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

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

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

**Thursday, 18 February 2016 at 2.00 pm**

**Town Hall, Oxford**

Peter G. Clark
Head of Paid Service

10 February 2016

*Contact Officer:* ***Katie Read, Policy & Partnership Officer***
*Tel: (01865) 328272; Email: katie.read@oxfordshire.gov.uk*

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## Membership

Chairman – City Councillor Ed Turner
Vice Chairman - District Councillor Anna Badcock

*Board Members:*

| | |
|---|---|
| Ian Davies | Cherwell & South Northants District Council |
| Cllr John Donaldson | Cherwell District Council |
| Laura Epton | Healthwatch Ambassador |
| Emma Henrion | Healthwatch Ambassador |
| Cllr Hilary Hibbert-Biles | OCC – Cabinet Member for Public Health & Voluntary Sector |
| Cllr Monica Lovatt | Vale of White Horse District Council |
| Dr Jonathan McWilliam | Director of Public Health |
| Cllr James F. Mills | West Oxfordshire District Council |
| Dr Paul Park | Vice Clinical Chair of Oxfordshire Clinical Commissioning Group |
| Jackie Wilderspin | Public Health Specialist |

***Notes:***

- ***Date of next meeting: 12 May 2016***

# 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 Chairman, City Councillor Ed Turner

## 2. Apologies for Absence and Temporary Appointments

## 3. Declaration of Interest - see guidance note opposite

## 4. Petitions and Public Address

## 5. Minutes of last meeting (Pages 1 - 6)

2.05pm
5 minutes

To approve the minutes of the meeting held on 27 October 2015 and to receive information arising from them.

## 6. Performance Report (Pages 7 - 22)

2.10pm
30 minutes

People responsible: Members of the Health Improvement Board

Performance report presented by: Jonathan McWilliam, Public Health, Oxfordshire County Council

A report on progress against the targets of the Health Improvement Board, including a breakdown of performance against housing indicators. The Health Improvement Board is recommended to agree a measure for monitoring the performance of the young people's supported housing pathway (10.6)

Immunisation report card presented by: Nisha Jayatilleke, Screening and Immunisation, NHS England

A report card on the prevention of infectious disease through immunisation.

## 7. Smoking Cessation Report (Pages 23 - 32)

2.40pm
15 minutes

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

An overview of smoking from a national and local perspective, including the wider changing behaviours of people who smoke and local cessation services.

## 8. Affordable Warmth Network Update (Pages 33 - 38)

2.55pm
15 minutes

Report presented by: Kate Eveleigh, Oxfordshire County Council

A report on the activities of the Affordable Warmth Network to address fuel poverty issues.

## 9. The District Council Contribution to Health & Wellbeing in Oxfordshire (Pages 39 - 48)

3.10pm
15 minutes

Report by: Val Johnson, Partnership Development Manager, Oxford City Council

The 4 February 2016 report to Oxfordshire Joint Health Overview & Scrutiny Committee, on behalf of Oxfordshire's District Councils, discussing the role of the district councils in relation to health and wellbeing and the current activities that they support in relation to this.

## 10. Air Quality Management Report (Pages 49 - 54)

3.25pm
15 minutes

Report presented by: Ian Halliday, Air Quality Officer, Oxford City Council

An overview of air quality in Oxfordshire the role of Local Authorities in improving air quality locally.

## 11. Draft Joint Working Protocol (Pages 55 - 78)

3.40pm
10 minutes

Protocol presented by: Tan Lea, Strategic Safeguarding Partnerships Manager, Oxfordshire County Council

A draft protocol setting out the framework within which a number of multi-agency Boards/Partnerships in Oxfordshire will work together to safeguard and promote the welfare of people living in the county, including the distinct roles, responsibilities and governance arrangements for each of them.

The Health Improvement Board is recommended to agree the draft protocol in principle.

## 12. **Forward Plan** (Pages 79 - 80)

3.50pm
5 minutes

Presented by: Councillor Ed Turner, Chairman of the Health Improvement Board

A discussion about the forward plan for the Health Improvement Board.

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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

# HEALTH IMPROVEMENT PARTNERSHIP BOARD

**OUTCOMES** of the meeting held on Tuesday 27 October commencing at 2.00 pm and finishing at 4.45 pm.

**Present:**

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| **Board Members:** | Councillor Ed Turner (Chairman), Oxford City Council<br>Councillor Anna Badcock (Vice-Chairman), South Oxfordshire District Council<br>Councillor John Donaldson, Cherwell District Council<br>Councillor James Mills, West Oxfordshire District Council<br>Councillor Monica Lovatt, Vale of White Horse District Council<br>Councillor Hilary Hibbert-Biles, Oxfordshire County Council<br>Dr Paul Park, Oxfordshire Clinical Commissioning Group<br>Ian Davies, Cherwell and South Northants District Council<br>Jackie Wilderspin, Public Health Specialist<br>Dr Jonathan McWilliam, Director of Public Health<br>Laura Epton, Healthwatch Ambassador (job share) |
| **Officers:** | |
| Whole of meeting: | Val Johnson, Oxford City Council<br>Katie Read, Oxfordshire County Council |
| Part of meeting: | |
| Agenda item 6 | Andy Symons, Turning Point |
| Agenda item 8 | Rachel Coney, Healthwatch Oxfordshire |
| Agenda item 10 | Heather McCulloch, West Oxfordshire District Council<br>Jo Paterson, South and Vale District Councils<br>Megan Horwood, GLL<br>Colin Williams, GLL<br>Chris Freeman, Oxfordshire Sport and Physical Activity<br>Jenny Webb, Oxfordshire Sport and Physical Activity<br>Anna Hinton, Oxford University Hospitals Trust<br>Sam Williamson, Oxford University Hospitals Trust |
| Agenda item 11 | Natalia Lachkou, 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 Katie Read (Tel 01865 328272; Email: katie.read@oxfordshire.gov.uk)*

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| **1. Welcome**<br><br>The Chairman, City Councillor Ed Turner, welcomed all to the meeting and all members introduced themselves. | |
| **2. Apologies for Absence and Temporary Appointments**<br><br>Apologies have been received from: Kate Terroni, Oxfordshire County Council | |
| **3. Declaration of Interest**<br><br>No declarations were received. | |
| **4. Petitions and Public Address**<br><br>No petitions or public addresses were received. | |
| **5. Minutes of Last Meeting**<br>The minutes of the July meeting were approved.<br><br>Action regarding a performance target for the young people's housing pathway – baseline data is being gathered for a target to be set at the next meeting. | |
| **6. Performance Report**<br><br>Jackie Wilderspin presented the performance report and highlighted the regional and national benchmarking data included to provide context for members on how outcome measures are set.<br><br>Discussion focused on the report card covering the treatment of opiate and non-opiate users. Andy Symons outlined the needs-led outreach and locality based model adopted by Turning Point, the service provider since April 2015.<br><br>During the first six months, the new service received over 500 referrals and has focused on training staff in new ways of working. It recently deployed roving recovery vehicles to facilitate outreach work in rural communities.<br><br>The service targets were acknowledged as stretching, but Board members were assured that a marked improvement is expected after the first 12 months of the service. It was emphasised that performance data for the service will always be behind, as the indicator is reliant on clients not representing within six months.<br><br>Members fed back that GPs and other agencies are already seeing improved access to support and education about drug use, as a result of the new service.<br><br>The Board was concerned that performance on smoking cessation (measure 8.4) has not improved, although Oxfordshire's performance | |

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| is better that the national average. **The Board will receive a report card on smoking cessation that will include a commentary on national evidence and societal change at its next meeting.** | **Jonathan McWilliam** |
| **7. Director of Public Health's Annual Report**<br><br>Jonathan McWilliam outlined the focus of each chapter in his annual report, summarising key findings and recommendations.<br><br>The tension between investing in prevention and spending on meeting immediate needs was acknowledged, as well as the important role of local services and communities in understanding and meeting their own local needs.<br><br>Board members highlighted the critical link between health and housing/local planning and the importance of the health sector working more closely with neighbourhood planning colleagues to consider the needs of communities in the round.<br><br>The Board was updated on the Public Health funding position; this continues to be uncertain. There is likely to be an in-year reduction in the Public Health grant nationally, but this is not yet confirmed. It is also unclear whether the Public Health budget will continue to be ring-fenced after 2016.<br><br>**Additional note:** It was confirmed on Thursday 5th November (after this meeting) that 6.2% cuts of the Public Health grant for 2015-16 will be implemented in each local authority and it is not being unring-fenced at this time. | |
| **8. Healthwatch Oxfordshire**<br><br>Rachel Coney provided an update on the role of Healthwatch Oxfordshire and wider work of the organisation.<br><br>Board members discussed the organisation's authority to 'Enter and View' sites of concern. **District and City Council representatives were invited to forward any concerns they have on services in their area to Healthwatch Oxfordshire.**<br><br>Healthwatch Oxfordshire is planning for a potential reduction in funding from the County Council, as this is an option being consulted on as part of its business and resource planning process. **The Board expressed an interest in being kept up to date on this issue.** | **ALL**<br><br>**Rachel Coney** |
| **9. Healthwatch Ambassadors' Report**<br><br>Laura Epton presented the Healthwatch Ambassadors' report which focused on concerns raised by the public and health professionals about the potential closure of breastfeeding support services provided by Oxford Baby Café. | |

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| Discussion focused on the type of support provided by the Baby Café and other forms of support available for breastfeeding mothers. **A report on the range of breastfeeding support provided by public bodies and other organisations in Oxfordshire was requested for a future meeting.** | **Jackie Wilderspin** |
| **10. Healthy Weight Strategy**<br><br>Councillor Anna Badcock chaired a discussion on healthy weight initiatives in the context of revising Oxfordshire's Healthy Weight Strategy. The Board received updates from the City and District Councils, the County Council, the Clinical Commissioning Group, Oxfordshire Sport and Physical Activity and the Oxford University Hospitals Trust on their current healthy weight promotion activities.<br><br>It was agreed that there is a need for a multi-agency strategy to coordinate the activities of organisations working across the county to tackle obesity among children and adults, and promote healthy weight. As a new national childhood obesity strategy is expected in January 2016, it was considered the right time to refresh the current Healthy Weight Action Plan and align this with national priorities.<br><br>The key areas of focus from the discussion were:<br>• The importance of each organisation making tackling obesity a strategic priority.<br>• The need for a greater focus on children and young people in order to promote healthy weight from a young age and stop people becoming obese.<br>• The need for organisations to focus their activities on reaching people who are already obese and not active at all.<br>• Learning from the work that Oxford University Hospitals Trust is doing with its staff, to enhance organisations' 'well at work' programmes.<br>• The importance of influencing healthy eating policies, ensuring healthier food and drink options are available in vending machines and from franchises based in organisations' premises and public facilities.<br>• The importance of engaging and involving primary schools in educating children and young people about healthy weight and the activities they do with pupils to promote this.<br>• The need to influence how primary schools are using their PE and sports premium grant to make additional and sustainable improvements to the quality of PE and sport they offer.<br>• The importance of agreeing robust monitoring of progress and measuring outcomes.<br><br>A number of issues/barriers to do with healthy weight were also identified:<br>• The lack of national or local sports participation data for young | |

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| people.<br>• Sustainability – people's ability / motivation to maintain activities that promote healthy weight over time.<br>• The psychological element of unhealthy eating and weight gain that is harder to tackle.<br>• Linking with planning policies to affect the location and number of fast food outlets, etc. which have a negative impact on healthy weight.<br>• Influencing transport and other planning policies which could do more to promote safe active transport such as walking and cycling.<br>• The increasing number of bariatric people and the difficulties faced by the Ambulance service in managing these patients.<br><br>The Board agreed the following next steps:<br><br>**i. All Board members to influence their own organisations to make tackling obesity and organisational priority.**<br>**ii. Board members will hold a workshop in the New Year to develop a new coordinated, multi-agency strategy. This will renew the focus of the work of the Healthy Weight Steering Group.**<br>**iii. The Board will have a particular focus on healthy weight over the next 12 months to monitor progress on the Strategy and action plan.**<br>**iv. External input will be sought to review the range of activities and policies already in place and make recommendations for areas to address.** | **ALL/Katie Read**<br><br>**Katie Read**<br><br>**Jackie Wilderspin**<br><br>**Donna Husband** |
| **11. Housing related support**<br><br>Natalia Lachkou provided a verbal update on the progress of recommissioning housing related support services.<br><br>The procurement exercise is now complete and contracts have been awarded for every part of the homelessness pathway within budget. Implementation has already begun and services will be in place from February 2016, with some being provided from different locations.<br><br>The Board raised concerns about the effect of the County Council's consultation on options to remove funding for housing related support on providers investing in the new homelessness pathway. This option is currently being consulted on as part of the council's business and resource planning process.<br><br>The Board was assured that the contracts have been awarded in spite of the budget consultation and the County Council will continue to be as transparent and open with providers as possible.<br><br>**Board members agreed to hold a workshop during the** | **ALL/Katie** |

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| **consultation to discuss how services could be delivered if funding was to be reduced.** | **Read** |
| **12. Forward Plan**<br>**From the meeting the following items will be added to the forward Plan**:<br>• Housing related support workshop<br>• Healthy weight workshop<br>• Healthy Weight Strategy<br>• Breastfeeding support services | **Katie Read** |
| The meeting closed at 4.45pm | |

..... in the Chair

Date of signing .....

# Health Improvement Board
# 18 February 2016

## Q2 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 some indicators that are reported on an annual basis and some on a half-yearly basis - these will be reported in future reports following the release of the data.

5. For the indicators that can be regularly reported on, current performance (at Q2) can be summarised as follows:

   **6** indicators are Green.
   **3** indicators are Amber (defined as within 5% of target).
   **7** indicators are Red

6. The indicators that are red are:
   **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)
   **8.4** At least 3650 people will quit smoking for at least 4 weeks
   **8.6** The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months
   **8.7** At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months
   **10.1** The number of households in temporary accommodation on 31 March 2016 should be no greater than level reported in March 2015
   **10.5** Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 70 (2014/15)
   **11.2** At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94%

Sue Lygo
Health Improvement Practitioner
4 February 2016

# Oxfordshire Health and Wellbeing Board
# Performance Report

| No | Indicator | Q1 Apr-Jun | RAG | Q2 Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Locality spread | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Priority 8: Preventing early death and improving quality of life in later years** | | | | | | | | | | | |
| **8.1** NHS England | At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years) | **Expected** 60%<br>**Actual** 59.2% | A | **Expected** 60%<br>**Actual** | | **Expected** 60%<br>**Actual** | | **Expected** 60%<br>**Actual** | | | Data for Q2 are not yet available. |
| **8.2** OCC | 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%<br>**Actual** 5% | G | **Expected** 7.5%<br>**Actual** 11.1% | G | **Expected** 11.25%<br>**Actual** 15.7% | G | **Expected** 15%<br>**Actual** | | <u>Cumulative Q3</u><br>North East: 13.1%<br>North: 13.3%<br>City: 17.6%<br>South East 17.6%<br>South West 18.1%<br>West 11.2% | |
| **8.3** OCC | 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%<br>**Actual** 42.2% | A | **Expected** 50%<br>**Actual** 45.7% | R | **Expected** 58%<br>**Actual** 48% | R | **Expected** 66%<br>**Actual** | | <u>Cumulative Q3</u><br>North East: 47.1%<br>North: 58.8%<br>City: 41.9%<br>South East 41.2%<br>South West 47%<br>West 63.9% | |

| No | Indicator | Q1 Apr-Jun | RAG | Q2 Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Locality spread | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 8.4 | At least 3650 people will quit smoking for at least 4 weeks (Achievement in 2014/15 = 1955) | **Expected** 913 | R | **Expected** 1825 | R | **Expected** 2738 | | **Expected** 3650 | | | |
| occ | | **Actual** 477 | | **Actual** 992 | | **Actual** | | **Actual** | | | |
| 8.5 | The number of women smoking in pregnancy should decrease to below 8% (recorded at time of delivery). (Baseline 2014/15 = 8.1%) | **Expected** <8% | G | **Expected** <8% | A | **Expected** <8% | A | **Expected** <8% | | | |
| occ G | | **Actual** 7.8% | | **Actual** 8.5% | | **Actual** 8.8% | | **Actual** | | | |
| 8.6 | The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months (baseline 7.8%) | **Expected** 7.6% | R | **Expected** 7.6% | R | **Expected** 7.6% | | **Expected** 7.6% | | | Please note that the completion data is from 01/03/2014 to 31/01/2015 and representations are up to 30/09/2015 (end Q2) |
| occ | | **Actual** 6.2% | | **Actual** 5.6% | | **Actual** | | **Actual** | | | |
| 8.7 | At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months (baseline 37.8%) | **Expected** **39%** | R | **Expected** **39%** | R | **Expected** **%** | | **Expected** **%** | | | |
| occ | | **Actual** 29% | | **Actual** 27.9% | | **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 16% (in 2013/14 this was 16.9%). No district population should record more than 19% | | | | | **Expected** 16% or less | A | | | Cherwell 19.7%<br>Oxford 19.2%<br>All other districts under 15% | |
| occ | | | | | | **Actual** 16.2% | | | | | |

| No | Indicator | Q1 Apr-Jun | RAG | Q2 Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Locality spread | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **9.2**<br>District | Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active People Survey) | | | **Expected** 22% or less<br>**Actual** 21.9% | G | | | | | | |
| **9.3**<br>NHS England & CCG | 63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual CCG locality should have a rate of less than 50% | **Expected** 63%<br>**Actual** 60.9% | A | **Expected** 63%<br>**Actual** 63.8% | G | **Expected** 63%<br>**Actual** % | | **Expected** 63%<br>**Actual** | | No CCG locality under 50% (Q1 & Q2). However, some practices across most localities have less than 50% | |
| **Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness** | | | | | | | | | | | |
| **10.1**<br>District Councils | The number of households in temporary accommodation on 31 March 2016 should be no greater than level reported in March 2015 (baseline 192 households) | | | **Expected** 192 or less<br>**Actual** 218 | R | | | **Expected** 192 or less<br>**Actual** | | | |
| **10.2**<br>OCC | At least 75% of people receiving housing related support will depart services to take up independent living (baseline 91% in 14/15) | **Expected** 75%<br>**Actual** 84.8% | G | **Expected** 75%<br>**Actual** 86.1% | G | **Expected** 75%<br>**Actual** % | | **Expected** 75%<br>**Actual** | | | |

| No | Indicator | Q1 Apr-Jun | RAG | Q2 Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Locality spread | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 83% in 2014/15 when there were 2454 households known to services). Reported 6-monthly | | | **Expected** 80% | G | | | **Expected** 80% | | | |
| District Councils | | | | **Actual** 82% | | | | **Actual** | | | |
| **10.4** | More than 700 households in Oxfordshire will receive information or services to enable 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. | | | | | **Expected** >700 | G | **Expected** >700 | | | This represents a cumulative figure for Q1, Q2 and Q3. |
| Oxfordshire Affordable Warmth Partnership | | | | | | **Actual** 1427 | | **Actual** | | | |
| **10.5** | Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 70 (2014/15) | | | | | **Target** < 70 | R | | | | |
| District Councils | | | | | | **Actual** 90 | | | | | |
| **10.6** | *Suggested measure: 95% of young people receiving housing* | | | | | | | | | | Measure to be agreed at February HIB meeting. |

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| OCC | *related support within the young people's supported housing pathway depart to a planned and positive accommodation option (baseline 70% from 2015-16 Q1 & Q2 performance data)* | | | | | | | | | | Breakdown of baseline data for positive move-on:<br>Package 1 - families provision = 100%<br>Package 2 - singles shared provision = 76%<br>Package 3 - self-contained, dispersed provision = 0%<br>Package 4 - specialist provision = 0% |

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

| No | Indicator | Q1 Apr-Jun | RAG | Q2 Jul-Sept | RAG | Q3 report Oct-Dec | RAG | Q4 report Jan-Mar | RAG | Locality spread | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 11.1 | At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94% | **Expected** 95% | | **Expected** 95% | | **Expected** 95% | | **Expected** 95% | | | Data for CCG localities are not available for Q2 |
| NHS England | | **Actual** 95.1% | G | **Actual** 94.5% | A | **Actual** % | | **Actual** | | Oxford = 93.3 (Q1) | |
| 11.2 | At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94% | **Expected** 95% | | **Expected** 95% | | **Expected** 95% | | **Expected** 95% | | | Data for CCG localities are not available for Q2 |
| NHS England | | **Actual** 92% | A | **Actual** 91% | R | **Actual** % | | **Actual** | | North = 91.6 (Q1)<br>Oxford = 91.7 (Q1) | |
| 11.3 | At least 60% of people aged under 65 in "risk groups" receive flu vaccination | | | | | | | **Expected** 55% | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS England | (2014/15 = 51.9%) | | | | | | | **Actual** | | | |
| **11.4** | At least 90% of young women will receive both doses of HPV vaccination. (2014/15 =91.7%) | | | | | | | **Expected** Over 90% | | | |
| NHS Englan | | | | | | | | **Actual** | | | |

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# 12Housing data collection, for performance reporting to Health Improvement Board in 2015-16

**Regular Performance reporting – outcomes for 2015-16 on priority 10 in the Joint Health and Wellbeing Strategy 2015-19:**
**Tackling the broader determinants of health through better housing and preventing homelessness**

**Data collection (Housing Support Advisory Group Chairman):**

| | | |
|---|---|---|
| Collecting | Phil Ealey, South Oxfordshire and Vale of the White Horse District Councils | phil.ealey@southandvale.gov.uk |
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| For performance report written by: | Sue Lygo, Oxfordshire County Council | sue.lygo@oxfordshire.gov.uk |

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| City | Lena Haapalahti | lhaapalahti@oxford.gov.uk |
| South | Jaffa Holland or Melissa Cripps | Jaffa.holland@southandvale.gov.uk or Melissa.cripps@southandvale.gov.uk |
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## Measure 10.1

| | | | |
|---|---|---|---|
| **10.1** | The number of households in temporary accommodation on 31 March 2016 should be no greater than the level reported in March 2015 (baseline 192 households in Oxfordshire in 2014-15)<br>***Responsible Organisation: District Councils***<br><br>**Proposal agreed:**<br>**Separate out the number in bed and breakfast accommodation**<br>**Six monthly instead of annually** | 6-monthly<br>Quarter 2<br>Quarter 4 | Housing Support Advisory Group District representatives<br>Collated by the Chairman of the Housing Support Advisory Group (rotates amongst Districts each year)<br>Phil Ealey, South Oxfordshire and Vale of the White Horse District Councils<br>(via Katie Read) |

**Quarter: 2**

**Data:**

| | | **Cherwell** | **City** | **South** | **Vale** | **West** | **Total** |
|---|---|---|---|---|---|---|---|
| 1 | The number of households in temporary accommodation | 42 | 128 | 20 | 16 | 12 | **218** |
| 2 | The number of households in temporary accommodation, housed in bed and breakfast accommodation | 6 | 10 | 0 | 2 | 2 | **20** |

## Measure 10.3

| | | | |
|---|---|---|---|
| **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 86% in 2014 - 2015). This can now be reported 6 monthly.<br>***Responsible Organisation: District Councils*** | 6-monthly<br>Quarter 2<br>Quarter 4 | Housing Support Advisory Group<br>District representatives<br>Collated by the Chairman of HSAG<br>Phil Ealey, South Oxfordshire and Vale of the White Horse District Councils<br>(via Katie Read) |

**Quarter: 2**

**Data:**

| | | | Cherwell | City | South | Vale | West | Total |
|---|---|---|---|---|---|---|---|---|
| 1 (E1) | Total number of applicant households who were homeless as defined by the Housing Act 1996, comprising the following categories | **A** | 36 | 52 | 16 | 14 | 28 | 146 |
| 1a (E1,1) | Eligible, unintentionally homeless and in priority need | | 19 | 27 | 13 | 9 | 19 | 87 |
| 1b (E1,2) | Eligible, homeless and in priority need but intentionally so | | 7 | 13 | 3 | 3 | 3 | 29 |
| 1c (E1,3) | Eligible, homeless and not in priority need | | 10 | 12 | 0 | 2 | 6 | 30 |
| 2 (E,10,1) | Total number of cases where positive action was successful in preventing homelessness of which | **B** | 151 | 236 | 105 | 97 | 98 | 687 |
| | **The Measure** | | 81% | 82% | 87% | 87% | 78% | **82%** |

References are to P1E return
Outcome indicator is calculated by expressing B as a percentage of A + B

## Measure 10.5

| | | | |
|---|---|---|---|
| **10.5** | Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2014-15 (baseline: 68) ***Responsible Organisation: District Councils*** | Annually Quarter 3 (November) | Housing Support Advisory Group District representatives Collated by the Chairman of HSAG Phil Ealey, South Oxfordshire and Vale of the White Horse District Councils (via Katie Read) |

**Quarter: 3**

**Data:**

| | | **Cherwell** | **City** | **South** | **Vale** | **West** | **Total** |
|---|---|---|---|---|---|---|---|
| 1 | The number of people estimated to be sleeping rough | 21 | 56 | 6 | 4 | 3 | **90** |

Count = 39

For 10.5 - from November 2014, all Districts will report their November estimate (according to the methodology set out by Homeless Link – so Oxford City will do an estimate according to this methodology, as well as their count).

**Health Improvement Partnership Board**
**Detailed performance report**

## 1. Details

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

**Strategic Lead**: *Nisha Jayatilleke (Consultant in Public Health), NHS England (South Central)*

**Last updated**:

**PROGRESS MEASURE:**
*At least 95% children receive PCV (Pneumococcal) Booster, Hib/MenC (Haemophilus Influenza type B/Meningococcal C) Boosters and MMR (Measles, Mumps and Rubella) dose 1,on or after 1st birthday and before 2nd birthday.*
*At least 95% of children receive DTaP/IPV (Diptheria, tetanus, pertussis and polio) booster and MMR (measles, mumps and rubella) dose 2 vaccinations by 5th birthday.*

**Current indicator RAG Rating** Red

## 2. Trend Data

**Quarterly uptake of 0-5 year children's immunisations in Oxfordshire - July 2014 to September 2015**

| Quarter/Year | DTaP/IPV/Hib 1 yr | PCVB 2 yrs | Hib/MenC 2 yrs | MMR 2 yrs | DTaP/IPV 5 yrs | MMR 5 yrs |
|---|---|---|---|---|---|---|
| Q3 14/15 | 96.4% | 95.0% | 95.0% | 95.2% | 92.7% | 92.5% |
| Q4 14/15 | 96.7% | 95.2% | 95.0% | 95.0% | 92.3% | 92.1% |
| Q1 15/16 | 96.7% | 95.6% | 95.5% | 95.1% | 92.9% | 92.0% |
| Q2 15/16 | 96.4% | 94.6% | 94.2% | 94.5% | 90.7% | 91.0% |
| Q2 15/16-England | 93.5% | 92.1% | 91.8% | 91.5% | 87.9% | 87.9% |

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

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

- **DTaP/IPV/Hib 1 yr -** This indicator is performing well above the national uptake target of 95% and also performing above England average.
- **PCVB, Hib/MenC, MMR 2 yrs –** These three indicators have historically achieved the national target of 95% and have remained stable until Q1 of 2015/16. The uncharacteristic dip in Q2 performance is due to Oxford Health NHS Trust Child Health Information Service (CHIS) migrating to a new clinical system. This complex migration has posed several technical issues and significantly affected

the CHIS team capacity to carry out the routine follow up and data quality work. CHIS report that the decline in performance does not accurately reflect the local uptake. CHIS are confident that technical issues with the new system and resulting capacity and data quality issues are likely to be resolved by Q3, which should positively reflect on the performance of these indicators.

- **DTaP/IPV and MMR 5 yrs –** These two indicators have historically performed below national uptake target of 95% however have remained stable until Q1 of 2015/16. It is important to note that despite the dip in Q2 performance, which is due to CHIS clinical system migration, the Oxon uptake remains above national average.
- It is important to note that there has been limited capacity within the current health system to undertake work to maximise uptake in children least likely to attend for vaccinations. NHS England Commissioners have prioritised work to increase capacity in Provider services to address this issue. (See more detail under current initiatives section)

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

| **Actions** *(in brief)(add more rows if you need to)* | **Commentary** *(is this working, if not why not?)* |
|---|---|
| ¤ **Identifying and rectifying anomalies in the data**<br>Oxon CHIS Service is working closely with their clinical system supplier and Oxford Health NHS Trust to resolve the technical issues in order to resume routine follow up and data quality checks to ensure accurate reflection of immunisation performance | • Due to current technical difficulties with new CHIS clinical system the level of follow up by CHIS of GP practices with data anomalies has been substantially reduced temporarily |
| ¤ **Targeted follow up with low performing practices and non-engaging families**<br>NHSE have commissioned a specialist Band 6 nursing post (job share) to lead targeted work to follow up unimmunised children. The priority focus will be on age 5 indicators to ensure improved uptake. | • Oxford Health NHS Trust has recently recruited to these posts and the work has commenced with targeted GP practices. The key outcome measure is a reduction in the proportion of unimmunised children<br>• All primary care practices received a GP briefing introducing the role and remit of inequalities nurses (3 Feb) |
| ¤ **Providing support to low performing practices**<br>Vaccination uptake is monitored at practice level and is scrutinised quarterly by NHS England Screening and Immunisation team to identify practices with low uptake rates<br><br>GP practices with low uptake rates are contacted by a member of the NHS England Screening and Immunisation team and offered specialist advice & support to improve uptake | • Quarterly performance data is analysed to identify low performing practices. Screening and Immunisation Coordinators then offer practice visits and best practice resources to encourage improved uptake |

**5. What needs to be done now? - New initiatives and actions**
*(this is the recovery plan. Details should show how this will get things back on track)*

| Action | By Whom & By When |
|---|---|
| • NHSE will work closely with Oxford Health NHS Trust and CHIS to ensure system migration issues are resolved as a matter of urgency in order to resume full data quality checks for anomalies and follow up with GP practices to improve data accuracy | NHSE/Oxford Health/CHIS - ongoing |
| • Continue to monitor practice level data and scrutinise quarterly to identify practices with low uptake rates and offer appropriate support | Screening and Immunisation team - ongoing |
| • Continue to monitor the work of specialist band 6 nursing post to focus on improving uptake of age 5 indicators & an overall reduction in the proportion of unimmunised children | NHSE/Oxford Health (specialist nursing post) – Ongoing |
| • NHSE to continue collaborative work with local stakeholders i.e. local authority, primary care, CCG, PHE South and the community trust through quarterly Immunisation Working Groups to promote and improve uptake of 0-5 immunisation programmes | Quarterly - ongoing |

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# Smoking in Oxfordshire.

A report to the Health Improvement Partnership Board

18 February 2016

**1.0 Purpose of the report**

1.1 This report will give an overview of smoking from a national perspective and also in the Oxfordshire population, the wider changing behaviours of smoking and local cessation services.

**2.0 Introduction**

2.1 Smoking is widely accepted as one of the most detrimental behaviours which can affect the health of an individual and increase the risk of suffering serious illness and premature death. In England there have been concerted efforts to reduce the number of smokers in the population through national policy and the increased education of the harm that smoking has on the health of smokers. Whilst there have been considerable reductions in the smoking population from 60% at the start of 1950s, still nearly one in five adults smoke (18.1%). However, while some in England 600,000 people stop smoking each year approaching 300,000 start using tobacco, nearly all of whom are in their teens or early twenties.

2.2 Cigarettes are the cause of death for about half of all long term smokers and greatly contribute to increased morbidity in those who are long term smokers. Smoking causes conditions ranging from cancers, vascular disease to respiratory diseases and events such as heart attacks and strokes, dementias, rheumatoid arthritis and macular degeneration - the leading cause of sight loss in people aged over 50.

2.3 Nicotine is highly addictive and this is why it is difficult for smokers to quit. Whilst addictive nicotine is not the major cause of smoking related deaths, it is the other chemicals in tobacco which cause the harm to health.

*"People smoke for nicotine but they die from the tar."* *Prof Michael Russell*

2.4 About half of attempted quits are made without the use of Nicotine Replacement Therapy or other aids. The use of NRT and pharmacotherapy helps reduce the nicotine cravings that arise with stopping smoking. However the likelihood of successfully quitting in the long term is increased through the use of professional smoking cessation services with psychological support.

**3.0 The changing challenge**

3.1 Whilst there has been considerable success in the reduction in the number of smokers, there has been a noted decline in the activity of stop smoking services nationally in recent years. The number of people using smoking cessation services in England and successfully quitting has reduced by 40% between

2010/11 and 2014/15. Current data would suggest that this decline is still continuing. There have been proposed reasons for this decline such as;

- Increase in the use of e cigarettes
- The remaining smokers are those more addicted to nicotine and less inclined to want to quit
- Those still smoking population are in more hard to reach groups of society
- Changing demands for service access with more people quitting independently

**4.0 Increased use of e-cigarettes**

4.1 E-cigarettes present one of the most interesting debates in modern day public health. Invented in by a Chinese pharmacist around 2003, these devices use a battery powered electric coil to vaporise liquid containing nicotine which is inhaled into the lungs (vaping). In England there has been a dramatic increase in the number of people who are using e-cigarettes. The current estimate of e-cigarette users in Great Britain is approximately 2.6 Million people[1]. This increase has been suggested as a substantial cause for the decline in the number of successful quits nationally in stop smoking services.

4.2 The increase in the use of e-cigarettes with smokers has now made this the most common form of quitting aid as a method of choice as seen in figure 1.

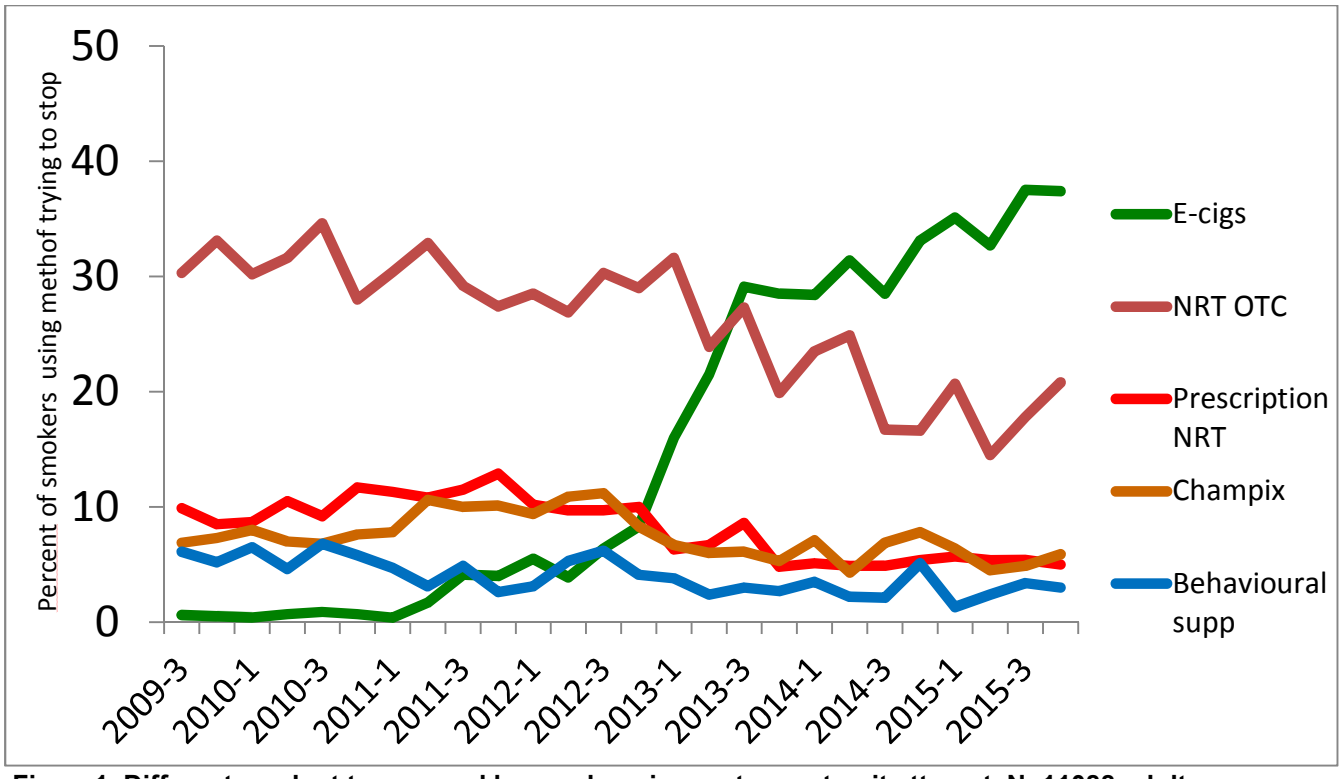


**Figure1. Different product types used by smokers in most recent quit attempt. N=11088 adults who smoke and tried to stop or who stopped in the past year; method is coded as any (not exclusive) use. *Source: www.smokinginengland.Info/latest-statistics***

[1] Action on Smoking and Health. *Use of electronic cigarettes (vapourisers) among adults in Great Britain*. 2015 23 July 2015]; Available from: http://www.ash.org.uk/files/documents/ASH_891.pdf.

4.3 Currently e-cigarettes are regulated as a consumer product, and there have been concerns about the varying quality of products that are available. From May 2016 e-cigarette products will have to comply with the European Tobacco Products Directive (TPD), which will create a level of regulation and quality control over the e-cigarette products available to consumers. Currently there is only one e-cigarette product that has been licenced as a medical device. This may give rise to calls for e-cigarettes to be made available under prescription as part of local stop smoking services and through a GP. Whilst medically licensed e-cigarettes could in theory be available under NHS prescription, the public health directorate in Oxfordshire currently would not be prepared to fund this unless there is a change in policy.

4.4 The use of e cigarettes as a quit aid and the increasing usage has opened a debate in the public health community on a national and international scale. Some consider e-cigarettes as harmful to health and a way of introducing young people and non-smokers to smoking. There has been increasing coverage in the media of studies which claim that e-cigarettes contain harmful chemicals such as formaldehyde and can potentially cause serious health conditions. This has seen an increase in the perception in the wider population that e-cigarettes are as harmful to health as normal cigarettes.

4.5 There are those who strongly advocate the use of e-cigarettes and see them as a vital tool for achieving the goal of a tobacco free generation by 2025. The “pro” e-cigarette advocates refute the claims that e-cigarettes are a significantly lower risk to health than smoking tobacco. Advocates of e-cigarette would caution against those who call for similar regulation of e-cigarettes to normal tobacco containing products as there is little incentive for smokers to switch to e-cigarettes.

4.6 With the increasing amount of conflicting information for and against e-cigarettes becoming available in the public arena there has naturally been confusion for the public and health professionals alike. In response, Public Health England published and evidence update[2] which concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking. Key findings of the report included:

- the current best estimate is that e-cigarettes are around 95% less harmful than smoking
- nearly half the population (44.8%) don’t realise e-cigarettes are much less harmful than smoking
- there is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers

4.7 The report demonstrated that evidence suggests some of the highest successful quit rates are now seen among smokers who use an e-cigarette and also receive additional support from their local stop smoking services.

[2] E-cigarettes: an evidence update. A report commissioned by Public Health England. (2015) Public Health England. Available to download https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf

4.8 Whilst the current position from PHE is that e-cigarettes are significantly less harmful that cigarettes they would encourage people to move towards not smoke either product and seek help to move to complete cessation. PHE have adopted a current watch and wait stance. In the future if more evidence arises of significant harm then the position could change to support stricter regulation of e-cigarettes.

4.9 The use of e-cigarettes has very rapidly changed the conversation on how people quit using tobacco. The current evidence suggests that there is a significant harm reduction in using e-cigarettes instead of tobacco. Public health would encourage any individual who has chosen to use e-cigarettes as a method of tobacco cessation to use the local stop smoking services to help them towards a nicotine free life. This current position is open to change with future developing guidance and policy.

**5.0 Smoking related health inequality**

5.1 Whilst there has been a reduction in the number of smokers in the population, nationally there are inequalities seen in smoking in the population. There are a higher proportion of smokers in deprived communities in England as shown in figure 2 below.

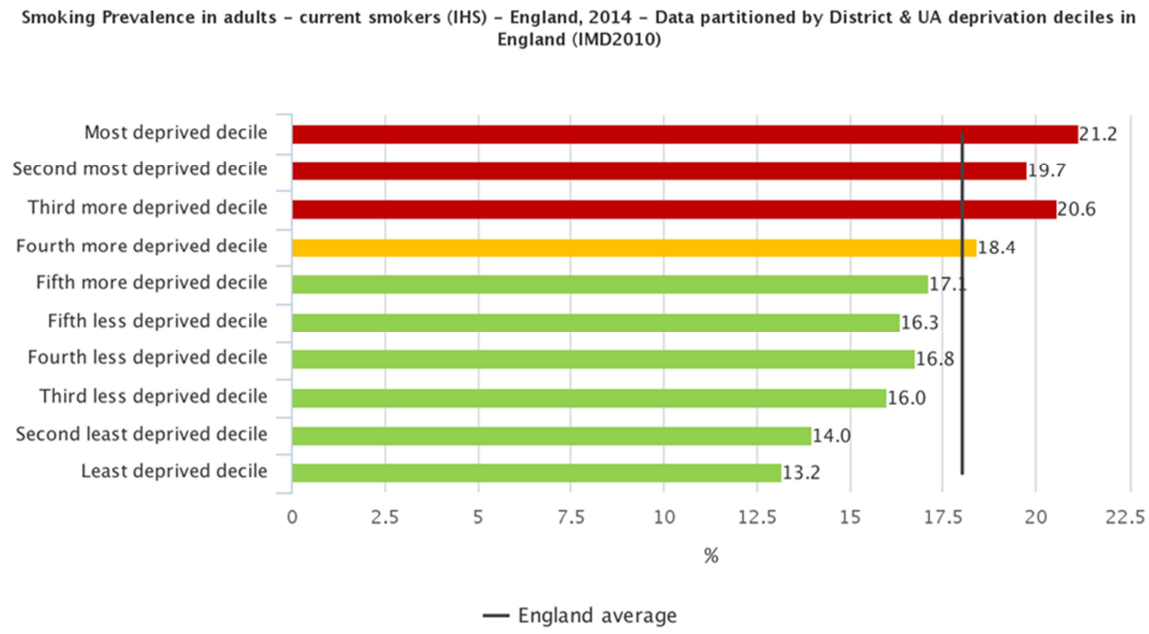


**Figure2. Smoking prevalence in adults by deprivation deciles in 2014** ***Source:*** ***www.smokinginengland.info***

5.3 This pattern of prevalence presents challenges that are seen in other areas of health services in engaging with groups that are historically difficult to reach. In future provision of services different prioritisation of resources to target these groups may need to be considered.

## 6.0 Smoking in Oxfordshire

6.1 In Oxfordshire the prevalence of adult smokers has seen a continued decline in the past few years. This decline is shown in figure 3 below. The prevalence of adults who smoke in Oxfordshire is currently estimated to be 13.6% which is better than the national prevalence (18.4%).

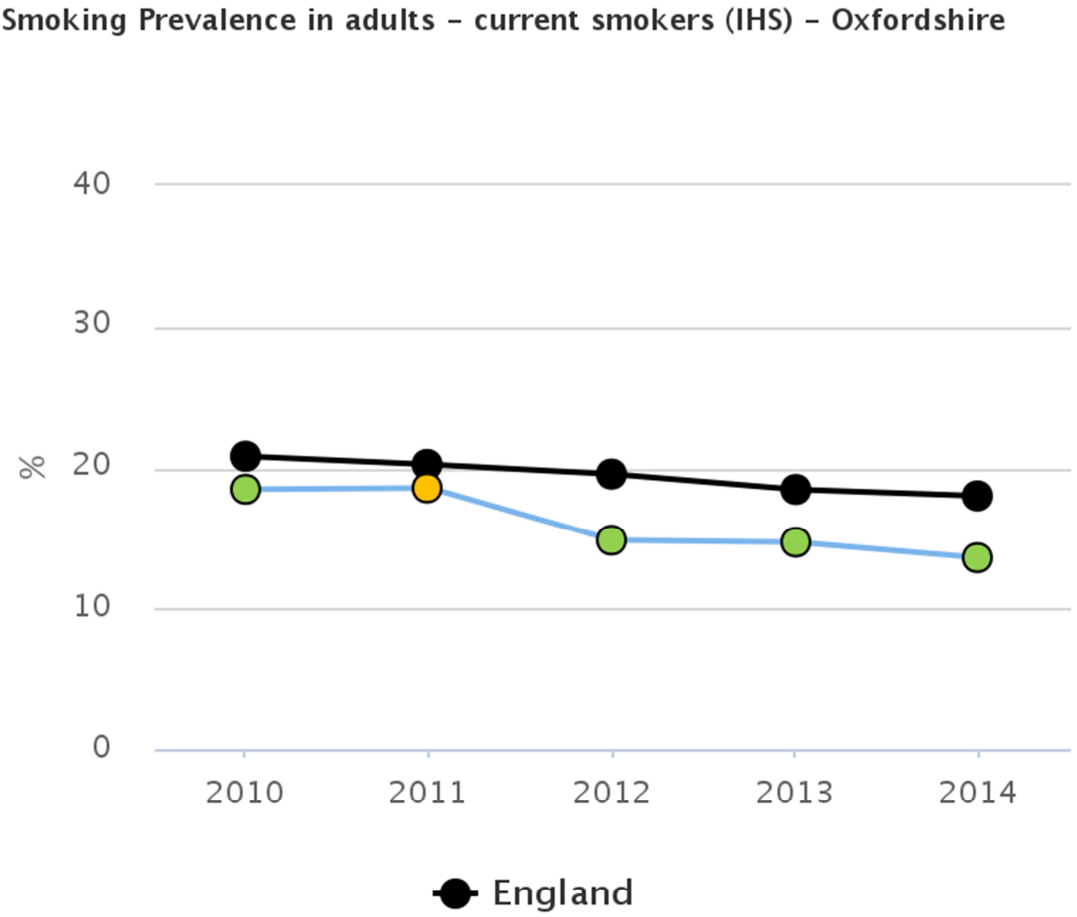


**Figure 3 Smoking prevalence in Oxon 2010-14** ***Source: PHE*** ***www.tobaccoprofiles.info***

6.2 While it is encouraging that the population of smokers in Oxon is less than that seen nationally there is an inequality in who smokes in the local population. There are a higher proportion of people who smoke in Oxford, the Vale of the White Horse and until recently in Cherwell, as seen in figure 4.

6.3 Whilst we do not have similar prevalence data by deprivation locally it can be inferred that there would be a similar expected inequalities pattern seen in smoking prevalence which can be supported by the higher rates in Oxford and Cherwell which have a higher number of deprived localities. Further investigation will be required to understand the increase in the prevalence in VOWH.

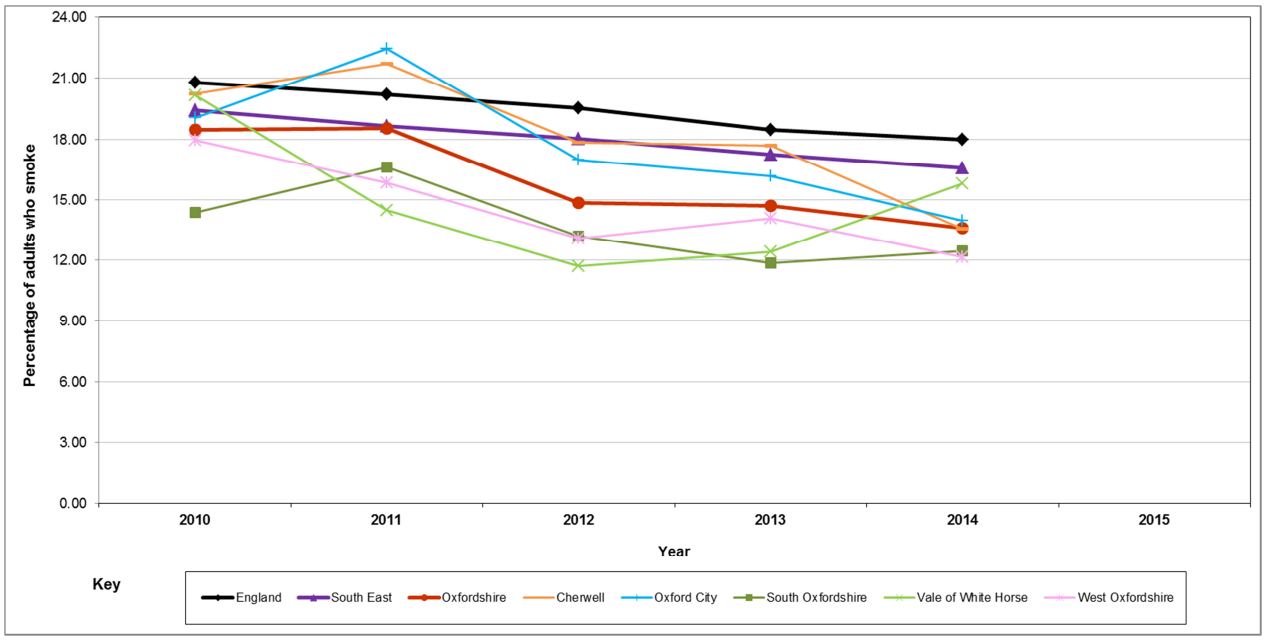


**Figure4. Percentage of adults who smoke by District *Source: PHE***

6.4 The prevalence of regular smoking in young people in Oxon has also seen a decline over the past years which is positive (figure 5). Current estimates are that 5.7% of 15 year olds are regular smokers; this is not significantly higher than the national average of 5.5%. More work is required to understand why there is more young people smoking and also how to engage to prevent them starting in the first place.

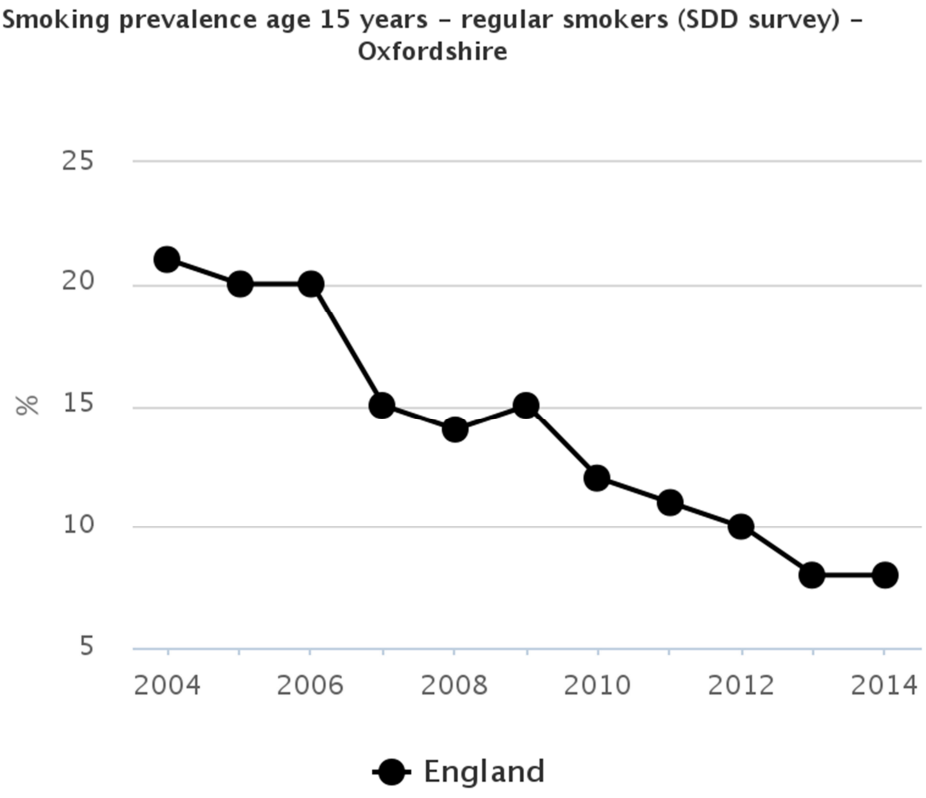


**Figure5. Smoking prevalence at age 15 years in Oxon. *Source:* [www.tobaccoprofiles.info](http://www.tobaccoprofiles.info)**

## 7.0 Quit rates in Oxfordshire

7.1 Successful quitting of smoking is recorded as an individual who reports not smoking tobacco products of any kind over a 4 week period. The decline in activity seen in stop smoking services nationally has also been seen locally. In 2013/14 the number of quits for Oxon was 2770. This number had declined to 1429 in 2014/15. The trend for the rate of quitters in Oxon is shown in figure 6. The rate of decline in 2014/15 is greater locally than nationally, we believe that this the natural end of the contract with the previous provider for stop smoking services may have contributed in part to this.

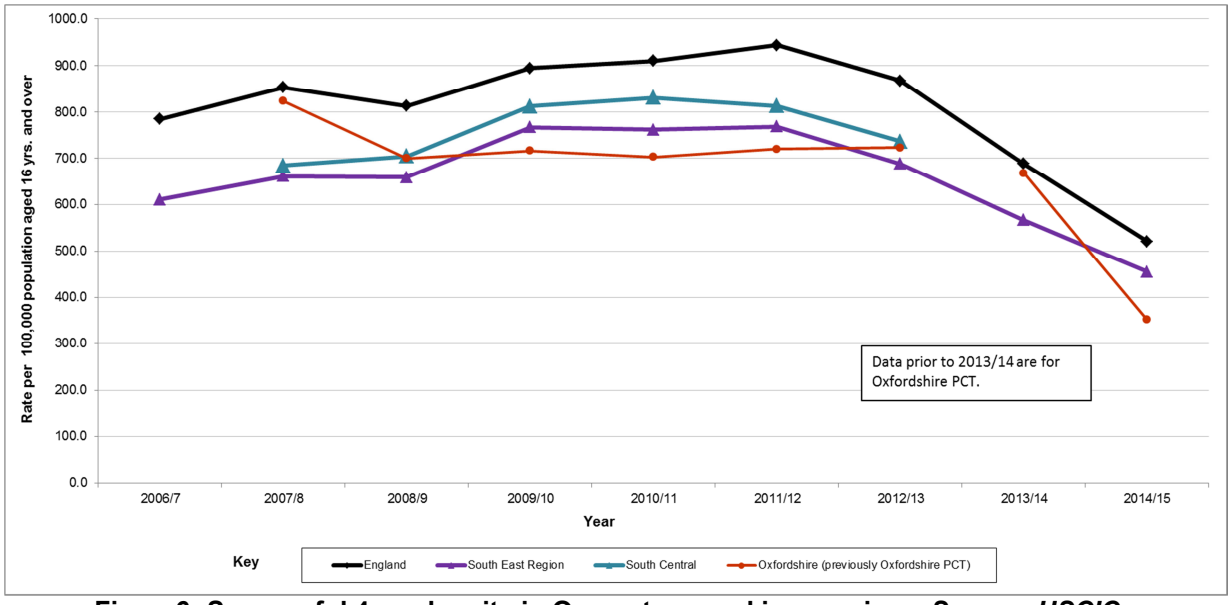


**Figure6: Successful 4 week quits in Oxon stop smoking services. *Source: HSCIC***

## 8.0 Allocated budget for smoking services

8.1 In 2015/16 the budget for smoking cessation services is £980k. The commitment for the budget is detailed below:

- £500k Smoking cessation outreach and support services
- £150k GP smoking cessation services
- £30k Pharmacy smoking cessation services
- £285k NRT prescribing costs
- £15k data support services
- £2k tobacco control

8.2 The future budget for smoking services will be dependant on the reduction of the public health grant announced in the spending review in November 2015.

**9.0 Smoking Cessation Services in Oxfordshire**

9.1 There is a wide provider accessibility of smoking services available for the local population of Oxfordshire. Oxfordshire County Council commissions services from the following providers

GP Services

9.2 GP surgeries are a key stakeholder in the delivery of local stop smoking services. Currently 76 GP practices in Oxon hold a contract to provide smoking cessation services for their patients. This service is open to any individual who requests it from their GP surgery. In 2014/15 the GP services delivered 1227 successful 4 week quits. In Q1& Q2 2015/16 the GP services have delivered 268 successful 4 week quits.

Pharmacy Services

9.3 There are 107 pharmacies who hold a contract to provide smoking cessation services. This service is available for any individual who requests it from participating pharmacies. In 2014/15 the pharmacies delivered 61 successful 4 week quits. In Q1& Q2 2015/16 the pharmacy services delivered 13 successful 4 week quits.

Soultions 4 Health

9.4 A contract to provide outreach and smoking cessation support services was let to Solutions4Health which commenced 1 April 2015. Soultions4Health provide:

- Smoking outreach service.

  9.4.1 Solutions 4 Health provide outreach services directly to the public in Cowley, Wheatley, Didcot, Abingdon and Banbury. They also have provided workplace based services to Unipart, Thames Water, Ruskin College and Siemens.

  9.4.1.2 Since Solutions4Health started delivering services on 1 April 2015 they have delivered 659 successful 4 week quits in Q1& Q2.

- Training for smoking cessation advisors.

  9.4.2 Solutions 4 Health provide training services for all contracted providers staff to ensure that all individuals providing cessation support are suitably trained. The provider also delivers training for the wider health workforce in delivering smoking cessation advice to the local population and signposting to services.

- Marketing of smoking cessation services.

  9.4.3 Solutions 4 Health host and run a dedicated website www.smokefreelifeoxfordshire.com which provides comprehensive information on qutting smoking and how to access stop smoking services locally.

  9.4.4 Solutions 4 Health also provide marketing of stop smoking services these have included the successful launch of the service which took place in Banbury, participation in canal day and a series of events in the county to promote Stoptober.

- Materials and equipment support for GP and Pharmacy services.

  9.4.5 Soultions 4 Health work with commissioners and the council comms team to develop promotional materials and provider resources which are available for the local service providers.

- Collaborative working with GP and Pharmacy to improve delivery of services.

  9.4.6 Solutions 4 Health provide support to GP and Pharmacy services, advising on current best practice, maintaining equipment and working with providers on improving uptake and quality of services.

- Data collection and support

  9.4.7 Solutions 4 Health work with commisioners to ensure data handling and intellingence to support the local programme and meet national requirements for data submission.

Oxfordshire School Health Nurse Services

9.5 The school health nurses are trained in smoking cessation and deliver this in all secondary schools.

**10.0 Local Challenges for Smoking Services**

10.1 The continued decline of numbers of quits in the local stop smoking services has been a concern for commissioners in the past year and addressing this is a priority.

10.2 With the new contract let in April of 2015 there would be an expected period of disruption that accompanies the implementation of services with a new provider. Commissioners are working with all providers to improve the uptake of smoking cessation services and have already begun to implement the following actions:

10.2.1 With the previous provider of support services GP practices recorded activiy on paper based forms. Public health have commissioned the development and implementation of electronic data recording of smoking activity on practice administration systems as used in other services such as the NHS healthcheck. This is in place from Q4 and will help improve the reliability and accuracy of recording activity and simplify the process for providers.

10.2.2 Analysing the activity of practices to identify GPs who are performing well and those who have dropped in performance. Solutions 4 Health will work with providers preforming well to identify good practice which can be shared with all providers.

10.2.3 Analysing prescribing activity. GP providers are anecdotally reporting that they are seeing patients and helping them quit. Initial analysis of prescribing would indicate that the levels of prescribing acitivty may not have declined as much as recorded quits. Using this data commissioners will work with providers to improve capturing quit data.

10.2.4 Reengaging with GP providers. Commissioners and Solutions 4 Health are currently meeting with practice managers, GP leads in the federations

and the CCG respiratory lead to discuss how GPs can contribute solutions to improving quits in their practice populations.

10.2.5 Solutions 4 Health are currently visiting practices to discuss how services are delivered in practices and will work with the staff in the practices to increase activity.

10.2.6 Continue work with the school health nurse services to deliver prevention messages, cessation advice and support.

Eunan O'Neill- Consultant in Public Health
Public Health Directorate
Oxfordshire County Council

**Oxfordshire Affordable Warmth Network**

**Health Improvement Board Briefing - February 2016**

## Summary

This paper includes an overview of fuel poverty issues in Oxfordshire and recent work to address them. The latest figures for the Fuel Poverty outcome measure are given. An outline of the British Gas funded Better Housing Better Health project, led by the Oxfordshire Affordable Warmth network is also included.

## Fuel Poverty in Oxfordshire

The Low Income High Cost (LIHC) fuel poverty indicator gives an indication of the proportion of households in a particular area are deemed to be in fuel poverty[1]. The latest figure for Oxfordshire is 8.7%, in England it is around 11%. This data is also available at District and Lower Super Output Area (LSOA) levels. The lowest level of fuel poverty for an LSOA in Oxfordshire is 2% and the highest is 33%. The figures in the LSOAs highlight the extremes of regional variation, even between wards.

Oxfordshire partners tackle Fuel Poverty, mostly through the Affordable Warmth Network (AWN), to which most partners contribute financially. The **National Energy Foundation** (NEF) provides the administrative work on behalf of all the partners. They support the work of AWN set out in the Action Plan and raise awareness of Fuel Poverty. This means that clients can make direct contact with NEF as well as getting information from their local district council. The key partners who contribute financially are Cherwell District Council (DC), West Oxfordshire DC, South Oxfordshire DC and Vale of White Horse DC, Oxfordshire County Council Public Health, Citizens Advice Bureau and Oxfordshire Clinical Commissioning Group. Other organisations have associate membership - Oxford City Council, Age UK, Low Carbon Hubs and Oxford Brookes University.

The offer to Oxfordshire residents by the AWN includes

- Sourcing and provision of funds to provide free or reduced loft insulation, cavity wall insulation, solid wall insulation, new boilers, to tackle cold and damp.
- Enforcement of poor housing conditions to reduce Excess Cold and Damp and Mould in private sector housing
- Provision of advice around keeping your home warm, through better knowledge and behaviours, including a free helpline around what additional financial help is available.
- Support accessing full benefit entitlements.

[1] **Low Income High Cost Indicator: Definition**
Under the new **Low Income High Cost** definition a household is considered to be fuel poor where:
* they have required fuel costs that are above average (the national median level)

*were they to spend that amount, they would be left with a residual income below the official poverty line.
The low income high cost indicator consists of two parts:
The **number** of households that have both low incomes and high fuel costs
The **depth** of fuel poverty amongst these households. This is measured in terms of a fuel poverty gap, which represents the difference between the modelled fuel bill for each household, and the reasonable cost threshold for the household. This is summed for all households that have both low income and high costs to give an aggregate fuel poverty gap.

- Development of projects to improve communications between existing and new partners, such as health and social and health colleagues.

## Oxfordshire's Fuel Poverty Outcome reported to the Health Improvement Board

The Fuel Poverty outcome is the number of "significant increases" made to a property as a result of the work of the partners of the AWN. Significant increases were defined as

- loft insulation (including top-ups where the insulation level was at least doubled),
- Cavity Wall insulation,
- External Wall insulation,
- Installation of a more efficient boiler,
- Installation of a more efficient heating system,
- Upgrading of windows from single glazing and
- Increase in the uptake of benefits (at least £1200).

The breakdown of the figures up to the end of Q3 in 2015-16 are in Appendix 1 of this report. This is a summary of the activity which has been carried out in line with 2014/2015 Fuel Poverty Action Plan, as well as the day to day activities of the partners who work on fuel poverty, for example by delivering benefits assessments, housing inspections, awarding of grants and loans and giving out advice.

*This figure reported is not complete and there may be some variation in how the measures are recorded and reported.*

The Health and Wellbeing Strategy sets a baseline target of 550 households being helped. We can report that there were 1418 properties in Oxfordshire who received significant increase in the energy efficiency of their homes in the latest reporting period (Q1 to Q3), up from 1109 in the same reporting period last year. 164 of these were physical improvements to homes, down from 249. 1245 benefits assessments were carried out, up from 860 and it is estimated that an additional £6.51 million of additional benefits were identified.

With the closure of the Green Deal (a flagship loan scheme for energy efficiency improvements in peoples homes) and currently no scheme to replace it, there continues to be a heavy reliance on lifting people out of fuel poverty predominantly through increase in income (increase in benefits). Fuel bills are affected by wholesale fuel prices and the families own unique circumstances, but if the property remains inefficient in its production and retention of heat then there may be little long term advantage to increasing income. This means it is not a long term solution, both for the residents and the potential impacts on their health, or the environment.

## Action Plan and other project updates

### Better Housing, Better Health

The Oxfordshire AWN and Buckinghamshire AWN were successful in winning £412,5000 grant from the British Gas Energy Trust (http://www.britishgasenergytrust.org.uk/ ) to deliver a year long project to tackle cold homes and health. The aim is to link up the work

of the AWN to Health and Social Care providers and also provide some additional grant funding for energy efficiency improvements to those whose inability to adequately heat their home is affecting their cardiovascular or respiratory condition. This is a well-timed and needed resource in light of the recommendations in the NICE guidance (NG6) on Excess Winter Deaths, which recommends a "single point of contact for health and housing referral service for people living in cold homes". The funding through this grant is for 2016 only. Funding will need to be found for the following year to

a) fund the administration of the scheme

b) fund the additional resources required to reach in to health and social care providers,

c) provide the enhanced offer from the AWN (Home Energy Checks),

d) maintain the additional grant fund for those with health conditions

e) fund the existing work of the AWN (free phone telephone number for local advise and access to grants, administrative support of the network, general promotional activity).

For more information please visit the website (www.nef.org.uk/bhbh ) or speak to Alex Steeland at National Energy Foundation (NEF): alexandra.steeland@nef.org.uk.

The need to maintain this investment is even greater now with the Green Deal being stopped as the Oxfordshire-based community interest company, Green Homes Together has now unfortunately ceased activities. This had been key in providing the building based measures to Oxfordshire residents.

References:

NICE Guidance (March 2015) Excess winter deaths and illness and the health risks associated with cold homes - https://www.nice.org.uk/guidance/ng6

Department for Energy and Climate Change: Fuel Poverty report 2013 (DECC 2013).

Written by Kate Eveleigh, Health Improvement Practitioner with the support of the Affordable Warmth Network

## Summary of the Affordable Warmth Network Activities 15/16

### "Offers and resource"

Easy Save booklet and factsheet for residents

Free cavity wall and loft insulation, utilising ECO grants

25 community group talks given / events attended

Assistance to switch to a cheaper energy tariff provided

CSCO areas mapped in Cherwell and Oxford

Off gas areas and fuel poverty on JSNA website

Health data (COPD) from GPs sourced and mapped by CSU/CCG

Better Housing, Better Health project launched following successful funding bid

### "Community Engagement"

Outreach activity has directly advised over 1,200 residents face-to-face

Assistance provided for community group thermal imaging projects, targeted towards fuel poor regions

### "Partnerships"

New referral sources from health and social care used to target vulnerable residents

Cross referrals between CAB, Age UK and NEF.

NEF attended Age UK CIN events

NEF worked with Consumer Empowerment Partnership through Big Energy Saving Week, and spoke at their Fuel Poverty Forum.

Links being developed with Oxfordshire Fire & Rescue Service

### "Communication and Promotion"

Community outreach offered

Easy Save booklet and factsheet

New banner stands produced, with health-housing link messaging

Editorial in The Volunteer, Resident Guides across the county and parish newsletters

Winter Warmth Pharmacy campaign

Appraisal and updates of council websites and communications

Targeted mail-outs undertaken with local authorities to promote availability of grants

**Appendix 1: Health Improvement Partnership Board – Update from Oxon Affordable Warmth Network, Q1, Q2 and Q3 of 2015/2016**

| | Vale of White Horse | South Oxon | West Oxon | Cherwell | Oxford City | Citizens Advice Bureaux | Affordable Warmth Network | AgeUK Oxfordshire | Green Deal Together | Other (inc. DECC Communities programme) | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # HHSRS excess cold resolved | 3 | 3 | 18 | 20 | 26 | | | | | | 52 |
| # HHSRS Damp & Mould resolved | 17 | 18 | 48 | 22 | 28 | | | | | | 85 |
| # Boilers installed | 0 | 0 | 0 | 3 | 2 | | TBC | | Ceased operating | 0 | 5 |
| # More efficient heating system | 3 | 0 | 0 | 5 | 0 | | TBC | | | 0 | 8 |
| # loft top ups | 1 | 2 | 0 | 1 | 0 | | TBC | | | 0 | 4 |
| # double glazed windows | 0 | 0 | 0 | 1 | 6 | | TBC | | | 0 | 7 |
| # Cavity Wall | 0 | 0 | 0 | 1 | 0 | | TBC | | | 0 | 1 |
| # External Wall | 2 | 0 | 0 | 0 | TBC | | TBC | | | 9 | 2 |
| # Uptake of benefit | | | | | | £4,500,000 for 790 clients.* | | £2,018,456 for 464 clients.* | | | 1254 clients £6,518,456 |
| | | | | | | | | | | Total | 1418 |

* Annual amount of additional benefits claimed on behalf of eligible residents.

**Report to Health and Overview Scrutiny Committee (HOSC) – 4 February 2016**

# 'The District Council Contribution towards Health and Wellbeing in Oxfordshire'

## Background

1. Oxfordshire is currently in discussion with Government with regard to a Devolution Proposal for Oxfordshire. The proposal has three key strands:
    - Planning Infrastructure and Housing
    - Business and Skills
    - Health and Social Care

2. The proposals, in particular for Health and Social Care element, are still at an early stage of development.

3. At the HOSC meeting in December 2015 there was a discussion about the Devolution proposals and as a result it was requested that there be an item at this meeting, to consider the Oxfordshire district council roles in health and wellbeing.

## The Health and Wellbeing Board Priorities

4. A summary of the priorities for the Oxfordshire Health and Wellbeing Strategy is set out in Annex 2. The delivery of these priorities are overseen by the:
    - Children's Trust Partnership
    - Joint Management Groups (for Older People, Mental Health etc)
    - Health Improvement Board

5. The district councils clearly have a role in delivering some of these priorities but this is very much in its infancy of being defined. There has not as yet been a meaningful discussion about what this may involve and how this will be funded. It is therefore opportune that a recent report has been produced by the Kings Fund which makes a number of recommendations in taking this area of work forward.

## The Kings Fund Report

6. The District Council Network (DCN) commissioned the Kings Fund by to undertake an assessment of the role of district councils in improving the health of their citizens and communities. The report 'The District Council contribution to public health: a time of challenge and opportunity' was published in 2015. It focuses on district councils' role in promoting public health through some of their key functions and enabling roles. The link to this report is below.

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/district-council-contribution-to-public-health-nov15.pdf

7. The report highlights both the current contributions of districts to the health and wellbeing of our communities and the potential for even greater district impact on local health outcomes.

8. District Councils have a long and proud history of providing public health services and supporting positive health outcomes for our communities. Recent proposals for devolution emphasise the need for clarity and recognition of the roles districts play in ill-health prevention, and greater understanding of the opportunities for increased collaboration and integration presented by devolution.

9. The key messages and recommendations presented by the report provide a direction of travel for establishing districts in the mainstream of health and social care policy for the future.

10. The report provides case studies illustrating some of the innovative and collaborative approaches taken by districts and providing examples of the possibilities for district-led innovation (including the Ladygrove 'loop' a 2.4 mile integrated walking, running and fitness route developed by South Oxfordshire).

11. The district councils in Oxfordshire all provide core services which support health and well- being. They also provide a variety of other services, primarily aimed at the different needs within their communities. Therefore there is not a 'one way' of doing things. Annex 1 provides a summary of the various activities that are provided by district councils across the county.

## The district council offer to public health


(Fig 1: Kings Fund Report: The District Council contribution to public health: a time of challenge and opportunity 2015)

## The Core District Functions

12. The core district council functions include:

- Housing, in particular affordable housing: housing costs "are the most important factor in the relationship between housing and poverty" and, as is widely recognised, the demand for affordable housing is a significant issue in many areas of the country – and especially in Oxfordshire.

- Reducing homelessness – on average homeless people's health costs are four times those of non-homeless people.

- Home adaptations: With almost half of all accidents occurring in the home, home adaptations to mitigate against trips and falls provide significant potential savings to the health services: for example, the hospital cost of a hip fracture is over £16,000 in the first two years.

- Leisure services provided by districts are a central element. Sport England's analysis estimates annual savings of £1.7bn to the NHS through sport, along with wider benefits to the economy an innovative use of green spaces through schemes such as walks to health, park runs, and green gyms all provide significant health benefits, with access to green spaces being recognised as important to mental as well as physical health. Some district councils have arts and cultural services which can also provide significant benefits for health and wellbeing.

- Environmental Health including functions such as monitoring and managing local air quality, noise nuisance, food safety, enforcing the smoking ban, ensuring compliance with occupational health and safety regulations, pest control, and dealing with contaminated land, among others.

**The District Council's Enabling Role**

13. Alongside the fundamental contributions made by services such as these, the report also highlights the importance of the enabling roles provided by district councils, specifically in three main ways:

- Planning: the impact of planning and sustainable development of neighbourhood infrastructure has a significant bearing on physical, social and mental health. Through taking into account factors such as open space, air quality, connectivity, active commuting and so forth planning plays a crucial enabling role in local health outcomes.
- Economic development: the importance of a strong local economy to health outcomes is identified by the report, particularly through the benefits of employment for the health of individuals, families, social networks and communities. District councils' key role as drivers of growth is thus central to this relationship.
- Engagement with communities: Supporting social capital by strengthening social networks and community centred approaches to health, particularly through greater volunteer involvement in health care support

**Current funding for health and wellbeing activities**

14. District Council funds originate from two main sources a grant from central government and locally generated income through Council Tax. Securing additional income is increasingly reliant on the New Home Bonus and the business rates retention scheme. A number of grants and sources of income are available for specific purposes. The ongoing switch in the source of revenue has important effects on district councils and their actions.

15. Because of recent changes in budgets the district councils in Oxfordshire are dependent upon funding from Oxfordshire County Council to deliver Supported Housing to those who are homeless or at risk of homelessness and the Disabled Facilities Grant. Any reductions in these funding will have significant impact on health.

16. Whilst the reduction in Government grant increases uncertainty (and the need to generate more income to compensate) it also means that district councils have more influence over their revenue and this incentivises activities such as planned house building and economic development. This activity and how it is planned will have a knock on effect on health.

**The Kings Fund Report: Key findings for future development**

17. Public health reform and localism create opportunities for districts' contributions to health and wellbeing to be more integrated and embedded in future public health systems.

18. The report recommends that to assist in this integration, districts require a more robust evidence base of return on investment from their actions on public health, in order to influence and inform health policy decisions.

19. In order to achieve this integration into mainstream health policy, the report sets out three key factors for districts to focus upon:

    - To continue to lead innovation in services and their delivery
    - To strengthen their enabling role in the health of their communities
    - To better demonstrate effectiveness and return on investment

20. A key recommendation in the report is that the Clinical Commissioning Groups (CCGs) and county councils should include district councils when discussing alignment as one key part of the 'out-of-hospital care' system and to ensure that district councils are a key partner in improving the relationship between the health and social care system and the community.

21. In Oxfordshire we are well set for district councils to play a coordinated role in delivering health and wellbeing. Oxfordshire Health and Wellbeing Board has two District Council Executive Board Members represented on the Board and there is an Oxfordshire Health Improvement Board which includes all of the District Councils and which is Chaired and Vice Chaired by the District Councils.

22. District Councils are also developing links with their Clinical Commissioning Locality Groups, to better understand their needs and to look at how district services may be better used, for example social prescribing. These connections will be valuable as a precursor to the changes being proposed.

23. District councils also work closely with Oxfordshire Sports Partnership and the Oxfordshire Arts Partnership which support the delivery of sports and cultural activities using external funding.

Val Johnson
Partnership Development Manager
On behalf of Oxfordshire District Councils

13 January 2016

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

**Priority 6**: 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 7**: Support older people to live independently with dignity whilst reducing the need for care and support

## 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

## Health Improvement Board some key activities undertaken in 2015-16

**A Healthy Weight Strategy and Action Plan** has been agreed which is currently in the process of review. The district councils have undertaken a thorough review of the services that they provide. An Action Plan is in the process of being drafted and this is likely to include a number of actions for district councils.

The **Public Health Campaigns** report: looking at how the members of the Board can support public health campaigns. As a result district councils have agreed to support these campaigns on websites, newsletters and through the local community partnerships and health groups.

The **Supported Housing Budget**: There has been a reduction by the County Council in the Supported Housing Budget. This has resulted in the need to redesign the provision of housing support services. Since then further cuts have been announced to this budgets and it is clear that this will need to be an urgent issue for the Board to address in the next few months.

The **Young People's Supported Housing Pathway**. It has been agreed that the Board will oversee the delivery of this service. This service is seeing a substantial increase in demand and has difficulty in identifying enough suitable accommodations for vulnerable young People. This will be an on-going priority for the Board.

**District Council activities to Promote Health and Wellbeing**
**January 2015**

| **Promoting healthy activities** | **Why are we doing it?** |
|---|---|
| **Promoting health and active lifestyles** | |
| The provision of: parks, pitches, play areas, skate parks, swimming pools, street sports, ice- rinks and countryside provision. | To promote healthy and active lifestyles for all children and young people.<br>To facilitate people to become more physically active in order to promote health and wellbeing. |
| The provision of community facilities and community centres which may well be able to accommodate healthcare provision (e.g. new Rose Hill Community Centre in Oxford). | To promote access to health and wellbeing by enabling people to use services within their local communities. |
| Targeted activities in sports centres and community venues(e.g. swimming and fitness classes)<br>There is some subsided provision for families on low incomes. To encourage those who may not be able to afford it to access sports and activities. | To increase the number of people taking part in physical activity in order to preventing long term health conditions. |
| Health Walks | To facilitate people to become more physically active in order to prevent/recover from long term conditions and obesity and to remain physically active for longer into old age. |
| Dance for Young People and Older People | To enable, encourage and empower people to be physically active, learn new skills and enjoy the social aspect of dancing. |
| **Promoting volunteering and community engagement** | |
| Volunteering in the local area. | To help people to engage and benefit from volunteer activities which is one of the “Five Ways to Wellbeing”. |
| Community grants for services that directly or indirectly benefit vulnerable groups. | To promote healthy and active lifestyles for all.<br>To increase the number of people who feel they are valued members of the community. |
| Support to Oxfordshire Council for Voluntary Action / Oxfordshire Community First – to enable them to provide support to voluntary and community groups. | To support and advice voluntary and community groups who provide support people e.g. healthy lifestyle activities and economic inclusion. |
| Grant funding to sports clubs and associations. | To promote healthy lifestyle activities and to strengthen communities through voluntary action. |
| **Raising awareness of local need and promotional activities** | |
| To actively engage with other agencies and partnerships, to promote local need and coordinate the delivery of services. | To ensure that local services meets local needs and reduce inequalities. |
| Information dissemination of public health messages<br>Working with partners to promote their public health activities and campaigns e.g. Fostering | To enable children, young people and families to access the services that they need. To promote healthy life styles and choices. |

| | |
|---|---|
| and Carers Campaigns. | |
| Employee Assistance Programs and Work Fitness Schemes | To improve the quality of life and to promote healthy lifestyles amongst staff. |
| **Promoting access to education, training and employment** | |
| Working with partners to promote life- long learning, training and employment initiatives, especially for particularly vulnerable groups. Support to Job Clubs. | To improve life opportunities and promote healthy lifestyles.<br>To promote financial inclusion and to mitigate the impact of poverty on poor health. |
| To work with partners to support NEETs the delivery of the NEETs/NILs Action Plan. | To improve life opportunities.<br>To promote financial inclusion and to mitigate the impact of poverty on poor health and diet. |
| **Provision of good quality housing** | |
| Regulation of private sector housing and Houses in Multiple Occupation. | To ensure families and individuals live in appropriate housing that is safe and not over-crowded. |
| Planning and Older People's Housing Strategy and Housing Allocations Policies. | To ensure that older people can access appropriate housing. |
| Provision of housing for people with special needs and Extra Care Housing | To ensure a suitable pool and range of properties to people with physical disabilities and care related needs related to aging. |
| Sheltered accommodation | Provision of suitable accommodation to enable older people to maintain independent living. |
| Advice and information on housing choices | To ensure older people live in appropriate housing and receive related support and information to assist them to maintain independent living and reduce the likelihood of hospital admission. |
| Support for Home from Hospital Scheme | Helps people to achieve full rehabilitation and regain independence, also enables quicker discharge from hospital. |
| Occupational Therapists | To assess the need for and specify adaptations for people with disabilities. |
| Disabled Facilities Grants | To help provide adaptations for disabled people which help them to stay in their own homes. |
| Essential Repairs Grant for people living on lower incomes living in private accommodation. | To help with home repairs and to enable people to remain in their own home. |
| Licencing of Houses in Multi Occupation | To ensure those living in private rented accommodation are living in safe, secure accommodation and that they are not overcrowded. |
| Promotion of Affordable Warmth Initiatives | Reduced deaths from cold and reductions in fuel poverty which is associated with poor health. |
| Tenants at Risk Team working with the Thriving Families. | Working with vulnerable families to prevent them from becoming homeless. |
| **Planning and transport** | |
| Ensuring adequate transport links, promotion of cycling and walking schemes | To promote healthy activities and wellbeing. |
| To design sustainable communities and promote life- long housing | To promote healthy lifestyles and ensure accommodation is suitable for older people and those with disabilities. |

| | |
|---|---|
| Grant aid to Shop Mobility / subsidised transport schemes | To improve access to services. |
| **Community safety and safeguarding** | |
| Safeguarding awareness raising, reporting incidents and concerns and the provision of information, advice and training for staff and volunteers. | To keep children and adults at risk safe from harm and to promote their health and wellbeing. |
| Reduce fear of crime which is particularly prevalent amongst older people. | Target hardening of properties. Raised community awareness and reduced stress and anxiety. |
| Community safety advice and support. | Talks to community groups on personal safety. |
| To raise awareness about Child Sexual Exploitation, provision of information, advice and support. | To keep children and young people safe from harm and to promote their health and wellbeing. |
| OSCB and Multi-Agency Public Protection Arrangements (MAPPA) | To collate and share information on known offenders and to keep children and young people safe from harm. |
| To work with Domestic Violence, Alcohol and Drugs Tactical Business Groups to support initiatives that address domestic violence. | To reduce the levels of domestic violence, to improve the safety and health and wellbeing of families and children. |
| To work with other agencies to reduce human trafficking and exploitation. | To keep children and young people and their families safe from harm and to promote their health and wellbeing. |
| | |
| Night Safe | To reduce the numbers of children and young people who are under- age from drinking and smoking.<br>To keep children and young people safe in the night time economy.<br>To reduce alcohol related harm in the adult population including admissions to Accident and Emergency Dept for alcohol related injury or violence. |
| **Environmental Health** | |
| Licencing food safety and health and safety at work | Ensuring that local restaurants and food outlets provide food in a safe hygienic manner and to minimise work place accidents. |
| Premises licencing for alcohol and entertainment | To reduce the numbers of children and young people who are under- age from drinking and smoking. |
| Air Quality Management and reducing pollution and making sure water is safe | To reduce pollution and improve the quality of air and water. |
| Environmental protection, investigation of noise complaints | To reduce noise pollution. To reduce neighbourhood complaints and to improve the quality of life in communities and neighbourhoods |
| Enforcement of smoking bans, health and safety at work regulations. | To ensure safe work and leisure environments and reduce smoking related illness. |

| | |
|---|---|
| Identifying, preventing harmful effects from, encouraging regeneration and taking responsibility for returning contaminated land to a suitable standard. | To ensure land is not contaminated. |
| Pest control | To reduce mice and rat infestations and the spread of disease. |
| Resilience and Emergency Planning | To keep communities and individuals safe from serious harm. |

**Air Quality and Public Health**

**Health Improvement Board**
**18 February 2016**

**National Context**

1. The health effects of air pollution have been widely publicised and it is now recognised by the government as the country's second-biggest health threat, after smoking.
2. There is now categorical evidence that long-term exposure to everyday air pollutants contributes to cardiovascular disease (CVD, including heart diseases and stroke), lung cancer, and respiratory disease (which includes asthma and chronic bronchitis).
3. The UK is currently failing to comply with its obligations under the Ambient Air Quality Directive 2008. As a result, the European Commission has launched legal proceedings against the UK for its failure to cut excessive levels of nitrogen dioxide ($NO_2$). This leaves the UK Government open to potential fines of up to £300m.
4. The Government has reminded Local Authorities of the discretionary power in Part 2 of the Localism Act under which the Government could require responsible authorities to pay all or part of an infraction fine.
5. The Department for Environment, Food and Rural Affairs (Defra) published 'Improving air quality in the UK. Tackling nitrogen dioxide in our towns and cities' in December 2015. The Plan sets out how the UK will comply with the Air Quality Directive in the 'shortest possible' time and has to be submitted to the European Commission for approval in response.
6. Client Earth, the organisation which took Defra to the Supreme Court and forced the revision of the National Air Quality Plan, has indicated that it does not believe that the Plan is adequate and intends to take the UK Government back to court.

**The role of District Councils**

7. The Environment Act 1995 requires district councils to carry out periodic review and assessment of air quality within their area. The air quality objectives applicable to Local Air Quality Management (LAQM) in England are set out in the Air Quality (England) Regulations. Short and long term objectives are set for a number of pollutants including nitrogen dioxide and particulate matter.
8. District councils are required to designate an Air Quality Management Area (AQMA) when, as a result of the review and assessment that it has carried out, it appears that any of the air quality objectives are not being achieved.
9. Once an AQMA has been designated the district council should prepare an Action Plan that sets out how it will achieve the air quality standards or objectives for the area that it covers. The district council should provide information on the timescales for the achievement of measures that it can take under the powers that it has. Relevant powers and mechanisms include environmental health functions including those concerning the Clean Air Act (e.g. the ability to declare smoke control areas), environmental permitting and land use planning. The Action Plan should be in place within 12 months of the district council identifying the need for one.
10. District councils report annually to the Department for Environment, Food and Rural Affairs (Defra) on the results of monitoring in their area and progress with the

implementation of their Action Plan (if relevant). These reports are independently assessed prior to approval by Defra.

11. The Oxfordshire Air Quality Group has developed a website (https://oxfordshire.air-quality.info/) which allows Oxfordshire residents are able to see real-time and historic information about the air quality across the county. The development of the website was funded through a £20,000 grant from Defra's Air Quality Grant Scheme after a successful bid by South Oxfordshire District Council.

**The role of County Councils**

12. County councils have a number of obligations under LAQM and in practice should proactively engage with the district council as soon as an air quality issue is identified.
13. Where a district council is preparing an Action Plan, the county council is obliged to submit measures related to their functions (i.e. local transport, highways and public health) to help meet air quality objectives in their local area. These measures will be for inclusion in the Action Plan being developed (or Plans that undergo revisions) and should include the timetable for implementation of measures to be adopted.
14. There is now very strong evidence on the significant contribution of transport emissions to air pollution in urban areas and the Government expects county councils to bring forward measures in relation to addressing the transport impacts in its area for inclusion in any Action Plan.
15. The county council is a consultee to Action Plans. The county council may make recommendations to the district council in relation to any review and assessment of air quality or development or amendment of Action Plans in the local authority area.
16. Oxfordshire County Council recently developed the Local Transport Plan 4 (LTP4). LTP4 contains a commitment to improve public health and wellbeing by increasing levels of walking and cycling, reducing transport emissions, reducing casualties, and enabling inclusive access to jobs, education, training and services.

**Oxfordshire**

17. Air quality across Oxfordshire is considered to be generally good as the county is largely rural in nature. In the more densely populated areas of the county, and those which experience high traffic flows, increased levels of air pollution are of concern. In these areas, road traffic is the most significant source of pollutant emissions.
18. Air quality is regularly monitored at many locations across Oxfordshire. At some locations air quality is at levels where legal intervention is required by Local Authorities. There are currently 13 AQMAs in Oxfordshire, where the annual mean objective for nitrogen dioxide is being exceeded (four in Cherwell, one covering the whole of Oxford, three in South Oxfordshire, three in Vale of White Horse and two in West Oxfordshire).
19. All of the AQMAs in Oxfordshire have been declared as a result of emissions from road vehicles.
20. Public Health England estimated the mortality burden attributed to long term fine particulate air pollution exposure in Oxfordshire to be 5.6% of the population, equivalent to 276 deaths (Age 25+) and equivalent to 2944 life years lost[1]. It should be

[1] *Public Health England Estimates of Mortality in Local Authority Areas Associated with Air Pollution (April 2014)* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332854/PHE_CRCE_010.pdf

noted that there is considerable uncertainty attached to this estimate. By contrast, there were 26 fatalities on Oxfordshire's roads in 2014[2].

21. The quantification of mortality burden associated with long term nitrogen dioxide concentration exposure throughout England is likely to be available during the first half of 2016.[3]
22. This analysis has been undertaken for London only by King's College London[4]. The total mortality burden of anthropogenic PM2.5 for the year 2010 is estimated to be 52,630 life-years lost, equivalent to 3,537 deaths at typical ages. Whilst much less certain than for PM2.5, the total mortality burden of long-term exposure to NO2 is estimated to be up to 88,113 life-years lost, equivalent to 5,879 deaths at typical ages (assuming the WHO value of up to a 30% overlap between the effects of PM2.5 and NO2). Some of this effect may be due to other traffic pollutants.
23. As well as the mortality burden, air pollution is associated with respiratory and cardiovascular illness, particularly in vulnerable people such as the elderly, the very young and those with pre-existing health conditions including asthma and cardiovascular disease. Acute health effects are usually associated with peak air pollution episodes where people are exposed to high levels of pollution for short periods of time.
24. Damage costs are a simple way to value changes in air pollution. They estimate the cost to society of a change in emissions of different pollutants. Damage costs are provided by pollutant, source and location.
25. The damage costs presented below[5] include values for the impacts of exposure to air pollution on health – both chronic mortality effects (which consider the loss of life years due to air pollution) and morbidity effects (which consider changes in the number of hospital admissions for respiratory or cardiovascular illness) – in addition to damage to buildings (through building soiling) and impacts on materials.

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[2] *Oxfordshire County Council Road Traffic Accident Casualty Data Summary 2014* https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/roadsandtransport/safety/CasualtyReport2014.pdf

[3] *Committee on the Medical Effects of Air Pollutants (COMEAP) Interim Statement on Quantifying the Association of Long-Term Average Concentrations of Nitrogen Dioxide and Mortality (December 2015)* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/485373/COMEAP_NO2_Mortality_Interim_Statement.pdf

[4] *King's College London Understanding the Health Impacts of Air Pollution in London (July 2015)* http://www.kcl.ac.uk/lsm/research/divisions/aes/research/ERG/research-projects/HIAinLondonKingsReport14072015final.pdf

[5] *Interdepartmental Group on Costs and Benefits Air Quality Economic Analysis Damage Costs by Location and Source (September 2015)* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/460398/air-quality-econanalysis-damagecost.pdf

**Table 1: Air quality damage costs per tonne, 2015 prices**

| | | Central (1) | Central sensitivities (2) | |
|---|---|---|---|---|
| | | | Low | High |
| Oxides of nitrogen (NOX) | Transport average | £25,252 | £10,101 | £40,404 |
| | Industry | £13,131 | £5,253 | £21,010 |
| | Domestic | £14,646 | £5,859 | £23,434 |
| Particulate Matter (PM) | Transport average | £58,125 | £45,510 | £66,052 |
| | Industry | £30,225 | £23,665 | £34,347 |
| | Domestic | £33,713 | £26,396 | £38,311 |

(1) This estimate is intended for use only where a single point estimate is necessary and should always be accompanied by the central range.

(2) The central sensitivity for PM reflects uncertainties around the lag between exposure and the health impact. The sensitivity for $NO_X$ also reflects the uncertainty around the link between $NO_2$ exposure and mortality.

**What is being done?**

26. The District Councils either have developed, or are in the process of developing Air Quality Action Plans for the AQMAs in their areas.
27. Annual reports on monitoring and implementation of Action Plans are submitted to Defra and reviewed by an independent body.
28. As the cause of all the AQMAs is road traffic, the actions focus on reducing emissions from these vehicles and can be grouped into the following themes:
    a. Influencing the development of the Local Transport Plan and area specific strategies to ensure that impacts on air quality are considered at an early stage;
    b. Reducing emissions from transport, for example through the introduction of Low Emission Zones;
    c. Promoting more sustainable forms of transport, particularly electric vehicles;
    d. Encouraging modal shift to more active forms of transport such as walking and cycling;
    e. Education and awareness raising around air quality to promote behavioural change; and
    f. Ensuring that air quality is given due consideration as part of the planning process.

29. Opportunities to draw down funding from a variety of sources to implement measures to improve air quality in Oxfordshire have been taken where possible. This has resulted in funding from:
    a. Defra's Air Quality Grant Scheme for a number of projects, including the development of the Oxfordshire Air Quality Group website, Low Emission Zone feasibility studies and the development of Low Emission Strategies;
    b. The Office for Low Emission Vehicles for projects including the installation of charging infrastructure, a feasibility study into the development of a charging network for taxis and most recently £800,000 to support plans to trial new on-street charging technologies.
    c. The Department for Transport's Clean Bus Technology Fund to assist with reducing emissions from buses.

**What could the Health Improvement Board do?**

30. Work collaboratively on initiatives that deliver beneficial impacts on air quality and health.
31. Policies that encourage a shift from motorised transport to walking and cycling would be expected to reduce total vehicle emissions, including particulate pollution. If this could be achieved in towns and cities, then we could expect local improvements in air quality. There would also be additional health benefits from increased physical activity through walking and cycling.
32. Provide warnings to at risk groups about the dangers of air pollution and give them advice about protecting themselves (i.e. adaptation) and reducing pollution for themselves and others (i.e. mitigation). For example, people can reduce their exposure to air pollution by up to 50% by walking or cycling down side streets rather than busy roads. People can also reduce air pollution by walking or cycling or using public transport rather than driving a diesel vehicle.
    - Identify particular groups at risk in Oxfordshire (COPD, asthma, young, elderly or pregnant).
    - Provide information for GPs on air quality and its impact upon asthma and existing COPD conditions.
    - Public health should work collaboratively with environmental health, planning and transport to ensure that major developments consider the impact upon air quality and by extension the public's health.

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# Protocol outlining the relationship between the Oxfordshire Health and Wellbeing Board, the Oxfordshire Safeguarding Children Board, the Oxfordshire Safeguarding Adults Board, Oxfordshire's Community Safety Partnerships and the Oxfordshire Safer Communities Partnership

## 1. Purpose

1.1 This protocol relates to the multi-agency Boards/Partnerships in Oxfordshire that are working to improve the health and wellbeing of Oxfordshire residents and safeguard children, young people and adults with care and support needs who are vulnerable to abuse and neglect. Specifically these are:

i. Oxfordshire Health and Wellbeing Board (HWB) and its associated partnership boards and joint management groups
ii. Oxfordshire Safeguarding Children Board (OSCB)
iii. Oxfordshire Safeguarding Adults Board (OSAB)
iv. Oxfordshire Community Safety Partnerships (CSPs)
v. Oxfordshire Safer Communities Partnership (OxSCP)

1.2 The protocol sets out the framework within which these Boards/Partnerships will work together to safeguard and promote the welfare of people living in Oxfordshire, including the distinct roles, responsibilities and governance arrangements for each of them. It also refers to the relationship between the Boards/Partnerships and other partnership forums in Oxfordshire.

1.3 The opportunities presented by formal working relationships between the Boards/Partnerships include:

- An integrated approach to tackling key issues and commissioning services by sharing information and intelligence; for example, each Board/Partnership contributes to the Joint Strategic Needs Assessment which is drawn to inform strategic plans.
- Aligning annual plans with shared strategic priorities, including safeguarding children, young people and adults with care and support needs.
- Evaluating the impact of the key business strategies on safeguarding outcomes, community safety and wider determinants of health.
- A coordinated approach to performance and risk management, quality assurance and transformational change.

1.4 Whilst some of the Boards/Partnerships have a broader focus, safeguarding is still 'everyone's business'. This protocol will clarify the means by which accountability, co-ordination and coherence is achieved for thematic areas that are relevant to more than one of the Boards/Partnerships. It will ensure that there is effective challenge and scrutiny of safeguarding arrangements across Oxfordshire and there is a strong interface with community safety work. The protocol aims to reduce duplication of effort, ensure there are no gaps in

thinking or service provision, and that the work of the Boards/Partnerships has a positive impact on outcomes for Oxfordshire residents.

1.5 Where the word safeguarding is used in this protocol it refers to:

- Protecting people from abuse, maltreatment or neglect;
- Preventing impairment of health or development;
- Ensuring that children and adults have safe and effective care;
- Taking action to enable people to have the best life chances.

## 2. Role of the Boards/Partnerships

2.1 The Boards/Partnerships have distinct, but complementary roles which are outlined below. The key functions of each Board/Partnership and their respective areas of responsibility are detailed in Appendix A.

***Oxfordshire Health and Wellbeing Board***

2.2 The Oxfordshire Health and Wellbeing Board (HWB) is a forum where key leaders from the health and care system work together to improve the health and wellbeing of the local population and reduce health inequalities. Each local authority is required to have a Health and Wellbeing Board under the Health and Social Care Act 2012.

2.3 Board members are expected to collaborate to gain an understanding their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils and a more effective and responsive local health and care system.

2.4 There are two partnership boards and four joint management groups that report directly to the HWB specifically on the priorities of the Health and Wellbeing Strategy they are responsible for. These are:

- *Children's Trust* - a multi-agency board that oversees joint strategic planning for children's services in Oxfordshire and monitors improvement of these services.

- *Health Improvement Partnership Board (HIB)* – a partnership board that oversees the coordination of a joint approach to influencing a broad range of health determinants to bring about health improvement and reduce health inequalities

- *Joint Management Groups (JMGs)* – a collection of groups that provide oversight and management of spending and activity to improve outcomes and meet the needs of older people, people with a physical disability, learning disability or mental illness.

***Oxfordshire Safeguarding Children Board***

2.5 The Oxfordshire Safeguarding Children Board (OSCB) is the means by which key local agencies responsible for child protection in Oxfordshire come together to agree how they will cooperate with one another to safeguard and promote the welfare of children and young people. Board members are expected to agree strategic safeguarding priorities and jointly monitor and evaluate the effectiveness of arrangements made by individual agencies and the wider partnership to achieve these.

2.6 Each local authority is required to have a Local Safeguarding Children Board under the Children Act 2004. The Act defines Board's core objectives and its functions are set out in 'Working together to safeguard children 2015'. They cover communication, quality assurance, learning from serious case reviews, reviewing child deaths and ensuring sound safeguarding policies and procedures are in place.

2.7 There are a number of themed sub-groups that report to the Board on specific areas of work, namely learning and improvement; training; communication; and multi-agency working.

2.8 In particular, the Performance, Audit and Quality Assurance sub-group (PAQA) is tasked with measuring the effectiveness of how partner agencies of the OSCB and the Children's Trust fulfil their legal responsibilities to safeguard and promote the welfare of Oxfordshire's children and young people. It oversees and reports to the OSCB and the Trust on the performance indicators in the Children and Young People's Plan, which includes safeguarding data.

***Oxfordshire Safeguarding Adults Board***

2.9 The Oxfordshire Safeguarding Adults Board (OSAB) brings together key partners involved in protection of vulnerable adults across Oxfordshire to ensure that effective adult safeguarding arrangements are in place in both the commissioning and delivery of services. Board members are expected agree strategic safeguarding priorities and jointly monitor and evaluate the effectiveness of arrangements made by individual agencies and the wider partnership to achieve these.

2.10 Each local authority is required to have a Safeguarding Adults Board under the Care Act 2014. The Act sets out the objectives of the Board which include the coordination of effective and proportionate multi-agency safeguarding work; learning from safeguarding adult reviews, holding partners to account; and using data and intelligence to identify risks and act on them.

2.11 There are a number of themed sub-groups that report to the Board on specific areas of work, namely training; safeguarding reviews; procedures; and performance and quality assurance.

2.12 In particular, the Performance, Information and Quality Assurance sub-group (PIQA) leads on auditing and monitoring the effectiveness of work to safeguard and promote the welfare of adults in need of care and support across Oxfordshire. It reports to the Board on performance against multi-agency indicators that include national comparison and benchmarking measures, and ensures that learning from quality assurance processes are disseminated across the workforce.

***Oxfordshire Safer Communities Partnership***

2.13 The Oxfordshire Safer Communities Partnership (OxSCP) provides strategic oversight for the prevention of crime and anti-social behaviour across Oxfordshire. The Partnership consists of an officer/member-led Board and an officer-led Business Group. It supports collaboration on community safety issues between the four district-led Community Safety Partnerships, Health, the Police, the County Council, Probation services, the Prison service and the voluntary sector and provides challenge to member organisations on their engagement with any common risk or priority.

2.14 Each local authority is required to have a county-wide strategy group under the Crime and Disorder (Formulation and Implementation of Strategy) Regulations 2007.Under these regulations the officer-led Business Group of the Partnership prepares an annual community safety agreement and work programme for the county area based on the shared annual strategic assessment of the responsible authorities in the area. This identifies ways in which responsible authorities might more effectively implement identified priorities and otherwise reduce crime and disorder through coordinated or joint working. The Agreement is approved by each Community Safety Partnership and reviewed by the officer/member-led Board before it is finalised.

***Community Safety Partnerships***

2.15 The four district-led Community Safety Partnerships (CSPs) are multi-agency forums where relevant partners work together to assess local crime priorities and agree how to deal with these issues. The Partnerships develop local plans for their respective areas to ensure delivery of community safety priorities that address local risks. They have direct lines of communication with the Safeguarding Boards for relevant issues or concerns to be escalated as necessary. CSPs are also represented on each Safeguarding Board through district council representatives.

2.16 Community Safety Partnerships were established under the Crime and Disorder Act 1998 to reduce reoffending, tackle crime and disorder, anti-social behaviour, substance misuse and any other behaviour that has a negative effect on the local environment. They are required to develop and implement a strategy for tackling crime and disorder in their local area jointly with the Police and to take account of the Police and Crime Commissioner priorities in developing their plans.

## 3. Principles of Joint working

3.1 The following principles of joint working underpin the work of the Boards/Partnerships, ensuring that resources are used effectively across Oxfordshire to safeguard the health and wellbeing of vulnerable people and the organisations responsible for their protection are held to account.

***Think partnerships***

3.2 All of the Boards/Partnerships will adopt a mind-set where they consider the wider partnerships context in relation to the work they are doing. Where there is mutual benefit in informing or working together with another partnership board they will do this.

***Understanding accountability***

3.3 The Boards/Partnerships will have an understanding of their remit and responsibilities in respect of the areas of work they oversee and the agencies they hold to account. Each Board/Partnership is also responsible for identifying themes that overlap with the work of other Boards/Partnerships and require a joint approach. They will have clear and effective processes in place for the escalation of issues and information sharing as appropriate.

3.4 Each Board/Partnership member will also have an understanding of their individual accountability as the appropriate representative for their organisation in each forum.

3.5 Where there is cross-over in membership of the Boards/Partnerships in respect of either an individual or partner organisation, members will be responsible for communicating and sharing relevant information or concerns that will facilitate effective joint working or a joint response to an issue.

***Work together on themes of common interest***

3.6 Some themes have relevance across a number of partnerships and in these cases the Boards/Partnerships will work together and take a pragmatic approach to achieve the best outcomes for people and ensure that there is no duplication of effort. In practice this means that each Board/Partnership has the opportunity to input into an area of work where it carries a responsibility and/or has relevant knowledge, expertise and experience.

3.7 Where a piece of work with a cross-cutting theme is identified, the other Boards will initially be contacted to ascertain the relevance of the theme / area of work for them. The relevant Boards will agree the following:

- The approach that will be taken,
- Which Board will lead on the area of work and how other partnerships will contribute,
- Responsibility and accountability for the area of work,
- Communication and reporting arrangements.

***Sharing information about risk***

3.8 The Boards/Partnerships will share all relevant information with each other on key risk or concerns. This will help partner organisations maintain a good awareness and understanding of emerging risks that are relevant to their area of work and will enable the Boards/Partnerships to consider strategic actions that can manage and reduce these risks. Sharing information also supports the principle of mutual challenge and support.

***Mutual challenge and support***

3.9 In addition to the specific scrutiny roles of the OSCB and OSAB, all the Boards/Partnerships will mutually challenge and support one another's activities to optimise safeguarding arrangements in Oxfordshire and ensure the best outcomes are achieved for vulnerable people in the county.

3.10 The OSCB and OSAB have a specific remit to ensure that effective safeguarding arrangements are in place across partner organisations. Within this remit, these Safeguarding Boards will work with, and offer challenge to, the OxSCP, the CSPs and the HWB, including the Children's Trust, the Health Improvement Board and the Joint Management Groups.

***Share good practice and resources***

3.11 To ensure the Boards/Partnerships continue to develop and increase their effectiveness, relevant good practice and resources will be shared. This includes sharing policies and practices, learning from other authorities and opening up training and development opportunities to the wider partnerships, e.g. Children's Trust members will benefit from attending the OSCB annual conference, usually themed around a current issue.

***Openness and honesty***

3.12 The Boards/Partnerships will work together in a way that is open and honest in recognition of their common aim to achieve the best outcomes for Oxfordshire residents. In practice this means sharing all relevant information, holding each other to account and maintaining open channels of communication.

## 4. Interfaces between Boards

4.1 Joint working is important for developing integrated arrangements that ensure priorities for change are delivered in practice. All the Boards/Partnerships will work together to develop effective joint approaches and to understand the impact of services on outcomes for vulnerable children, young people and adults with care and support needs. Where appropriate this understanding will be used to challenge delays in progress and drive further improvements.

4.2 To ensure effective joint working across the Boards/Partnerships the following arrangements will be put in place to facilitate a co-ordinated and coherent approach. The formal relationships set out in this protocol reflect the respective roles of HWB, OSCB, OSAB, CSPs and OxSCP in relation to one another.

**Reporting**

4.3 In respect of shared priorities the Boards/Partnerships will share information through regular or thematic reports that also include the response and/or action required from the receiving Board/Partnership. This includes regular performance reports from PAQA and PIQA that highlight pressure points and related actions.

4.4 Key annual reports will be shared between Boards/Partnerships to inform priority setting. Where it is appropriate to do so, Boards/Partnerships may be asked to have input into the development and finalisation of each other's key reports. Appendix B outlines a timetable for these reports to shared and for what purpose.

4.5 If issues or reports need to be shared outside of this timetable the Chairman of a Board/Partnership may:

- Request information from another Board/Partnership and its consideration of an issue or concern,
- Request that an item be placed on another Board's/Partnership's agenda for discussion,
- Hold a meeting with one or more of the other Boards'/Partnerships' Chairmen to consider a particular issue and agree a way forward.

4.6 Where an issue cannot be resolved within the above framework, a resolution meeting will be held between the Board/Partnership Chairman/Chairmen and the appropriate senior officer(s) from the organisation(s) concerned.

4.7 Annual reports will include an honest evaluation of performance against annual plans and provide an opportunity for reciprocal scrutiny and challenge that will inform the development of future years' strategies and action plans. These reports may set out key findings from performance monitoring throughout the year and include recommendations for improvement.

4.8 Needs analyses that drive the formulation of the Health and Wellbeing Strategy and the county-wide Community Safety Agreement (e.g. the Joint Strategic Needs Analysis and the Strategic Intelligence Assessment) will be shared with Boards/Partnerships at key points in the development of their annual plans.

4.9 Annual plans will be shared between Boards/Partnerships in the formulation stages to avoid duplication, identify gaps, and enable co-ordination and shared business priorities where areas of work overlap - for example, work on domestic abuse is a priority for all the Boards/Partnerships.

**Liaison and consultation**

4.10 The key officers for each Board/Partnership will meet regularly, to ensure that key issues are identified and respective roles and responsibilities are clear in emerging areas of concern. The lead officers will also review current work to safeguard vulnerable people and discuss the Boards' annual reports and plans to reduce duplication of effort and identify opportunities for joint working.

4.11 Board/Partnership membership will include cross-partnership representation to enable on-going communication and provide opportunities for cross-cutting issues to be raised directly in meetings by lead members.

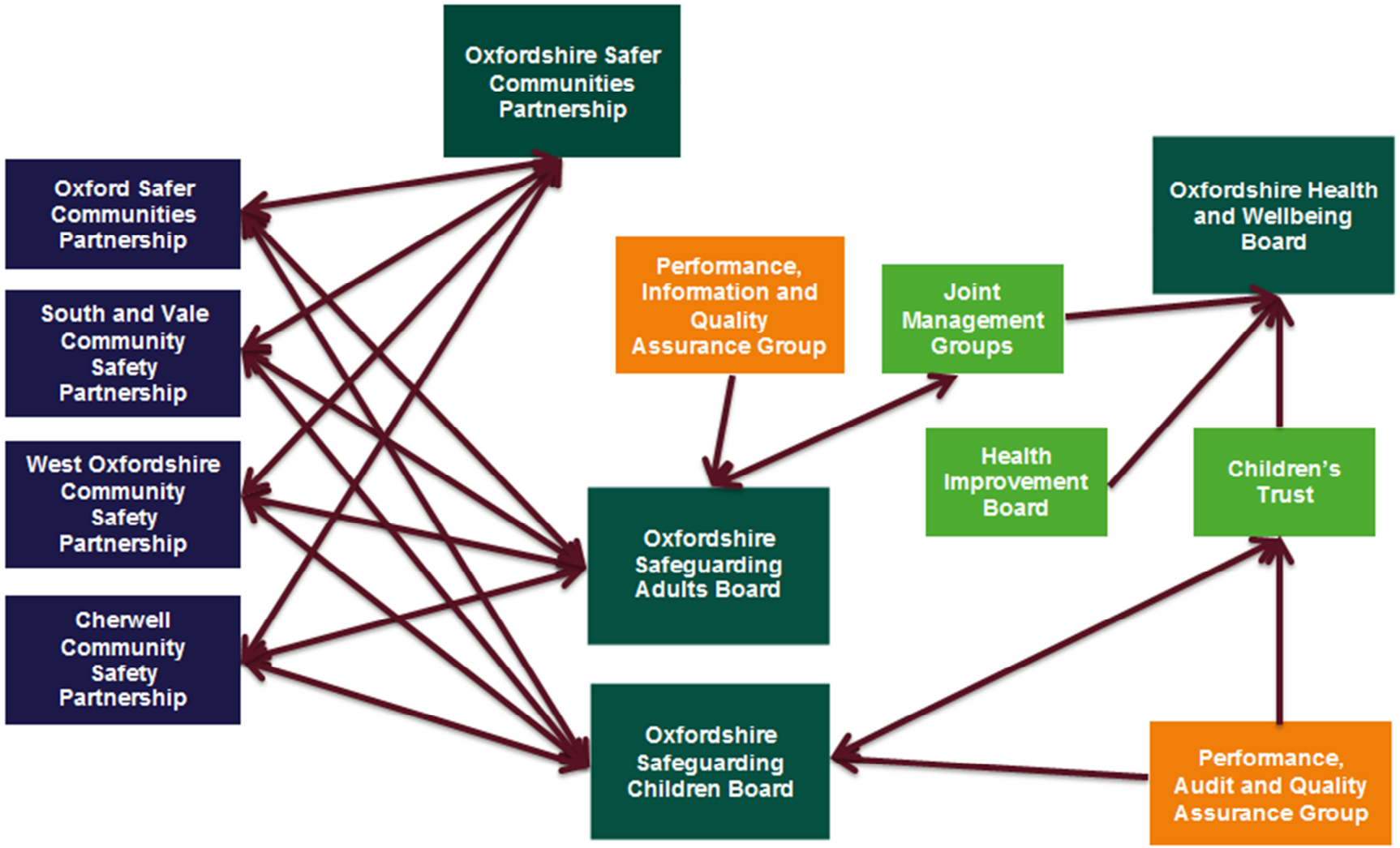
**Escalation of safeguarding concerns**

4.12 Any issues that relate to the abuse or potential abuse of children and/or adults with care and support needs and have not been resolved within a single-agency or multi-agency context will be escalated via the appropriate safeguarding route.

4.13 As a multi-agency issue, a concern will be raised at the respective Board/Partnership meeting and members will agree which partner will escalate the concern with the OSCB and/or OSAB Chairman.

4.14 The appropriate information sharing protocols will be followed to resolve the issue in a timely manner.

## 5. Governance Structure / Map



## 6. Review and monitoring

6.1 The effectiveness of this protocol will be reviewed and evaluated at least annually by the key officers and amended at any time by agreement between all the Boards/Partnerships or in response to any changes in legal responsibilities.

6.2 The protocol will be effective if:

- There are identifiable improvements attributable to multi-agency work on themes of common interest/concern.
- Areas of emerging concern are identified in a timely manner and reflected in business priorities as a result of effective risk management quality assurance, and issue escalation processes.
- Board/Partnership members have a clear understanding of the remit and responsibility of the Board/Partnership(s) of which they are a member.
- Each Board/Partnership is informed and aware of the work of other Boards/Partnerships and its interface with and effect on the areas of work it oversees.
- The intelligence gathered through needs analyses is evident in the shared priorities of the Boards/Partnerships.

6.3 Where an individual agency has a concern that this protocol is not being adhered to or is not effective, the agency will refer their concerns in the first instance to the Chairman of the Board/Partnership(s) of which they are a member. The Chairman will seek to resolve their concerns informally with the Chairmen of the other Boards/Partnerships. Where one or more of the Boards/Partnerships has a concern about the protocol the Chairmen will refer the matter to the relevant senior officer(s) in the appropriate organisation(s), who will identify a resolution in consultation with the relevant lead member as appropriate.

## 7. Supporting documents

7.1 The annual plans, supporting policies and protocols, and terms of reference for each Board/Partnership can be found on the following websites:

| Partnership Board | Website |
|---|---|
| HWB | www.oxfordshire.gov.uk/healthandwellbeingboard |
| OSAB | www.osab.co.uk |
| OSCB | www.oscb.org.uk |
| OxSCP | www.oxfordshire.gov.uk |
| Oxford CSP | www.oxford.gov.uk |
| South and Vale CSP | www.whitehorsedc.gov.uk |
| West Oxfordshire CSP | www.westoxon.gov.uk |
| Cherwell CSP | www.cherwell.gov.uk |

7.2 Relevant statutes and statutory guidance to be aware of are:

Health and Social Care Act 2012

Children Act 1989

Children Act 2004

Working Together to Safeguard Children, March 2015

Care Act 2014

Care and Support Statutory Guidance, October 2014

Crime and Disorder Act 1998

Crime and Disorder (Formulation and Implementation of Strategy) Regulations 2007

7.3 Schedule of circulation for the draft protocol for discussion, comment and agreement in principle:

| **Board/Partnership meeting** | **Provisional meeting date** |
|---|---|
| Oxfordshire Safeguarding Children Board | 27 January 2016 |
| Older People's JMG | 27 January 2016 (tbc) |
| Physical Disability JMG | 28 January 2016 (tbc) |
| Learning Disability JMG | 28 January 2016 (tbc) |
| South and Vale CSP | 28 January 2016 |
| West Oxfordshire CSP | 2 February 2016 |
| Health Improvement Board | 18 February 2016 |
| Oxford CSP | 1 March 2016 |
| Cherwell CSP | 1 March 2016 |
| Oxfordshire Health and Wellbeing Board | 3 March 2016 |
| Oxfordshire Safer Communities Partnership | 10 March 2016 |
| Oxfordshire Safeguarding Adults Board | 24 March 2016 |
| Mental Health JMG | 24 March 2016 (tbc) |
| Children's Trust | 31 March 2016 |

## Appendix A | Functions of the Boards

## Oxfordshire Health and Wellbeing Board (HWB)

**Key functions**

- Prepare a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy to determine priorities and objectives for health and social care services and drive the development and delivery of these services.
- Provide advice, assistance or other support to encourage integrated working between health and social care commissioners that meets the health and social care needs of Oxfordshire and uses resources effectively.
- Produce a pharmaceutical needs assessment (PNA).
- Agree how the Better Care Fund (formerly the Integrated Transformation Fund) is used in Oxfordshire and oversee its implementation.
- Use its power of influence to encourage closer working between commissioners of health-related services and the Board itself.
- Use its power of influence to encourage closer working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
- Undertake any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012.

Terms of reference and membership of the Health and Wellbeing Board can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

## Health Improvement Partnership Board (HIB)

**Key functions**

- Bring a coordinated and coherent approach to influencing a broad range of determinants of health to bring about health improvement and reduce health inequalities.
- Work together to recommend priority areas to improve health to the Health and Wellbeing Board in order to make a real and measurable difference to outcomes.
- Recommend actions and responsibilities to make that improvement a reality.
- Hold each other to account for making the agreed change and for reporting progress.

Terms of reference and membership of the Health Improvement Partnership Board can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

## The Children's Trust

**Key functions**

- Agree and recommend to the Health and Wellbeing Board, a Children and Young People's Plan for Oxfordshire and where resources should be focused to deliver the Plan
- Report on multi-agency performance for delivering the Plan to the Health and Wellbeing Board.
- Make specific recommendations on key outcomes for children and young people in Oxfordshire and as they move into adulthood, to include in the Joint Health and Wellbeing Strategy.
- Collaboratively solve issues and find solutions, jointly plan services and align and/or pool resources as appropriate to deliver improvements.
- Work in close partnership with the Oxfordshire Safeguarding Children Board to ensure that safeguarding concerns are fully considered in promoting the health and wellbeing of children and young people
- Work in partnership with other strategic boards, such as the Health Improvement Board, Joint Management Groups and the Oxfordshire Safer Communities Partnership to ensure that their plans and performances targets are in synergy with those of the Children's Trust.

Terms of reference and membership of the Children's Trust can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

## Joint Management Groups (JMGs)

**Key functions**

- Oversee and manage spending and activity to improve outcomes and meet the needs of older people and people with a physical disability, learning disability or mental illness.
- Agree pooled resources and deliver shared objectives under a single agreement between the County Council and the Oxfordshire Clinical Commissioning Group (under section 75 of the National Health Services Act 2006)
- Monitor strategy and governance, finance, performance and risk in their respective areas of commissioning against key outcomes in the Joint Health and Wellbeing Strategy.

Terms of reference and membership of the Joint Management Groups can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

## Oxfordshire Safeguarding Children Board (OSCB)

**Key functions**

- Prepare an annual Business Plan that identifies shared priorities for the safeguarding of children and young people in Oxfordshire, based on local issues and demands.
- Produce and publish an annual report on the effectiveness of safeguarding arrangements within Oxfordshire, which is reported to the Children's Trust and the Health and Wellbeing Board.
- Develop policies and procedures for safeguarding and promoting the welfare of children, including those in relation to thresholds, training, recruitment, investigations and allegations, privately fostered children and cooperation with other children's services.
- Monitor and scrutinise multi-agency activity in relation to safeguarding, highlighting underperformance and advising on ways to improve. This is done via case files audits, reviews and inspections.
- Communicate and raise awareness with professionals and within local communities about the need to safeguard and promote the welfare of children and young people.
- Undertake independent serious case reviews where abuse or neglect is known or suspected to be factor in a child's death or serious injury and advise on lessons learnt.
- Take responsibility for checking that the recommendations from an independent serious case review are delivered.
- Monitor and evaluate the effectiveness of training, including multi-agency training for all professionals in Oxfordshire.
- Lead on or contribute to specific safeguarding initiatives and be responsible for cascading information about national guidance and how this is implemented in Oxfordshire.

The OSCB has an Independent Chair who holds all agencies to account by scrutinising and monitoring their work with children and young people. The Chair is directly accountable to the County Council's Head of Paid Service, but works closely with all OSCB partners, in particular the Director of Children's Services for Oxfordshire.

Terms of reference and membership of the Oxfordshire Safeguarding Children Board can be found at: www.oscb.gov.uk

## Oxfordshire Safeguarding Adults Board (OSAB)

**Key functions**

- Prepare an annual Business Plan that identifies shared priorities for the safeguarding of vulnerable adults in Oxfordshire, based on local issues and demands.
- Produce and publish an annual report on the effectiveness of safeguarding arrangements within Oxfordshire, which is reported to the Health and Wellbeing Board.
- Develop, agree and oversee local policies and procedures for inter-agency work to protect vulnerable adults, within the national framework provided by No Secrets (Department of Health, 2000).
- Ensure there is agreement and understanding across agencies about operational definitions and thresholds for intervention.
- Support the provision of multi-agency training and workforce development on safeguarding of vulnerable adults and consider any scope to jointly commission training with other partnerships, such as Community Safety Partnerships.
- Ensure mechanisms are in place to coordinate effective safeguarding activities between agencies based on national and local evidence and experience, and ensure that lessons learned are shared, understood and acted upon.
- Undertake independent serious case reviews where abuse or neglect is known or suspected to be factor in an adult's death or serious injury and advise on lessons learnt.
- Monitor and evaluate the effectiveness of safeguarding arrangements in Oxfordshire and the impact of the Board.
- Ensure compliance with formal governance requirements.

The OSAB has an Independent Chair who holds all agencies to account by scrutinising and monitoring their work with adults who have care and support needs. The Chair is directly accountable to the County Council's Head of Paid Service, but works closely with all OSAB partners, in particular the Director of Adult Social Services for Oxfordshire.

Terms of reference and membership of the Oxfordshire Safeguarding Adults Board can be found at: www.osab.co.uk

## Oxfordshire Safer Communities Partnership (OxSCP)

**Key functions**

- Agree the community safety risks, opportunities and priorities that partners will address on a county-wide basis.
- Oversee and agree a Strategic Intelligence Assessment, Community Safety Agreement and work programme for the county to inform partners of the current community safety risks, using a combination of data and environmental scanning.
- Provide strategic direction and challenge member organisations on their engagement with any common risk or priority in the Community Safety Agreement and work programme
- Ensure the community safety work programme supports the local Community Safety Partnerships' strategies and links with cross-cutting priorities in Oxfordshire 2030.
- Ensure that partners are meeting their statutory responsibilities to identify how they might more effectively implement the identified priorities and otherwise reduce crime and disorder through coordinated or joint working.
- Provide a focal point for dialogue with the Police and Crime Commissioner.

The broad membership of OxSCP ensures strong linkages with other strategic partnerships, with several OxSCP Board members representing community safety on the partnership boards of the Health and Wellbeing Board as well as sub-groups of OSCB and OSAB.

Terms of reference and membership of the Oxfordshire Safer Communities Partnership can be found at:
https://www.oxfordshire.gov.uk/cms/content/oxfordshire-safer-communities-partnership

## Community Safety Partnerships

**Key functions**

- Produce and monitor an annual Community Safety Plan and Strategy for the local area based on priorities identified through the Strategic Intelligence Assessment and send this to the Thames Valley Police and Crime Commissioner.
- Publish an annual report on progress towards delivering the plan.
- Liaise with the Thames Valley Police and Crime Commissioner to discuss local crime priorities.
- Provide guidance for local communities to promote active citizenship and build their capacity to play a role in reducing crime and the fear of crime locally.
- Provide strategic direction for community safety action groups, such as Joint Agency Tasking and Coordination and scrutinise the progress of these groups.
- Act as a channel for communication with local communities on community safety and safeguarding matters, reporting any concerns back to the Safeguarding Boards.

The four district/city–led partnerships are:

- Oxford Safer Communities Partnership
- South and Vale Community Safety Partnership
- West Oxfordshire Community Safety Partnership
- Cherwell Community Safety Partnership

Terms of reference and membership of the Oxfordshire Community Safety Partnerships can be found on the district / city council websites:
www.oxford.gov.uk
www.whitehorsedc.gov.uk
www.westoxon.gov.uk
www.cherwell.gov.uk

## Appendix B | Reporting timetable

| | HWB | Children's Trust | HIB | JMGs | OSCB | OSAB | OxSCP | CSPs |
|---|---|---|---|---|---|---|---|---|
| **Joint Strategic Needs Assessment** | Agree (Spring) | Inform (Spring) | Inform (Spring) | Inform (Spring) | Inform (Spring) | Inform (Spring) | Inform (Spring) | |
| **Health and Wellbeing Strategy** | Agree (Summer) | Consult (Summer) | Consult (Summer) | Consult (Summer) | | | | |
| **Children and Young People's Plan** | Agree (Summer) | Agree (Spring) | | | Inform (Summer) | | | |
| **OSCB Annual Report** | Inform (Autumn) | Inform (Autumn) | | | Agree (Autumn) | | | |
| **OSCB Business Plan** | | | | | Agree (Autumn) | | | |
| **OSAB Annual Report** | Inform (Autumn) | | | | | Agree (Autumn) | Inform (Autumn) | |
| **OSAB Business Plan** | | | | | | Agree (Autumn) | | |
| **OxSCP Annual Report** | | | | | Inform (Summer) | Inform (Summer) | Agree (Summer) | |
| **OxSCP Community Safety Agreement** | | | | | | | Agree (Spring) | Inform (Spring) |
| **Strategic Intelligence Assessment** | | | | | | | Agree (Spring) | Inform (Spring) |
| **CSP Community Safety Plans** | | | | | | | Inform (Spring) | Agree (Spring) |

Agree = Sign-off Inform = Use to inform work Consult = Board has input into

## Appendix C | Good practice examples of joint working in Oxfordshire

In particular the following areas of work represent themes of common interest where there is already an integrated approach to delivering change. These are good practice examples from 2015-16.

| Theme | Lead | Joint working arrangements |
|---|---|---|
| **Child Sexual Exploitation (CSE)** | **OSCB** | The OSCB's CSE sub-group provides oversight of the CSE Strategy which describes the strategic and operational arrangements for tackling CSE, including a multi-agency action plan.<br><br>The OSCB and OxSCP provide mutual challenge and support to one another, with a particular focus on a prevention, disruption and enforcement. This will be facilitated by:<br>• Community safety managers sitting on the CSE sub-group and contributing to the development of the CSE sub-group work plan,<br>• The OSCB providing regular updates on CSE to the OxSCP,<br>• Community Safety Partnerships developing local action plans to raise public awareness of CSE.<br><br>The Children's Trust supports the work of the OSCB and the OxSCP by having representatives from both Boards as members and receiving reports on the progress of the OSCB's work on CSE as required. Work in this area will be fed up to the HWB via the regular reporting mechanisms of the Trust.<br><br>The OSAB has a role in ensuring that appropriate provision is in place for children who continue to be exploited as they transition into adulthood, and for adults who disclose CSE in their past.<br><br>CSE is also a priority for the Police and Crime Commissioner (PCC) and just over £50,000 of PCC funding has been provided through OxSCP to the OSCB sub-group to support CSE activity across Oxfordshire.<br><br>The HWB will ensure that the JSNA includes robust and up-to-date profiling of CSE and the factors linked to the risk of CSE to inform commissioning decisions. |

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| **Female Genital Mutilation (FGM)** | **OSCB** | Due to the impact that FGM has on the health, safety and wellbeing of women and girls it has been identified as a priority by the Thames Valley Police and Crime Commissioner.<br><br>The OSCB's FGM Strategy ensures a coordinated approach to tackling FGM across Oxfordshire in consultation with community groups, the Police and Crime Commissioner and the other Boards.<br><br>The OxSCP has a role in raising awareness of FGM through the allocation of Police and Crime Commissioner funding to support of victims of domestic abuse and exploitation and train professionals across Oxfordshire.<br><br>The Children's Trust supports the work of the OSCB and the OxSCP and will receive reports on the progress of the OSCB's work on FGM as required. Work in this area will be fed up to the HWB via the regular reporting mechanisms of the Trust.<br><br>The HWB will ensure that the JSNA includes robust and up-to-date profiling of the FGM to inform health and wellbeing priorities and future commissioning decisions. |
| **Human trafficking and modern slavery** | **CSPs** | The CSPs lead on Oxfordshire's multi-agency response to human trafficking and modern day slavery, including awareness raising activities and building an evidence base to develop an county-wide strategic plan and district level plans to tackle adult and child exploitation.<br><br>The links between human trafficking, modern slavery and CSE are recognised by means of CSPs representation on the CSE sub-group of the OSCB, which enables relevant information to be cascaded and escalated to the OSCB where necessary.<br><br>The OSAB, OSCB and the CSE sub-group have a role in offering support and challenge to CSPs on work being undertaken to tackle modern slavery and the outcomes this is achieving for vulnerable children, young people and adults. The CSPs will update the other Boards/Partnerships on progress in this area when necessary. |
| **Preventing extremism** | **OxSCP** | The OxSCP has strategic oversight of the Prevent duty to stop people becoming involved in or supporting terrorism. This includes:<br>• Overseeing the Channel Panel - the multi-agency forum for sharing the assessment of risk where individuals are vulnerable to becoming radicalised,<br>• Providing support and challenge to ensure the |

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| | | effective co-ordination of prevent through the district level Prevent action plans,<br>• Providing regular updates on the volume of referrals to Prevent<br>• Advising agencies on training frontline staff on the Prevent duty and developing training materials,<br>• Liaising with other agencies and organisations subject to the Prevent duty, such as schools, to share learning and gather best practice to disseminate to partners,<br>• Providing a single point of contact for information on the Prevent duty for the other Boards.<br><br>The County Council has a Prevent strategy and the CSPs have developed action plans to deliver this agenda locally. Preventing extremism will be identified as a priority the county-wide Community Safety Agreement and the OxSCP business group will support and challenge CSPs on how they are managing the risk of extremism through their local action plans.<br><br>The proportionate arrangements for the assessment of risk are agreed at the Channel Panel, which is chaired by the County Council. The CSPs have a duty to cooperate with the Panel and the OxSCP business group supports the co-ordinated approach to Prevent as appropriate.<br><br>The OSCB has a focus on the radicalisation of children and young people as part of its work to raise awareness of serious safeguarding issues through its practitioner and training subgroups, and through increased engagement with the voluntary, community and faith sector. The Board aims to work in partnership with the OxSCP and the CSPs to promote key messages about preventing extremism.<br><br>Safeguarding concerns relating to extremism are directly addressed through the appropriate Safeguarding Board via the CSP representative or County Council community safety representative, depending on the nature of the concern. |
| **Domestic Abuse** | **OxSCP & Children's Trust** | The OxSCP is the strategic lead for domestic abuse and oversees the Oxfordshire Domestic Abuse Strategy Group, receiving regular reports on the implementation of the Domestic Abuse Strategy. There are multi-agency referral risk assessment processes in place that the OxSCP monitors.<br><br>The Children's Trust oversees the Children's Domestic Abuse Strategy Group and receives regular reports on the progress of work in this area. |

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| | | The OSCB works closely with the OSAB and Domestic Abuse Strategy Group on domestic abuse as a shared priority, given that it often underpins child abuse and neglect. Safeguarding of adolescents is also an OSCB priority as domestic abuse in peer relationships is reflected in the high numbers of young people subject to child protection plans and in the care system.<br><br>The links between domestic abuse, honour based violence, forced marriage and FGM are recognised by means of CSPs representation on the CSE sub-group of the OSCB, which enables relevant information to be cascaded from the OxSCP and escalated to the OSCB where necessary. |

# Comments and Feedback

**On the draft protocol outlining the relationship between the Oxfordshire Health and Wellbeing Board, the Oxfordshire Safeguarding Children Board, the Oxfordshire Safeguarding Adults Board, Oxfordshire's Community Safety Partnerships and the Oxfordshire Safer Communities Partnership**

The draft protocol has been presented for discussion, comment and agreement in principle at the following meetings:

| Board/Partnership meeting | Meeting date | Presented by | Protocol agreed in principle? | Comments / Feedback |
|---|---|---|---|---|
| Oxfordshire Safeguarding Children Board | 27 Jan 2016 | Richard Webb | Yes | No comments / suggested changes |
| Older People's JMG | 27 Jan 2016 | Ben Threadgold | Yes | No comments / suggested changes |
| Physical Disability JMG | 28 Jan 2016 *cancelled* | | | |
| Learning Disability JMG | 28 Jan 2016 | Tan Lea | Yes | • Delegated authority to Chairman to sign-off final version.<br>• Governance diagram needs a two-way link between the OSCB and the JMGs, as some of the JMGs cover children's issues.<br>• Appendix A is particularly useful.<br>• Individual members' internal accountability and responsibility to feedback safeguarding issues within their organisation should be emphasised.<br>*Suggested amendment:*<br><br>*3.4 Each Board/Partnership member will also have an understanding of their individual accountability as the appropriate representative for their organisation in each forum. They are responsible for ensuring that they put in place such arrangements that are necessary to share information within their organisation and with their organisation's representatives on other groups and partnerships.*<br><br>*3.5 Where an individual represents their organisation at more than one Board/Partnership they will be responsible for communicating and sharing* |



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| | | | | *relevant information or concerns across those Boards/Partnerships to facilitate effective joint working or a joint response to an issue.* |
| South and Vale CSP | 28 Jan 2016 | Carys Alty-Smith | Yes | No comments / suggested changes |
| West Oxfordshire CSP | 2 Feb 2016 | Carys Alty-Smith | Yes | No comments / suggested changes |
| Health Improvement Board | 18 Feb 2016 | Tan Lea | | |
| Oxford CSP | 1 Mar 2016 | Richard Adams | | |
| Cherwell CSP | 1 Mar 2016 | Mike Grant | | |
| Oxfordshire Health and Wellbeing Board | 3 Mar 2016 | Tbc | | |
| Oxfordshire Safer Communities Partnership | 10 Mar 2016 | Richard Webb | | |
| Oxfordshire Safeguarding Adults Board | 24 Mar 2016 | Richard Webb | | |
| Mental Health JMG | 24 Mar 2016 | Ben Threadgold | | |
| Children's Trust | 31 Mar 2016 | Tan Lea | | |



***N.B.*** *Comments and feedback from all Boards/Partnerships will be collated in this document and attached with the original draft protocol for each meeting. After all Boards/Partnerships have had the opportunity to consider the protocol, appropriate amendments will be made to incorporate feedback and a final version will be circulated for agreement and sign-off.*

Updated: 03/02/2016

# Health Improvement Partnership Board
# Forward Plan 2015-16

| Date | Item |
|---|---|
| Thu 12 May 2016<br>2-4pm<br>Oxford Town Hall | • Annual Basket of Housing Indicators<br>• Health Improvement Board Priorities 2016-17 |
| Thu 7 Jul 2016<br>2-4pm<br>Oxford Town Hall | • Health Protection Forum Annual Report<br>• Domestic Abuse services review |
| Thu 20 Oct 2016<br>2-4pm<br>The King's Centre | • |
| | |
| **Standing items:** | |
| • Minutes of the last meeting and any matters arising<br>• Healthwatch Ambassadors' Report<br>• Performance Report (including any report cards)<br>• Forward Plan | |
| **Proposals/periodically:** | |
| To be kept under regular review:<br>• Re-commissioning of housing-related support<br>• Welfare reform<br>• Oral Health Needs Assessment<br>• Healthy Weight Action Plan<br>• Oxfordshire Sports Partnership | |

*10 February 2016*

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