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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

Tuesday, 27 June 2017 at 3.00 pm

Town Hall, Oxford

Peter G. Clark
Chief Executive

19 June 2017

Contact Officer: ***Katie Read, Policy & Partnership Officer***
Tel: 07584 909530*; Email: katie.read@oxfordshire.gov.uk*

Membership

Chairman – District Councillor Anna Badcock
Vice Chairman - City Cllr Marie Tidball

Board Members:

Cllr Jeanette Baker	West Oxfordshire District Council
Cllr John Donaldson	Cherwell District Council
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Education
Cllr Monica Lovatt	Vale of White Horse District Council
Dr Jonathan McWilliam	Strategic Director for People and Director of Public Health
Dr Paul Park	Vice Clinical Chair of Oxfordshire Clinical Commissioning Group
Diana Shelton	West Oxfordshire District Council
Jackie Wilderspin	Public Health Specialist
Vacancy	Healthwatch Ambassador

Notes:

- ***Date of next meeting: 26 September 2017***

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 **07776 997946** 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, District Councillor Anna Badcock

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)

3.05pm
5 minutes

To approve the minutes of the meeting held on 20th April 2017 and to receive information arising from them.

6. Performance Report (Pages 7 - 20)

3.10pm
25 minutes

Performance report presented by Dr Jonathan McWilliam, Director of Public Health, Oxfordshire County Council.

A report on progress against the targets of the Health Improvement Board in Quarter 4.

Annual Basket of Housing Indicators Report presented by: Jon Dearing, West Oxfordshire District Council & Chairman of the Housing Support Advisory Group

An annual report on performance against the housing indicators monitored by the Health Improvement Board under priority 10 and suggested areas for joint working going forward.

7. Draft 2017-18 priorities for the Oxfordshire Joint Health and Wellbeing Strategy (Pages 21 - 30)

3.35pm
20 minutes

Report presented by: Dr Jonathan McWilliam, Oxfordshire County Council

A draft revision of the Health Improvement Board priorities 8-11, for inclusion in the 2017-18 update of the Oxfordshire Joint Health and Wellbeing Strategy 2015-19. The final revision to the Strategy will be agreed at the Health and Wellbeing Board on 13 July.

8. Barton Healthy New Town (Pages 31 - 54)

3.55pm
25 minutes

Report presented by: Kate Austin, Oxfordshire County Council and Azul Strong, Oxford City Council.

A progress report on Barton's participation in the NHS England Healthy New Town Programme to support shared learning and consider how this can inform future work with planners and developers to tackle health inequalities.

9. Exercise on Referral

4.20pm
25 minutes

Presentation by: Oxfordshire Sport and Physical Activity and Oxfordshire's district and city councils

An overview of the scale and impact of inactivity across the County and the referral schemes in place to address this.

10. Fuel Poverty workshop outcomes

4.45pm
10 minutes

Presented by: Councillor Anna Badcock, Chairman of the Health Improvement Board.

A verbal update on the outcomes of the Board's workshop on fuel poverty which aimed to:

1. Encourage greater join up between organisations tackling fuel poverty and identify areas for further targeted work.
2. Set the strategic direction for Oxfordshire fuel poverty work.

11. Forward Plan (Pages 55 - 56)

4.55pm
5 minutes

Presented by: Cllr Anna Badcock, 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 Thursday 20th April commencing at 2.00 pm and finishing at 3.45 pm.

Present:

Board Members:

Councillor Anna Badcock (Chairman), South Oxfordshire District Council
Councillor Mark Lygo (substituting for Councillor Ed Turner, (Vice-Chairman), Oxford City Council)
Councillor Jeanette Baker, West Oxfordshire District Council
Cllr Monica Lovatt, Vale of White Horse District Council
Marianne North, Cherwell District Council (substituting for Councillor John Donaldson, Cherwell District Council)
Jackie Wilderspin, Public Health Specialist
Dr Jonathan McWilliam, Director of Public Health
Emma Henrion, Healthwatch Ambassador
Dr Paul Park, Oxfordshire Clinical Commissioning Group

Officers:

Whole of meeting:

Val Johnson, Oxford City Council
Katie Read, Oxfordshire County Council

Part of meeting:

Agenda item 6

Sarah Carter, Oxfordshire County Council
Sarah Breton, Oxfordshire County Council

Agenda item 7

Dr Nisha Jayatilleke, NHS England

Agenda item 8

Andy Symons, Turning Point

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 07584 909530; Email: katie.read@oxfordshire.gov.uk)

ITEM	ACTION
1. Welcome The Chairman, Councillor Anna Badcock, welcomed all to the meeting. It was announced that Diana Shelton, Shared Head of Leisure and Community Services, is joining the Board as the new district council officer representative.	
2. Apologies for Absence and Temporary Appointments Apologies were received from: Cllr John Donaldson, Cllr Hilary Hibbert-Biles and Diana Shelton. Cllr Mark Lygo substituted for Cllr Ed Turner and Marianne North substituted for Cllr John Donaldson.	
3. Declaration of Interest Cllr Jeanette Baker declared that she has a part share in the office building rented by Turning Point.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Minutes of Last Meeting The minutes of the October meeting were approved. As a matter arising under the Health Inequalities update, feedback was provided on the proposals put to the Growth Board: - The Board supported OxSPA's Sport England bid and agreed that if it was not successful, it could still be used as a blueprint for tackling health inequalities going forward. - All councils represented at the Growth Board supported the proposal to establish an Innovation Fund and each agreed to contribute £2,000. Criteria for awarding the £12,000 fund are now being developed. Broader work on health inequalities continues: - A multi-agency workshop was held to discuss how to implement the Health Inequality Commission's recommendations, - The recommendations were also discussed by the City Council's Scrutiny Committee and Executive, and - The Public Health team is developing a basket of indicators that aim to measure health inequalities in Oxfordshire.	
6. Strategic Review of Domestic Abuse The outcomes of the review and progress on implementing its recommendations were presented by Sarah Carter and Sarah Breton. The following key concerns emerging from the review were shared with members: - Invisible / hidden abuse - Interventions for perpetrators	

- Intergenerational impacts - Inequality of access to support & help - Insufficient provision of resources / funding - Information: provision, data capture & sharing - Improvement and review processes and structures - Inconsistently targeted services The Board was informed that work in this area is being taken forward by three key groups: 1. A strategic group is developing the vision for domestic abuse services, 2. An operational group is mapping current pathways, and 3. A commissioning group is delivering the co-commissioning approach. A number of key challenges and opportunities of this approach were identified as: - Bringing together complex funding and delivery mechanisms for existing services. - Understanding hidden abuse and the impact this will have on demand for services. - Enabling families to remain in Oxfordshire, rather than being sent out of county for protection. - Being clear on the services needed in order to target alternative funding streams. A Domestic Abuse Summit planned for May/June will look to ratify the vision, discuss the resources available to deliver co-commissioned services and identify a robust governance structure. It was acknowledged that it can be difficult for professionals to know the most appropriate routes for referral in, for example, cases of child sexual exploitation, female genital mutilation or radicalisation. There was concern that this might be the case for domestic abuse support. Members were assured that a communications strategy will be developed to publicise the route for referral and, as domestic abuse is closely linked with sexual violence, there is a recommendation to develop these services in an integrated way. The Board fully endorsed the planned co-commissioning approach and encouraged the join up of services, referencing how effective the joint approach to housing related support services had been. It was proposed that the Health Improvement Board would be an appropriate body to oversee the co-commissioning of domestic abuse services, although a key agency (Thames Valley Police) is not represented on the Board. There would need to be clear escalation processes in place and a reporting matrix. **The Board agreed to recommend to the Summit that HIB oversees the work on domestic abuse services.**	**Sarah Carter**
7. Performance review	

Jonathan McWilliam presented the quarter 3 performance report. It was highlighted that 9 indicators are rated green, not 8 as reported. The Chairman commended Public Health colleagues and providers for the fact that none of the indicators are rated red. An extract on NHS Health Checks from the Director of Public Health's 2015/16 Annual Report had been circulated to Board members following a query about undiagnosed health conditions at the previous meeting. Members queried the high number of people provided with advice about physical activity as part of their NHS Health Check. It was confirmed that anyone considered to be at moderate risk of cardiovascular problems would receive this advice, including everyone aged over 60 years old. We are all recommended to be doing at least 150 minutes of moderate intensity aerobic activity each week (such as cycling or fast walking). <u>Immunisation report card</u> Dr Nisha Jayatilleke presented the report card on immunisation rates and expanded on the role of the Health Inequalities Nurse who follows up individually with families whose children have missed a vaccination. Members queried the links between the Health Inequalities Nurse and Health Visitor who works closely with homeless families and those in temporary accommodation. It was confirmed that these two posts share a line manager and they work closely together. It was highlighted that even the immunisation statistics at a local level mask geographical inequalities within smaller areas, e.g. north and south of the City. The high numbers of unvaccinated children often correlate with the areas of social disadvantage. The collaborative work undertaken by NHS England with local stakeholders was described further; this includes a local forum bringing together commissioners and providers to consider projects holistically and to share learning. There is a plan to make this Thames Valley-wide and to learn from similar inequality initiatives in Buckinghamshire and Berkshire. The Board agreed to maintain a watching brief on immunisation rates to track when the target of 95% is reached and ensure this is sustained.	
8. Drug and Alcohol Treatment Service Andy Symons presented a progress report on the performance of the drug and alcohol treatment service and some of the key achievements since the service began in April 2015. In particular the improved working relationships between the service and primary care were highlighted as a success, and the targeted work being done with hard to reach groups, such as the homeless population and sex workers.	

Members were impressed that performance within the service had significantly improved since Turning Point became the new provider. The Board was also pleased to be informed that heroin use, particularly in the younger population, has been decreasing in Oxfordshire. The Board queried whether significant inequalities existed among service users and how Turning Point targeted its work. Members were informed that the drug using population does vary across Oxfordshire, with hotspots in Banbury and the City. Turning Point recognises the gender imbalance in the drug using population (approx. 70:30 male to female split), and tailors its treatment programmes with this in mind. Some specific work is currently underway with members of the Black, Asian and Minority Ethnic community. **The Board thanked Andy Symons for his report and suggested that it is also presented to the Safer Oxfordshire Partnership.**	**Andy Symons**
9. Review of Health Improvement Board Priorities Jackie Wilderspin led a discussion with Board members about the areas of focus they would like to propose for health improvement in 2017-18, for inclusion in the revised Oxfordshire Joint Health and Wellbeing Strategy. Members proposed including the following new areas of focus: a) Older people, particularly tackling loneliness, isolation and keeping fit. b) Improving mental health and wellbeing. The Board discussed the difficulties finding a reliable measure for these areas. **It was suggested that organisations / charities already working in these areas should be approached to help determine appropriate measures and learning from the Healthy New Town vanguards should be incorporated.** **Members also discussed inviting a mental health expert to a future meeting to elaborate on key barriers to mental wellbeing and how this can be improved.** It was acknowledged that the collection of new data has resource implications, therefore wherever possible new measures will be based on data that is already collected and available. Members agreed that none of the current indicators should be excluded going forward. However, given the number of existing indicators, it was agreed that two categories of indicators would be included: a set that is actively monitored and a set that members keep a watching brief on. The Board also endorsed an ongoing focus on health inequalities through performance reporting. **Final priorities and performance indicators will be presented to the**	**Jackie Wilderspin** **Katie Read** **Jackie**

Board in June for approval and proposed at the July Health and Wellbeing Board meeting.	**Wilderspin**
10. Review of Health Improvement Board Terms of Reference The Board reviewed its terms of reference and agreed to include a greater focus on the unique benefits of having district/city council, county council, NHS and lay members. The lines of accountability and governance for the Board were clarified; whilst the Oxfordshire Joint Health and Wellbeing Board is a statutory board, it is solely advisory and cannot make any binding decisions. Its strength lies in its partnership arrangements, of which the Health Improvement Board is one element, and their powers of influence. It was also proposed that the responsibilities of the Board should be strengthened to include a focus on reducing health inequalities, as well as bringing about health improvement. **The terms of reference will be updated to reflect the Board's discussion and circulated for agreement before being approved by the Health and Wellbeing Board in July.**	**Katie Read**
11. Forward Plan The following suggestions were added to the forward plan: - Welfare reform (impact of Universal Credit) proposed for discussion in February 2018. The following amendment was made: - The Oxford University Hospitals Trust Public Health Strategy will be discussed in September 2017 From discussion at the meeting the following items will be added: • Mental wellbeing	
The meeting closed at 3.45pm	

..... in the Chair

Date of signing .....

Health Improvement Board
27 June 2017

Q4 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 only reported on an annual basis and 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 can be summarised as follows:

   9 indicators are Green.
   5 indicators are Amber (defined as within 5% of target).
   0 indicators are Red

   3 indicators do not yet have information available for Q4 – these are indicators 8.1 Bowel screening uptake, 10.4 Affordable Warmth Network energy efficiency indicator and 11.4 HPV uptake in 12-13 years (second dose).

Sue Lygo
Health Improvement Practitioner
13 June 2017

Oxfordshire Health and Wellbeing Board
Performance Report

Priority 8: Preventing early death and improving quality of life in later years											
	Indicator	**Target**	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Comments**
			Fig.	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	
8.1	At least 60% of those sent bowel screening packs will complete and return them (aged 60-74 years) - and adequately screened	60%	59.1%	A	60%	G	59%	A	0%		Data at least six months in arrears.
8.2	Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%.	15%	5.0%	R	10.2%	A	14.4%	G	18%	G	All CCG localities over 15%
8.3	Take-up of invitation for NHS Health Checks should exceed national average (2015-16 = 47.9% nationally) and aspire to 55% in year ahead. No CCG locality should record less than 50%.	>47.9% (Aspire 55%)	35.1%	R	40.8%	R	44.7%	G	51.5%	G	Some localities above 50% North 60%, South West 56.3%, South East 54.2% Some below 50% West 48.3%, North East 46.2%, Oxford City 45%
8.4	Number of people quitting smoking for at least 4 weeks should exceed 2015-16 baseline by at least 10% (15-16 baseline = 1923)	> 2115 by end year	551	G	978	R	1471	A	2037	A	
8.5	Mother smoking at time of delivery should decrease to below 8% - Oxfordshire CCG	<8%	7.8%	G	7.2%	G	7.8%	G	8.0%	G	-
8.6	Number of users of OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.	> 4.5% 5% end yr (Aspire 6.8% long term)	4.6%	G	4.3%	A	6.1%	G	7.0%	G	

8.7	Number of users on NON-OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.	> 26.2% 30% end yr (Aspire 37.3% long term)	20.8%	R	20.0%	R	31.6%	G	44.3%	G	-

Priority 9: Preventing chronic disease through tackling obesity											
	Indicator	**Target**	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Comments**
			Fig.	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	
9.1	National Childhood Measurement Programme (NCMP) - obesity prevalence in Year 6.	<=16%					16.0%	G			2015/16 - Inequalities across the county - Cherwell 17% and Oxford City 20%
9.2	Reduce by 0.5% the proportion of people who are NOT physically active for at least 30 minutes a week (baseline for Oxfordshire 21.9% Jan14-15)	Reduce by 0.5% from baseline (21.9%)					17.5%	G			Updated from Active Lives Survey (Nov - Nov 16). Cherwell 21.7% and West Oxon 22% PLEASE NOTE CHANGE IN METHODOLOGY MEANS NOT DIRECTLY COMPARABLE TO DATA FROM ACTIVE PEOPLE SURVEY
9.3	Babies breastfed at 6-8 weeks of age (County) No individual CCG locality should have a rate of less than 55%)	63%	62.2%	A	61.7%	A	61.8%	A	62.5%	A	Q4 - South West Oxfordshire and West Oxfordshire localities <55%. All others are higher - South East and Oxford City localities >70%

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness											
	Indicator	**Target**	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Comments**
			Fig.	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	
10.1	The number of households in temporary accommodation on 31 March 2017 should be no greater than level reported in March 2016 (baseline 190 households)	≥190			192	A			161	G	
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.2% 2015-16)	75%	85.1%	G	84.2%	G	85.4%	G	87.3%	G	
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.	80%			86.4%	G			80%	G	
10.4	Through the work of the Affordable Warmth Network, 1430 residents will receive help, support or information to improve fuel poverty, with an aspiration that, by 2020, 25% of the interventions will be building based improvements to energy efficiency.	1430 residents							0		New indicator agreed at HIB Feb 2017. Data will be available for Q4 (and Q2 in 2017/18)
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 90 (2015)	≥90					79	G			
10.6	At least 70% of young people leaving supported housing services will have positive outcomes in 2016-17, aspiring to 95%	<=70% Aspire 95%					73.2%	G	70.7%	G	Sum of all four quarters shown for Q4

Priority 11: Preventing infectious disease through immunisation

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
11.1	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 years No CCG locality should perform below 94%	95%	95.0%	G	94.5%	A	94.6%	A	94.8%	A	Oxford City and North Oxfordshire localities are below 94% in Q4
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 years No CCG locality should perform below 94%	95%	93.4%	A	92.5%	A	93.1%	A	92.6%	A	Oxford City, S E Oxfordshire and West Oxfordshire localities below 94% in Q4
11.3	Seasonal Flu <65 at risk (Oxfordshire CCG)	≥ 55%							52.4%	A	
11.4	HPV 12-13 yrs (Human papillomavirus) 2 doses	≥ 90%							0%		Data available annually for school year Sept-Aug so published after September.

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Health Improvement Board
Basket of Indicators for Housing and Health
Annual Report 2016-17

One of the Joint Health and Wellbeing Strategy Priorities the Health Improvement Board has responsibility for is "Tackling the broader determinants of health through better housing and preventing homelessness" (Priority 10).

At the May 2013 Health Improvement Board, the 'basket of housing indicators' that would be reported annually to the Board meeting were agreed. These were then amended and updated slightly at the May 2014 meeting, which agreed the following measures.

The full dataset of statistics for 2016-17, and the previous two years, are shown on the last page of this report.

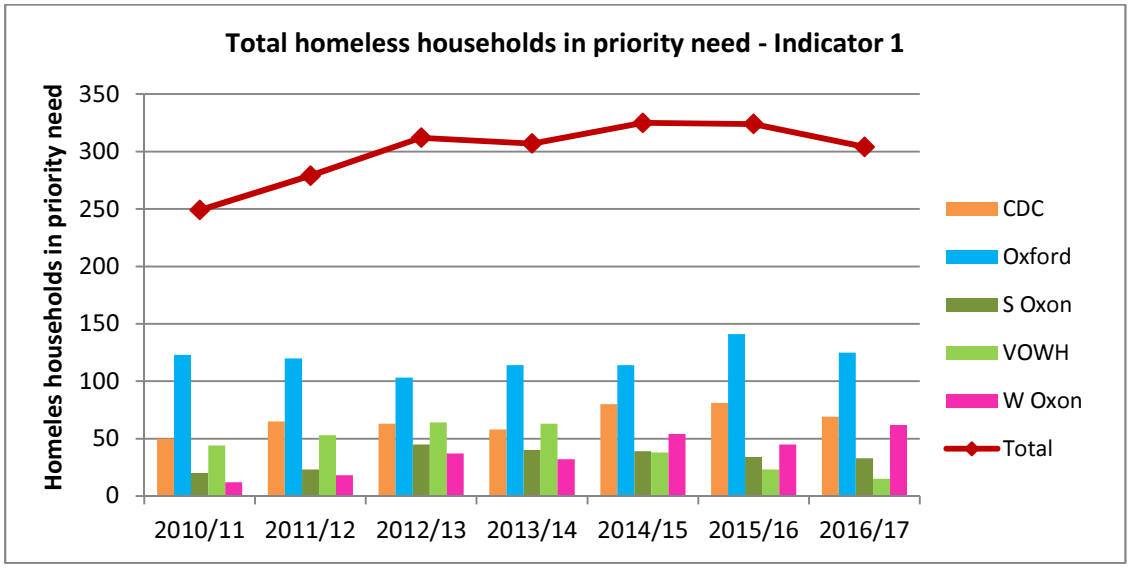
Key:

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

Homelessness Presentations (Indicator 1)
There has been an upward trend in people presenting as homeless*, over the whole County, in the past six years, rising from 457 in 2011/12 to 482 in 2016/17, although the figure has fallen from last year's figure (2015/16) of 505.The situation differs across Districts, with some experiencing greater volumes of presentations and some less, over this six year period.

The reasons for homelessness presentations are changing. The loss of private rented accommodation is becoming an increasing cause of homelessness and in some Districts has overtaken exclusion by family or friends as the main reason for homelessness.

There has been an increase in people who are accepted as statutorily homelessness and are in **priority need** in the County since 2011/12 to 2016/17 (279 to 304 households). There was however a reduction in acceptances from 324 in 2015/16. There are differences between Districts however. Over the past year, all Authorities have seen reductions apart from West Oxfordshire.



** It should be noted that the indicators reported here exclude homeless applicants with a 'not homeless' or a 'not eligible' decision, so the total figure is not entirely the full number of all homeless presentations*
The numbers of people found to be **intentionally homeless** has fallen for four years in a row; from a total of 141 in 2013/14 to 94 in 2016/17.

The numbers of people presenting as homeless but **not in priority need*** rose during 2015/16. Over the County as a whole, the numbers have increased from 50 in 2011/12 to 85 in 2016/17. As in previous years, there are considerable variations between the Districts with most cases recorded in West Oxfordshire, Cherwell or Oxford City (26, 29 and 27 households respectively).

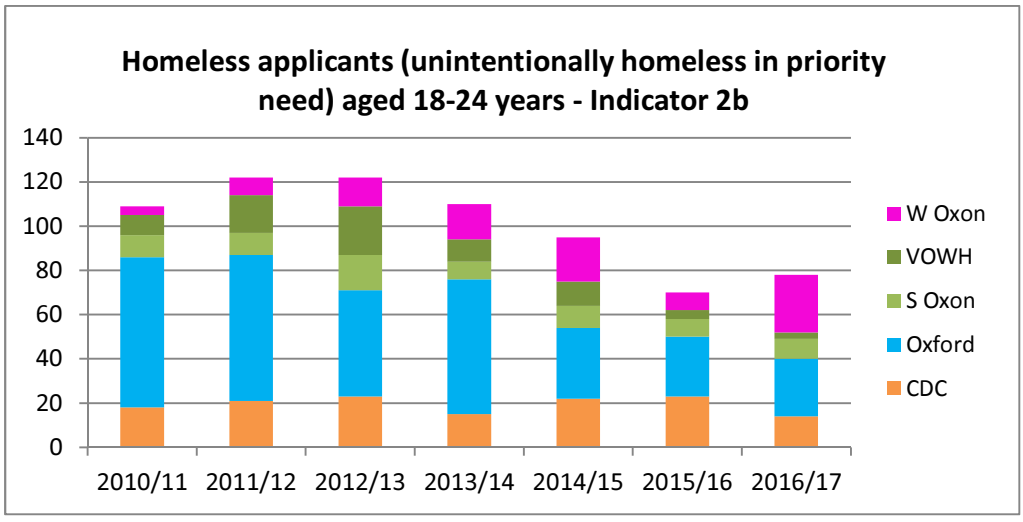
** Local housing authorities have a duty to secure accommodation for households who are in priority need under homelessness legislation. Categories of priority need are pregnancy, dependent children, vulnerable as a result of old age, mental illness or handicap, or physical disability or other special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

People found to be homeless expressed as a percentage of the number of people of cases where positive action was successful in preventing homelessness was 86%*. This is above the target (10.3) of 'at least 80%' and exactly the same percentage as was recorded in 2015/16.
(3057 preventions/ 3539 homeless applications plus preventions)*

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

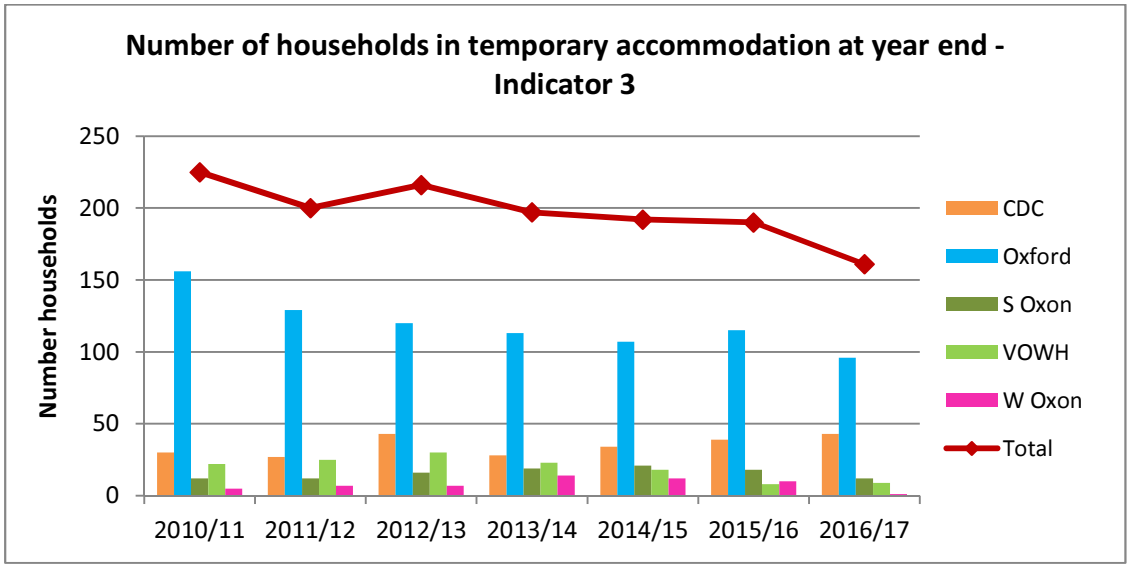
In 2015/16, 70 people aged 18 -24 were accepted as homeless in Oxfordshire. There was no–one aged 16 or 17. In 2016/17 the 18-24 figure rose slightly to 78; however this is still significantly lower than 2011/12, 2012/13 & 2013/14 figures (respectively: 122, 122 & 110).

The number of households who are in priority need because of physical or mental illness remains moderately low. In 2016/17, there were 11 homeless households where a member had a physical disability and 23 because of mental health. In 2016/17 just 13 households accepted as homeless with the main reason being rent arrears (same figure as 2015/16).



Number of households in Temporary Accommodation (Indicator 3)

There were 161 households in temporary accommodation at the end of the financial year 2016/17, a reduction of 29 from the previous year (exceeding target 10.1). There are, of course, local variations within Districts.

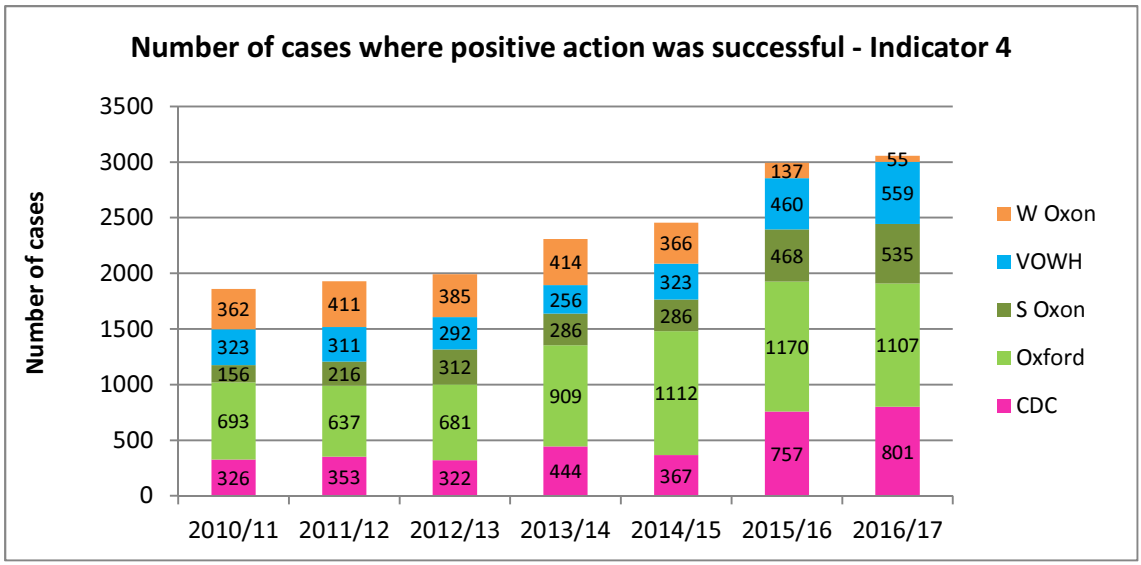


Number of households in Bed and Breakfast accommodation (New indicator)

As at the 31st March 2017, 5 households in Oxfordshire, out of the 161 indicated above, were in bed and breakfast (non-self-contained style) accommodation. This was a decrease on the 2015/16 figure of 8 households.

Positive action preventing homelessness (Indicator 4)

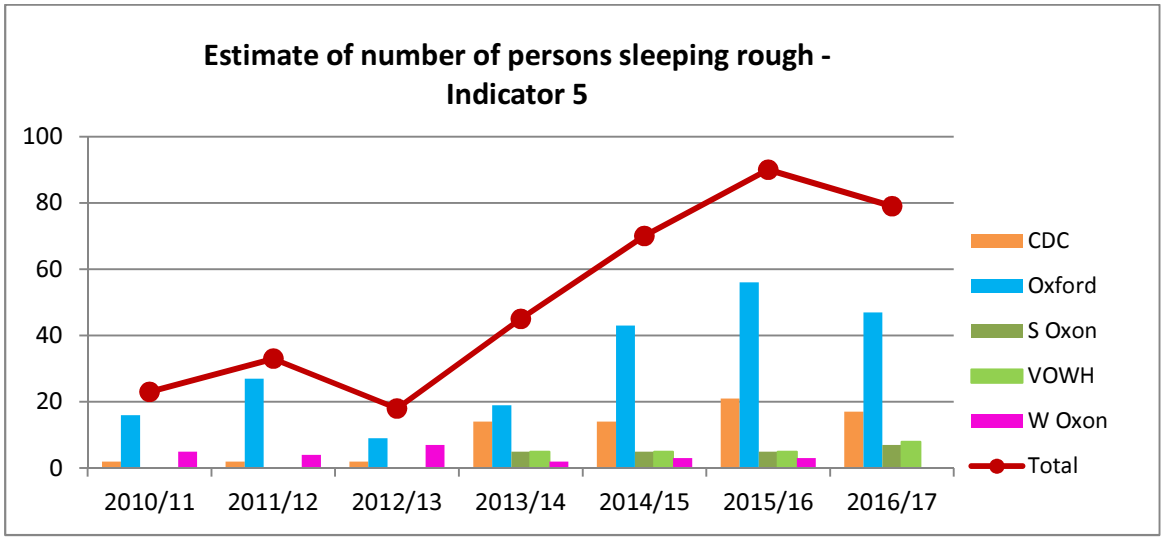
There were 3057 cases recorded where positive action prevented homelessness, compared to 2992 in 2015/16. In fact, 3057 is the highest figure recorded over the six year period. Positive action covers securing accommodation with a housing association or in the private rented sector as well as a result of the provision of advice, support or other intervention.



Rough-Sleeping (Indicator 5)

The estimated number of people rough sleeping in 2016/17 is 79, showing a decrease from 90 persons in 2015/16.

The reduction in Oxfordshire bucks the National trend; as there was a 13% increase in rough sleeping, nationally, between autumn 2015 to autumn 2016 (based on most recent DCLG statistics).



Removal of Spare Room Subsidy

In 2016/17, the number of households who found that their housing benefit has been reduced because of the Social Sector size criteria** was 2,053. This is a reduction from 2,154 households in 2015/16.

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

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

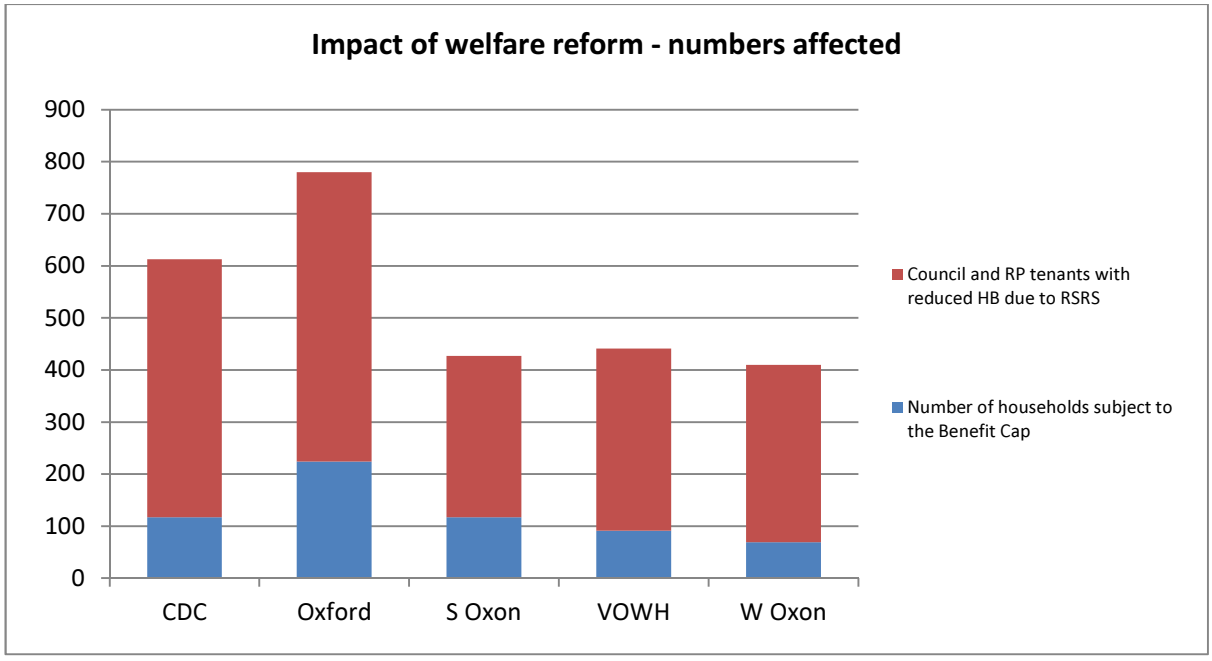
Tenants who are under occupying by one bedroom, have their benefit reduced by 14% of eligible rent, and tenants who are under occupying by two or more bedrooms have their benefit reduced by 25% of eligible rent.

Benefit Cap

The number of households affected by the Benefit Cap across the County increased significantly in 2016/17 to 618; from 125 in 2015/16. This is because of the reduction in Benefit Cap levels during 2016/17. In November 2016, levels were reduced as follows:

- The maximum level for single adults who don't have children or whose children don't live with them fell from £50.00 per week to £257.69 per week, and

- The maximum level for couples (with or without children living with them) and single parents whose children live with them fell from £500.00 per week to £384.62 per week.



Joint Working in 2016/17

There have been a number of areas of joint working over the 2016/17 year, between the County Council, District Councils, and other statutory partners such as the Oxfordshire Clinical Commissioning Group and health. This has included:

- Implementation of new Government-funded initiative working with offenders, led by Cherwell District Council.
- Review and re-commissioning of Housing Related Support for single adults with complex needs; following the reducing funding announcement in 2016.
- On-going review of Domestic Abuse services across the County.
- A broad agency review of the Hospital Discharge policy.
- Formation and submission of a Trailblazer funding bid to DCLG.

Going Forward – Opportunities for joint working in 2017/18

Joint working will be further built upon in 2017/18. Areas of joint work already identified include:

- Continued review and development of services around Housing Related Support, Hospital Discharge and Domestic Abuse.
- Collaboration around the implementation of the Homelessness Reduction Bill.
- Implementation of the resources and processes resulting from the successful Trailblazer funding bid. This aims to put in place homelessness prevention actions much earlier in the process; with particular attention being given to Hospital Discharge and Prisoner Release.

Annual 'Housing Basket of Indicators' report, for end of year HIB meeting (June 2017)

	2014/15						2015/16						2016/17					
Indicator 1 Homeless households																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
(1a) in priority need	80	114	39	38	54	**325**	81	141	34	23	45	**324**	69	125	33	15	62	**304**
(1b) intentionally	25	51	13	11	11	**111**	25	43	9	14	10	**101**	27	46	11	4	6	**94**
1c) no priority need	23	29	2	5	3	**62**	25	28	5	11	11	**80**	29	27	1	2	26	**85**
	128	194	54	54	68	**498**	131	212	48	48	66	**505**	125	198	44	21	94	**482**
Indicator 2 Homeless applicants who were unintentionally homeless and in priority need who were/had																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
(2a) aged 16/17yrs	0	0	0	0	0	**0**	0	0	0	0	0	**0**	0	0	0	0	0	**0**
(2b) aged 18 to 24	22	32	10	11	20	**95**	23	27	8	4	8	**70**	14	26	9	3	26	**78**
(2c) physical disability	2	7	1	3	2	**15**	6	5	3	1	5	**20**	0	4	4	2	1	**11**
(2d) mental illness	2	7	5	6	2	**22**	2	8	1	3	7	**21**	3	10	2	2	6	**23**
(2e) rent arrears	0	7	2	1	2	**12**	1	10	2	0	0	**13**	0	9	0	0	4	**13**
Indicator 3 Number of households in temporary accommodation at end of year (10.1 in JHWS)																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
	34	107	21	18	12	**192**	39	115	18	8	10	**190**	43	96	12	9	1	**161**
Indicator 4 Number of households where positive action was successful in preventing homelessness																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
	367	1112	286	323	366	**2454**	757	1170	468	460	137	**2992**	801	1107	535	559	55	**3057**
Indicator 5 Rough Sleeping (10.5 in JHWS)																		
	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total	CDC	Oxford	S Oxon	VOWH	W Oxon	Total
Estimate/count of persons sleeping rough	14	43	5	5	3	**70**	21	56	5	5	3	**90**	17	47	7	8	0	**79**
Impact of Welfare Reform																		
Council and RP tenants with reduced HB due to RSRS	603	622	332	389	358	**2304**	538	571	334	357	354	**2154**	496	556	310	350	341	**2053**
Number of households subject to the Benefit Cap	20	144	22	29	42	**257**	25	66	11	13	10	**125**	117	224	117	91	69	**618**

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Draft Joint Health and Wellbeing Strategy

Health Improvement Board section, Priorities 8 – 11

Background
The Joint Health and Wellbeing Strategy(JHWBS) for Oxfordshire sets out 11 priorities for the Oxfordshire Health and Wellbeing Board (HWB). The publication of the JHWBS is a statutory requirement under the Health and Social Care Act (2012). Work to take forward the priorities is monitored through a set of outcome measures which are monitored at each meeting of the Board and the whole strategy is revised and refreshed annually.

The priorities set out in the Oxfordshire JHWBS are shared between the 3 partnership boards as set out below:

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 Group (for Older People, Mental Health)

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 Board
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

The final JHWBS for last year can be found here:
https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf

The purpose of this paper
This paper sets out draft narrative and proposed outcome measures for 2017-18 for priorities 8 to 11. This draft is based on discussions held at the Health Improvement Board in April 2017.

The members of the Health Improvement Board are asked to comment and finalise the draft below. It will then be included in the revised draft Joint Health and Wellbeing Strategy and discussed at the Health and Wellbeing Board in July 2017.

Joint Health and Wellbeing Strategy - Priorities for Health Improvement *(draft)*

A new approach to addressing priorities

The Health Improvement Board has overseen and delivered improvements across each of the 4 priorities that it leads. At the end of 2016-17 the Board discussed progress and noted that all outcomes measures set at the beginning of the year were rated either amber or green. Some of these had been rated red earlier in the year or had been deliberately set as "stretch" targets. The discussion, therefore, centred on whether the Board should move to work on other topics instead.

In discussing the prospects of "dropping" some of the existing work where targets have been met, the Board members reviewed data on the inequalities of outcomes. For many of the areas of work there is still considerable variation, with some areas or groups still facing poor outcomes, even though a county wide improvement may have been made. For this reason the Board members decided they did not want to drop any topic completely, as there is still a need to focus on reducing the variation in outcomes. However, it was suggested that some topics could be placed into a "watching brief" while others stayed in the spotlight with more active work for improvement.

The Board members proposed new topics for discussion in the year ahead so that needs can be assessed and plans can be drawn up for health improvement. These areas are

- more work on tackling health inequalities, especially in preventing chronic disease,
- exploring how the board can work to improve mental wellbeing,
- work to improve the chances of a healthy older age, including an understanding of whether the Board can add more value to work being done to address loneliness.
- The Health Improvement Board has also offered to oversee the strategic work of joint commissioning of domestic abuse services and this is also a new topic for discussion.

The Joint Health and Wellbeing Strategy will therefore reflect this new approach to addressing priorities in the Health Improvement Board. Each of the sections on priorities will include

1. The rationale for continuing to focus on this priority
2. A summary of the current situation – "where are we now?"
3. Topics to be discussed and developed during 2017-18 but which do not yet have any specific outcome measures
4. Specific outcomes where it is the ambition of the Board to bring further improvement which will be monitored at every meeting.
5. A list of outcomes which will be kept under surveillance by the Board to ensure that recent improvement is sustained.

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

Rationale

This priority aims to add years to life and life to years – something we all aspire to. The biggest killers are heart disease, stroke and cancers. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services but we can encourage healthier lifestyles and prevent disease through early detection and screening to improve outcomes. The role of Social Prescribing can also be explored as a prevention strategy.

A gap in life expectancy still remains within Oxfordshire, with women likely to live longer than men, though the gap between women and men is narrowing as life expectancy for women seems to be reaching a plateau while that for men is still increasing. People living in more deprived areas are likely to die sooner and be ill or disabled for longer before death. These health inequalities remain and need to be addressed by targeting those areas and communities with the worst outcomes.

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

There is growing evidence of the link between physical inactivity (lack of physical activity) and preventable disease and early death. For example, regular and adequate levels of physical activity in adults can reduce the risk of hypertension, coronary heart disease, stroke, diabetes, breast and colon cancer, depression and the risk of falls.

The following areas for action will remain the priorities in the year ahead:

- To reduce levels of smoking in the county by encouraging more people to quit as smoking remains a major cause of heart disease and cancer.
- To boost our cancer screening programmes so that more people are protected, focusing on the bowel cancer screening programme.
- To promote the 'Health Checks' programme which offer adults a full health 'MOT' and looks at many lifestyle factors such as obesity, physical activity smoking, blood cholesterol levels, diabetes, blood pressure and alcohol consumption.
- Reducing the harm caused by the over-consumption of alcohol is another priority of the Health and Wellbeing Board. It is being taken forward by the Oxfordshire Alcohol and Drugs Partnership and progress will be monitored by the Health Improvement Board.
- To continue to monitor measures of success for those in drugs or alcohol treatment services with the aim of improving recovery rates.
- Building a multi-agency collaborative approach to increasing participation in physical activity within Oxfordshire
    - To consider issues affecting mental well-being in the population and what outcomes could be used to monitor it.
    - A programme of public awareness campaigns will support this work by raising awareness of prevention and early intervention services.

Addressing Inequalities

Wherever possible the outcome measures will target poor outcomes to reduce inequalities.

Where are we now?

- The national target of 60% people eligible for bowel screening should complete and return the kit was nearly met. Latest figures show 59.1% people completed the screening (Q1 in 2016-17). Death rates from bowel cancer in Oxfordshire are similar to the national average.
- Targets were met for the number of people invited for NHS Health Checks and a steady increase in uptake was noted throughout the year. Latest figures show poorer uptake in the City and NE Oxfordshire.
- Estimated prevalence of smokers in Oxfordshire is now down to 15.5% (2015) but fewer people are quitting using the commissioned services. It is thought that use of e-cigarettes has had an impact on this. There are still twice as many smokers in "routine and manual" occupations than in the Oxfordshire population as a whole.
- Less than 8% of women are recorded as smoking during pregnancy, less than the national figure of over 10%
- The numbers of people successfully completing treatment for drugs use has improved markedly. Oxfordshire is now above the England rate.

Topics to be discussed and developed in 2017-18

1. Health and Wellbeing of Older Adults, including participation in physical activity and access to social networks / preventing loneliness. This work will build on what is already being done in the County including the Oxfordshire Sport and Activity work to increase participation of older people in physical activity and the Loneliness Summit which will be held in July 2017.
2. Promoting Mental wellbeing. An overview of current work to promote mental wellbeing will be presented to the Health Improvement Board in the autumn of 2017. The Board will consider how value can be added to existing work and a plan will be drawn up.

Outcomes for 2017-18

8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years). ***Responsible Organisation: NHS England***

8.2 At least 95% of the eligible population 40-74 will have been invited for a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 80% (Baseline at Q3 2016/17 Oxon was 77.1%, England at Q3 is 69.7%, South East is 65.3%) ***Responsible Organisation: Oxfordshire County Council***

8.3 At least 45% of the eligible population 40-74 will have received a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 40%. (Baseline at Q3 2016/17 Oxon was 37.6%, England at Q3 is 33.8%, South East is 29.4%) ***Responsible Organisation: Oxfordshire County Council)***

8.4 Rate of successful quitters per 100,000 smokers aged 18+ should exceed the baseline set in 2017-18 (Baseline: 2016/17 Oxon baseline was 2315 quitters per 100,000 adult smokers. ***Responsible Organisation: Oxfordshire County Council)***

8.5 The number of women smoking in pregnancy should remain below 8% recorded at time of delivery (baseline 2015-16 was 7.9%). ***Responsible Organisation: Oxfordshire Clinical Commissioning Group***

Indicators to be kept under surveillance in 2017-18

8.6 Oxfordshire performance for the proportion of opiate users who successfully complete treatment ***Responsible Organisation: Oxfordshire County Council***

8.7 Oxfordshire performance for the proportion of non-opiate users who successfully complete treatment ***Responsible Organisation: Oxfordshire County Council***

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

After smoking, obesity is the biggest underlying cause of ill health (obesity is defined by a BMI of over 30). It can lead to high blood pressure, heart disease, stroke, diabetes, cancer and early death. It also increases immobility and makes any other disability more severe than it would otherwise be. There is a national trend for rising obesity rates across the population and although Oxfordshire fares better than the national picture, this remains a local priority and needs a long term perspective.

Surveillance of these issues shows that

- Rates of obesity in the county continue to rise. Data from surveys show a cause for concern.
- The percentage of people diagnosed with diabetes by their GP continues to rise across the county.
- The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire.
- Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates, but show over 16% obesity at year 6. These are year on year snap shot measures so trends cannot be identified.

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

Promoting breastfeeding

Breastfeeding gives the best start to life and has been proven to lead to fewer overweight children and adults. The national figure for breastfeeding prevalence at 6-8 weeks is just under 44% but in Oxfordshire we want to keep the stretching target of 63% and will only achieve this if we focus on the areas where rates are low.

Halting the increase in childhood obesity

Children in Reception class and Year 6 are weighed and measured every year and results show that around 7% of reception year and 16% of Year 6 children are obese. This feeds through into ever increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to. Healthy eating initiatives are part of the approach though the Healthy Weight action plan in Oxfordshire also includes physical activity, environmental planning and

workplace based initiatives. Levels of obesity are also linked to social deprivation, with more deprived parts of the County showing higher rates of obesity along with some ethnic groups, so some targeting of effort is called for here too.

Promoting physical activity in adults

Physical activity is an important component of maintaining a healthy weight for all ages and there is local encouragement here, with Oxfordshire still doing well according to the 'Active People' survey. However, the survey showed that almost 17% of the population are inactive – not even attaining 30 minutes of physical activity a week. Regular participation in physical activity will have an impact on mental wellbeing and be critical to good health in the county.

Where are we now?

- Between 2014-15 and 2015-16, the prevalence of obesity in Oxfordshire increased in reception year and declined slightly in year 6. In reception obesity increased from 6.6% to 7%, and in year 6 declined from 16.2% to 16%.
- There is variation in the percentages of children who are overweight or obese with higher rates in some minority ethnic groups and in more disadvantaged communities.
- Oxfordshire continues to have high numbers of people who are physically active and the proportion that are inactive has fallen.
- **82%** of mothers in Oxfordshire initiated breastfeeding. This rate is similar to the previous year and is significantly higher than the England average (74.3%) and that for the South East (78.0%).
- At 6-8 weeks after birth, over **60%** of mothers in Oxfordshire were breastfeeding, this was well above the national average of 43%

Topics to be discussed and developed in 2017-18

1. Addressing inequalities issues in preventing chronic disease by tackling obesity and improving participation in physical activity. In order to implement the recommendations of the Health Inequalities Commission, all of the work to tackle this priority area will include a focus on reducing inequality of outcome.

Outcomes for 2017-18

9.1 Ensure that the obesity level in Year 6 children is held at below 16% (in 2016 this was 16.0%) No district population should record more than 19% ***Data provided by Oxfordshire County Council***

9.2 Reduce by 0.5% the percentage of adults classified as "inactive" (Oxfordshire baseline Nov 2016 of 17%). ***Responsible Organisation: District Councils supported by Oxfordshire Sport and Physical Activity***

Indicators to be kept under surveillance in 2017-18

9.3 63% of babies that are breastfed at 6-8 weeks of age ***Responsible Organisation: NHS England and Oxfordshire Clinical Commissioning Group***

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

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

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

- 'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses
- Homeless people die earlier and suffer worse health than people with a stable home. The threat and experience of homelessness also has an impact on mental wellbeing.
- Safe, secure housing contributes to improving health outcomes. Some vulnerable people need support to maintain their tenancies and live ordinary lives as fully participating members of the wider community. This is an essential ingredient for preventing ill health and homelessness.

These housing issues all have to be tackled in partnership.

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

Concerns remain including

- Changes to local funding and arrangements for commissioning housing related support.
- Changes to the welfare benefit system which has potential to put more households at risk of homelessness.
- The high cost and low availability of private sector housing within the County.
- Fuel poverty is still a risk for a large number of households. New systems for improving energy efficiency of homes have been introduced and need to be established.
- Young people, especially those who have been Looked After, may need support to find and remain in appropriate housing.

Where are we now?

- The number of households in temporary accommodation fell by 29, to 161 from 190 in 2016-17
- There were 3,057 households presenting at risk of being homeless that were prevented from being homeless because of the efforts of district councils; compared to 2,992 cases in 2015/16.
- The number of rough sleepers fell to 79 (from a figure of 90 in 2015/16).
- New contracts are to be let for housing related support based on a joint commissioning arrangement and pooled budget.

Topics to be discussed and developed in 2017-18

1. Domestic abuse – strategic approach to joint commissioning. The work to jointly commission high quality services for prevention, early intervention and support for victims of domestic abuse is building on a major review carried out in 2016. The Health Improvement Board will consider its role in governance and strategic leadership for this work.

Outcomes for 2017-18 were set as follows and outturns will be reported at the meeting:

10.1 The number of households in temporary accommodation on 31 March 2017 should be no greater than the level reported in March 2017 (baseline161 households in Oxfordshire in 2016-17). **Responsible Organisation: District Councils**

10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.3% in 2016-17). **Responsible Organisation: Oxfordshire County Council**

10.3 At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 80% in 2016-17). **Responsible Organisation: District Councils**

10.4 Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2016-17 (baseline 79) **Responsible Organisation: District Councils**

10.5 Measure on young people's housing related support to be confirmed at the HIB in July 2016. Proposed measure is "at least 70% of young people leaving supported housing services will have positive outcomes in 16-17, aspiring to 95%" (baseline 70.7% in 2016-17). **Responsible Organisation: Oxfordshire County Council Children, Education and Families Directorate.**

Indicators to be kept under surveillance in 2017-18

10.6 At least 1,430 residents are helped per year over the next 4 years where building based measures account for 25% of those interventions by the final year. **Responsible Organisation: Affordable Warmth Network.**

Priority 11: **Preventing infectious disease through immunisation**
Immunisation is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire remain good, but it is imperative that this is maintained. Constant vigilance is needed to make sure that individual children have access to immunisation. This means working closely with GPs, community nurses and individual families.

It is important that immunisation rates remain high throughout the population to maintain "herd immunity". Responsibility for commissioning immunisation services sits with NHS England. High levels of coverage need to be maintained in order to continue to achieve the goal of protection for the population.

New immunisations were introduced in 2013-14. This includes flu immunisation being given to children, (which started with 2-3 year olds and is adding more ages each year), and Shingles vaccinations are offered to people aged 70 and 79.

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met. The leadership for these services has changed during the last few years and maintaining our current position will be a real challenge.

We are proposing priorities for improving immunisation levels across the board, focussing on childhood immunisation and ensuring that flu immunisation reaches those at particular risk.

Where are we now?

- Rates of immunisation for Measles, Mumps and Rubella remained high but just failed to reach the national target of 95%. This was true for both first and second doses. NHS England have given details of their work to improve this performance and ensure the children who are missing out are included.
- The rate of take up for people aged under 65 who are invited for flu vaccination fell in the last year and did not meet the target.
- All targets have been met for HPV vaccination of young women to protect them from some causes of cervical cancer.

Outcomes for 2017 -18
11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 94.6%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 93.1%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.3 At least 55% of people aged under 65 in "risk groups" receive flu vaccination (baseline from 2015-16 45.9%) ***Responsible Organisation: NHS England***

Indicators to be kept under surveillance in 2017-18
11.4 At least 90% of young women to receive both doses of HPV vaccination. (Baseline in 2015-16 tbc) ***Responsible Organisation: NHS England***

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Health Improvement Board

27th June 2017

Barton Healthy New Town – Information Update and Learning

1. Purpose of report

To provide the Oxfordshire Health Improvement Board with a progress update on Barton's participation in the NHS England Healthy New Town Programme to support shared learning.

2. Recommendations

The Health Improvement Board is asked to:

- Note the current position and progress to date of the Barton Healthy New Town as detailed in the end of year report (Appendix 1).
- Note the learning identified through the Barton project and consider how this may inform future practice of work with planners and developers to address health priorities and inequalities.

3. Background

This paper follows a report presented to the Health Improvement Board by Bicester Healthy New Town in October 2016.

The Health Improvement Board has a remit of 'effective partnership working across Oxfordshire to meet peoples' health and social care needs'. The NHS Healthy New Town Programme can help to contribute towards this aim through its contribution to improving health through the built environment.

The national NHS Healthy New Town programme links to the NHS Five Year Forward View to improve health through the built environment. Barton was selected as one of ten national demonstrator sites to take forward this work. The Barton Park development will create 885 lifetime homes, 40% of which will be social housing.

Oxford City Council is the accountable organisation closely working with Grosvenor, Oxfordshire County Council Public Health, Oxfordshire Clinical Commissioning Group and other partners. Barton Healthy New Town was awarded a grant of £126,000 from NHS England in August 2016 to contribute

towards the delivery of the project in 2016/17. The Healthy New Town project includes the existing areas of Barton as well as development in Barton Park.

The work of the Barton Healthy New Town contributes to addressing 3 of the key Health Improvement Board priorities set out for 2016/17.
These include:

- Preventing early death and improving quality of life in later years.
- Preventing chronic disease through tackling obesity.
- Tackling the broader determinants of health through better housing and preventing homelessness

The Health Improvement Board have requested an update on the progress of the Barton Healthy New Town to contribute to discussions around how learning from this programme can help inform future practice in other areas.

4. Achievements

The key achievements, opportunities and challenges of the Barton Healthy New Town have been detailed in the attached end of year report compiled by Oxford City Council (Appendix 1).

The end of year report outlines the projects aims and objectives and details the key outputs delivered in 2016/17 (pages 5-12). Some key outputs and successes to note are highlighted below along with page numbers to the appendix where further detail can be found.

- Eight community-led health and wellbeing pilots grant-funded to generate learning from practice and in some cases, innovation. A total allocation of £30,000 was available to award grants of up to £5,000 (page 8-11).

- A programme of new partner-implemented physical and wellbeing activities attracting some ‘hard to reach’ sections of the Barton population (page 10).

- A Health Impact Assessment to understand the impact of new developments in Barton on health (page 6).

- Research to develop a specific data set of health needs and assets specifically for the Barton population. This can be used going forward to inform a more relevant future health and wellbeing service provision and also infrastructure enhancements. The research piece also includes population projections to consider the needs of existing and future residents (page 12).

- Training events and workshops for community workers including mental health awareness, food poverty awareness and IBA for smoking and alcohol, aligned to the existing Barton Health Plan (page 8)

- Identification of ‘recipes for change’ and project work that can be replicated in other areas e.g. Health Champions training, Getting Heard ‘Appointment Buddies’ (page 8) to support residents to attend appointments and the Youth Ambition Toolkit to help young people to describe their learning journey and give them prompts to express the changes that may have occurred for them over time (page 9). Others include approaches to address food poverty such as establishing the Barton Community Cupboard work to increase the uptake of Healthy Start vouchers (page 8-11).

- Communications videos describing the project, the challenges it seeks to address and key learning to date. In total, through Facebook and Twitter, these messages were seen 220,450 times and the videos were watched 36,980 times (three second views, as defined by social media) (page 6).

- A delivery plan, investable propositions and a logic model for the next phase of the project. Some of the outcomes in the delivery plan may be dependent on the level of funding from NHS England, once confirmed (page 6).

5. Learning to consider applying in other areas

Learning from others, sharing our learning and replicability of projects and activities has been an important theme in the Healthy New Town work.

Three particular areas of learning to share are:

- The importance of carrying out in depth analysis of the assets and health needs of existing and future residents
- Community engagement
- The benefits of carrying out a Health Impact Assessment

The commissioned piece of research, which focussed on a detailed health needs assessment and asset mapping of the area, was important to help build a more localised picture of existing and future residents’ health needs and to inform priorities going forward. The research gave a forum for residents and local stakeholders to share their views about local health issues.

The data collection included a review of published health intelligence, future housing and population projections and focus groups, telephone interviews and door to door surveying of current residents.

Engagement with the community is key and this has been achieved through joint working groups such as BICEP and regular engagement between Grosvenor and the community. Building on aspirations and relationships already in place, such as the Barton Health and Wellbeing Partnership has given this project strong foundations to develop from and has fostered good

collaborative working. The Health and Wellbeing Partnership has enabled us to focus on the assets and needs of Barton and brings organisations together to maximise opportunities and build in sustainability for project work.

The Health and Wellbeing Partnership membership has wide representation from stakeholders including amongst others; the Barton GP Surgery, Barton Community Association, Oxford City Council, Oxfordshire County Council Public Health, Oxfordshire Clinical Commissioning Group, the Centre for Sustainable Healthcare, local Councillors, advocacy organisations, leisure providers, voluntary organisations, Health Visitors and Good Food Oxford.

We found that social media, notably Facebook, can reach certain groups who may be difficult to engage with offline (especially younger and middle aged audiences) and that working with partners can increase reach within the community as well as supporting future sustainability.

A clear focus on integration between the existing and new communities has been essential. This has been reflected in the 'One Barton' work stream of the delivery plan that aims to achieve this. The £3.9M Oxford City Council funded regeneration programme in existing Barton will help to mirror investment while development takes place as part of the creation of a new and wider Barton community.

The community grants scheme has also supported this theme with early investment in community activities to test activities and increase community capacity ready for new residents to join. Time invested up front to bring potential grant applicants together to enable collaboration rather than duplication of activities has been important. Opportunities have been provided to enable grant funded groups to support each other in the delivery of their funded projects by forming a delivery group.

The Health Impact Assessment was an extremely useful tool to not only understand any health impact from the new development but also to identify opportunities for retrospective enhancements to the original masterplan and recommendations for Underhill Circus regeneration and Barton Healthy Living Centre developments. Conducting a Health Impact Assessment at the earliest possible stage can provide a greater window of opportunity to understand and influence the health impacts of a development.

A Health Impact Assessment can help inform decisions by highlighting any potential health consequences if a proposal/policy/project/action is implemented. The tool can contribute to recommendations as to how to enhance health improvement opportunities and also how to mitigate any potentially negative health impacts that may be identified. Public Health have been encouraging the inclusion of Health Impact Assessments in a range of planning policy consultations. More information about Health Impact Assessments can be found here: http://www.who.int/hia/en/ and here http://www.healthyurbandevelopment.nhs.uk/our-services/delivering-healthy-urban-development/health-impact-assessment/

The opportunities to influence local planning policy with health through the Healthy New Town work have been wider than expected and early discussions and relationship building has been key. Ensuring that infrastructure to support good health such as the linear park being in place ready for new residents creates an ethos of 'facilities first' which captures a window of opportunity for encouraging healthy behaviours. This can provide commercial as well as health benefits.

6. Next steps

- Consolidate learning and evidence gained from phase one to prioritise actions within the phase two delivery plan.

- Continue discussions with NHSE to confirm funding and expectations for the next phase of the project.

- Implement recommendations from commissioned work to implement new governance structures and delivery models for phase two. This includes strategic governance with representation from Oxford City Council, Oxfordshire Clinical Commissioning Group, Grosvenor and Oxfordshire County Council Public Health. It is also planned that there will be a delivery group with wider representation to support the long term sustainability of the project.

7. Appendices

Barton Healthy New Town, End of Phase One report. Oxford City Council, May 2017.

https://www.oxford.gov.uk/info/20272/barton_healthy_new_town/1152/barton_healthy_new_town_activities

Report by:

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27th June 2017

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Barton Healthy New Town

End of Phase One report

May 2017

Contents

Appendices

1 Introduction

1.1. This report sets out a summary of the aims of Barton HNT, significant achievements made in phase one (August '16 – March 2017), outcomes from the last period (Feb – Mar 2017) [Appendix 1] and key outcomes from the health profile research and independent evaluation.

1.2. This report has been produced by Oxford City Council, agreed by Barton Healthy New Town Steering Group made up of Oxford City Council, Grosvenor Developments Ltd, Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Public Health, and signed off by Head of Community Services and Executive Director responsible for Barton.

2. Executive summary

2.1. The Barton Healthy New Town overall project aim is: *All Barton residents (Barton and Barton Park) have an equal opportunity to good physical and mental health and good health outcomes.*

2.2. In a relatively short amount of time, it was identified through independent evaluation that the project "*had already began to deliver the objectives it set itself at the outset of the funding*". Some major strengths demonstrated include:

2.2.1. The work to commission independent research into the needs of the community and a health impact assessment.
2.2.2. The commitment of partners to the project at a senior level, with pragmatic and dynamic decision making at Steering Group level.
2.2.3. The delivery of a successful grants programme, which was relevant and contributed learning and innovation.
2.2.4. The preparation of a logic model and plan with investable proposals aligned with National HNT programme aims and local priorities.

2.3. Achievements in the last period (Feb – Mar 2017) are also set out with in this report according to the four themes identified in the logic model. Key achievements are:

2.3.1. **Physical and Built Environment which supports health and wellbeing**

i. Completion of a Health Impact Assessment to identify opportunities for retrospective enhancements at Barton Park and proactive recommendations for Underhill Circus & Barton Healthy Living Centre developments.
ii. Relationship established between Oxfordshire Clinical Commissioning Group's Transformation Team and Oxford City Council's Policy Planning Team; brokered by the project team to improve communications and embed health into the Local Plan

2.3.2. **Health Systems to support health and wellbeing**

i. Creating increased awareness, knowledge of local support and referral networks, and development of action planning was achieved via up-skilling of professionals working in Barton though training, workshops on food, poverty, alcohol and smoking intervention, and mental health.

ii. Development of a Mental Health vision for Barton Healthy New Town with Oxford Mental Health Partnership.

2.3.3. **Healthy Behaviours**

i. Training of Community Health Champions completed including the production of a recruitment and training pack.

ii. Launch of Barton Community Cupboard in Barton Neighbourhood Centre replacing the Food Bank and improving healthy food provision and reducing stigma for those accessing it.

2.3.4. **One Barton**

i. Establishment of working group to deliver the coordinated approach to signage, fit trail and green space furniture in existing Barton, to link in with Barton's Park promoting active lifestyles and integration.

2.4. Health profile baseline research

2.4.1. A key part of the project, during Phase One, was to commission research on the health profile of Barton using existing data, primary research and best practice population projections that could be replicated in Barton Park. The aim was to have an up-to-date, relevant and comparable baseline for health, well-being and any inequalities to guide future project plans. The research commissioned in Dec 2016 and undertaken between Jan – Mar 2017 identified the following as key health issues in Barton:

i. Poor nutrition, with only 14% eating the recommended portions of fruit/ vegetables.

ii. Mental health, including high levels of depression and anxiety.

iii. Older people and middle age men are most at risk from isolation and experiencing multiple disadvantages.

iv. High levels of alcohol consumption were identified within existing and future Barton Park populations through demographic analysis.

2.5. Key learning points from the independent project evaluation undertaken in March 2017 identified the following:

i. Project governance needs to be better integrated with existing structures covering Barton.

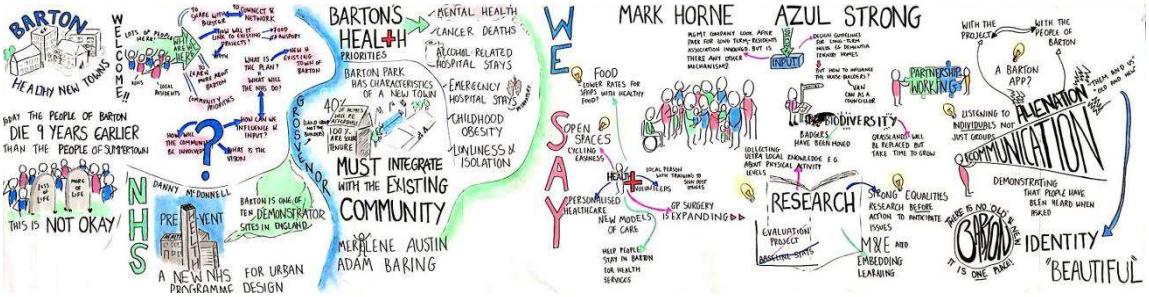
ii. A wider 'action group' is needed with a range of active partners.

iii. The research findings should inform a review of health and wellbeing plan focus.

2.6. Phase Two review

2.6.1. In Phase Two (funding-dependent), there is a senior commitment to review governance, and programme management to secure buy-in at the most senior level particularly in Oxford City Council, Grosvenor Developments Ltd, Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Public Health.

2.6.2. It is envisaged that with a strong governance, effective programme management and an active delivery group, using up to date health data, informed by the Health Impact Assessment, Mental Health vision and actions plans agreed by partners, the project will be able to effectively deliver against the logic model and agreed investible propositions.



3. Project aims and objectives

3.1 The following aims were agreed for the Barton Healthy New Town by NHS England and project partners in August 2016:

3.1.1. To contribute learning and innovation around how to reduce health inequalities for current and future residents of Barton, with particular attention to those with additional vulnerabilities.

3.1.2. To contribute to learning and innovation for the integration of existing residents of Barton and future residents of Barton Park.

3.1.3. To contribute and apply practical recommendations on the design of the new development, infrastructure and services.

3.1.4 To support integration and adaptation of service models which can be sustained, scaled and replicated beyond the life span of this project within local resources.

3.2. The specific objectives were identified for 2016-7 as follows:

3.2.1. Through the grants process, to ensure timely and effective delivery of health and wellbeing initiatives which pay special attention to the most vulnerable members of the Barton population and contribute to learning and innovation.

3.2.2. Through the monitoring and evaluation working group, to conduct health research, collate robust data and ensure learning and innovation is identified.

3.2.3. Through community-level partnerships and engagement, to organise health and wellbeing activities and identify recommendations for a healthy neighbourhood and physical environment.

3.2.4. Through the work of the steering and working groups and existing community networks, to plan for the future sustainability of health and wellbeing initiatives, learning and innovation.

4. Key outputs delivered in 2016-17

4.1 An independent evaluation of the project was commissioned and took place in March 2017. This helped to identify that in Phase One of the project the significant outputs delivered by the Steering Group include:

4.1.1. Senior level buy-in to the project by the statutory partner agencies, a project identity, establishment of a governance structure, and mapping of this structure to existing local health, well-being, regeneration and community development networks.

4.1.2. A logic model to underpin the relationship between project activities and desired outcomes (a later requirement of NHSE). [Appendix 2]

4.1.3. Eight community-led health and wellbeing pilots grant-funded to generate learning from practice and in some cases, innovation.

4.1.4. Initial evidence and learning about a social prescribing approach adopted at Bury Knowle surgery in Barton Neighbourhood Centre that eases pressure on front-line health services and makes more effective use of community and voluntary led service provision.

4.1.5. A programme of new partner-implemented physical and wellbeing activities attracting some ‘hard to reach’ sections of the Barton population.

4.1.6. A delivery plan and investable propositions for the next phase of the project for submission to NHSE.

4.1.7. A Health Impact Assessment to understand the impact of new developments in Barton on health. [Appendix 4]

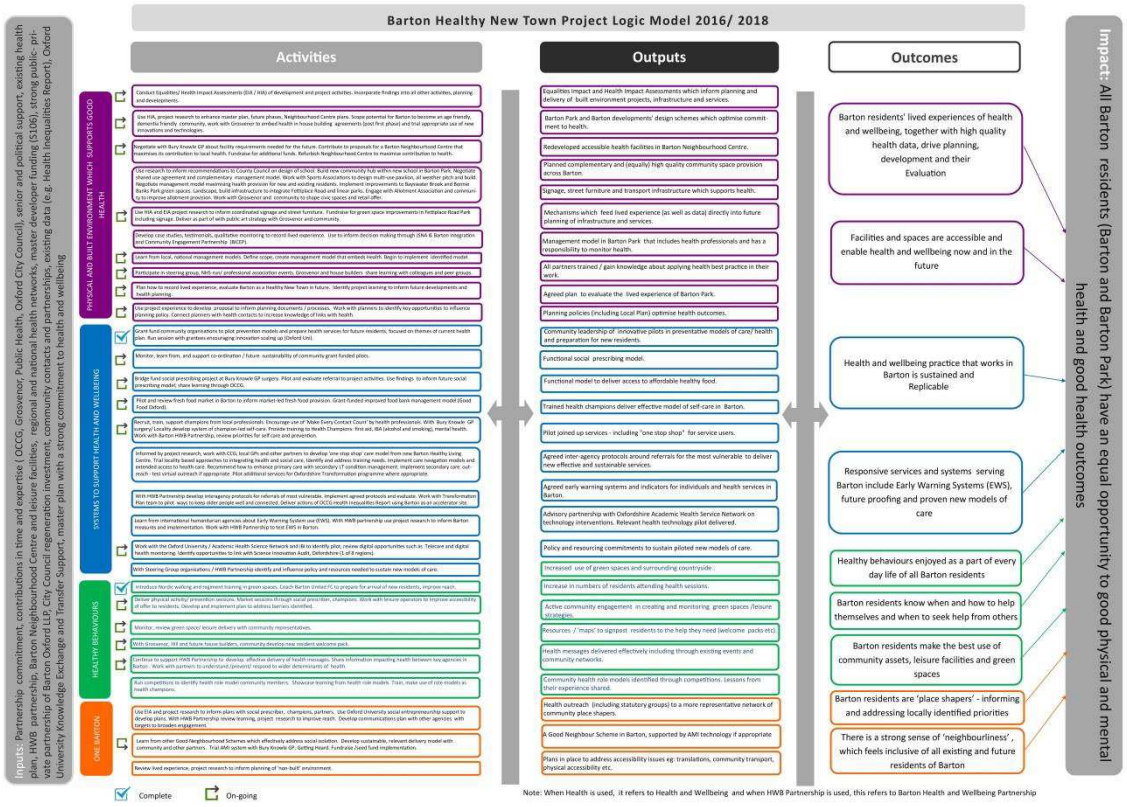
4.1.8. Research to develop a specific data set of needs and assets specifically for the Barton population; to be used to inform more relevant future health and wellbeing service provision and infrastructure enhancements. [Appendix 5]

4.1.9. Training events and workshops for community workers including mental health awareness, aligned to the existing Barton Health Plan.

4.1.10. Identification of 'recipes for change' and project work that can be replicated in other areas. Some already being replicated in Bicester Healthy New Town (showing of Flat 73 play about loneliness) and in other regeneration areas of Oxford City (e.g. food poverty services in Blackbird Leys and Health Champions in Rose Hill).

4.1.11. Communications videos describing the project, the challenges it seeks to address and key learning to date. In total, through Facebook and Twitter, these messages were seen 220,450 times and the videos were watched 36,980 times (three second views, as defined by social media).

4.1.12. A delivery plan and investable propositions for the next phase of the project for submission to NHSE. [Appendix 3]



5. Achievement in last period

5.1. Achievements between 1st February and 31st March 2017 to be read in conjunction with previously submitted Quarterly reports in October 2016 [Appendix 16] and January 2017 [Appendix 17].

5.2. This review is set out according to the four themes identified in the Barton Healthy New Town logic model.

5.3. **Physical and Built Environment which supports health and wellbeing**

5.3.1. Ongoing negotiations now underway between Oxford City Council, Bury Knowle GP Surgery and Oxfordshire Clinical Commissioning Group on facility requirements for Barton Healthy Living Centre.

5.3.2. Relationship established for the first time between Project Steering Group partners including Oxfordshire Clinical Commissioning Group's Transformation Team and Oxford City Council's Policy Planning Team (who lead on revision of the Oxford Local Plan). This was brokered by the project team to improve communications and embed health into the Local Plan.

5.3.3. The Steering Group have now also secured an opportunity to feed project learning into the development of Oxford's forthcoming Housing Strategy.

5.3.4. Completion of a Health Impact Assessment to identify opportunities for retrospective enhancements at Barton Park, proactive recommendations for Underhill Circus & Barton Healthy Living Centre developments.

5.4. **Health Systems to support health and wellbeing**

5.4.1. Through the provision of bridge-funding for Bury Knowle's social prescribing pilot, the project enabled continuous provision for three months until April 2017 when the service was at risk due to a lack of funding. This has strengthened the relationship between primary care providers and other funded organisations (Getting Heard and Barton Community Association), generated key information about social prescribing (what works and what does not), access to health data to inform health, and the research and commitment from the surgery to share learning with other practices across Oxford city. A replicable model will be further developed following a deeper review of learning from social prescribing and the appointment buddy pilot, subject to further funding being secured. [Pilot report, Appendix 6]

5.4.2. As part of the BHNT grants programme, Getting Heard a Barton based advocacy service were funded to deliver a pilot project 'Appointment Buddies' to support isolated older Barton residents access health services, advocacy support and increase social and physical mobility. Residents themselves along with volunteers were actively involved in co-producing the services delivered through the project. In the short period of time, Getting Heard have been able to set up the pilot, recruit and train volunteers, test out policies and procedures and referral forms, and have used the support from Barton Healthy New Town to apply for further funding from other sources.

5.4.3. Completion of research commissioned to create a deeper understanding of both existing and future residents' health needs which will be used by health and other service providers (e.g. GPs, leisure and physical activity, Green Spaces) to inform a more relevant local health offer. Using demographic analysis of existing and future populations, health issues projections have been made on the likelihood of health issues to inform service and facilities planning locality, city wide and STP work.

5.4.4. Increased awareness, knowledge of local support and referral networks and development of action planning was achieved through up-skilling of professionals working in Barton and other deprived areas with in Oxford city:

i. Food poverty awareness training delivered by Good Food Oxford, with 22 professionals in attendance, including the head teacher of Bayards Hill, church vicar and community café manager. As a result of the session, the Eatwells Café Manager reported an increased understanding of the nature of food poverty and the situations people may find themselves in, as well as the high importance of offering food services which provide healthy and affordable food. She is committed to continue to offer a 99p meal for children, and healthy affordable soup made from food bank ingredients on a long term basis. [Training presentation, Appendix 7]

ii. Training to provide brief intervention and advice to those experiencing alcohol and smoking addictions (IBA) took place and to a varied set of organisations and key workers including the Tenancy Management & Sustainment Officer for Barton, Health Care Assistant and Cardiac Rehabilitation Specialist nurse. [Appendix 8] These messages will now be incorporated into their work with residents in Barton.

iii. Mental Health awareness training was delivered to 15 local professionals raising awareness of common mental health issues, approaches to supporting those experiencing these

and identifying opportunities to implements the 5 ways to Wellbeing (5WTWB) into everyday work. The session was followed by action-planning to take forward mental health commitments in Barton. Attendance included the Youth Ambition young people's Engagement Officer, Community Response team (responsible for low level Anti-Social Behaviour management) and health visitors. Following this training, the Youth Ambition Team agreed to incorporate the 5WTWB into all youth sessions and the Tenancy Officer committed to incorporating considerations about mental health into tenancy visits that take place in Barton. [Appendix 9]

5.4.5. Development of a Mental Health Vision for Barton Healthy New Town with Oxford Mental Health Partnership to influence future developments and initiatives in Barton and Barton Park. Report from workshop attached. [Appendix 10]

5.4.6. Completion of commissioned Literature Review produced by Oxfordshire MIND on 'What does excellence look like in terms of considering the future mental health needs of the population of the Healthy New Town.' This review will inform future thinking and approaches to mental health in Barton. [Appendix 11]

5.5 **Healthy Behaviours**

5.5.1 Community Health Champions training delivered to six local professionals including the Family and Children's Centre and Community Association staff. Co-ordination has been established with Bury Knowle Surgery to link this with social prescribing and on-going updating of health messages. Training material, job descriptions, Introduction to Health Champions for employers and the recording template can be used in other sites. [Recruitment and Training pack, Appendix 12]

5.5.2. The Youth Ambition programme piloted sport and physical activity sessions for inactive girls aged 10-17 in Barton over a 12 week period, with 13 girls taking part. The outcomes that these sessions aimed to achieve were for the participants to improve their health and wellbeing and engage in regular sport and physical activity. An hour of physical activity of their choice was followed by an hour workshop on, for example, healthy eating and the benefits of regular exercise. After the 12 weeks:

"The young people said that they now better understand the positive things they can do to improve their own health; they recognise the factors that contribute to a healthy lifestyle; they can make informed choices about their health and they feel good about themselves and have a positive self-image."

5.5.3. The tools Youth Ambition used help young people to describe their learning journey and give them prompts to express the changes that may have occurred for them over time. [Report & tool kit, Appendix 13]

5.5.4 New adult physical activities including Buggy Friendly Bootcamp and Nordic Walking sessions utilising existing facilities and green spaces delivered through the Council's Sports and Physical Activities Teams, these attracted 8 participants.

i. 6 regular walkers all over 55 years old who have really enjoyed and completed their 'Learn to Nordic Walk Course'.
ii. Using the Sport England MOVES assessment tool an NHS Return on Investment of £9.39 for every £1 invested was calculated.
iii. QALY Return on Investment methodology indicates a return on investment of £24.76 for every £1 invested. This approach considers the benefits from the programme and assumes that with less disease, residents live longer and the value of the programme therefore increases.

5.5.4. Resident feedback included: *"I have recently retired and was looking for a new activity to help get me fitter and more active. The Nordic Walking course was ideal as I could go at my own pace and Kate helped me to use the poles correctly on flat and hilly ground. Having the poles helped with my co-ordination and balance. I have met some new people and enjoyed their company and the fresh air and feel excited about using my newly learned skills together with my brand new poles this summer!" Dot Mills, Barton resident.*

5.5.5. Partnering with Oxford Brookes University's Healthy Urban Mobility project, the project informed a study into improving access to cycling in Barton for the older people. The first Special Interest Group on Research on Transport and Mobility from the British Society of Gerontology met in Barton on Friday 21st April 2017. The project steering group presented work on the progress of the Healthy New Town project to date, highlighting work streams relating to improving the health of older people.

5.5.6. With the aim to reduce stigma, increase knowledge of cooking on a budget and to improve the offer available, as well as increase the life of perishable goods, Good Food Oxford delivered a full independent review of Food Bank provision, usage and management. This review will shape future management within Barton Neighbourhood Centre so that those facing food poverty, now and in the future, are best supported. This led to the development and installation of Barton Community Cupboard; a market-style provision which includes a fridge, recipe cards and a cook book inspired by recipes from local residents attending the intergenerational cooking session.

[Where can I find food in Barton? leaflet, Appendix 14]

5.5.7. 33 new eligible adults took up the Healthy Start Vouchers during the project due to interventions delivered by Good Food Oxford following a request from local midwives and health visitors for better supporting materials at the Barton Health and Wellbeing Partnership. The initiatives delivered included:

i. A paper and electronic map of retailers which accept Healthy Start Vouchers.
ii. Promotion by local retailers of their participation in the scheme.
iii. Use of posters and the community newspaper.
iv. A guidance leaflet for frontline service providers to support individuals more effectively to complete the form. [Information pack, Appendix 15]

5.5.8. Commitment from student volunteers at Oxford Brookes University Nutrition Department was secured to roll out these interventions in Barton Park at a later date.

5.5.9. Frontline health service providers have reported an increased awareness of the value of the scheme and an increased commitment to promote and support its uptake.

5.5.10. Good Food Oxford also made representations to the Department of Health following feedback received:

i. Barton would be an excellent beta test site for digital Healthy Start Vouchers
ii. Some concerns were raised about the shelf life of vitamins which could impact on their distribution
iii. The sign-up form could be assessed for Plain English

5.6 **One Barton**

5.6.1. Working group established to deliver a coordinated approach to signage, fit trail and green space furniture. This followed a successful funding application (£50k) to WREN for physical improvements to Fettiplace Road; linking the linear park to Barton Park via what is now called 'Barton's Park'.

6. Health profile baseline research - key findings

6.1. A key part of the project during Phase One was to commission research on the health profile of Barton; using existing data, primary research and best practice population projections that could be replicated in Barton Park. The aim was to have an up-to-date, relevant and comparable baseline for health, wellbeing and any inequalities to guide future project plans.

6.2. The following project research findings will also need consideration in future delivery:

6.2.1. The key health issues highlighted in door-to-door interviews were poor nutrition (only 14% of residents were eating the recommended portions of fruit/vegetables per day relative to 29% England average) and 31% were smokers (England average 19%).

6.2.2. Other issues may have been under-reported due to social stigma issues (e.g. the GP surgery reported that 16% of residents have depression and 4.5% of the working population is currently in receipt of mental health related benefits compared to an England average of 2.9%).

6.2.3. Particular concerns were raised during stakeholder and door-to-door interviews about the health of older people and middle aged men

6.2.4. High levels of alcohol consumption were identified in both the Barton health profile and the projected Barton Park health profile.

6.2.5. According to survey data, Black and Minority Ethnic groups in Barton are significantly more likely than White residents to report improvement in their health in the last year and more commonly cooked meals from scratch (rather than relying on ready meals or takeaways).

6.2.6. Residents reported a strong sense of belonging in Barton, significantly higher than the England average.

7. Independent evaluation findings

7.1 Given an underspend, the BHNT Steering Group decided to commission an independent evaluation.

7.2. Although a very short project, the financial commitment and notably, human resource commitment to project has been significant. If additional funding is secured, project

partners will use findings to review logic model, delivery plan and ways of working to ensure the most effective use of this funding.

7.3. The evaluation aimed to provide evidence-based findings about the relevance, early indications of potential to achieve impact, efficiency, effectiveness and sustainability (OECD DAC criteria) of the project as delivered to-date. More specifically, it set out to:

7.3.1. Assess the achievements of the project to-date and the key factors influencing these.

7.3.2. Identify case studies of success which could be communicated / learned from by comparable sites/communities.

7.3.3. Guide partners to assess areas for improvement in the project to-date and the key factors influencing these.

7.3.4. Make recommendations on how the sustainability of key activities, ways of working or achievements can most effectively be sustained (within the resources available or likely to be available).

7.3.5. Support partners to identify recommendations on how to improve delivery of this or other projects in future, with particular reference to achieving impact, sustainability, effectiveness, efficiency.

7.4. Key learning points and findings from evaluation and feedback in March 2017 to inform future delivery include:

7.4.1. Project governance needs to be better integrated with existing structures covering Barton, and a wider 'action group' is needed with a range of active partners.

7.4.2. The research findings should inform a review of health and wellbeing plan focus.

7.4.2. More work is needed to build on current community assets in order to extend engagement with the community.

7.4.3. The project should consider different ways and locations to engage with residents since not all will want to engage through Barton Neighbourhood Centre.

7.4.4. Social media, notably Facebook, can reach certain groups who may be difficult to engage offline (especially younger and middle aged audiences).

7.4.5. 'Pragmatic and dynamic' decision making by the Steering Group should continue, recognising that opportunities to achieve the outcomes and outputs in the logic model may emerge during implementation.

7.4.6. Innovation - notably radical innovation - was constrained by timescales and the funding mechanism. Open dialogue with NHSE is needed to address this in Phase Two.

7.4.7. Barton project team can strengthen the case for the support of an existing deprived community next to a new community. This should be a selling point to NHSE.

7.5. The OECD DAC Evaluation Framework on page 15 summarises the independent evaluation for Phase One (Aug 2016 to Mar 2017) of the project. The framework takes into consideration the relevance, effectiveness, efficiency, sustainability and impact of the project at Phase One and the columns should be read separately.

8. Phase Two review

8.1. In Phase Two (funding-dependent), there is a commitment to review governance and programme management to secure buy-in at the most senior level in Oxford City Council, Grosvenor Developments Ltd, Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Public Health.

8.2. It is envisaged that with a strong governance, effective programme management and an active delivery group using up to date health data, informed by the Health Impact Assessment, Mental Health vision and actions plans agreed by partners, the project will be able to effectively deliver against the logic model and agreed investible propositions.

8.3 Irrespective of funding, the Barton Healthy New Town project will take learning from Phase One to coordinate and deliver services in Barton and Barton Park in the future. It is also an Oxford City Council priority for Barton to '*work in partnership to address health and wellbeing inequalities.*'

Project Barton Healthy New Town	**Purpose:** Aims in Phase One: Contribute learning and innovation around how to reduce health inequalities for current and future residents of Barton, with particular attention to those with additional vulnerabilities: older people (over 65), people experiencing long term physical and mental ill health, social isolation, food poverty or poor nutrition, or alcohol, smoking or substance misuse.			**Stage of delivery** Phase One completed; externally evaluated (basis of our assessment). Phase Two planned
Relevance	**Effectiveness**	**Efficiency**	**Impact**	**Sustainability**
All 8 BHNT grants awarded addressed needs identified within health and wellbeing plan. All needs criteria addressed by at least one funded project or commissioned training (mental health/ substance misuse). Steering Group had most of the relevant partners. Some representatives unable to link to wider organisational work. Future phase must review how community organisations/local networks/two surgeries are involved. Less relevant due to unclear insight into community assets from some grant recipients Despite NHSE approval, project not seen as clearly aligned to national objectives in first phase. Through delivery plan/logic model work, significant shift to address this has been made. According to evaluators, top line understanding of need and insufficient needs assessment. Programme evaluation, research, HIA and grants experience, will lead to stronger evidence for Phase Two.	On track with work plan and budget at end of Phase One, despite capacity issues. Significant staff turnover in Grosvenor, OCC and NHSE, which made managing effective relationships and communications challenging (e.g. developer commitment to enhance master-plan shifted?) More effective monitoring of grants awarded would lead to clearer evidence of case studies, outputs, learning and innovation. Of the 8 grant funded projects, 5 fully achieved the objectives in their original plans. The project team took a 'dynamic pragmatic approach' using underspends to commission training on mental health for front line service providers serving Barton, social prescribing at Bury Knowle, and an independent evaluation.	Large proportion of costs on staffing (60%). However, initial purpose of NHSE funding was capacity for participating statutory partners. Of non-staff costs, 59k of project activity via competitive tender; 14k through non-competitive. Evaluators recommended that grant-making processes are slimmed down, although considered them robust. Particularly as a result of NHSE shifts in expectations of programme scope, demands on staff time through the project significantly higher than budgeted: 40% of Locality Officer time before December, and Communities Manager 20% rising to 55% in December. Grant funded activities: Despite the challenges of the 50+ project, a higher % of the local population was reached than through their city wide event. Appointment Buddies – the cost /beneficiary in the first phase was £500, raising concerns for future sustainability. However this included project set up, so envisaged reduction in cost/beneficiary in future phases.	Very early to assess. 'Likely to take 5-6 years' Evaluators identified the following: Commissioned activities themselves will have little impact because not supported by strong evidence and relatively low reach. Has the project learnt from previous regeneration activities? Evidence of impact (evaluation): Signage influenced by project and presenting Barton as one. Organisations not previously in Barton made new contacts there. Organisations considering how to bridge the gap between the current and future community. Health impact assessment and research will deepen likely impact. Networks developed between groups to help reach residents. Strong successes/ innovations: GFO – social media reach (30 Bartoners on foraging walk). Social prescriber – accessed isolated people but over-dependence on one person. Potential to help residents with additional vulnerabilities to access primary healthcare through Appointment Buddies.	Encouraged through grant making process. Focus on ending from outset and technical support provided (Oxford University). Evaluator 'mixed picture'. Use of social media to get messages out. Early engagement to feed health into wider policies but need to deepen. Asset mapping (but should be more on social assets.) Strong leadership backing. Detailed needs assessment coming through research/HIA. Community networks developed. Training of volunteers to champion health – BUT probably needs wider system than individual organisations. Training professionals in health related topics, to mainstream in their work. Some resistant health attitudes and behaviours in residents. Limited public sector resources. More community participation needed in future; need to work with community organisations to extend their reach.

OECD DAC Evaluation Framework: These are internationally agreed criteria for assessing 'world-class' community programmes performance. Developed by the Organisation for Economic Co-operation and Development's Development Assistance Committee

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Health Improvement Partnership Board
Forward Plan 2017-18

Date	Item
26 Sep 2017 2-4pm Oxford Town Hall	• Health Protection Forum Annual Report • Air Quality Management Report • Housing Related Support update • Oxford University Hospitals Trust Public Health Strategy • Oxford Health Public Health Strategy • Mental Wellbeing Action Plan • Future work on fuel poverty
8 Feb 2017 2-4pm Oxford Town Hall	• Welfare reform – impact of Universal Credit
April / May (tbc)	• Housing Related Support Joint Management Group annual report
Standing items:	
• Minutes of the last meeting and any matters arising • Report from HIB Healthwatch Ambassadors • Performance Report (including any report cards) • Forward Plan	
Proposals/periodically:	
To be kept under regular review: • Re-commissioning of housing related support • Welfare reform • Oral Health Needs Assessment • Healthy Weight Action Plan • Oxfordshire Sport and Physical Activity • Health Protection Forum • Air Quality Management • Domestic Abuse services	

19 June 2017

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