Public Document Pack

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, 25 September 2014 at 2.00 pm

Kings Centre, Oxford

Peter G. Clark
County Solicitor

Published: 17th September 2014

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

---

Membership

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

Board Members:

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

Notes:

- ***Date of next meeting: 20 October 2014***

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on (01865) 815270 or glenn.watson@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 Vice-Chairman, District Councillor Ed Turner

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

People responsible: Members of the Health Improvement Board

To approve the Note of Decisions of the meeting held on 29th May and to receive information arising from them.

6. Housing-related Support Services Consultation Update

2.15
10 minutes

To receive a verbal update on the housing-related support services consultation, following its closure on 17th September.

Presented by: Natalia Lachkou, Oxfordshire County Council

7. Public Involvement Network Update (Pages 7 - 50)

2.25
20 minutes

Report presented by: Paul McGough and Aziza Shafique

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.

Asian Women's group report

There will also be a report written by the Asian Women's group, led by Aziza Shafique

and funded by Healthwatch, on the Asian Women's Wellbeing Project. This will be presented by Aziza Shafique and Rachel Coney, Healthwatch. As this paper will not be public until the 25th September, it will be circulated to members separately following its press release on 19th September.

Further information:
The Asian Women's Group successfully applied to Oxfordshire Healthwatch Project Fund in 2014 for a grant to undertake research into Asian Women's experiences of health and social care services. The resulting report is an analysis of 130 responses to questions about Asian Women's experience of services in Oxfordshire, focussing on 4 key areas: GPs, Mental health, Access to Services and Domiciliary Care. Healthwatch Oxfordshire is sponsoring the publication of this report as part of its statutory responsibility to listen to patient's and service user's on the ground experience. Healthwatch Oxfordshire is committed to working with commissioners and providers of services to listen to 'experts by experience' and make improvements, based on hearing their recommendations. The report is due for release under embargo on 19th September. The date for publication is 25th September.

8. Healthy Weight Strategy and Action Plan (Pages 51 - 88)

2.45
30 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Rebecca Cooper, Oxfordshire County Council

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

The Board is recommended to discuss the draft action plan (and appendices) which set out proposed activity for 2014-15. It is being developed through consultation with stakeholders and includes suggestions made by Health Improvement Board members at the April meeting and at the joint Health Improvement Board and Children and Young People's Board workshop in July. The Board is asked to approve that this action plan is developed on an ongoing basis, in partnership with stakeholders.

This item will also include a presentation from Chris Freeman on the work of the Oxfordshire Sports Partnership, in contributing to this action plan.

9. Welfare Reform Update (Pages 89 - 94)

3.15
15 minutes

Paper presented by: Paul Wilding, Oxford City Council

To receive an update on Oxford City Council's welfare reform projects.

10. Performance Report (Pages 95 - 134)

3.30
25 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin, Oxfordshire County Council

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

The updated Joint Health and Wellbeing Strategy 2012-16 is included for information.

11. Forward Plan (Pages 135 - 136)

3.55
5 minutes

People responsible: Members of the Health Improvement Board

Presented by: Councillor Ed Turner, Vice-Chairman

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

This page is intentionally left blank

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Thursday 29 May 2014 commencing at 2.00 pm and finishing at 4.00 pm.

Present:

Board Members:

District Councillor Mark Booty (Chairman), Cherwell District Council
City Councillor Ed Turner (Vice Chairman), Oxford City Council
District Councillor Anna Badcock, South Oxfordshire District Council
District Councillor George Reynolds, Cherwell District Council
District Councillor Alison Thomson, Vale of White Horse District Council
Dave Etheridge, Chief Fire Officer & Head of Community Safety
Ian Davies, Cherwell & South Northamptonshire District Councils
Paul McGough, Public Involvement Network Representative
Aziza Shafique, 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

Part of meeting

Agenda Item	**Officer Attending**
Agenda item 10	Rachel Coney, Oxfordshire Clinical Commissioning Group
Agenda item 12	Dale Hoyland, National Energy Foundation Katharine Eveleigh, 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 Chairman, District Councillor Mark Booty, welcomed all to the meeting.	
2. Apologies for Absence and Temporary Appointments Apologies have been received from Councillor Hilary Hibbert-Biles. 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 March Meeting The minutes of the March meeting were approved. Jackie Wilderspin gave a verbal update on the social fund arrangements, on behalf of Sarah Breton (Strategic Commissioner Children, Oxfordshire County Council): - The Support Fund ceased in Oxfordshire on 31st March and the contract with Auriga who managed the fund was finished. - This saved the Council £500k. - They have continued to work with people who had outstanding claims, submitted before 31st March but most of these are now completed. - For this year (14/15) the remaining money has been split between adults and children's operational teams and will be used for funds to support anyone for whom the Council has a statutory responsibility. - Anyone else can be referred to our Customer Services Centre where they will be assessed and signposted to advice/support e.g. foodbanks. All invited to contact Sarah directly for more information: Sarah.Breton@Oxfordshire.gov.uk The Board was informed that Ian Brooke (Head of Leisure, Parks and Communities, Oxford City Council) will represent the District Councils on the joint Oxford University Hospitals Trust and Oxfordshire County Council Public Health Strategy steering group. Outstanding actions as follows:	

ACTION: **Once released, the Healthwatch report on patient experiences of GP services will be brought to a future meeting.** **Board members will receive an invitation to a Healthy Weight Strategy workshop on 2nd July.**	**JW** **SK**
6. Performance Report Jonathan McWilliam introduced and explained the performance report, highlighting the measures currently rated red. Additional information presented included the range of outcomes for each indicator and Health check uptake by ethnicity. Marianne North, Chairman of the Housing Support Advisory Group, presented the annual Basket of Indicators for Housing and Health report 2013-14. Correction on pg 4/ pg 24 on report pack noted: '255 households in the County ~~excluding West Oxfordshire~~ are affected by the benefit cap.' It was agreed to accept the recommendations of the report for the paper to the Joint Health and Wellbeing Board, with further discussion over the next two weeks on rough sleeping indicators. **ACTION:** **A report card on GP health checks will be brought in two meetings' time.** **Any further suggestions for rough sleeping indicators to be sent to Jackie Wilderspin by Friday 13th June 2014.** **Oxford City Council's welfare reform pilot evaluation report to be brought to the September Health Improvement Board meeting.**	 **JM** **ALL/JW** **VJ/SK**
7. Alcohol and Drugs Partnership Jackie Wilderspin introduced the proposal to establish an Alcohol and Drugs Partnership, overseen by the Health Improvement Partnership Board. The Board welcomed the proposal, making some further suggestions. These included: member input; representation from council Chief Executives; and governance link with adult social care and mental health. **ACTION:** **The Board will be updated on plans going forward.**	 **JW**
8. Health Improvement Board Priorities 2014-15 Jackie Wilderspin introduced the paper, inviting the Board to discuss and decide 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.	

The Board discussed the proposals and accepted the recommendations in the paper. **ACTION:** **The Healthy Weight workshop will discuss action plans to achieve the outcomes being set.** **Any further suggestions and comments to be sent to Jackie by 13th June 2014.**	 **JW/BC** **ALL/JW**
9. Public Involvement Network Report Paul McGough and Aziza Shafique briefly outlined the work they are undertaking to gather public opinion on key areas of health improvement. **ACTION:** **Schedule the PIN representative report earlier on the agenda in future.**	 **SK**
10. Health Inequalities Commission Rachel Coney (Assistant Director Localities, Clinical Commissioning Group) introduced a briefing paper on the Health Inequalities Commission, inviting the Board to feedback comments on the proposals. Members welcomed the approach. Areas discussed included: timescales; data used to identify practices; coordinating with existing initiatives; and working with District councils.	
11. Health and Housing Roundtable Report Councillor Ed Turner and Val Johnson introduced the report on the Health and Housing roundtable event held in February. Members welcomed the feedback and examples offered.	
12. Affordable Warmth Network Report Katharine Eveleigh and Dale Hoyland introduced the briefing on the fuel poverty outcome and associated action plan. The Board welcomed the approach, accepted the proposed outcome and thanked both for their work on it. **ACTION:** **The Board will receive an update in a year's time, once data has been collected.** **Correction on pg. 4: '*improve energy efficiency* in Hard to Treat properties'**	 **SK** **KE/DH**

.....

13. Forward Plan The Board agreed to hold the Healthy Weight workshop in July instead of the Board meeting.	**SK**
The meeting closed at 4:00 pm.	

..... in the Chair

Date of signing

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 25th Sept 2014

Title of report: Public Involvement Network Report

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

Purpose of Report: To update HIB on main areas of focus, highlight key issues and messages from the public to inform the board and to identify forward activity.

Action Required:

Impact on Public:

Authors: Aziza Shafique and Paul McGough HIB PIN lay representatives

Aziza Shafique – summary

1. **Asian Women's Group Healthwatch Oxfordshire (Separate report)**

2. **Asian Community Women's Group Research Focus Group for Public Health**

   Six focus group meetings with Asian women group - held in Children's centre in Rose Hill and Cowley.

- 42 women were over 40 and under 60 years of age
- 39 women had not heard of NHS Health Check and had not been invited
- Very high diabetes levels identified: 31 women out of 42 - had type 2 diabetes, and were on medication for it – so therefore were not eligible for NHS Health Check.
- All of the women had family members over 40 years of age and said they had not received an invitation for health checks
- The discussions led in to individual GP attitudes to their patients and health advice they receive.
- A need for dieticians was identified to work in communities offering advice and information on diets: e.g. sugar, salt, and fat content of food – and strategies to modify food and ingredient choice whilst keeping food tasty. The idea of cooking demonstration was repeatedly raised.

The main discussions

These centred on how much preventative measures are in place by Public Health. Women were concerned that not much active preventative measures were in place. (i.e. awareness and access to them was low)

Themes: Lack of information, lack of women only facilities are a cause for concern in community – discourages participation in exercise and so contributes to disease and long term illness – associated with overweight and diabetes - heart disease and stroke.(Need to Link to Healthy Weight Strategy)

Conclusions

1. This needs a cultural change on how services are delivered for example make sure patients attend six months diabetes check up appointments - as well as arrange general women's wellbeing clinic - to assess their overall health and wellbeing, giving advice, offering practical recommendations accordingly.

2. A culture change for each individual family - with the support of the nurse and dieticians

3. A community approach to how health issues and messages get across

4. Public Health Education in appropriate community facilities – geared to women with families.

Paul McGough - Summary

- **NHS Health Checks** – (refer to 2 separate summaries - one from Aziza (above) the other from Paul. (**refer to Appendix 1**) NHS Health check awareness event).

- **Mental Wellbeing Community Forum** – a follow on event is being planned - to the Muslim Faith & Wellbeing Workshop (held at Regal Community Centre 29th April). Planning meeting being set up by Chairman of Community Forum to meet with Dr A Hameed Latifi – Consultant Psychiatrist (Afghanistan). **Aziza Shafique** & **Paul McGough**.

- **NHS Health Checks (subject to discussion) may be included as part of the same meeting above – if so it may become a Mental Wellbeing and Physical Health Forum?)** Possibly with GP speaker alongside Psychiatrist. Plus open forum to probe issues – including improving uptake and delivery of NHS Health Check service.

- **Health Inequalities - Donnington Health Centre & Rose Hill Development Consultation meetings held** - with NHS England Thames Valley Area Team, Oxfordshire Clinical Commissioning Group, the GP Practice, Community Forum representatives. **Key issue** centres on community need for **Urdu speaking GP**. **Next steps** – **Workshop** to be arranged in autumn by Thames Valley Area team - to which minority ethnic groups and stakeholders are to be invited – including Public Involvement Network and community representatives.

- **Older People's Partnership Board - Open meeting on Integration of care -** attended 3 June 2014– (minutes available through Lynn Smith; Oxfordshire County Council)

- **Public Forum - for Patients and Carers to discuss dementia and mental health services** in North Oxfordshire Locality Group (Chipping Norton) & **focus on how to create dementia friendly communities**. Attended 18 June.

- **Housing Related Support** – **Workshop 29th May** - Health Improvement Board proposal – discussion in closed meeting.

- **Healthy Weight Strategy Workshop** – attended 2nd July

- **Oxford University Hospitals – Oxfordshire County Council - Joint Public Health Steering Committee** – 24th July Attended 1st meeting (refer to forward activity section)

- **Infection theme – Antibiotic Resistance – Health Protection Research Unit - Research Priority Group** –. Reviewed research business plan, grant applications, attend Management Group and Public Patient consultations.

Forward plan:

Core activity:

- **PIN Transition to Healthwatch – future role and responsibilities to be re-defined** (discussions underway)

- **Asian community follow up projects**

- **Housing related support**

- **Older People: Frail elderly pathway, Dementia Friendly Communities**

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

- **Oxford University Hospitals – Oxfordshire County Council Joint Public Health Steering Committee - Strategy and action plan implementation.**

  Priorities Team & committee):- (for Aug Sept Oct) for discussion/report in Nov:

  - Getting the health improvement advice centre up and running;
  - Developing business case for a public health function at OUH;
  - Developing a consultation proposal for identification of longer-term priorities; and
  - Identifying opportunities in the next commissioning round.

- **Donnington Health Centre Rose Hill Developments Workshop** (autumn)

- **Input into Health Inequalities Commission**

Other activity: not Public Involvement Network

- **OUH - National Patient Staff Survey programme – Patient Public**
- **Procurement Working Group – Patient Public representative** - to review & select service provider
- **Patient leadership Task and Finish Group -** purpose is to steer the development of within OUH Trust, Oversee fact finding work about the PPI groups. Set the future partnership agenda – i.e. how the public/staff work in partnership to improve services both at clinical service level and strategically within the Trust (plus additional remits & responsibilities)

Appendix 1.

Summary: NHS Health Check awareness event: Madina Mosque Friday 25th July

- **Estimated some 350 men and boys** attended the mosque prayers **(no women)**
- **I'd prepared a one page brief for Mosque Chairman** - describing what Public Involvement Network rep did, why I was there, and gave a little background on the NHS Health check
- **No exhibition stand was available** – so I brought along my own flip chart with some basic bullet points – plus a table. Set up outside the Madina Mosque entrance and used this to raise awareness and as prompt to discussion
- **Numbers attending Mosque** - of the 350 or so folk who we greeted - I estimate we probably **spoke to about 80-100 or so**, who were in the right (40 -74) age range and eligible for the NHS health check
- **of which we spoke to 39** in sufficient detail, for 2 or 3 minutes - about the NHS health check.
- **Those who <u>were sure</u> they had received invitations, 10 men, and those who hadn't received an invitation - and we reckoned should have - from what they said about no underlying illness - was 29 men**
- **The awareness event was a success – many very good discussions** - we have since had further good feedback via the Chairman.

Conclusions:

1. **There was approximately a 1 in 3 uptake from the invitations** received (from the sample who definitively responded when asked the question, "have you been invited for an NHS health Check" with some clarification about any relevant ongoing illness - of those that confirmed they had been invited but didn't take up the offer (no numbers were recorded) - it was noted that the younger ones 40 -50 range who hadn't taken up the offer to attend - ***because they assumed they were healthy!*** The older ones tended to go - or were already in the health system for other ongoing reasons and were therefore not recorded as a "yes" or a "no". **It was the Chairman who made this valuable observation** about the younger 40 - 50 range not taking up the offer so well

2. **This underlines the value of working in partnership with faith communities on health and social care issues.**

Lessons:

- **Importance of having the Mosque Chairman there** - **Rapport** was instant - knew many personally - inviting folk over to talk, asking whether they knew about the NHS Health Check - pointing to the flip chart - we asked their age when we felt we needed to – and quickly got into conversation - typically for 2 to 3 minutes each engagement. Working as a pair it worked very well.

- **Vital to have had the support of the Imam** ahead of the event and on the day - he made a point of greeting us at the beginning and at the end – in front

of many - which was very much appreciated and contributed to the success.

- **A small exhibition stand would have been very useful** - **with key messages** alongside my personal flip chart and table with leaflets (The URDU was most popular plus English - some Bengali taken).

Discussion:

- **95% of the discussion and advise was about NHS health check** - but inevitably folk ask for some personal advice sometimes too. I kept it general, not personal, and encouraged those with specific concerns to go see their GP.

- **We briefly discussed the NHS health check - what it covered** - why it was good to have it - often I focused on diabetes saying this **is a silent illness** (a higher incidence in Asian community) saying that it often goes undetected for a while – mentioned the checks - blood pressure, family history, some lifestyle questions, a blood sample to check for diabetes and cholesterol, increased the risk of heart and vascular diseases - like stroke – if untreated –

- **Mentioned the NHS Health Check only took 20-30 minutes.**

- **Highlighted benefit of having NHS health check**, to pick up any illness early – so <u>you</u> can alter things <u>in your life</u> - <u>before</u> you do damage <u>to your</u> health and wellbeing - we gave a brief outline of some consequences of diabetes, if left undetected - heart disease, risk of stroke, kidney disease.

The Next steps:

- **There was some interest shown** (in ad hoc conversations when asked) **in favour of GPs coming out to the community to give a NHS Health Check talk** (and also about the possibly of providing NHS Health Checks in a community setting - these will be explored further)

- **There was definite interest** (from community leaders: Mosque Chairman and Imam) **in holding a follow up Community Forum - focused on Mental Wellbeing**

Appendix 2. Key messages from Public Forum - Patients and Carers discussing dementia and mental health services: North Oxfordshire Locality Group (Chipping Norton):

- **Most of dementia care is provided by relatives (estimated 90%)**
- **Uncertainty expressed on how GPs enable access to mental health and dementia support services** – The group felt this could (and should) be addressed and more work was needed on the detail of the referral pathway - and on the obligations of health and social care staff to identify and support Carers and patients.
- **Not just the responsibility of GPs -** it is multilayered, family, neighbours, Carers, Church, Age UK Mind etc. Police Community Support officers. **All Carers and support groups need greater clarity on their respective roles in relation to dementia - to help identify and signpost people to appropriate services** – keep it as simple as possible – when signposting - (not multiple) telephone numbers. Named person take the lead where appropriate and arrange support from others.
- **There is under referral to specialists** – Group not clear why - perhaps fear - avoidance of diagnosis – of getting labelled - or lack of awareness?
- **Needs a clear well publicised strategy** (a national dementia strategy was published in 2009) – however Groups were not clear on who is responsible and how to access dementia services.
- **Needs a mapping exercise** (working with stakeholders and GPs to coordinate and integrate health and social care elements of strategy and plan – care pathways, socialisation and stimulation (enjoyment).
- **Part of dementia plan will need to include outreach services** – i.e. services coming out to the community - working closely with carers - delivered at home or close to home - so there's less need to travel for dementia and other services (cancer, diabetes, heart - combined with appropriate home based e-monitoring.) integrate with domiciliary care.
- **Discussed importance of planning now for the demographic changes of elderly population with co-morbidities**
- **Social isolation** - stimulation is an issue; need to think through how to integrate services – to create local dementia support systems and networks.
- **Pivotal role of charities** in linking services – good example given of Age UK connecting people to **Community Information Network** – a new service to share information and identify people who are isolated / lonely and need help with 'little' things. Mentioned how they will assist people by providing a greater level of access to existing services, onward referral to statutory services and improvements in social contact for isolated individuals.

- **Carers Oxfordshire** – Can give a grant to Carer to have break away – "respite care for the carer" plus someone to take care of the family member. Described as "magical"

- **Face-to-Face social engagement essential** - valuable role of Cafe's, Pubs, Theatres (especially matinee sessions), some good examples mentioned – of Art clubs (use of creative activities to stimulate and engage - activities based; music, drawing, painting and memory club.

- **Integration issue:** Some good activities are reported to be taking place – but at local community level there is lack of clarity and awareness of Dementia services and support available for individuals and families. – **It is perceived to be disconnected**.

- **Oxfordshire Rural Communities Council project:** Oxfordshire Dementia Community Learning Partnership has funding for a 12 - month project **to develop Dementia Friendly Communities across Oxfordshire**. Working with Oxfordshire communities to develop volunteer-led community learning and action groups. **Looks like an excellent initiative.**

- **Questions: Who is (are) responsible and accountable for integrating all dementia initiatives**, such as Dementia Friendly Communities project - with other initiatives – to ensure access to services and community support? For delivering a coherent and integrated dementia health and social care programme?

- **Who is (are) responsible and accountable for monitoring implementation tasks and activities -** Who's responsible for co-ordinating and spreading Dementia best practice? Who's accountable for ensuring support gets to affected people - and Carers in need of support? For the creation of successful Dementia Friendly Communities and support services?

- **Request:** these questions are answered and disseminated to health and social care professionals, voluntary organisations and community networks **for communicating to the 'would be service users' in the community. Because based on this Chipping Norton Public Forum meeting – although evidence of some good initiatives - clarity of understanding and integration is currently poor.**

The Asian Women's Group

Empowering Women

The Asian Women's well-being project

Report prepared

By Aziza Shafique

June 2014

Contents

This report was produced by the Asian Women's Group with support and a grant from Healthwatch Oxfordshire. The views and recommendations set out here are those of the participants in the project. Healthwatch Oxfordshire is pleased to be able to bring them to your attention.

Acknowledgments

Foremost I would like to acknowledge the time and commitment shown by the Asian women: mothers, daughters and daughter in law carers, for giving up their time to take part in this research project. And, of course, to the single women who participated too. There were so many times when we researchers and facilitators felt the depth of feeling and courage of participants for sharing personal experiences and talking about important health and social care issues. New findings emerged, as well as findings that corroborated issues we had heard anecdotally and from other research. From these additional insights we can, together with agencies, stakeholders and local government, turn our minds and energies to innovate purposefully new ways to make things better for Asian women in Oxfordshire. Without the full support of The Asian Women's Group and Healthwatch Oxfordshire this project would not have happened. I would like to thank them for their encouragement and Healthwatch Oxfordshire, in particular, for funding this project. I had the privilege of working closely with Annie Davy, from Healthwatch Oxfordshire. The questionnaire analysis was carried out by Fiona Mullins, So Local Ltd, a social enterprise supporting community groups. Her analysis included all the tables and charts – something I hope will bring much of the data to life. I would like to thank Oxfordshire Mind and Core Assets Children's Services, and Rose Hill Children's Centre, for their ongoing support and encouragement. I would also like to thank Public Involvement Network colleagues for their comments and support. Many colleagues and co-workers provided help in many different ways, from the early stages of planning through to carrying out the research itself; most notably the facilitators and translators – I am indebted to all the Asian Women facilitators – without them this project would not have been possible. Thank you.

Aziza Shafique

Executive Summary

Background: Asian women's Health

People from Asian communities form the largest minority ethnic group in Oxfordshire and within Oxford city in particular. South Asians (Indian, Bangladeshi, Pakistani or Sri Lankan origin) can be up to six times more likely to have diabetes than the general population. Pakistani women are especially at risk. The risk of dying early from coronary heart disease is twice as high among South Asians as compared with the general population. There are many cultural dimensions to improving health and wellbeing, as there are to understanding illness, which is particular to the Asian community. The socio-economic pressures of a low income, home based, sedentary lifestyle are associated with poor diet, being over-weight and higher incidence illnesses such as diabetes and mental health issues - above the average for the general population. Cultural issues, stigmas and taboos also have an influence on how mental health issues are viewed and addressed at an individual level.

Women are the mainstay of the family – with men working long hours to support their families, often leading to a somewhat limited and isolated social interaction for women. Strong religious beliefs, duty and extended family relationships are a central part of the Asian culture and have an influence on attitudes towards and perceptions of health services.

The research

Against this background of an increasing Asian population, specific health risks and health needs, some cultural barriers surrounding access to GP services, domiciliary care, and mental health, the Asian Women's Group and Healthwatch Oxfordshire decided that a research project engaging with Asian women to probe their experiences and attitudes around these three areas was a priority.

A semi-structured qualitative-quantitative methodology was chosen, with a degree of deliberate informality. Participants took part either in the focus groups, face to face interviews or a *"What Matters to You"* questionnaire based interviews and discussions, as well as more informal forms of engagement at leisure centre talks and on a coach trip. Data was collected in four local communities by volunteer facilitators from local families in Rose Hill, Cowley, Woodfarm and Headington areas of Oxford, where there are large populations of Pakistani, Afghani, Bangladeshi and Arabic families, and also in Ruscot and Woodgreen, Banbury. Participants tended to be of working age, working part time and often had caring responsibilities as well. 28 women took part in focus groups, over 130 women took part in informal discussions and interviews on a targeted coach trip and an international women's day event. 101 women responded to a survey, in many cases with support from an interpreter. 143 women took part in the project overall.

Gross household income was mainly under £20,000; with eligibility for benefits - and most participants claiming a range of benefits, living in owned or private rented housing often with several children, parents – and/or parents in law.

Key Findings and Recommendations

General Practitioners

One significant finding of the research was that despite some dissatisfaction surrounding GP access, most Asian Women visit their GP at least monthly. GP services are by far the most frequently used health service by the majority of Asian Women.

Many women reported cultural barriers to accessing services such as feeling embarrassed talking to someone they don't know, or their husband not liking them seeing a male doctor or nurse and having to relying on a family member such as daughter or daughter-in-law mainly to act as interpreters or carers. Sometimes their children or husbands fulfilled these roles. Unfriendly receptionists at GPs surgeries and language difficulties were other barriers to access that were reported. Participants said they did not know how to complain or were not confident in doing so.

Access to Services (General Practice)

Many found initial access to all health services was either only "acceptable" or "harder than expected". Barriers to using health services included lack of transport or support, language barriers and lack of adequate information. Many women choose to travel to services where they know they will be respected and there is a cultural understanding and/or their language is spoken. This creates transport and access issues. The extended families' needs were not always considered - and in some cases greater support for husband and close family members needs to be in place.

Recommendation 1:

1. The provision of culturally aware GP surgeries and **drop-in appointments with GPs in accessible centres** with a less formal structure (e.g. clinics in appropriate community settings or children's centres), and support to **overcome the barriers Asian women face accessing GP services**, such as women feeling embarrassed by consulting with a male doctor, or practices failing to recognise the need to have Halal medication.

Mental Health

Although it is difficult to quantify from this study, many Asian families appear to suffer from mental health issues and there is a lack of support around seeking medical advice. Mental health is often seen as a taboo subject and kept hidden from extended family members and local communities. It is something "to be kept private". Race, language, culture and religion

play a big role in how mental health is perceived in some Asian communities. More support is needed to encourage women to seek medical advice.

Recommendation 2 (mental health):

The need for educational work within the Asian community **to reduce stigma and promote understanding about mental health issues**. The call is for the provision of more community outreach to:

- support women from the Asian community who have had experience of mental health issues themselves, so that they in turn **can support isolated women in their own homes** and provide information and signposting to services;
- work with the wider community and facilitate **support groups to eradicate cultural myths** around mental illness.

Domiciliary Care

Despite the increasing numbers of older people amongst the Asian population, most Asian families care for their family members themselves at home as much as possible. Daughters and daughters-in-law are the main carers for the elderly or disabled elders. The cultural expectations that an elderly family member would be cared for at home, as far as possible, poses many challenges for women carers – who usually have young families too. There are strong cultural and religious pressures to accept and taking on a caring role means the recipient of care becomes highly dependent on daughters, daughters-in-law, or wives. For this reason it appears that domiciliary care services are not as widely taken up as in the general population. However in situations where domiciliary care services are taken up, once carers and clients have built relationships and learnt to appreciate the different cultural and religious needs these domiciliary services are generally very well regarded, providing valuable support, respite and additional socialisation.

Recommendation 3:

Better information and support to enable the take up of **help available for families caring for family members at home** (including direct payments and personal budgets). There is a need for **more research to identify the needs of the disabled and elderly** and training to put culturally appropriate care packages in place.

Background

The Asian women's group is a constituted community group with 18 members on the steering group. This was developed in 2009 as a result of a needs analysis undertaken by the Rose Hill and Littlemore Children's Centre in 2006, which highlighted that Asian women in Oxford face many challenges when accessing mainstream services, and are often "hard to reach" because of social isolation, racism in communities, organisations and institutions. In addition they have the further challenges of language, cultural, religious and social barriers. The current, harsh reality is that the Asian community is often associated with poverty, deprivation, overcrowded housing, poor health and early death.

'South Asians' (a description also used to describe anyone of Indian, Bangladeshi, Pakistani or Sri Lankan origin) each have their own unique culture and background, however they all share some common health issues.

1. People from South Asian communities can be up **to six times** more likely to have diabetes than the general population. Pakistani women are especially at risk.
2. The risk of dying early from coronary heart disease is **twice as high** among South Asian groups compared with the general population.
3. Experts aren't sure why this is the case, but it may be linked to diet, lifestyle and different ways of storing fat in the body**.**

Source: http://www.nhs.uk/Livewell/SouthAsianhealth/Pages/Overview.aspx

Women from South Asian countries suffer more health issues as a result of many different life factors including poverty, educational attainment, employment, disability, housing conditions and psychosocial factors.

Large-scale surveys like the Health Survey for England in "**Disease in Different Ethnic Groups"** show that black and minority ethnic groups on the whole are more likely to report ill health, and that ill health among black and minority ethnic people starts at a younger age than in the White British population.

Source: http://www.patient.co.uk/doctor/Diseases-and-Different-Ethnic-Groups

According to Diabetes UK - Children of South Asian origin in the UK are more likely to have type 2 diabetes than their Caucasian peers. Weight gain caused by eating traditional foods high in sugar and fat, alongside Western "fast foods", is thought to be a contributing factor.

Oxford is increasingly an ethnically diverse city as shown in the changes between the 2001 and 2011 census.

- People from Asian communities form the largest minority ethnic group in the county. Most come from Indian or Pakistani backgrounds (2.45%)

- The largest Non-White ethnic groups represented in Oxford are Pakistani, Indian, Black African, 'other Asian' and Chinese ethnic groups.
- 4.8% of the population are from Asian backgrounds, twice the 2001 figure of 2.4%.
- The number of people from all ethnic groups increased, with the exception of people in the White British and White Irish ethnic groups.
- All the county's Black or Minority Ethnic communities have grown and now account for 9.2% of the population, just under double the 2001 figure of 4.9%
- 22% of residents were from a black or minority ethnic group in 2011, compared to 13% in England.
- An additional 14% of residents are from a White but non-British ethnic background. There has been a growth in this section of the community, who now account for 6.3% of the population. Much of this increase is explained by the movement of people from the countries which joined the EU in 2004 and 2007
- The child population is considerably more ethnically diverse than the older population, which is one reason why the population is expected to become even more ethnically diverse in the future.

Source: Oxford City Council Insight Ethnicity data:
http://www.oxford.gov.uk/PageRender/decC/Ethnicity_occw.htm

It is well known that Pakistani women are at greater risk of early death. Also, the death rate from coronary heart disease is higher among South Asian men and women who were born outside the UK than it is among the general population. New healthy weight advice was issued in July 2013 to South Asian adults to try to address some of the weight related lifestyle issues by the National Institute for Health and Care Excellence (NICE).

http://www.nhs.uk/Livewell/SouthAsianhealth/Pages/Overview.aspx

The reason for the research project

Against this background of an increasing Asian population in Oxford, particular community health needs, reported cultural issues surrounding access to GP services and Domiciliary Care and Mental Health, the Asian Women's Group and Healthwatch Oxfordshire decided a research project would be helpful to probe what is underlying these issues. The Asian Women's Group and the Oxfordshire Community and Voluntary Action (OCVA) 2011/2012 study on Stigma surrounding Mental Health issues within the Asian community had increased awareness amongst Asian women of mental health, and provided valuable insights into, and demonstrated the value of discussing hitherto taboo and cultural challenges.

The Asian Women's Group, in consultation with Healthwatch Oxfordshire, decided to raise awareness of health and lifestyle issues among Asian women and other ethnic minority

women, (Afghani, Arabic, Pakistani, Bangladeshi and Somali) in parallel to carrying out the Asian research project.

The aims of the Asian Women's Group (AWG);

1. To involve and include isolated women from South Asian communities to come together and learn/share their skills and values in order to build a network.

2. To promote the health and well-being of Asian women

3. To empower Asian women to support each other in challenging some of the inequalities in society.

AWG's objectives;

- To work in partnership with government and other organisations in identifying gaps and barriers and work with them to improve services to make them accessible to South Asian families.

- To run community led weekly support groups in Oxford to enable Asian/ethnic minority women to develop self-esteem and confidence

- To support and signpost Asian women to access local health services, Children's Centres, parenting groups, English as a second language classes and job centres.

Most families use health facilities on a regular basis. However, we were aware that a combination of personal, socio-economic, cultural, political and environmental barriers may discourage families from South Asian groups from accessing some mainstream health services. In addition we were aware that racial, cultural and language barriers may also contribute to the lack of understanding of the needs of Asian communities and the services they use.

The Asian Women's Group was funded by Healthwatch Oxfordshire, a new independent champion for everyone who uses health and social care services in Oxfordshire, to gather views about three priority services:

1. **Access to GP services**
2. **Mental Health Services**
3. **Domiciliary Care (Home care services)**

The information will be used to help improve services for Asian Women and to enable Healthwatch to understand what really matters in improving health services. The findings

and recommendations will be used to feed in to the current and future work of the Health and Wellbeing Board to improve the health and wellbeing of Asian Families in Oxfordshire.

The aims of the research project:

1. To seek and gather Asian Women's experiences, attitudes and views of the above three identified areas and feed these in to the Oxfordshire Health and Wellbeing Board which informs policy decisions, strategy development and programme delivery with the ultimate aim of improving health progressively and sustainably in Oxfordshire at excellent value to public.

2. To make sure data is robust and relevant and represents the public's views in an unbiased and objective way.

3. To devise and deliver an effective needs analysis which can influence commissioners to plan appropriately for the Asian Community in Oxfordshire.

This targeted work took place over a three month period, between January 2014 and March 2014.

Methodology

Data was collected in four local communities by volunteer facilitators from local families in the Rose Hill, Cowley, Woodfarm and Headington areas of Oxford, where there are large populations of Pakistani, Afghani, Bangladeshi and Arabic families.

The volunteers spoke nine languages between them such as, Urdu, Punjabi, Hindi Bangladeshi, Sylheti, Pashto, Gujarati, Farsi and English. The facilitators and all the women interviewed were all local parents living in Oxford.

Home based interviews were also carried out in two different areas in the Wood Green and Ruscote areas of Banbury with Pakistani and with Afghani women.

The methods used to capture a cross section of the Asian Women's Community views included both qualitative and quantitative tools:

- **Focus groups** (interactive group work)
- **Interviews at home** (one to one interviews)
- **Questionnaires** (one to one)
- **Discussions in Leisure Centres** (some group discussions and some one to one conversations)
- **Coach trip to Birmingham** (group discussions)
- **International Women's day** (general informal discussions)

Focus Groups

These took place over six weekly sessions, with about 2 hours for each session in two areas of Oxford City: Rose Hill and Cowley. The focus groups were run by two facilitators interpreting in four different languages (Urdu, Punjabi, Hindi and Pashto) and translating in two languages (Urdu and English) (see appendix 1 and 2).

These were interactive sessions with the facilitators prompting; probing, summarising and identifying collective themes on each topic. During the discussion 14 women took part in each focus group. Out of the 28 women who took part in the two groups all women spoke English as their second language, 12 could speak reasonable English and 16 spoke very little or were beginner learners of English.

The focus groups consisted of:

- Mothers of young children or pregnant women
- Carers of elderly relatives
- Users of services such as hospitals and local GPs
- Women who suffer from depression or anxiety
- Women from families with low incomes

Interviews in Women's Homes in Oxford and Banbury

In addition to the focus groups we carried out five interviews at home. These were carried out by two facilitators who had undertaken one to one interviews in the community. Interviews lasted between 30 minutes to one hour each. Two women were interviewed in depth about access to GP practices, two who had experienced mental health issues and one who used domiciliary care. A simple open questions approach was used:

1. How do you find access to your GP?
2. What are your thoughts around mental health services in Oxfordshire and do you use any Mental Health services?
3. Do you use carers to care for your relative (at home). If so how do you find the service?

Birmingham coach trip

The primary aim of the Birmingham coach trip was to get feedback from women using domiciliary care. Trips are always a good opportunity to share ideas, information and advice and to offer support to women and for them to offer support to each other. The Birmingham trip proved popular and was enjoyed by 42 women from different backgrounds. The trip was aimed at women who find it hard to get out of their homes and take a break due from caring for family members. Four workers assisted this trip gathering views during group and individual discussions.

International Women's day

This was a final celebration of the project. More than 90 women from diverse backgrounds took part. Conversations took place around Mental Health and Domiciliary Care.

Finding and Analysis

Questionnaires

We carried out questionnaire based discussions about women's experiences and their thoughts and feelings about the health services they use. Discussions took place in three Leisure Centres, Children Centres and in service users' homes. Most respondents were of working age: 25-40 or 40-60 years (see pie chart). We had hoped 130 questionnaires would be completed; however 29 questionnaires were given out and not returned. As a result of this we decided to adapt our approach and sit with women and help them individually as necessary to complete the questionnaires. In this way we were able to achieve 101 completed questionnaires to gather the Asian women's perspectives on all three priority areas – GP access, Mental Health and Domiciliary Care. This is approximately 1% of the total population of Asian women in Oxford (2011 census).

Analytical results

a) Information about the respondents

Most respondents were of working age: 25-40 or 40-60 years.

Table 1

Age Group	Number of respondents
18-25	19
25-40	49
40-60	25
over 60	7
Not reported	1
Total	101

The range of occupations reported ranged from full or part time employment, to full time housewife, to full time carer. Many (nearly one-quarter) have a combination of part time work, housework, and caring responsibilities.

Table 2

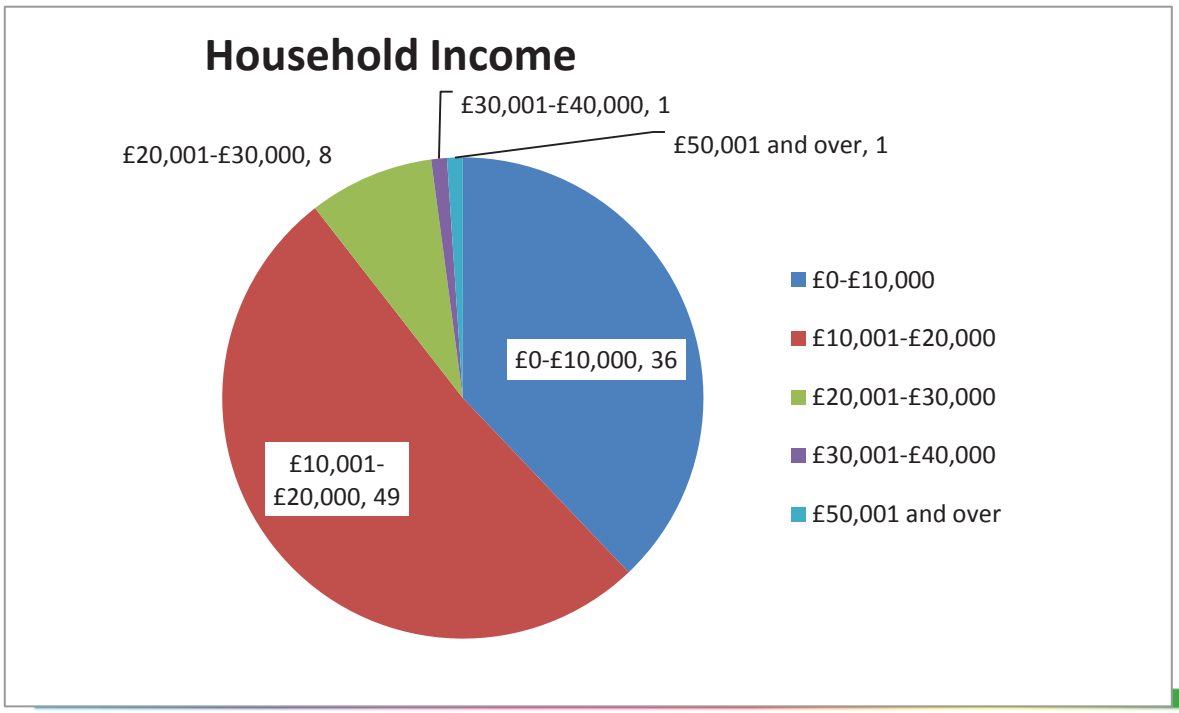
Occupation	Number of respondents
Full time	10
Part time	38
Housewife	34
Care for children or elderly	10
Other	9
Combination of work and care responsibilities	23

Nearly half of respondents reported their gross household income as being £10,000 to £20,000 per year and 36 reported household incomes under £10,000. Only 2 respondents reported a household income of over £30,000 per year.

Table 3

Household income	Number of respondents
£0-£10,000	36
£10,001-£20,000	49
£20,001-£30,000	8
£30,001-£40,000	1
£50,001 and over	1
Not reported	6

1



We undertook the questionnaire interviews in six different languages: Urdu, Punjabi, Hindi, Pashto, Bangladeshi and English. This was carried out by 4 key members in the community who were fluent in the above languages.

The data collected and the identities of the respondents were kept strictly confidential. All of the analysis is reported in aggregate form rather than as individual responses. Most (84 out of 101) respondents reported claiming benefits of some kind. 60 claim child benefit. Very few claim job seekers allowance. Over half claim a combination of benefits.

Table 4

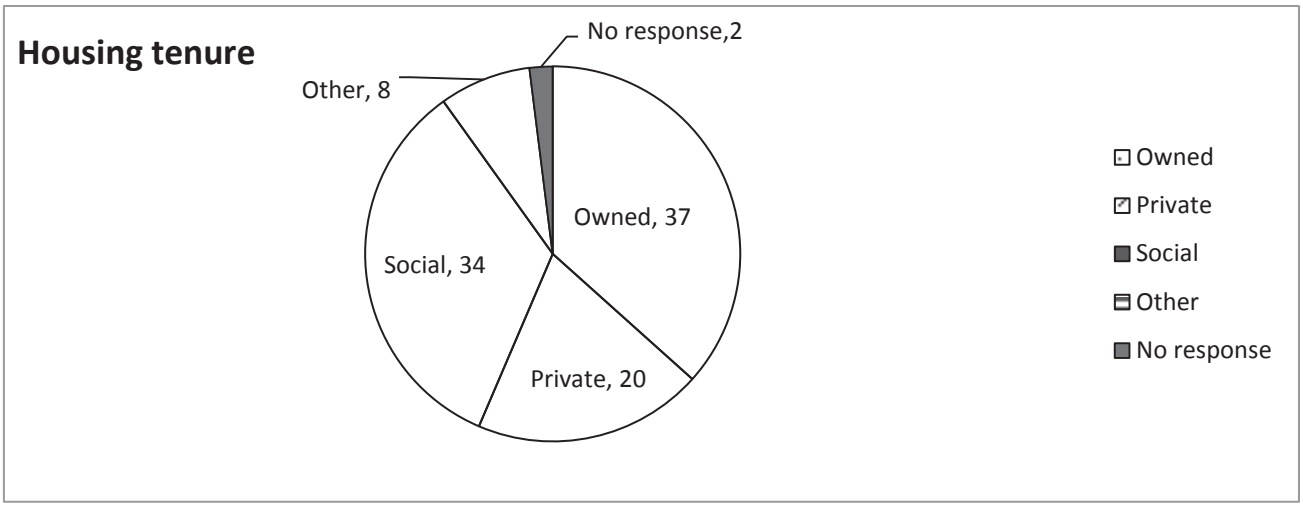
Benefit	Number of respondents
Working tax credit	47
Child benefit	60
Childcare and tax credits	11
Jobseeker's Allowance (JSA)	3
Employment and Support Allowance (ESA)	2
Pension Credit	9
Income Support	4
Disability Living Allowance (DLA)	14
Carer's Allowance	4
Combination	53

Over half of respondents (57 out of 101) live in owned or private rented housing. One third (34 out of 101) live in social housing, and 8 reported living in “other “accommodation such as with another family member.

Table 5

Housing tenure	Number of respondents
Owned	37
Private rented	20
Social	34
Other	8
No response	2

Chart 2



In summary, the respondents tended to be of working age, working part time, often with caring responsibilities as well, with a household gross income under £20,000, eligible for and claiming a range of benefits, and living in owned or private rented housing.

Access to GP Services

Through the discussions and flip chart exercises four key themes emerged, centred on:

- **Race**
- **Language**
- **Culture**
- **Religion**

The women in our groups discussed their lifestyle and social and financial issues. Most families were on a low income and the women were bringing up children on their own due to husbands working long hours and receiving low wages – all this contributed to create more stress related illness and poorer health. Some women are living in poverty, in social housing and poor conditions, often with extended families in overcrowded houses. One Asian woman explained "I've had high blood pressure and diabetes since I was 23 years old and my GP said it is due to your race and culture...I often visit my GP more than once a week and find accessing my GP practice good"

"I like my GP Practice I find it friendly and easy to access."(Appendix 3)

The discussions in both groups highlighted living standards and lack of education, contributing to poor health in women and children. Ten out of fourteen women in the group said two or more of their family members suffer from asthma, diabetes and at least one other health issue - which means more appointments and visits to GP surgeries and

hospitals. The women talked about some racist attitudes towards women by some receptionists, their first point of contact and said...

> ***"My receptionist is so rude, if we cannot get pass the receptionist what hope is there"***

Other women said

> ***"I do not know where to complain"*** **(See appendix 3)**

a) Use of health services

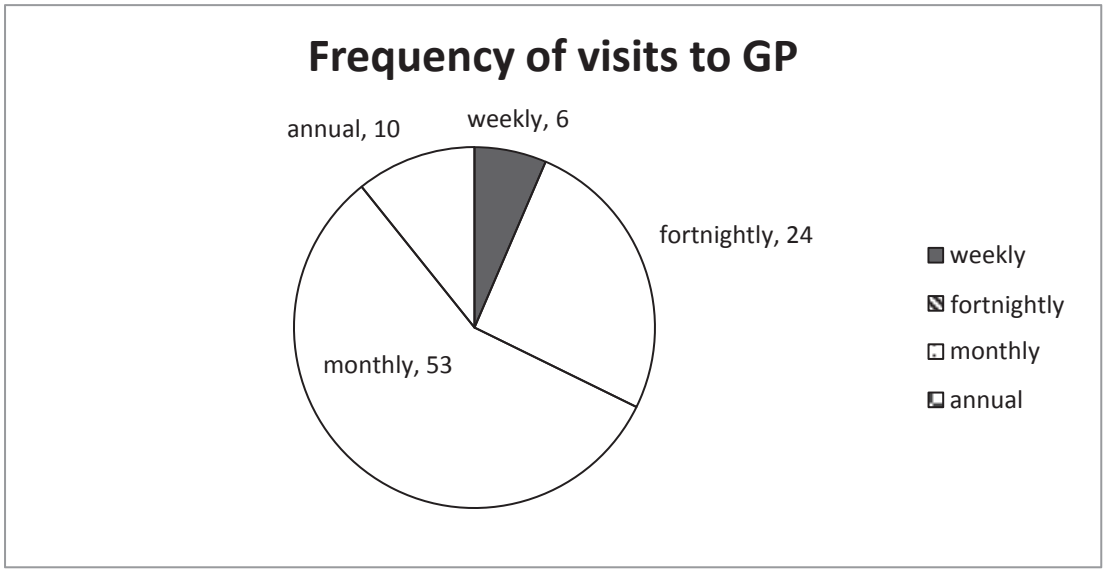
Of the 101 respondents 51 reported that they use mental health services, almost all (96) see their General Practitioner (GP), and 23 use Home Care. Many of the respondents (59) use a range of services, for example of the 96 who see their GP, 50 also reported using Mental Health services and 21 also use Home Care services.

Table 4.6

Service used	Number of respondents
Mental Health	51
GP	96
Home Care	23
Other (specific hospital services)	2
A combination of services (2, 3 or 4 services)	59

Most respondents report that they see their General Practitioner (GP) at least once a month.

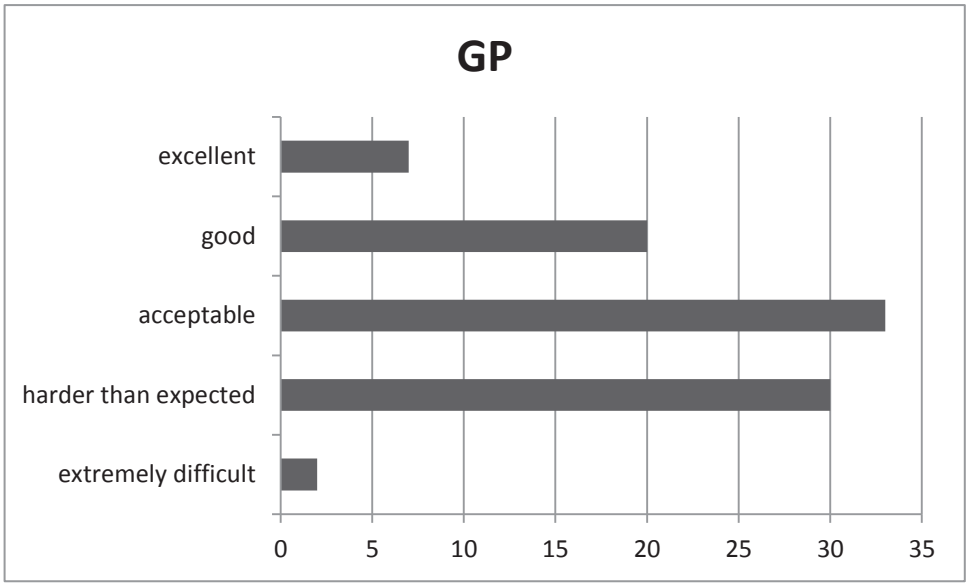
Chart 3



b) Ease of access to services

Many respondents reported that they found initial access to General Practitioner (GP) services harder than expected (30) or acceptable (33) out of the 92 responses received on this question. 20 reported that they found initial access to be good, 7 found it to be excellent and 2 found it to be extremely difficult.

Chart 4



There were too few respondents to report on ease of access to initial access Mental Health services (43 responses) and Home Care (32 responses). However, in aggregate, the responses on access across all 3 service areas showed that most respondents found initial access to be either acceptable or harder than expected

Barriers to Accessing GP Services

Geographical areas created physical barriers to accessing GP services, as most women travelled further out of their area to visit their GP surgeries. Reasons cited for doing this were:

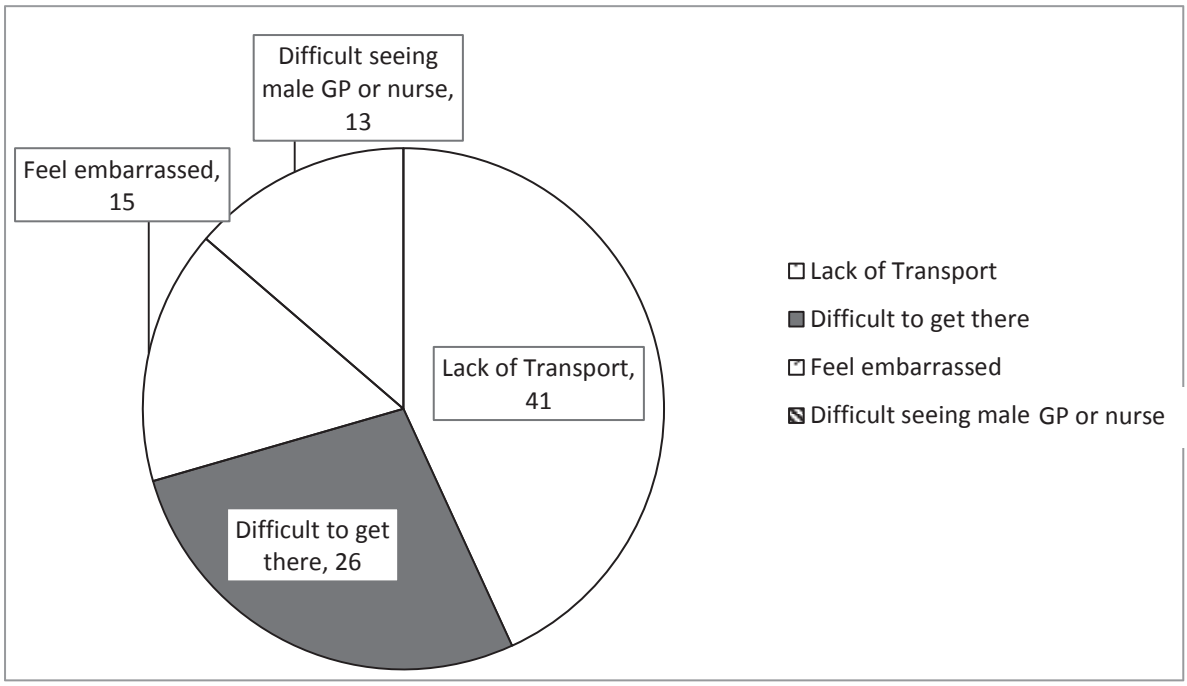
- A good relationship with their GP
- Confidence and trust in their GP
- GP coming from a similar culture
- GP speaking the same language
- GP recommended by other family member
- Feeling loyal to their GP, if they have been with them for a long time

This in itself creates additional challenges to get to the GP practices such as:

- Lack of transport to and from their homes to doctor's surgery - because most of the women do not drive
- Having to change buses to get to their GP surgeries
- Bus fares and taxis costing too much
- Not feeling like going to the surgery on their own or family barriers with regards to going out alone
- Experiences of racism and Islamophobic attitudes on the bus on the way to the doctor's surgery.

62 of the 101 respondents reported having difficulties accessing services. Many of their difficulties related to problems getting to the service, due to lack of transport (41 responses), finding it difficult to get there without support (26), feeling embarrassed talking to someone that they do not know (15), or their husband not liking them seeing a male doctor or nurse (13 responses).

Chart 5



Language Barriers

It was clear from the discussions that in most cases language was a significant barrier accessing GP surgeries because all the leaflets, flyers, posters on the wall and the appointment cards were written in English. Some women in the group could read basic English, but others could not read English. Very few women wrote and read Urdu as their first language. Some women said they use family members or husbands to interpret for them. The women felt they were not treated properly due to language barriers.

***"They don't take me seriously because of language barriers" (*see appendix 3)**

Another woman said

"I can't speak English and the receptionist does not help, very rude" (**See appendix 3)**

Most women felt that the GP surgeries do not make an effort to get interpreters from outside and expect patients to bring a family member to interpret for them. This presents the following problems:

- Women's confidentiality is compromised
- Interpreting for a family member may not accurately reflect the women's concerns or feelings
- Women may feel embarrassed to have to take children with them to interpret for personal issues
- Depending and relying on husband or other relatives to be available at the time of medical need (this often means having to wait longer for an appointment)
- It costs, time and money

Some women felt they had no choice but to take whoever was available to appointments as one woman explained,

"I had to take my 12 year old son to talk about having a hysterectomy. It was so embarrassing for both of us."

One woman explained,

"I live in an extended family with my two sisters in law, and my father and mother in law. We cannot afford to live separately as my husband is the only earner in the house. My mother in law has heart disease. When I phone up on her behalf to get an appointment in an emergency it is hard accessing my GP. I only contact a doctor when she is in pain or needs help and when my doctor's surgery do not answer the phone or get back to me, I get really frustrated. I often end up taking her to Accident and Emergency"

Another woman said,

"*Communicating with my GP is a real issue as I do not understand his language and culture and he does not understand mine, I have to rely on my husband to interpret for me."*

Cultural issues can affect many aspects of health and was highlighted in focus groups; there is a cultural difference between the majority white culture and the ethnic minority cultures. Understanding different cultures can support access to health and social care organisations. For example in some South Asian communities families live as extended families with the mothers and fathers- in-law seen as head of the family and the ones who make decisions on all aspects of the family's life. The whole family may be involved in decision making such as signing consent forms for operations, for how and when treatment should be taken and booking appointments. The other big cultural difference is that in some South Asian countries the private health care is provided and in some rural areas in Pakistan, Bangladesh and India there is no appointments system and women just informally drop in and get treated. The women talked about a number of cultural barriers when accessing GP Practices:

- The cultural expectation of the medical care in general
- Different attitudes to sexual relationships and marriages
- Different attitudes to male doctors with women patients
- Different attitudes to social life of women
- Feeling embarrassed by talking to a male doctor

Some women find formal structures, such as booking appointments, waiting for a blood test or letter from the hospital, a challenge which can lead to frustration.

Religion plays a vital role in Asian families' lives and is a way of life. Islam encourages healthy lifestyles and behaviours play a vital role. There are many health benefits to be gained by adhering to Islamic morals and ethical and ritual practice. For example, the Quran prescribes breast feeding an infant for 30 months, promotes personal hygiene, emphasizes the significance of purity and hygiene for performance of daily prayer, prescribes avoidance of intoxicating drinks and smoking and offers guidance on parenting and human rights for everyone. The body has rights and seeking medical help is seen to fulfill the rights of your body. Illness and health have a spiritual dimension and illness can be seen as divine and a test from Allah that purifies the soul.

All the women in our focus groups were Muslim and were from diverse backgrounds and cultures. We discussed how religion may be a barrier to accessing health services and the women responded that it is not a big barrier as such - but there are important facts to be aware of, for example:

- Muslims are prescribed to pray five times a day, with Friday being the special day where most Muslims have to cleanse themselves to go to their mosque to pray. Any appointments booked on Friday need to coincide with Friday prayer times.

- Muslims fast for one month for Ramadan every year, except for those who are ill, having blood transfusions, taking medicine or pregnant. Drinking any liquid during daylight is forbidden and with long summer days this can be for up to 18 hours, so access to GP practices need to be avoided during this month if at all possible and it is vital that this is considered when prescribing medication.
- Halal foods are foods that Muslims are allowed to eat or drink under Islamic Shari'ah. The criteria specify what foods are allowed, and how the food must be prepared. The foods addressed are mostly types of meat and animal tissue. The most common example of non-halal (or *haram*) food is pork. While pork is the only meat that cannot be eaten by Muslims at all (due to historically perceived, cultural and religious concerns around hygiene), foods other than pork can also be haram. The criteria for non-pork items include their source, the cause of the animal's death, and how it was processed.
- Most capsules tablets are made of gelatine, animal fat, which is considered haram for Muslims.
- Male circumcision is also a religious requirement for boys - usually carried out in the first year of their life.

Understanding the religious, cultural and language needs of patients can improve the health and well-being of families and will support the family to access all services provided.

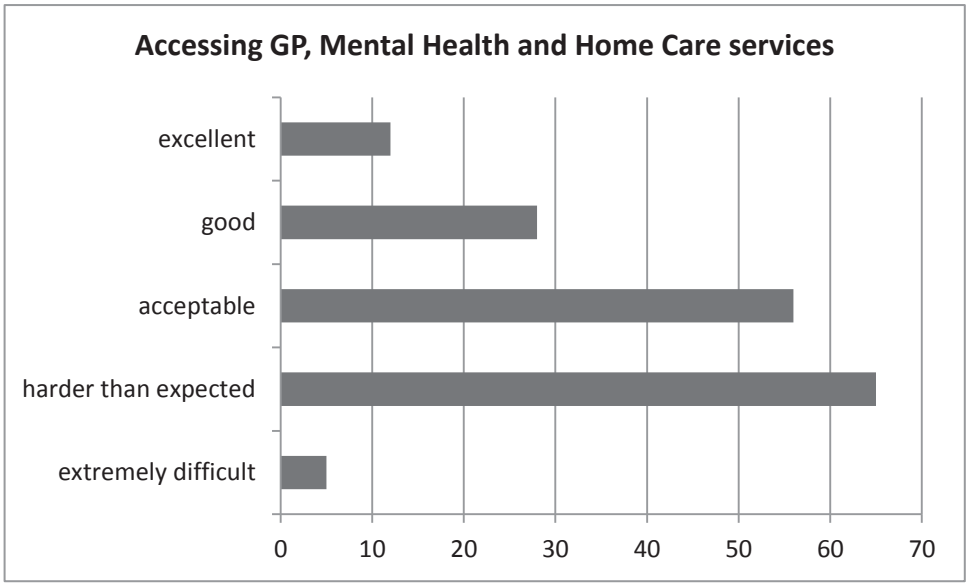
Mental Health services

Many Asian families suffer from mental health issues and lack the support needed to seek medical advice. Mental Health is a hidden issue and considered as something that is to be kept private. This is something that was strongly emphasised in the focus groups (see appendix 5).

Race, language, culture and religion play a big role in how mental health is perceived in some communities. Mental health is seen as a taboo subject, with many families trying to keep it hidden from extended family members and local communities.

The work carried out in the groups and for home interviews was carefully worded because of the sensitivity around how mental health is perceived by some Asian communities. The workers that led the group discussions and did the home interviews had previously suffered some form mental health issues themselves so they could empathise with them.

In reporting the types of mental health services that they use, only 1 respondent reported using Cognitive Behaviour Therapy, 1 reported using counselling/talking therapy, and 1 reported using some other type of service (not specified). Most respondents (69) reported using GP prescriptions (and many specified that this was for stress or depression).



The women talked about the barriers they face when suffering from depression and other forms of mental health. One woman said,

> ***"I faced additional challenges on a daily basis and was made to feel guilty and incompetent when I had depression."***

Some families are in denial of their own and maybe a family member's mental health issue. Family and community members may believe that depression, for example:

- Is something to be ashamed of and is embarrassing.
- Is not something you talk about
- Does not exist and is made up.
- Is a short term thing that will go away
- Is not something doctors can do anything about

Many mental health illnesses are seen as:

- a curse to the family
- black magic cast on the individual or family
- a spell cast on you by someone who wants to harm you
- punishment for past sins
- being a sinful person

A family member with mental health issues may often deny themselves the opportunity to go out and interact with the rest of the community and consequently they deprive

themselves of benefits of the wider learning and development that comes from networking and engagement with the rest of the society.

This means that the person suffering with mental health issues is discriminated against by their own community and the wider society and therefore faces even more isolation. One Bangladeshi woman told her story of her suffering and the stigma she faced in her own culture and the majority culture. (See appendix 5 flip chart sheets of the group's views on mental health issues)

Case study 1

"I am 36 years old Bangladeshi woman and I came to England fifteen years ago with my husband. I live in a 3 bedroom house owned by a housing association with my husband who is deaf and can't speak and my four children aged between 13 years and two years old. My husband has severe learning difficulties and is dependent on me to support him. Two of my children are also deaf but can speak enough so I can understand them. We have been on benefits all the years I have migrated to England."

..."I have learnt a few words of English but cannot communicate fluently in English and face many challenges on a daily basis to keep the family going."

..."Three years ago when I was pregnant with my last child I experienced severe depression and felt I could not cope with life any more. I often had headaches and could not get out of bed in the mornings and did not want to eat. I felt I was no use to this world and often thought of ending my life and as the days went by my feelings of taking my life became stronger and on a number of occasions my thirteen year old son stopped me from overdosing myself and he became my carer."

"I do not have any family in this country and my husband's family stigmatised me as mad and said you've got a spell on you and you should purify yourself and get on with it. I felt so lonely and hopeless."

"My husband did what he could to keep the house going, but at times would get frustrated with me saying you are putting it on. I was hoping his social worker would come and see the situation but my husband was ashamed of my actions and cancelled the appointment by my thirteen year old saying we are going away for a month."

"My doctors surgery is in a different area and the reason I chose that is because there were Bangladeshi speaking health advocates there so it made it easy for me

to explain stuff and get support but that service was finished due to cuts and I felt alone. Travelling to my doctors was a challenge because I did not drive and had to change several buses and I could not speak English."

"I rang to book an appointment with my GP and the receptionists could not understand that I needed an urgent appointment because of language barriers I got an appointment two weeks later. I was so desperate I didn't like what was going on with me - and the children did not attend school for weeks, as I had no energy to organise them and get them out of bed to go. My thirteen year old son had spoken to a Bangladeshi teaching assistant in school explaining why he had not attended school and the lack of support for me. She visited me at home and assisted me to the doctors and explained what had happened to the doctors. I was assessed straight away and was sent to psychiatric ward in hospital where I received treatment and care until I was able to come home. The children were offered support by a support worker. I received care after I came home for six months which supported me to take medication and take care of myself and my new-born baby girl. I am still getting a lot of stigma because of my depression from the Bangladeshi community, some people will say hello and do not have conversations with me because they say you have a mental issue meaning you are mad but I am strong and will carry on for the sake of my children, I have a strong faith and praying gives me strength."

This case study highlights many of the challenges of being an Asian woman with a mental health issue and the stigma and difficulties they face as a result. Furthermore a short term project carried out in 2011-2012 by the Asian Women's Group funded by Oxfordshire Community and Voluntary Action (OCVA) highlighted the prejudice and oppression experienced by women with depression and the stigma attached to Mental Health issues (see Appendix 7)

Domiciliary Care

The elderly population in the Asian community is rapidly increasing with most Asian families caring for their sick or disabled family members at home. The role of daughters and daughters-in-law is becoming increasingly important in the care of elderly or disabled elders. The cultural expectations that an elderly person would be cared for at home as far as possible pose many challenges for women who care for their elders. Most families do not access any services because they feel there is a lack of services appropriate to their culture and religion. This means the care becomes dependent on the daughter, daughter-in-law, or wife in most situations.

In some cases the support that's provided by health and social care services is taken up and much appreciated by the carers because it offers them and the client a break because it is contact with the outside world which increases wider social interaction.

On the trip to Birmingham we discussed domiciliary care in the Asian communities.

The women talked about how it feels to depend on someone for daily life and routine activities and the frustrations that comes with dependency. As one woman said,

> ***"I used to live an independent life and after my accident I depend on other people for personal care. It is so sad."***

They talked about the importance of understanding, caring and empathic carers to provide the care. One woman said,

> ***"It makes all the difference when they turn up with a smile"***

Attitudes and behaviours of care providers was the main topic on the way to Birmingham. From these discussions we identified the following issues with regards to home carers:

- Lack of cultural understanding and religious events by carers
- Need for a clear understanding about the person they care for.
- Consistency in carers as the women stated that they have different carers in and out all the time. When relationships are building with one carer "they change the staff over".
- Language and cultural barrier needs to be taken in to account
- More time needs to be spent with the carers.

On the other hand carers were also praised for:

- Being friendly and smiley
- Providing good services
- Having a flexible approach
- Having a willingness to learn about different cultures
- Trying to communicate with pictures
- Being respectful to our religion

Overall the feelings were positive towards care providers as demonstrated in this case study (see appendix 6).

Case study 2

> ***"I am a 44 year old Pakistani woman, I suffer from a severe form of Arthritis and cannot perform day to day duties for myself - therefore I am dependent on family members to care for me.***
>
> ***I live with my daughter in law who took care of all my personal care such as helping me out of bed each morning to have a wash and get changed, making my***

breakfast, lunch and dinner and doing my washing. I tried to keep active but my condition was getting worse and after a stroke... my care needs became more intense... I became bedbound. At first my daughter and daughter in law were reluctant to have outside care and were determined to care for me themselves as they felt it dishonourable and disrespectful to have outside care.

They took it in turns to share the care for four years but I could see them struggling to juggle with their own family's needs and my care needs and I was so relieved when my care manager came and talked to them about sending in carers from an agency that are employed by social services.

It took a lot of convincing and encouragement to agree to outside care so we started as a trial and thought let's see how it works out but after a while I got used to them and my daughter and daughter-in law were relieved as it allowed them to do more for their families."

"I look forward to my carers every morning; they are part of my family"

The woman acknowledged that most people do not access outside care and lack of information prevents people accessing services.

Strengths and Limitations of the Project

Strengths of the project

- The existing relationships with the women
- Delivered in local communities by local groups
- We reached 143 women in this project
- The project was delivered in five different languages including English
- Working with women in their own homes
- The staff were well known in the community and had similar experiences as the women who took part in the projects so could understand and empathise with the women
- Working in partnership with other organisations
- Used existing relationships with other organisations such Children's Centres and Oxfordshire Mind
- Shared resources with partner agencies
- The Asian women's group developed a further understanding of the issues that women face
- Potential for future work to improve health and wellbeing of Asian families

Limitations of the project were:

- The limitations of time for the project delivery. High demands on women to deliver on time.
- Being from the same community can also be a limitation
- Short term project may have raised expectations of women
- Focused only on three issues around health
- There are too few survey responses (101) and too few responses to certain questions to draw inferences that relate to the whole population of Asian woman in Oxfordshire.

Important messages from this study

General Practitioner

1.1 A person's language, culture and religion need to be considered on registration with a GP.

1.2 Cultural awareness training for all frontline staff at GP surgeries e.g. training for receptionists.

1.3 Systems put in place where a person who cannot speak English can alert the health staff and can be called back by interpreters speaking their language.

1.4 More resources needed across health and social care to provide interpretation.

1.5 General practitioners needs to be aware which medication is Halal.

Access to Services

2.1 Travel arrangements need to be considered for women who have to travel in from different areas.

2.2 GPs need to deliver surgeries in different areas so they can be accessible to women who use public transport (perhaps ways could be found to encourage GPs to hold some clinics in appropriate community centres – with sufficient privacy).

2.3 The extended family members need to be considered - and in some cases support for husbands and close family members needs to be in place.

2.4 Information needs to be translated in different languages and verbalised to women around GP access, mental health and Domiciliary Care.

Mental Health

3.1 Access to GPs needs to improve (starting with the receptionist training at GP surgeries?)

3.2 More awareness in Asian communities around Mental Health issues so that Mental Health support provided in local Asian communities by local people

3.3 Open access, early intervention approaches for women at risk of depression e.g. as a result of a major event in life

3.4 Tailor made services are needed to suit the needs of the Asian community suffering from mental issues.

3.5 Health service to provide support groups to enable the families to develop confidence and self-esteem to get support, and to challenge the prejudices and stigma in the community around mental health issues.

Domiciliary Care

4.1 More awareness of care managers for the support needed to care for the elderly.

4.2 More awareness and clarity around direct payments and how they can be used to overcome literacy barriers.

4.3 Support with paper work when offering personal budgets or direct payments.

4.4 Religious and cultural sensitivity when providing care for the elderly or disabled.

4.5 Care agencies to work closely with Asian families to provide care that is tailored to the needs of that family.

4.6 More support and information in community languages for families caring for their elderly relatives at home.

Conclusions and Key Recommendations

Public health organisations need to work collaboratively with local Asian-communities, to Identify gaps and barriers in services and to support the communities. They need to:

1. Work to overcome the barriers Asian families face when accessing GP services.
2. Ensure early identification and prevention measures in place for Mental Health issues and to reduce stigma.

3. Identify needs of the disabled and elderly and put culturally appropriate care packages in place, including support with accessing services and eligible payments.

Asian women reported facing many barriers to accessing health services on a daily basis. These issues are mainly related to the location and having to travel in from different areas on public transport. In addition the women faced language, cultural and religious barriers. Language is one of main barriers in accessing their GP services, with a shortage of interpreters. GPs need to be made aware of the key issues such as women feeling embarrassed to consult with a male doctor or nurse and religious events such as fasting in the month of Ramadan and the need to have Halal food and medication.

Data from the GP questionnaire analysis shows around 50% of Asian women use GP services at least once a month – and many are prescribed antidepressant medication. This needs to be probed further with a view to looking at preventive, early intervention approaches.

Further educational work is needed within the Asian community on Mental Health to overcome the myth and stigma and give good clear information on signs to look out for and provide signposting on what to do and where to go – e.g. publicise telephone numbers where they can call someone who can speak their language to have a confidential discussion or arrange a meeting. More awareness within the health and community sectors around mental health issues in the Asian population is needed to overcome internal and external barriers. Public health services need to take more preventive Mental Health measures and have ways of identifying at risk individuals and families. Many women isolate themselves from their own communities and the wider society. Lack of awareness and community services mean women suffer in silence.

With regards to domiciliary care, lack of information about direct payments and personal budgets, and the cultural expectations of caring for elderly at home by family members create barriers to individuals accessing home care services. More needs to done to break down some of the barriers when planning services for the Asian families. Cultural awareness training and interpreter services are also needed.

In summary, there is still a long way to go for Health and Social Care services to develop the cultural awareness and work in partnership with the Asian community. There is potential capacity and expertise to be gained by working with religious institutions, voluntary groups and other cultural organisations to support the Asian community to be able to use all three services more effectively.

1. The need for educational work within the Asian community **to reduce stigma and promote understanding about mental health issues**. The call is for the provision of more community outreach to:

    - support women from the Asian community who have had experience of mental health issues themselves, so that they in turn **can support isolated women in their own homes** and provide information and signposting to services;

- work with the wider community and facilitate **support groups to eradicate cultural myths** around mental illness.

2. The provision of culturally aware GP surgeries and **drop-in appointments in accessible centres** with a less formal structure (e.g. clinics in appropriate community settings or children's centres), and support to **overcome the barriers Asian women face accessing GP services**, such as women feeling embarrassed by consulting with a male doctor, or the need to have Halal medication.

3. Better information and support to enable the take up of **help available for families caring for family members at home** (including direct payments and personal budgets). There is a need for **more research to identify the needs of the disabled and elderly** and for training to put culturally appropriate care packages in place.

End

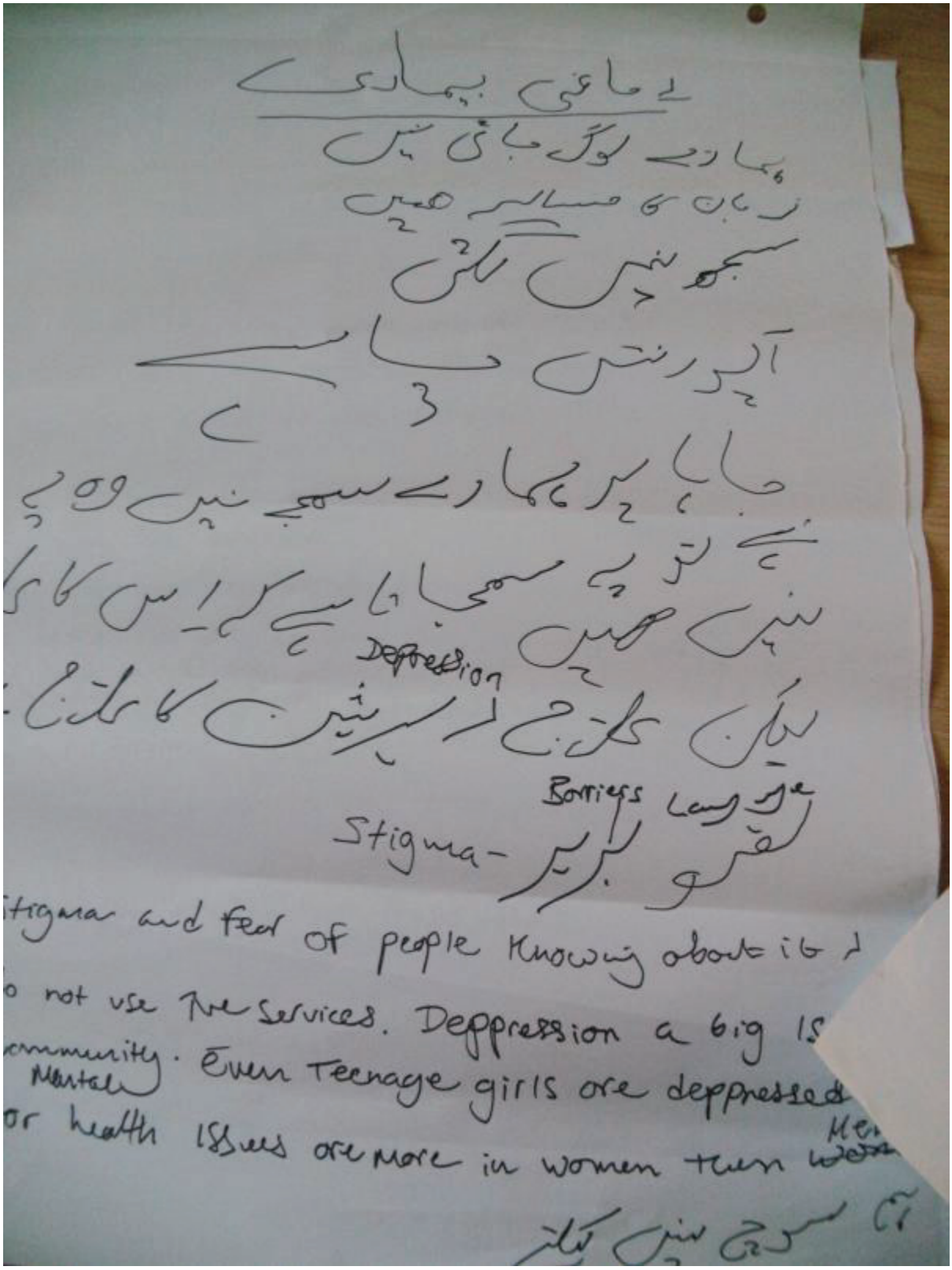
References and Bibliography

Council, O. C. (2013, May 7th). *Ethnicity statistics*. Retrieved March 02, 2014, from Communities: http://www.oxford.gov.uk/PageRender/decC/Ethnicity_occw.htm

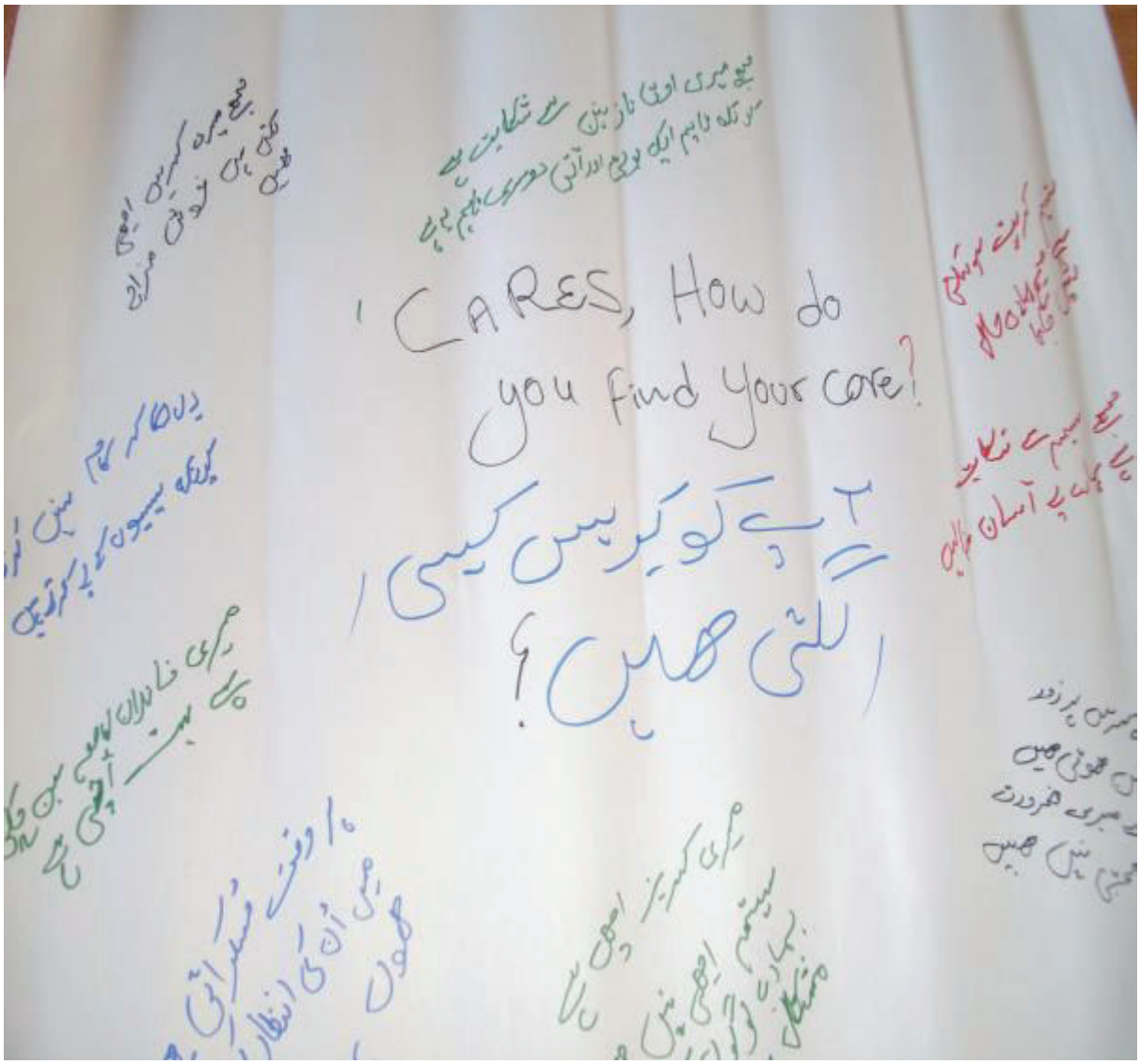
Rull, D. G. (2011, August 19). *Diseases and Different Ethnic Groups*. Retrieved March 02, 2014, from patient.co.uk: http://www.patient.co.uk/doctor/Diseases-and-Different-Ethnic-Groups.htm

South Asian Health Issues. (2014, Janaury 01). Retrieved March 02, 2014, from NHS Chioces Your Health Your chioce: http://www.nhs.uk/Livewell/SouthAsianhealth/Pages/Overview.aspx

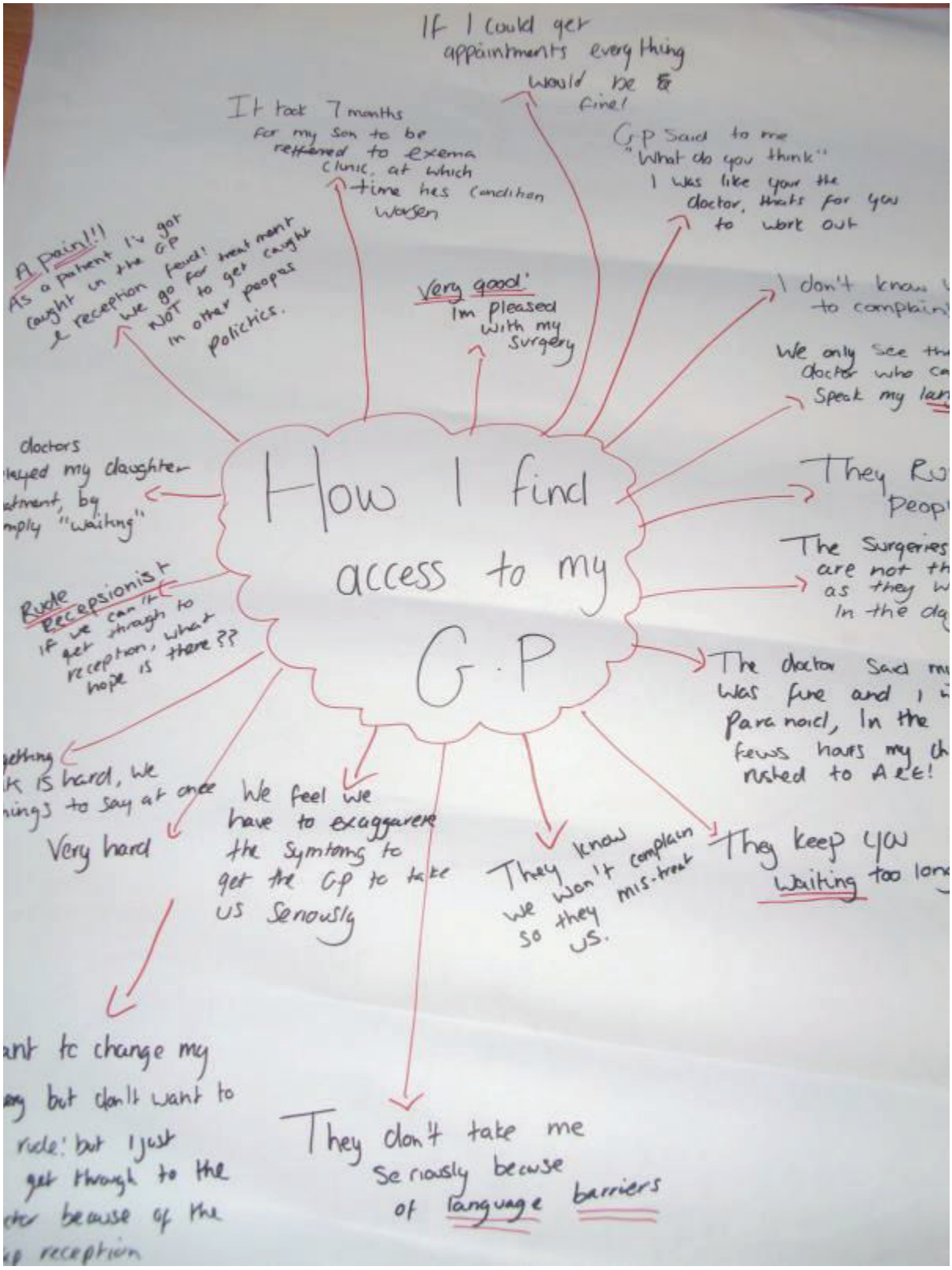
Appendices


Depression
Barriers
Stigma-
itigma and fear of people Knowing about it
o not use the services. Deppression a big is
ommunity. Even Teenage girls are deppressed
Mental
or health issues are more in women than

Appendix 1



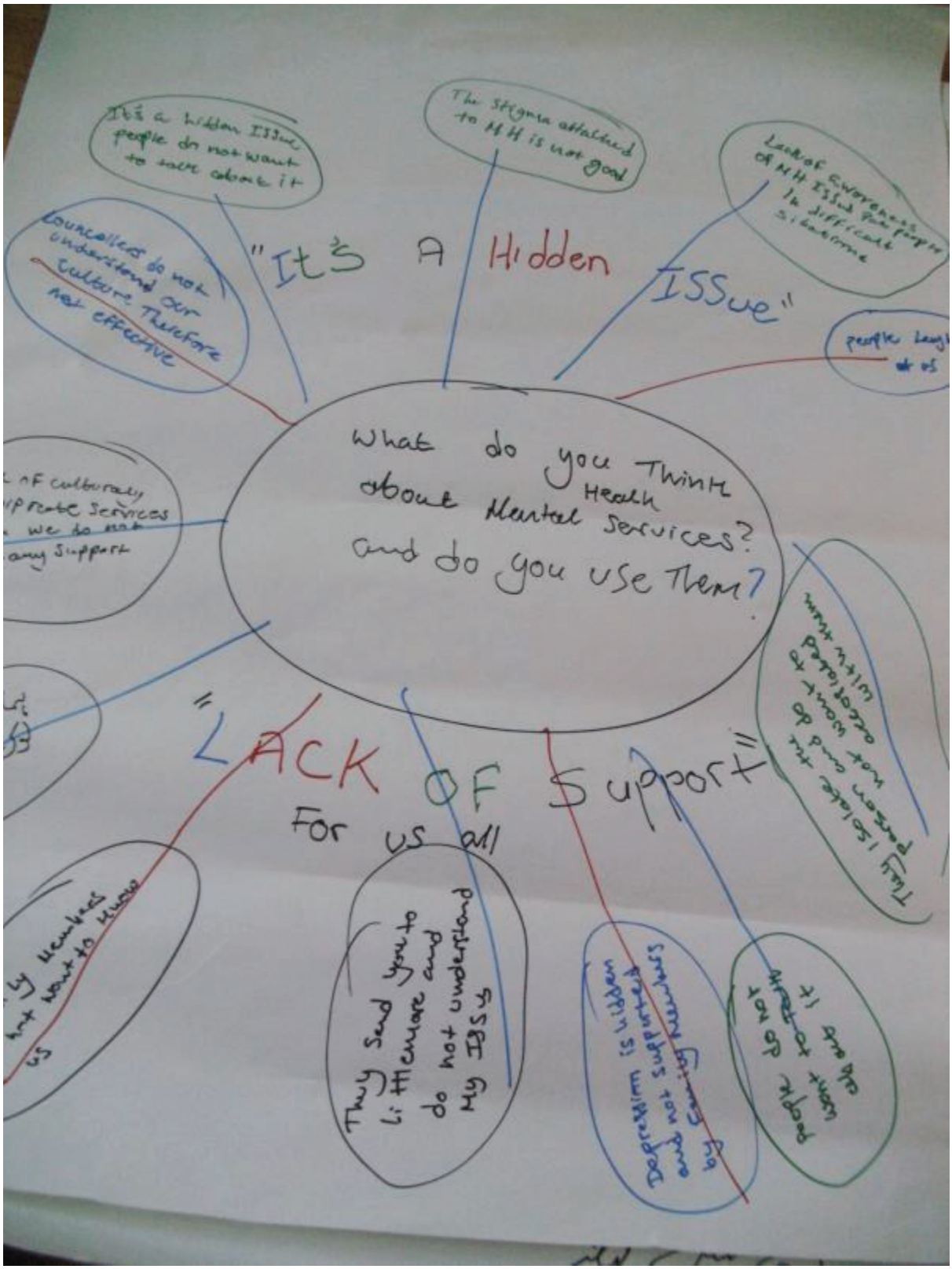
Appendix 2


How I find access to my G.P
If I could get appointments everything would be fine!
It took 7 months for my son to be referred to exema Clinic, at which time hes condition Worsen
G.P Said to me "What do you think" I was like your the doctor, thats for you to work out
A Pain!! As a patient i've got caught in the GP & reception we go for treatment NOT to get caught in other peoples politics.
Very good' Im pleased with my Surgery
I don't know to complain
We only see the doctor who can Speak my lan
They Re... peop...
The Surgeries are not th... as they w... In the da...
The doctor Said my was fine and I ... Paranoid, In the fews hours my ch... rushed to A&E!
They keep you Waiting too lon...
They know we won't complain so they mis-treat us.
We feel we have to exaggarate the Symtoms to get the GP to take us Seriously
Very hard
Rude Receptionist if we can't get through to reception, what hope is there??
doctors ...ayed my daughter ...tment, by ...mply "waiting"
...ant to change my ...ong but don't want to ... rude' but I just ... get through to the ...ctor because of the ... reception
They don't take me Seriously because of language barriers

Appendix 3

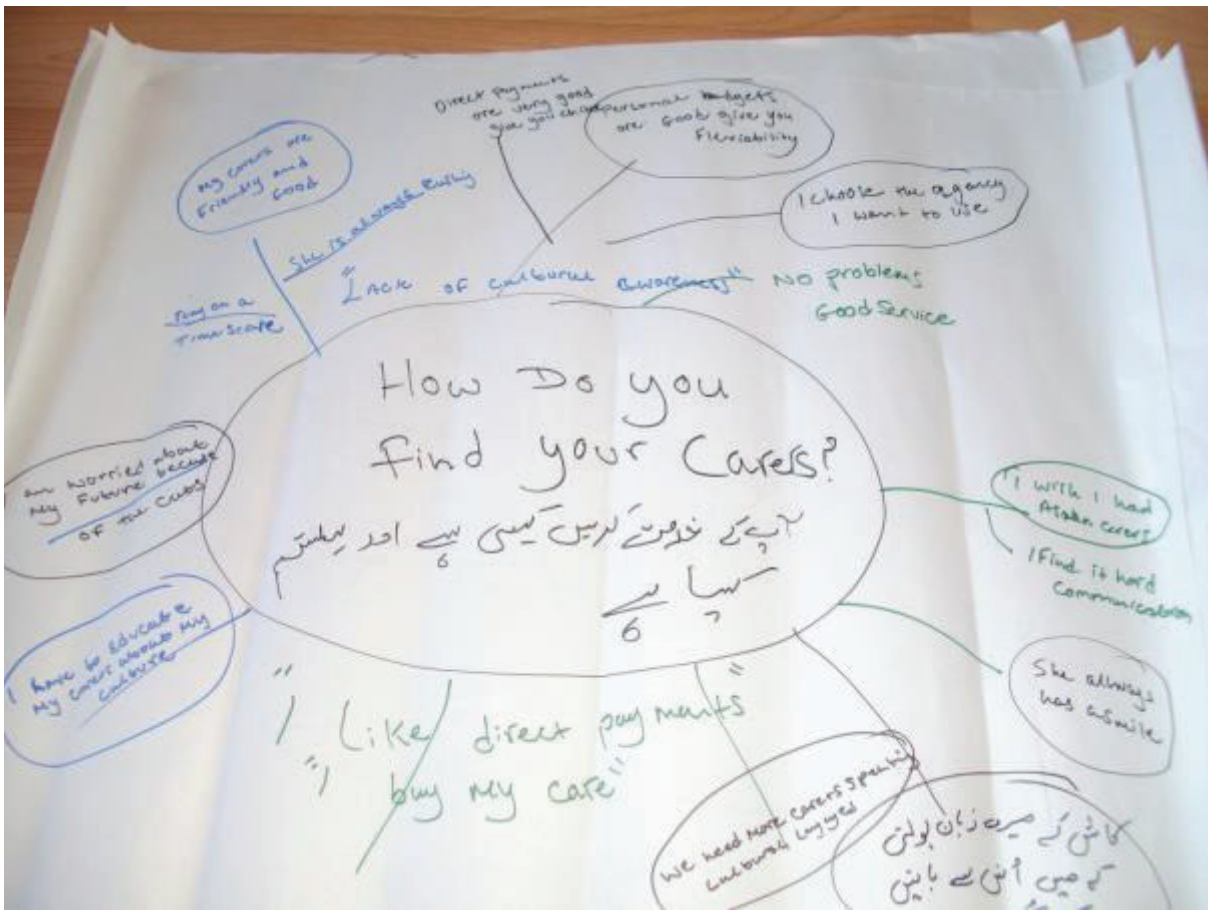

How I find access to my GP.
My receptionist is so rude I do want to call my Surgery
access to GP is so hard it's a mission to get through
I can't speak English and the practice do not help v rude!
My GP practice is good and Friendly
I do not know the system to complain
Lack of Good doctors and Friendly receptionists in Oxford
My GP practice offers one hour that no one picks up
I see a different doctor everytime I go I don't like it,
Our Surgery is all over the place nobody knows what's going on
My doctor is good if I can get
I can't communicate with my GP
Less abuse money not people
Gone out of the window

Appendix 4



Appendix 5

Also see attached Mental Health Stigma report 2012 (Appendix 7)


How Do you find your Carers?
I like direct payments "I buy my care"
Lack of cultural awareness
No problems Good Service
I choose the agency I want to use
Personal budgets are good give you Flexibility
Direct payments are very good you get choice
My carers are Friendly and Good
Stay on a time scale
I have to educate my carers about my culture
I am worried about my future because of the cuts
I wish I had Asian carers
I find it hard Communication
She always has a smile
We need more carers speaking Urdu and Punjabi

Appendix 6

Oxfordshire Community and Voluntary Action

Development Team

Tel: 01865 251946

Email: hilary.burr@ocva.org.uk

Mental Health Anti-Stigma Project

Registered Charity No.1108504 Company No. 5363946
Registered address: The Old Court House, Floyds Row, St. Aldates, Oxford, OX1 1SS. Tel: 01865 251946

End of Project Report Form

Please complete this form with reference to your own project plan. If you have any questions or concerns, please contact the OCVA Development Team.

1. Name of Organisation
The Asian Women's Group
2. Name of project
The Wonderful Women's Project
3. Aims of your project
• Raise awareness of stigma attached to mental health issues in the Asian community. 1. Highlight the prejudice and oppression experienced by women with depression. 2. Challenge some of the attitudes that prevent women talking about their experiences. 3. Breaking down barriers between women that have experienced depression and bipolar disorder and those women who have not experienced it.
4. Output Indicators
▪ *Explain briefly what happened, referring back to your project plan. Be as specific as possible. For example, if the plan said '3 workshops' - did they all take place? Where did they take place? How many people came? Etc.* ▪ *Please include an estimate of how many individual face-to-face contacts between people with differing mental health experiences occurred during the project*

The project started with two events to raise awareness of the project. The first event was in the Rose Hill area, for all the Asian community to come together and start dialogue around this taboo subject in a comfortable and welcoming environment. We had over 175 women and children come to this event.

The second event was in East Oxford a targeted approach at mother in laws and elderly women in the community. As many Asian families live in extended families and with a hierarchy in the family often the father in-law or mother-in law is the head of the family; they make the ultimate decisions in the house. Lack of understanding of the illness such as postnatal depression meant that the person suffering does not get any support instead is seen as incompetent and unable to cope with daily chores. We had over 70 mother-in laws attended and this was an interesting session. Following the two events we decided to deliver the programme in the following areas in Oxford; Rose Hill, East Oxford, Cowley, Headington and Wood farm area.

We also decided to deliver the programme in different ways as consequently families of Asian person Adult/Children. Here in Oxford tend to disengage from the rest of the community and live predominantly in self-imposed isolation. Women do not freely mix and interact with the rest of the community because they do not want their mental illness to be seen in public. Most of such women are embarrassed by their illness, women and family members and would either leave the person with the illness at home with a member of the family if there was a need to attend a social event or choose not to attend the event if it means having to come into the public domain.

To some families this is a curse and a taboo and they tend to avoid families with a known mental health issues. They tend to treat the family with disdain. Families will therefore tend to feel socially rejected and discriminated against in their own communities.

The consequences of the effects of the taboo and social stigma associated with mental health means most Asian communities:

- Mental illnesses kept hidden as far as possible and are not brought out into the public unless it is vitally necessary. This denies the person the right and ability to come into the public and be part of the community.
- The mind-set that mental illness is the result of some evil act perpetrated by the person in
- Similarly people without mental illness do not want to be associated with person with mental illness
- By withdrawing from their community and choosing not to engage with the rest of the community for fear of ridicule and discrimination. Families tend to suffer from social isolation, loneliness and associated health problems such as stress and depression for the extended family members.
- The by-product of the self-imposed social isolation is that such families are often not aware of the help available from statutory and other sources of support in the County and they tend not to access vital services that would help them.
- Families often deny themselves the opportunities to go out and interact with the rest of the community and consequently they deprive themselves of benefits of the wider learning and development that comes from networking and engagement with the rest of the society.

The sensitivity around mental health issues was identified and some careful consideration was given to the way we would deliver this project. Delivering services in the homes was vital to the success of the project in terms of getting the message across to the hard to reach women. It was agreed that the existing contacts of volunteers in the community would be used to deliver services in their homes. We delivered services in the homes in three areas; Cowley, East Oxford and Rosé Hill with weekly sessions with volunteer's often on a week day night for two hours.

This enabled the women to have discussion around:

- **The impact of feelings on day to day life**
- **Experiences leading to those feelings, Bereavement, grief of loss of family members and past and present experiences**
- **Postnatal depression and depression in general**
- **The family dynamics, break up of relationships**
- **The stigma attached to mental health**
- **Coping mechanisms**
- **No blame no shame**
- **The clinical model of depression**
- **Looking after yourself**

The engagement of 39 women took place in their homes.

Additionally there were two groups running simultaneously discussing all of the above issues using art based activities. Engaged with 65 women in both groups. We used glass painting, canvas painting, flower arranging and bracelet making, using the activities to attract women to the groups. Various discussions around mental health issues took place, such as feeling guilty for not being well, family members blaming and the shame of having mental health issues. Their discussed past and present stories of depression, some women were asylum seekers from Afghanistan and Somalia spoke about the trauma and impact on mental health, when they left their country and the experiences and prejudices in this country against them.

There were 41 women who at some point in their lives suffered depression and 21 women who stated that they have not suffered depression. We also had five sessions with the older community members such as mother-in laws and mothers. 23 women attended and had discussions around how postnatal depression impacts of the lives of a nursing mother. In total we engaged with 247 women and children through different approaches to raise awareness of mental health issues.

The last event was a celebration and a display of arts and crafts that had been displayed, fun, food, music and activities for children. We had 123 women and children came to the event with community members sharing their stories of mental health issues and how they overcome them.

Outcomes

To what extent were the project's aims achieved?

The project has achieved more than we had planned as the integration enabled families to have an insight and appreciation of the emotions and struggles of families with mental health issues and dispelled the taboo and stigma that they held against depression and other mental health.

- The integration offered the women an opportunity to freely interact with other women. This also helped families to dispel previously held myths and misconceptions about mental health and the taboo associated with this.
- The integration has enhanced networking and promoted friendship between the women and reduced the social isolation suffered by women.
- The integration has enhanced the self-esteem of families with mental health issues and increased their desire to integrate more with their community and become more socially active, which is good for their health and socioeconomic development.
- Discrimination and rejection of families with mental health issues within the community is reducing and this is increasing the confidence of families with metal health issues to engage with the wider community and society generally

Meetings were facilitated by the leader, in a group two trained facilitators. A trained crèche lead and two crèche assistants were always available to look after the children brought by the parents.

The growth of the Project was facilitated by a dedicated outreach volunteers who used social networks and community relations to "spread the word" and bring the leader into contact with families with mental health issues.

The leader also spent evenings and weekends in the community identifying and attending meetings of community groups to introduce the project. The leaders used personal social contacts and social networks to publicise the project and encouraged each person to recruit a minimum of five families.

The leader also attended the meetings of faith groups such as the community mosques and the meetings of Muslim groups to introduce the project and its potential benefits to the target members and the community as a whole.

The membership increased rapidly as the participants started to spread the word about the project and started to attend meetings with other families.

There has been a known increase of visits to the GP by Asian women to discuss depression and other mental health issues. One GP reported in the last year there has an increase of 15% of Asian women coming forward with depression.

Describe any unplanned outcomes or achievement

The integration has enabled families of suffering from mental issues to understand that they are no different from families without mental illness and that they are "normal" and can reach the levels of achievement attained by women who do not experience any kind of depression. This has inspired the women to aspire to further education and even consider gaining employment and many have enrolled on to English classes.

The project have a ripple effect on those communities that were hard to reach with Families discussing

mental health issues openly and are raising awareness by spreading the word and offering support in their community to women who are experiencing depression.

5. *Learning for the Future*

What further needs have been identified?

- Tailor made services are needed to suit the needs of the Asian community suffering from mental issues. We identified by working with community, in the community enable the families to develop confidence and self-esteem to get support and challenge the prejudices and stigma in the community around mental health issue.

Recommendations for Future work

- The needs of the Asian community with resources set aside for this type of work to take place in long term, to see the impact on Asian communities.
- Dealing with mental health issues or looking at it in isolation does not reflect the needs of the community. As short term project are scratching the surface and many families need intense support ,lack that support because of timing or resources.
- The added social issues such as poverty, linked to low paid jobs, social isolation, lack of resources and language and cultural barriers needs to be considered when planning any intervention around mental health. This needs carefully planned intervention and flexibility around how it can be delivered.
- The extended family members needs to consider and in some cases support for husband and close family members needs to be in place.
- Information needs to be translated in different languages as well as verbalised to women around mental health and specifically post natal depression.

What lessons have you learned for future work?

Through this project we did not anticipate the scale of the work or the needs of the Asian communities. This type of work needs longer than the time given with emotional support for workers who deliver this work.

Most Asian community do not use counselling so the workers were delivering counselling services to families who are depressed through a major life event. We as a group we could have further work with some families for another six months as there is a feeling of a team of volunteers raising some very sensitive issues and not having time and resources to deal with it , in particularly in the home programmes. There is a feeling of frustration from the volunteers on the timescale.

6. Key Impacts - have you seen any impacts from your project in the three key areas outlined below? Please explain briefly		
Increased public awareness of prejudice or discrimination against people who have experienced mental distress The project was designed around discussions around prejudices and the oppression women experience when suffering from mental illness and depression. The cultural myths around magical spells and being a curse were challenged. We discussed the discrimination women face with from family, culture and the wider society that leads to further isolation.	*Improved social contact between people with and without mental health problems* The groups and home programmes build contact with the wider communities members. As Asian women are socially isolated the groups and events gave them an opportunity to get out of the house and develop relationships and friendships. It also provided a safe environment to discuss some of the wider issues and past and present experience linked to mental health.	*Empowerment of people to speak out in positive and constructive ways on their personal experiences of living with a mental health problem* As illustrated above in the case study, the groups and home programmes enabled the women to overcome the myths and was able to discuss their experience of mental health. Many women were empowered to take positive steps in building there self-esteem and confidence and educate other women of the impact of depression.

Financial details
▪ *Please report your actual spending against the budget plan given in your application.* *Please see attached budget*

Form submitted by:	
Signed..A ..Shafique..... Print Name....Aziza Shafique..... Position in Organisation .....The.....ASIAN Women's Group.....	Date:03/02/2012

Please return this form to Hilary Burr by 31st January 2012 hilary.burr@ocva.org.uk

Healthy Weight Strategy and Action Plan

2.45
30 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Rebecca Cooper, Oxfordshire County Council

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

The Board is recommended to discuss the draft action plan (and appendices) which set out proposed activity for 2014-15. It is being developed through consultation with stakeholders and includes suggestions made by Health Improvement Board members at the April meeting and at the joint Health Improvement Board and Children and Young People's Board workshop in July. The Board is asked to approve that this action plan is developed on an ongoing basis, in partnership with stakeholders.

This item will also include a presentation from Chris Freeman on the work of the Oxfordshire Sports Partnership, in contributing to this action plan.

OXFORDSHIRE COUNTY COUNCIL

Healthy Weight Strategy 2014 - 2017

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

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

Table of Contents

1. Introduction

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

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

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

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

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

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

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

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

---

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

Why a healthy weight strategy?

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

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

Rationale for refreshing the strategy at this juncture

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

Developing the Strategy

The development of this strategy is occurring in three stages:

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

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

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

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

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

2. Background

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

The previous strategy aimed to prevent overweight and obesity in children by providing advice and group support to parents on parenting, weaning and breastfeeding. We commissioned HENRY (Health Exercise Nutrition for the Really Young) training which enables practitioners to provide 1-2-1 and group based support and expertise that empowers parent and families to make healthier choices.

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

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

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

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

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

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

This strategy has three key focus areas:

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

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

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

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

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

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

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

3. Key Focus Areas

3.1 Influencing choice, addressing social norms and cultural values

Background

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

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

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

For example:

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

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

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

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

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

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

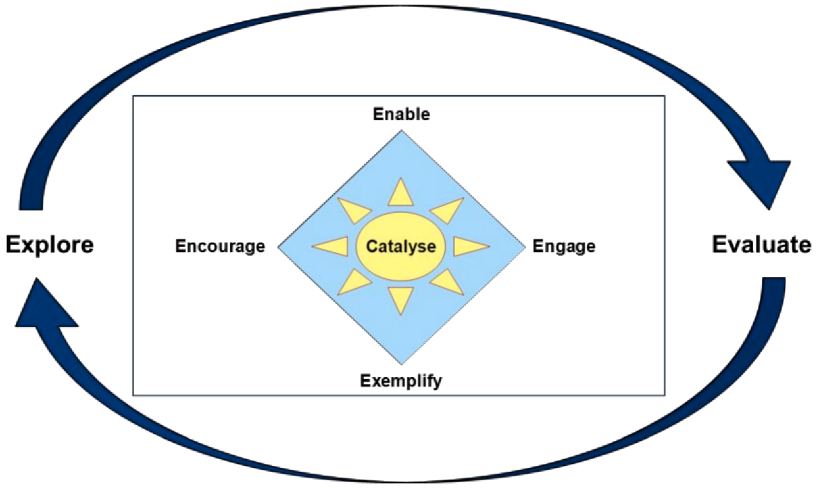
Behavioral Economics

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

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

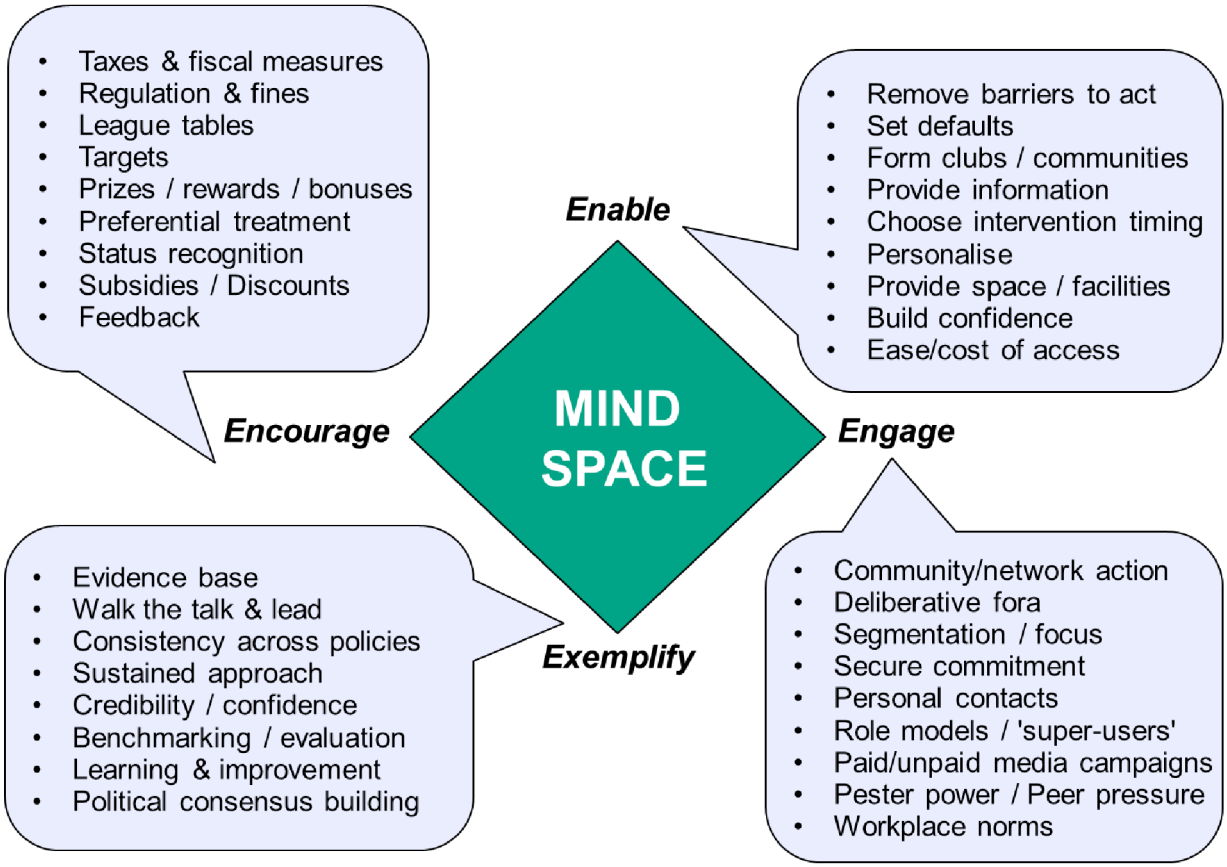
[13] Cabinet Office (2010) Applying behavioural insight to health. Available at https://www.gov.uk/government/publications/applying-behavioural-insight-to-health-behavioural-insights-team-paper

Figure 1.The 6Es policy framework



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

Figure 2: Approaches to behaviour change



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

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

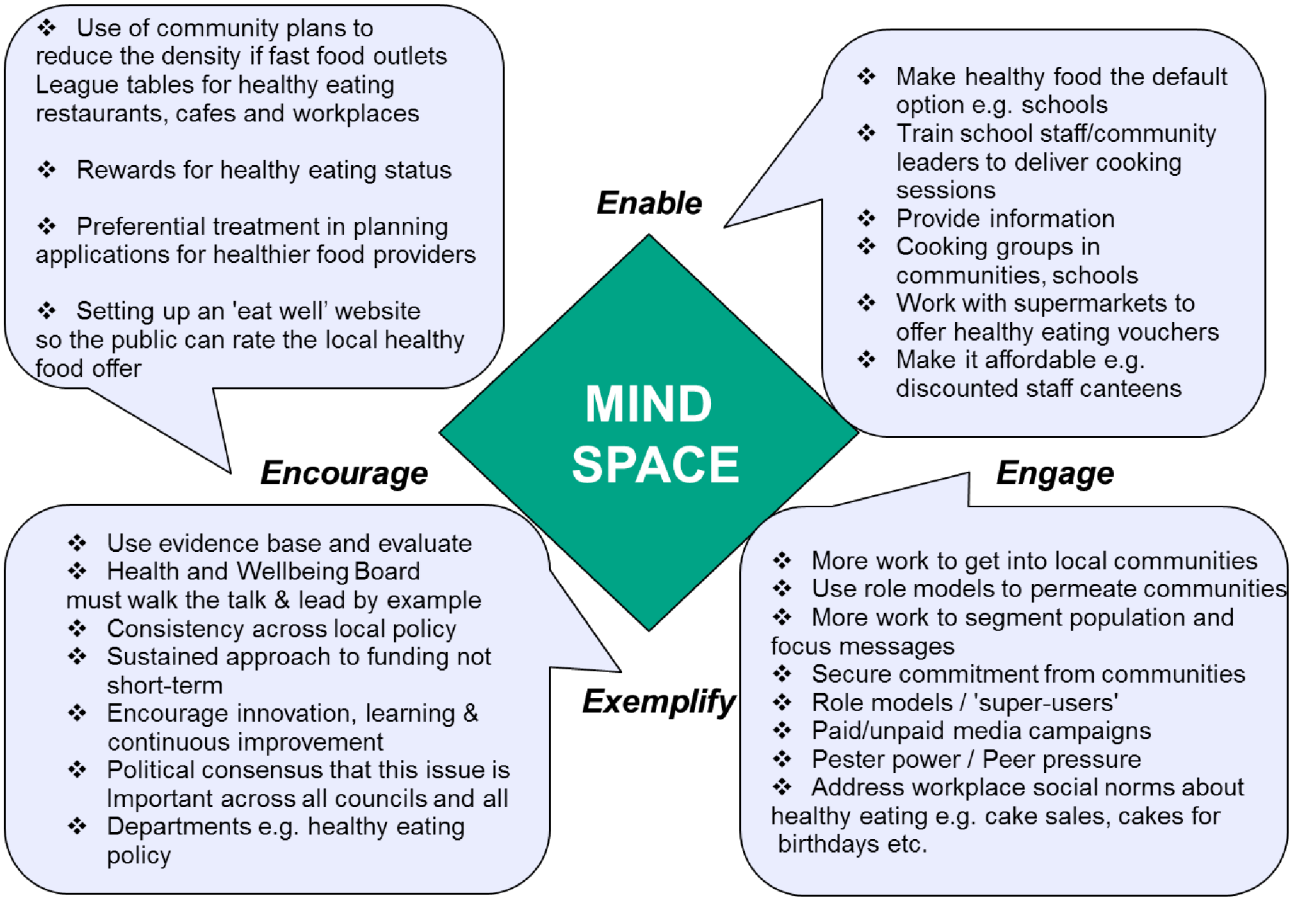
Implications for current and future work programmes

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

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

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

Figure 3. Approaches to behaviour change, Healthy Eating



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

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

Example: Go Active, Get Healthy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2 Working with partners in the Local Authority

Background

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

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

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

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

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

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

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

Working with District Councils

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

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

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

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

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

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

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

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

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

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

Planning

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

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

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

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

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

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

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

Environmental Health

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

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

Leisure Services

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

Working with the County Council

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

Transport

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

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

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

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

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

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

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

Education

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

Trading Standards

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

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

Examples of Best Practice in Local Authorities

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

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

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

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

Taking a life course approach and embedding healthy weight into the strategies and plans of partner organisations will create a golden thread of healthy weight from pre-term to later years.

Preventing obesity begins in the pre-school years, perhaps even before a child is conceived. In Oxfordshire, nearly 1 in 5 children are already overweight or obese when they begin school and evidence is now emerging that an overweight or obese mother in pregnancy is an indicator of a child's future weight. In addition, eating and physical activity behaviours in adulthood have their roots in the early years and association between parent's lifestyle and their children's has been demonstrated. The transfer of School Nursing and Health Visiting services to the County Council (Health Visiting from the autumn of 2015) presents an exciting opportunity to address this agenda more holistically, through the collaborative delivery of the Healthy Child Programme.

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

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

Source: HENRY

Early Years

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

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

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

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

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

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

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

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

Adults

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

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

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

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

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

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

4. Action Plan

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

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

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

An action plan has been produced following consultation with stakeholders. This action plan will form the basis of the healthy weight work in Oxfordshire and will be subject to annual revision and review.

Appendix 1 – Healthy Weight Service Mapping March 2014

Age	Service/Intervention	Type	Description/Size of programme	Partners	Type
Generic work across all age groups	Increase participation in physical activity, sport & active recreation	Prevention Exercise	Receive & distribute national lottery funding from Sport England – whole Oxon pop	Oxfordshire Sports Partnership	Partnership
	Encourage active travel through transport strategy	Prevention Activity	Cycling, walking use of public transport – whole Oxon pop	OCC	Partnership
	Health Weight Network	All	Provide overarching steer by co-ordinating work – whole Oxon pop	ALL	Partnership
	Change4Life campaigns	Prevention Exercise Eating	National Campaigns and initiatives – whole Oxon pop	PHE/LPH	Partnership
Pregnant women	Silver star specialist care for obese mothers	Treatment All	Specialist maternity care - approx. 800 preg women per year	OUHT	OCCG Commission
	Antenatal classes	Prevention Eating Exercise	Breastfeeding advice healthy eating in preg - approx 8000 preg women per year	OH/LPH	LAT Commission
Prenatal to 5	Maternity Service	Prevention All	Maternity care includes supporting women to start & continue breastfeeding - approx. 640 per year	OH/LPH	OCCG Commission
	Health Visiting services	Prevention All	Parenting advice, weaning, breastfeeding advice and support to all - approx. 8000 families per year	OH/Children/LPH	LAT Commission
Birth to 18 years old	Community Breast feeding Support service in areas of deprivation	Prevention Eating	Specialist support to women in areas of deprivation – 900 babies per year	OH/LAT/ Children	OCC/LPH Commission
	Early Intervention Service and Social Care	Prevention All	Provides support to children at greater risk – unknown	Districts/ OCC/OH	OCC Provider
1 – 3 years	HENRY Parenting Programme Programme	Prevention Eating	Healthy Eating & Nutrition in really young - approx 8000 families per year	OCC/LPH/ OH	LPH Commission
1 – 3 years	Breastfeeding support, healthy eating policy, parenting programmes	Prevention All	Children Centres as healthy living champions	OCC	Commission/ Provider
5 – 11 years	NCMP	Monitoring awareness	National Childhood measurement programme – 16,000 children per year	OH/Schools	OCC/ LPH Commission
5 – 16 years old	School based PE & Sport offer	Prevention All	Exercise in schools provision all school children 5 – 16	Schools/ Sports part	Partnership
	Pupil Premium for Sport & PE	Prevention All	National ring-fenced funding for primary schools	Sports part	Partnership

	School Health Nursing Services	Prevention Treatment All	Parenting advice, Healthy Eating & Exercise – all school children 5 – 16	OH/Children/OCC	OCC/LP Commission
	Reach4Health Programme	Treatment	Intensive programme to improve eating & exercise behaviours in families	OH/Children/OCC	OCC/LPH Commission
5 – 16 years old	Free swimming for Children in Oxford City	Prevention Exercise	Offered during certain time periods, all children in Oxford City	District Councils	Commission
3-16 years old	Oxfordshire Play Partnership	Prevention Exercise	Increasing opportunities for children & young people to enjoy active play	ALL	Partnership
16+	Bariatric Surgery	Treatment All	Surgical treatments for obesity Approx. 80 - 100 patients per year	OUHT/ RBFT	NCB Commission
	Adult Weight Management Service	Treatment All	Intensive programmes to support weight loss –2000 patients per year	More Life SW and WW	OCC/LPH Commission
	Dietetics Services	Treatment All	Individual referral from GP for those with LTC/Obesity	OH/More Life	OCCG Commission
	Exercise on referral	Treatment Activity	GP referrals to leisure providers	GP's/Sports part/District	Partnership
Age	**Service/Intervention**	**Type**	**Description/Size of programme**	**Partners**	**Type**
16+	GO Active	Prevention Exercise	Exercise programme which co-ordinates activity – whole Oxon population	Sports partnerships Districts	Partnership
	Active Women	Prevention Exercise	Exercise programme which co-ordinates activity for women – whole female Oxon population	Sports partnerships Districts	Commission
	GO Active, Get Healthy	Prevention Exercise	Experimental exercise programme and motivational interviewing with focus on sedentary population.	Sports Partnership LPH/ Brookes University	Commission
	Health Walks	Prevention Treatment Exercise	Walking initiatives to encourage non walkers to walk – whole adult population	Sports Partnership Districts	Partnership
	Green Gyms	Prevention Treatment Exercise	Gardening initiatives – WODC, SODC areas	District Councils Vol	Partnership
	Health checks/Disease registers	Monitoring awareness	GP identification of obesity and treatment – Oxon GP registered population	OCCG/GP's/LPH	OCC/NCB Commission
16 – 18 year olds	College Nursing Service	Prevention Treatment	Personal advice and weight management advice – 16 – 18 yr olds	OH/Children/LPH	OCC/LPH Commission
65+	Generation Games	Prevention Treatment All	Co-ordinating and development of older peoples physical activity Over 65 population of Oxon	Age UK/Leisure Providers/ Vol	OCCG Commission
	Leisure Services for Older Adults	Prevention Treatment Exercise	Exercise for the older person	Leisure Providers	District Commission

Healthy Weight Action Plan – Draft

- Action plan to run until end of 2015/2016, with mid-term review at end of current financial year (2014/2015). This will enable us to incorporate the Public Health England (PHE) Physical Activity (PA) Framework due October 2014 and the upcoming NICE guidelines *Maintaining a healthy weight and preventing excess weight gain among children and adults* (due Feb 2015)
- Preventative measures related to healthy weight will likely take a number of years before any change is obvious, and therefore looking for a 'quick fix' may not be the answer. However, there are a number of intermediate effects that can be measured. This is reflected in short and long term measures in the plan.
- This action plan is an iterative document and it is therefore expected to undergo changes as a result of both the stakeholder workshop and HIB consultation, and on-going input from the Healthy Weight Steering Group (HSWG).
- *Appendix 1* contains specific new ideas and initiatives to assist with achieving the points on the action plan

1) Influencing Choice, Addressing Social Norms & Cultural Values
Using MINDSPACE Tool of 6 Es (Explore, Enable, Encourage, Engage, Exemplify, Evaluate)

Action	*Objective(s) of Action*	*Responsible Officer and Organisation*	*Timeline (Start and End Dates, Review Dates)*	*Measurable Indicators*	*Any other information*	*Relation to Strategy*
Explore future partnership working, and commissioning of innovative PA and Nutrition programmes that have been successfully employed in neighbouring Local Authorities.	• Make available the best possible PA & Nutrition opportunities and choices for the whole of the county. Incorporate reducing the wider barriers to PA & nutrition,	Sal Culmer, Public Health (PH) Oxfordshire County Council (OCC) Other members of the PH Team Helena Fahie, PHE (Thames Valley - TV) HWSG	July 2014 – on-going Review 2015 as budget allows	*On-going*: Regular discussion/update at the Healthy Weight Steering group Liaison with PHE (TV) *Long term*: Number of new initiatives commissioned and effectiveness of their aims and objectives. *Long-term*: Number of OW/obese individuals in the population	This is on-going work as relationships are formed between other LA PH teams, and other external providers/3rd sector.	3.1 Behavioural Economics, encouraging behaviour change of population through MINDSPACE tool 3.2 Working with partners in Local Authority
Commission a pilot project in 12 schools across the county to encourage C&YP to actively travel to school.	Increase the number of school aged children meeting their daily physical activity needs,	Richard Kuziara, OCC PH	Financial year 2014/2015 – exact date TBC	*Short term:* Provider's evaluation at end of pilot project. *Long term*: Number of	Intention of these schools being able to maintain	3.1 Leading by example, creating a 'norm' of active travel through Encouragement,

	though active travel, to reduce weight and maintain a healthy weight.			children who maintain active travel to school, number of parents who change behaviour to support their children to use active travel modes NCMP reduced obesity and overweight rates	active travel for pupils work has been completed. If successful to roll out to other schools, budget pending.	Enablement, Engaging and Exemplifying the project 3.3 Taking a Life Course Approach
Making sure that healthy weight is part of the wider PH agendas. The action plan to work in collaboration with other Oxfordshire Public Health strategies which influence the wider determinants of healthy weight. This will include, but is not exclusive to; Healthy Workforce Strategy Public Mental Health Strategy Drugs and Alcohol Strategy	Outlining the wider determinants of healthy weight in ALL relevant strategies developed by the PH Directorate so that the population has as many opportunities as possible to achieve this.	Public Health Directorate, OCC Identified partners within the strategies	On-going with specified review dates per strategy and resulting action plan	*Short term*: Reviewed strategies and action plans will incorporate healthy weight action points *Long term*: Healthy weight indicators improving in target groups		3.1 Influencing choice, addressing social norms and cultural values 3.2 Working with partners in Local Authority Multi-agency approach to obesity Community engagement
Use findings of OCC commissioned research report to inform appetite of local need for the development of a Healthy Workforce network across the county to identify Health Champions. Encourage businesses to sign up to the Public Health Responsibility Deal	Ensure that workplaces encourage physical activity during and after work time, including active travel and have access to healthy eating options and initiatives at the workplace.	Public Health Directorate Oxfordshire Employers	*Jan 2015* – Recommendations for developing network *April 2015* - Set up network	*Long term*: Development of a sustainable healthy workforce network to improve healthy weight of working population within Oxfordshire. Number of businesses signed up to PH Responsibility Deal		3.1 Influencing choice, addressing social norms and cultural values 3.1 Using 6 x Es 3.2 Community engagement 3.3 Improving and maintaining health and wellbeing for the population

3.2 Working with the partners in Local Authority						
Action	*Objective(s) of Action*	*Responsible Officer and Organisation*	*Timeline (Start and End Dates, Review Dates)*	*Measurable Indicators*	*Any other information*	*Relation to Strategy*
Public Health Team to work closely with other Local Authority directorates, District Councils, NHS, 3rd Sector and other key stakeholders to provide effective information sharing, communication and planning for the future healthy weight of the County. In the first instance this will take form in the Healthy Weight steering group, to establish key relationships for future work.	Ensure the wider determinants of Healthy Weight are addressed early on in all stages of planning across all Local Authority directorates, District Council directorates, NHS and 3rd sector. To receive regular feedback from the County on current issues, success, targets, and future planning in adhering to the county's Healthy Weight Strategy.	Public Health Directorate (County) Transport/Environment & Economy (County) Environmental Health (Districts) Planning (County & Districts) Leisure (Districts) Fire and Rescue Service (County)	September 2014 – first steering group's meeting; then on-going every quarter.	*Short term*: Attendance at Steering Group by key Local Authority stakeholders for appropriate consultation on specific agenda items. *Long term*: Public Health issues are routinely considered in future Local Authority plans relating to the wider determinants of health		3.2 Working with local partners 3.2 Access to public services, open and green space, community interaction, transport, housing 3.2 Multi-agency approach to obesity 3.2 Community engagement 3.1 Influencing choice, addressing social norms and cultural values
Environment and Economy and Public Health to work together for Local Transport Plan 4; continue to develop opportunities to work together on future consultations/plans	To ensure that Active Transport/Travel is encouraged and developed within the county as widely as possible as a form of **prevention** of OW/obesity & related diseases	Richard Kuziara, HIP, PH OCC David Early, Transport Planner, E&E, OCC District Council members as identified through HWSG	July 2014 – on-going	Numbers of children and adults walking and cycling as a means of transport.	This piece of work is on-going as relationships are formed between new departments.	3.2 Prioritise the need to be physically active through daily routine 3.2 Community engagement 3.2 Multi-agency approach to obesity 3.1 Influencing choice, addressing social norms and cultural

Review the effectiveness of promotion of PA programmes available to the general county population	Ensure that current PA initiatives are being marketed and targeted to reach county population to help **prevent** unhealthy weight and reach recommended PA targets.	Toni Flanders, OSP Responsible officers from District Councils Health Improvement Principal – PH, OCC Tom White, PH OCC Sal Culmer, PH OCC	Every quarter – to be reported via PA Network meeting	*On-going:* Reports of offer and uptake of current PA initiatives across the County in relation to each District's population. Cost effectiveness of PA programmes (e.g. using the NICE Physical Activity Return on Investment Tool (*Appendix 2*) or equivalent to ascertain cost effectiveness of OSP & other PA programmes.		3.2 Multi-agency approach to obesity 3.2 Working with local partners 3.1 ***Exemplifying*** and ***Evaluating*** the projects
3.3 Embedding healthy weight into a life course approach						
Action	*Objective(s) of Action*	*Responsible Officer and Organisation*	*Timeline (Start and End Dates, Review Dates)*	*Measurable Indicators*	*Any other information*	*Relation to Strategy*
Engaging with families to explore ways of making healthy eating affordable and time manageable to all. This should include LAC. Scoping exercise on weaning and family engagement in Healthy Eating[1]	Ensuring that healthy eating is embedded into family life, so that children learn positive eating behaviours from a young age through modelling from their parents/carers. Make sure the approach is sustainable through community	Sal Culmer, PH OCC Engagement Team, OCC Early Intervention Team, CEF, OCC Partners identified through HWSG and scoping report.	Scoping report by end of March 2015	*Short-term:* Report on weaning and healthy eating for young families to be completed. Actions /recommendations from report to be disseminated to HWSG *Long-term:* Reduced obesity rates in NCMP and in adults.		3.3 Creating a healthy weight from pre-term to children in reception year and beyond (reducing obesity rates in NCMP) 3.1 Influencing choice, addressing social norms and cultural

[1] Waters et al (2011) Interventions for preventing obesity in children (review), Cochrane Library. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001871.pub3/pdf/standard

	engagement.			Greater confidence in parents ability to cook from 'scratch' and improve chance of choosing healthy option when feeding their children.		
Ensure all children's centres and nurseries in the County have a food policy that agrees to provide milk, water, fruit and healthy food to all children attending.	Give young children the best possible start in life and demonstrating	PH Team Liz Benhamou, CEF, OCC		*Short term:* Number of Children's Centres with food policy *Long term:* Healthy food and drink provided in children's centres Number of children eating fruit and reduction of the consumption of sugary drinks.		3.3 Creating a healthy weight from pre-term to children in reception year and beyond (reducing obesity rates in NCMP) 3.1 MINDSPACE 6xEs 3.2 Working with local partners
Run campaigns which specifically address topics of healthy eating, physical activity and healthy lifestyles from a young age. These should be aimed at different age range of the population, from pre-birth to older adults, and use a variety of ways of reaching these groups. In particular this should include social marketing. *Examples to date*: Eat Well, Move More Be a Star Breastfeeding	Reaching as many families as possible to raise awareness of the importance of healthy lifestyle through nutrition, healthy eating and physical activity	Public Health Directorate, OCC Partners as identified PH Team Members, OCC PH Team Members,	Campaigns to run throughout each financial year EWMM June – Sept 2014 Be a Star to run	*Short term*: Campaign evaluation reports Measures of effectiveness of social marketing used during campaigns Numbers of people using active travel for work *Long term*: Increased physical activity levels and improved dietary habits of the population. Reduced OW/obesity levels	Evaluation reports of relevant campaigns to be shared at HWSG	3.3 Taking a life course approach 3.3 Improving and maintaining health and wellbeing for the population 3.2 Working with local partners 3.1 MINDSPACE 6xEs

project Sugar Sweetened Beverages Oxfordshire Travel Challenge		OCC PH Team, OCC Oral Health Promotion Unit, Oxford Health Behavioural Change Team, PHE British Heart Foundation, University of Oxford PH Team, OCC Oxfordshire Sports Partnership	from September 2014 onwards Jan – December 2015 October 2014			
Oxfordshire agencies to continue providing specific physical activity programmes for vulnerable populations, such as physical and mental health difficulties, older adults. Review the effectiveness of these programmes and identify areas of improvement/gaps in the services. Discover if the nutritional needs of these vulnerable populations are also met through scoping exercise	Ensure that **vulnerable communities** are included in the Healthy Weight strategy and freely have access to physical activity and healthy nutrition Identify any gaps in provision of healthy eating and nutritional needs of vulnerable populations across the county.	Age UK, NHS Health Trusts (Oxford Health), OCC PH Adult Social Services Public Health Team, OCC Helena Fahie, PHE NHS Trusts	On-going Report by March 2015	*Short term*: Scoping exercise report with recommendations *Long term*: Potential to commission new projects which are aimed toward specific vulnerable groups. Increased fruit, vegetable and healthy diet intake, physical activity and reduced sedentary time in these populations.		3.3 Life course approach 3.2 Multi-agency approach to obesity 3.2 Working with local partners 3.1 Working with MINDSPACE 6xEs

Appendix 1 – Healthy Weight Strategy Group Future Ideas

Nice guidelines *'Obesity: Working with communities'*

Key points to take into account;

- Identifying and addressing barriers to access and participation, for example, by keeping costs low to ensure affordability, and by taking account of different working patterns and education levels.
- Using community resources to improve awareness of, and increase access to, interventions. For example, they involve community organisations and leaders early on in the development stage, use media, plan events or make use of festivals specific to black and minority ethnic groups.
- ensuring the strategy defines long-term goals and also includes short and intermediate measures
- cross-sector and two-tier (as appropriate) coordination and communication between transport, planning and leisure services at strategic level and better involvement of local communities in each of these policy areas
- All of the above should ensure all strategies, policies and activities that may impact on the obesity agenda (whether intended or not) are monitored in a proportionate manner. *Monitoring arrangements should be built into all relevant contracts.*

Future Ideas

The following are potential commissioning ideas for both PA and Nutrition to contribute towards healthy weight, and prevention of OW and obesity (rather than a treatment based approach). These are based on the themes that were identified during the Healthy Weight Workshop in July 2014. This also incorporates feedback from the Childhood obesity sounding board report from 2013, and the Healthy Eating Report in Aug 2014, both undertaken by the Engagement Team at OCC.

Physical Activity

Physical activity levels are lower in low-income households[1] and cost has been identified as a major barrier to PA for adults[2]. The Department of Health[3] has identified reducing sedentary time and increasing number of adults reaching a target of 150 mins of PA per week. Sedentary time is associated with increased weight gain from childhood to adulthood, including increased risk of mortality[4]. Meeting the recommended target of PA per week may help contribute towards a healthy weight[5].

---

[1] Moving More, Living More (2012) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279657/moving_living_more_inspired_2012.pdf
[2] Childhood obesity report (2013) Engagement Team, OCC (internal publication).
[3] DH (2011) Physical Activity Guidelines for Adults. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213740/dh_128145.pdf
[4] Owen et al (2011) Sedentary Behaviors and Subsequent Health Outcomes in Adults: A Systematic Review of Longitudinal Studies, 1996–2011. DOI: 10.1016/j.amepre.2011.05.004
[5] Donovon et al (2010) The ABC of Physical Activity for Health: A consensus statement from the British Association of Sport and Exercise Sciences Journal of Sport Sciences, 28(6), **DOI:** 10.1080/02640411003671212

Children aged 5-18 should be meeting 60 minutes of PA per day[6], however 40% of children watch more than 2 hours of television per day on weekdays[7] .Oxfordshire Engagement Team's report highlighted that parents found it difficult to get children away from screen viewing to go outside to play.

1) One idea is to explore future partnerships echoing successful London Borough engagement with Our Parks. This provides free physical activity classes in local parks for prevention of obesity and maintenance of healthy weight to adult populations, particularly in rural areas of the county. Initial reports from Our Parks on their boroughs indicate successful take up of the initiative with the majority of their classes being run at capacity. In addition, the Hackney Boroughs have recruited healthy weight (n=378), overweight (n=297) and obese (n=247) participants to their classes, indicating that the model has appeal and potential across both the prevention and treatment of obesity.
   OPFA are keen to be engaged in physical activity initiatives using a community centred approach that incorporates local outdoor, green spaces with physical activity, which would fit well with the Our Parks model. This initiative would give the opportunity of partnership working, with potential collaborations between District Councils, OPFA, OSP and the County Council. As well as increasing physical activity in the local population it has the potential to increase footfall to local parks and outdoor spaces and create a sense of community in these areas.

2) Commission programmes that work with local businesses to engage employees to actively commute using Active Travel Planning. This uses a sustainable model so that on-going funding is not required for many years.

3) Walking rates have dropped 30% since 1995[8]. Ideas to increase walking rates could be to use Living Streets or similar to encourage walking to work/school, and time this with 'Walk to Work month' in May 2015.

4) The Engagement Team (OCC) Obesity Report (2013) outlined that parents found it difficult to get their children to reduce screen viewing and get outside to play. Playing Out and 'Reclaiming the Street' initiatives in Bristol and Hackney aim to increase the number of children playing outside through temporary play street policy which is supported by local councils and volunteers. This model would work with other partners such as Oxford Play Association, local District councils and Fire & Rescue Service as it crosses over to engaging communities and road safety.

Nutrition

The most recent Diet and Nutrition Survey [9] indicates that the UK population over consumes saturated fat, sugar and salt, and under consumes fruit and vegetables

[6] DH (2011) Physical Activity Guidelines for Children. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213739/dh_128144.pdf
[7] Health and Social Care Information Centre (2013). Health Survey for England 2012. Volume 1: Chapter 3 – Physical activity in children. Health and Social Care Information Centre: Leeds.
[8] Department for Transport (2013) National Travel Survey, Available from:https://www.gov.uk/government/publications/national-travel-survey-2013
[9] PHE (2014)
National Diet and Nutrition Survey: Results from Years 1-4 (combined) of the Rolling Programme (2008/2009 – 2011/12) Available from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/310997/NDNS_Y1_to_4_UK_report_Executive_summary.pdf

and oily fish. When combined with exercise, a healthy diet is likely to improve health of those with overweight or obesity, and can also help to maintain a healthy weight[10]. To reduce obesity in children particularly, it has been recommended to use environments that support healthier food choices and activity, and giving parents support through professional bodies such as schools[11]

1) The research by the Engagement Team highlighted encouragement of role models such as teachers & parents/carers to eat healthy so this behaviour is modelled to children. In addition they suggested free cooking lessons so that families can learn fast food favourites. The Lighter London - Flagship Boroughs of the School Food Plan are trialling local businesses paying for schools to stay open in the evening to use schools for cooking lessons for local communities. In light of free school meals to years 1&2 pupils and many parents being time scarce, this model could work in providing and utilising specific spaces for cooking lessons. This could work in collaboration with the Children's Food Trust using the FEAST training kitchen at Rose Hill Community Centre as an example; could we roll out this model further afield across the county? This also links into the work that is currently on-going between Children Education and Families (CEF) Directorate and PH Directorate around the ethos of the Healthy School Programme.

2) Food for Life Partnership to work in schools to engage children, young people, families & communities in benefits of healthy eating and growing own vegetables for example. This has the potential for a wide reach and could potentially work with the ideas in point 1. A good local example of this is the Cropredy Primary School Farm project (details to follow). This could be expanded to be used across different primary schools across the county, as it engages school children, parents and local communities in the benefits of growing your own and healthy eating.

3) The Real Junk Food Project in Leeds engages with local business to use otherwise wasted food in a café in exchange for donations from customers. Something similar could work using Cultivate / Good Food Oxford- Feeding the Gaps to prevent food waste, engage local communities and businesses, and also work in collaboration with other district departments such as recycling, love food hate waste etc. This could also tie into reducing inequalities, food bank use, homeless shelters and the 'reducing the cycle of deprivation' work currently undertaken by Public Health Directorate.

[10] Shaw et al (2009) Exercise for overweight and obesity, Cochrane Database of Systematic Reviews, 4, DOI: 10.1002/14651858.CD003817.pub3

[11] Waters et al (2011) Interventions for preventing obesity in children, Cochrane Database of Systematic Reviews, 12, DOI: 10.1002/14651858.CD001871.pub3

Health Improvement Board

Background briefing note on the

OXFORDSHIRE SPORTS PARTNERSHIP

1. Background

The Oxfordshire Sports Partnership is one of 49 Independent County Sports Partnerships throughout England and was set up in 2004-06 by the Oxfordshire District Councils and Sport England.

In 2009 after a request by the Department of Health and partner's agreement the Partnership took on the broader remit of Physical Activity as well as sport.

2. Purpose

The purpose of the Partnership is to:

Work together to create strong, effective partnerships which will increase participation in sport and physical activity leading to improved health and well-being for the people of Oxfordshire

3. Why is this important?

In Oxfordshire according to the latest Active People survey results published in 2013:

- 116,943 people aged 16 years and older in Oxfordshire are termed sedentary
- 207,307 are not doing the recommended weekly activity by Department of Health

It is estimated in the study 'Turning the tide of inactivity' UK Active 2014 that this results in

- 1254 premature deaths per year in Oxfordshire with a
- Minimum cost to Local Authorities in Oxfordshire of £14 million per year

4. What does the Partnership aim to do?

The Partnership's vision for Oxfordshire is :

'**To be the most active and sporty community in the country by 2017**'

In practical terms our main target is to get 70,000 people more active by 2017

5. Who are the Partners and Stakeholders?

Local Authorities, Public Health, Sport England, National Governing Bodies of Sport, NHS, Schools, Universities, Clubs, Leisure providers, Voluntary Sector etc. .

6. What has been achieved?

Since the Partnership was launched in November 2006 we have moved from the 30th area in England for participation to the 4th, securing over £8 million for the County.

Since 2006 43,502 adults are now more active in Oxfordshire based on the NI8 Active people measure.

7. Further information

Can be found at the Partnership's web site at http://www.oxfordshiresport.org/

Welfare Reform Update to the Health Improvement Board, 25th September 2014

European Social Fund (ESF) Project
Bi – Monthly Update - August 2014

Programme Overview
The Welfare Reform Team (WRT) brings together a range of existing work streams in Revenues and Benefits, particularly around customers affected by Welfare Reform, and through support and training opportunities helps to bring customers in to welfare reform, or closer to the workplace.

The main work streams of the WRT are as follows:

Localised Support Services Framework (LSSF) pilot project. This part ESF funded project is building on the learning of last year's LA led pilot, supporting people with 1-2-1 casework, referrals, and training, and developing a network of local delivery partners: in the process establishing an operational LSSF as envisaged under the forthcoming Universal Credit.

Discretionary Housing Payments(DHP's). The Welfare Reform programme monitors and awards DHPs, measures expenditure and the effectiveness of short term 'conditions' that are applied to each award under the Council's DHP policy.

Key Measures
The Welfare Reform Team have a total of 113 customers active in casework as at the end of August. A further 57 customers are managed by the Discretionary Housing Payment Officer, helping customers who are further from the workplace with downsizing, reducing costs, or assisting with other methods of gaining exemption from the Benefits Cap.

25 customers have been moved into work so far this year, compared with 13 customers at the end of June.
DHP expenditure for the year is £188,928 to the end of August.
451 DHP's have been awarded from a total of 551 applications. An applicants' success rate of 82%.
DHP applications are awarded with 'conditions' of customer activity attached to each award. 'Finding Work' is the top condition attached to this year's DHPs, currently running at 40% of successful awards against an annualised target of 50%.

ESF Performance & Reporting
The ESF pilot project commenced in June and by the end of August has enrolled 80 customers into supported casework. This compares with a projected number of 130 enrolled customers for the same period. 6 ESF enrolled customers have found work so far, against a projected number of 24.

The participant numbers are lower than target for the first two months of the project. Initially the target numbers were flattened across the life of the project, whereas there has been a relatively slow take up of participants in the early stages of the project.

In addition to this there were limited availability of partner referrals and training projects which were wound down during the school holidays period. These referrals/outcomes are coming back on stream in September. WRT staff resources were also reduced over the same summer holiday period.

The number of self-referrals of customers applying directly to the WRT for DHPs are lower than hoped, as are referrals of customers who are on Jobseekers Allowance (JSA), probably as a result of the overall reduction in the number of Oxford residents claiming Housing Benefit and JSA.

The WRT are working with numerous partners, particularly the Job Centre Plus (JCP) and Citizens Advice Bureau (CAB), to actively promote the project and increase the number of participants in the project. Other initiatives have been undertaken with internal Council teams including Benefits and HomeChoice with the aim of increasing referrals of potential participants to the ESF project.

ESF Partners Network
In addition to supporting customers directly through casework meetings, WRT refer customers to a network of partners including;

- Citizens Advice Bureau. For financial inclusion training and support around managing debts.
- Job Clubs/Aspire. Referring customers who are seeking work for group and 1-2-1 coaching with work/CV specialist advice at the Job Clubs around the city.
- 1-2-1 employment advice sessions held at St Aldate's with an Employment Coach who has been seconded to the WRT from JCP.
- Workers Educational Association (WEA) run courses commissioned by WRT exclusively for our customers. After reviewing specific customer needs, WRT have run a 'Communicating With Confidence' course for customers further from the workplace, and in September WEA are commencing a 5 week course 'Preparation For Work' for customers who are closer to the workplace.

The delivery network of partners has grown to include local providers across a wide spectrum of support areas. In addition to the CAB, Job Clubs/Aspire, and WEA mentioned above the WRT are also working with/referring customers to Crisis Skylight and City of Oxford College for training, MIND, Connections, and Restore for support around Mental Health issues, and EMBS (Ethnic Minorities Business Service) for language and IT/Digital skills training.

In partnership with the JCP Oxford, the WRT are organising a Job Fair at the Town Hall on October 1st. We have invited 30+ employers who are currently recruiting to exhibit and promote their vacancies in The Assembly Room. In addition we are inviting partners to exhibit in the support/training area in the Old Library.

Communications
The WRT has an approved Communications plan, which aims to promote and create awareness of the ESF project, and the wider work of the WRT. Further to actively

encourage delivery partners and other stakeholders to refer potential participants to the project.

Recent articles have appeared in community newsletters, explaining the work of WRT and outlining the help that can offer to customers.

The forthcoming Job Fair is being marketed by postcard mailouts, emails, and calls to our existing and potential customers, and via posters at community centres, job clubs, city parks and leisure centres, and internally at the Customer Contact centres. Post cards and flyers are also being distributed via the JCP, who are inviting JSA and other claimants who are closer to work to attend.

CASE STUDIES

Recent Case Study 1

WRT - Thriving Families (Troubled Families) Joint case study

The customer came to our attention in July 2013 after the Department of Work and Pensions (DWP) applied the Benefit Cap to her Housing Benefit (HB) claim. The customer was seeing a £151.14 per week reduction in HB which was unaffordable and would make her tenancy unsustainable.

Using our established data sharing agreement, we initiated a meeting with Oxfordshire County Council's Thriving Families team and the customer. We established that the Thriving Families Team were already tackling issues the customer was already facing, such as their children's school truancy and anti-social behaviour. They were beginning to look at the customer moving into work after being unemployed since at least 1993 (when records began) which is when the Welfare Reform Team identified that the customer's only way forward to sustain her tenancy in Oxford would be to increase her income through work and become exempt from the Benefit Cap. The officers and customer agreed to work together to help her achieve this.

To further support the customer, the Welfare Reform Team helped her to complete a Discretionary Housing Payment (DHP) application. This was successful, and covered the full Benefit Cap shortfall for 3 months. The conditions within the DHP award required the customer to continue to engage with the two teams and to undertake training with the ultimate aim to find 16 hours work.

Over the second half of 2013 the customer engaged with basic employability training supplied by Thriving Families, and more enhanced support aided by the Welfare Reform Team through support from the city's Work Clubs. As a result, the customer started applying for jobs. The officers stayed in regular contact, and the DHP was renewed for a further 3 months via a verbal application due to the customer's positive activity.

When a housing benefit overpayment occurred and the customer fell into rent arrears, a "customer crisis" which had the potential to affect the customer's progress into work was averted by close and intense work by the two officers. The Social Worker led on helping the customer with her home finances, bank account issues,

gathered evidence for Housing Benefit assessment and dealt with the private sector landlord. At the same time the Welfare Reform officer communicated exactly what the benefit issues were and how to resolve them, sped up the reassessment of the Housing Benefit by working with Housing Benefit colleagues and gave advice on now to move to direct payment to landlord to control the arrears. This work stabilised the situation, avoided homelessness and allowed the customer then to refocus on the job search.

In early 2014 the customer and two officers met for a review. The customer confirmed she had attended a few interviews and had successfully found 11 hours work in a bar. While this was not enough to exempt the customer from the Benefit Cap it lowered her cap loss and saw her start work for the first time in years. We agreed to continue to keep pushing for the target of 16 hours work and the Welfare Reform Team adjusted and extended the customer's DHP accordingly.

Regular contact was maintained and a few months later the customer and social worker contacted the Welfare Reform Team officer informing them that the customer had been offered extra hours in a local school. However, they were not sure she would be better off as a result.

The Welfare Reform Team completed a 'Better Off In Work' calculation which showed the customer would be significantly better off taking the extra hours; this was also adapted to factor in changed Local Council Tax Support given a fuller picture than most calculations. As a result the customer accepted the job and the combination of jobs took her to 16 hours, qualifying her for Working Tax Credit and an exemption from the benefit cap.

This working partnership and sustained support now means that the customer no longer requires DHP and can sustain her tenancy herself.

Recent Case Study 2

The customer applied for DHP due to being effected by the Bedroom Tax. She met with an officer and identified that she wanted to sustain her 3 bed tenancy by increasing her income through work, but advised she would need support to overcome the barriers to achieving this. The team referred the customer to Skills Training UK to support her with her move into work and temporarily sustained the tenancy through a DHP payment which was tied to a condition that she must engage with the support to find employment.

Another issue stopping the customer progressing was the burden of credit card and catalogue debts, she agreed to be referred to CAB to resolve this, and this was added as a condition of the DHP. The customer worked with both partners, starting to apply for jobs in schools, enrolled on a course on working with children and found a voluntary placement at a school. We later agreed to move her to a different partnership at the Littlemore Job Club to better suit her needs. Every 3 months we would go through a renewal of the DHP where progress was taken stock, conditions checked and then updated to better reflect the next period.

After 6 months the customer was offered a part time permanent job at a local school and started claiming working tax credit this was found through the Job Club, and while she is still claiming partial housing benefit she can now afford to cover the Under Occupancy Charge herself. The CAB has helped her with a debt relief order and now is clear of all debts.

Performance Report

3.30
25 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin, Oxfordshire County Council

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

The updated Joint Health and Wellbeing Strategy 2012-16 is included for information.

Updated: 17th September 2014

Health Improvement Board
25 September 2014

Performance Report

Background

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

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

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

Current Performance

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

4. There are 7 indicators that are only reported on an annual basis and these will be reported in future reports following the release of the data.

5. For the 11 indicators that can be regularly reported on, current performance can be summarised as follows:

   5 indicators are Green.
   2 indicators are Amber (defined as within 5% of target).
   3 indicators are Red
   1 indicator does not yet have information available (completed and returned bowel screening packs). This should be available for the next meeting.

6. The 3 indicators that are currently rated as red are:
   a. 8.3 – attendance at NHS Health Checks
   b. 8.4 – quitting smoking for at least 4 weeks
   c. 8.6 – non opiate users successfully leaving treatment

   It is suggested that report cards are prepared for the next meeting on these indicators in order that the board can see the work being undertaken to address these priorities.

7. The performance report now shows the difference in performance between localities within Oxfordshire where this is available. This enables the board to understand the difference in performance throughout the county. This is currently provided for 4 indicators (8.2, 8.3, 9.3 and 10.3)

Although indicator 8.3 is rated as Red for the county, the locality figure shows that there is a wide variation in performance with 85% of people attending health checks in West Oxfordshire (significantly above the quarterly target of 46%) whereas only 31% of people in Oxford City did so.
Similarly indicator 8.2 is rated as Green for the county, however in West Oxfordshire CCG locality 3.1% of people (aged 40-74) eligible for health checks attended, this falls below the set quarterly target.

Alison Wallis
Performance & Information, Joint Commissioning
September 2014

Updated: 17th September 2014

Appendix A: Oxfordshire Health Improvement Board
Performance Report

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	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) and an equity audit should be conducted to ensure all population groups are responding	**Expected** 60% (age 60-69) 60% (age 70-74)		**Expected** 60% (age 60-69) 60% (age 70-74)		**Expected** 60% (age 60-69) 60% (age 70-74)		**Expected** 60% (age 60 -69) 60% (age 70-74)			Q1 data should be available for the next HIB meeting
NHS England		**Actual** (60-69) (70-74)		**Actual**		**Actual**		**Actual**			
8.2	Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%	**Expected** 3.75%	G	**Expected** 7.5%		**Expected** 11.25%		**Expected** 15%		Q1 South West – 7.5% West Oxfordshire – 3.1%	
OCC		**Actual** 5.4%		**Actual**		**Actual**		**Actual**			
8.3	At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)	**Expected** 46%	R	**Expected** 50%		**Expected** 58%		**Expected** 66%		Q1 West Oxfordshire – 85.3% Oxford City – 31%	
OCC		**Actual** 42%		**Actual**		**Actual**		**Actual**			

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
8.4	At least 3800 people will quit smoking for at least 4 weeks (Baseline 3622 in 13/14) Baseline women smoking in pregnancy (%) – 9% (Q4 1314)	**Expected** 868	R	**Expected** 1672		**Expected** 2574		**Expected** 3800			Women smoking in pregnancy – 8%
OCC		**Actual** **626** Women smoking in pregnancy – 8%		**Actual**		**Actual**		**Actual**			
8.5	8.6% of opiate users successfully leaving treatment by the end of 14/15 (baseline 6.5% 2013/14)	**Expected** **7.0%**	G	**Expected** **7.5%**		**Expected** **8.0%**		**Expected** **8.6%**			The number of non-opiates users successfully completing treatment is below the set target. Through the introduction of the Public Health Outcome Framework the performance measure has changed from counting drug users safely supported in services to counting those who successfully complete treatment. The current performance in Oxfordshire is being addressed with a comprehensive recovery plan with Public Health England support to develop and implement system wide action plans.
OCC		**Actual** **7.1%**		**Actual**		**Actual**		**Actual**			
8.6	38.2% of non-opiate users successfully leaving treatment by the end of 14/15 (baseline 15.5% 2013/14)	**Expected** **21.2%**	R	**Expected** **26.9%**		**Expected** **32.6%**		**Expected** **38.2%**			
OCC		**Actual** **14.5%**		**Actual**		**Actual**		**Actual**			
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% with no district population recording more than 19%. (Baseline 15.2% in 2013)			**Expected** 14.9% or less							

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
OCC				**Actual**							
9.2	Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 22.2% against 28.5% nationally, 2013-14 Active People Survey)							**Expected**			
District councils								**Actual**			
9.3	63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual health visitor locality should have a rate of less than 50%	**Expected** 63%	**A**	**Expected** 63%		**Expected** 63%		**Expected** 63%		Q1. 80.9% North Oxford/ Cumnor/ Botley 44.1% Didcot	Didcot is the only locality to fall below the 50% target
NHS England & CCG		**Actual** **60.3%**		**Actual**		**Actual**		**Actual**			

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness											
10.1 District Councils	The number of households in temporary accommodation as at 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire)							**Expected** 197 or less **Actual**			
10.2 OCC	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 83.9% in 13/14)	**Expected** 75% **Actual 91%**	G	**Expected** 75% **Actual**		**Expected** 75% **Actual**		**Expected** 75% **Actual**		The majority of people receive a service from a county wide service which means it isn't possible to accurately provide data on a locality basis	
10.3 District Councils	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 81% in 2013- 2014 when there were 2837 households known to services)	**Expected** 80% **Actual** 82%	G	**Expected** 80% **Actual**		**Expected** 80% **Actual**		**Expected** 80% **Actual**		Q1 West Oxfordshire – 89% (108/122) Vale – 79% (70/89)	

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
10.4	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. It is hoped that an aspirational baseline target of 550 households will be reached							**Expected** 550			
Affordable Warmth Network								**Actual**			
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure for 2013-14 (to be tabled at the meeting)							**Target** <74			
District Councils								**Actual**			

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 11: **Preventing infectious disease through immunisation**											
11.1	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.8%) and no CCG locality should perform below 94%	**Expected 95%**	**G**	**Expected 95%**		**Expected 95%**		**Expected 95%**		No locality information available	
NHS England		**Actual 95.2%**		**Actual**		**Actual**		**Actual**			
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 93.7%) and no CCG locality should perform below 94%	**Expected 95%**	**A**	**Expected** 95%		**Expected** 95%		**Expected** 95%		No locality information available	
NHS England		**Actual 92.6%**		**Actual**		**Actual**		**Actual**			
11.3	At least 60% of people aged under 65 in "risk groups" receive flu vaccination (baseline 55% 13/14)							**Expected** 55%			
NHS England								**Actual**			
11.4	At least 90% of young women will receive both doses of HPV vaccination. (baseline to be confirmed)							**Expected** Over 90%			
NHS England								**Actual**			

Oxfordshire's Joint Health & Wellbeing Strategy

2012 - 2016

Final Version July 2012,
Revised July 2013 and June 2014

Oxfordshire Clinical Commissioning Group

healthwatch Oxfordshire

OXFORDSHIRE COUNTY COUNCIL

CONTENTS

1. Foreword to the Revised Version of this strategy, July 2014

This revision of our joint strategy leads us into a third year of work together in Oxfordshire through the Health and Wellbeing Board. In the last year, now with statutory status, we have continued to build on the foundations we laid as a shadow board and have demonstrated progress in a wide range of areas. Working arrangements have bedded down, relationships have grown and our focus on improving health outcomes for the people of Oxfordshire has continued. Oxfordshire Healthwatch is very well established and continues to add a valuable contribution to the work of the Board.

We made good progress in 2013-14. Our approach of setting outcomes for all our Health and Wellbeing priorities and for receiving updates on performance each time we meet is working well. It has enabled us to keep our focus on the issues that matter and to drive improvement.

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

- There have been improvements in the take up of free early education for eligible 2 years olds;
- Teenage pregnancy rates continued to fall;
- The "Thriving Families" programme has worked with over 800 families;
- We took more steps forward in establishing integrated, patient-centred services;
- The number of hospital admissions for acute conditions that would not normally require hospital admission fell for people of all ages.
- Work to reduce obesity and maintain a healthy weight has gathered momentum;
- More people with long term conditions received their winter flu immunisations;
- Even more people have quit smoking this year in Oxfordshire – still one of the best ways to improve your life expectancy;
- The Public Involvement representatives have brought a useful perspective to discussions in all the partnership boards.

However, we still have more to do. This revised strategy sets out our renewed intentions for the year ahead. We have proposed outcome measures so that we can continue to monitor improvements in 2014-15. We will hold each other to account, expect good results and continue to strive for good quality in all health and social care services.

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

Dr Joe McManners, Vice Chairman of the Board
Clinical Chair of the Oxfordshire Clinical Commissioning Group

2. Introduction

A Health and Wellbeing Board was set up in Oxfordshire to make a measurable difference to the health and wellbeing of its people. Oxfordshire has a rich history of partnership working which strives to improve the health of Oxfordshire's people and the care they are offered. This Board was, therefore, very much the next logical step for Oxfordshire to take, and through it we also fulfil a key requirement of the Health and Social Care Act (2012).

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

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

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

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

3. Vision

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

By 2016 in Oxfordshire:

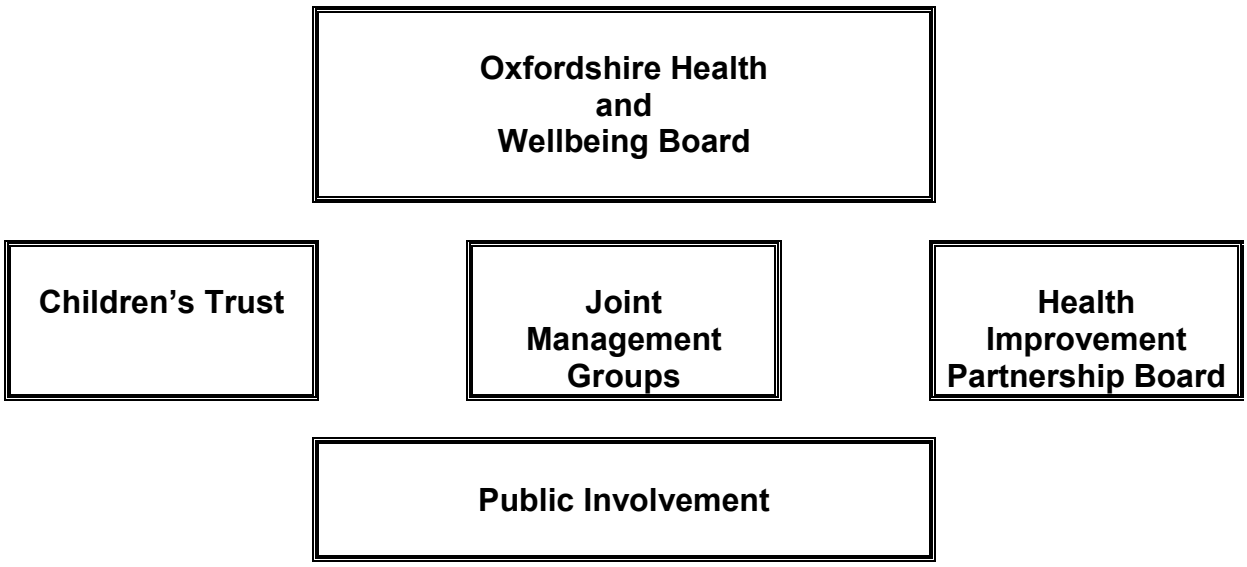
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and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

The priorities set out in this document put flesh on these themes. The priorities are intended to run to 2016 while the measures and targets set out within each priority are for the financial year 2014-15.

4. The structure of the Health and Wellbeing Board

4.1 What does the Health and Wellbeing Board look like?

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



The purpose of each of the Boards, Groups and for Public Involvement are outlined below:

Joint Management Groups	Children's Trust	Health Improvement Board	Public Involvement
To improve outcomes and to support adults to live independently with dignity by accessing support and services they need while achieving better value for money, especially through oversight of our pooled budgets for older people and for mental health.	To keep all children and young people safe; raise achievement for all children and young people and improve the life chances for our most disadvantaged and vulnerable groups	To add life to years and years to life, focusing on the factors underpinning wellbeing, while levelling up differences in the health of different groups in the County	To ensure that the genuine opinions and experiences of people in Oxfordshire underpin the work of the Health and Wellbeing Board.

4.2 How do decisions get made?

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

In turn, the Partnership Boards and Joint Management Groups are committed to working with a wide range of health and social care providers, voluntary agencies, carers, faith groups, members of the public and advocacy groups. We invite these partners to formal meetings as 'expert witnesses' and to workshops during the year as a means of

engagement. In this way, the decisions of the Health and Wellbeing Board aim to be truly inclusive.

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

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

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

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

4.3 The Work of Other Partnerships and Cross-Cutting themes

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

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

- Youth Offending Service Board

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

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

1) Social disadvantage

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

2) Helping communities and individuals to help themselves

As the public purse tightens, we need to find new ways of supporting people to help themselves. Since the early days of this approach there has been some progress including direct payments to people to buy their own care and the County Council's use of the 'Big Society Fund'.

3) Locality working

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

5. A strategic focus on Quality

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

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

The intention is to ensure that governance and assurance systems are joined up between organisations across the County. Performance measures which show patient and public satisfaction or dissatisfaction with services will be embedded in our performance framework

again. The development of Healthwatch Oxfordshire has brought independent and informed views to the Board. .

A process has now been established for giving more assurance on quality issues across the system. This includes continuing to include a range of patient reported outcome measures in this strategy and monitoring performance closely. In addition there will be a joint annual report of quality issues which will highlight any particular concerns to the Health and Wellbeing Board for a common response.

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

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

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

This analysis is the scientific bedrock on which this strategy rests. During 2013-14 the data collection was further improved and made more accessible. An annual summary report was accepted by the Board in March 2014. It can be found here:
http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

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

6.2 What are the specific challenges?

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

11. The recent **tightening of the public purse** which has knock-on effects for voluntary organisations.
12. The need to work with and through a **wide patchwork of organisations** to have any chance of making a real difference in Oxfordshire.
13. The changing face and **roles of public sector organisations.**

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

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

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

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

6.4 What criteria have been followed in selecting priorities?

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

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

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

A summary of the priorities can be found in Annex 1

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

The section below examines each priority in turn. Building on the original rationale for agreeing each, we have updated this strategy to illustrate why this issue is still a priority and the areas of focus going forward. In addition to this narrative the Board considers specific outcomes for each priority and consults the public and stakeholders on their proposals. The agreed outcomes for the year ahead become the performance framework and progress is reported at every Board meeting.

A. Priorities for Children's Trust

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

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

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

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

Young people tell us that there is much more we could do to improve the transition between young people's services and younger adults' services. This is particularly relevant to young people with mental health needs and we have already acted on this with a specific focus on looked after children. Young people also told us that they want more information and support around mental health issues and we made this a priority for the past year.

The public mental health strategy will be developed in the Autumn, The strategy will have a strong focus on promoting wellbeing and developing resilience, particularly in children and young people. Suicide risk reduction work is already underway. The working group is developing a coherent approach to this area, through the plan that was drafted with key stakeholders and in consultation with the safeguarding boards.

This priority should be read together with priorities 9 and 11 in the Health and Wellbeing Strategy which proposes the promotion of breastfeeding and improved immunisation for children as further priorities. The Health Improvement Board has also been working on the Healthy Weight Strategy for the county which also crosses over with this work.

Where are we now?

- A high number of women are seeing a midwife or maternity health care professional within the first 13 weeks of pregnancy, though data has not been available to show this as a percentage of all pregnancies.
- A very high proportion of children aged 2 – 2.5 years receive a Health Visitor Review.
- There has been good progress in reducing the rate of children admitted to hospital with infections as emergency cases.
- Oxfordshire continues to perform well against a range of indicators important for a healthy start in life monitored by the Health Improvement Board. This includes breastfeeding and immunisation.
- The increasing level of obesity in Year 6 children remains a cause for concern.

Outcomes for 2014-15

1.1 Increase percentage of women who have seen a midwife or maternity health care professional by 13 weeks of pregnancy from 90% to 92% by the end of March 2015.
1.2 Reduce the rate of emergency admissions to hospital with infections, maintaining low rates through 2014-15 (currently 152.2 per 10,000 2013-14)

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

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

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

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

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

Where are we now?

- The Joint Teenage Pregnancy Strategy has led to significant reductions in the teenage pregnancy and conception rates in Oxfordshire.
- The Thriving Families workers are exceeding their target of working with 810 families.
- Persistent absence rates from school generally improved and the target was met. A baseline of children in need who were persistently absent was established.
- Work was not completed on establishing a baseline of children and young people on the autistic spectrum who have had an exclusion from school due to difficulty in getting a full set of data from academies.
- The target to improve the attainment gap at all key stages for those entitled to free school meals was not met.

Outcomes for 2014-15

2.1 Increase the take up of free early education for eligible 2 year olds in 2014/15 to 1800 (from 1036 in 13/14)

2.2 Maintain the take up of free early education for 2 year-old Looked After children at 80% (Currently 80% 2013-14)

2.3 Maintain the current low level of persistent absence from school for looked after children. Target for 2013-14 academic year is 3.3%. A target for the 2014/15 academic year will be set in the autumn term.

2.4 Maintain the number of looked after children permanently excluded from school at zero.

2.5 Reduce the proportion of children in need who are persistently absent from school from 19.8% (baseline in 2012/13 academic year)

2.6 Establish a baseline of children and young people on the autistic spectrum who have had an exclusion from school (for the year 2013/14)) and work to reduce this number in the 2014/15 academic year.

2.7 Identify, track and measure the outcomes of all 810 families in Oxfordshire through the Thriving Families Programme, working with 90% of identified families and turning around 80% of families.

2.8 Improve the free school meals attainment gap at all key stages and aim to be in line with the national average by 2014 a) KS2 23% points, b) KS4 26% points

Priority 3: Keeping all children and young people safe

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

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

In Oxfordshire we have done a great deal of work together – County Council, Police, Health, District Councils and other organisations to prevent child sexual exploitation and to protect and support its victims. This includes setting up the multi-agency dedicated Kingfisher team and increasing capacity by recruiting additional social workers. Nationally and locally there is

growing awareness about young people who are victims of sexual exploitation. There is a need to concentrate even greater emphasis on better recognition and prevention of such exploitation. We need to continue to focus on this important work in Oxfordshire and continue to work together as agencies to prevent this type of crime happening.

We know that going missing is a key indicator that a child might be in great danger and they are at very serious risk of physical and sexual abuse and sexual exploitation. Nationally 10,000 children are estimated to go missing from care in a year (UK Missing Persons Bureau 2012).

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

Quality assurance audits look at the quality of the casework that agencies deliver to reduce the risk of abuse and neglect of children and young people. In 2013/14 a baseline was established by working with independent auditors to grade the multi-agency audits. In the year ahead a new indicator will be introduced.

Keeping children safe is a key priority for all agencies.

Where are we now?

- An Ofsted inspection of children's social care services has rated them as "good" across all 3 key categories - Children who need help and protection, Children looked after (including adoption performance and experiences and progress of care leavers) and Leadership, management and governance
- The reduction in risk for victims of domestic abuse was good, though the target of reducing 85% of high risk cases to medium or low risk was not quite achieved.
- The prevention of child sexual exploitation continues to be a key priority in Oxfordshire. Regular reports of prevalence and action taken have been made.
- There is a much greater focus on children who go missing from home but the number that go missing 3 or more times in 12 months is still similar to last year. Mitigating actions have been introduced.

Outcomes for 2014-15

3.1 Establish a baseline in order to reduce the assessed level of risk of high risk Domestic Abuse victims managed through Multi-Agency Risk Assessment Conferences (MARAC).

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

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

3.4 Monitor the number of children who go missing and the proportion who go missing 3 or more times within a 12 month period.

3.5 Increase the proportion of quality assurance audits undertaken and reviewed through the Oxfordshire Safeguarding Children Board that show a positive overall impact from a baseline of over 76% (13/14)

Priority 4: Raising achievement for all children and young people

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

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

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

Where are we now?

- There has been a significant increase in the number of funded 2-4 year olds attending good and outstanding early years settings.
- The improvement in reading at Key Stage 1 has been maintained
- 78% pupils in Oxfordshire made expected progress in Key Stage 2 reading, writing and maths – not quite reaching the target of 80%
- Pupils achieving 5 or more A*-C GCSEs including English and Maths in Oxfordshire has increased in 2012-13 to 60.6%. (57.9% in 2011-12).
- The percentage of children taught in good/ outstanding primary schools has increased from 67% to 77% and in secondary schools from 74% to 80%
- The proportion of year 12-14s who are Not in Education, Employment and Training is down to 4.7% (from 5.4% in 2012-13) and the number whose status is unknown has dropped.

Outcomes for 2014-15

4.1 Increase the number of funded 2-4 year olds attending good and outstanding early years settings to 85% (baseline 83% 2013-14)

4.2 84% of children will achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2013/14 (currently 81% for the academic year 2012/13)

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

4.4 63% of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2013/14 (currently 61% or 3840 children 2012-13)

4.5 a) At least 72% of young people will make the expected 3 levels of progress between key stages 2-4 in English (baseline 71% 12/13 academic year) and b) At least 73% of young people will make the expected 3 levels of progress between key stages 2 and 3 in maths. (baseline 71% 12/13 academic year)

4.6 Increase the proportion of pupils attending good or outstanding: a) primary schools to 75% at the end of 13/14 academic year (baseline 73% 12/13 academic year) and b) secondary schools to 87% at the end of 13/14 academic year (baseline 84% 12/13)

4.7 Of those pupils at School Action Plus, increase the proportion achieving 5 A* - C including English and Maths to 17% (baseline 10% 2012-13 academic year)

4.8 Reduce the persistent absence rates in primary schools to 2.8% and secondary schools to 6.7% by the end of 2013/14 academic year. (The baseline rates are 3.2% for primary schools and 7.4% for secondary schools 2012-13)

4.9 Continue to reduce the number of young people not in education, employment or training to below 5% (baseline 4.7% or 937 young people 2013-14).

4.10 Reduce the number of young people whose NEET status is not known to less than 8% (currently 11% March 2014)

B. Priorities for Joint Management Groups

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

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

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

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

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

Access to good health care is an area for improvement in Oxfordshire for people with learning disabilities and for people with mental health needs. The physical health check target we set, of at least 60% for adults with learning disabilities was seen as a step in the right direction.

Where are we now?

- Although the number of people who say they find information about health and social care easy to find has remained fairly constant there has been a drop in the

satisfaction level for working age adults.

- A high proportion of those with a long term condition feel supported in managing their condition.
- There have been some reductions in the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages.
- Targets for reducing unplanned hospitalisation for chronic conditions that can be actively managed were met.
- Over 500 front line health and social care workers received autism awareness training in the last year.

Outcomes for 2014-15

5.1 1800 people to receive information and advice about areas of support as part of community information networks

5.2 Excess under 75 mortality in adults with serious mental health illness (PHOF 4.9 from outcomes framework)Baseline and targets to be determined

5.3 Access to psychological therapies to be improved so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery.

5.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP (baseline 45.7% 2013-14)

5.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (baseline rate of 951.4 per 100,000)

5.6 Reduce unplanned hospitalisation for chronic conditions that can be actively managed (such as congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension) for people of all ages (baseline rate of 565.4 per 100,000 IN 2012-13)

5.7 Increase the employment rate amongst people with mental illness from a baseline of 33.2% in 2013/14

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

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

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

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

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. To achieve this we are focusing together on better use of

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

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

Another key issue is the increase in the number of people with dementia who need access to newly emerging treatments. To enable us to develop high quality care for people with dementia we need to diagnose it earlier. In Oxfordshire our ambition is for 60% of the expected population to have a diagnosis.

Where are we now?

- Delayed transfers of care remain a priority issue for the Board
- A model for matching capacity to demand for health and social care has been implemented across the system to support smooth discharge from hospital.
- The rate of permanent admissions to care homes has dropped though the overall number exceeded the target set for the year.
- A new national tool has been introduced for estimating the number of people with dementia and this has increased the estimate for Oxfordshire. A number of initiatives have been put in place to increase the number of diagnoses made.
- There have been increasing numbers of people starting reablement but the total remained below the target for the year.
- High numbers of people reported that they had been treated with dignity when they received care at home.
- The growth in supply of Extra Care Housing in on track.
- Service users report high levels of satisfaction with access to information and that they receive support and care in a timely way.

Outcomes for 2014-15

6.1. Reduce the number of days that a patient is delayed in hospital by 38% from an average of 4688 per month in 2012/13 to 2908 per month in 2014/15 (baseline 14.8 days in acute hospitals)

6.2 Reduce the number of avoidable emergency admissions to hospital for older people (aged 65+) per 100,000 population from a baseline of 23,389 in 13/14

6.3 Reduce the number of permanent admissions of older people (aged 65+) to residential and nursing care homes from 582 in 2012/13 to 546 in 2014/15

6.4 Increase the proportion of older people with an ongoing care package supported to live at home from 61.9% in April 2012 to 63.0% (currently 2122 of 3537 clients)

6.5 60% of the expected population (4251 of 7086 people) with dementia will have a recorded diagnosis (baseline 44.2% or 3516 people)

6.6 Increase the number of people referred to reablement from their own home (as opposed to a hospital stay) to 1875 in 2014/15 from a baseline of 881 in 2013/14

6.7 Increase the proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services to 80% by April 2015 from a baseline of 71.7% in April 2013

6.8 Maintain the number of organisations providing social care in Oxfordshire that meet the standard of treating people with respect and involving them in their care at above 95%.

6.9 Include the Better Care Fund national patient / Service User experience measure once this is developed.

6.10 Ensure an additional 523 Extra Care Housing places by the end of December 2015, bringing the total number of places to 768 by the end of March 2015 and 930 by the end of December 2015

6.11 Increase the proportion of people approaching the end of life who receive consistent care that is coordinated effectively across all relevant settings leading to patients dying in their preferred place of care.

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

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

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

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

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

Where are we now?

- Progress is being made in the integration of services and establishment of pooled budgets for older people.
- Patient Outcome measures show high levels of satisfaction with care and support received from social care, hospital care and GP surgeries.
- Over 15000 carers are now known and supported by adult social care.
- 880 carers received Carer Breaks accessed through their GP and jointly funded.

Outcomes for 2014-15

7.1 A measure to be developed relating to how the County Council and the Clinical Commissioning Group and Oxford Health FT are responding to Better Care Fund national conditions for shared care coordination, 7 day access and accountable lead professionals

7.2 A national measure of patient / service user experience will be added once developed (in line with the Better Care Fund)

7.3 Increase the number of carers known and supported by adult social care by 10% to 17,000 (baseline 15,475 April 2014)

7.4 At least 880 carers breaks jointly funded and accessed via GPs (currently 880)

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.
- Adding measures of success for those in drugs or alcohol treatment services with the aim of improving recovery rates.

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. Outcomes will be set to target the groups with worst outcomes as well as the overall average.

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

Where are we now?

- Bowel screening kits are being sent out to 60-74 year olds but a large proportion of the target group are still not returning them for analysis.
- Uptake of invitations to attend NHS Health Checks improved during the year but did not meet the aspirational target of 65% and there was considerable variation in different parts of the county.
- Smoking quit rates in the county remained largely on target throughout the year. There has been some concern over quit rates during pregnancy.
- Discussion on the rates of recovery from drugs and alcohol dependency has led to the decision that the Health Improvement Board should see regular reports on progress in improving abstinence based recovery rates.

Outcomes for 2014-15

8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years) and targeted promotion of uptake will take place based on an equity audit conducted in 2013-14 to ensure all population groups are responding. ***Responsible Organisation: NHS England***

8.2 Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%. ***Responsible Organisation: Oxfordshire County Council***

8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66%.(baseline 46% April 2104) ***Responsible Organisation: Oxfordshire County Council***

8.4 At least 3800 people will quit smoking for at least 4 weeks (baseline 3622, 2013-14). Report the baseline and rate for women smoking in pregnancy in Oxfordshire. ***Responsible Organisation: Oxfordshire County Council***

8.5 The 2014-15 target for opiate users should be set at 8.6% successfully leaving treatment (baseline 6.5%) ***Responsible Organisation: Oxfordshire County Council***

8.6 The 2014-15 target for non-opiate users should be set at 38.2%% successfully leaving treatment (baseline 15.5%). ***Responsible Organisation: Oxfordshire County Council***

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 63% 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. For the years ahead we will be encouraging those who are inactive to start to move more.

Where are we now?
- There was an improvement in obesity rates for children in year 6 but it remains above 15% across the county. There are some variations in different parts of the county.
- Over 61% of adults do at least 150 minutes of physical activity a week but over 20% of our population do less than half an hour a week.
- In some parts of the county over 84% of babies are still breastfed at 6-8 weeks and in other areas the rate is about 45%. The overall rate is increasing but the range is very wide.

Outcomes for 2014-15
9.1 Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2013 this was 15.2%) No district population should record more than 19% ***Responsible Organisation: Oxfordshire County Council***

9.2 Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 22.2% against 28.5% nationally, 2013-14 Active People Survey). ***Responsible Organisation: District Councils through Oxfordshire Sports Partnership***

9.3 63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual health visitor locality should have a rate of less than 50% ***Responsible Organisation: NHS England and Oxfordshire Clinical Commissioning Group***

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 few years 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 will 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?

- District councils have reported similar success rates as last year in preventing homelessness. This reflects more activity as changes in the welfare system have been introduced.
- The number of households in temporary accommodation has remained at similar levels to last year.
- A large proportion of people who had received housing related support services were able to leave the services and live independently.
- A new national indicator for fuel poverty has been introduced and there is more clarity on the new arrangements for improving energy efficiency of homes.

Outcomes for 2014-15

10.1 The number of households in temporary accommodation on 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire in 2013-14) ***Responsible Organisation: District Councils***

10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 83.9% in 2013-14). ***Responsible Organisation: Oxfordshire County Council***

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 81% in 2013- 2014 when there were 2837 households known to services). This can now be reported 6 monthly. ***Responsible Organisation: District Councils***

10.4 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. It is hoped that an aspirational baseline target of 550 households will be reached. ***Responsible Organisation: Affordable Warmth Network.***

10.5 Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2013-14 (baseline to be confirmed) ***Responsible Organisation: District Councils***

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.

New immunisations were introduced last year. From July 2013, a rotavirus vaccination was offered at 2 months and at 3 months, flu immunisation is being given to children, (starting with 2-3 year olds and adding more ages each year), and Shingles vaccinations are offered 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 has changed profoundly during the last 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. This included the number of children receiving their first dose of MMR vaccine which remained above the 95% target.
- Rates of flu immunisations for people aged under 65 who are at risk of illness improved last year as a result of focussed effort by several organisations.
- It remains important to keep these indicators under surveillance and for the Public Health Protection Forum to ensure that good performance in Oxfordshire is continued.

Outcomes for 2014-15

11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.8%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 93.7%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.3 – At least 60% of people aged under 65 in "risk groups" receive flu vaccination (currently 55% 2013-14) ***Responsible Organisation: NHS England***

11.4 At least 90% of young women to receive both doses of HPV vaccination. ***Responsible Organisation: NHS England***

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

Children's Trust

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

Joint Management Groups (for Older People, Mental Health etc)

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

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

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

Health Improvement

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

Annex 2: Glossary of Key Terms

Terms

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

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

Health Improvement Partnership Board
Forward Plan 2014-15

Date	Item
Meeting: 27th November 2014 2-4 pm Oxford Town Hall Jury Room	• Making Every Adult Matter pilot outcomes report • Performance report to include a report card on GP health checks – Public Health, Oxfordshire County Council • Performance report to include an equity audit on bowel screening – NHS England
Meeting: 22nd January 2015 2-4 pm Oxford Town Hall	
Forward plan suggestions:	
• No Second Night out • Domestic abuse review • Re-commissioning of housing-related support • Older People's Housing Strategy Needs analysis • Welfare reform update • Fuel Poverty/Affordable Warmth Network • Making Every Adult Matter • Basket of Indicators • Healthy Weight Strategy • Older People's Commissioning Strategy • Community Information Networks • Health and housing workshop actions follow-up • Tobacco control • Mental wellbeing	

15th October 2014

Sophie Kendall, Oxfordshire County Council
Sophie.kendall@oxfordshire.gov.uk
01865 32 8530

This page is intentionally left blank