevention, through early intervention to harm reduction and treatment.

- **Primary Prevention**
  - School Curriculum / campaigns in schools ("in-formed"),
  - Primary care "day job" by GPs and others
  - Campaigns e.g. Change 4 Life, Alcohol Awareness Week, Pharmacy campaigns, Men's Health Week etc.
  - Licensing – training for retailers; enforcement activity; Nightsafe

- **Alcohol Screening** (Detecting "harmful / hazardous" drinkers)
  - NHS Health Checks
  - GPs in primary care
  - Police interventions e.g.for drink driving
  - other settings

- **Brief Advice for harmful drinkers**
  - Primary Care,
  - Non-NHS settings,
  - Accident and Emergency Dept,
  - Other NHS Hospital settings
  - Early Intervention Hubs (Young People),
  - Training for practitioners

- **Information and advice drugs and/or alcohol services**
  - Single Front Door (replacing Local Area Single Assessment and Referral Service (ASARS)

- **Assessment and Treatment for Addiction**
  - Oxford Health - Harm Minimisation Service. Includes Shared Care.
  - Lifeline - Recovery Service. Community Detoxification and Treatment
  - Young Addaction

- **Residential Rehabilitation/Detoxification**
  - Range of approved providers out of county.
  - Howard House in Oxford - Residential Detoxification

- **Recovery Network**
  - Aftercare support
  - Alcoholics Anonymous, Narcotics Anonymous etc
  - SMART recovery

- **Medical Treatment**
  - Emergency Departments and Ambulance service.
  - Treatment for alcohol or drug related diseases- in the community or hospital. e.g. fatty liver disease, alcoholic hepatitis, liver cirrhosis.
  - Treatment for diseases which alcohol or drugs exacerbate: Heart disease, some cancers etc

Appendix B
Summary of proposals

1. The DAAT Board and Alcohol Tactical Business Group will be disbanded

2. The Aims and Objectives set out above will be agreed

3. An Alcohol and Drugs Strategy will be set out for 2014-15, led by Public health and with the agreement of all relevant partners. This will identify priority areas for partnership working and will link directly to the Safer Communities Business Plan. Areas considered "business as usual" for individual organisations will not be included.

4. Working groups will be established on priority topics and set out action plans and goals.

5. Partnership meetings to oversee development and implementation of the strategy will be held twice a year.

6. Governance will be through the Health and Wellbeing Board, with reports also to the Community Safety Partnership. Outcomes will be included in performance reporting for both boards.

Review of Priorities for the Health Improvement Board

Purpose of this paper

1. To review current priorities in the Joint Health and Wellbeing Strategy in the list of recent performance and findings in the JSNA
2. To propose amendments and additions to the list of priorities of the Health Improvement Board
3. To enable discussion and decision on the priorities and outcomes to be included in the Joint Health and Wellbeing Strategy when it is presented to the Health and Wellbeing Board in July 2014.

Overview

The full text currently set out in the Joint Health and Wellbeing Strategy as it was agreed in July 2013 is included in Appendix 1. The sections below set out a brief review for each of the existing priorities, with a recommendation for discussion by the Board. There is also a proposal that the Health Improvement Board should oversee work to improve outcomes for people in drugs and alcohol treatment services. A decision will be sought on whether this work should be part of an existing priority area or be set up as a new priority.

Comments received following circulation of an earlier draft of this paper have been incorporated.

Review and Recommendations on current priorities

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

Outcomes set in 2013-14	Performance in 2013-14 (latest figures reported May 14)	JSNA findings
8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	Bowel screening performance data was difficult to obtain through 2013-14. Reports showed underperformance and the latest report at the end of Q2 was rated Amber at 56.1% packs returned (target 60%)	Late reporting of bowel screening uptake has made analysis difficult
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	Invitations to attend NHS Health Checks met the numerical target set. However, there was considerable variation between practices in the number of invitations sent out. Every year invitations should be sent to 20% of the population aged	Although performance by GP practices in sending out invitations to NHS health checks has met the numerical target, there have been some variations in performance across practices with some practices not participating

as more people were eligible in 2012-13)	40-74. • County 13.74% • CCG City locality 10.4%, • CCG SW locality 17.6%	and others more fully engaged.
8.3 At least 65% of those invited for NHS Health Checks will attend (ages 40-74)	Uptake of invitations to attend NHS Health Checks improved during the year but did not meet the aspirational target of 65%. The indicator remained Red. The target was 65% • County 46.51% • CCG city locality 41.7% • CCG North locality 59.9% An audit showed no significant differences in attendance by ethnicity.	Uptake of NHS Health Checks is subject to considerable variation and there are some groups in the population who seem less likely to respond e.g. • men aged 40-50 • people from more disadvantaged localities.
8.4 At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)	Smoking quit rates in the county remained on target throughout the year and the indicator was Green. The overall achievement up to May 2014 was • County 161 / 100,000 people aged 16+ • South Oxon 92/100,000 • City 221 / 100,000 NB Smoking prevalence may vary across the county so quit rates will be low in areas where few people smoke.	Analysis of smoking prevalence is mainly based on survey results but shows higher prevalence in "routine and manual" groups and some minority ethnic communities. There is ongoing concern about smoking rates among pregnant women (although in all cases the rates in Oxfordshire are lower than national rates)

Recommendation for discussion

1. We should continue to measure performance on the same topics in 2014-15 as these are still important issues for improvement and monitoring. It is suggested that we maintain our resolve for stretch targets if we are going to make a difference to the health of a growing older population.

2. Adjust targets to include both a county wide improvement on each indicator and also a focus on the groups with worst outcomes. This will show that targeted work is having an impact on reducing inequalities of uptake and outcome. Some specific proposals for this will be tabled at the Health Improvement Board meeting.

Priority 9: <u>Preventing chronic disease through tackling obesity</u>

Outcomes set in 2013-14	Performance in 2013-14 (latest figures reported May 14)	JSNA findings
9.1 Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2012 this was 15.6%)	There was an improvement in obesity rates for children in year 6 but this did not meet the target so the indicator remained Amber. • County wide average 15.2% • West Oxon 13.6% • Oxford City 19.5%	There is considerable variation in childhood obesity rates in different parts of the county. Figures are an annual snap-shot so trends cannot be analysed.
9.2 Increase to 62.2% the percentage of adults who do at least 150 minutes of physical activity a week. (Baseline for Oxfordshire 61.2% 2011-12)	The report from the Active People Survey showed high levels of activity and the indicator was GREEN. • County wide average 61.2% • Cherwell 59.3%, Vale 59.4% • West Oxon 64%	Oxfordshire shows consistently high rates of reported levels of physical activity, through there is some variation between districts.
9.3 65% of babies are breastfed at 6-8 weeks of age (currently 59.1%)	Breastfeeding rates at 6-8 weeks improved during 2013-14 but did not reach the ambitious target of 62% (which is much higher than national rates). The indicator remained Amber • County wide average 60.4% • Banbury Health Visitor locality 45.1% • North Oxford/Cumnor/Botley HV locality 84.3%	There is considerable variation in breastfeeding rates at 6-8 weeks which are related to age of the mother, areas of deprivation and cultural norms.

Recommendation for discussion

1. Keep the same indicators for obesity and breastfeeding in 2014-15 as these are still important issues for improvement and monitoring overall county wide rates.

2. Set targets to include both a county wide improvement on each indicator and also a focus on the groups with worst outcomes. This will show that targeted work is having an impact on reducing inequalities of access and outcome. Some specific proposals for this will be tabled at the Health Improvement Board meeting.

3. Change the physical activity indicator to reflect the number of people who are NOT physically active and set an outcome to reduce this rate. The latest Active People Survey reported that 116,943 aged 16 or older are termed sedentary (doing less than 30 minutes of activity per week). This is a rate of 22.2% against 28.5% nationally. In addition the survey reports that 207,307 are not doing the guideline amount of 150 minutes per week.

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

Outcomes set in 2013-14	Performance in 2013-14 (latest figures reported May 14)	JSNA findings
10.1 The number of households in temporary accommodation on 31 March 2014 should be no greater than the level reported in March 2013 (baseline 216 households in Oxfordshire)	The number of household was reported as 197 which means performance on this outcome is rated GREEN. The numbers vary between districts but is a factor of differences in housing tenure, leading to highest numbers in the City (113) and lowest numbers in West Oxon (14)	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).
10.2 At least 75% of people receiving housing related support will depart services to take up independent living.	The number of people departing services to take up independent living was 93.1% making the performance rating GREEN. The range across the county showed 75% success in the City and 97% success in South Oxon.	No information on this indicator was included in the JSNA report
10.3 At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 2012-2013 when there were 2468 households known to services, of which 1992 households were prevented from becoming homeless. 1992/2468 = 80.7%)	The report at the end of 2013-14 showed 81% households at risk of being homeless and known to specific services were prevented from becoming homeless. This outcome is rated GREEN. The number of households who presented in this way increased across the county compared to 2012-13 with all districts except South Oxon seeing increased numbers. The range was 256 households in Vale and 916 households in the City.	No information on this indicator was included in the JSNA report
10.4 Fuel poverty outcome to be determined in Sept 2013	No outcome was set for fuel poverty. A new national indicator was brought into use during the year and reported that 8.7% of households in Oxfordshire were likely to be fuel poor, compared with 11% nationally	No information on this indicator was included in the JSNA report

Recommendation for discussion

- Keep the same indicators for 2014-15 as these are still important issues for improvement and monitoring.
- The Affordable Warmth Network propose to establish a baseline of the number of households in Oxfordshire, who have received significant increases in the energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners.
- Discuss how variations between different parts of the county can be targeted to improve outcomes for the worst.

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

Outcomes set in 2013-14	Performance in 2013-14 (latest figures reported May 14)	JSNA findings
11.1 At least 95% children receive dose 1 of MMR vaccination by age 2 (currently 95%)	The number of children receiving their first dose of MMR vaccine has remained above the 95% target so this indicator is rated Green • County wide average 95.8% • CCG north locality 93.3% • CCG West Oxon locality 98.5%	Oxfordshire rates of immunisation uptake remain high when compared with local and national benchmarks
11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.7%)	The number of children receiving their second dose of MMR has not reached the 95% target and this indicator remained Amber • County wide average 94.7% • City CCG locality 91.1% • CCG SE locality 95.1%	
11.3 At least 55% of people aged under 65 in "risk groups" receive flu vaccination (currently 51.6%)	Improvements in uptake of seasonal flu vaccination by those aged under 65 which particular needs mean this indicator will be rated Green. • County wide average 54.5% • CCG city locality 49.6% • CCG West Oxon locality 60.1%	
11.4 At least 90% 12-13 year old girls receive all 3 doses of human papilloma virus vaccination (currently 88.1%).	Uptake of HPV vaccinations has still not been reported for 2013-14.	

Recommendation for discussion

- It remains important to keep these indications under surveillance and for the Public Health Protection Forum to ensure that good performance in Oxfordshire is continued and that national targets are met.
- The poorest performing localities should improve performance in comparison with the county average.

Proposed additional priority 12 - <u>Improving Recovery from alcohol and drugs misuse</u>

Rationale for adding this priority

At the meeting of the HIB in May a paper will be presented which will outline proposals for new partnership arrangements for work to prevent or treat alcohol and drug misuse. It will be proposed that this work is governed through the Health Improvement Board and that relevant outcomes are included in the Joint H&WB Strategy. The full detail of this report will not be reproduced here, but the outline below is in line with that fuller proposal.

Recent changes have meant that the function for commissioning services for drugs and alcohol treatment has become part of the Public Health function in the County Council. In addition to this commissioning function there is a need for wider partnership working, particularly in preventing alcohol and drug related harm and providing early intervention.

Drugs and alcohol treatment services which were commissioned before this transition are currently underperforming and a programme for improving recovery rates is underway. It is proposed that the Health Improvement Board take on oversight of this work, monitoring plans that involve service providers, users and commissioners and ensuring a multi-agency approach to improvement.

Performance in 2013-14

The Public Health Outcomes Framework includes several indicators which measure the success of various aspects of drugs and alcohol treatment. A full picture of 2 of these indicators is given in Appendix 2. The measures we propose to use are:

- Number of users of **opiates** who left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months, or by the end of the period if this is less than 6 months, as a percentage of the total number of non-opiate users in treatment. We would hope to see this figure increase over time (Data supplied by National Drugs Treatment Monitoring System, Public Health England)
- Number of users of **non- opiates** who left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6

months, or by the end of the period if this is less than 6 months, as a percentage of the total number of non-opiate users in treatment. We would hope to see this figure increase over time (Data supplied by National Drugs Treatment Monitoring System, Public Health England)

The data in the appendix shows that

1. The number of people completing treatment and remaining drug free of opiate use is 6.5% of those in treatment.
2. The completion rate for non-opiate use is 15.5% of those in treatment.

These are among the lowest rates in the country. There have been some recent improvements and the recovery plan is being implemented.

JSNA findings relevant to this priority

A comprehensive needs assessment of drugs and alcohol users in Oxfordshire shows that

- Engagement with services is good. A high proportion of those thought to misuse substances do engage with services.
- Some people in treatment for opiate use remain in services for long periods of time, often on methadone prescriptions, but do not successfully complete treatment and achieve abstinence.
- The number of people accessing alcohol treatment services is rising.
- Numbers of young people accessing services are low but include children whose parents are substance misusers.

Recommendation for discussion

- Targets for the two indicators outlined above can be added to the range of outcomes that are managed and monitored by the Health Improvement Board.
- A 2014-15 target for opiate users should be set at 8.6% successfully leaving treatment (baseline 6.5%)
- A 2014-15 target for non-opiate users should be set at 38.2% successfully leaving treatment (baseline 15.5%)

Jackie Wilderspin, May 2014

Appendix 1 C. Priorities for Health Improvement

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

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

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

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

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

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

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

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

Where are we now?

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

Outcomes for 2013-14

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

14.2 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)

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

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

Priority 9: <u>Preventing chronic disease through tackling obesity</u>

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

Surveillance of these issues in the last year show that

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

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

Promoting breastfeeding

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

Halting the increase in childhood obesity

Children in Reception class and Year 6 are weighed and measured every year and results show that around 8% of reception year and 15% of Year 6 children are obese. This feeds through into ever increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to.

Healthy eating initiatives are part of the approach. Levels of obesity are also linked to social deprivation, with more deprived parts of the County showing higher rates of obesity, so some targeting of effort is called for here too.

Promoting physical activity in adults

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

Where are we now?

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

Outcomes for 2013-14

17.1 Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2012 this was 15.6%)

17.2 Increase to 62.2% the percentage of adults who do at least 150 minutes of physical activity a week. (Baseline for Oxfordshire 61.2% 2011-12)

17.3 65% of babies are breastfed at 6-8 weeks of age (currently 59.1%)

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

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

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

- 'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses

- Homeless people die earlier and suffer worse health than people with a stable home. The threat and experience of homelessness also has an impact on mental wellbeing.
- Safe, secure housing contributes to improving health outcomes. Some vulnerable people need support to maintain their tenancies and live ordinary lives as fully participating members of the wider community. This is an essential ingredient for preventing ill health and homelessness.

These housing issues all have to be tackled in partnership.

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

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

Where are we now?

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

Outcomes for 2013-14

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

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

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

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

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

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

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

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

Where are we now?

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

Outcomes for 2013-14

21.1 At least 95% children receive dose 1 of MMR vaccination by age 2 (currently 95%)

21.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.7%)

21.3 At least 55% of people aged under 65 in “risk groups” receive flu vaccination (currently 51.6%)

21.4 At least 90% 12-13 year old girls receive all 3 doses of human papilloma virus vaccination (currently 88.1%).

Appendix 2 Improving Successful Completions in Drugs Treatment

Detailed performance report

a. The number of adult service users who successfully completed treatment (free from drugs/alcohol dependence) in the latest rolling 12 month period of time, and have not re-presented to treatment within 6 months, or by the end of the period if this is less than 6 months. Separate figures are calculated for opiate drug users and non-opiate drug users. We would hope to see this figure **increase** over time (Data supplied by National Drugs Treatment Monitoring System, Public Health England)

Current indicator RAG Rating

2. Trend Data

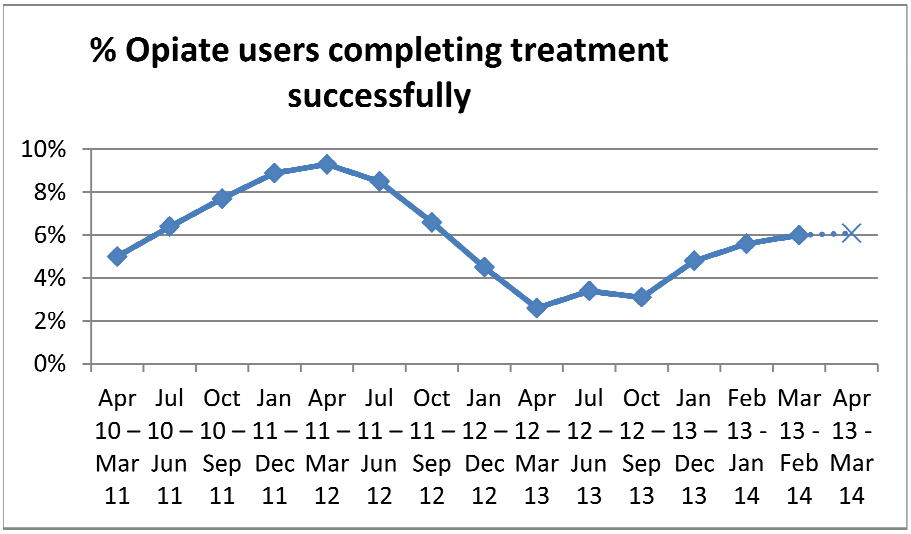
Red

a. Opiate users :

Opiate Cluster Group C	Oct 10 – Sept 11	Jan 11 – Dec 11	Apr 11 – Mar 12	Jul 11 – Jun 12	Oct 11 – Sept 12	Jan 12 – Dec 12	Apr 12 – Mar 13	Jul 12 – Jun 13	Oct 12 – Sept 13	Jan 13 – Dec 13	Feb 13 – Jan 14	*Mar 13 – Feb 14*	*Apr 13 – Mar 14**
% Completions	7.7%	8.9%	9.3%	8.5%	6.6%	4.5%	2.6%	3.4%	3.1%	4.8%	5.6%	*6.0%*	*6.1%*
Number of completions / Total no. of clients				137/ 1604	105/ 1595	71/ 1580	41/ 1552	53/ 1561	49/ 1583	77/ 1600	89/ 1579	*94/ 1573*	*96/ 1573*
Cluster Average			9%				8%				8.3%	*8.4%*	

Position in cluster Mar 13 - Feb 14: 27/31

*Latest figures are provisional from local data



- The chart shows the percentage of clients who left treatment successfully and did not represent within 6 months or by the end of the measuring period if that was less than six months.
- These data are compared within "clusters" of areas where there is a similar profile of clients accessing treatment. Oxfordshire is in cluster "C" with 30 other areas and is ranked 27th in that cluster.
- The figures are percentages for the previous 12 months, updated on a quarterly basis.
- There has been a sharp decline since April 12, reaching a low point in January/February 2013. Data work undertaken since November 2013, and increased completions at the Recovery Service as they had been in place longer have brought a 3% increase to these figures.
- The number of clients successfully recovering in the last report was 94 out of a total of 1573 in treatment

Source: National Drugs Treatment Monitoring Services, Public Health England

b. Number of users of non- opiates who left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months, or by the end of the period if this is less than 6 months, as a percentage of the total number of non-opiate users in treatment. We would hope to see this figure **increase** over time (Data supplied by National Drugs Treatment Monitoring System, Public Health England)

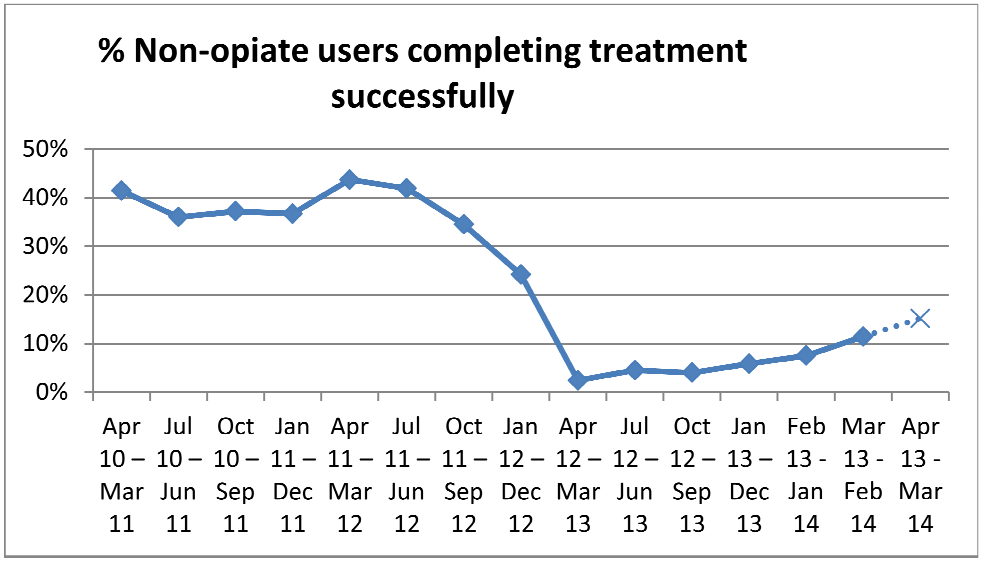
Current indicator RAG Rating Red

b. Non- Opiate users :

Non - Opiate Cluster Group C	Oct 10 – Sept 11	Jan 11 – Dec 11	April 11 – Mar 12	July 11 – June 12	Oct 11 – Sept 12	Jan 12 – Dec 12	Apr 12 – Mar 13	July 12 – June 13	Oct 12 – Sept 13	Jan 13 – Dec 13	Feb 13 – Jan 14	*Mar 13 – Feb 14*	*Apr 13 – Mar 14**
% Completions	37.2%	36.7%	43.7%	41.9%	34.5%	24.2%	2.4%	4.5%	4.0%	5.8%	7.5%	*11.4%*	*15.2%*
Number of completions / Total no. of clients				98/234	70/203	47/194	4/167	9/201	9/224	13/226	16/214	*24/210*	*32/210*
Cluster Average			43%				43%				38.3%	*38.6%*	

Position in cluster Mar 13 – Feb 14: 38/38

*Latest figures are provisional from local data



- The chart shows the percentage of non-opiate using clients who left treatment successfully and did not represent within 6 months or by the end of the measuring period if that was less than 6 months.
- These data are compared within "clusters" of areas where there is a similar profile of clients accessing treatment. Oxfordshire is in cluster "C" with 37 other areas and is the worst performing in that cluster.
- The figures are percentages for the previous 12 months, updated on a quarterly basis.
- The major reduction in percentage in the year ending March 13 implies a major issue with reporting.
- The number of clients successfully recovering in the last report was 24 out of a total of 210 in treatment.

Source: National Drugs Treatment Monitoring Services, Public Health England

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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 29th May 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 and to 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
HIB PIN lay representatives

Overview:

- **Asian Community Women's Group Research** – Aziza Shafique has written report and this has been circulated within Healthwatch Oxfordshire - awaiting publication (June): PIN Lead Aziza Shafique + Annie Davey Healthwatch Oxfordshire (HWO). 3 projects covering; GP access, Mental Health, Domiciliary Care

- **Public Health** – Working with Dr Adam Briggs and Dr Louise Marshall - Steering Group currently being formed - Terms of reference circulated – Paul McGough has been invited and accepted role as initial patient representative.

- **Housing related support Workshop – options –** (covered this morning)

- **Muslim Faith Wellbeing Workshop**

- **NHS Health Check (Minority Ethnic focus)**

- **Focus on Patient Participation Groups and Oxford Clinical Commissioning Group Strategy Forum (Oxford City)**

Asian Community Women's Group Research
Lead - Aziza Shafique (in partnership with Annie Davey HWO)

1. **Gather views from Asian women on NHS physical health checks**
2. **Five focus groups** starting 15th May 2014 – 19th June 2014 with a break for half term May holidays
3. **Break for Ramadan from 26th June till end of July**
4. **During the summer activities Eid events**
5. **Asian Women's Group Healthwatch Oxfordshire Report** - will be published sometime in June (Report Focus: Access to General Practitioners, Mental Health and Domiciliary care)

Muslim Faith & Wellbeing Workshop Regal Community Centre Tues 29th April

Paul McGough attended meeting for Asian public, faith & community elders to discuss ways to strengthen public wellbeing – focusing on mental health – presentations followed by discussion. (Public attendees were men, plus a few female professionals – female public were invited but not present (awareness & cultural issues). The report below is included for information for the Health Improvement Board and is not the formal report of the meeting.

- Imam Monawar Hussain (Chair)
- Imam Ataullah Khan - Madina Mosque
- Patrick Taylor - Oxfordshire Mind
- Dr A Hameed Latifi - Psychiatrist (Afghanistan)
- Ian Bottomley - Oxford Clinical Commissioning Group

Key messages:

- Around ¼ of people will experience mental ill-health in a year (particularly anxiety depression) important to recognise "this is normal" – plus other behavioural and psychotic illness. Important to "destigmatise" mental health within Asian community. (Many cultural issues).

- Around 60,000 people in Oxfordshire will have mild to moderate anxiety and depression. 1/3 of presentations to GP have a mental health component.

- Importance of person centred care approach – to empower the person to live beyond their illness.

- **5 ways to wellbeing highlighted**

  - Connect with what's happening around you
  - Be active (get out, get involved, physical & leisure activity)
  - Take notice – be curious
  - Keep learning – libraries – mental stimuli
  - Give – Feels good – and benefits vulnerable members of community

- **Faith** – good evidence people with religious beliefs helps to positively sustain them – however some negative cultural issues highlighted too. **Special challenges – How make services accessible to all communities we serve – including the homeless, the isolated, the disenfranchised** how to integrate mental health services across health and social care

- **Big opportunity – to work together** with Imams through Mosques as focal point on issues of health - to get positive messages to public and counter cultural stigmas and misunderstandings.

- **Visionary messages from Imam** Monawar Hussain (Community Support Forum) and Imam Ataullah Khan – to give supportive mental health messages - involve women more (through Asian Women's Group) and also work together with stakeholders on other health and wellbeing issues.

- **Some Ideas suggested from participants:**
  - **Address health and mental health <u>early</u> at school through education** increase awareness, understanding and reduce stigma
  - **Health engagement** - target specific groups through leisure events
  - **Psychiatric outreach services delivered in community settings** (GP practices & other open access community venues)

Key outcome:

- **Positive offer of support from Imam Ataullah Khan (Madina Mosque)**

plus Imam Monawar Hussain from the Community Support Forum

- To engage with PIN on health issues – 1st Preventive health – NHS Health Check (Asian Community and Minority ethnic focus) – agreed focus groups to be arranged (at Mosque). Follow up next steps meeting **TBC** by Paul McGough May-June (before Ramadan starts)

- Further opportunities: Public health and other HIB health priorities

Oxford City Patient Participation Group Forum Meeting - Kings Centre, Osney Mead 7th May 2014.

The report below is included for information for the Health Improvement Board and is not the formal report of the meeting.

The meeting included an overview of Oxfordshire Clinical Commissioning Groups 5 Year Commissioning Strategy – Presentation by Rachel Coney
Break Out Groups: Discussion – Patient Participation Group's role in relation to Commissioning Plans &Priorities

Key message from Public at this meeting:

- **Feeling that Preventative Public Health aspect was missing** from Oxford Clinical Commissioning Group strategy. Even after it was explained this was Oxfordshire County Council's responsibility - Public are confused by different health organisation separation of responsibilities - demarcation "not our responsibility" – need to explain better "who does what"... how different organisations fit together and why they focus on different areas
- **Concern expressed about closing care homes**
- **Public want more detail on plans** – not just summaries
- **Statements about Integration of health and social care were challenged –Comments that integration is NOT happening in reality** - around Better Care fund
- **Health Inequalities Commission** - how will this relate to Healthwatch and other organisations? Need to differentiate roles and responsibilities
- **Widespread recognition that need to broaden base of Patient Participation Group -** more grassroots representation, Black Minority Ethnic and Younger Person.
- **Event focused Preventive Health engagement** – explored idea raised by Public in Muslim Faith Wellbeing Workshop – to target specific groups through leisure events (e.g. women's group, keep fit, cooking, embroidery – Idea received a very positive response. (A similar approach could also be used to target at risk men – football, bikers (already used in cancer awareness) – could extend concept to sports clubs, and workplace?)

Attended Oxford University Hospitals NHS Trust - Peer Review Conference on 24th April - a review with clinical-management-patient representatives – Review followed by working groups – (The internal Peer Review Programme itself - in its first phase - brought together 57 clinicians, non-medical employees and patient representatives, visited 103 wards and departments across the five divisions of the Trust). Peer reviewer feedback was very positive. And in the conference there was overwhelming support for the continuation of the programme - views were sought on learning - and alternatives to the shape and focus of the next phase – which is now in planning.

Forward activity:

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

- **Keep building Asian contacts and networks**, Minority Ethnic Consultative Forum, Mosques, other Asian Community groups. Paul to focus on Asian men, Aziza on Women – Paul to meet and plan with Imam Ataullah Khan Madina Mosque. **Confirm May** - and then extend focus groups to other Mosques

- **Contribution to workshop & scrutiny of impact of housing related support – review of options & next steps (start 29th May 2014)**

- **Involvement in Older People's Partnership Board Open Meeting - 3 June 2014.** (Aziza sourcing Carer from Asian Women's network + Paul)

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

- **Public Health Steering Committee – joint Oxford University Hospitals NHS Trust and County Council strategy implementation.** Paul initially - plus Aziza to advise / consult on Asian Community health issues

- **Substance & Alcohol Misuse – Service Support User views** (if capacity?)

- **Input into Health Inequalities Commission –** Paul to liaise with Rachel Coney Oxford Clinical Commissioning Group.

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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 29th May 2014

Title of report: Tackling Health Inequalities in Oxfordshire

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

Purpose of Report: To inform Health Improvement Board members of Oxfordshire Clinical Commissioning Group's approach to tackling health inequalities in Oxfordshire (particularly the establishment of a Health Inequalities Commission) and to gather feedback on the proposals.

Action Required: Partners are asked to note that this work is underway, and to feedback comments on the proposals as set out in this short briefing paper.

Impact on Public:

Authors: Rachel Coney, Oxfordshire Clinical Commissioning Group Dr Paul Park, Oxfordshire Clinical Commissioning Group

Tackling Health Inequalities in Oxfordshire

Background

1. In its new 5 year strategy OCCG has committed to working with NHS England, OCC, local District Councils and other partners to deliver a joint approach to tackling health inequalities in Oxfordshire by targeting support and resources in 2014/15 to a small number of practices in each locality, whose patient populations experience significant health inequalities. A detailed joint working proposal has been drafted and is attached at Appendix 1.

2. OCCG's new Clinical Chair has subsequently announced his intention to launch multi-agency Health Inequalities Commission for Oxfordshire, with the objectives of:
   a) Undertaking work with local community groups to try and improve our understanding of barriers to accessing health services and public health interventions.
   b) Reviewing existing initiatives across the UK, and assessing their impact, evidence base and cost.
   c) Improving shared understanding of our mutual objective for reducing health inequalities across Oxfordshire.
   d) Recommending a tightly defined programme of work to be jointly delivered by health, local government and third sector partners over the next 2-5 years, in addition to the action plan already agreed and attached.

3. Work now needs to begin to:
   a) Define the TOR and membership for the Commission.
   b) Share the Commission proposals with a wider group of stakeholders and gain the necessary formal agreements to participate from relevant organisations.
   c) Establish a multi-partner programme board that can oversee delivery of the already agreed practice based action plan as set out overleaf.

4. OCCG has asked the AD Localities (City and NE), to draw these development threads together, and to develop and manage this programme, under the Clinical Leadership of Dr Paul Park and Dr Merlin Dunlop.

Partners are asked to note that this work is underway, and to feedback comments on the proposals as set out in this short briefing paper.

Immediate next steps

5. In order to progress this work the CCG will:
   a) Meet with and brief the relevant staff in the OCCG locality teams (22/4/14)
   b) Meet with and brief District Council Leads (1/5/14)
   c) Meet with and brief Locality Clinical Directors for OCCG (8/5/14)
   d) Arrange to brief the OCCG Executive in late April/early May
   e) Brief the Health Improvement Board
   f) Work with partners to shape the nature and scope of the proposed commission

g) Establish a multi-partner programme delivery group, with representation from OCC, NHS England Thames Valley, District Councils and the third sector to progress detailed action and milestone planning for the agreed action plan set out overleaf.

Extract from OCCG 5 year strategy – already agreed action plan

1.1 Supporting measure 1: Improving health and reducing health inequalities

1.1.1 OCCG, OCC and NHS England have agreed a joined up approach to improving health and tackling health inequalities in Oxfordshire, which is described briefly below. This model follows the 5 steps recommended in Commissioning for Prevention and is designed to close the gap for those population groups who experience worse outcomes, by supporting delivery of agreed Health and Wellbeing Board targets and trajectories, which can be found here: http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf. These priorities are derived from the data in the JSNA.

1.1.2 The steps we will take are:

a. Each OCCG locality will identify a small number of practices where there are populations that have been agreed as priorities because they have worse outcomes. These are:

   i. Children in poverty
   ii. Ethnic minorities
   iii. Carers
   iv. Lonely old people
   v. High number of mental health service users
   vi. People with physical and learning disabilities

b. These practices will then be reviewed using OCC, NHS England and practice data to identify those which also have :

   i. Low uptake of core PH prevention interventions (smoking cessation, breastfeeding, weight loss, screening, immunisations, healthchecks)
   ii. Populations with potential to benefit from improved blood pressure, cholesterol, anti-coagulation and blood sugar control. (National Audit Office recommendations)
   iii. Low carer registration

c. Those practices which fit both categories (and which we expect to include practices in areas of deprivation) will form the target group for offers of intensive support to tackle health inequalities and provide early intervention and prevention services from OCC's providers, NHS England's screening and immunisation providers and locality teams.

d. Local PPG fora will be asked to endorse the proposed selection of target practices.

e. An implementation group will be established to ensure that OCC, NHS England provider and locality teams will work together in joint teams as below:

   i. Locality Support Pharmacists will work in priority practices to identify individuals who would benefit from individualised outreach to encourage take up of prevention and early intervention measures (taking burden off Practice Managers).

   ii. CCG (City team) will work with CSU and OCC to get a flag on all GP systems for members of the countywide Troubled Families initiative and will ensure GPs have access to contact information for case workers for each member of a Troubled Family, to assist with this identification/outreach work and to support whole system working around our most disadvantaged citizens.

iii. CCG Locality Equality and Access teams will undertake targeted outreach work to encourage identified individuals/families and or communities to take up these services.

iv. ADLs / Locality Clinical Directors will work with GPs in these priority practices to encourage increased delivery of specific clinical interventions , including those recommended by the National Audit Office to reduce health inequalities:
- Increased prescribing of drugs to control blood pressure;
- Increased prescribing of drugs to reduce cholesterol;
- Increased anticoagulant therapy in atrial fibrillation;
- Improved blood sugar control in diabetes
- Registration of carers
- Increased referral to healthy lifestyle interventions
- Early interventions and prevention for maternal and child health.

v. OCC/OCCG joint commissioning lead for children and maternity will be asked to get Health Visitor and breast feeding support services to target work with the priority practices.

vi. OCC will target smoking cessation, and other prevention measures at priority practices/identified individuals.

vii. NHS England will prioritise support to increase uptake of screening and immunisations within targeted practices.

viii. CCG locality teams will manage relationships with practices on behalf of joint OCC/NHSE/CCG so practices are not overwhelmed.

ix. CCG locality teams will focus PPG development work on same priority practices.

f. In addition to the above, CCG Equality & Access teams will focus on neighbourhood based strategic partnership programme work, work with carers and work with military and veteran communities.

g. For vulnerable children and adults, NHS England, OCC and OCCG will:

i. Deliver joined up services to prevent, detect and intervene early where children are being exploited or at risk of being exploited.

ii. Deliver a ‘core offer’ for all children who are Looked After or Leaving Care so that there is consistent assessment of their health needs, early intervention where necessary and speedy access to more specialist services (such as Child and Adolescent Mental Health Services) when required.

iii. Explore the potential for co-commissioning with NHS England to meet the primary and community care needs of our homeless population and to develop services for vulnerable adults in frequent contact with the criminal justice system.

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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 29th May 2014

Title of report: 'Housing and Health Working Together' – Developing and Oxford City Council Action Plan

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

Purpose of Report:
To inform Health Improvement Board members of the outcome of the Housing and Health Working Together Round Table event held in February, including the resulting action plan for Oxford City Council and partner organisations.

Action Required:

Impact on Public:

Authors:
Val Johnson, Oxford City Council Councillor Ed Turner, Oxford City Council

Report to the Health Improvement Board on 29th May 2014

'Housing and Health Working Together' – Developing and Oxford City Council Action Plan

Introduction

1. The Housing and Health Working Together Round Table event organised by Oxford City Council was held on Thursday 27th February 2014 at Oxford Town Hall.

2. The event was attended by approximately 50 people from a wide range of organisations and with representation from:
   - Oxfordshire County Council public health, joint commissioning
   - NHS and Health centres
   - Oxfordshire Clinical Commissioning Group
   - Oxford City Council – housing, environment health, benefits, energy efficiency, landlord services
   - Children's centres
   - Social landlords
   - The voluntary sector – homelessness, mental health, citizen's advice

3. Welcome and introductions were given by Cllr Ed Turner (Oxford City Council), Jackie Wilderspin Public Health specialist (Oxfordshire County Council) and Dr Joe McManners (Oxfordshire Clinical Commissioning Group).

Aims of the event

4. The first aim of the event was to consider how we currently work together on health promotion activities and how we could work better together. For example on:

   - Take up of health checks
   - Promotion of leisure and sports activities
   - Provision of support to Public Health Campaigns
   - Identifying hazards in the home
   - Affordable warmth

5. The second aim of the event was to consider information sharing and referrals, how does this happen now and how can we work better together. For example on:

- Privately rented housing: Houses in Multiple Occupation, overcrowding, and preventing vulnerable groups from exploitation
- Providing support in the community: addressing low incomes and impact of welfare reform, accessing information and advice, affordable warmth and community safety
- Hospital discharge. Occupational Therapist, Disabled Facilities Grant and support services
- Complex needs, homelessness, mental health, substance misuse, domestic violence.

The outcomes of the event

6. A report captured the actions agreed by tables on what we could do better and the key issues to be addressed in the plenary discussion. This has been sent to participants. It is available to others on request.

7. Further work has been done on refining the issues into clear aims for some specific areas of work. These include:

a) Joining up and targeting health promotion campaigns
   - Joint promotion of health promotion campaigns
   - To promote health campaigns within targeted groups and communities
   - To improve information to tenants, landlords and members of the public
   - Dental Health – promote access to dental care
   - Affordable Warmth – promote awareness of the services and support that is available

b) Working across Oxford City Council services and with the housing sector
   - To ensure housing planning process ensures that adequate types of housing are available
   - To ensure that there are clear routes for referral and signposting across Housing and Environmental Health Services and with other council services

c) Improving referral processes, joint working and information capture across agencies
   - To improve referral routes for health professionals to City Council Services
   - To improve awareness amongst professionals about what other professionals do
   - To improve housing input in hospital discharge planning
   - To improve data sharing

d) Supporting those with complex needs
   - To gain a better understanding of different agencies roles and responsibilities
   - Harm minimisation especially for vulnerable groups

8. **An Initial Action Plan** for each of these aims has been developed and is available in Annex 1t.

Annex 1
PROPOSED ACTIONS

1. **Joining up and targeting health promotion campaigns**

Action	Who	By when	City Council	With partners	Partners	Comments
Aim: Joint promotion of health promotion campaigns						
To include the PCT's Health Promotion Programme as a part of the City Council's Communication Calendar (internal and external).	Val Johnson and Louisa Dean	To be reviewed March 2015	✓	✓		
To ensure that this is considered in the Oxford City Council Mental Health Action Plan.	Val Johnson	Draft Strategy September 2014	✓	✓		
Aim: To promote health campaigns within targeted groups and communities						
To ensure that the CaN Team is aware of health promotions and activities and that these are promoted through community partnerships and local networks.	Angela Cristofoli	To be reviewed March 2015	✓	✓		
Aim: To promote immunisation and health checks to targeted groups and communities						
To ensure that the CaN Team is aware of immunisation campaigns and activities and that these are promoted through neighbourhood partnerships and local networks and tenants and residents groups	Angela Cristofoli and Garry Parsons	To be reviewed by March 2015	✓	✓		
Aim: To improve information to tenants, landlords and members of the public						
To review the current housing and health guides available on the web site and identify any gaps.	Ian Wright. Mike Browning and Dave Scholes	June 2014	✓	✓		
Aim: Dental Health – promote access to dental care						
Provide up-to-date list of NHS	Val Johnson to	May	✓	✓		

Action	Who	By when	City Council	With partners	Partners	Comments
dentists taking new patients. Publish reminders about availability of NHS dentists at tenants sign up, Tenants in Touch, Your Oxford.	contact OCCG for details. Louisa Dean to include in Communication Plan	2014				
Aim: Affordable Warmth – promote awareness of the services and support that is available						
Publicise the telephone number of the Affordable Warmth Network to deprived communities e.g. through CaN Team and community newspapers.	Debbie Haynes	May 2014 Review March 2015	✓	✓		

2. Working across Oxford City Council services and with the housing sector

Action	Who	By when	City Council	With partners	Partners	Comments
Aim: The housing planning process ensures that adequate types of housing are available						
Put health at the forefront of developing housing strategy, e.g. refresh to incl. Older People Needs	Gary Parsons and Stephen Clarke	September 2014 (Draft Strategy for consultation)	✓			
County Council to provide input to the developing housing strategy on Extra Care Home needs in the city.	Garry Parsons to liaise with the County Councils	By August 2014 (In time for developing Draft Strategy)	✓	✓		
Improve register of adapted properties: making the best use of them and making best use of money spent on adaptations..	Stephen Clarke	Autumn 2014 CEB	✓			

To produce a business case for funding for Housing Improvement Agency (HIA) services for older people.	Ian Wright	June/July 2014	✓	✓		
Aim: To ensure that there are clear routes for referral and signposting across Housing and Environmental Health Services and with other council services						
Review internal housing and environmental services A-Z and referral processes.	Nichola Griffith and David Stevens	June / July 2014	✓			
To investigate the feasibility of implementing a monitoring and evaluation process for referrals to Environmental Health Services and to measure their impact.	Ian Wright	June 2014	✓			

3. Improving referral processes, joint working and information capture across agencies

Action	**Who**	**By when**	**City Council**	**With partners**	**Partners**	**Comments**
Aim: To improve referral routes for health professionals to City Council Services						
To consider setting up a dedicated e-mail address for health workers to use for enquiries.	Val Johnson and Helen Bishop	May 2014	✓			
Aim: To improve awareness amongst professionals about what other professionals do						
To seek to have regular slots for the '6 GP meetings on Wednesday lunchtimes.	Val Johnson to discuss with OCCG and liaise with Stephen Clarke and John Copley	May 2014	✓	✓		
To arrange a series of information sharing sessions and to provide	John Copley and Stephen	June 2014	✓	✓		

tailored information for GPs and other front-line staff e.g. community midwives, health visitors / care workers, CCG outreach workers.	Clarke					
To hold initial discussions with other agencies on how Oxford City Council can improve our working to keep children out of hospital (particular those in HMO's).	Ian Wright and John Copley	July 2014	✓	✓		
2 page leaflet who does what at the City Council leaflet (e.g. for GPs and other health workers)	Stephen Clarke and John Copley	July 2014	✓			
Aim: To improve housing input in hospital discharge planning.						
To arrange a meeting of key agency staff to discuss having questions on housing circumstances on hospital admission forms, to aid referral in hospital discharges.	Dave Scholes and Val Johnson	June/July 2014	✓	✓		
Aim: To improve data sharing between the City Council, County Council, Thames Valley Police and Mental Health Services.						
Review of data protection protocols underway as part of MASH.	Lucy Neville	September 2014.	✓	✓		
To identify opportunities to ask the individual's permission to share information with other agencies.	Lucy Neville	September 2014	✓			

4. Supporting those with complex needs

Action	Who	By when	City Council	With partners	Partners	Comments
Aim: To gain a better understanding of different agencies' roles and responsibilities						
To hold initial discussions with other agencies about referral paths (Mental Health, Hospital Trusts, Social Services, Community Safety) to prevent clients falling between agencies.	Richard Adams and Val Johnson	July 2014	✓	✓		
To have initial discussions with agencies to look at holding 'serious case reviews' to identify risks.	Richard Adams and Val Johnson	July 2014	✓	✓		
Develop common assessment form for housing linked to a single assessment process, across agencies.	Dave Scholes to lead through Single Homelessness Group	July 2014	✓	✓		
Consider staff being jointly employed with other agencies including secondments.	all	To be reviewed March 2015	✓	✓	✓	
Aim: Harm minimisation especially for vulnerable groups						
Uncategorised substances (legal highs): consider what powers agencies have to take action.	Richard Adams and Ian Wright with Trading Standards and TVP	June 2014	✓	✓		
Public Health Drug & Alcohol Services Treatment consultation.	Richard Adams to respond.	May 2014	✓			
To request that OCCG consider this as part of their mental health commissioning.	Richard Adams andVal. Johnson	June 2014	✓		✓	

Action	Who	By when	City Council	With partners	Partners	Comments
To have initial discussions with partner agencies on how services can be co-designed and commissioned for complex needs client group.	Richard Adams, Dave Scholes and Val Johnson	To be reviewed March 2015	✓	✓		

Oxford City Council Contact List

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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 29th May 2014

Title of report: Briefing on Fuel Poverty Outcome and associated Action Plan

Is this paper for:	Discussion	Decision	Information

Purpose of Report: To inform Health Improvement Board members of the proposed outcome measure for fuel poverty and the associated action plan for 2014/15.

Action Required: The Board is recommended to adopt the proposed outcome and endorse the proposed actions in the plan for 2014/2015.

Impact on Public:

Authors: Dale Hoyland, Affordable Warmth Network Katharine Eveleigh, Oxfordshire County Council

Health Improvement Partnership Board, 29th May 2014

Briefing on Fuel Poverty Outcome and associated Action Plan

The Health and Wellbeing strategy 2013-2017 identified the need to make reducing Fuel Poverty a priority. The board set the objective of coming up with an outcome to measure work undertaken, that would contribute to reducing fuel poverty levels across Oxfordshire.

The Affordable Warmth Network (AWN) is co-ordinated by National Energy Foundation (NEF) who in turn are funded by the six Oxfordshire local authorities. The AWN, besides comprising of partners who fund the Network, also includes other organisations who have a part to play in reducing fuel poverty in Oxfordshire, such as Age UK and the Citizens Advice Bureaux.

Fuel Poverty Outcome

The AWN were tasked with proposing an outcome and, as such, now propose the following outcome;

To establish a baseline of the number of households in Oxfordshire, who have received significant increases in the energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the AWN and their partners.

Significant increases are defined as:

Loft insulation (including top ups, where the insulation level is at least doubled), cavity wall insulation, external / internal solid wall insulation, Installation of a more efficient boiler, installation of a more efficient heating system, upgrading of windows from single glazing[i] and Increase in the uptake of benefits (at least £1200[ii])

The various figures will come from the work of Private Sector Housing teams in local authorities, Home Improvement Agencies, Green Deal installations (such as installed by Oxfordshire-based Green Deal Together), the AWN (including partner installing companies) and the number of successful benefit claim cases that the CAB processes[iii].

There may be other projects and associated sources of funding (such as Energy Company Obligation (ECO), or Home Improvement Fund (HIF)) that are subsequently identified that could contribute to the outcome. These will be identified and collated by the AWN and will be detailed in any reporting.

In future years it is hoped that more detailed information, such as the targeting of vulnerable groups can be quantified and reported.

It is hoped that through the combined efforts of partners, an aspirational baseline target of 550 households will be helped through the activities of the AWN. This figure is made up in the following way and needs to be confirmed at the next AWN meeting.

Partner	Measure	Total
Environmental Health teams in each of the five local authorities	Number of excess Cold hazards identified and resolved and licence conditions applied and complied with.	300
Home Improvement Agencies teams in each of the five local authorities	Number properties where grants and loans for energy efficiency work	20
NEF partner installing companies	Number of properties where energy efficiency measures installed	20
Green Deal and Green Deal Together	Number of properties where energy efficiency measures installed	100
Oxfordshire Citizens Advice Bureaux	Number of cases where there has been a successful benefit claim	110

Due to the recent significant changes and complexity of the Governments' funding mechanisms of energy efficiency measures, the number of installation measures are likely to be significantly reduced. Under old schemes, 9832 Oxfordshire households had received energy efficiency measures in a year, under the new ECO programme, there have only been 990 energy efficiency measures *recommended*. Anecdotal reports suggest that uptake of these recommendations are very low.

In order to ensure what limited resources are available, are directed towards the most vulnerable households and are used most effectively the AWN have developed an Action plan for 2014/2015.

Action Plan

In Appendix 1 is a plan for 2014/2015 for the partners of the AWN which outlines how the network will direct its' existing resources over the coming year.

Recommendation

The board should adopt the proposed outcome and endorse the proposed actions in the plan for 2014/2015.

Appendix 1: OXFORDSHIRE COUNTY FUEL POVERTY ACTION PLAN 2014 – 2015

Factor	Objectives	Key Actions	Who/Lead
Low Income/Vulnerable	1. Overall target activity to reach those on low income or who are vulnerable – over 60 / families with children aged 5 or under / with a disability that makes them housebound/more vulnerable to cold	• Use data mapping to target outreach activity • Develop database on JSNA of housing conditions and other Fuel Poverty related intelligence • Strengthen cross-referral mechanism between CAB & AgeUK and AWN • Promote schemes to Health and Social Care and Health Care Providers (GPs, District Nurses, Health Visitors, OTs and care workers) • Develop plans for a Switching Day – possibly linked with Registered Housing Providers (RP's)	National Energy Foundation / District councils, Oxfordshire County Council & NEF
	2. Use benefit assessments to increase income		CAB lead with AgeUK & NEF
	3. Increase awareness of available schemes		NEF, Oxfordshire County Council
	4. Supplier switching to reduce energy bills		NEF with Registered Providers
Poor Energy Efficiency	1. Improve the energy efficiency of properties in owner occupied tenure	• Develop opportunities for community focused projects • Explore opportunities for discounted energy-efficiency measures • Use the Housing Health and Safety Rating System to facilitate owners to carry out appropriate work • Explore the use of the Building Research Establishments calculator to evidence formal action. • Develop relationships with Housing Associations • Develop area-based projects to maximise uptake of Energy Company Obligation funding, for example to deal with solid walled properties • Signpost to the Affordable Warmth Helpline – work with community action groups to link with action on fuel poverty • Maintain levels of outreach activity and face-to-face assistance. • Increase awareness of energy use through current cost monitors loan • Build links with trading standards on promoting/checking reputable installers • Link up with Age UK Community Information Network and the Consumer Empowerment Partnership	NEF, and Local Authorities
	2. Improve energy efficiency of properties in private rented tenure		NEF Local Authorities
	3. Improve energy efficiency of properties in social tenure		NEF with RP's
	4. Hard to Treat Properties		NEF with targeted local authorities
	5. Promote Energy Saving Advice		NEF with network partners and Community Action Group Oxfordshire
	6. Reduce impact of schemes on vulnerable people		NEF, OCC, Age UK and Oxford CAB

Expensive Fuels	1. Encourage bulk buying oil	• Promote Oxfordshire Rural Community Council, bulk buying oil scheme in off gas network communities	ORCC, NEF
	2. Electric only heating	• Develop a factsheet, and update information in EasySave booklet.	NEF
Accessing hard to reach groups	1. Work with the disabled and long-term sick	• Work with health and social care professionals - promote advice line and establish referral mechanisms e.g. through GP surgeries, flu campaigns	Public Health Oxfordshire, NEF, Carers Oxfordshire
	2. Work with the unemployed		NEF
	3. Work with older people	• Establish relationships with job centres / job clubs	NEF
	4. Target single parent families or families with very young children	• Work with OPAC's (Older Persons Action Groups) • Continue to work with children centres	NEF
	5. Work with BME groups	• Establish links to minority community leaders	NEF
	6. Develop partnerships with other agencies who work with hard to reach groups		NEF with CAG Oxfordshire / Low Carbon Hub
Confusion among residents	1. Promote the Affordable Warmth Helpline as referral service	• Promote helpline through partner's websites, newsletters and relevant publications (likely to reach vulnerable residents) • Provide affordable warmth talks to community groups	NEF and network partners Carers Oxfordshire
	2. Continue to attend events to educate residents		NEF
	3. Work closely as partners		All AWN partners
Targeting appropriate areas/groups	1. Target through GIS mapping	• Make use of GIS mapping to find areas with high levels of fuel poverty and opportunity for targeted area-based approaches	NEF
	2. Use partner databases to target vulnerable groups		Cherwell DC, Oxford City Council & West Oxfordshire DC
	3. Develop Cold Weather Plan	• Develop a cold weather plan for AWN members	All AWN partners

[i] This may translate in to a reduction from a category 1 to category 2 hazard for Excess Cold under the Housing Health and Safety Rating Scheme. Or in other instances the increase of a band on an Energy Performance Certificate (EPC).
[ii] The value chosen as what the average cost of powering a house is, 44% of which is on heating.
[iii] It is estimated that each successful benefit check can increase income by an average of £5000.

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Health Improvement Partnership Board
Forward Plan 2014-15

Date	Item
Workshop: July	• Healthy Weight Strategy (a workshop with Children and Young People's Partnership Board members and a range of stakeholders, to set an action plan) • To decide: Instead of July Board Meeting (2-4pm, 31st July 2014, Oxford Town Hall)
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 • Healthwatch primary care services report • 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

21st May 2014,

Sophie Kendall, Joint Commissioning, Oxfordshire County Council
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