Public Document Pack

NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 26 September 2019 at 10.00 am
Jubilee House, 5510 John Smith Drive, Oxford Business Park, Oxford

Yvonne Rees
Chief Executive

Contact Officer: ***Deborah Miller, Tel: 07920 084239***
deborah.miller@oxfordshire.gov.uk

Membership

Chairman – Councillor Ian Hudspeth (Leader, Oxfordshire County Council)
Vice Chairman - Dr Kiren Collison (Clinical Chair, Oxfordshire Clinical Commissioning Group)

Board Members:

Stuart Bell CBE	Chief Executive, Oxford Health Foundation Trust
Lucy Butler *(Oxfordshire County Council)*	Director for Children's & Adult Services
Christine Gore	District Councils Representative
Cllr Steve Harrod *(Oxfordshire County Council)*	Cabinet Member for Children & Family Services and Chairman, Children's Trust
Dr Bruno Holthof	Chief Executive, Oxford University Hospitals Foundation Trust
Cllr Andrew McHugh *(Cherwell District Council)*	Chairman, Health Improvement Partnership Board
Val Messenger *(Oxfordshire County Council)*	Director of Public Health -Interim
Louise Patten	Chief Executive, Oxfordshire Clinical Commissioning Group
David Radbourne *(NHS England)*	Director of Commissioning Operations (South Central)
Yvonne Rees *(Oxfordshire County Council)*	Chief Executive, Oxfordshire County Council
Dr Ben Riley *(Oxfordshire GP Federation)*	GP Representative
Prof George Smith	Chairman, Healthwatch Oxfordshire
Councillor Lawrie Stratford *(Oxfordshire County Council)*	Cabinet Member for Adult Social Care & Public Health and Chairman, Older People's Joint Management Group
Louise Upton *(Oxford City Council)*	Vice-Chairman, Health Improvement Partnership Board

Notes:•Date of next meeting: 5 December 2019

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, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decisions of Last Meeting (Pages 1 - 12)

To approve the Note of Decisions of the meeting held on 13 June 2019 (**HBW5**) and to receive information arising from them.

6. Integrated Care System Plan for Delivery of NHS Long Term Plan (Pages 13 - 24)

10:10

To receive a summary of the Integrated Care System 5 Year Plan and discuss priorities for Oxfordshire (**HWB6**).

7. Family Safeguarding Service (Pages 25 - 58)

10:30

To inform the Board of the work being undertaken for discussion (**HWB7**).

8. Better Care Fund Plan 2019-20 (Pages 59 - 62)

10:50

The Better Care Plan for 2019-20 is before the Board for discussion and approval (**HWB8**).

Health & Wellbeing Board is RECOMMENDED to:

(a) delegate approval regarding the national submission of the Better Care Fund Planning template to the Director for Adult Services, Oxfordshire County Council and the Chief Executive, Oxfordshire Clinical Commissioning Group;

(b) ask officers to bring a report outlining this plan, and trajectory against the performance measures to the next meeting of the Health & Wellbeing Board.

9. Prevention Framework (Pages 63 - 136)

11:00

The Board is asked to accept the report (**HWB9**) and discuss priorities for Prevention work in Oxfordshire.

10. Healthy Place Shaping

11:20

A presentation will be given to inform and update the Board on work for Healthy Place Shaping in the County.

11. Healthwatch Report

11:50

To receive a verbal report from Healthwatch Oxfordshire including an update on plans for the Stakeholder Network.

12. Performance Report (Pages 137 - 142)

12:00

To monitor progress on agreed outcome measures (**HWB12**).

13. Reports from the Partnership Board (Pages 143 - 166)

To receive updates from the partnership boards, including details of performance issues rated red or amber in the performance report (above) (**HWB13**).

(a) Report form the Children's Trust;
(b) Report from the Older People Joint Management Group;
(c) Report from the Adults Joint Management Group;
(d) Report from the Health Improvement Board;
(e) Report from the Integrated Services Delivery Board (To follow)..

Close of Meeting – 12.25 pm

Information Only

Community Pharmacies Contractual Framework - Stakeholder letter

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 13 June 2019 commencing at 2.00 pm and finishing at 4.05 pm

Present:

Board Members: Dr Kiren Collison (Vice Chairman) – in the Chair

Stuart Bell
Lucy Butler
District Councillor Andrew McHugh
Kathy Hall (in place of Dr Bruno Holthof)
Councillor Mrs Judith Heathcoat (in place of Councillor Ian Hudspeth)
Val Messenger
Louise Patten
Yvonne Rees
Ben Riley
Professor George Smith
City Councillor Louise Upton

Officers:

Whole of meeting Julie Dean, Committee Officer

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 Julie Dean, Tel: 07393 001089 (julie.dean@oxfordshire.gov.uk)

	ACTION
1 Welcome by Vice - Chair, Dr Kiren Collison (Agenda No. 1)	
The Vice-Chair welcomed all to the meeting. She thanked Christine Gore for her services to the Board, as she had stood down from her membership. Yvonne Rees was now representing both Oxfordshire County Council and all the District Councils.	

2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Kathy Hall attended for Dr Bruno Holthof and Councillor Mrs Judith Heathcoat for Councillor Ian Hudspeth. Apologies were received from Councillor Steve Harrod, Councillor Lawrie Stratford and David Radbourne.	Andrea Newman
3 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
Dr Ben Riley declared a personal interest on account of his position as Director of OXFED and as a GP in Oxford.	Andrea Newman
4 Petitions and Public Address (Agenda No. 4)	
There were no requests to address the Board or to receive a petition.	
5 Note of Decisions of Last Meeting (Agenda No. 5)	
The Note of Decisions of the last Meeting held on 14 March 2019 was approved and signed. Professor George Smith listed a number of issues which he had raised over a number of meetings where no decision had been made. The following issues were referred on to the appropriate body to consider: • Safeguarding of Children receiving home education – Children's Trust Board • Safeguarding of children excluded from school – Children's Trust Board • More facilities needed to enable new homes to become Lifetime Homes and to ensure care could be provided, if needed, such as stronger ceiling joists to withstand hoists; – this was an issue for the new joint Housing Officer • Initiatives and practical solutions which could be implemented at local level, for example, ensuring podiatry service was available to encourage older people to become more active. Also, local shops to be encouraged to provide chairs for older people to be seated – Older People Strategy Implementation	))Children's Trust Board) Joint Housing Officer Older People Strategy Implementation Group

With regard to Matters Arising from the Decisions List, the Board welcomed the idea of an Action Log to be provided to each meeting of this Board, in order to report back outcomes. Professor Smith was reminded that it had been decided at the last meeting that his proposal for a long-term, strategic vision of a five-year rolling plan would be taken to a future Board workshop for consideration.	Jackie Wilderspin
6 Oxfordshire Healthwatch Report (Agenda No. 6)	
Professor Smith presented the latest update from Healthwatch Oxfordshire (HWO) (HWB6). He highlighted a number of additional issues not contained within the report: • Further to Healthwatch Oxfordshire's support to Patient Participation Groups (PPG's), it was his view that these should be developed at Primary Care Network (PCN) level to enable discussion on any issues they had in common; • Healthwatch Oxfordshire was calling for a systematic review of Community Hospital provision across the county; • He concurred with the Oxfordshire Joint Health Overview & Scrutiny Committee's (HOSC) and OUH's concern regarding the PET/CT scanner at the Churchill Hospital. It was noted that as the issue of the PET/CT scanner was being addressed elsewhere, these were not matters for discussion at this Board. On the topic of work with the armed forces community, Councillor Mrs Heathcoat suggested that Healthwatch officers could contact SSAFA or the County Council Officer who led work on the Armed Forces Covenant. Louise Patten, in response to Professor Smith's comments, stated that the CCG had agreed with the Oxfordshire Joint Health Overview & Scrutiny Committee and OCC Performance Scrutiny Committee to look to scoping 'out of hospital' services, physical assets (buildings), bed-day equivalents and challenges to the workforce. The Board **AGREED** to thank Healthwatch Oxfordshire for the report.	Healthwatch Oxfordshire

7 Performance Report (Agenda No. 7)	
The Board agreed to move this item to Agenda Item 12 in order to consider it prior to discussion on the reports from the Partnership Boards.	
8 Presentation: Health and Care System Strategy Development (Agenda No. 8)	
Kathy Hall, Director of Strategy, OUH, gave a presentation which informed the Board about strategic developments across the county and at a wider level, inviting requests from the Board for in-depth reports on specific elements. Comments were then invited from Board members. - In response to comments from Professor Smith, Kathy Hall confirmed that strategic, annual planning was the intention. He stated that he would await specified targets for each successive year, together with target indicators and an annual review to take account of the rapid changes occurring in Health and Social Care; - Professor Smith raised his concern about travel into Oxford's John Radcliffe Hospital, and the parking problem, which in his view, was aligned with the centralisation of services in Oxford, as against that of care closer to home. Kathy Hall explained that a variety of ways of solving the parking situation were being considered including digital means and parking for those attending planned visits around appointments. She stated that the option of a multi – storey car park had not been included. It was also noted that moving care into the community, away from the hospitals and the work of Primary Care Networks would also eventually be part of the solution; - The Board considered the pros and cons of seeking an Oxford weighting for NHS staff, which was raised by Councillor Louise Upton. Board members were generally positive about this but felt that there were mitigating factors aligned with it, for instance, a weighting could pull staff way from other public services if salaries could not then be matched.	

The Chair thanked Kathy Hall for the presentation commending all organisations for working together on its development.	Dr Holthof (Kathy Hall)
9 Developing Our Primary Networks in Oxfordshire (Agenda No. 9)	
Dr Collison introduced the report (HWB9) which updated the Board on recent developments in forming Primary Care Networks (PCN) in Oxfordshire. Dr Riley gave a presentation which provided an overview of the key points; how the network would be set up in Oxfordshire; and how it would evolve. Members of the Board were asked to receive the report for information and for their consideration. Comments and input from Board members to steer the direction of travel at this very early stage were invited. Councillor Andrew McHugh declared an interest on account of his past employment as a GP primary care manager and also in relation to his involvement in setting up a NOxMed network (PML Federation – a collaborative group of GPs in north Oxfordshire). It was his view that contractual arrangements were needed to reduce barriers to GPs working together, for example in delivering services to nursing homes. Louise Patten stated that each individual GP practice would retain their own contract. Groups of GPs within the PCNs would then hold additional contracts for the network. She added that the result would look almost like the healthy towns concept, with a much wider social cohesion. Dr Collison concurred, adding that the PCN had the potential to be very local in nature and to become a natural community, aligned with local leisure centres, schools, libraries etc. Moreover, patient engagement would be sought and community groups would be empowered to develop their own groups. Stuart Bell reported that he had attended a workshop that morning on the future of integration of PCNs. The speed of developing PCNs to date had tended to focus attention on contracts, but now the emphasis could be on contributions from as many different organisations as possible, as these may have very valuable contributions to make. He likened this to the Healthy Abingdon work. Yvonne Rees added that it could also join/link up with Health Place-shaping, and with the Growth Board, taking Oxfordshire as one large locality, with joined-up working. It was her view that proactive conversations needed to take place with members of this Health & Wellbeing Board, who had a significant part to play	

in this. To this end she proposed that this matter be brought to a future Board workshop. Professor Smith added HWO's support to this also, asking however that participants should ensure that it delivered benefits for the patients themselves. He believed that there was a need to understand how social prescribing could be delivered, and how it could be joined up with voluntary organisations, as practically as possible. Professor Smith also suggested that good use of the in-services training between GP and consultant level in the teaching hospital could be made. Louise Patten responded that, to date there had been a registration process for PCNs, which had been very light touch, to ensure full coverage. She added that there was a need at the present time to concentrate on the delivery of all the outcomes that were currently being required to be delivered. Val Messenger also reported that the Health Improvement Board was planning a social prescribing workshop, with the aim of learning from best practice. Dr Riley was thanked for the presentation.	All Board Members to note
10 Care Quality Commission (CQC) Action Plan (Agenda No. 10)	
Lucy Butler gave a presentation (HWB10(a), on the CQC Action Plan whilst highlighting the report from the CQC (HWB 10(b). Following a discussion, the Board **AGREED** that good progress had been made and that the remaining actions needed to be regarded as business as usual, embedded in the work of the whole system. This was because they had become a way of working and therefore did not need to be in a separate action plan. This way of working would be possible due to strong relationships between the partners represented on the Board with open processes and accountability.	Lucy Butler (Darren Moore/Robert Winkfield)

11 Prevention Framework (Agenda No. 11)	
Dr Collison presented a summary of the draft Prevention Framework and also gave an update on progress (HWB11). She spoke of the large overlap between prevention and health inequalities and reported that she had been seeking the views of various people about what the next steps should be and what the approach and focus(s) could be. She sought the views of the Board members in relation to this. Views expressed by members of the Board were as follows: - Yvonne Rees – expressed the view that prevention was fundamental to the way forward and it should therefore be embedded in all thinking across local authorities. She invited Dr Collison to the next Chief Executive's meeting to discuss this. She also stated that there was a fundamental and very important core link in relation to health inequalities with housing support and leisure. She believed that this could be achieved in Oxfordshire given the power and strength of relationships within Oxfordshire; - Councillor McHugh offered some case studies which had been prepared at Cherwell District Council on their 'Families Active, Sporty Together' programme. Val Messenger responded that joining up with district councils was very positive, adding that everyone around the table was a champion for prevention in some manner or another; Kathy Hall stated that, as part of the OUH Strategy, there was a focus on prevention within the population. She also stated that she would welcome prioritisation to enable the whole system to work on common issues for prevention simultaneously; - Professor Smith highlighted the importance and practicality of what could be achieved within available resources. He gave loneliness as an example of a preventable condition and the value of voluntary groups and community groups in helping with specific initiatives to combat it. In addition, he highlighted the cost-effectiveness of the treatment of toenails, corns and bunions to aid mobility in older people; and respite support for carers; and - Dr Riley commented that lists of registered patients at each GP practice could be used to identify groups of	Yvonne Rees/Dr Collison Councillor McHugh

people who were not engaging and Val Messenger stated that there were tools for health improvement which could be accessed in primary care. All were thanked for their input.	
12 Reports from Partnership Boards (Agenda No. 12)	
The Board received updates from the Board's Partnership Board (HWB12). <u>Children's Trust</u> – Lucy Butler reported the following: - Oxfordshire Youth had taken the lead for the whole of the 'be supported' programme, the 'Children Missing out on Education' project had been very successful; - A Statement of Action for children with SEND would be submitted to a future meeting of this Board; and - A significant amount of thought was going into the new model family safeguarding model which would be reported in more detail at a future meeting. Councillor Upton asked whether the £5.4m funding for children on the CAMHS programme was sufficient. Lucy Butler explained that this was a specific piece of work to support schools. She added that it had been started in Oxford City, where the greatest need was, and it was hoped it would be rolled out to the whole county. Louise Patten added that nationally there had been an unprecedented rise in referrals to CAMHS and demand had continued to rise. A large amount of funding had been devoted to this. <u>Joint Management Groups for Adults</u> Ele Crichton, Lead Commissioner, reported, highlighting the following: - HART services – OUH was leading on the development of an improvement plan; - Work was taking place in relation to supporting capacity in home care; on a home care commissioning strategy; and on urgent care planning for the winter; and - Engagement was also taking place on the co-production of an Adults Strategy with partners. This would be brought for comment to a future meeting of this Board.	Lucy Butler Lucy Butler Lucy Butler

Health Improvement Board

Councillor Andrew McHugh, Chairman, highlighted the following:

- Significant progress had been made on the production of a Domestic Violence Strategy;
- There was concern over a drop in the take up of MMR vaccinations. As a result, the HIB had requested a performance report from NHSE;
- In relation to social prescribing, the Board was in the process of scoping a workshop on this subject.

Integrated System Delivery Board (ISDB)

Louise Patten reported that the key priorities of this officer group was to both oversee and enable any issue that prevented Chief Executives from developing an integrated agenda. She reported that it was now viewed as having an integrated agenda and also seen as an equal partner with Berkshire and Buckinghamshire. Progress had been speedy towards getting everything aligned. The next step was to develop it into an Integrated Care Partnership Board whilst encouraging the involvement of other people.

Professor Smith re-iterated an issue voiced by some which was that the ISDB was a 'closed shop'. In response to this, Yvonne Rees defined it as a place where conversations took place which then enabled decisions to be made in the public domain. Officer conversations were required as part of the process, without this informed decision-making would suffer. She suggested that perhaps 'network' was a better description than 'Board'.

Professor Smith suggested that engagement with staff had not been visible – and real engagement with the grass roots was required. Louise Patten responded that this took place at individual, organisational level. There was agreement that there was still more to be done, as plans were developed. Yvonne Rees agreed, adding that in order for chief executives to deliver strategies and performance indicators, buy in from staff was needed to provide assurance to those doing the work. This was part of the business as usual' strategy.

All were thanked for their updates.

..... in the Chair

Date of signing .....

Health and Wellbeing Board Action Log

Date	ISSUE	ACTION	RESPONSIBILITY	PROGRESS
13.6.2019	Collate and maintain an action log for the HWB	HWB Secretariat	Jackie Wilderspin, Catherine Mounford	Completed
13.6.2019	Safeguarding of Children who are excluded from school or home educated	Refer to Children's Trust	Lucy Butler	Completed
13.6.2019	Influence planning and design of new homes to enable adaptation for health and care services if needed	Refer to Joint Housing Officer		In Progress
13.6.2019	Practical initiatives to ensure older people can be active e.g. access to podiatry, seats in shops	Older People Strategy Implementation Group	Rachel Pirie	In Progress
13.6.2019	Healthwatch to facilitate links with armed forces community	Contact SSAFA and/or the County Council officer leading the Armed Forces Covenant	Healthwatch Oxfordshire	tbc
13.6.2019	Discussion at the HWB on Healthy Place Shaping	Schedule and agenda item on Healthy Place Shaping for Sept 19	Jackie Wilderspin, Catherine Mounford	In progress
13.6.2019	CQC action plan can now be embedded as business as usual	Ensure all outstanding actions from CQC action plan are taken forward as business as usual	Darren Moore, Rob Winkfield	In Progress
13.6.2019	Prevention Framework to be influential across the system	Discuss draft Prevention Framework with Local Authority Chief Executives	Kiren Collison, Yvonne Rees	completed

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BOB
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

Improving health and care in Buckinghamshire, Oxfordshire and Berkshire West

Who we are, how we work together and our developing priorities and plans for the next five years

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Introduction

1

Welcome to the first of a number of public updates about the development of a five year strategy for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

Our aim in this update is to provide you with information on:

- How we work together as a Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS)
- Our vision and aims
- Our thoughts about priorities
- Our work to develop a five year plan by the end of November 2019

The BOB ICS five year, one system plan will set out how all ICS partners will work together locally and together at scale to meet the current and future health and care needs of the communities we serve. It will describe how the BOB ICS will deliver the requirements of NHS Long Term Plan (www.longtermplan.nhs.uk) and address BOB ICS's specific priorities.

We are fully committed to being open and transparent about how the plan is developing over the coming months - this document is the first step in that process. It will be followed by the publication of our draft "technical" submission to NHS England / NHS Improvement in early October and a final version of this technical document, once reviewed and signed off later in the year. Both documents will be made available on our website www.bobstp.org.uk

Our BOB ICS five year plan will be published towards the end of 2019. It will build on the feedback received about our priorities, opportunities and challenges; describe how we will tackle these important issues and how we will deliver the aims of the NHS Long Term Plan.

We are ambitious for the communities we serve. We want to prevent ill health, improve care for patients, reduce pressure on staff and make the best use of the funding available to us.

Our plan will describe how we will accelerate the design of patient care to:

- Improve out of hospital care
- Reduce the pressure on hospital services
- Give people more control over their health and more personalised care when they need it
- Provide digitally enable primary and outpatient care
- Work in partnership with local councils to improve the health of our communities

Delivering improved health and care across the ICS requires a well-developed system and underpinning infrastructure. We will start to set out, in response to the Long Term Plan and the changing nature of clinical commissioning, how we see the commissioning and provider landscape developing, including the role of Clinical Commissioning Groups.

The development of the BOB ICS five year plan is just the start. We can only achieve our ambitions by working together and continuing to listen to and discuss with the communities we serve what changes to health and care will look and feel like in the future.

We would welcome your thoughts and comments, which will be fully considered as the plan develops – please see page 18 for contact details. We look forward to hearing from you.

David Clayton-Smith
Independent Chair
Buckinghamshire Oxfordshire and Berkshire West ICS

Fiona Wise
Executive Lead,
Buckinghamshire Oxfordshire and Berkshire West ICS

Our vision 2

Health and care organisations across Buckinghamshire, Oxfordshire and Berkshire West are working together with their local communities to help them to stay healthy, make sure services meet individuals' needs and are easier to access.

Our vision is to create a joined up health and care system where everyone can live their best life, get great treatment, care, and support now and into the future.

As well as working within our individual organisations and our communities, we are working together to bring the best of our skills, expertise and resources to make sure the people we serve receive high quality, safe and joined up health and social care services.

Together we are called the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

Our aims are:

- To work together to deliver joined up health and care services based on the needs of individuals and shaped by the circumstances and priorities of local communities
- To support people to live longer, healthier lives and treat avoidable illness early on
- To make the best use of limited public funds and resources so that, together, we can secure the best outcomes
- To make our focus local unless it is more efficient and effective for us to pool our expertise and resources to work together as an integrated health and care system across Buckinghamshire, Oxfordshire and Berkshire West (BOB).
- To reach out, where appropriate, beyond our borders and work in partnership with others – for example, across the wider Thames Valley region on specialist cancer services.

Together, we serve a total of 1.8 million people, stretching from Banbury in the North to Wokingham/ Riseley in the South, from Hungerford in the West to Amersham in the East.

Our population is one the fastest growing in the country, predicted to increase by almost 25% by 2033 – and more, as the ambition of what is known as the Oxfordshire-Cambridge ARC to stimulate economic growth, research and business opportunities for the area is realised.

www.gov.uk/government/publications/the-oxford-cambridge-arc-government-ambition-and-joint-declaration-between-government-and-local-partners

By working together, we will be in the best position to maximise this opportunity, while making sure our health and care services are fit for such a promising future.

About us

3

We are not a single organisation but a partnership covering Buckinghamshire, Oxfordshire and Berkshire West that includes:

6 NHS Trusts
Providing hospital care, including community care, mental health and ambulance services:

- Oxford University Hospitals NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- The Royal Berkshire Hospital NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- South Central Ambulance Service NHS Foundation Trust

5 Local Authorities
With social care responsibility, across adults and children's services:

- Oxfordshire County Council
- Buckinghamshire County Council*
- Reading Borough Council
- West Berkshire Council
- Wokingham Borough Council

3 Clinical Commissioning Groups (CCGs)
Responsible for the planning and commissioning of health services for their local area:

- Buckinghamshire CCG
- Oxfordshire CCG
- Berkshire West CCG

9 District Councils
With housing, waste, and planning responsibilities:

- Oxford City Council
- West Oxfordshire District Council
- Cherwell District Council
- Vale of White Horse District Council
- South Oxfordshire District Council
- South Bucks District Council*
- Aylesbury Vale District Council*
- Chiltern District Council*
- Wycombe District Council*

1 Academic Health and Science Network

- Oxford AHSN

We work with our 5 Healthwatch organisations in Buckinghamshire, Oxfordshire, Reading, West Berkshire and Wokingham and engage with voluntary and community sector organisations across our geography to help join up our efforts to provide the best possible services and support to the people we serve.

NHS England, NHS Improvement and Health Education England are important partner organisations.

**There will be one unitary council for Buckinghamshire from April 2020*

4 Positives

There are many positives about people, places and services in the BOB ICS area:

People are generally healthier than in other parts of the country:

- People live longer
- Diabetes cases are far lower across the area
- Lower smoking rates than the national average
- Adult obesity rates are below the national average
- There are lower rates of many major diseases compared to the national average including cancer, dementia and stroke

The quality of care provided is recognised by national regulators and by the people we serve

- Many of our services are rated well by the Care Quality Commission (CQC), providing good overall quality of care
- People have told us that, when they do receive services, staff are compassionate and caring
- People have told us that their experience of specialist teams, such as cancer treatment, heart failure services or MacMillan staff has been good

We are at the forefront of advances in digital technology

- We are part of the Thames Valley and Surrey Care Records Partnership – connecting local records across the region so that people can benefit from more joined up care www.thamesvalleysurreycarerecords.net
- We have a number of "Global Digital Exemplars" – Berkshire Healthcare Trust, Oxford Health, South Central Ambulance Service and Oxford University Hospitals Trust. These internationally recognised NHS Trusts are delivering improvements in the quality of care, through the world-class use of digital technologies

We cover an area with strong infrastructure that is predicted see significant economic growth, and which will bring an increase in the numbers of people living in the BOB ICS area

- We have a number of highly regarded medical schools, universities and biomedical research centres
- There is strong investment in research, development and innovation, including over 500 life sciences businesses with major strengths in medical diagnostics and digital innovation
- The government has committed to significant investment in business and infrastructure (including transport links) in our area, over the coming years

5 Challenges

We are ambitious for the communities we serve. We want to prevent ill health, improve care for patients and reduce pressure on staff but face a significant challenge to make the best use of the funding available to us to meet current and future health and care needs, particularly given the population growth we expect to see.

Although, on the whole, people have good health, it is not the case for everyone.

Parts of Oxford, Banbury, Aylesbury and Reading are in the 20% most deprived areas of the UK. In these areas there are higher levels of:

- Homelessness
- Childhood obesity
- Diabetes
- Falls in elderly people
- Smoking rates amongst people with anxiety and depression

50% of people living in the Buckinghamshire, Oxfordshire and Berkshire West area have one or more long term condition.

There is a higher number of premature deaths of people with serious mental illness compared to the national average.

Some services are struggling to meet demand:

- Our hospitals have not met the **95%** national target of A&E attendees being seen within 4 hours
- Demand for our services is in some cases exceeding our individual capacity to provide them for several specialties and this gap is expected to grow
- People have told us that they continue to find it difficult to get a GP appointment
- People have told us that they are waiting too long from referral to treatment
- People have told us that they or their loved ones are waiting too long to receive a number mental health services, particularly for Child Adolescent Mental Health Services ("CAMHS")
- The estimated **25%** population growth will add new pressures on services

We, along with independent and voluntary sector service providers, have difficulty recruiting and retaining staff across the BOB health and social care system. This is due to the high cost of living and competitive local jobs markets

- The cost of both purchasing and renting accommodation is high across our area
- Nursing staff are likely to have to spend **58%** of their monthly salary on housing
- The average price of housing in the BOB ICS area is **70%** higher than the national average price of housing
- Our care workers tell us they would leave sector/area for jobs that enable them to buy family homes
- There is significant house building in some areas of our system but in other locations, building is restricted - which can limit the availability of rented accommodation and social housing. It also means that, if staff can't find homes closer to where they work, their journey time is increased, adding an additional cost
- Many of our areas have high employment rates, which is a great success but makes attracting people to health and care jobs more challenging

Our buildings and medical equipment are becoming outdated

- We face a challenge to maintain our buildings to keep them fit for purpose
- Our equipment does not always keep up with advances in technology

How we work together

6

Local First

Our **Integrated Care System** is a partnership covering a large area, but we all understand that the majority of improvements are made by applying our efforts to helping people to live healthy lives and get joined up care in their neighbourhoods, villages and towns wherever possible.

That's why GP practices are coming together as **Primary Care Networks** to serve communities of around **30,000 to 50,000 people** so that they can offer patients access to a wider range of services. For example, more convenient access to some hospital treatments, mental health, social care services or help and support from local voluntary and community groups.

Broadening the focus to cover a wider local geography (areas covering between **250,000 and 500,000 people**) are three **Integrated Care Partnerships** (one in Buckinghamshire, one in Oxfordshire and one in Berkshire West).

These partnerships include clusters of Primary Care Networks, local hospitals and councils, community, mental health and voluntary sector services. **Integrated Care Partnerships** work together to make a shared assessment of local need, plan how to use collective resources and to join up what they offer – including beyond traditional health and care services – to make best use of overall public and community resources.

Facing the Big Challenges and Opportunities Together

Although our first priority is local through our **Local Authorities**, **Primary Care Networks** and **Integrated Care Partnerships**, there are times when it makes sense to broaden our focus to the whole of Buckinghamshire, Oxfordshire and Berkshire West as an **Integrated Care System**.

In coming together as an Integrated Care System, we can seize opportunities to make the best use of our resources, skills and expertise; and we can reduce duplication to maximise the value of every pound spent – particularly where we face similar health and care challenges. There are also some services that will be safer and more clinically effective if they cover a larger number of patients across a bigger area – for example, some more specialist cancer services.

Answers to how best meet the needs of our increasing and ageing population can also only be found if we apply our knowledge and resources together. We are facing a number of opportunities and challenges:

- We expect to see an additional 300,000 people living in the area by 2033
- The numbers of people over the age of 85 are expected to more than double
- Significant investment is expected from government and the private sector to support economic growth
- There will be a substantial increase in housebuilding
- Improvements are being made to the rail and road infrastructure
- There will be planned increases in government funding as part of the June 2018 NHS funding settlement. We will be expected to use this money to deal with current pressures, increasing demand and new priorities

We will need to work together to ensure that we have the health and care services to meet the demand from this increased population, while taking advantage of the excellence and innovation that comes from our partnerships with leading universities across the our area and the opportunities that economic growth will bring.

The **BOB Integrated Care System** is also part of a number of wider partnerships, where we work with other systems in the NHS to join up care for patients and improve our services – for example, we are part of the Thames Valley Cancer Alliance; the Thames Valley and Wessex radiotherapy network; and we work with partners in the Thames Valley and Surrey on our Local Health and Care Records programme.

We understand that patients travel outside of our geographical area – for example, going to Milton Keynes from Buckinghamshire or Basingstoke in some parts of west Berkshire. With this in mind we work closely with other health and care systems.

How care is planned for and delivered

7

Primary Care Networks (PCNs)
GP practices working together with local councils, other NHS, voluntary and communities services to serve communities of around 30,000 to 50,000 people, offering patients access to a wider range of services.

- More support to help you stay fit and well before things become a problem
- More focus on your physical and mental health and wellbeing, recognising that people have different needs
- Better access to the care you need, when you need it with a physiotherapist, nurse, clinical pharmacist, GP or non-medical service such as help from a voluntary or community group

Integrated Care Partnerships (ICPs)
Covering towns and counties (areas of between 250,000 and 500,000 people)
ICPs include clusters of Primary Care Networks, local hospitals and councils, community, mental health and voluntary sector services.

- Better joined up care between health and social services
- More hospital care provided closer to home
- Helping people access urgent and emergency care in the right place for their needs
- Reducing length of stay in hospital to support people to return home more quickly
- More personalised care

Integrated Care System (ICS)
Covering Buckinghamshire, Oxfordshire and Berkshire West and serving 1.8 million people the BOB ICS includes, NHS organisations, local councils and the Oxford Academic Health Science Network (AHSN) wider services to join up and improve care e.g. the Thames Valley Cancer Alliance, the Thames Valley and Surrey Care Records Partnership

- Working across a larger geography it means we can make the best use of our resources, skills and expertise
- Reducing long waiting times for our services by working together to best meet the needs of patients
- Planning to meet future needs created by population and housing growth
- Working together to address the workforce challenges of operating in a high cost area with a competitive job market; and supporting the best development opportunities for our staff
- Ensuring our buildings and estate are fit for the future

Healthy places to live, great places to work - our people strategy 8

We have described how we are organising ourselves to work together for our local communities, whether that's in neighbourhoods, villages, towns, counties or across the Buckinghamshire, Oxfordshire and Berkshire West area.

But the key to providing safe, high quality services are our staff and those who volunteer their time to care or provide support. They are all equally important. We are proud of the thousands of the dedicated individuals, teams and groups working hard for the people and communities we serve, often in challenging circumstances. Living in this part of the country is expensive and we are facing a shortage of health and care staff across the board.

Those providing care and support are passionate about what they do. We know from what they have told us that they often struggle with the way things are done, the duplication of effort and very practical problems to providing joined up care such as computer systems which do not talk to each other.

It is important to us that the people who work to provide health and care services are supported, feel valued and can provide these services in ways that are manageable and rewarding.

Together we want to create opportunities to help staff to develop new skills and shape new roles to meet the multiple needs of patients and finding ways to make it worthwhile for people to come to work and live our area.

We are doing this through our Primary Care Networks, Integrated Care Partnerships and through the development of a BOB-wide people strategy that will support us to make our Integrated Care System the best place to work, a place where workforce shortages are addressed, where we have a thriving leadership culture and together are able to deliver care fit for the 21st century.

Together as an ICS we have five joint areas of work:

Our priorities 9

In the same way that we group together and organise ourselves as Primary Care Networks, Integrated Care Partnerships or as an Integrated Care System, we are tackling our opportunities and challenges in different ways. We have described below our thinking and would welcome your views.

ICS role	Description	Clarification and rationale	
System design & delivery	Design approach to a problem at ICS level Deliver solution at ICS level	Population and economic growth; Acute collaboration; Strategic planning, system design & resource allocation	ICS oversight running through all strategic priorities Partnerships & Engagement, including patient and public involvement
System design & place/org delivery	Design approach to a problem at ICS level but leave places/orgs to deliver	Digital; Workforce; Capital & estates	
Set or confirm ambition and hold to account	Agree ICS ambition (or confirm ICS signs up to nationally set ambition) and hold places to account for/ support delivery	Primary care, inc. Primary Care Networks (PCNs); Financial balance & efficiency; Mental health; Urgent & Emergency Care; Cancer; Maternity	
Coordinate, share good practice, encourage collaboration	Bring places/ organisations together as a community of practice to share approaches and solutions	Research & Innovation; Children & young people; Personalised care; Prevention & reducing inequalities; Population health	

Key					
	ICS workstream		ICS Financial Oversight Group		Place delivery supported by ICS-wide group
	ICS Exec Lead		Place infrastructure		

Developing our five year plan

10

We are working together as the **BOB Integrated Care System** to develop a five year plan. It will describe how all partners within the ICS will work together locally and, when appropriate, together across the Buckinghamshire, Oxfordshire and Berkshire West area, to ensure current and future health and care needs are met.

In establishing our plan, we have started with current Health and Wellbeing Board strategies and the strategic plans of each organisation in our partnership – identifying common ambitions, challenges and opportunities that we can tackle together.

The BOB ICS Five Year Plan will be published at the end of 2019. It will build on feedback received, describe how we are tackling our health and care priorities and how we will deliver the ambitions set out in the NHS Long Term Plan so that together we can:

- Deliver care that is fit for the 21st century – offering more services closer to where people live, tailoring care so that it better suits individuals' needs and making the most of technology
- Recruit people into health and care jobs, offer new and exciting roles at all levels to help deliver our ambitions and keep our staff through more flexible and supportive employment opportunities
- Support people to live longer, healthier lives and treat avoidable illness early on
- Help people earlier rather than later, keeping them well and helping them to cope with any health and care needs at home or in the community, wherever possible
- Reduce health inequalities, including for our more deprived communities which see poorer outcomes and for groups who may be disadvantaged due to their characteristics (such as gender, race or disability) or their needs (such as poor mental health).
- Improve care quality and outcomes for stroke, cancer, mental health services
- Take advantage of the opportunities provided by world class research, technological and medical advances to provide more innovative, accessible and personalised health and care services
- Make best use of taxpayers money, including getting value for money by doing some things such as procurement once and on a larger scale.

We will be able to do this by:

Improving out of hospital care

Reducing pressure on hospital services

Giving people more control over their health and more personalised care when they need it

Providing digitally enable primary and outpatient care

Working in partnership with local councils to improve the health of our communities

Delivering improved health and care across the ICS requires a well-developed system and underpinning infrastructure. We will also start to set out, in response to the Long Term Plan and the changing nature of clinical commissioning, how we see the commissioning and provider landscape developing, including the role of Clinical Commissioning Groups.

Our plan is being developed by a range of staff and clinicians who are experienced in planning for and delivering a wide range of services, such as mental health, children's services, primary and hospital care.

In developing their proposals, they are reflecting on the feedback given by local people, patients and carers through the many Clinical Commissioning Group, Local Authority and Healthwatch engagement activities that have taken place in recent years. These health and care leaders are also giving careful consideration to how their ideas and plans address other important areas such as health inequalities, preventing ill health, improving outcomes and being financially sustainable.

We recognise the importance of continuing to link to each area's Health & Wellbeing Strategy and, as our plan develops, we will be engaging with local councillors on Health and Wellbeing Boards and Healthwatch, as well as talking to our staff and local communities; and keeping all of our stakeholders informed and involved.

How are decisions made? Our timeline and next steps 11

How are decisions made?

Our legal and statutory responsibilities are still firmly based in the duties placed upon statutory boards and committees. These Boards are kept fully engaged when key decisions are required

We work collectively as a partnership to make decisions together about strategy and priorities. We have a BOB ICS Systems Leaders Group, made up of Chief Executives of all NHS organisations, Local Authority Chief Executives and clinical representatives. The group works to a set of principles, which have at their heart an agreement that activities and decision making should be kept as local as possible, as this is where the most difference can be made to improving care and outcomes.

The System Leaders Group meets every month. A key role of each member of this group is to ensure their own organisations, local boards, council committees and communities have been engaged on key issues, challenges and decisions and that strategies and plans are aligned at each level of our system. The System Leaders Group will be overseeing the implementation of the BOB ICS five year plan.

We also use other communications to make sure our stakeholders are kept informed – for example, regular updates published following each BOB ICS Systems Leaders meeting:
www.bobstp.org.uk/what-is-the-ics/keeping-in-touch/

Our Timeline

Date	Activity
9th September	We publish this document as the first step in developing the BOB ICS Five Year Plan
Late September	We will publish a slide pack summarising the key points from the first draft of our technical submission to NHS England/ NHS Improvement
Early October	We will publish the full draft "technical submission" sent to NHS England/NHS Improvement – this will describe the responses to the deliverables required in the Long Term Plan
18 October	Deadline to give your thoughts and views
1st November	Final technical document submission to NHS England/NHS Improvement
End of November	Final plan published, following review by NHS England/ NHS Improvement
On-going	Continued engagement with communities and stakeholders

Next Steps – we welcome your views

We would welcome your views on our priorities.
Please do email them to the following contact addresses by 18 October 2019:

- Oxfordshire queries: OCCG.media-team@nhs.net
- Berkshire West queries: communications@royalberkshire.nhs.uk
- Buckinghamshire queries: ccgcomms@buckscc.gov.uk

We are making progress and change is happening 12

> Each of our Integrated Care Partnerships are improving services and developing innovations to better serve their local communities. For example:

Designing Neighbourhoods in Berkshire West with Health and Wellbeing In Mind
The Berkshire West "Design our Neighbourhoods" initiative puts health at the heart of the community in a bid to ease pressures on NHS services. It brings together health and care organisations, local community groups and residents to help create healthy environments across the villages and towns of Berkshire West, in which people can walk and travel safely and access healthy activities, events and support networks. These activities and networks can help to boost physical wellness and mental health and reduce unnecessary GP appointments.

Trailblazer mental health care scheme to benefit children in Buckinghamshire
Around 16,000 children and young people in Buckinghamshire are set to benefit from a new 'Trailblazer' scheme to transform children's mental health care and ensure those in need get the right support at the right time. The county is one of 25 areas across the country so far to receive Government funding for this new initiative, equating to £2 million over a two-year period.

Two dedicated 'Mental Health Support Teams' will work closely with 40 schools (both primary and secondary) and colleges, to offer timely assessments and interventions for pupils in need, treating those with mild to moderate mental health issues in school. If pupils have more severe need, the teams can link smoothly to specialist NHS services at Buckinghamshire Child and Adolescent Mental Health Services (CAMHS) and ensure they get the right support and treatment as quickly as possible.

Oxford Hospital Scheme Gets Stroke Patients Home Sooner
Oxford University Hospitals has helped thousands of stroke patients recover in their own homes in the past year. The Oxfordshire Early Supported Discharge (EDS) service for stroke helps patients by continuing their rehabilitation in their home after they leave hospital, providing them with the same level of rehabilitation at home as would be delivered on an inpatient Stroke Unit. The service covers Oxfordshire from three hubs at the John Radcliffe, the Horton General and Cowley. The Trust's ESD team is made up of stroke consultants, physiotherapists, occupational therapists, speech and language therapists, dietitians, and rehabilitation assistants.

The teams provide a six-day-a-week service helps stroke patients return to normal, daily activities such as walking, shopping, reading, cooking, and driving. In addition, ESD has played a vital role in helping patients avoid an otherwise necessary admission to hospital by delivering the required therapy at home. Overall, 307 patients received therapy in their own homes provided by ESD in its first year.

> People are benefiting as innovations in one area are rolled out across all of our Integrated Care System

Good Hydration! – award winning care home residents' hydration improvement programme
Berkshire East CCG and Oxford AHSN Patient Safety Collaborative won a national Patient Safety Award for Quality Improvement Initiative of the Year for the Good Hydration! Initiative in care homes. The scheme has reduced hospital admissions due to urinary tract infections by 36% and is being introduced across the BOB ICS and more widely.

Atrial fibrillation programme – reducing the number of strokes in the Thames Valley

The Oxford AHSN has brought together expertise from the NHS in Berkshire, Buckinghamshire and Oxfordshire and industry to reduce morbidity and mortality related to stroke caused by atrial fibrillation (AF). AF is the most common cardiac arrhythmia, affecting around 2.5% of the population (58,000 people in the Oxford AHSN region).

AF is a major cause of stroke, responsible for 20% of all strokes in the UK but the relative risk of stroke for these patients can be reduced by up to 66% with oral anticoagulation therapy.

Through the AF programme:

- Over 1,000 patients received a review by a specialist pharmacist to ensure their anticoagulation was optimised and 465 patients received a consultation with a specialist pharmacist. We estimate that up to 13 strokes per year have been prevented
- 4,440 patients across 28 GP practices in had a detailed review, resulting in an additional 266 patients now receiving oral anticoagulation, 227 of whom have a high risk of stroke. This equates to up to 17 fewer strokes each year.

Educating young people about careers in health

Health Education England, has worked with the BOB Integrated Care System to help set up an education programme to educate young people on the NHS and inspire them to become part of its future workforce. Healthtec is a unique health simulation centre located in Aylesbury within the Buckinghamshire College group campus.

Young people are given the opportunity to work alongside NHS professionals whilst learning basic first aid skills in an experiential environment where the hospital is recreated and simulated. Within Healthtec young people are able to learn about the variety of healthcare careers within the NHS and the different avenues there are for entering these careers.

Healthtec professionals ensure these important lessons are spread beyond the Aylesbury located facility and travel to primary schools to ensure that children have the opportunity to learn about health care. Healthtec staff also attend careers fairs to talk about the NHS, and its roles. The programme has currently engaged with 7,000 students.

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Developing the Family Safeguarding Plus Model in Oxfordshire – Report to the Health and Wellbeing Board

Introduction

1. The Family Safeguarding Plus model is designed to improve the main statutory children's social work services from the assessment of vulnerable children through to children that are the subject of children in need or child protection plans and those children who first come into care.

2. Family Safeguarding was developed by Hertfordshire County Council in 2015, where it has delivered a radical impact in improving outcomes for children and their families whilst also significantly reducing demands and costs for the county. The model has been independently evaluated as being very effective (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625400/Family_Safeguarding_Hertfordshire.pdf), complimented by Ofsted and is being replicated by at least 8 other English local authorities (some with financial investment from the DfE). Key to its success is the initial intensive support provided to both children and the adults in their families.

3. FSP will implement changes to the Children and Families Assessment Teams (CAFAT) and statutory Family Solutions Services (FSS) teams within the Children, Education and Families Directorate. FSP will not change the current early help and targeted support services within CEF but it will consider the interdependencies with these services and others such as the Looked After Children/Leaving Care teams and the Children with Disabilities service.

4. These changes are being made to address the significant rise in service demand for statutory children's social work services. The National Audit Office (NAO) report published in January 2019 outlined the national picture as one of increasing demand over the last five years.

5. The Oxfordshire position is similar to the national one where we have seen an increase in referrals and interventions. The NAO report points to the characteristics of domestic abuse, parental mental health and drug/alcohol abuse as the key drivers of increasing demand. We have seen a similar pattern in Oxfordshire and it is acknowledged that, although the current service model is good at managing the demand, it does not address the root causes.

6. The FSP model is being developed as one of the main workstreams within the CEF transformation programme over the next five years. It is envisaged that the FSP model will go-live in June 2020.

About the Family Safeguarding Plus Model

7. The four Key elements of the FSP model are:

- Introduction of multi-disciplinary Family Safeguarding Teams using evidence-based interventions delivering 'whole family' plans
- Having a core skill set with Motivational Interviewing at its heart
- Using a single structured 'Workbook' approach to assess parents' capacity for change
- Agreeing a partnership outcomes-based performance framework

8. The Family Safeguarding Model is predicated on multi-disciplinary joint children and adult teams. The model will therefore be implemented by building on the skills mix of our current Children's Social Work teams by adding community-based mental health staff, domestic abuse specialists and substance misuse workers. In addition to this we will enhance the offer by co-locating the teams with our targeted Early Help teams and by providing dedicated working arrangements with other key services (Housing Support and Leisure and Youth Services) through our partnership with Cherwell District Council.

9. The model uses evidence-based interventions that contribute to improved levels of engagement and safeguarding with parents and children. The key intervention models will be:

- A structured parenting assessment
- Parenting programmes tailored to different age groups of children
- Treatment programme for male perpetrators of Domestic Abuse (including impact on children)
- Treatment and Recovery programmes for women victims of Domestic Abuse (including impact on children)
- Programmes to promote children's resilience
- Drug and Alcohol Recovery Programme
- 'Foundations of Change' Programme
- Mental Health interventions

10. We know from the Hertfordshire evaluation that these interventions will also improve parental and child engagement with practitioners, leading to swifter more sustained outcomes.

11. The *plus* element of the FSP model refers to our plans to work more closely with Cherwell and other district councils. This is an addition to the model developed by Hertfordshire. The first element of the project is developing in advance of implementation of FSP. The focus of this will be closer working together on the prevention of homelessness for families and vulnerable young people; an improved offer of discounted leisure services and targeting of Cherwell's '*sports activators'* towards children in receipt of social care and early help services. With immediate effect we are starting a pilot which will include the co-location of housing staff with FS teams, increasing expertise across disciplines and improving access for families to housing support. We aim to build on this development and roll out to other district councils.

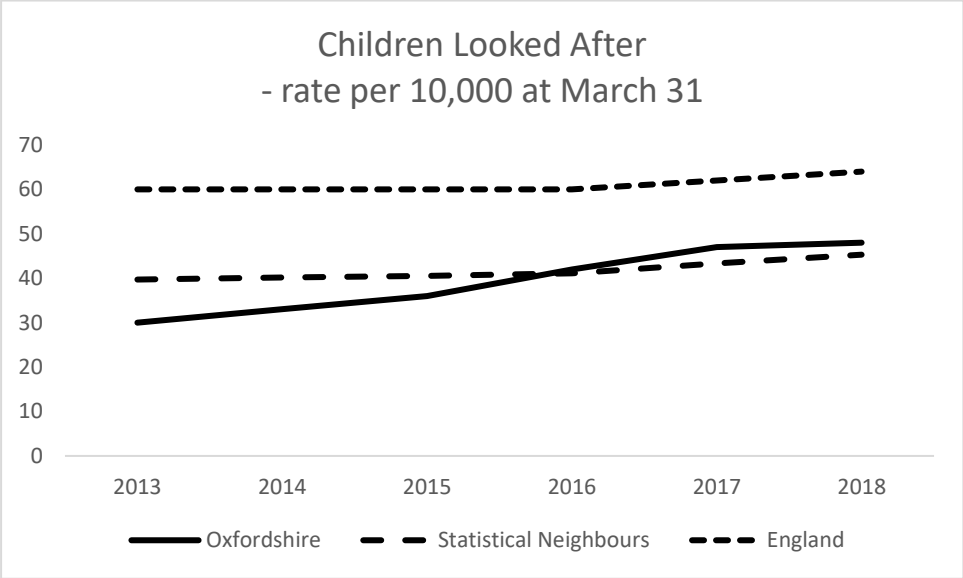
12. We plan to learn from our experience of working with Cherwell District Council and use this as an evidence base to encourage our other district colleague partners to develop and replicated similar services across the County.

13. We are intending to develop an Oxfordshire name for our version of the Family Safeguarding model that better reflects the way we are developing it. This will be identified through working with other stakeholders and people who use our services. We are committing to undertake a consultation/co-production process to arrive at a name and description our services that makes sense to the people who will use it.

The Local and National Context

14. Doing nothing is not an option for Oxfordshire. Nationally in 2017/18 children's services were responsible for £872m of local authority overspend and finance directors identified it as the area facing greatest pressures in future years. A significant element of this pressure relates to demand, between 2007 and 2018 when the number of children looked after nationally increased from 61,000 to 75,000 (with the rate per 10,000 moving from 54 to 64). There were similar increases in the number of children subject to child protection plans, children in need and open cases to children's services.

15. Oxfordshire has experienced similar increases across children's services. The graph below shows how in 2013 we had 30 children per 10,000 looked after. By 2018 this had risen to 48 children per 10,000 looked after. This equates to a total of 415 children in 2013 rising to 780 in 2019, an increase of 365 children. Very few local authorities have managed to avoid the national trend and prevent this increase.



16. Hertfordshire is an exception to the increasing number of looked after children and child protection cases. Using the FS model has helped them to safely keep children at home and reduce the need for child protection interventions.

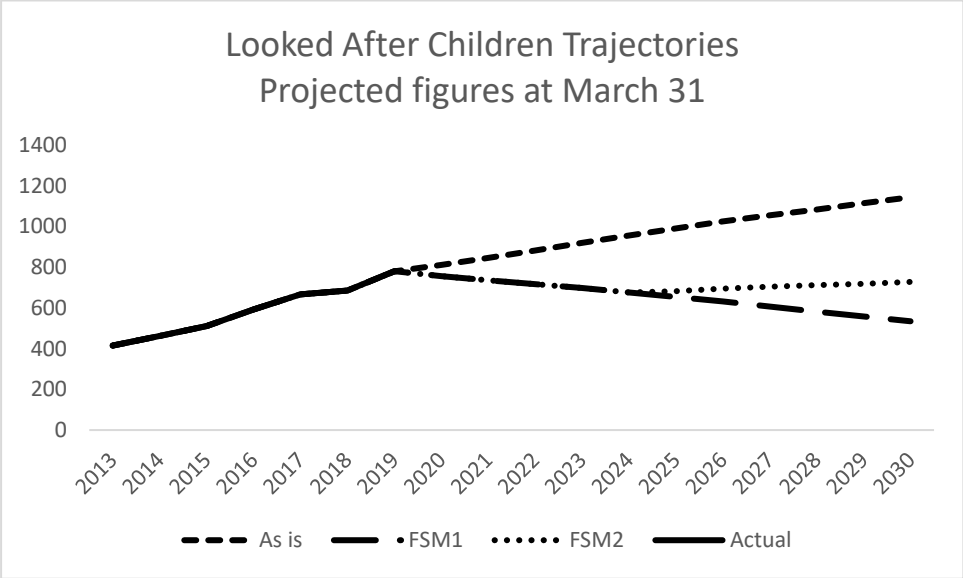
This has been achieved through a careful and diligent approach that provides families high quality help and support when they need it. It has also enabled them to create a virtuous circle where resources can be recycled into their children's services.

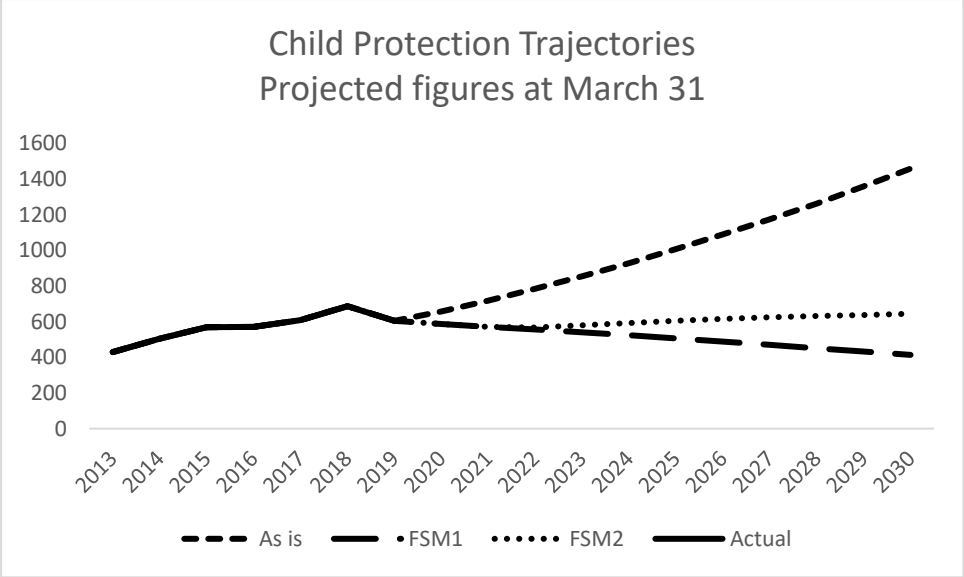
Reasons for Implementing Family Safeguarding Plus

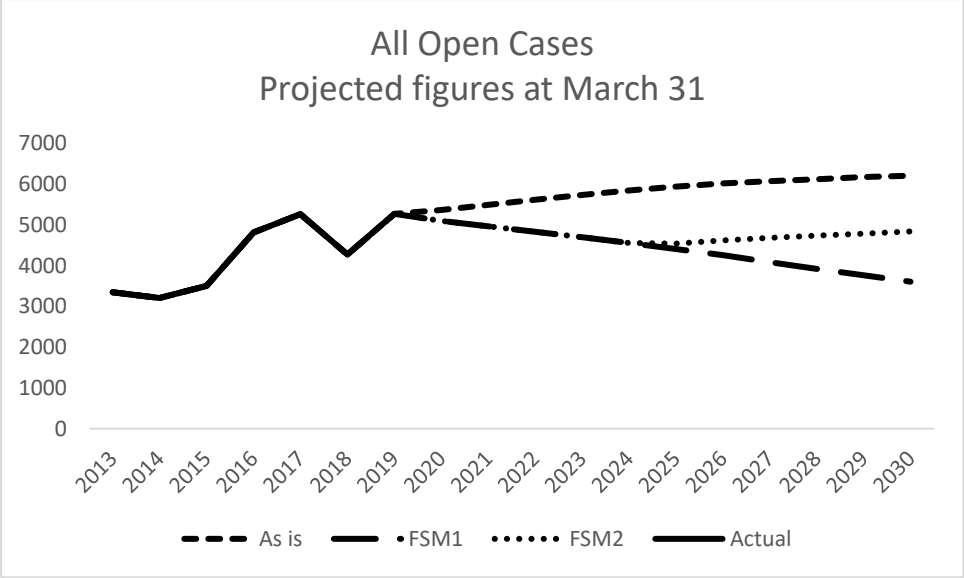
17. OCC is investing almost £5 million to develop and roll out FSP. FSP represents a strategic approach to managing the ever-increasing demands facing children services.

18. The graphs below show the predicted future demand for children's services across a range of measures (looked after children, children subject child protection plans and total number of open cases). All the projections include anticipated growth in demand due to demographic factors (e.g. house building).

19. The '*as is'* line replicates recent historic trends and anticipates likely demand levels if no changes are made. FSM 1 (Family Safeguarding Model 1 assumes a decrease of 5% year on year (this is more modest than the decrease achieved by Hertfordshire). FSM 2 (Family Safeguarding Model 2) also assumes a decrease of 5% year on year but caps it at the rate of the top of the lowest quartile of statistical neighbours (again Hertfordshire have gone below this since the roll out of FS).







20. The key factor to consider is the potential difference between the as is line and the FSM lines. The table below highlights the likely size of the differences of demand if no changes are made and if the FSP model is implemented.

	2020	2023	2025	2030
As Is LAC	810	919	990	1143
FSM 2 LAC	756	697	682	727
FSM Reduction in LAC	54	222	308	416
As Is CP	658	854	1008	1459
FSM 2	587	581	606	654
FSM Reduction in CP	71	273	402	805
As is Total Cases	5372	5737	5940	6210
FSM 2 Total Case	5103	4560	4543	4841
FSM Reduction in Total Open Cases	269	1177	1397	1369

21. The table highlights that if no changes are made by 2023 we are likely to have 919 looked after children, 854 children subject to CP plans and 5737 open cases. These projections are based on a combination of likely need and demographic changes. This would result in a significant requirement to invest in additional social work staff and uplift of other associated costs (e.g. looked after children placements). The alternative FSP version identifies significant reductions with 222 fewer looked after children, 273 fewer children subject to CP plans and 1177 fewer open cases delivering better outcomes and significant savings.

22. The costs associated with implementing FSP can be broken down into three key areas, they are:

- **Project Costs** - These are one off costs associated with making the planned changes (e.g. the project team, training and development for staff, ICT changes etc). The project costs will be focused on service improvement with minimal spend on buildings and relocation of staff.

- **Children's Service Investment** – An investment of £0.8m is being made from 2020/21 in children's services to create the additional teams required to bring case loads down to enable intensive support to be provided quickly to children and their families. As the model starts to impact the number of teams will be reduced, delivering savings addressed below. The success of the model is based on social workers having reasonable case loads that enable them to provide rapid and intense help. This is supported by developing a culture and ethos that enables workers to spend a much greater proportion of their time directly supporting families (rather than servicing bureaucratic demands).

- **System-change Posts** – A single investment of £2.2 million (over 2 years) has been funded by OCC to pump-prime 30 new posts (Mental Health, Domestic Abuse and Substance Misuse) for the first 18 months (£1.5m in year one and a further £0.7m in year 2) whilst work is undertaken with partners to secure longer term sustainability. These are specialist posts focused on supporting parents. The post-holders will be co-located in the FSP teams but will retain their professional identity and clinical supervision by being employed in the relevant partner organisations. The aim is for these posts to be self-sustaining after the initial 18 months. There are different strands of working taking place in relation to each group of posts:

  (a) Alcohol & Substance misuse workers (10 posts) - Discussions have already started with Public Health (and other partners) including briefing the new Director of Public Health. A pilot has also taken place with Public Health funded drug/alcohol workers working closely with children's services (this has been evaluated and has reported to both directorates in September)
  (b) Domestic Abuse Workers (10 posts) We are in discussions with various community safety and criminal justice partners with a view to longer term funding of theses posts.

(c) Mental Health Workers (10 posts) Talks are taking place with various elements of the local health economy (e.g. Clinical commissioning Group, mental health providers)

We are working with partners to develop these roles together. As part of this process, we aim to align them to partners' service priorities and develop a process that builds sustainability into the future of these key posts. This issue will be subject to further cabinet report in late 2019 or early 2020.

Project governance

23. **Partnership Board** – Chaired by the Director for Children, Education & Families. Each of the key stakeholder agencies has identified a senior representative to sit on the Partnership Board which meets monthly and has the following tasks:
    - Steer the creation of FSP in Oxfordshire (including system leadership and creative problem-solving)
    - Identify shared goals and a performance framework for the new service
    - Find ways to make system-change posts sustainable within 12 months
    - Develop collaborative solutions to develop the local workforce in accordance with the aspirations of FSP
    - Report to the H&WB and link with other governance structures (Children's Trust Board, OSCB, Community Safety partnership)
    - Commission the evaluation and analysis of benefits for FSP

24. **Project Team** – The County Council has appointed project support and developed an internal team of workstream leaders led by the Deputy Director for Children's Social Care to oversee the implementation of the new service.

25. Progress towards implementing FSP is monitored through OCC's Transformation Programme.

Conclusion

26. FSP is a Children's Service project, but its aims and aspirations are system-wide. It is designed to improve families' lives through closer working together. It is based on the principle that the root causes of many children's issues are linked to parental issues. The new teams will improve outcomes for parents across a range of measures linked to health, public health, policing and other societal benefits.

27. The project will impact on multiple generations as the work with mental health, substance/alcohol misuse and domestic abuse will help to reduce the number of adverse childhood experiences (ACEs) experienced by the Oxfordshire population. Research [1] highlight adults who experience 4 ACEs or more

[1] http://www.wales.nhs.uk/sitesplus/documents/888/ACE%20Chronic%20Disease%20report%20%289%29%20%282%29.pdf

likelihood of experiencing the negative outcomes below as multiplied by the factor shown.

(a) High risk drinker x4
(b) Smoker x6
(c) Cannabis smoker x11
(d) Crack or heroin user x16
(e) Victim of violence x14
(f) Committed violence x15
(g) Being imprisoned x20

28. They are also strong links to a range of poor health outcomes (e.g. mental illness, diabetes, heart disease and respiratory illnesses) and 4+ ACEs.

Recommendations

29. We see a vital role for the Health and Wellbeing board in supporting this landmark project. The specific areas where we would value help and support are:

- The Health and Wellbeing Board to endorse and support the Family Safeguarding Plus project
- The Health and Wellbeing Board to note the governance structure and accept regular update reports on the progress toward implementation and go-live.
- Support the creation of the system-wide (adult-focused) posts; secure agreements with suitable employing organisations and identify the long-term funding of the posts.
- Support the creation of a partnership performance framework to measure and monitor the impact of the new services across a range of outcomes (that cut across traditional service boundaries).

Oxfordshire County Council
Children, Education & Families
Health and Wellbeing Board

26th September 2019

Family Safeguarding Plus Model

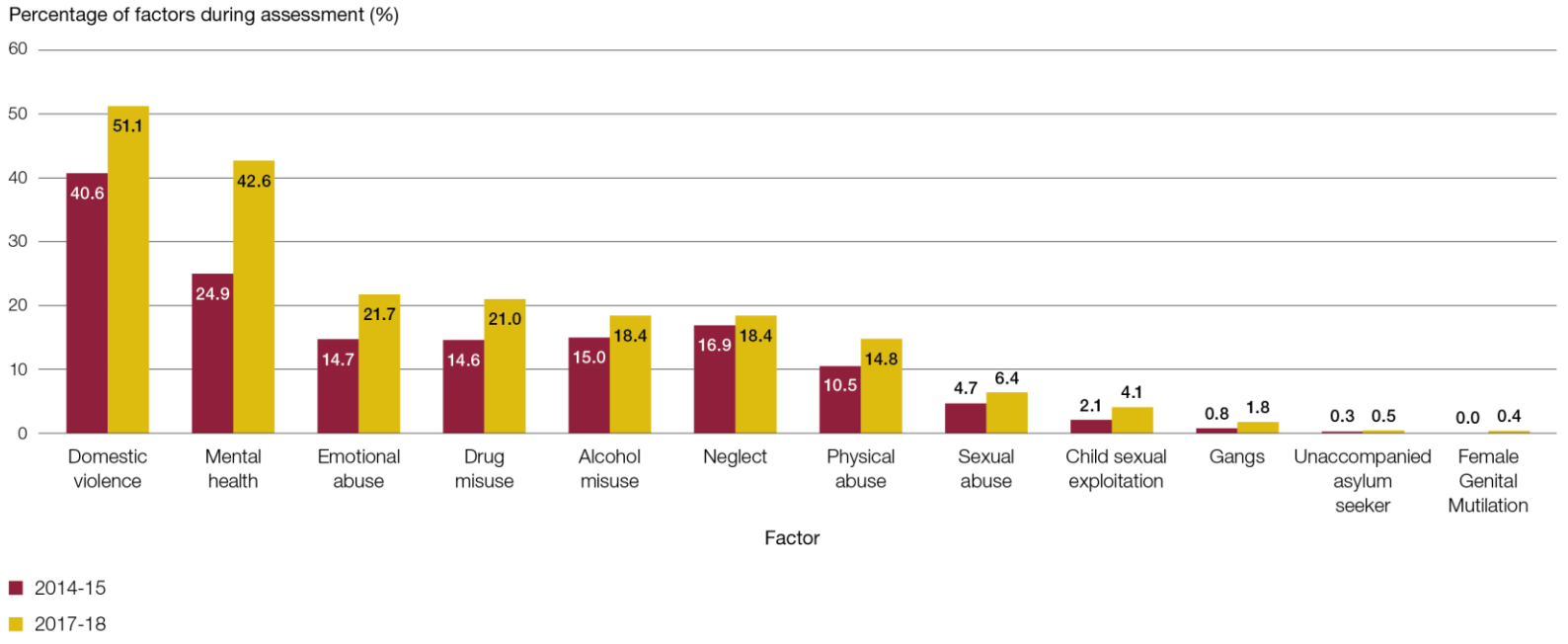
OXFORDSHIRE COUNTY COUNCIL

What is driving demand?

Figure 6

Incidence of risk factors in local authority safeguarding assessments between 2014-15 and 2017-18

In 2017, domestic violence was the most common risk factor identified at the end of an assessment for children in need



Notes

1 Not all factors from Statistical First Release included in analysis.

2 An assessment may have more than one factor recorded.

Source: National Audit Office analysis of Department for Education's Statistical First Release on children in need

OXFORDSHIRE COUNTY COUNCIL

2017/18 Oxfordshire safeguarding activity – Risk Factors

Risk factor	How often a child went on to a plan where this risk factor was recorded		Number of assessments identifying this risk	% of times it went to a plan
	No	%		
Parent Domestic Violence	455	58.9%	1829	24.9%
Child Emotional Abuse	433	56.0%	1232	35.1%
Child Neglect	410	53.0%	859	47.7%
Parent Mental Health	374	48.4%	1500	24.9%
Child Physical Abuse	251	32.5%	1052	23.9%
Parent Alcohol Misuse	247	32.0%	840	29.4%
Parent Drugs Misuse	233	30.1%	680	34.3%
Child Domestic Violence	193	25.0%	620	31.1%
Child Unacceptable Behaviour	173	22.4%	714	24.2%
Child Sexual Abuse	54	7.0%	396	13.6%

Ambitions of Family Safeguarding Plus

- Work more effectively with parents
- Increase engagement with families by increasing the help they receive (specifically domestic abuse, mental health & substance/alcohol abuse)
- Keep more high risk families together safely
- Improve health and educational outcomes for children
- Reduce physical and emotional harm in families
- Strengthen information-sharing and shared decision-making to better protect children and reduce harm to their parents
- Reduce the amount of time children spend in care

Family Safeguarding Model

The **Four Key** elements are:

1. Partnership working through multi-disciplinary Family Safeguarding Teams – Group supervision
2. A core skill set with Motivational Interviewing at its heart - shared unified model of practice
3. A structured ‘workbook’ approach to assessing parent’s ‘capacity for change’ - reducing bureaucracy
4. Tracking impact - an outcomes based performance framework

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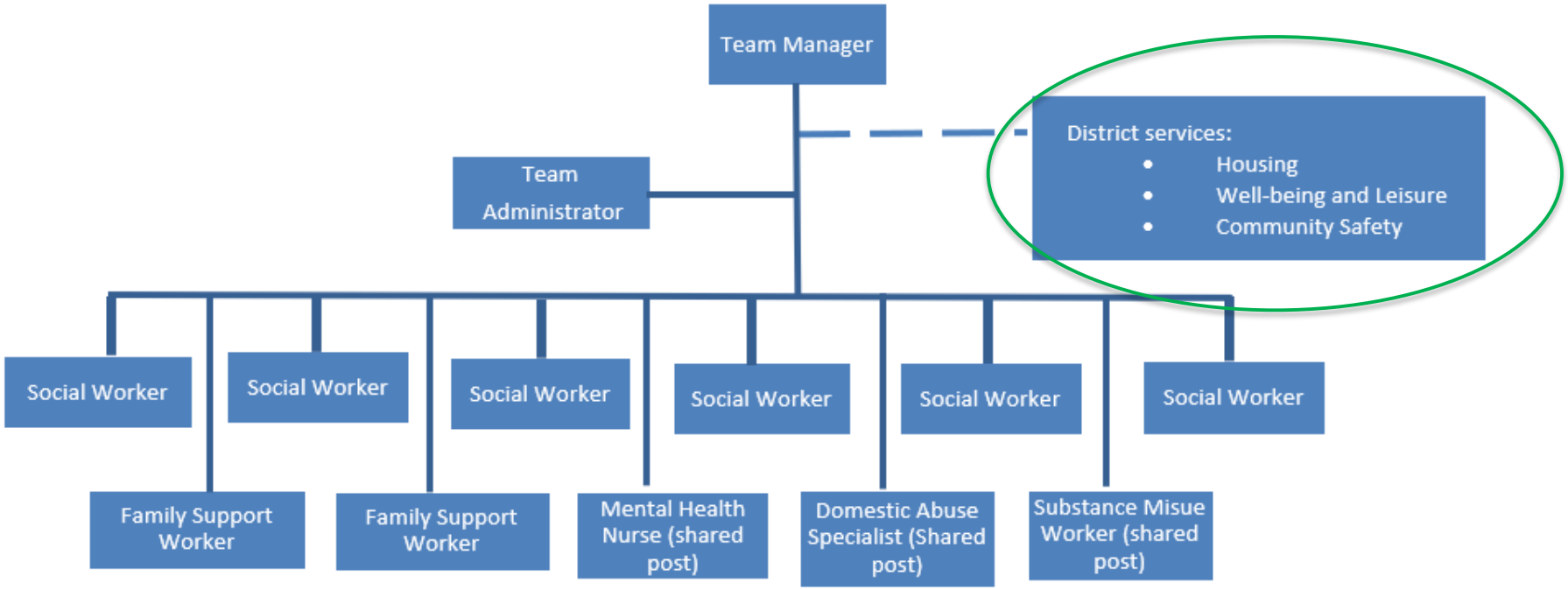
Family Safeguarding Model

Proposed Team Structure



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Family Safeguarding Model
Indicative benefits (Herts after 18mths)

For families

- 66% reduction in repeat police call outs to domestic abuse incidents
- 53% reductions in emergency hospital admissions for adults
- 50% reduction in use of ‘care’ by the County Council - 200 fewer under 12s in care
- 38% improvement in school attendance
- 50% reduction in children subject to CP plans
- 38% reduction in care proceedings

For the service

- Reductions in A&E and Police expenditure
- Staff across all disciplines feel more confident and less stressed
- Improved recruitment and retention of staff with 7% vacancies in hard to recruit posts (December 2017)
- £2.6m reduction in expenditure for the Local Authority in first year including placements, legal and staffing costs

OXFORDSHIRE COUNTY COUNCIL

Progress to date

- Secured £4.8 million investment and commitment from OCC to roll out FSP
- Engaged project lead and project manager
- Set up project governance
- Extensive analysis of needs and potential impact
- Engagement with key stakeholders
- Agreed to develop local name and brand (co-produced with service users)

SYSTEM CHANGE POSTS

System Change Posts

- Alcohol & Substance misuse workers (10 posts) - A pilot has also taken place with Public Health funded drug/alcohol workers working closely with children's services (this is being evaluated and is due to report shortly)
- Domestic Abuse Workers (10 posts – to work with perpetrators and complement social care work with victims)
- Mental Health Workers (10 posts)

- Also developing a pilot with housing and leisure staff from CDC

System Change Posts

- The specialist adult workers are important for improving outcomes providing not just specialist input but a move towards a more multidisciplinary way of thinking about families. They will work with families with the most severe difficulties (in Herts - Families' use of other services reduced after allocation to FSP)

Funding Adult Focused Posts

- OCC has agreed to fund the 30 new posts for up to 18 months
- This funding is to create a catalyst for change and focus on helping whole families
- This approach has been successful in Herts and other areas, delivering real improvements for both children and parents

WORK FORCE DEVELOPMENT

Five General Principles of MI

- Express Empathy
- Explore Ambivalence
- Develop Discrepancy
- Roll with Resistance
- Support Self-Efficacy

Throughout – emphasise the desirable

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Partnership Outcomes Based Performance Framework

Children &Young People Factors	Parental Factors	Partnership Factors	Process Factors
- Learner engagement School attendance Elective Home Education - School attainment - Child emotional health & wellbeing	- Home environment scores - Family relationship scores - Domestic abuse incidents - Substance misuse rates	- Parental police arrests and cautions - Parental prosecutions - Parental attendance at A&E	- Repeat referrals - Repeat child protection plans - Rate of child protection plans -Rate of children entering care

What would we like to see in an Oxfordshire partnership framework?

OXFORDSHIRE COUNTY COUNCIL

Mapping & Understanding System Need

1. Why whole family working?

2. The trigger trio – need; provision; gap

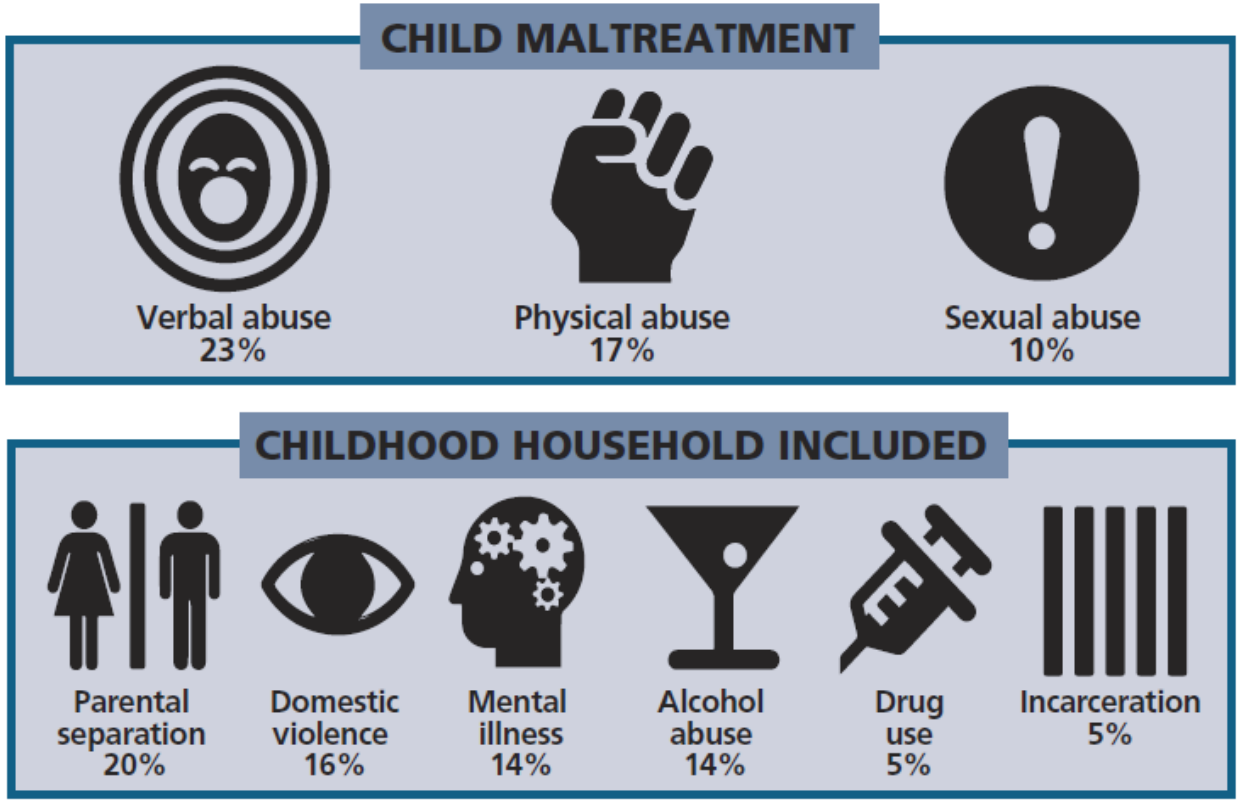
3. Moving into the gap

Adults in Wales exposed to ACEs

0 ACEs	53%
1 ACE	20%
2-3 ACEs	13%
4+ ACEs	14%

Compared to people with no ACEs those with 4 or more were the following times more likely to be

High risk drinker	4
Involved in teenage pregnancy	6
Smoker	6
Underage sex	6
Smoked cannabis	11
Victim of violence	14
Committed violence	15
Used crack cocaine or heorin	16
Been incarcerated	20



Tackling these can turn many lives around

OXFORDSHIRE COUNTY COUNCIL

"Its art not science …
& more surreal than expressionism"

So it would suggest the potential for …

- > 1000 fewer heroin/crack cocaine users
- 250 fewer people jailed a year
- 3,000 fewer violent crimes a year
- 4,000 fewer DV call outs
- 11,000 fewer binge drinkers
- 6,000 fewer smokers
- 350 fewer Looked After Children
- 350 fewer Child Protection Plans

Better lives

Saved resources

Estimates of the Trigger Trio

	Common Mental Disorder	Borderline personality disorder	Antisocial personality disorder	Psychotic disorder	psychiatric disorders
Cherwell	16,706	2,122	2,973	620	6,371
Oxford	19,761	2,511	3,631	741	7,601
South Oxon	15,294	1,942	2,709	566	5,825
Vale	14,408	1,830	2,561	534	5,493
West	11,892	1,510	2,106	440	4,529
Oxfordshire	78,099	9,919	13,985	2,902	29,833

	Alcohol dependency (mild, mod &severe)	Drug Dependency (mild, mod & severe)
Cherwell	5,323	3,014
Oxford	6,499	3,659
South Oxon	4,851	2,749
Vale	4,586	2,597
West	3,771	2,137
Oxfordshire	25,043	14,165

	Domestic Violence notifications (17/18)
Cherwell	1,904
Oxford	1,550
South Oxon	1,076
Vale	1,046
West	1,045
Oxfordshire	6,621

Data taken from www.pansi.org.uk: run by Institute Public Care; Estimates are based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009

Data taken from Thames Valley Police: Domestic Violence Notifications 2017/19

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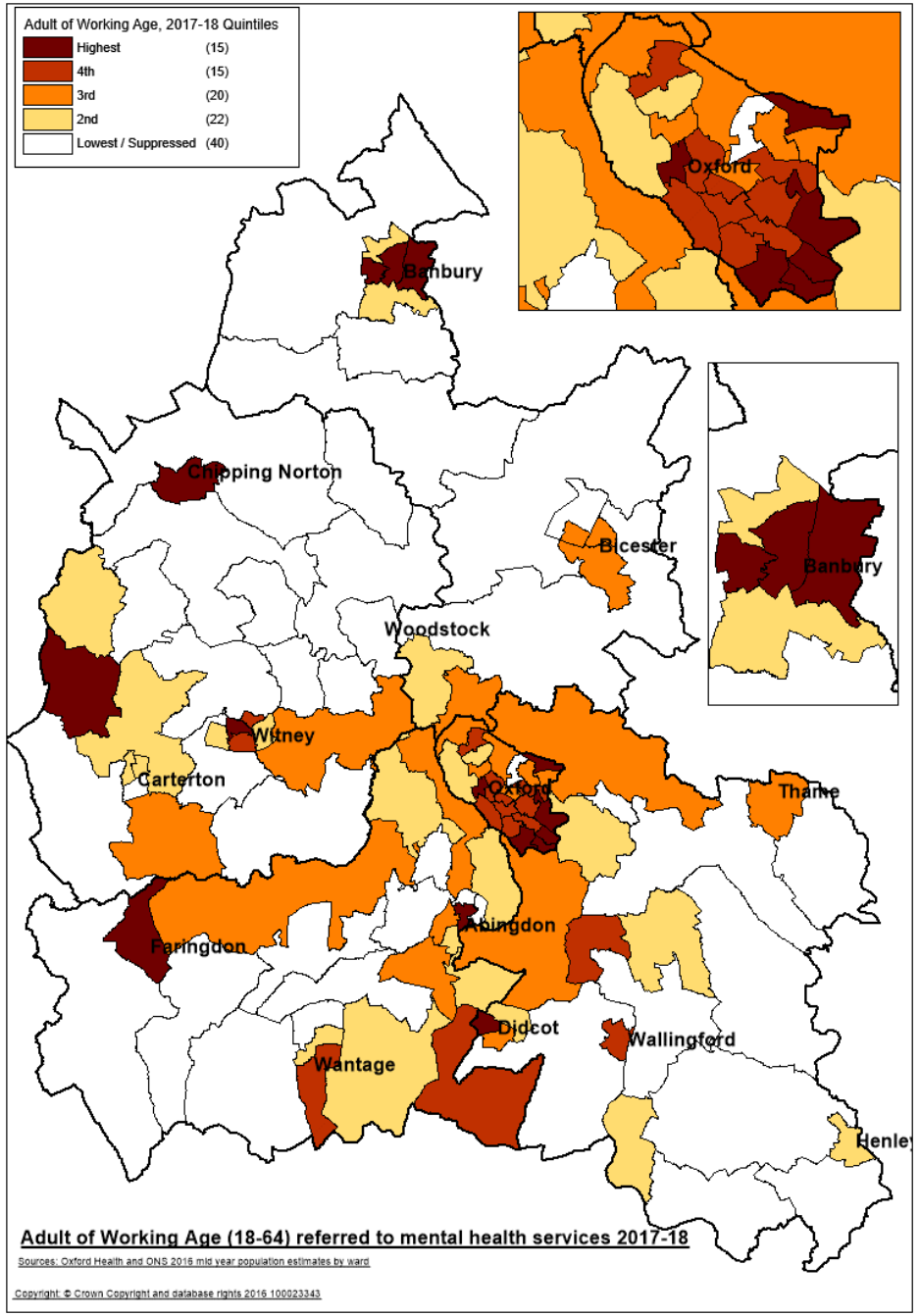
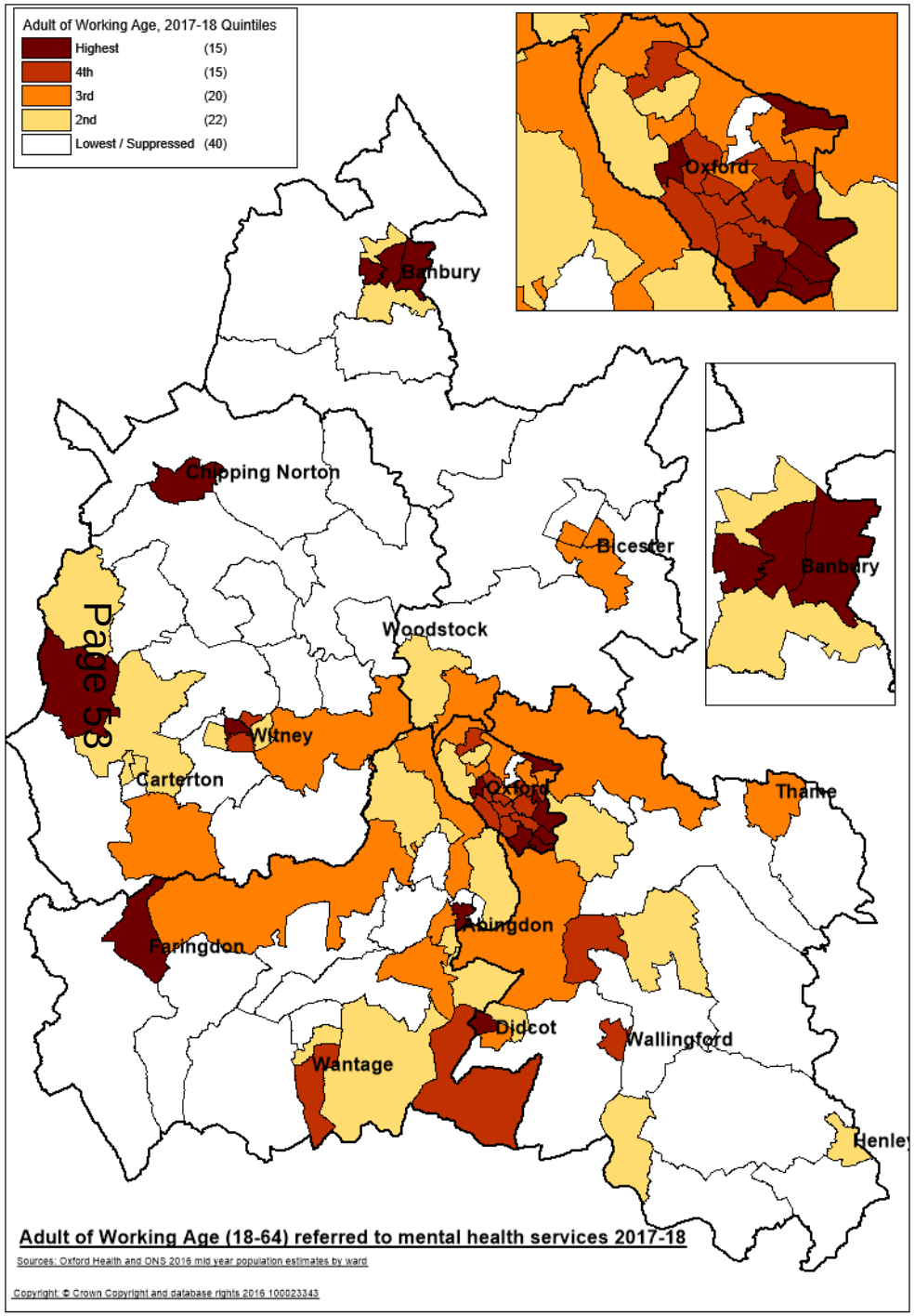
Referrals: Adults of a Working Age for Mental Health Services (2017-18)

In 2017/18: 12,804 referrals of adults of a working age to Oxford Health Mental Health Services.

A third were from Oxford City; a fifth from Cherwell, and the lowest rate number was from West Oxfordshire

	No.	%
Cherwell	2,623	20%
Oxford	4,082	32%
South Oxfordshire	2,107	16%
Vale of White Horse	2,266	18%
West Oxfordshire	1,726	13%
Oxfordshire	12,804	100%



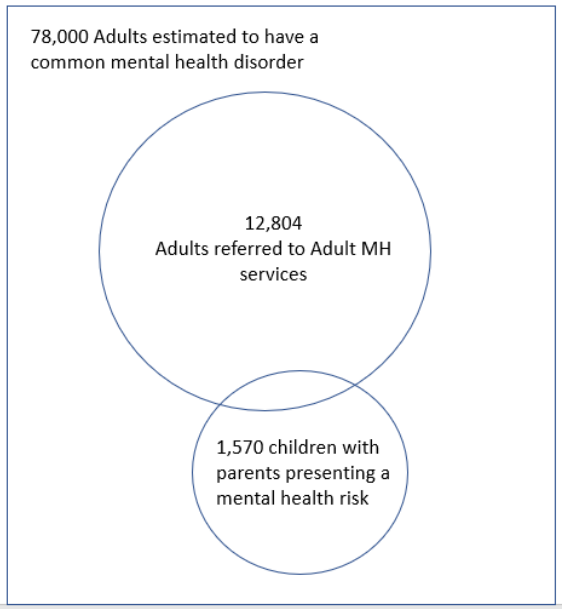


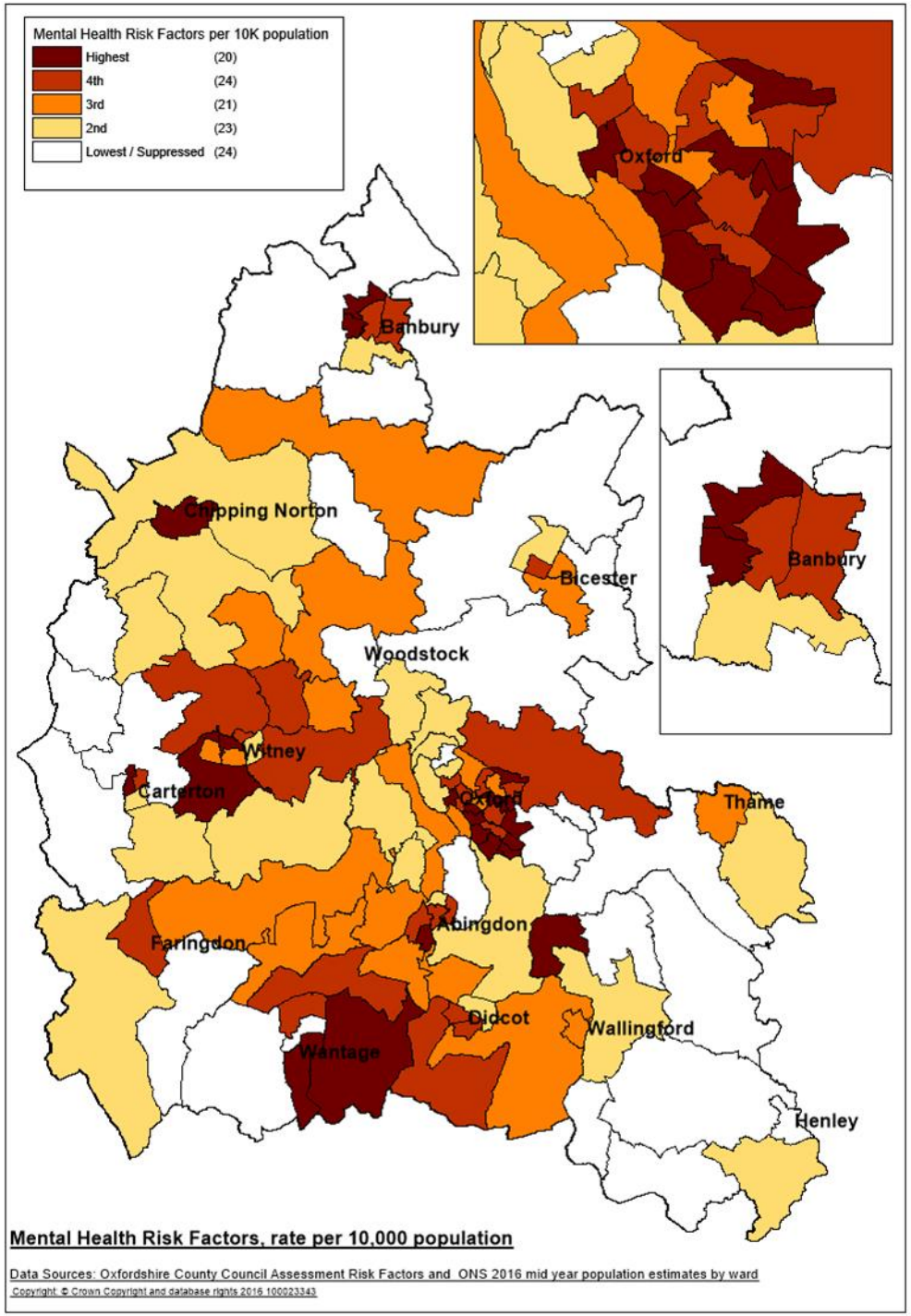
78,000
Common mental heath disorder

13,000
Referrals (AWA)

1,570
social care cases (39%) with adult mental health risk factor

Wider distribution of cases where risk factors identified than service use



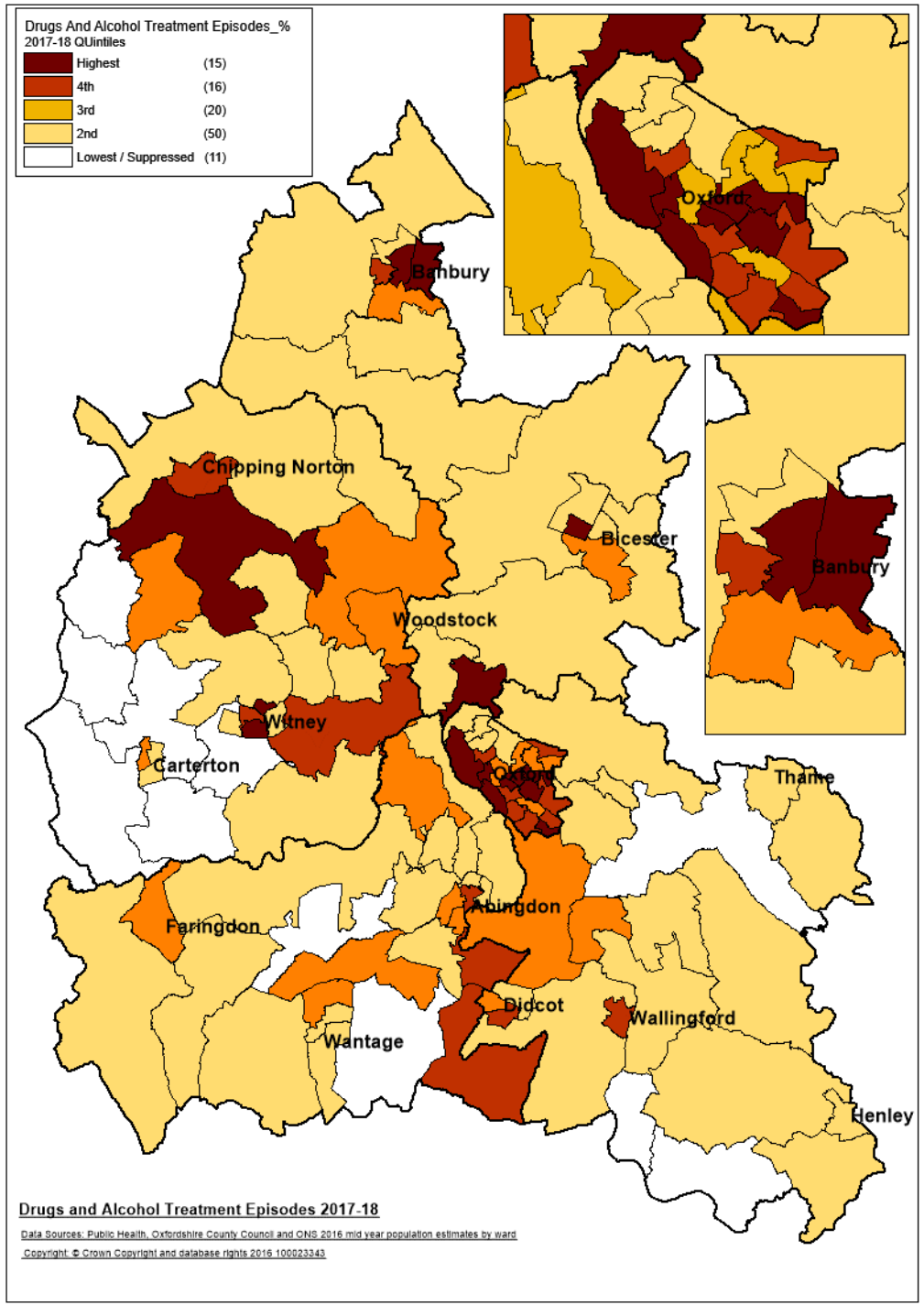


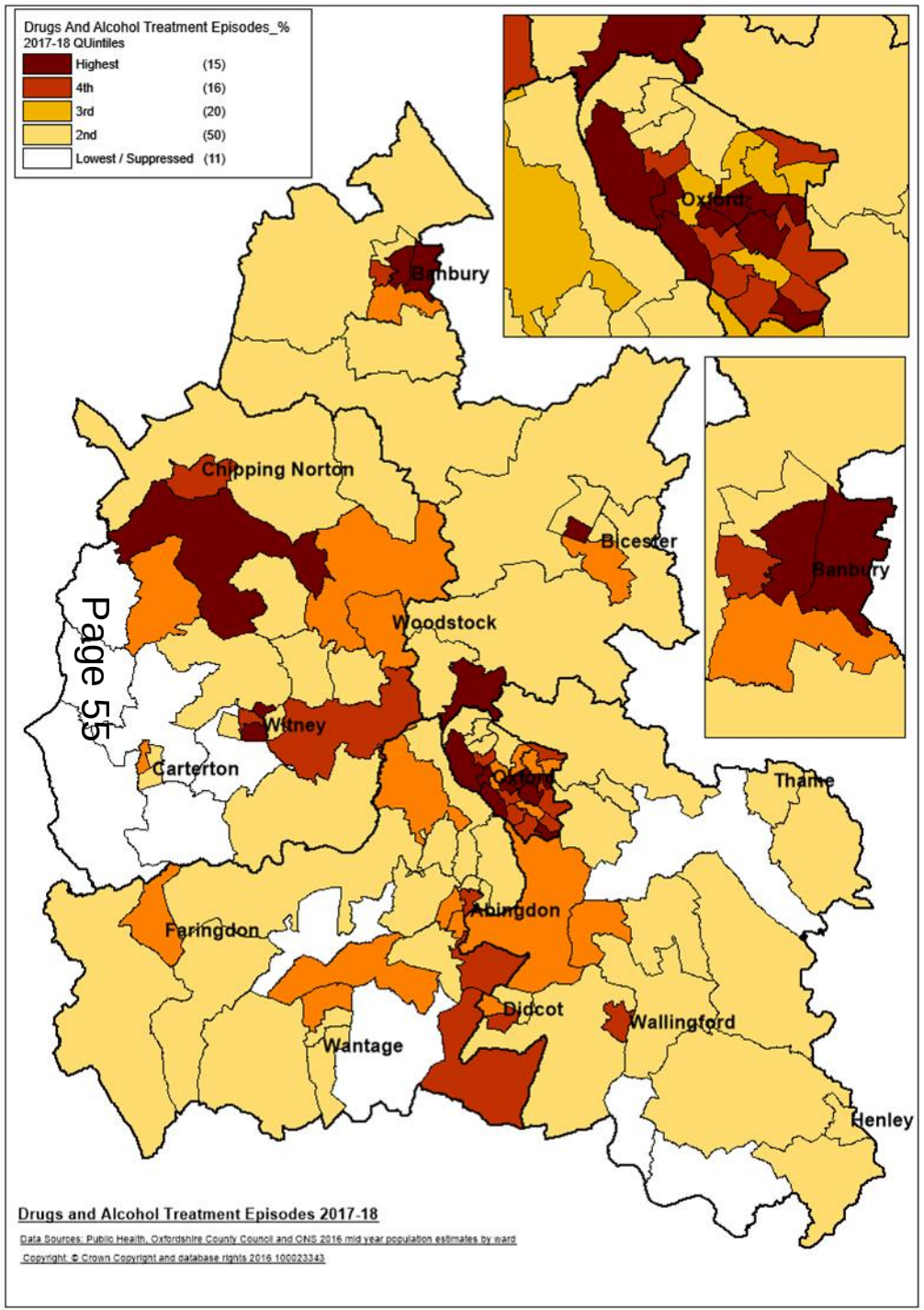
Drug & Alcohol Services (2017-18)

In 2017/18 there were 4,583 people attended Drug and Alcohol services commissioned through public health.

A third were in Oxford City and a quarter in Cherwell

	No.	%
Cherwell	1,159	25%
Oxford	1,580	34%
South Oxfordshire	585	13%
Vale of White Horse	652	14%
West Oxfordshire	607	13%
Oxfordshire	4,583	100%





Est 25,000

Adults mild to severe alcohol dependence

Est 14,000

Adults mild to severe drug dependence

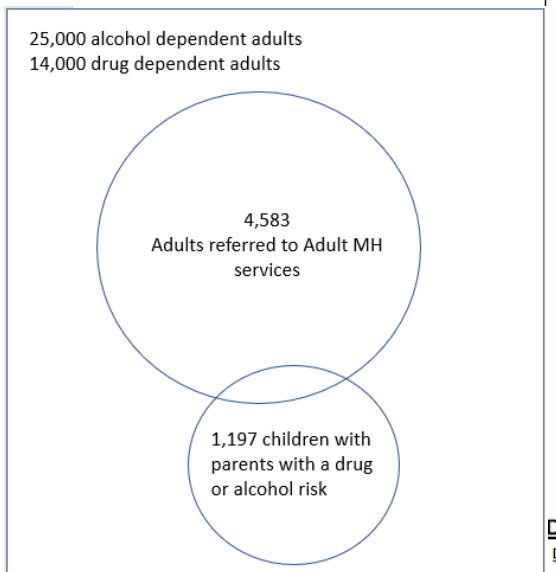
4,583

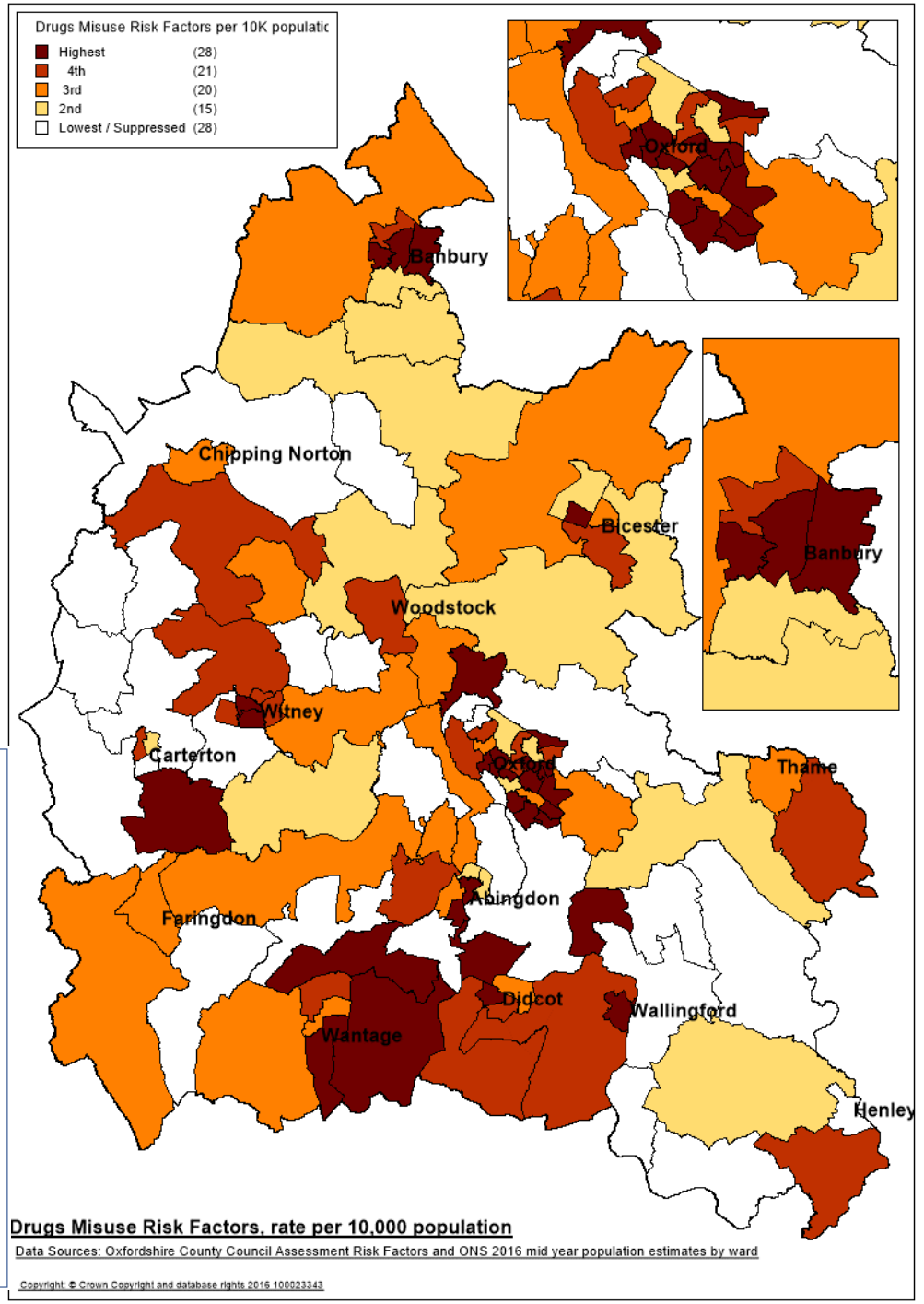
People receiving treatment

1,197

social care cases (30%) with adult drug / alcohol risk factor

Slightly wider distribution of cases in the risk factors but similar distribution

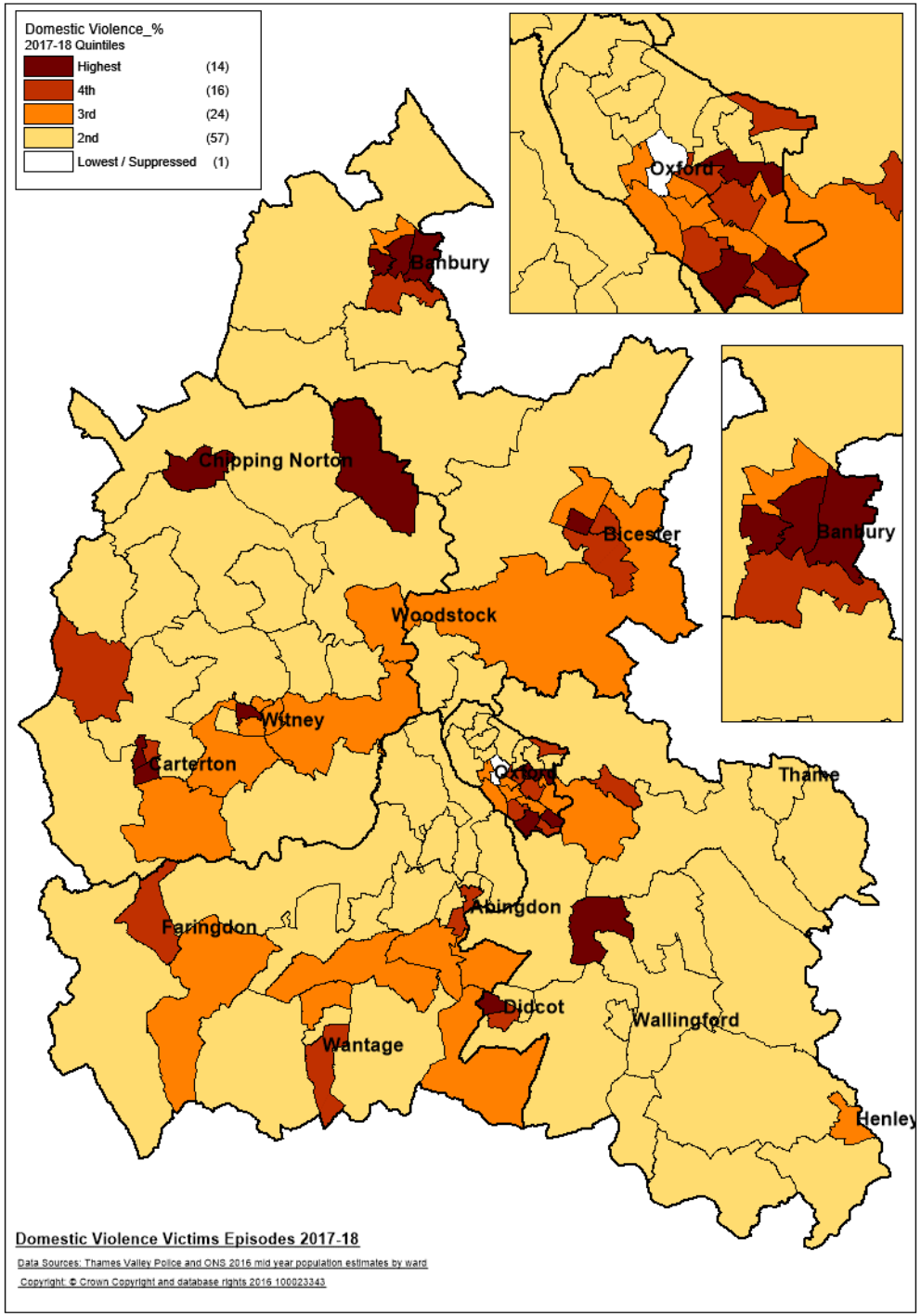


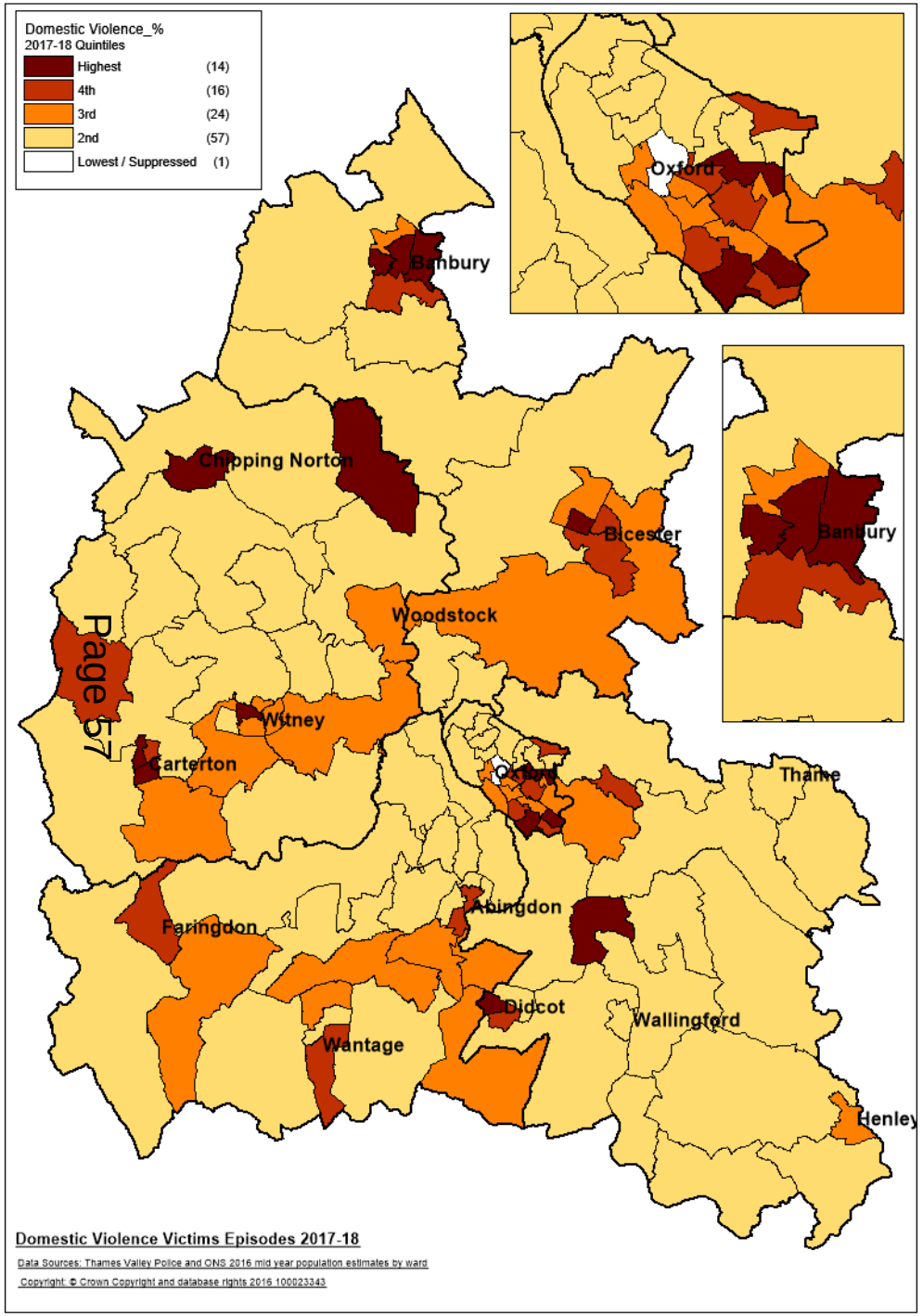


Domestic Violence Notifications (2017-18)

In 2017/18 there were 6,621 domestic violence notification. Over a half occurred in Cherwell and Oxford City – with Cherwell at 29%

	No.	%
Cherwell	1,904	29%
Oxford	1,550	23%
South Oxfordshire	1,076	16%
Vale of White Horse	1,046	16%
West Oxfordshire	1,045	16%
Oxfordshire	6,621	100%



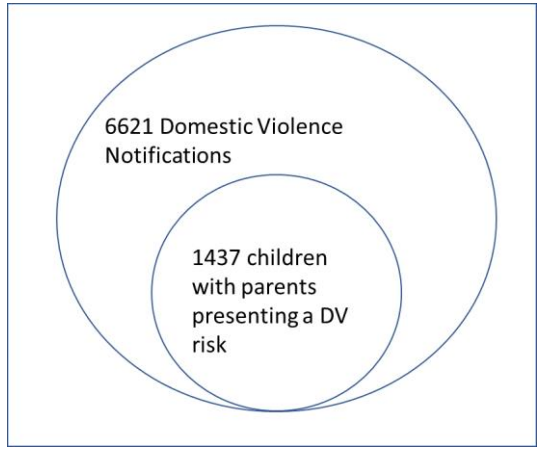


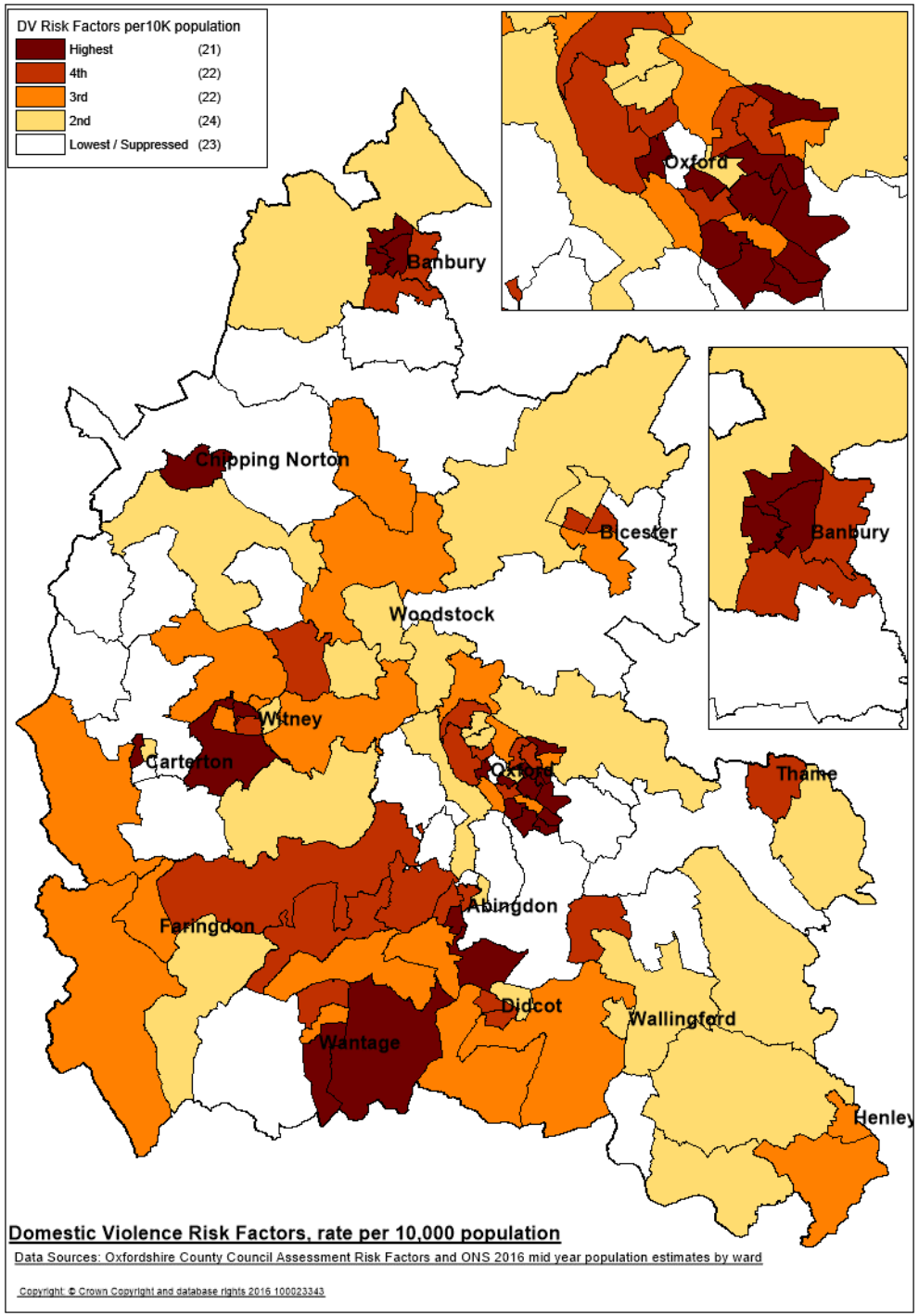
6,621

Domestic Violence Notifications

1,437

social care cases (37%) with domestic violence risk factor

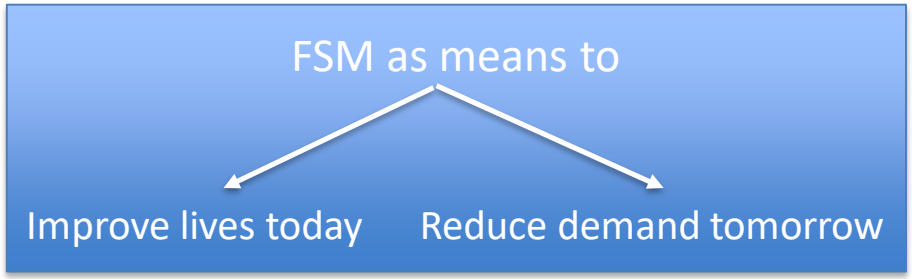




Some thoughts

Benefits of whole family working: today and tomorrow

Known Gap - Some sits with vulnerable families



HEALTH & WELLBEING BOARD
26 SEPTEMBER 2019

Better Care Fund: Our Plans for Delivery

Report by the Director for Adult Services & Chief Executive of Oxfordshire Clinical Commissioning Group

SUMMARY

1. The Better Care Fund is a programme spanning the NHS and local government which seeks to join up health and care services, so that people can manage their own health & wellbeing and live independently in their communities for as long as possible. This includes the Improved Better Care Fund which is paid to local government for funding of local care services and reducing pressures on the NHS
.
2. The Better Care Fund invested £50,361,088 in the Oxfordshire System in 2018-19 to improve health and social care outcomes for local people.

3. In 2017 local systems were asked to produce two year plans outlining our intentions for delivering outcomes from the Better Care Fund; the Oxfordshire plan was approved by the Health & Wellbeing Board on 11th September 2017.

4. On July 27th 2019, the planning template for Better Care Fund plans was issued to local areas. This paper brings an update regarding our planning process and future opportunities for the Better Care Fund going forward.

BACKGROUND

5. Currently under the Section 75 NHS Act, the Joint Management Group between the Council and Oxfordshire Clinical Commissioning group manages the Better Care Fund and reports to the Health & Wellbeing Board.

6. The Pooled Budget Section 75 structure continues to demonstrate positive intent for the health & social care partners to work together local and provides an opportunity to improve flow through the whole health & social care system. The Joint Management Group oversees the implementation and outcomes from Oxfordshire's Improved Better Care Fund allocation.

7. The Joint Management Group oversees the deliverables under the Ageing Well section of Oxfordshire's Joint Health & Wellbeing Strategy (2018-2023) and is working to develop and deliver the implementation of Oxfordshire's Older People's Strategy.

8. In addition to the measures agreed locally, the Joint Management Group and the Health & Wellbeing Board oversee the deliver of the 4 national Better Care Fund measures:
    a. Non – elective admissions (general and acute)
    b. Admissions to residential and care homes
    c. Effectiveness of reablement
    d. Delayed transfers of care

2019-20 AND BEYOND

9. As is noted in the September 2019 Performance Report, there are challenges regarding these measures and, as a system we must use the Better Care Fund plan as an opportunity to ensure that we are addressing these measures in the most effective way and delivering transformation that brings fundamental change to our system and improvement in outcomes for Oxfordshire's older population.

10. This includes building on the work currently being led by Oxford University Hospitals to deliver an improvement plan within the HART service, as well as wider system working to support and develop the reablement and out of hospital pathways.

11. As a system, we are delivering a revised approach to commissioning short stay beds in care homes. This approach is designed to ensure consistency in the services provided for people, and to strengthen our strategic partnerships with care homes. Implementation is underway to deliver this model in advance of Winter 2019-20.

12. We also recognise the challenges experienced in supporting people to live at home. As such, we are leading the redesign of commissioning arrangements for home care services. This longer term work involves co design with people and provider partners and will result in new contracting arrangements in 2020. However, in recognition of the challenges for Winter 2019-20 we are working with providers to develop short term initiatives that can provide a response for the coming winter period.

13. These initiatives, and the wider system working regarding social prescribing and delivery of the NHS long term plan form essential elements of the Better Care Fund Plan and delivery of the Better Care Fund National metrics. This plan is currently being prepared in line with the national timescales for submission and for future discussion with the Health & Wellbeing Board.

RECOMMENDATIONS

Health & Wellbeing Board is RECOMMENDED to:

(a) delegate approval regarding the national submission of the Better Care Fund Planning template to the Director for Adult Services, Oxfordshire County Council and the Chief Executive, Oxfordshire Clinical Commissioning Group;

(b) ask officers to bring a report outlining this plan, and trajectory against the performance measures to the next meeting of the Health & Wellbeing Board.

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Health and Wellbeing Board's Vision

To work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire

Oxfordshire Prevention Framework 2019-2024

(working draft)

Dr Kiren Collison, Clinical Chair of Oxfordshire Clinical Commissioning Group
Jackie Wilderspin, Public Health Specialist, Oxfordshire County Council

Oxfordshire Prevention Framework – Summary

Prevention - The Headlines

"Half of all mental illnesses begin by the age of 14"

"Being overweight is linked to 11 types of cancer"

"Loneliness is as bad for your health as smoking 15 cigarettes a day"

"80% of health spending on diabetes is on its complications"

"Stress, anxiety and depression are the leading cause of lost work days"

Executive Summary

Whilst it seems that every strategy and plan being published calls for more prevention measures, what is often less well articulated are some key issues:

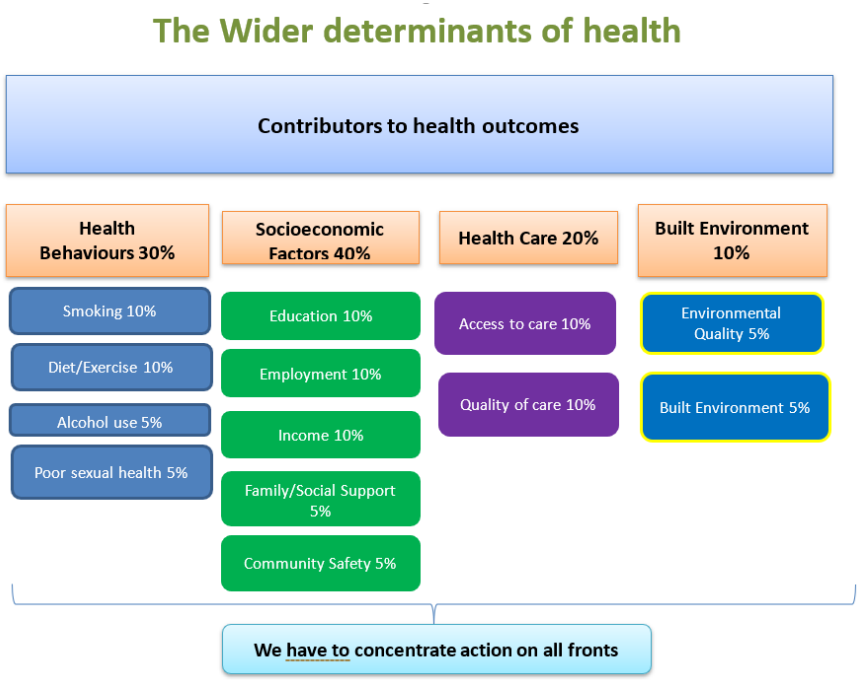
- What are our local prevention priorities?
- What are we already doing?
- How can we fill the gaps?
- How can we close the inequalities gap?
- How are we going to resource this work?

This framework aims to start addressing these questions.

We identified why people are dying or suffering from poor health. We then went back to basics to tell the story of why this is happening. These include a combination of individual choices and factors, social and economic circumstances and the places we live, learn, work, travel and socialise.

The overall structure for the framework covers the wider determinants of health as shown on the chart on the right. Our focus is on:

- **Lifestyle factors**: particularly obesity, poor diet, lack of physical activity, smoking and alcohol
- **Built environment and Socioeconomic factors** including Healthy Place Shaping, loneliness, low income and affordable warmth
- **Health care factors** and how prevention initiatives can be embedded in all parts of the health and care system.



The recommendations in this framework are based on an in-depth look at local health needs and the bedrock of proven good practice.

The resulting short list of priorities needs the attention of all partners in the system – which means the NHS, local government at all levels, the third sector and everyone who lives in Oxfordshire. We also need to encourage people to look after themselves so that they don't come into contact with health professionals until they really need to. There is something for everyone and it is hoped that you will all recognise your contribution and the need to build on what you are already doing, joining things up and working ever more closely together.

This is just the beginning of an ongoing process. Over time, we will need to keep renewing our focus and checking our priorities. There is already a lot going on. Let's do some more!

"Delivering big change with financial and operational pressures is hard, but the prize is great if we get it right"
Duncan Selbie, Chief Executive, Public Health England

Why is prevention needed?

Demand for health and care services is rising, yet the system's workforce and financial resources are struggling to keep pace. We need to work differently, shifting to a more pro-active approach to prevention as set out below:

PREVENT illness	**REDUCE** the need for treatment	**DELAY** the need for care
Preventing illness and keeping people physically and mentally well, e.g. being active, breathing clean air, having social connections	Reducing impact of an illness by early detection e.g. cancer screening, and preventing recurrence e.g. lowering blood pressure or cholesterol to prevent another stroke	Soften the impact of an ongoing illness and keep people independent for longer
(**primary prevention)**	(**secondary prevention)**	(**tertiary prevention**)

The aim is to:

- Improve quality of life by creating and promoting health and wellbeing
- Reduce health inequalities
- Save our public services from the spiralling costs of treating avoidable illness and ongoing needs and improve the efficiency and wellbeing of the workforce.

Are we doing all we can on prevention in Oxfordshire?

There is a lot of good work already happening

- **Healthy life expectancy** in Oxfordshire is significantly higher than national and regional averages for both males and females (men 81.6yrs, women 84.6yrs)
- In Oxfordshire, the average **wellbeing** scores for life satisfaction have gone up recently
- The percentage of babies with **low birth weight** in Oxfordshire remains lower than national levels, and breastfeeding prevalence stays high in the county, well above national levels
- The rate of **teenage conceptions** in Oxfordshire is significantly lower than the national average and is decreasing broadly in line with national trends
- The **number of smokers** in the county is lower than the national average and is decreasing
- Pedestrian **casualties on the roads** have reduced in recent years.
- In 2015-16, Oxfordshire's rate of **emergency hospital admissions** due to falls was above the England average. Since then, the overall county rate has fallen and is now lower than the national and regional rates. The City rate remains significantly higher than national averages.
- There has been an increase in the proportion of older social care clients **supported at home**

Issues that continue to be a problem in Oxfordshire

Traditionally, there have been:

- Urgent, reactive matters crowding out preventative, proactive interventions (including the use of resources)
- Piecemeal prevention services
- Lack of joined up working between individuals, community groups, health organisations, emergency services and local authorities

- The top 4 causes of death for under 75s in Oxfordshire are: **cancer**, **cardiovascular disease, respiratory disease and liver disease.**
- **Half of these are considered to be preventable.**
- A higher proportion of these deaths is in areas of **deprivation**.

- Oxfordshire is generally a healthy county, but **cardiovascular disease, cancer, depression and musculoskeletal problems** (including a recent rise in osteoporosis), were more prevalent than the England average in the most recent year of data.
- The proportion of all **school pupils with social, emotional and mental health needs** has increased over recent years in Oxfordshire and in England.
- Since 2013/14, prevalence of **depression** has increased from 6.6% to 10.3% amongst adults
- **Smoking** prevalence in Oxfordshire is lower than the England average and is decreasing, but prevalence remains high for adults in **routine and manual occupation groups.**
- The latest data (2017/18) shows that smoking prevalence at time of delivery in Oxfordshire is 7.8% - indicates there were over **510 women smoking throughout pregnancy that year.**
- Over half of adults in Oxfordshire are **overweight or obese (**and the rates are rising), and three in ten adults are not meeting physical activity guidelines
- One in five children in Reception, and one in three children in Year 6 are **overweight or obese**. These rates seem to be fairly stable for both age groups but there are indications that it may be increasing among year 6 children
- **MMR immunisation rates** are declining**.** The immunisation rate for dose 2 of the Measles, Mumps and Rubella vaccination has recently dipped below the minimum threshold of 90% which is a cause for concern.
- 1 in 5 children in Oxfordshire have **tooth decay**. Tooth decay is a predominantly preventable disease. Significant levels remain, resulting in pain, sleep loss, time off school and in some cases, treatment under general anaesthetic. High levels of consumption of sugar-containing food and drink is also a contributory factor to other issues of public health concern in children – for example, childhood obesity.
- **Isolation and loneliness** have been found to be a significant health risk and a cause of increased use of health services. Areas with the highest risk of loneliness are in Cherwell (Banbury, Bicester Town); Oxford (Blackbird Leys, Wood Farm, Barton, St Clements, Jericho, Cowley) and South Oxfordshire (Didcot South)
- Indicators that are worse than average are: **killed and serious injured on roads**; hospital stays for **self-harm**; **diabetes** diagnosis rates and **alcohol**-specific hospital stays in young people.
- Oxford City has been the only Oxfordshire district with a rate of **falls** consistently significantly worse than England. Rates in the rest of the county have fallen recently and are in line with, or better than, national averages.

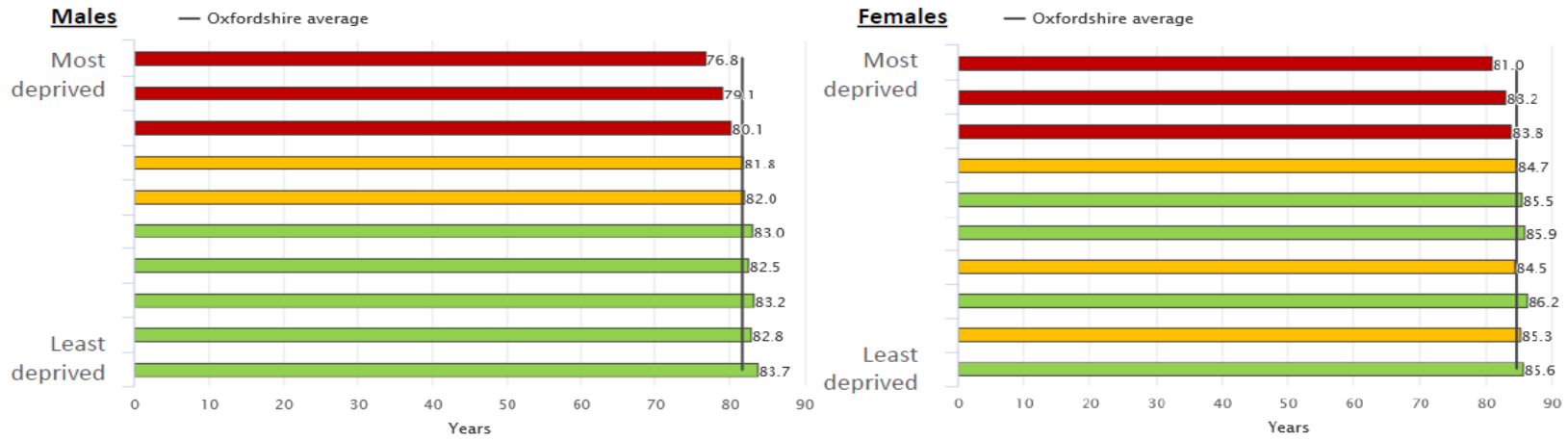
Health Inequalities

Whilst the overall **life expectancy** for men and women in Oxfordshire has increased in the last 30 years (with men's life expectancy increasing faster, closing the gap between the sexes to 3 years):

- **There is a gap of almost 7 years** for men between the most and least **deprived areas** (data for the combined years 2015 to 2017)
- For females this gap is just under **5 years**
- Many of the cases of illness and early death are more prevalent in areas of **deprivation**
- Health inequalities may also be linked to **ethnicity, age, sex** and other factors

This chart illustrates the differences in life expectancy across Oxfordshire as a result of multiple deprivation

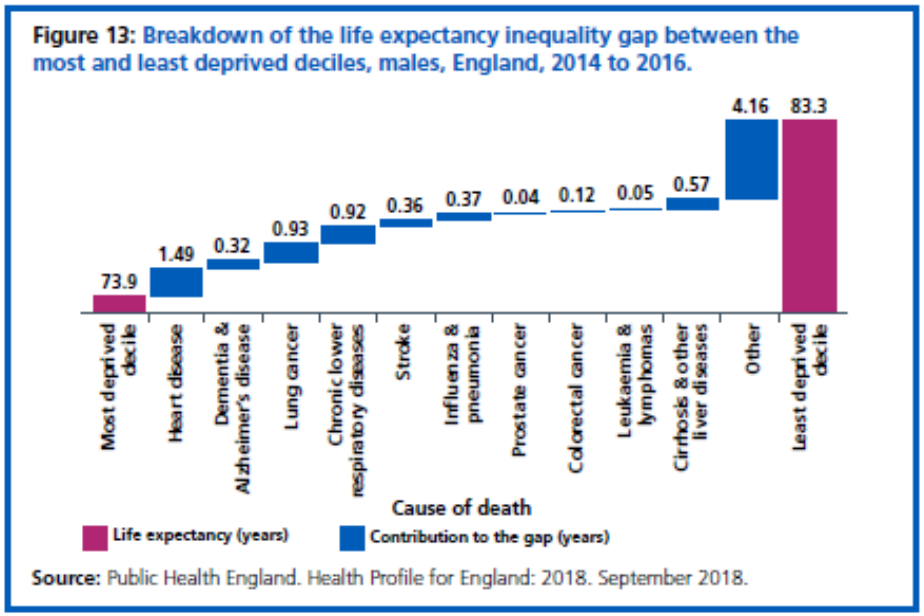
Oxfordshire Life Expectancy at birth by LSOA deprivation deciles: males and females, 2015-17



Source: Life Expectancy at Birth, ONS from PHE Public Health Outcomes Framework

The table below shows how long, on average, someone might expect to live without disability or long-term conditions in the most and least deprived areas of Oxfordshire (JSNA 2017):

	Most deprived 10%	Least deprived 10%
Men	60.7 years	70.8 years
Women	60.9 years	70.5 years



The table above illustrates the factors which add up to give a gap in life expectancy for men in England.

Oxfordshire Prevention Framework - How we will make a difference

- Address the biggest risk factors causing preventable premature death or disease
- Create healthy communities where people can maintain and improve their health as they live, learn, work, travel, connect and socialise
- Recognise that everyone and every organisation has a role in prevention.

Deciding on priorities

We need to consider:

- Which factors have the biggest effect on health?
- Which affects most people?
- What are the biggest health inequalities?
- Which are the lowest hanging fruit? (i.e. easiest for us to change)

Suggested system-wide priorities for the next 5 years (in addition to business as usual):

This is to be discussed at HWB and refined into a timeline for each priority over 5 years

1. Establishment of local cross-organisational leadership for prevention, making resources available.
2. Optimise the first 1000 days of life, including reducing smoking in pregnancy, focussing on maternal mental health, promoting healthy eating and increasing immunisation of children
3. Promote and create emotional wellbeing, including the '5 ways to wellbeing' and the 'CLANGERS[1]' approach to wellbeing, for children, young people, adults and families. (C
4. Shape Healthy Places throughout Oxfordshire, including the physical environment, the cultural offer and building communities.
5. Address priority socio-economic factors – loneliness and the impact of debt.
6. Tackle the growing problem of obesity through prevention and weight management interventions
7. Improve early detection, self-care and clinical management of long term conditions, particularly Cardiovascular Disease, Respiratory, Diabetes, Mental health and Cancer

Plus targeted work to reduce health inequalities in all of the above.

[1] CLANGERS = Connect, Learn, be Active, Notice, Give, Eat well, Relax, Sleep

Strategy

1. **Optimise first 1000** days of life to get the best start in life.
2. **Promote** healthy behaviours for all children and young people
3. **Prevent long term conditions (LTC)** through healthy lifestyles, addressing socio- economic factors and shaping healthy places to live and work (primary prevention)
4. **Reduce harmful impact** of physical and mental health conditions through early detection and optimal treatment (secondary prevention)
5. **Delay the need for care**, empowering people to remain independent in their own homes (tertiary prevention)
6. **Tackle health inequalities** and prevent premature deaths and illness

Actions

1. Optimise preconception, antenatal and postnatal care and health in early years.
2. Enable and promote physical activity, healthy eating and resilience in children and young people.
3. System wide weight management interventions including behaviour change approaches
4. Fill in gaps in current primary prevention programmes (smoking, alcohol, falls, debt advice, workplace health)
5. Improve early detection, self-care and clinical management of long term conditions, as highlighted in the NHS long Term Plan
6. Enhance independence by supporting carers, preventing falls and strengthening social networks through social prescribing

General Enablers

- Whole systems approach including individuals, healthcare access and wider determinants of health
- Shift in cultural mindset - embedding primary and secondary prevention in all clinical and care pathways
- MECC training embedded in all organisations
- Primary Care Networks using a proactive, holistic approach
- Healthy Place Shaping
- Development of health and wellbeing programmes in early years, schools, colleges and workplaces
- Targeted interventions to people and areas of high need to narrow health inequalities gap using Population Health Management methods
- Collaborate with and support voluntary sector and community groups who are engaged in supporting the health and wellbeing of their communities. Build on community assets.

Embedding Prevention in all decisions, plans and processes

Contents

1. **Foreword**
2. **Summary**
3. **Purpose, Aim, Definitions**
4. **The causes and influencers of poor health**
5. **Strategic context**
6. **Health needs in Oxfordshire**
    - Causes of premature death and disease and associated risk factors
    - Health inequalities
    - High patient impact and high cost complications of preventable disease

7. **What are the priorities for embedding prevention in all aspects of life in Oxfordshire?**
    A. Lifestyle Factors
        - Obesity
        - Alcohol
        - Smoking
        - Physical Inactivity

    B. Socioeconomic factors and the Built Environment
        - Built Environment and healthy place shaping
        - Low income and debt
        - Loneliness and social isolation
        - Better Homes, Better Health

    C. Healthcare factors - Embedding prevention in all aspects of the Health and Social Care System
        - Implementing the NHS Long Term Plan
        - Everybody's role and responsibility
        - The First 1000 days
        - Prevention in Primary Care
        - Prevention across county wide organisations

8. **Conclusion and Recommendations**

Bibliography, Annexes

Oxfordshire Prevention Framework

Foreword – The Purpose of the Prevention Framework-
The need for "Prevention" has a high profile these days, both nationally and locally.
It seems that every strategy and plan being published calls for more prevention measures. However, what is often less well articulated are some key issues: What are our local prevention priorities? What are we already doing? What are the gaps?

This framework sets out the priorities for prevention in Oxfordshire. It is a companion document to the Joint Health and Wellbeing Strategy (2019-24) which has recently been revised and which has Prevention as a major cross cutting theme.

We want to focus on identified need in Oxfordshire, draw from evidence of what will work and recognise the valuable assets and enablers that are already in place and which need to be maintained. So, in order to draw up this framework, we have looked at local population health needs (using our Joint Strategic Needs Assessment (JSNA) and other analyses of need), learned from published evidence of effectiveness, discussed the issues with a wide range of colleagues and identified gaps.

The resulting short list of priorities needs the engagement of all partners in the system – which means the NHS, local government at all levels, employers, the third sector and everyone who lives in Oxfordshire. There is something for everyone to do and we encourage you to recognise your contribution and the need for building on what you are already doing, joining things up and working ever more closely together.

This is just the beginning of an ongoing process. We will monitor our progress and will need to keep renewing our focus and checking our priorities. There is already a lot going on. Let's do some more!

1. **Aim**

Prevention interventions aim to:

- Improve quality of life by creating and promoting health and wellbeing
- Reduce health inequalities
- Save our public services from the spiralling costs of treating avoidable illness and ongoing needs and improve the efficiency and wellbeing of the workforce.

This framework is to be used by all partners in Oxfordshire to embed “Prevention” in our services, our workforce and our planning.

The 3 main ways we will do this are:

1. Recognise that every individual and every organisation has a role in prevention. We want to develop those roles even further
2. Create healthy communities where people can maintain and improve their health as they live, learn, work, travel and socialise - where healthy choices are the easiest choices
3. Address the biggest risk factors causing preventable premature death or disease and soften the impact of existing disease

2. Definitions

Prevention can mean different things to different people. Defining what we mean is important to allow all partners to be aligned. We are using the definition set out here throughout this document and want it to become the **definition adopted throughout the county**.

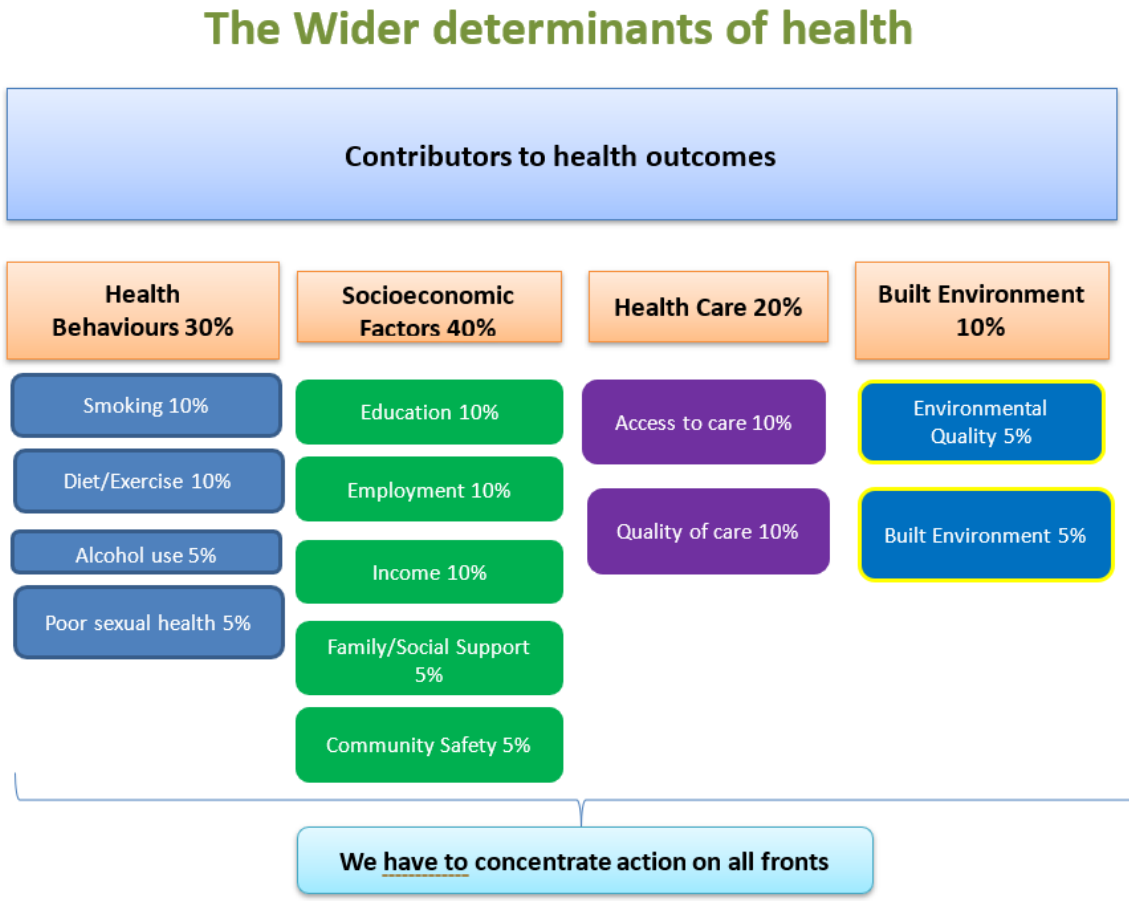
PREVENT illness	**REDUCE** the need for treatment	**DELAY** the need for care
Preventing illness and keeping people physically and mentally well, e.g. being active, breathing clean air, having social connections (**primary prevention)**	Reducing impact of an illness by early detection e.g. bowel screening/smear tests, and preventing recurrence e.g. lowering blood pressure or cholesterol to prevent another stroke (**secondary prevention)**	Soften the impact of an ongoing illness and keep people independent for longer (**tertiary prevention**)

Prevention can also be categorised according to the causes and influencers of poor health

Multiple factors influence health

- **Lifestyle factors/health behaviours**: particularly obesity, poor diet, lack of physical activity, smoking and alcohol
- **Socioeconomic factors:** including low income, social isolation
- **Health care factors:** detection and treatment of physical and mental health conditions (see Annex 4 for more detail on interventions)
- **Built environment:** such as green spaces, cycle lanes, air quality, housing quality, accessibility of services and facilities

Diagram 1: Marmot's wider determinants of health (The Marmot Review 2010)



Everyone has a role in this work – whether they are individuals managing their own health or organisations from every sector, shaping the living, learning or working environment or providing services for the population.

4. The Strategic Context

National Strategies setting out the imperative for increasing prevention work include:

- The Five Year Forward View for the NHS
- The Five Year Forward View for Mental Health
- The Five Year Forward View for Primary Care
- The NHS Long Term Plan (January 2019) and Implementation Framework (June 2019)
- The Care Act (2014)
- Advancing our Health: prevention in the 2020s. Green Paper published July 2019

Our local partnership strategies which embed this principle include:

- The Joint Health and Wellbeing Strategy (2019-24)
- The Children's Plan
- The Older People Strategy
- Oxfordshire Health Inequalities Commission report (2016)
- The agreed priorities of the Health Improvement Board
- Oxfordshire Mental Health Partnership
- Endorsed by Oxfordshire Growth Board for inclusion within strategic outputs including the Oxon Plan 2050, the Local Industrial Strategy and Local Transport and Connectivity Plan 5.

The **Health Inequalities** Commission recommended 5 principles for ensuring health inequalities issues are considered and addressed, which are worth repeating here:

1. The profound influence and impact of poverty on health needs to be widely recognised and systematically addressed
2. Commitment to prevention needs to be reflected in policies , resources and prioritization
3. Resource re-allocation will be needed to reduce inequalities
4. Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organizations
5. Data collection and utilization needs to be improved for effective monitoring of health inequalities

The **Integrated Care System (ICS) for Buckinghamshire, Oxfordshire and Berkshire West** are developing their 5 year plan as this framework is being finalised in Autumn 2019. The Guiding Principles for Prevention in that plan also contribute to the strategic context here. They are:

- **Strategic and Clinical Leadership** on prevention and inequalities needs to be identified and recognised in each organisation and ICS workstream.

- The whole system should adopt the steps **Prevent, Reduce, Delay** – as follows:
    - **PREVENT** illness. Preventing illness and keeping people physically and mentally well, e.g. being active, breathing clean air, having social connections. (**primary prevention)**
    - **REDUCE** the need for treatment. Reducing impact of an illness by early detection e.g. bowel screening/smear tests, and preventing recurrence e.g. lowering blood pressure or cholesterol to prevent another stroke. (**secondary prevention)**
- **DELAY** the need for care. Soften the impact of an ongoing illness and keep people independent for longer. (**tertiary prevention**)

    - It should be noted that the top risk factors set out in the NHS Long Term Plan are smoking, obesity, alcohol, air pollution, anti-microbial resistance and stronger NHS action on health inequalities. All will need to be addressed during the lifetime of this plan.

- **Everyone has a role in prevention**. Every part of the system and every workstream of the ICS is to identify priority areas and actions it can take.
    - As a minimum it is expected that in year 1 of this plan there will be improved outcomes for workforce wellbeing and for identification, intervention and referral for people who smoke or misuse alcohol.

- **Identify priority areas** for improving population health and addressing inequalities by using agreed and consistent evidence and methodology e.g population health management methodology.

- **Recognise and respond to the impact of socio-economic factors** (including housing and poverty) and the physical environment on health and the role of the wider system in prevention.

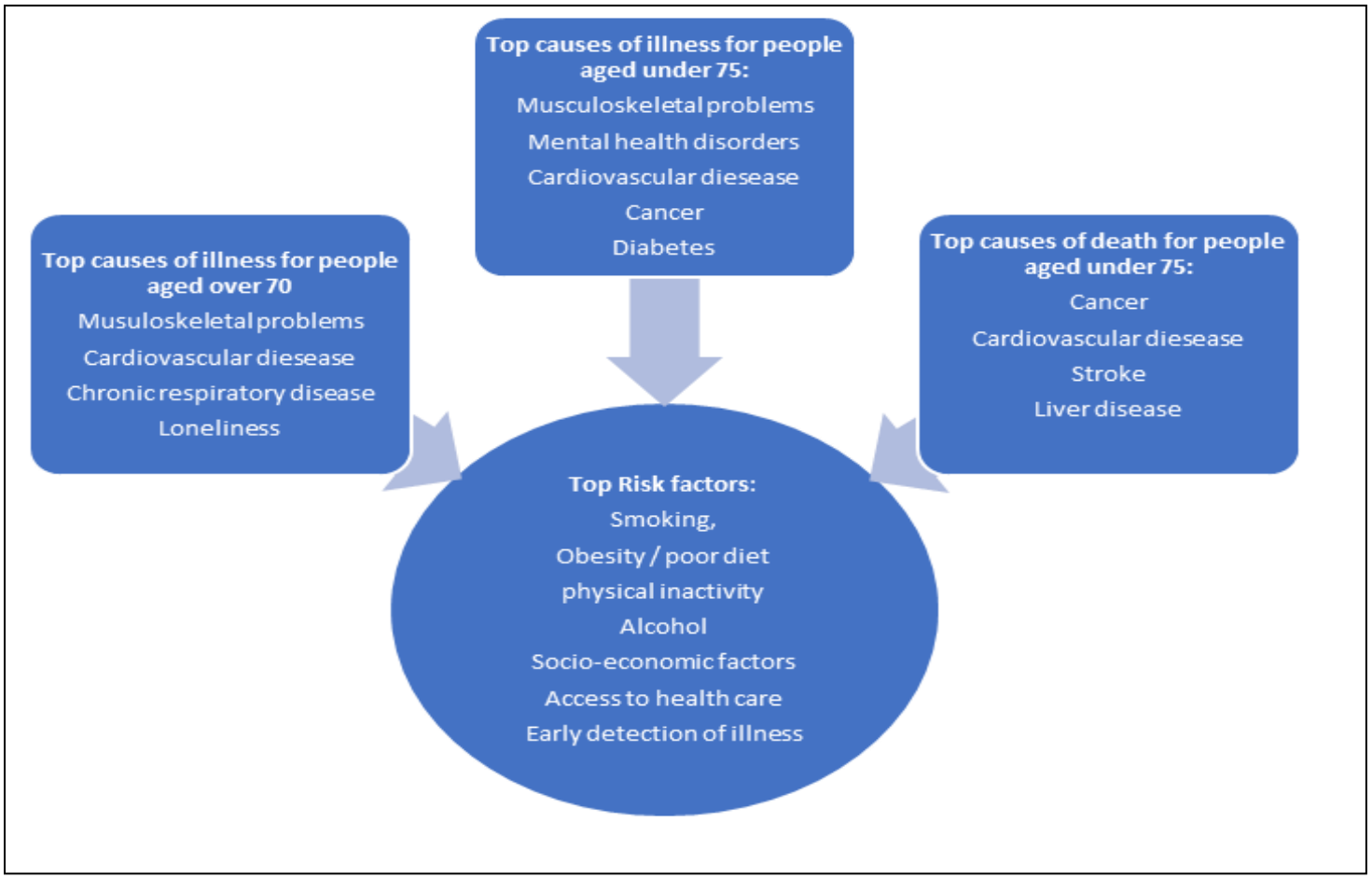
- Ensure that a system wide view is applied to decisions on **how all resources are allocated** to address prevention and inequalities priorities.

5. Health Needs in Oxfordshire

A detailed analysis of causes of death and disease in Oxfordshire has led to the conclusions summarised in the diagram below. Details from the analysis are included as Annex 1

The focus of the health needs analysis is on:

- **Premature death and premature ill-health** (those dying or ill aged under 75)
- **The top preventable causes** of premature death and ill-health (taken from Global Burden of Disease and Marmot's "Social determinants of Health")
- **High patient impact and high cost complications of preventable disease**
- **Health inequalities**
- **Causes of ill-health for people aged over 70**



Health Inequalities

Impact of Deprivation on health outcomes
There are much higher rates of premature death in some areas of Oxfordshire. For example, **there is a 15-year difference in life expectancy between the most and least deprived areas of Oxford City.**

In the same way that there is variation in death rates across the County, there is also variation in prevalence of diseases. For example, **people suffer from ill-health ten years earlier on average in the most deprived areas compared to the least deprived of Oxfordshire**. This is linked to multiple deprivation and differences between ethnic groups.

There are 7 wards which include smaller areas (super output areas) that are among the worst 20% for multiple deprivation in England. These wards are the most likely to have significantly worse outcomes for a wide range of indicators including life expectancy, disability-free life expectancy, obese children, emergency admissions and deaths from preventable diseases. The wards are:

- Banbury Grimsbury and Hightown (Cherwell)
- Banbury Ruscote (Cherwell)
- Barton and Sandhills (Oxford)
- Blackbird Leys (Oxford)
- Northfield Brook (Oxford)
- Rosehill and Iffley (Oxford)
- Abingdon Caldicott (Vale of White Horse)

Source: Basket of Inequalities Indicators, Oxfordshire JSNA
Details of the indicators for which these wards have significantly worse outcomes than the rest of Oxfordshire can be found here: https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202018%20ANNEX%20Inequalities%20Indicators%2012Apr18.pdf

Social and Economic factors affecting inequalities
Some aspects of deprivation relate to social and economic factors which also need to be addressed as part of a comprehensive approach to prevention as they have an impact on health outcomes. Housing and homelessness rank as one of the high priorities for addressing the wider determinants of health in Oxfordshire.

The JSNA summary of issues related to housing and homelessness in 2019 included:

- The cheapest market housing is over 10 times the lower earnings in each district in Oxfordshire
- Tenure estimates suggest that 26% of private dwellings in Oxfordshire were privately rented in 2017, up from 22% in 2012.
- The cost of renting privately in Oxfordshire remains well above the South East and national averages
- Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services. Areas with the highest risk of loneliness are in Cherwell (Banbury, Bicester Town); Oxford (Blackbird Leys, Wood Farm, Barton, St Clements, Jericho, Cowley) and South Oxfordshire (Didcot South)
- There has been a fall in the number of people in temporary accommodation
- The number of people sleeping rough has continued to rise

(Source: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment)

Population Groups - sex, age, minority communities

Inequalities are also visible between sexes, for people of different ages, for particular minority ethnic communities and others such as LGBTQ+ groups. It is important to explore these issues in planning prevention initiatives. The groups or areas affected will vary with the issues being addressed. The table below includes some headlines on inequalities affecting the population in Oxfordshire which link to our priorities.

Table: Specific examples of health inequalities across different groups and conditions

(Source: The NHS Long Term Plan and Oxfordshire Joint Strategic Needs Assessment, also see Annex 4 for more detail)

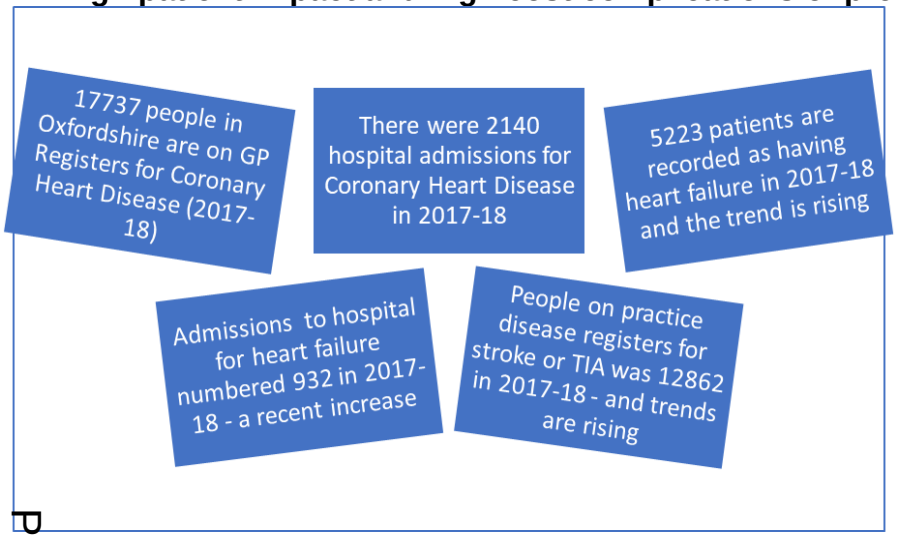
Cardiovascular disease and stroke	The largest cause of premature mortality in areas of deprivation
Respiratory disease	Increased incidence and mortality in areas of deprivation
Type 2 diabetes	The risk is up to six times higher in certain Black, Asian and Minority Ethnic (BAME) groups
Maternity	Women from the poorest backgrounds and mothers from Black, Asian and Minority Ethnic (BAME) groups are at higher risk of their baby dying in the womb or soon after birth.
Obesity	Higher prevalence of childhood obesity in areas of deprivation
Tooth decay	Higher in areas of deprivation

Physical activity	Less physical activity in women, with increasing age and in areas of deprivation
Physical health	Poorer outcomes if severe mental health problems, learning disabilities and autism
Use of emergency department	Higher from people from areas of deprivation
Healthcare access	Lower if housebound

Further detail on disease prevalence and death rates in Oxfordshire wards and GP practices can be found in The Basket of Inequalities Indicators, which is published as part of the Oxfordshire Joint Strategic Needs Assessment. Find it here: https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202018%20ANNEX%20Inequalities%20Indicators%2012Apr18.pdf

Targeting our prevention work will help to reduce this variation, using a Population Health Management approach. This is outlined in the outline of our approach to implementing the NHS Long Term Plan later in this document.

High patient impact and high cost complications of preventable disease



Source: PHE Fingertips https://fingertips.phe.org.uk/profile/general-practice

Source: SUS data. Commissioning Support Unit, July 2019

What are the priorities for Prevention in Oxfordshire?

We must address the biggest preventable risk factors causing premature death or disease. As we have seen above, there is a useful way to categorise the factors which affect health which was set out by Sir Michael Marmot

A. Lifestyle factors: particularly obesity, poor diet, lack of physical activity, smoking and alcohol
B. Built environment and Socioeconomic factors
C. Health care factors

This framework sets out each of these major factors in turn and uses the layout below to consider a range of issues in Oxfordshire. This approach aims to gives practical detail, setting out relevant information to galvanise action across the range of issues that have to be tackled.

A section on Mental Wellbeing is included first as this underpins every other topic in this framework.

<table>
<tr><th colspan="3">Name of the preventable risk factor</th></tr>
<tr><td>Describe the local challenge</td><td colspan="2">Set out what can be done (including as recommended by the Public Health England menu of preventive interventions and the NHS Long Term Plan)</td></tr>
<tr><td colspan="2">List what will be prevented if action is taken</td><td rowspan="2">Describe what is already in place (Assets and Enablers)</td></tr>
<tr><td colspan="2">Outline how will we know we are successful</td></tr>
</table>

The enabling effect of mental wellbeing in addressing these priorities

Mental Wellbeing is a key issue that needs to be highlighted here. Achieving a positive state of health, physical or mental, is highly reliant on having good mental wellbeing. If you are resilient and empowered you are better able to make positive lifestyle choices and better able to respond to adverse events. This means that work on all the initiatives outlined in this framework needs to be underpinned by our collective efforts to maximise mental wellbeing across the population.

"Mental Health" and "Mental Wellbeing" tend to be terms that are used interchangeably, when talking about a person's ability to cope with adversity and thrive in life. The following definitions give more clarity:

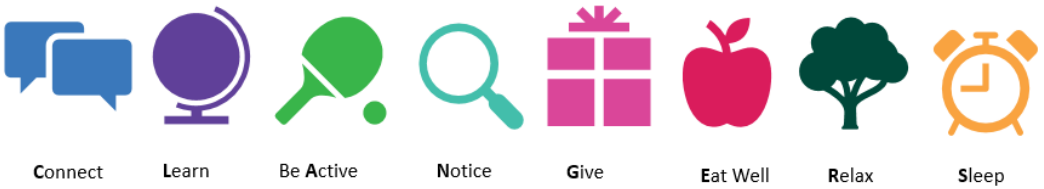
- **Mental ill-health** is concerned with disorders (such as depression, anxiety, schizophrenia, personality disorder) that are used to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions.
- **Mental Health: a state of wellbeing** in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.
- **Mental wellbeing** can be understood as how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole.

Since the mid-1990s academics have studied mental health in a more positive way, looking at what conditions create positive mental wellbeing. Based on these theories and models, the New Economic Foundation (NEF) in 2012 formulated the Five Ways to Wellbeing. This approach has been adopted nationally by MIND and is recognised by many.

In Dr Phil Hammond's book "Staying Alive" (2015), this concept was added to and perhaps been made more memorable. CLANGERS, is made up of the 5 Ways to Wellbeing plus Eat Healthily, Relax and Sleep. The elements of both these models are illustrated below:

Five Ways to Wellbeing

CLANGERS: Connect, keep Learning, be Active, take Notice, Give, Eat Well, Relax and Sleep



Topic: Mental Wellbeing

What is the challenge?

Achieving a positive state of health, physical or mental, is highly reliant on having good mental wellbeing. If you are resilient and empowered you are better able to make positive lifestyle choices and better able to respond to adverse events.

Measuring wellbeing is difficult so national survey figures are used. The data presents annual estimates of personal well-being on a rolling quarterly basis. These estimates provide a timelier picture of how the UK population are feeling and allows us to monitor how well-being is changing in the UK more frequently.

However, this is a very high-level indicator and will not show whether local work is having an impact on local people. Therefore it is also recommended that we also report on activity for other local outcomes to supplement this.

Consensus Statements from PHE Prevention Concordat for Better Mental Health

- To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focussed leadership and action throughout the mental health system; and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.
- There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equality.
- We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.
- We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of limited resources.
- We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, as outlined in the Public Mental Health Leadership and Workforce Development Framework Call to Action.
- We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.
- We are committed to supporting local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers and the voluntary and community sector to adopt this Concordat and its approach.

Definitions related to prevention – what are we trying to do?

Mental ill-health is concerned with disorders (such as depression, anxiety, schizophrenia, personality disorder) that are used to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions.

Mental Health: a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Mental wellbeing can be understood as how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole.

There are two schools of thought about the relationship between mental health and mental wellbeing. The first is that mental wellbeing is on a continuum with mental wellbeing at one end, leading through to mental ill health at the other. The second, is that mental wellbeing is entirely separate from mental health, though there is a relationship between the two. The Health

What is already in place? (Assets and Enablers)

- Many partners have already signed up to the Mental Health Prevention Concordat and pledged to do more to create and sustain mental wellbeing in their workforce and in the population by agreeing to the Consensus Statements above.
- Recognition and promotion of 5 Ways to Wellbeing across the county.
- A vibrant and proactive voluntary sector who support wellbeing across

Improvement Board has adopted the understanding of mental wellbeing as being separate to mental health. This means that promoting mental wellbeing is a universal approach.	the county. • Talking Space to help people with mild to moderate mental health problems such as anxiety and depression. By referral or self-referral. • Community Asset Based Development approaches embedded in our Healthy Place Shaping work
How will we know we are successful? The Mental Wellbeing Framework needs to include a range of measures which can be used at population level to monitor mental wellbeing. This is an area for development. Reference to the 5 Ways to Wellbeing or CLANGERS will enable some measurement.	

Recommendations

- The Mental Wellbeing Framework for Oxfordshire should set out comprehensive plans to create, promote and sustain mental wellbeing for all ages. Following up from signing the Prevention Concordat,
    a. Organisations need to show that they intend to continue to promote and support mental health and wellbeing.
    b. Organisations promoting the adoption of these principles will make a public statement that this is what they are and will be doing to tackle mental health.
    c. Sign off and ongoing leadership from the Health and Wellbeing Board
    d. Nominate a mental health champion, ideally for each organisation
- Review what is covered in the NHS Health Check with a view to adding a mental health element
- Health Inequalities must be addressed with a focus on communities with poorer health and wellbeing outcomes
- Implementation of the Mental Health Support Teams in schools and promoting 'whole school working'

A Lifestyle factors

Our analysis of local prevention priorities has given us a short list of lifestyle factors that have a big impact on health. These will be outlined in turn:

- Obesity
- Alcohol
- Smoking
- Physical inactivity

As stated above, all this work needs to be underpinned by creating and promoting Mental Wellbeing in the population.

Topic: Obesity

What is the local challenge?

- An estimated 55% of people aged 16 or over in Oxfordshire are classified as overweight or obese. (JSNA) These figures are taken from survey data so it isn't possible to show if some areas have higher prevalence.
- Data from the National Child Measurement Programme (2017-18) shows a similar level of obesity in younger children (aged 4-5 years) as last year in Oxfordshire (7.3%) and a slight increase in obesity of children aged 10-11.(16.3%). There is great variation linked to deprivation, with the ward of Littlemore having the highest percentage of obese children in the county (28.2%) and other deprived wards being significantly worse than Oxfordshire too.
- In the 2016/17 academic year, a measure of prevalence of severe obesity was introduced. In 2017-18, around 180 (2.7%) children were severely obese – lower than the year before. Levels were highest in Oxford City.

Evidence based recommendations from PHE and the NHS Long Term Plan

- **Tackle the obesogenic environment**. CCGs and local authorities work together to support healthier food and drink choices, increase physical activity opportunities and reduce sedentary behaviour and access to energy dense food and drinks
- **Implement Government Buying Standards for food and catering services (GBSF)** across a range of public settings and facilitate the uptake of nutrition policy tools. CCGs and local authorities to require providers to do this and promote consistency across hospital and health settings and local businesses
- **Make every contact count**. Health and care professionals empower healthier lifestyle choices and improve access by sign posting to relevant and appropriate obesity services supported by All Our Health.
- **Weight management services:** CCGs and local authorities to ensure there are evidence-based services accessible to their local population through commissioning together across the obesity pathway and that these are robustly evaluated
- **Integrate weight management and mental health services and/or with learning disabilities**. CCGs and local authorities work together with providers to enable access into appropriate community and clinical obesity services for these individuals
- **National Diabetes Prevention Programme: access to be doubled** (NHS LTP)

What will be prevented?

Reduce the risk of a wide range of long-term diseases, principally type 2 diabetes, hypertension, cardiovascular disease, stroke and some cancers (including being three times more likely to develop colon cancer)

How will we know we are successful?

Prevalence of obesity in the population will be reduced. Increase in prevalence of type 2 diabetes will slow down

What is already in place? (Assets and Enablers)

- **Healthy Place Shaping Principles** – endorsed by the Growth Board, included in the Joint HWB Strategy
- **Whole System Approach to Healthy Weight**– led by Health Improvement Board
- **Achieve Weight Loss service** commissioned by Public Health enabling access to Slimming World, Weight Watchers, Man v Fat and tier 2 support
- **National Diabetes Prevention Programme**
- **NHS Health Checks** with good levels of take-up across the county. Checks include Body Mass Index.
- **Making Every Contact Count** local training and also requirement SC8 in the NHS Standard Contract
- **Here for Health** offering advice and support to patients, relatives and staff at OUH hospitals
- **Sugar Smart initiatives** to encourage sale and demand for sugar-free alternatives

Recommendations

- **Healthy Place Shaping principles to be embedded** in Oxfordshire 2050 and embedded in the Growth Agenda. This will tackle the "obesogenic environment"
- **Commission joined up services for obesity treatment:** A review of weight management services in 2017 concluded that tier 3 services (providing specialist psycho-social support for people with BMI 40+ who do not want bariatric surgery) should be developed.
- **Integrate weight management and mental health services and/or with learning disabilities**
- **Whole System Approach to Healthy Weight** to be fully developed (it is currently in early stages), Sugar Smart and MECC to be rolled out more widely.
- **Capacity of National Diabetes Prevention programme to be doubled** (as set out in the NHS Long Term Plan)
- **Implement Government Buying Standards for food and catering services (GBSF)**

Topic: Alcohol

What is the local challenge?

- Hospital admissions for alcohol attributable conditions were significantly worse than the England average in 6 wards in Oxford City
- National figures indicate that 20% of the population may be drinking at levels which are harmful to health. A further 4% are at increased risk of ill health because of their alcohol consumption and another 1% are classified as dependent drinkers. Many people in these groups may be among the 17% of the population who binge drink – that is having at least double the recommended maximum in one session.
- It is estimated that over 86% of people who would benefit from treatment for harmful and hazardous drinking are not known to services

Evidence based recommendations from PHE and the NHS Long Term Plan

- Alcohol focussed identification and brief advice (IBA) in **primary care** including increasing screening of patients (using Audit-C scratch cards); providing brief advice on alcohol consumption to cover potential harm and strategies to reduce alcohol intake; referral for specialist treatment where relevant. This can be facilitated in primary care by ensuring effective delivery within NHS Health Check
- Alcohol care teams (ACT) in **secondary care** along with training for healthcare staff on screening, and brief advice (refer to the associated national CQUIN). Work should also incorporate comprehensive alcohol use assessments, Care planning, Delivering medically assisted alcohol withdrawal management and psychotherapeutic interventions when appropriate, Planning safe, accelerated discharge and continued alcohol treatment in community services (note: alcohol assertive outreach teams should be considered as a complementary intervention)

What will be prevented?

Alcohol misuse contributes significantly to 48 health conditions, wholly or partially, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, cancers, depression and accidental injuries. Risk of ill health increases exponentially as regular consumption levels increase. Most of these harms are preventable

How will we know we are successful?

Reduction in alcohol attributable hospital admissions
Reduction in A&E attendance for alcohol related injury or ill health
Reduction in estimated unmet need for services to alcohol users
Community safety and social factors improved.

What is already in place? (Assets and Enablers)

- Alcohol Partnership and the Alcohol and Drugs Strategy
- Alcohol treatment services through Turning Point - rated Outstanding by CQC (2019)
- Preventing ill health - alcohol and tobacco CQUIN for 2017-19,
- Making Every Contact Count local training and MECC requirement SC8 in the NHS Standard Contract
- NHS Health Checks with good levels of take-up across the county. Checks include AUDIT to assess risk of harm from drinking alcohol.
- Identification and Brief Advice Training commissioned by Public Health for a range of organisations
- Community Safety Practitioner based in A&E – following up all patients who attend due to alcohol use
- Here for Health offering advice and support to patients, relatives and staff at OUH hospitals
- Access to Self help for all levels of alcohol users - including Drink Coach app
- Successful capital bid for improvements to alcohol clinics.
- Licensing policy and enforcement by District Councils
- Health Promotion about the impact of drinking on health in schools and colleges

Recommendations

- Revise and articulate a joint ambition for addressing alcohol related harm across the partnership
- The Alcohol Care Team (ACT) in the hospital trust is expanded to cover more in-patient departments and funding is sustained. Further training in Fibrosis scanning to enable ACT and others to assess alcohol related liver damage early.
- The Community Safety Practitioner service in the Emergency Dept is increased in capacity to work with the ACT and other services.
- Identification and Brief Advice / referrals in primary care are increased.
- Offer alternative access points for alcohol services to increase accessibility to the whole population, including those drinking at harmful but not hazardous levels.

Topic: Smoking

What is the local challenge?

In 2018 an estimated 10.1% of adults in Oxfordshire were smokers (down from 15.5% in 2015), this equates to 54,804 residents. Whilst there has been an overall decline in smoking locally, some groups within the population are being left behind. For example:

- *Smoking prevalence in adults in routine and manual occupations was estimated at 17% in Oxfordshire*
- *Smoking at time of delivery (i.e. during pregnancy) in Oxfordshire has reduced to 7.8%, remaining below the England average however 513 residents remained smokers.*
- *Smoking prevalence in adults with a long term mental health condition was estimated at 23.4%*

Evidence based recommendations from PHE and the NHS Long Term Plan

- Provide screening, advice and referral in secondary care settings. Secondary care providers to provide screening, advice and referral in acute and mental health trusts, and ensure that the care plan at discharge of patients who smoke addresses their tobacco dependence
- Trusts to implement NICE guidance PH45 "Smoking: Harm reduction". Trusts to provide support for temporary abstinence for smokers unready to stop smoking completely or permanently. May include cutting down to quit and long-term nicotine use to prevent relapse to smoking.
- Assess all pregnant women for carbon monoxide to identify potential smoking and refer for specialist support. Healthcare professionals screen all pregnant women at ante-natal appointments and refer women with elevated levels to specialist services.
- All mental health trusts to have smokefree buildings and grounds with staff trained to facilitate smoke cessation. CCGs require acute trusts to implement smokefree policies on estate grounds and support staff to encourage compliance with the policy

What will be prevented?

Smoking causes cancers, circulatory disease, respiratory disease and premature labour (leading to high neonatal intensive care unit costs) as well as impotence and infertility. Smokers that manage to quit reduce their lifetime cost to the NHS and social care providers by 48%.

How will we know we are successful?

- Reduction in smoking prevalence, especially in routine and manual groups
- Reduction in smoking at time of delivery

What is already in place? (Assets and Enablers)

- Smokefreelife Oxfordshire, a specialist stop smoking service commissioned by Public Health, targeting routine and manual smokers, pregnant women, living with a long-term condition and mental ill-health
- NHS Health Checks with good levels of take-up across the county. Checks include smoking status
- Tobacco Control Alliance with clear priorities following a peer led assessment process.
- Preventing ill health - alcohol and tobacco CQUIN for 2017-19
- Making Every Contact Count local training and requirement SC8 in the NHS Standard Contract
- Here for Health offering advice and support to patients, relatives and staff at OUH hospitals
- Integrated Respiratory Team project using a Population Health Management Approach to reduce the impact of respiratory conditions.

Recommendations

- Adopt and implement the recommendations in the NHS Long Term Plan
  - **a.** By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
  - **b.** A new smoke-free pregnancy pathway including focused sessions and treatments
- A universal smoking cessation offer as part of specialist mental health services, and in learning disability services
- Develop a Tobacco Control Plan for Oxfordshire
- All workplace sites to actively promote and support being smoke free environments with support in place for them to effectively achieve this

Topic: Physical Inactivity

What is the local challenge?

- There are 105,700 physically inactive people in Oxfordshire (May 2018) - 19.1% of adult population of Oxfordshire
- Only 21.2% of children and young people in Oxfordshire meet the recommendations for 60 mins of activity a day. 29.5% are considered "less active" - doing less than 30 mins per day.

Evidence based recommendations from PHE and the NHS Long Term Plan

- Healthcare professionals to deliver effective brief advice on the benefits of physical activity. Invest in raising skills and knowledge of healthcare professionals such as the PHE Clinical Champions Programme
- NICE guidance on "Physical Activity: encouraging activity in the community" – local authorities and healthcare commissioning groups have senior level physical activity champions who are responsible for developing and implement local strategies, policies and plans.
- Increase active travel for staff, patients and local population. Influence strategic plans and Develop travel plans with supporting local activation to get staff, patients and the local population to walk and cycle
- CCGs and local authorities to invest in evidence-based exercise programmes for patients. For example, providing exercise referral schemes where patients receive supervised support by trained professionals
- Adopt and promote PHE's campaigns. Partners to draw on Start4Life, Change4Life and One You campaigns.
- Local authorities to encourage employers through Chamber of Commerce and NHS procurement levers to participate in local workplace health accreditation schemes such as the Better Health and Work Award, Workplace Wellbeing Charter and Mindful Employer Charter to put in place a structured, evidence-based approach to employee health and wellbeing.
- NICE guidance on physical activity interventions published June 2019

What will be prevented?

Physical activity can reduce the risk and help the management of over 20 long-term conditions. It is an independent risk factor (not just linked to obesity).

How will we know we are successful?

Percentage of adults considered inactive to decrease
Percentage of young people considered fully active to increase.
Percentage active journeys (cycling, walking) to increase

What is already in place? (Assets and Enablers)

- Active Oxfordshire – the physical activity and sports partnership for the County
- Healthy Place Shaping – active travel and access to green spaces
- Community Safety partnerships enabling confidence that open spaces are safe
- Leisure Services, Parks and Green spaces provided by District Councils
- Making Every Contact Count local training and also a requirement in NHS Standard Contract
- Five Ways to Wellbeing includes physical activity.
- NHS Health Checks with good levels of take-up across the county. Checks include levels of physical activity
- Community groups, local sports clubs and voluntary organisations across the county
- Moving Medicine in some hospital wards and Here for Health to encourage physical activity for patients.

Recommendations

- Increase knowledge and capabilities of the Health Care Professional network across Oxfordshire through MECC, social prescribing pathways and training/development programmes around Moving Medicine for primary and secondary practitioners.
- Co-ordinated local and national campaigning to promote active lifestyles and raise levels of health literacy.
- Work together to target parents & children who are inactive e.g. FAST – families active, sporting together
- Joined up collaboration and investment in working together in the community to reach and engage people with health conditions, at-risk groups and older people.
- Work with local government and OXLEP to encourage business investment that will provide a range of local work opportunities that enable active travel
- Targeted funding for people with or at risk of long- term health conditions (including mental health) to provide activity and exercise in prevention / treatment pathways.
- Focus investment and layered interventions to create healthier communities in existing places of clearly identified need and address inequalities.
- Promote active travel and active design to help make walking and cycling part of everyday life as part of Oxfordshire's Growth Agenda
- Promotion of PE Pupil premium to schools to enable schools and nurseries to be active learning environments and adopt the Daily Mile, Walking to School etc.
- Promotion of workplace health and well- being targeting major employers with good numbers of low socio economic workers

B. Socioeconomic factors and the Built Environment

In our summary of the factors which determine health it is stated that socio-economic factors such as education, employment, income, family and social support and community safety have a big impact on health. These factors also need to be addressed in any effort to prevent ill health and address inequalities in health outcomes for the population. When we also add the impact of the built environment and environmental quality these factors make up 50% of the impact on health. This is especially important in the context of a fast-growing economy and plans for new housing developments – we need to make sure Growth is Inclusive and health improving.

The diagram below is taken from the publication "Place Based Approaches for Reducing Health Inequalities" by Public Health England (PHE), the Association of Directors of Public Health and the Local Government Association. This sets out a very useful model showing the equal importance of Civic-led, Community Centred and Service Based interventions. Together these have been shown to have an impact on Place-Based planning for reducing health inequalities and can be applied to prevention initiatives.

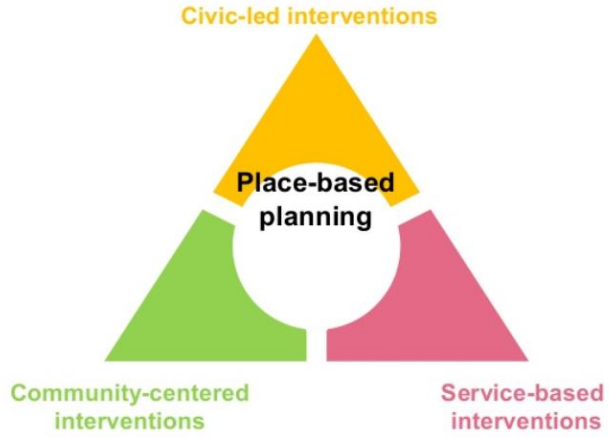
Civic-led interventions: focus on the wide-ranging policy actions that impact populations

Community-centred interventions: focus on place and shared identity. They centre on community life, social connections and ensuring people have a voice in local decision-making

Service-based interventions: focus on services, in particular addressing unwarranted variability in quality, delivery and use.

Deliberate joint working between the civic, service and community sectors can help the whole be more than the sum of its parts.

The **Civic-led interventions** include the work of both national and local government. The national policy framework for our work is set out in the framework, but here we will focus on the role of local government in addressing the socio-economic factors which affect health.



In the **Community-centred interventions** from the model above, the role of voluntary and community sector is vital. Oxfordshire has a vibrant and thriving Voluntary and Community sector (VCS) and their invaluable contribution to prevention is acknowledged. Small local groups and county wide / national charities all play a vital role. Some are commissioned by the public sector and many provide additional resources, adding value, engaging professionals and volunteers and bringing expertise to countless initiatives. They have a major role to play in promoting Mental Wellbeing. They support people of all ages and are responsive to local need. Their role in this work is essential and the support they need has to be considered if this 3 strand model is to be robust. There are many examples of community centred interventions which address socio-economic factors e.g. mentoring and befriending schemes, support for new parents, advice centres, car sharing schemes etc.

Service-based interventions include ensuring good access for everyone. The services in scope for reducing inequalities and promoting prevention are not just within the NHS. From a very wide range of services, some examples that impact socio-economic factors include Personal, Social and Health and Economic Education (PSHE) in Schools, workplace wellbeing schemes, unemployment services, social prescribing etc.

Our local authority system in Oxfordshire means that different services are provided by different authorities, as set out in the table below**.**

Oxfordshire County Council	**Cherwell, Oxford City, South Oxfordshire, Vale of White Horse and West Oxfordshire District Councils**	**Town and Parish Councils** **responsibilities may include:**
• Education • Transport • Planning • Public health • Fire and Rescue / Public Safety • Social care • Libraries • Waste management • Trading standards • Cultural services e.g museums, music, arts.	• Rubbish collection • Recycling • Council Tax collections • Housing • Planning applications • Environmental health • Leisure and sport • Community development • Economic development • Development and maintenance of green spaces	• Allotments • Bus shelters • Community centres • Play areas and play equipment • Grants to help local organisations • Consultation on neighbourhood planning • Levying fines for litter, graffiti, dog offences

Source: Local Government Association / District Councils' Network "Shaping Healthy Places, exploring the district council role in health" February 2019

What do we need to do?

We need to create healthy communities where people can maintain and improve their health as they live, learn, work, travel and socialise.

The needs of the population vary and therefore the best approach to addressing socio-economic factors is to work locally, focussing on particular issues that are highlighted as important needs or on particular places to give a holistic approach. Three areas of work are outlined in the following tables

1. Healthy Place Shaping
2. Social isolation and loneliness
3. Low Income and Debt
4. Healthy Homes, Healthy People

1. Built environment - Healthy place shaping

The pioneering work of the Healthy New Towns in Bicester and Barton have produced valuable learning that can be applied elsewhere. As part of a national pilot scheme funded by the NHS they have shown that planning a healthy environment, working with the local community and designing health services for a particular place can have a positive impact on health.

This is why our priority is Healthy Place Shaping. This is an approach that has been adopted by the Oxfordshire Growth Board and the Safer Oxfordshire Partnership as well through the Joint Health and Wellbeing Strategy (2019-24).

There are different types of communities where the work of preventing ill health can be focussed. These include:

- Residential housing – both new and existing. Healthy Place Shaping seeks to ensure that new and existing housing developments in Oxfordshire will promote health, enable active travel, support community activation and provide access to green space, cultural and heritage and community facilities (among other things!). It is crucial to create healthy communities in this era of housing growth and apply the principles to existing areas too. These principles can be designed in.

- Access to green spaces and the natural environment are fundamental to both individual wellbeing and planetary health. Investment is required to develop and maintain green spaces so that they feel safe, are attractive to people of all ages, and promote biodiversity.

- Workplaces are communities where prevention can be developed. This is not only in terms of health and safety and reduction of occupational hazards, but also in promoting health and wellbeing of the workforce.

- School communities and Early Years settings are already doing a lot to keep children and young people healthy and are an ideal setting for this. Sharing experiences between schools and adopting good practice is a way to keep the momentum going and investment is required to build their capacity to sustain this work.

- Communities where people can meet, socialise, share interests and look out for each other are also health enabling. These are sometimes in a particular place but may also be groups of people with shared interests. Social prescribing can help people get involved who might otherwise be lonely, lack confidence or are otherwise unsure how to access services and participate in local activities.

Topic: Healthy Place Shaping

What is the local challenge?

To use Healthy Place Shaping as a practical mechanism for creating healthier communities. This has been defined as follows:

"Healthy Place Shaping is a collaborative process which aims to create sustainable, well-designed communities where healthy behaviours are the norm and which provide a sense of belonging and safety, a sense of identity and a sense of community.

It is also a means of shaping local services, infrastructure and the economy through the application of knowledge about what creates good health, improves productivity and benefits the economy, thus providing efficiencies for the tax-payer."

What will work to meet this challenge?

Local learning from the Healthy New Towns in Bicester and Barton along with the other 8 demonstrator sites has been published. https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/

The Government has recently issued planning guidance (in June 2019) to improve housing provision for older people in order to keep older people active, well and independent for longer see https://www.gov.uk/guidance/housing-for-older-and-disabled-people

What will be prevented?

- Physical inactivity and the results of inactive lifestyles which include a range of preventable diseases
- Loneliness and poor mental wellbeing
- Poor productivity
- Air pollution
- Crime and community safety issues

How will we know we are successful?

- Healthy Place Shaping principles will be embedded in planning policy and processes
- Increased active travel
- Enhanced Community development and social networks
- Improvements in a range of health and wellbeing indicators

What is already in place? (Assets and Enablers)

- Healthy New Towns in Bicester and Barton
- The Growth Deal in Oxfordshire and the sign-up of the Growth Board to the principles of Healthy Place Shaping
- Embedding the principles of Healthy Place Shaping in the Joint Strategic Spatial Plan (currently being drafted for consultation) and other Growth Deal policy documents.
- Local government services
- Evaluation being conducted to determine impact and change in deprived communities in Bicester, Kidlington and Banbury (Sport England)

Recommendations

- Sustain healthy place shaping as a county wide strategic priority and work with district councils to ensure that it is reflected in their business plans and service delivery
- Public health to work closely with colleagues in planning, transport and highways so that Local Plans and transport policies reflect good practice, address local health needs and align with healthy place shaping principles
- Invest in the capacity of the third sector to increase community capacity and support social cohesion
- Workforce wellbeing and skills development to be promoted through Oxfordshire's Local Industrial Strategy and District Industrial/economic strategies so that economic development in the county supports inclusive growth
- Support good practice in the stewardship of green and blue spaces, with investment to increase their attractiveness to people of all ages and to sustain their biodiversity
- NHS providers and commissioners to engage with place based approaches to promoting health and wellbeing and to ensure that our health estates reflect new models of care
- Social prescribing. Encourage referrals to social prescribing schemes and evaluate and share learning of different approaches across the county.
- Commissioning of new schools to include criteria which embed healthy place shaping principles and invest in the capacity of education providers to follow good practice in developing and sustaining healthy behaviours

Topic: Social Isolation / Loneliness

What is the local challenge?

- An estimated 20,400 people in Oxfordshire experience loneliness at least some of the time, with at least 3,500 experiencing loneliness 'often or always'. They are likely to be of all ages and include people new to Oxfordshire or in insecure housing.
- In a wide ranging consultation on developing the Older People Strategy for Oxfordshire, the key findings showed that the 4 most important issues for people as they grow older were Loneliness and isolation, Keeping active and healthy , Access to services, Planning and lifestyle
- Loneliness and isolation are not only experienced by those living alone but also by others, including those who have become carers
- National studies have found that, aside from age, several other factors are associated with loneliness. These include living alone, never being married, widowhood, support network type, poor health, cognitive impairment or poor mental health.
- ONS Measuring National Well-being (2018) shows that in 2017-18, 8% of 25 - 34 year olds reported feeling lonely often or all of the time, compared to 5% of 50 - 64 year olds and 3% of 65 – 74 year olds. These proportions remain constant since 2013 - 14

What works to meet this challenge?

The Campaign to End Loneliness and Age UK have developed a framework to tackle loneliness. The framework features four distinct categories of intervention that could be put in place to provide a comprehensive local system of services to prevent and alleviate loneliness:

Foundation Services that reach lonely individuals and understand their specific circumstances to help them find the right support.

Gateway Services like transport and technology that act as the glue that keeps people active and engaged and makes it possible for communities to come together.

Direct Interventions that maintain existing relationships and enable new connections – either group-based or one to-one support, as well as emotional support services.

In developing these services, commissioners should consider what **Structural Enablers** are needed in their communities to create the right conditions for ending loneliness, such as volunteering, positive ageing and neighbourhood approaches.

What will be prevented?

Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services.

- Loneliness can be as harmful for our health as smoking 15 cigarettes a day1.
- Lonely individuals more likely to visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term health care2

How will we know we are successful?

There will be reduced levels of people reporting that they experience loneliness 'often or always'

What is already in place? (Assets and Enablers)

- Older people strategy with a strategic priority to reduce loneliness.
- A partnership of organisations including Active Oxfordshire, Age UK Oxfordshire, Archway, Oxfordshire Mind, Oxfordshire Youth, Oxfordshire Community Foundation and OSAB are working together to alleviate loneliness
- Leisure, sport, arts and creative activities in our communities - keeping active was cited by respondents to a consultation on the Older People Strategy as a way of remaining socially connected and avoiding loneliness
- Vibrant and proactive voluntary and community sector organisations who provide a range of befriending and volunteering opportunities.
- Recognition and promotion of 5 ways to wellbeing across the county
- An approach to Healthy Place Shaping which includes community activation and community asset based approaches including through local assets such as libraries.
- Age Friendly Banbury, Age Friendly Oxford, Healthy Abingdon and other local initiatives

Recommendations

- To implement the Older People Strategy priority to reduce loneliness
- Ensure that Healthy Place Shaping is embedded in the Growth Deal and Health and Wellbeing Strategy (see above)
- To learn from the summit on Loneliness to be held in October 2019 and take forward priorities in partnership.
- Support the development of Age Friendly Communities across Oxfordshire.
- Review what is covered in an NHS Health Check with a view to increasing the range of health and care advice that the checks can offer.

Topic: Low Income and Debt

What is the local challenge?

- Estimates of annual household income (after housing costs) for small areas in Oxfordshire show a wide variation across the county from £49,200 in the Shiplake/Highmoor area of South Oxfordshire (rural area outside Henley-on-Thames) to £23,100 in part of Blackbird Leys ward, Oxford
- As of May 2018 there were 12,320 claimants of Employment and Support Allowance (for people where illness and disability affects ability to work) in Oxfordshire. Over half of these people have a primary condition of mental and behavioural disorder.
- More people are seeking advice on financial matters, either because of low income, debt, gambling or gaps in knowledge about entitlement to benefits. The switch to Universal Credit has also had an impact for some people.
- Money worries are shown to have a negative impact on mental wellbeing and overall health.

The 2019 Green Paper "Advancing Our Health: Prevention in the 2020s" states

"We need to lay the foundations for good mental health across all parts of our society. This is because the circumstances we're born into – and the conditions in which we live – all have a major bearing on our mental health. We need to take urgent action to tackle the **risk factors** that can lead to poor mental health, such as adverse childhood events, violence, poverty, problem debt, housing insecurity, social isolation, bullying and discrimination. We also need to **invest in the protective factors** that can act as a strong foundation for good mental health throughout our lives, such as strong attachments in childhood, living in a safe and secure home, access to good quality green spaces, security of income, and a strong set of social connections."

What will be prevented?

- Mental ill health related to debt / low income
- Insecure housing tenure due to rent arrears
- Food and fuel poverty

How will we know we are successful?

Variation in household income across the county will reduce
The number of children deemed to be living in poverty will fall
Local monitoring of advice centres, food banks will be needed.

What is already in place? (Assets and Enablers)

- Advice services and Advice Centres including Citizens Advice, Mind, Age UK, MacMillan and local neighbourhood centres around the county
- Benefits in Practice initiative which enables people to access advice in some GP practices. Work is also underway to find out whether this also results in tangible health improvement, including reduced demand on health services.
- Food banks and community cupboards
- Oxfordshire Industrial Strategy, setting out the case for tackling inequalities and improving life chances for everyone by promoting Inclusive Growth.
- Health Inequalities Commission Implementation Group, reporting to the HWB
- Oxfordshire's economic activity rate remains significantly above the England average. Residents are counted as economically active if they are employed, self-employed or unemployed. This excludes people who are retired, looking after home/family or full time students. The rate is calculated as a proportion of the working age population.

Recommendations

- Ensure good access to debt and benefits advice is developed and sustained
- Monitor feedback from organisations such as food banks, advice centres etc on the pressures faced by residents and respond by adjusting services as needed.
- Complete and report the evaluation of benefits advice services, showing any impact of increasing income on health improvement
- Join up the effort to help people who experience money problems across the health and care system.
- Work with OXLEP and district economic development teams to support skills development, career progression, and flexible working patterns in local employers and to ensure Inclusive Growth across the county.
- Maintain awareness of NHS initiatives to commission specialist help for people with serious gambling problems as set out in the Long Term Plan and work together to tackle the problem at source

Topic: Better Housing, Better Health

What is the local challenge?

Living in poor quality inaccessible homes, whether owned or rented, has a detrimental impact on older people's physical and mental wellbeing, according to the All Party Parliamentary Group for Ageing and Older People.

Housing conditions, including cold and damp, affect health and wellbeing. People with long term conditions, especially respiratory disease, will be adversely affected by poor living conditions. Improvement in the quality of their accommodation will enable prevention of ill health and enable them to recover from bouts of sickness.

The current challenge in Oxfordshire includes a lack of join up between health and social care services and the agencies who can improve living conditions for people most at risk. Help is available to replace old boilers, repair windows, install cavity wall and loft insulation, install heating controls and make onward referrals on to other sources of financial and social support. Appropriate referrals from health and social care services will make the most of this work.

What works to meet this challenge?

Housing investment which improves thermal comfort in the home can lead to health improvements, especially where the improvements are targeted at those with inadequate warmth and those with chronic respiratory disease. Best available evidence indicates that housing which is an appropriate size for the householders and is affordable to heat is linked to improved health and may promote improved social relationships within and beyond the household. (*Cochrane 2013*)

What will be prevented?

Emergency and unplanned admissions, particularly during the winter months, due to heart attacks, stroke, COPD/asthma

How will we know we are successful?

- Reduction in fuel poverty
- Downward trend in excess winter deaths
- Fewer cold homes with excess damp and mould growth
- Annual formal reporting of Quality Standard 117
- More referrals to the "single point of contact" for Better Housing Better Health

What is already in place? (Assets and Enablers)

- Oxfordshire Councils oversee and fund the NICE recommended "single point of contact" referral hub Better Housing Better Health (BHBH) in order for clinicians and residents to access support to repair and maintain their homes. BHBH can navigate funding sources from energy company schemes and the grants and loans provided by the District Councils to help residents improve their homes.
- There is a "placeholder" on EMIS for cold homes for GPs to refer to BHBH on line.
- There is an EMIS code for housing advice so it is possible to search for patients who have received advice.
- Some links are being made with the community respiratory team and
- Awareness is being raised via screens in GP practice waiting rooms to encourage self referral.
- Fire and Rescue Community Wardens project and Safe and Well visits incorporating Making Every Contact Count

Recommendations

- Request reports to the Health and Wellbeing board on Quality Standard (QS117) which will include numbers of people who have been screened due to risks from cold homes and referred to the Single Point of Contact for Better Homes, Better Health.
- Establish working links between the Better Homes Better Health work and the Winter Team and other appropriate services.
- Train staff in the health and social care system on the support and services available to improve the health and safety of people's homes, with particular regard to cold, damp, falls and overcrowding, and providing information and advice about housing options for older people, so as to increase referrals to support.
- Review what is covered in an NHS Health Check with a view to increasing the range of health and care advice that the checks can offer .

C. Embedding prevention in all aspects of the Health and Social Care System

Health care factors play a part in influencing health outcomes, albeit not as much as one might expect, with lifestyle choices, housing, employment and social networks being the key drivers of preventable illness.

In addition, the NHS Long Term Plan (January 2019) prevention programme outlines the top five risk factors for premature deaths: smoking, poor diet, high blood pressure, obesity, and alcohol and drug use, in addition to air pollution and lack of exercise.

However, the NHS Long Term Plan also sets out interventions for addressing secondary prevention of specific conditions including: cardiovascular disease, stroke, respiratory disease, mental health, cancer, maternity and children (interventions summarised in **Annex 2**.

This section of our Prevention Framework considers the priorities for Oxfordshire in implementing the NHS Long Term Plan and sets out our recommendations for

- **The First 1000 days**
- **Implementing the NHS Long Term Plan across the system**
    a. **Primary Care Organisations**
    b. **County Wide organisations**

However, it can also be stated again here that change to the overall health of the population is the product of the choices of **individuals in the community**. As set out in the executive summary, the choices we all make on what we eat and drink, whether we smoke and how much we exercise are important. In addition, our mental wellbeing and capacity to be good neighbours are also essential in building our healthy communities. So our prevention framework needs to include not only the system wide focus set out below, but also the individual responsibility of each of us.

It is also worth pointing out that some recommendations keep cropping up in these areas of work. These include the evidence based initiative of **Making Every Contact Count** – raising the topic of health at every appropriate opportunity. This is an effective tool for helping people consider their health behaviours and needs to be adopted widely across the system, building on the good work already in place. This is not just for the NHS but for everyone.

Topic: The First 1000 Days

What is the problem?

Giving children the best start in life is a key priority of the Oxfordshire Joint Health and Wellbeing Strategy. The main challenge in a relatively healthy population is to address inequalities by making sure we build on our assets to give the same access and outcomes to everyone. Some of the inequalities issues are:

- **Smoking during pregnancy** - latest figures show it is still 7.8% of women are smoking at time of delivery in Oxfordshire (between 550 and 600 women a year). The national target is 6%
- **Maternal health** – including substance abuse, mental health, poor nutrition and maternal obesity
- **Perinatal Mental health** – in 2017-18 there was an estimated number of 168 women in Oxfordshire with perinatal mental illness[2]
- **Oral health** – this is worse for children from deprived circumstances (who have 3x the rate of dental caries than more affluent children nationally).
- **Breastfeeding** – generally much better than national averages in Oxon but maybe lower in younger women and more deprived communities.
- **Immunisation** rates – have been falling in Oxon
- **Childhood obesity** – we know there is a range by deprivation and ethnicity across the county, even though on average we are better than England.
- Children and Young People **mental health** including the impact of **Adverse Childhood Experience**. This might include the impact of domestic abuse, parental substance misuse and mental health issues.
- Environmental factors such as **air quality, housing quality and poverty**
- **Accidents and injuries** – including water safety, blind cord safety, safe sleeping but also traffic, self-harm and suicide

Evidence based recommendations from RCPCH Prevention Vision for Child Health

- The DHSC Prevention Vision published in November 2018 identifies smoking cessation as “a major priority” and identifies “stopping smoking before or during pregnancy [as] the biggest single factor that will reduce infant mortality”.
- Substance abuse (e.g. drug/alcohol use), smoking and poor maternal nutrition before and during pregnancy are all associated with adverse outcomes for both underweight and overweight women. Obesity before and during pregnancy and gestational diabetes are associated with an increased risk of stillbirth and foetal and infant deaths.
- Tooth decay is almost entirely preventable. It remains the most common single reason that children age five to nine require admission to hospital.
- Breastfeeding is important to ensuring children have a healthy start in life. It is a natural process that is highly beneficial for infant and mother, and benefits the child across their lifespan. Breastfeeding helps protect against infections and against risks of infant mortality (especially for infants born preterm).
- Infants should not be given sugar-containing drinks and where possible, sugar should be consumed in a natural form through human milk, milk, unsweetened dairy products and intact fresh fruits. This is particularly important during the weaning process
- The DHSC’s 2018 Prevention Vision notes the importance of helping families to take a “whole families approach” to child health, including supporting families to address parental conflict and acknowledging the wider health impacts of household problems including housing, debt and mental and physical health
- children living in poverty are more likely to die before the age of one, become overweight, have tooth decay or die in an accident
- Evidence suggests air pollution’s impact on children’s health can be profound: exposure of pregnant women to air pollution is linked with higher risk of premature birth, low birth weight, adverse respiratory outcomes and adverse neurological development. Toxic air can stunt growth of children’s lungs, heighten the risk of developing asthma, and make children more prone to coughs, wheezes and lung infections. Children living in highly polluted areas are four times more likely to have reduced lung function in adulthood.

[2] The estimated number of women with severe depressive illness, calculated by applying the national prevalence estimate (30 in 1,000) to the total number of maternities (including stillbirth deliveries) in the area.

What will be prevented?	What is already in place? (Assets and Enablers) • Midwifery, Health visiting services and school health nurses • Linked to sugar in drinks and food. Sugar Smart is a local initiative that has been making progress, but I am not sure whether the oral health of young children is improving yet. • Adverse Childhood Experiences are central to service planning in Oxfordshire e.g. the Safeguarding Families project with multi-agency teams addressing substance misuse, domestic abuse and mental illness in parents • Accident prevention initiatives for Year 6 primary school pupils include Injury Minimisation Programme for Schools and the Junior Citizen programme. • Community Dental Services target schools in areas where children have worse dental health • Addressing Adverse Childhood Experiences through the Family Safeguarding Project and Domestic Abuse Strategy • Services and support delivered through libraries such as stay and play encourage lifelong learning (self empowerment) and access to ongoing information and support
How will we know we are successful?	
Recommendations	

Topic: Implementing the NHS Long Term Plan

What is the local challenge?

- Address the top five risk factors for premature deaths: smoking, poor diet, high blood pressure, obesity, and alcohol and drug use, in addition to air pollution and lack of exercise.
- address secondary prevention of specific conditions including: cardiovascular disease, stroke, respiratory disease, mental health, cancer, maternity and children

What evidence does the Long Term Plan cite for prevention?

"Chapter Two of the Long Term Plan sets out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities. Wider action on prevention will help people stay healthy and also moderate demand on the NHS. Action by the NHS is a complement to - not a substitute for - the important role of individuals, communities, government, and businesses in shaping the health of the nation. Nevertheless, every 24 hours the NHS comes into contact with more than a million people at moments in their lives that bring home the personal impact of ill health. The Long Term Plan therefore funds specific new evidence-based NHS prevention programmes, including to cut smoking; to reduce obesity, partly by doubling enrolment in the successful Type 2 NHS Diabetes Prevention Programme; to limit alcohol-related A&E admissions; and to lower air pollution."

What will be prevented?

The overall aim of the NHS Long Term Plan is:

"The longstanding aim has been to prevent as much illness as possible. Then illness which cannot be prevented should where possible be treated in community and primary care. If care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home."

How will we know we are successful?

- Reduction in premature death from cardio vascular disease, cancer and other diseases
- Fewer people getting ill from preventable diseases during their working life e.g. diabetes, respiratory illness, musculo skeletal problems
- Early detection of cancer and other long term conditions

What is already in place? (Assets and Enablers)

- The Health and Wellbeing Board have agreed that Prevention and Tackling Health Inequalities are cross cutting priorities across the system
- Individual NHS organisations have their Operating plans which include prevention initiatives
- A 5-year plan for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System will be implemented from April 2020, including a range of prevention initiatives
- We have well-established partnerships and a shared history of collaborative work
- Population Health Management methodology - This approach uses data to identify health and care needs of the local population including cohorts with the poorest outcomes or the highest needs. This then enables targeting of services and interventions for specific populations. It aims to reduce unwarranted variation in outcomes and to achieve maximum impact in improving health and care.

Recommendations

- Ensure that the prevention initiatives set out in the NHS Long Term Plan are included in our system wide and individual organisation plans and are implemented
- Put the NHS Health Check at the heart of local CVD prevention planning and commissioning
- Consider and act on the opportunities of Primary Care Networks for population level prevention work and also targeting particular groups with poor outcomes.
- Work across the health and social care system to embed Prevent, Reduce, Delay into all relevant clinical pathways.
- Increase the numbers and spread of front line professionals trained and delivering behaviour change interventions including Making Every Contact Count, brief advice and onward referral to appropriate support
- Address health inequalities using the PHE Toolkit and other enablers to identify and focus on variation in outcomes.
- System wide approach to tackling the determinants of health including investment in **the protective factors** that can act as a strong foundation for good mental health throughout our lives - strong attachments in childhood, living in a safe and secure home, access to good quality green spaces, security of income, and a strong set of social connections

a. Prevention through GP practices and Primary Care Networks

A Primary Care Network is a group of GP practices (covering 30 000 - 50 000 population) working closely with each other and with other health, social care and third sector partners to enable coordinated preventative, proactive, planned and urgent holistic care in local communities.

This section gives a practical guide to evidence based initiatives from the Long Term Plan and local good practice that can be undertaken in primary care.

Menu of practical options for Primary Care prevention plans

In my practice or neighbourhood, I might consider implementing primary prevention by: • *Upskilling my team by "making every contact count (MECC)" or "All Our Health" training and nudging people to improve their lifestyle choices* • *Becoming a "Park run" practice to lead by example* • *Referring my patients to social prescribing teams to enable them to develop social connections, learn new skills and gain confidence* • *Improving systems to maximise immunisation uptake* • *Increasing referral into the NHS Diabetes Prevention Programme for those at risk of Type 2 diabetes (in the non-diabetic hypergycaemia range)* • *Referring my patients to weight management and exercise referral and coaching schemes*	
I might consider implementing secondary and tertiary prevention by:	
	a. Earlier detection and treatment of disease by: - *Increasing uptake of NHS Health Checks and focus on risk management pathways – both lifestyles and clinical follow up* - *Case finding of atrial fibrillation or high blood pressure by nurses or pharmacists or through use of technology (e.g. self measurement of BP or practice use of Alivecor machines for AF)* - *Case finding and then treatment of COPD when the history suggests high risk* - *Encouraging patients to attend for cancer screening, reduce referral threshold and raise awareness to both patients and healthcare professionals*

	- *Encouraging patients to make lifestyle changes that will help them to better manage their long term condition*	
b. Identifying patient cohorts that have complex needs: - *Patients with frailty, in care homes or housebound will receive holistic proactive and reactive care by multidisciplinary health, care and 3rd sector teamsPatients with multimorbidity (but who are not necessarily frail) may benefit from more joined up care instead of separate condition-specific pathways* - *Patients with similar health needs may benefit from group consultations or educational sessions e.g. lifestyle advice for patients with type 2 diabetes, obesity or cardiovascular disease*		
	c. Reducing the impact on hospitals *The Long Term Plan is turning to Primary Care Networks to influence avoidable A&E attendances, avoidable emergency admissions, timely hospital discharge and avoidable hospital outpatient appointments. This may include adopting:* - *'Anticipatory Care Service' and 'Enhanced Health in Care Homes'* - *Primary and community integrated teams to support timely discharges* - *Some elective care/appointments closer to home that were traditionally provided in the hospital"* -	
Addressing health inequalities - *Identifying and engaging with cohorts at highest risk e.g. BAME communities (diabetes) or deprived populations (obesity/cardiovascular/respiratory disease)* - *Identifying and engaging with cohorts who engage less frequently with preventative services e.g. patients with severe mental illness or learning disabilities (for annual health check), deprived populations (for cancer screening) or those who have inequality of access (e.g. in rural settings or housebound)* - *Improving recognition and support for carers, including young carers*		

b. Prevention across our countywide organisations

An Integrated Care System (ICS) is now being established across Buckinghamshire, Oxfordshire and Berkshire West (BOB), with a "place-level" focus on Oxfordshire. This Prevention Framework is the prevention plan for Oxfordshire, complementing and adding detail to the 5-year plan for BOB which is to be implemented from April 2020.

The BOB plan sets out some priorities across the ICS on smoking, obesity, alcohol, air quality and anti-microbial resistance. It also emphasises the action needed to address health inequalities and ensure prevention is embedded in all workstreams.

This section gives a practical guide to evidence based initiatives from the Long Term Plan and local good practice that can be undertaken by county-wide organisations in Oxfordshire. These complement and add value to the BOB level plan.

Menu of practical options for county wide organisations to draw up prevention plans

We can implement the specialist prevention measures set out in the NHS Long Term plan with: • *Upskilling teams by "making every contact count (MECC)" or "All Our Health" training and nudging people to improve their lifestyle choices* • ***Smoking****: Smoking cessation services for hospital inpatients, expectant mothers and mental health service users* • ***Alcohol****: Establishing and expanding alcohol care teams in hospitals* • ***Obesity****: Treating children who have severe complications related to obesity e.g. diabetes, cardiovascular disease, sleep apnoea, poor mental health.* • ***Mental health****: Expanding access to therapy for anxiety and depression* • ***Learning disabilities and autism****: Providing the right care for children with learning disabilities and reducing waiting times for autism assessments.* ***Maternity****: Reducing still births and mother and child deaths by 50% and expanding support for perinatal mental health conditions"*	
	"Across the county, we can ensure that prevention is embedded in planning and policy. ***We might consider implementing prevention by****:*

	- *Embedding Healthy place-shaping principles (see section 6.2)* - *Warm homes* - *Cleaner air* - *Promotion of healthy living in schools and workplaces (e.g. through Chamber of Commerce and NHS procurement levers to participate in local workplace health accreditation schemes)* - *Health champions in local communities and organisations* - *Promoting Public Health England's campaigns including Start4Life, Change4Life and One You campaigns* - *Use of digital technology to enable patients to access advice and care* - *Central government can support us in our aims by implementing its policy on salt reduction, folic acid food fortification, pricing of alcohol and nutrition training in medical schools"* -

We can use a common approach to incorporating Prevention into every patient pathway

A. PREVENT

This is preventing illness, slowing the progression of illness or prolonging independence by building and maintaining resilience, optimising management of long term conditions and building social networks.

This addresses the 'Prevent, Reduce, Delay' approach to prevention as set out in the Health and Wellbeing Board Strategy 2018 and the Health Improvement Board Strategy 2018:

1. **PREVENT** illness developing and build up resilience (primary prevention)
2. **REDUCE** the need for treatment by detecting illness early (e.g. screening) or optimising management of disease (secondary prevention)
3. **DELAY** the need for care by keeping people independent for as long as possible (tertiary prevention)

B. PROACTIVE

By identifying a person's needs early, anticipating any deteriorations and intervening early, avoidable hospital attendances may be reduced.

C. RESPONSIVE

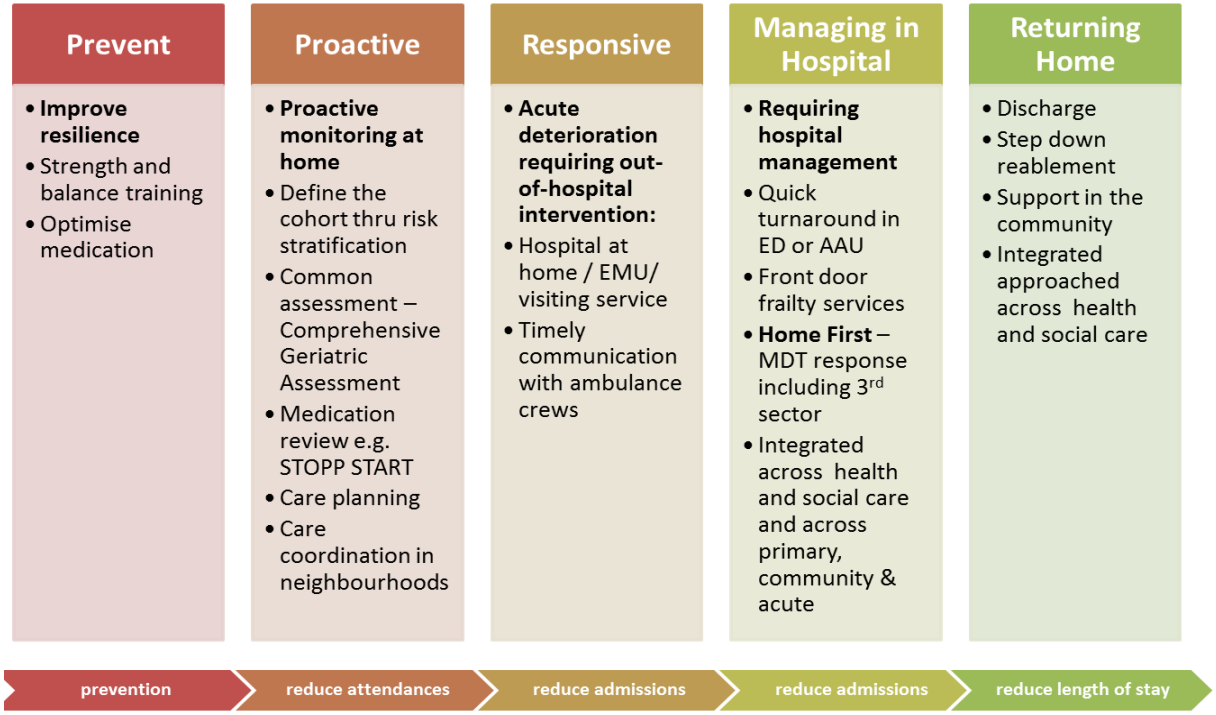
The development of an effective care plan and responding to deteriorations in out-of-hospital settings may reduce the need for hospital care.

D. MANAGING IN HOSPITAL AND RETURNING HOME

Quick discharges and reduced length of stay may be supported by step down reablement and integrated health and social care teams in the community.

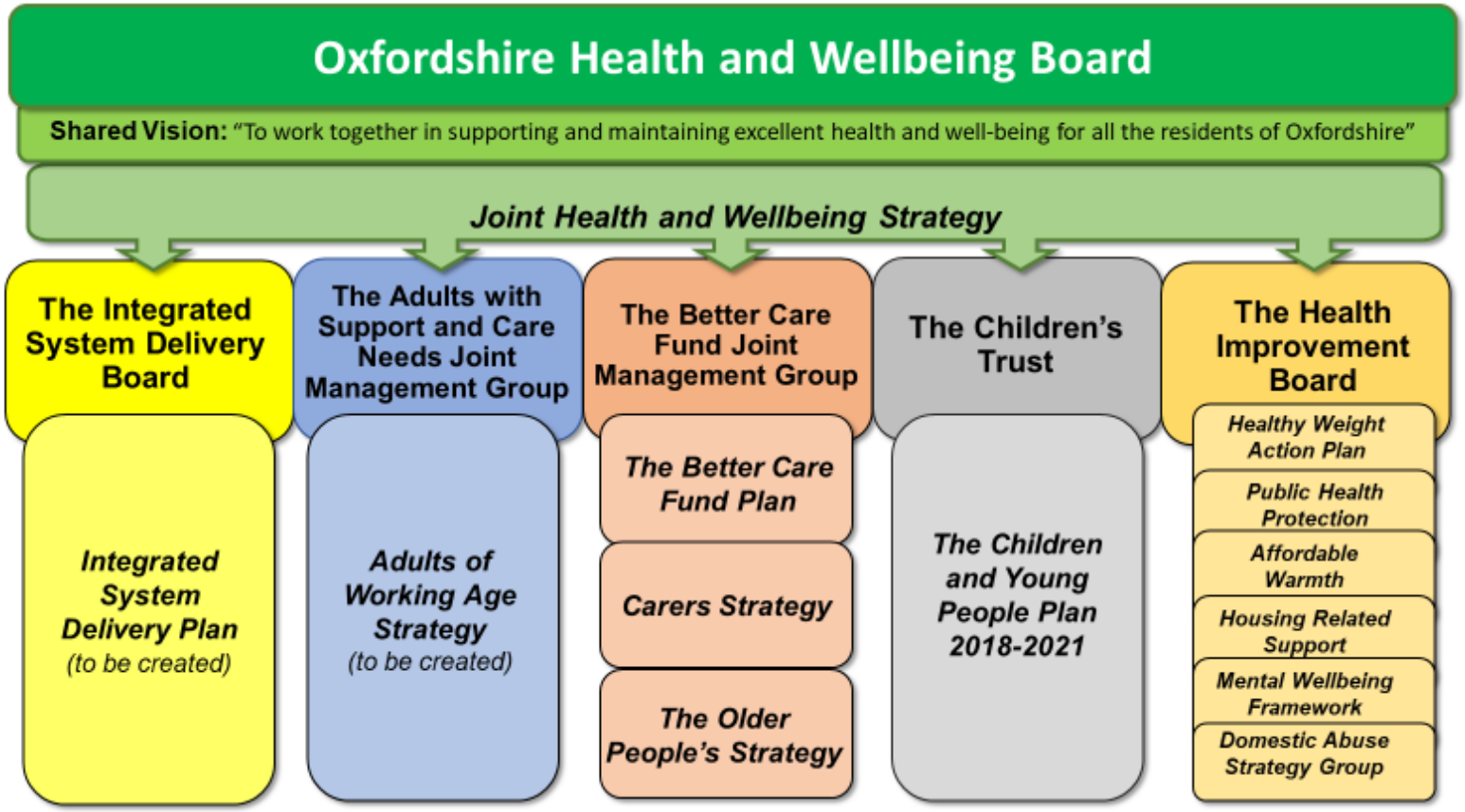
Every step may have input from integrated teams involving primary care, community health, public health, mental health, hospital services, domiciliary care and the voluntary sector.

For every model of care, this 5-step pathway may be considered, with a particular emphasis on the upstream step of prevention. The below is an example for frailty but these 5 steps could be applied to all conditions:



Governance

This framework underpins the Joint Health and Wellbeing Strategy approved by the Health and Wellbeing Board and is governed through the structures of that Board, illustrated in the diagram below. Monitoring progress and reporting is an essential role for this governance structure.



Conclusion

Prevention interventions may be planned and delivered at different scales. There is plenty of evidence of what works and a strong strategic imperative to act. In order to do this, we recognise that everyone and every organisation has a role in prevention

These range from an individual decision to eat more fruit or fewer takeaways to a system wide decision to embed prevention into plans and processes. These levels of decision making could be categorised:

a. **Self empowerment**. Individual lifestyle choices related to healthy eating, physical activity, going smoke free, drinking sensibly, being a good neighbour and practicing the 5 Ways to Wellbeing. People may need support to make changes e.g. to give up smoking or lose weight and Making Every Contact Count is a good tool to prompt this.

b. In an **individual organisation.** For example through workplace wellbeing initiatives such as encouraging employees to take a walk at lunchtime or providing cycle racks for them to make active travel to work an easier option.

c. Through **services** where there is an emphasis on prevention and early intervention e.g. encouraging people to attend for screening or Making Every Contact Count by asking open questions about health and wellbeing.

d. Through **partnerships** where all plans include elements of Prevent, Reduce, Delay as appropriate. For example, the Whole System Approach to Obesity will cover the whole range of environmental, personal, cultural and treatment factors that link to achieving and maintaining a healthy weight.

e. In particular settings such as **workplaces or schools**, where health and wellbeing programmes can ensure consistency of approach and provide opportunities which may be difficult to access outside working hours.

f. Across **the whole system** of health and local government services where the actions and plans of part of the system have a knock-on effect on others.

Next steps - Deciding on priorities

We need to consider these questions:

- Which factors have the biggest effect on health?
- Which affects most people?
- What are the biggest health inequalities?
- Which are the easiest for us to change?

Suggested system-wide priorities for the next 5 years (in addition to our Business as Usual for Prevention):

1. Establishment of local cross-organisational leadership for prevention[3].
2. Optimise the first 1000 days of life, including reducing smoking in pregnancy and increasing immunisation of children
3. Promote and create emotional wellbeing, including the '5 ways to wellbeing' and the 'CLANGERS' approach to wellbeing, for children, young people, adults and families.
4. Shape Healthy Places throughout Oxfordshire, including the physical environment and building communities.
5. Address priority socio-economic factors – loneliness and the impact of debt.
6. Tackle the growing problem of obesity through prevention and weight management
7. Improve early detection, self-care and clinical management of long term conditions, particularly Cardiovascular Disease, Respiratory, Diabetes, Mental health and Cancer

Plus targeted work to reduce health inequalities in all of the above

This is to be discussed at HWB and refined into a timeline for each priority over 5 years.

[3]A King's Fund paper (Nov 2018) suggests: **"Local and regional system leaders and politicians should champion population health and ensure that there is clear leadership and plans are in place which are co-ordinated across the area and across those responsible for the wider determinants of health"** *https://www.kingsfund.org.uk/sites/default/files/2018-11/A%20vision%20for%20population%20health%20online%20version.pdf*

Recommendations to the Health and Wellbeing Board:

1. Ensure that the implementation of the Joint Health and Wellbeing Strategy (2019-24) in Oxfordshire delivers a wide-ranging prevention agenda so that each individual, organisation and partnership can play their part.

2. Set priorities for each year for the whole system to address, while also implementing business as usual and new initiatives at organisational level.

Kiren Collison, Clinical Chair of Oxfordshire Clinical Commissioning Group
Jackie Wilderspin, Public Health Specialist, Oxfordshire County Council

List of all Recommendations from the document

A Lifestyle Factors

Mental Wellbeing

- The Mental Wellbeing Framework for Oxfordshire should set out comprehensive plans to create, promote and sustain mental wellbeing. Following up from signing the Prevention Concordat,
    a. Organisations need to show that they intend to continue to promote and support mental health and wellbeing.
    b. Organisations promoting the adoption of these principles will make a public statement that this is what they are and will be doing to tackle mental health.
    c. Sign off and ongoing leadership from the Health and Wellbeing Board
    d. Nominate a mental health champion, ideally for each organisation
- Review what is covered in the NHS Health Check with a view to adding a mental health element
  Health Inequalities must be addressed with a focus on communities with poorer health and wellbeing outcomes

Obesity

- **Healthy Place Shaping principles to be embedded** in Oxfordshire 2050 and embedded in the Growth Agenda. This will tackle the "obesogenic environment"
- **Commission joined up services for obesity treatment:** A review of weight management services in 2017 concluded that tier 3 services (providing specialist psycho-social support for people with BMI 40+ who do not want bariatric surgery) should be developed.
- **Integrate weight management and mental health services and/or with learning disabilities**
- **Whole System Approach to Healthy Weight** to be fully developed (it is currently in early stages), Sugar Smart and MECC to be rolled out more widely.
- **Capacity of National Diabetes Prevention programme to be doubled** (as set out in the NHS Long Term Plan)
- **Implement Government Buying Standards for food and catering services (GBSF)**

Alcohol

- Revise and articulate a joint ambition for addressing alcohol related harm across the partnership
- The Alcohol Care Team (ACT) in the hospital trust is expanded to cover more in-patient departments and funding is sustained. Further training in Fibrosis scanning to enable ACT and others to assess alcohol related liver damage early.

- The Community Safety Practitioner service in the Emergency Dept is increased in capacity to work with the ACT and other services.
- Identification and Brief Advice / referrals in primary care are increased.
- Offer alternative access points for alcohol services to increase accessibility to the whole population, including those drinking at harmful but not hazardous levels.

Smoking

- Adopt and implement the recommendations in the NHS Long Term Plan
    - **a.** By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
    - **b.** A new smoke-free pregnancy pathway including focused sessions and treatments
- A universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services
- Develop a Tobacco Control Plan for Oxfordshire

Physical Inactivity

- Increase knowledge and capabilities of the Health Care Professional network across Oxfordshire through MECC, social prescribing pathways and training/development programmes around Moving Medicine for primary and secondary practitioners.
- Co-ordinated local and national campaigning to promote active lifestyles and raise levels of health literacy.
- Work together to target parents & children who are inactive e.g. FAST – families active, sporting together
- Joined up collaboration and investment in working together in the community to reach and engage people with health conditions, at-risk groups and older people.
- Work with local government and OXLEP to encourage business investment that will provide a range of local work opportunities that enable active travel
- Targeted funding for people with or at risk of long- term health conditions (including mental health) to provide activity and exercise in prevention / treatment pathways.
- Focus investment and layered interventions to create healthier communities in existing places of clearly identified need and address inequalities.
- Promote active travel and active design to help make walking and cycling part of everyday life as part of Oxfordshire's Growth Agenda
- Promotion of PE Pupil premium to schools to enable schools and nurseries to be active learning environments and adopt the Daily Mile, Walking to School etc.

- Promotion of workplace health and well- being targeting major employers with good numbers of low socio economic workers

B Socio-economic factors

Healthy Place Shaping

- Sustain healthy place shaping as a county wide strategic priority and work with district councils to ensure that it is reflected in their business plans and service delivery
- Public health to work closely with colleagues in planning, transport and highways so that Local Plans and transport policies reflect good practice, address local health needs and align with healthy place shaping principles
- Invest in the capacity of the third sector to increase community capacity and support social cohesion
- Workforce wellbeing and skills development to be promoted through Oxfordshire's Local Industrial Strategy and District Industrial/economic strategies so that economic development in the county supports inclusive growth
- Support good practice in the stewardship of green and blue spaces, with investment to increase their attractiveness to people of all ages and to sustain their biodiversity
- NHS providers and commissioners to engage with place based approaches to promoting health and wellbeing and to ensure that our health estates reflect new models of care
- Social prescribing. Encourage referrals to social prescribing schemes and evaluate and share learning of different approaches across the county.
  Commissioning of new schools to include criteria which embed healthy place shaping principles and invest in the capacity of education providers to follow good practice in developing and sustaining healthy behaviours

Social Isolation and Loneliness

- To implement the Older People Strategy priority to reduce loneliness
- Ensure that Healthy Place Shaping is embedded in the Growth Deal and Health and Wellbeing Strategy (see above)
- To learn from the summit on Loneliness to be held in October 2019 and take forward priorities in partnership.
- Create Age Friendly Communities across Oxfordshire.
- Review what is covered in an NHS Health Check with a view to increasing the range of health and care advice that the checks can offer

Low Income and Debt - A priority issue across the county

- Ensure good access to debt and benefits advice is developed and sustained

- Monitor feedback from organisations such as food banks, advice centres etc on the pressures faced by residents and respond by adjusting services as needed.
- Complete and report the evaluation of benefits advice services, showing any impact of increasing income on health improvement
- Join up the effort to help people who experience money problems across the health and care system.
- Work with OXLEP and district economic development teams to support skills development, career progression, and flexible working patterns in local employers and to ensure Inclusive Growth across the county.
- Maintain awareness of NHS initiatives to commission specialist help for people with serious gambling problems as set out in the Long Term Plan and work together to tackle the problem at source

Better Housing, Better Health

- Request reports to the Health and Wellbeing board on Quality Standard (QS117) which will include numbers of people who have been screened due to risks from cold homes and referred to the Single Point of Contact for Better Homes, Better Health.
- Establish working links between the Better Homes Better Health work and the Winter Team and other appropriate services.
- Enable staff in the health and social care system to receive training on the support and services available to improve the health and safety of people's homes, with particular regard to cold, damp, falls and overcrowding, so as to increase referrals to that support.
- Review what is covered in an NHS Health Check with a view to increasing the range of health and care advice that the checks can offer

C Health care factors

The first 1000 Days

- **tbc**

Implementing the NHS Long Term Plan

- Ensure that the prevention initiatives set out in the NHS Long Term Plan are included in our system wide and individual organisation plans and are implemented
- Put the NHS Health Check at the heart of local CVD prevention planning and commissioning

- Consider and act on the opportunities of Primary Care Networks for population level prevention work and also targeting particular groups with poor outcomes.
- Work across the health and social care system to embed Prevent, Reduce, Delay into all relevant clinical pathways.
- Increase the numbers and spread of front line professionals trained and delivering behaviour change interventions including Making Every Contact Count, brief advice and onward referral to appropriate support
- Address health inequalities using the PHE Toolkit and other enablers to identify and focus on variation in outcomes.
- System wide approach to tackling the determinants of health including investment in **the protective factors** that can act as a strong foundation for good mental health throughout our lives - strong attachments in childhood, living in a safe and secure home, access to good quality green spaces, security of income, and a strong set of social connections

Conclusion

- Ensure that the implementation of the Joint Health and Wellbeing Strategy in Oxfordshire delivers a wide-ranging prevention agenda so that each individual, organisation and partnership can play their part.
- Set priorities for each year for the whole system to address, while also implementing business as usual and new initiatives at organisational level.

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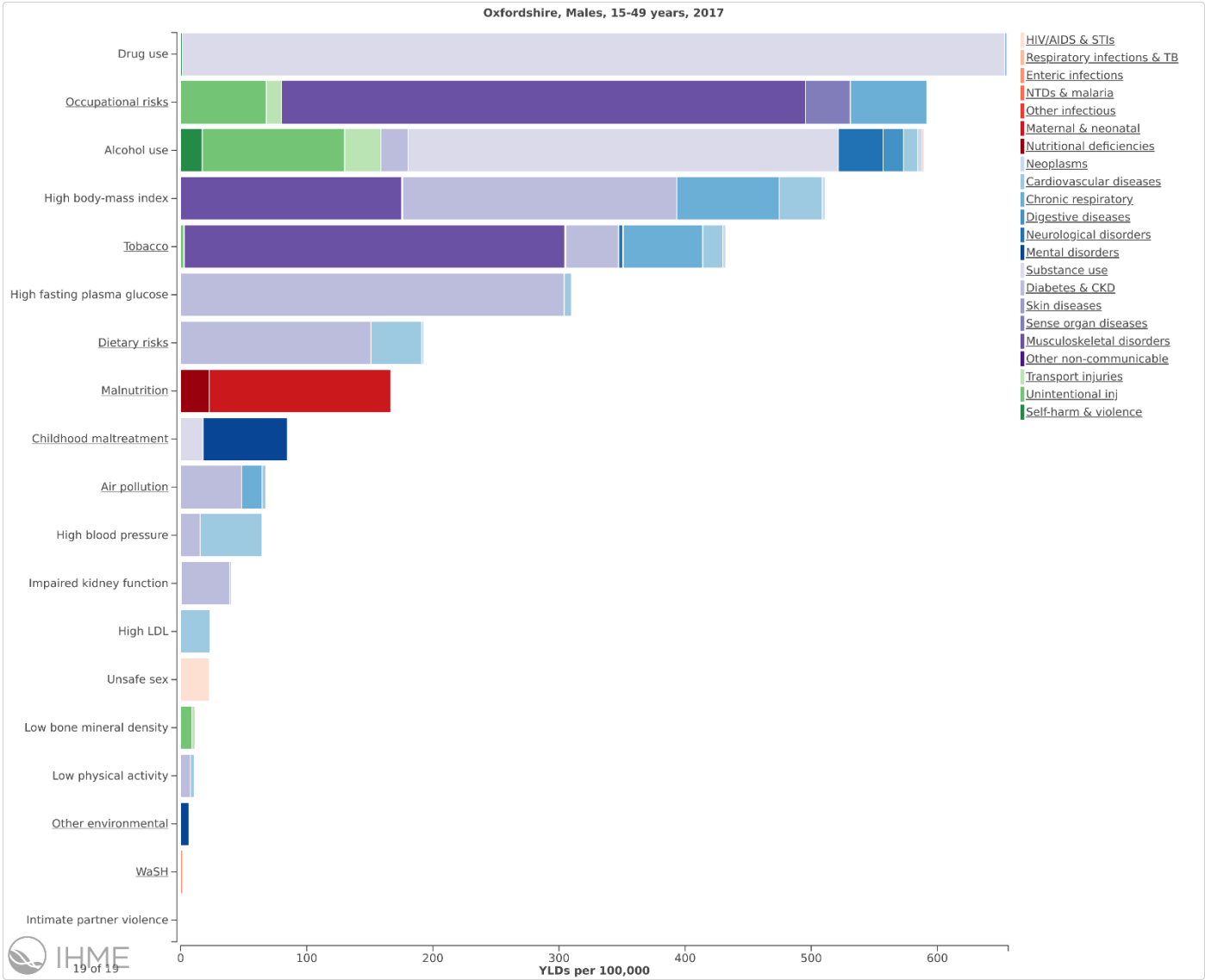
Staying Alive: How to Get the Best From the NHS by Dr Phil Hammond 2015

Annex 1 Top causes of disease

Oxfordshire
Males, 15-49 years, YLDs per 100,000
2017 rank

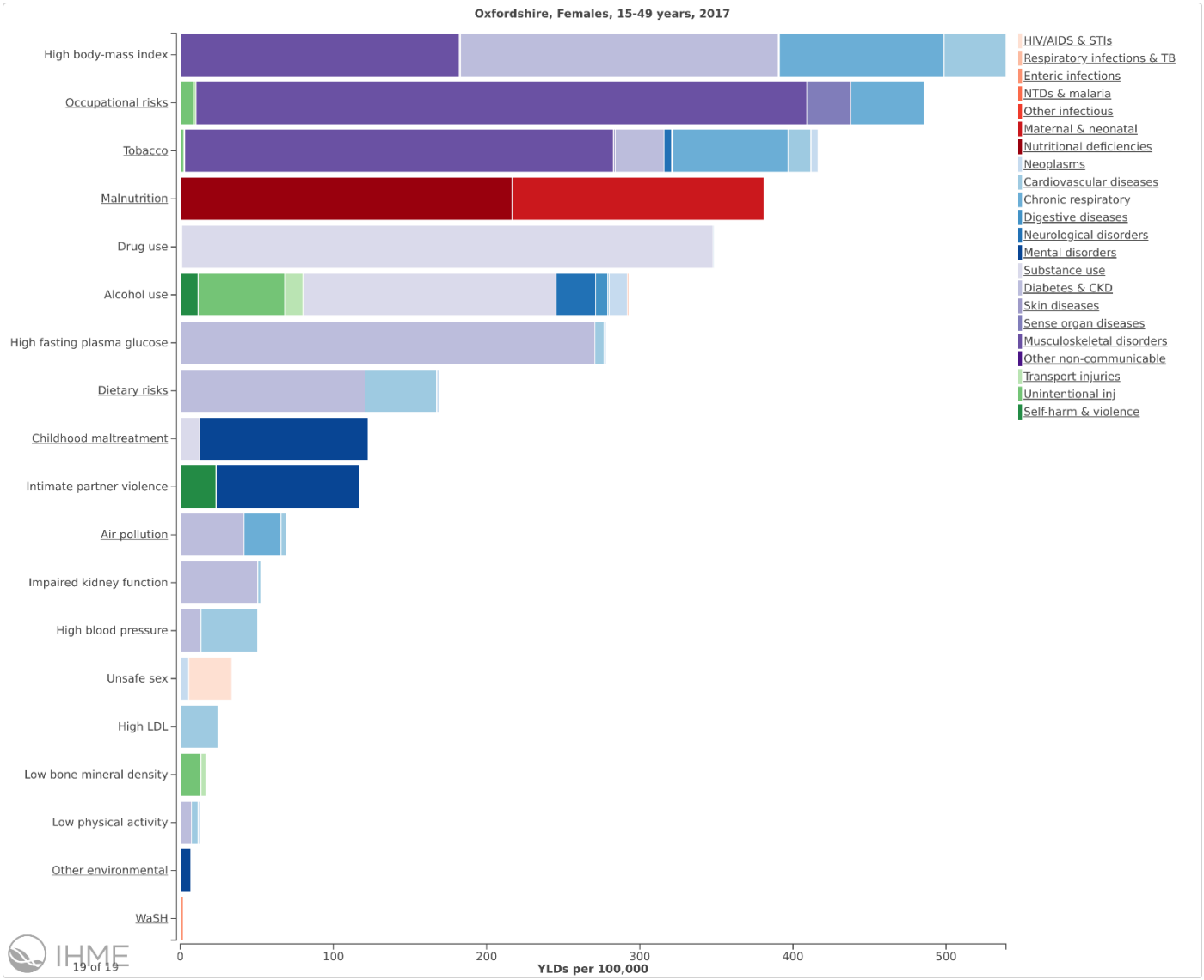
1 Musculoskeletal disorders
2 Mental disorders
3 Substance use
4 Neurological disorders
5 Unintentional inj
6 Skin diseases
7 Chronic respiratory
8 Other non-communicable
9 Maternal & neonatal
10 Diabetes & CKD
11 Digestive diseases
12 Sense organ diseases
13 Transport injuries
14 Respiratory infections & TB
15 Cardiovascular diseases
16 Neoplasms
17 Self-harm & violence
18 Enteric infections
19 Nutritional deficiencies
20 HIV/AIDS & STIs
21 Other infectious
22 NTDs & malaria



Oxfordshire
Females, 15-49 years, YLDs per 100,000

2017 rank

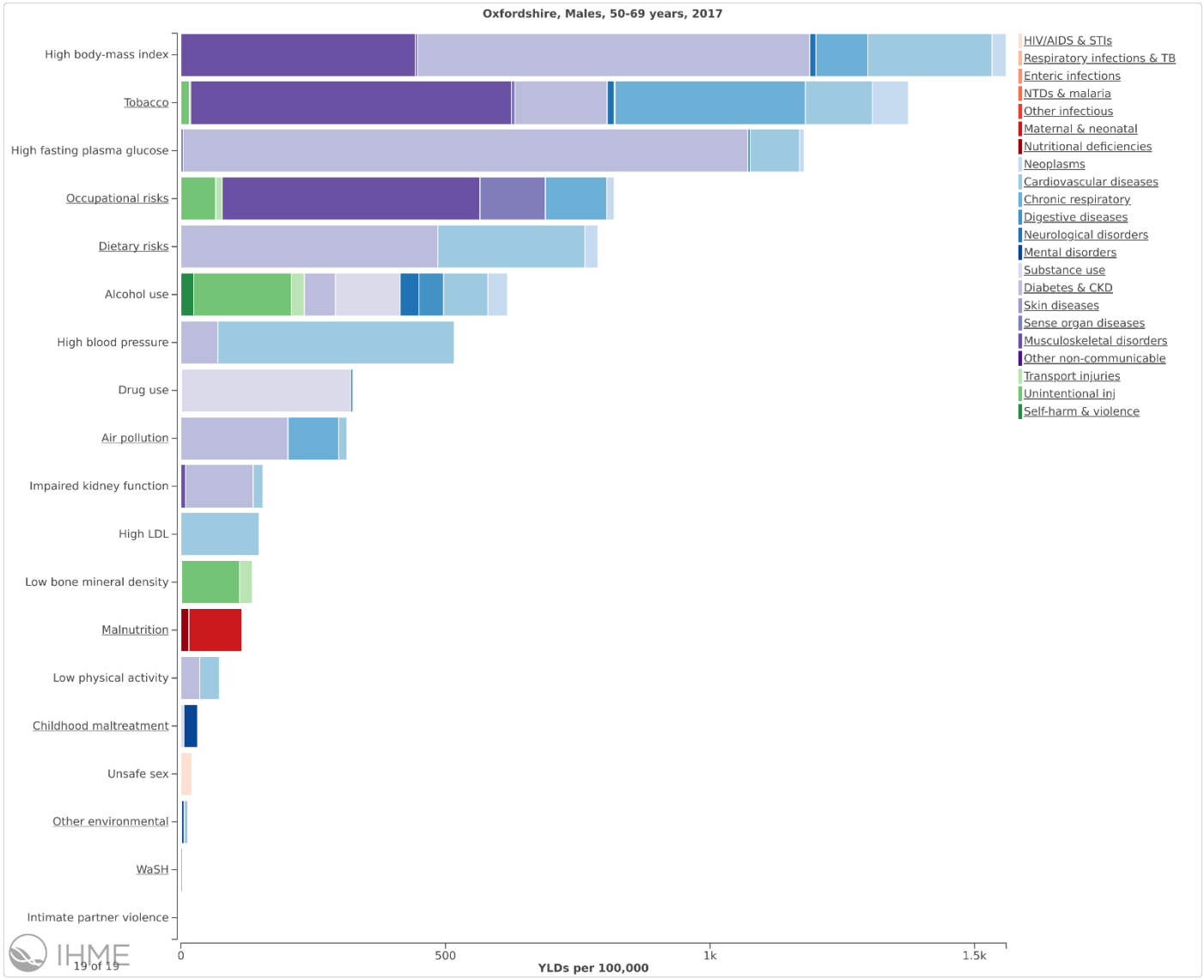
1 Musculoskeletal disorders
2 Mental disorders
3 Neurological disorders
4 Other non-communicable
5 Skin diseases
6 Chronic respiratory
7 Unintentional inj
8 Substance use
9 Maternal & neonatal
10 Digestive diseases
11 Diabetes & CKD
12 Sense organ diseases
13 Nutritional deficiencies
14 Neoplasms
15 Cardiovascular diseases
16 Respiratory infections & TB
17 Transport injuries
18 Self-harm & violence
19 Enteric infections
20 HIV/AIDS & STIs
21 Other infectious
22 NTDs & malaria



Oxfordshire
Males, 50-69 years, YLDs per 100,000

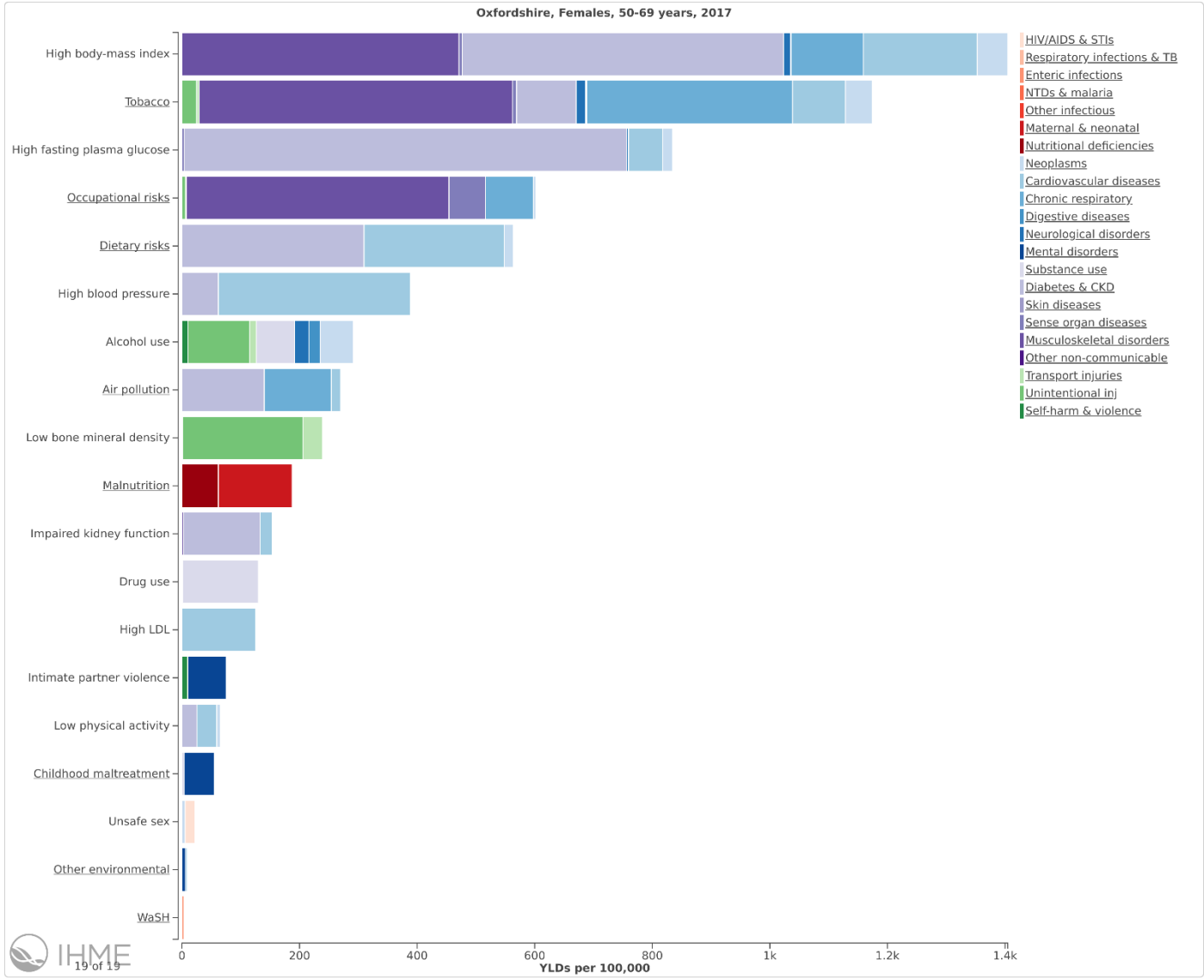
2017 rank

1 Musculoskeletal disorders
2 Mental disorders
3 Unintentional inj
4 Sense organ diseases
5 Diabetes & CKD
6 Chronic respiratory
7 Neurological disorders
8 Cardiovascular diseases
9 Other non-communicable
10 Skin diseases
11 Neoplasms
12 Digestive diseases
13 Substance use
14 Maternal & neonatal
15 Transport injuries
16 Respiratory infections & TB
17 Self-harm & violence
18 Enteric infections
19 NTDs & malaria
20 Nutritional deficiencies
21 HIV/AIDS & STIs
22 Other infectious



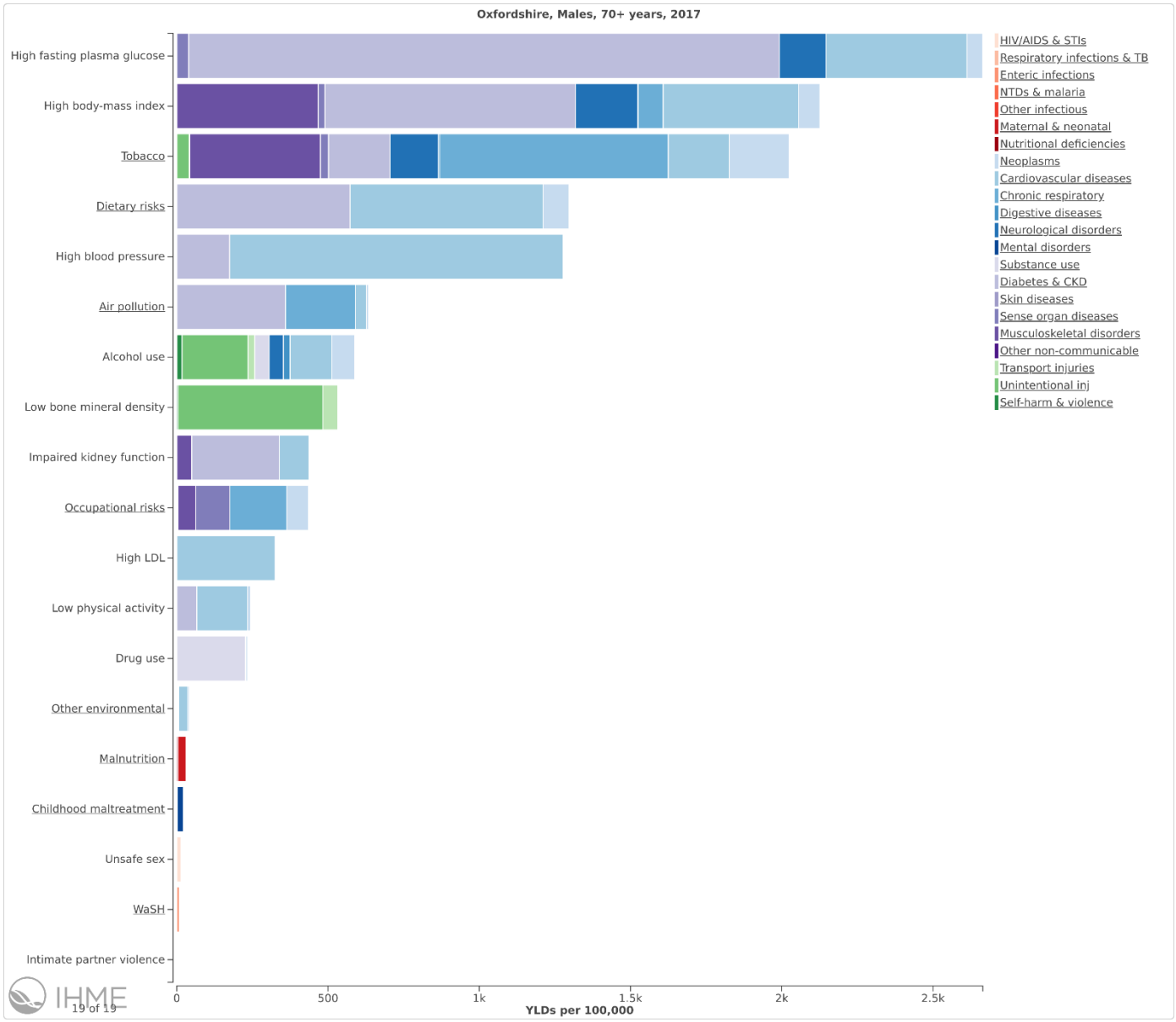
Oxfordshire
Females, 50-69 years, YLDs per 100,000
2017 rank

1 Musculoskeletal disorders
2 Mental disorders
3 Neurological disorders
4 Chronic respiratory
5 Unintentional inj
6 Other non-communicable
7 Skin diseases
8 Sense organ diseases
9 Diabetes & CKD
10 Cardiovascular diseases
11 Neoplasms
12 Digestive diseases
13 Maternal & neonatal
14 Transport injuries
15 Substance use
16 Respiratory infections & TB
17 Nutritional deficiencies
18 Enteric infections
19 Self-harm & violence
20 NTDs & malaria
21 Other infectious
22 HIV/AIDS & STIs



Oxfordshire
Males, 70+ years, YLDs per 100,000
2017 rank

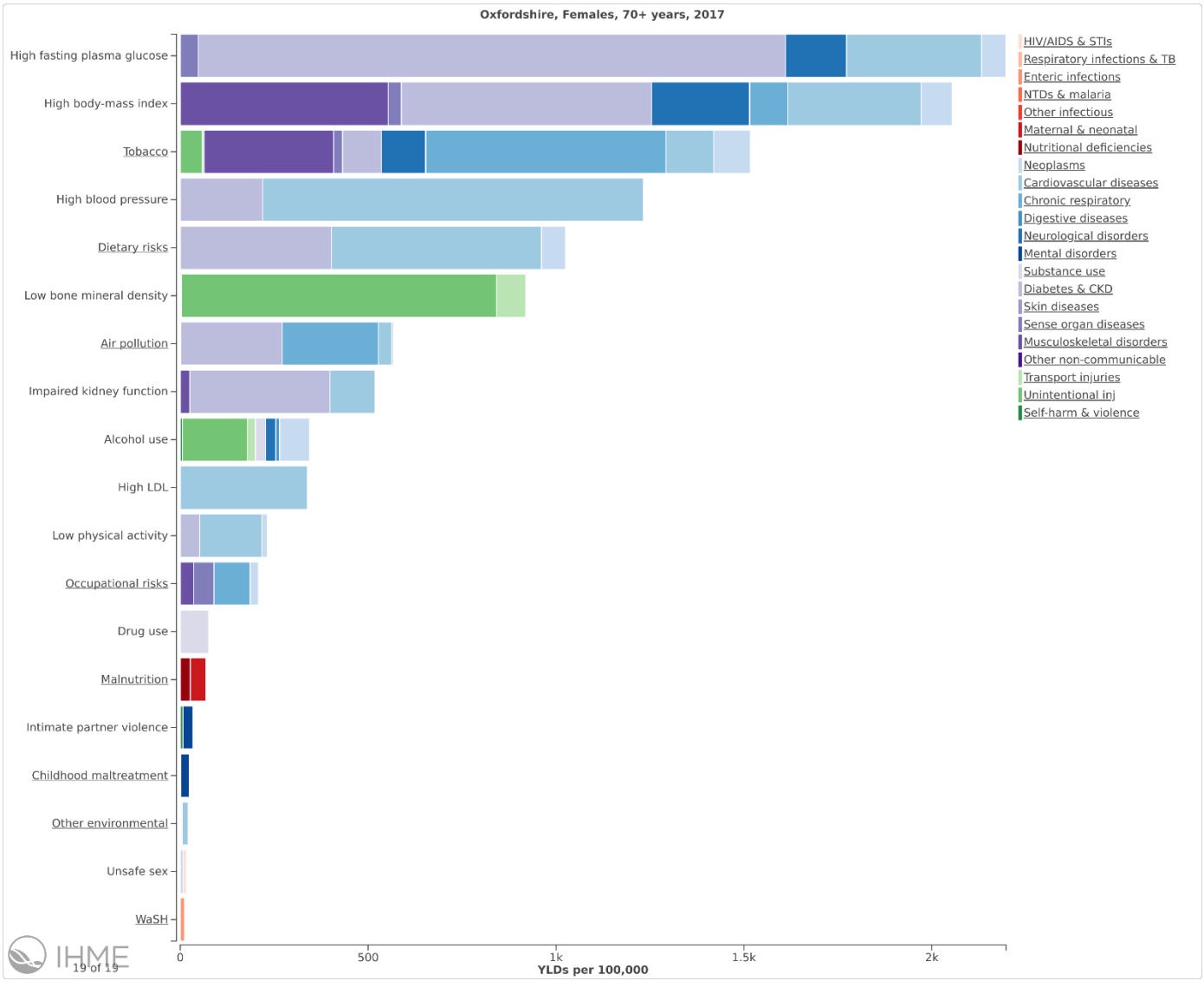
1 Musculoskeletal disorders
2 Sense organ diseases
3 Cardiovascular diseases
4 Chronic respiratory
5 Diabetes & CKD
6 Unintentional inj
7 Neurological disorders
8 Neoplasms
9 Mental disorders
10 Other non-communicable
11 Skin diseases
12 Digestive diseases
13 Transport injuries
14 Substance use
15 Enteric infections
16 Maternal & neonatal
17 Respiratory infections & TB
18 Self-harm & violence
19 NTDs & malaria
20 Other infectious
21 Nutritional deficiencies
22 HIV/AIDS & STIs



Oxfordshire
Females, 70+ years, YLDs per 100,000

2017 rank

1 Musculoskeletal disorders
2 Sense organ diseases
3 Neurological disorders
4 Cardiovascular diseases
5 Chronic respiratory
6 Unintentional inj
7 Mental disorders
8 Diabetes & CKD
9 Neoplasms
10 Other non-communicable
11 Skin diseases
12 Digestive diseases
13 Transport injuries
14 Enteric infections
15 Maternal & neonatal
16 Substance use
17 Respiratory infections & TB
18 NTDs & malaria
19 Self-harm & violence
20 Nutritional deficiencies
21 Other infectious
22 HIV/AIDS & STIs



Causes of death for under 75s considered preventable (JSNA 2019)

8

Cancer is the highest cause of preventable deaths in Oxfordshire in people under 75 years

These deaths could be prevented by reducing associated risk factors, such as obesity, inactivity, smoking and alcohol consumption

- Overall, preventable mortality in all ages is decreasing nationally as well as locally
- Preventable deaths continue to make up almost half of all deaths in those under 75 years of age and there is a higher proportion of these deaths in areas of deprivation
- Between 2015 and 2017 there were a total of 3,474 deaths from cardiovascular disease, cancer, respiratory or liver disease, 2,011 (58%) of which were considered preventable
- There was a gender difference, with 59% male deaths under 75 from these causes considered preventable and 56% of female deaths
- The highest cause of preventable deaths for people aged under 75 in Oxfordshire was cancer, with just over 1,000 deaths from 2015 to 2017

Deaths under the age of 75 from four causes considered preventable, Oxfordshire 2015-2017

Deaths aged under 75 by cause	All deaths aged under 75			Deaths considered preventable		
	Males	Females	Total	Males	Females	Total
Cardiovascular diseases	590	280	870	398	136	534
Cancer	1,024	920	1,944	527	513	1,040
Liver disease	153	84	237	127	69	196
Respiratory disease	240	183	423	135	106	241
Total of these four disease groups	2,007	1,467	3,474	1,187	824	2,011
% of total considered preventable				*59%*	*56%*	*58%*

Source: Public Health Outcomes Framework, PHE

Oxfordshire Joint Strategic Needs Assessment

Annex 2 Summary of NHS Long Term Plan Prevention Programme for specific conditions (adapted)

Condition	What is the problem?	Suggested solutions for prevention
Cardiovascular disease and stroke	CVD causes a quarter of all deaths in the UK It is the largest cause of premature mortality in deprived areas **This is the single biggest area where the NHS can save lives over the next 10 years** Stroke is the fourth single leading cause of death in the UK and the single largest cause of complex disability	**Primary prevention:** Addressing lifestyle factors of smoking, obesity, inactivity, diet and alcohol (see section 6.1 above) Salt reduction: government has agreed to set out by Easter 2019 the details of how the programme's targets will be met. **Secondary prevention:** As above plus - Early detection and treatment of 'ABC' risk factors (atrial fibrillation, blood pressure, cholesterol), including increased access to NHS Health Checks and case finding by pharmacists and nurses in Primary Care Networks and focussing on risk management pathways – both lifestyles and clinical follow up
Diabetes	Complications of diabetes can be debilitating 80% of the budget spent on diabetes is on its complications The risk of developing type 2 diabetes is up to six times higher in certain Black, Asian and Minority Ethnic (BAME) groups	**Primary prevention:** Preventing and treating obesity (as above in 6.1a) Increased access to NHS Diabetes Prevention Programme for those at risk of Type 2 diabetes. Access for all but also targeted at those at highest risk e.g. BAME **Secondary prevention:** Access to weight management services in primary care to be targeted at people with type 2 diabetes or hypertension with a BMI > 30 Very low calorie diets for obese Type 2 diabetics to be tested
Respiratory	Three top causes for years of life lost in the UK: lung cancer, chronic obstructive airways disease and lower respiratory tract infections Increased incidence and mortality in areas of	**Primary prevention:** Target smoking, cold homes, air pollution, immunisation

	deprivation Hospital admissions for lung disease have risen at 3x the rate of all admissions generally and are a major factor in the winter pressures faced by the NHS.	**Secondary prevention**: Diagnose earlier – 1 in 3 people with a first hospital admission for a COPD exacerbation have not been previously diagnosed. Optimise clinical management: right medications, integrated team around the patient to address all needs Address health inequalities
Mental health	The life expectancy of people with severe mental illnesses can be up to 20 years less than the general population Stress, anxiety and depression were the leading cause of lost work days in 2017/18 - reducing the impact of common mental illness can increase our national income and productivity	**Primary prevention:** Multifactorial root causes but Global Burden of disease cite the top *preventable* cause to **be alcohol and drug use** **Secondary prevention:** Increased access to IAPT * with an increased focus on those with long-term conditions Increased access to an annual physical health check for those with severe mental health problems, learning disabilities and autism Single, universal point of access for people experiencing mental health crisis NHS LTP cites plans for a new community access to psychological therapies, improved physical health care, employment support and support for self-harm and coexisting substance use Increased access to Mental Health Support Teams for children and young people, including in schools
Cancer	Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival	**Primary prevention:** Lifestyle factors above (section 6.1) **Secondary prevention:** Detect and treat earlier including - raising awareness

		- lowering threshold for referral by GPs - optimise screening
Maternity	Stillbirths and maternal death are reducing but pre-term birth is increasing. Women from the poorest backgrounds and mothers from Black, Asian and Minority Ethnic (BAME) groups are at higher risk of their baby dying in the womb or soon after birth. 700-900 pregnancies a year are affected by neural tube defects	**Primary prevention** Reduce smoking in pregnancy Targeting higher risk mothers: younger and from deprived background Government will consult on the mandatory fortification of flour with folic acid to prevent foetal abnormalities Introduction of a perinatal mental health services
Children (aspects also covered in sections above)	Children and young people account for 25% of emergency department attendances and are the most likely age group to attend A&E unnecessarily Tooth decay experienced by a quarter of England's five year olds	**Primary prevention:** Improvement in childhood immunisation The Starting Well Core initiative to support dentists to see more children from a young age to form good oral health habits and preventing tooth decay **Secondary prevention:** NHS LTP proposes that local areas will design and implement models of care that are age appropriate, closer to home, to prevent unnecessary A&E attendances

***** IAPT = Improving Access to Psychological Therapies programme treats common mental health conditions (using techniques such as cognitive behavioural therapy)

Priority: Healthy Place Shaping

Use the checklists to note what YOU and YOUR ORGANISATION can do to contribute to this priority

Healthy Lifestyles

- Social prescribing ❑
- Physical activity ❑
- Health walks ❑
- Safe cycling routes ❑
- Cycle friendly employers ❑
- Healthy schools ❑
- Sports clubs ❑
- Gardening & allotments ❑
- Access to healthy food ❑
- Access to lifelong learning and cultural engagement ❑
- Licensing policy and practice ❑
- Workplace wellbeing schemes ❑

Socio-eocnomic factors / Built Environment

- Green Spaces / waterways ❑
- Community hubs ❑
- Community development / activation ❑
- Good quality, well-designed houses ❑
- Pedestrian zones ❑
- Clean air ❑
- Age Friendly communities ❑
- "Good work" ❑
- Community Employment plans ❑
- Workplace wellbeing ❑
- Transport plans ❑
- Industrial strategy ❑
- Oxfordshire 2050 and Local Plans ❑
- Safe Communities ❑
- Reduce impact of noise ❑
- Road safety ❑

Heath care and other services

- One Public Estate / co-location of services ❑
- Neighbourhood models of service provision ❑
- Voluntary sector capacity and investment ❑
- Co-production and community involvement, building on community assets ❑
- Care Closer to Home ❑
- Personalised care ❑
- Leisure and recreation services ❑
- Community Centres ❑
- Dementia Friendly services and communities ❑
- Befriending services ❑

Tackle Health Inequalities:

- Identify people or groups with poor outcomes and improve them ✓

Priority: Preventing Cardiovascular Disease

Use the checklists to note what YOU and YOUR ORGANISATION can do to contribute to this priority ❑

Healthy Lifestyles

- Reduce the number of people who smoke ❑
- Tobacco Control measures ❑
- Promote Healthy Eating ❑
- Reduce obesity ❑
- Enable Active Travel ❑
- Promote physical activity ❑
- Reduce alcohol consumption ❑
- 5 ways to Wellbeing ❑
- Lifestyle advice for people with long term conditions e.g. Cardiovascular disease ❑

Socio-eocnomic factors / Built Environment

- Healthy Place Shaping ❑
- Walking routes ❑
- Safe cycle routes ❑
- Clean air ❑
- Warm homes ❑
- Leisure and community facilities ❑
- Green and Blue spaces ❑

Heath care and other services

- Making Every Contact Count ❑
- Workplace wellbeing ❑
- Social prescribing ❑
- NHS Health Checks ❑
- Weight management services ❑
- Case finding for atrial fibrillation and high blood pressure ❑
- Identifying high risk groups ❑
- Alcohol Care Teams in hospitals ❑
- Access to psychological therapies ❑

Tackle Health Inequalities:

- Identify people or groups with poor outcomes and improve them ✓

Priority: Loneliness and Social Isolation

Use the checklists to note what YOU and YOUR ORGANISATION can do to contribute to this priority ❑

Healthy Lifestyles

- Making Every Contact Count ❑
- Promote Physical Activity ❑
- Promote 5 ways to Wellbeing ❑
- Access to information on local initiatives ❑
- Employer support to workforce to prepare for retirement ❑

Socio-eocnomic factors / Built Environment

- Healthy Place Shaping ❑
- Community activation ❑
- Community asset based approaches ❑
- Age Friendly communities ❑
- Dementia Friendly communities ❑
- Community Safety ❑
- Co-production and community involvement ❑
- Transport to help people be active and engaged ❑

Heath care and other services

- Social prescribing ❑
- Befriending services ❑
- Vibrant, proactive and well supported voluntary and community organisations ❑
- Volunteering opportunities ❑
- Support for Carers ❑
- Appropriate digital services ❑
- Intergenerational work ❑
- Helping people be independent at home ❑
- Accident prevention at home / Safe & Well ❑

Tackle Health Inequalities:

- Identify people or groups with poor outcomes and improve them ✓

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Health & Wellbeing Performance Framework: 2019/20
September 2019 Performance report

	Measure	Responsible Board	Baseline	Target 2019/20	Update	Q1 Report		Q2 Report		Notes
						No.	RAG	No.	RAG	
A good start in life	1.1 Reduce the number of looked after children by 50 in 2019/20	Children's Trust	789 (Jan 19)	750	Q4 2018/19	794	R	780	R	
	1.2 Maintain the number of children who are the subject of a child protection plan	Children's Trust	602 (Jan 19)	620	Q4 2018/19	608	G	592	G	
	1.3 Increase the proportion of children that have their first CAMHS appointment within 12 weeks to 75%	Children's Trust	26% (Apr-Nov 2018)	75%	Feb-19	26%	R	26%	R	
	1.4 Increase the number of early help assessments to 1,500 during 2019/2020	Children's Trust	1083 (Apr-Jan 2019)	1,500	Q4 2018/19	923	A	1371	A	
	1.5 Reduce the number of hospital admissions as a result of self-harm (15-19 year) to the national average (rate: 617 actual admissions 260 or fewer)	Children's Trust	312 (2016/17)	260	Q4 2018/19	nya		nya		To be routinely reported from April 2019
	1.6 Increase the proportion of pupils reaching the expected standard in reading, writing and maths	Children's Trust	65% (17/18)	73%	Q4 2018/19	nya		nya		Annual figure reported on academic year
	1.7 Maintain the proportion of pupils achieving a 5-9 pass in English and maths	Children's Trust	52% (17/18)	50%	Q4 2018/19	nya		nya		Annual figure reported on academic year
	1.8 Reduce the persistent absence rate from secondary schools	Children's Trust	13.7% (T2 18/19)	12.2%	Term 4 2018/19	nya		13.90%		
	1.9 Reduce the number of permanent exclusions	Children's Trust	26 (T2 18/19)	tbc	Term 4 2018/19	nya		55		
	1.10 Ensure that the attainment of pupils with SEND but no statement or EHCP is in line with the national average	Children's Trust	**KS2** 20% cf 24%: (17/18) **KS4** 28.5 c.f 31.9 (16/17)	tbc	Q4 2018/19	KS2 20% 17/18 ac yr KS4 NYA	A	KS2 20% 17/18 ac yr KS4 28.0 17/18 ac yr	R	KS2 fig (% SEN support pupils reaching at least the expected standard in reading writing and maths 17/18 academic year. Oxon=20% (17% 16/17); National=24% (21% 16/17). Joint 6th of our 12 statistical neighbours. KS4 fig (Average point score of SEN support pupils 17/18 academic year). Oxon = 28.0; National = 32.2. Oxfordshire is ranked bottom out of statistical neighbours
	1.11 Reduce the persistent absence of children subject to a Child Protection plan	Children's Trust	32.8% (16/17)	tbc	Q3 2018/19	32.8	R	36.2	R	Annual Figure National figure (17/18) =32.7%.
	1.12 Reduce the level of smoking in pregnancy	Health Improvement Board	8% (Q1 18/19)	8%	Q4 2018/19	6.7%	G	7.7%	A	Data incomplete for OCCG - no return from Great Western Hospital this quarter. RAG based on 18/19 targets
	1.13 Increase the levels of Measles, Mumps and Rubella immunisations dose 1	Health Improvement Board	94.3% (Q2 18/19)	95%	Q1 2019/20	92.8%	A	94.6%	A	RAG based on 18/19 targets
	1.14 Increase the levels of Measles, Mumps and Rubella immunisations dose 2	Health Improvement Board	92.7% (Q2 18/19)	95%	Q3 2018/19	89.4%	R	91.7%	A	RAG based on 18/19 targets
	1.15 Maintain the levels of children obese in reception class	Health Improvement Board	7.8% (17/18)	7%		n/a				The baseline for children who are obese and does NOT include those overweight (but not obese)
	1.16 Reduce the levels of children obese in year 6	Health Improvement Board	16.2% (17/18)	16%		n/a				Data for 2018/19 academic year is likely to be released in November / December 2019
	Surveillance measures									
	Monitor the number of child victims of crime	Children's Trust	2238 (Apr-Dec 2018)	Monitor only	Q3 2018/19	2238		3021		
	Monitor the number of children missing from home	Children's Trust	1494 (Apr-Dec 2018)	Monitor only	Q3 2018/19	1494		2050		
	Monitor the number of Domestic incidents involving children reported to the police.	Children's Trust	4807 (Apr-Dec 2018)	Monitor only	Q3 2018/19	4807		6314		
	Monitor the crime harm index as it relates to children	Children's Trust	Set in Q1	Monitor only	Q3 2018/19	n/a		n/a		

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Living Well	2.1 Number of people waiting a total time of less than 4 hours in A&E	Joint Management Groups	88% (Apr-Nov 18)	tbc	Jun-19	87%	R	86%	R	June 2019 saw OUHFT Accident and Emergency (A&E) fail to reach the 95% national and 89% NHSI agreed performance trajectory targets, achieving 85.78%. This shows a slight dip from May's performance of 86.63%. There still appears to be a reduction in case mix.
	2.2 Proportion of all providers described as outstanding or good by CQC remains above the national average	Joint Management Groups	91% Oxon; 86% national. (Jan 2019)	86%	Sep-19	92%	G	92%	G	Sept 2019; 92.4 % of health & social care providers in Oxfordshire are good or outstanding compared with 86.1% nationally
	2.3 Improving access to psychological therapies: The % of people who have depression and/or anxiety disorders who receive psychological therapies	Joint Management Groups	18% (Apr - Nov)	22%	Apr-19	20%		18%	R	This is a nationally set target. 18% is year to date figure to June. Actual Feb figure is 20%. Target last year 19%).
	2.4 The proportion of people who complete psychological treatment who are moving to recovery.	Joint Management Groups	51% (Apr - Nov)	50%	Aug-18	51%	G	47%	R	Figure to March
	2.5 The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment	Joint Management Groups	100% (Apr - Nov)	95%	Aug-18	100%	G	99%	G	Figure to March
	2.6 The % of people who received their first IAPT treatment appointment within 6 weeks of referral.	Joint Management Groups	99% (Apr - Nov)	75%	Sep-19	99%	G	98%	G	Figure to March
	2.7 The proportion of people on General Practice Seriously Mentally Ill registers who have received a full set of comprehensive physical health checks in a primary care setting in the last 12 months.	Joint Management Groups	23.6%	60%	Jun-19	nya		29%	R	Figure is YTD (June as repoerted in August)
	2.8 Number of people referred to Emergency Department Psychiatric Service seen within agreed timeframe: JR (1 hour); HGH (1.5 hours)	Joint Management Groups	98% JR; 96% HGH (2017/18)	95%	Jul-19	87% JR; 72% HGH	R	77%	R	
	2.9 Proportion of people followed up within 7 days of discharge within the care programme approach	Joint Management Groups	96% (Apr - Dec)	95%	Jun-19	96%	G	98%	G	Latest figure Dec 2018
	2.10 The proportion of people experiencing first episode psychosis or ARMS (at risk mental state) that wait 2 weeks or less to start a NICE recommended package of care.	Joint Management Groups	75%	56%	Jun-19	89%	G	89%	G	YTD figure 75%; June fig 71%
	2.11 Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by March 2020	Joint Management Groups	57% (Sep 2018)	75%	Mar-19	41%	R	23%	R	Figure to December
	2.12 The number of people with severe mental illness in employment	Joint Management Groups	18% Dec 2018	18%	Jul-19	18%	G	22%	G	
	2.13 The number of people with severe mental illness in settled accommodation	Joint Management Groups	96% Dec 2018	80%	Jul-19	96%	G	96%	G	
	2.14 The number of people with learning disabilities and/or autism admitted to specialist in-patient beds by March 2020	Joint Management Groups	9	10	Jun-19	nya		6	G	
	2.15 Reduce the number of people with learning disability and/or autism placed/living out of county	Joint Management Groups	177 (Dec 2018)	< 175	Sep-19	181	A	179	A	Small decrease in numbers since last report
	2.16 Reduce the Percentage of the population aged 16+ who are inactive (less than 30 mins / week moderate intensity activity)	Health Improvement Board	19.1%	18.6%	Nov 2018	n/a		19.1%		This is an interim figure. Directly comparable data will be available later in the year.
	2.17 Increase the number of smoking quitters per 100,000 smokers in the adult population	Health Improvement Board	>2,337 per 100,000 (2017/18)	> 2,337 per 100,000*	Q4 2018/19	2,929	G	2,929	G	Target and RAG relate to 2018/19. The 2019/20 target will be set in Q1 once baseline is known. Data always a quarter in arrears
	2.18 Increase the level of flu immunisation for at risk groups under 65 years	Health Improvement Board	52.4 (2017/18)	55%	Sept 18 to Feb 19	51.4%	A	51.4%	A	
	2.19 Maintain the % of people invited for a NHS Health Check (Q1 2014/15 to Q4 2019/20)	Health Improvement Board	97% (2018/19)	97%	Q1 2019/20	94.9%	G	84.4%	G	Target and RAG relate to 2018/19. The 2019/20 target will be set in Q1 once baseline is known. Data always a quarter in arrears
	2.20 Maintain the % of people receiving an NHS Health Checks (Q1 2014/15 to Q4 2019/20)	Health Improvement Board	49% (2018/19)	49%	Q1 2019/20	47.1%	G	42.0%	G	Target and RAG relate to 2018/19. The 2019/20 target will be set in Q1 once baseline is known. Data always a quarter in arrears
	2.21 Increase the level of cervical Screening (Percentage of the eligible population women aged 25-64) screened in the last 3.5 years	Health Improvement Board	68.2% (Q4 2017/18)	80%	Q3 2018/19			67.8%	A	

	2.21 Increase the level of cervical Screening (Percentage of the eligible population women aged 25-64) screened in the last 5.5 years	Health Improvement Board	68.2% (Q4 2017/18)	80%	Q3 2018/19			76.3%	A	

Ageing Well [1]	3.1 Increase the number of people supported to leave hospital via reablement in the year	Joint Management Groups	1036 (Apr-Dec 18)	2000	Aug-19	123	A	112	R	On average this year 95 people started reablement from hospital with HART; 17 from Oxford health. It would equate to 1342 for the year
	3.2 Increase the number of hours from the hospital discharge and reablement services per month	Joint Management Groups	8596 (Dec 2018)	8920	Aug-19	8842	A	6726	R	Average figures for first 5 months of year. 25% below contract levels. But large increase in August (8022)
	3.3 Increase the number of hours of reablement provided per month	Joint Management Groups	4350 (Dec 2018)	5750	Aug-19	5944	G	5402	A	Average figures for first 5 months of year.6% below contract levels. The level of hours is not delivering the level of cases as the amount of care provided per person is higher than predicted.
	3.4 Increase the proportion of discharges (following emergency admissions) which occur at the weekend	Joint Management Groups	20.8% (2016/17)	>18.8%	Jun-19	21%	G	21%	G	Year to date to June; 24% in June
	3.5 Ensure the proportion of people who use social care services who feel safe remains above the national average	Joint Management Groups	74% Feb 2018	> 69.9%	Feb-19	70.1	G	70.1	G	National social care user survey February 2019
	3.6 Maintain the number of home care hours purchased per week	Joint Management Groups	21,353 Dec 2018	21,779	Mar-19	21,327	A	20,876	A	The number of home care hours increased substantially till 2 years ago. It has now stabilised despite increased need, due to workforce capacity
	3.7 Reduce the rate of Emergency Admissions (65+) per 100,000 of the 65+ population	Joint Management Groups	22,822 (2017/18)	24,550 or fewer	Jun-19	19,677	G	23,559	G	Year to date to June
	3.8 90th percentile of length of stay for emergency admissions (65+)	Joint Management Groups	16 (2017-18)	18 or below	Jun-19	13	G	13	G	Year to date to June
	3.9 Reduce the average number of people who are delayed in hospital [2]	Joint Management Groups	85 (Dec 2018)	TBC	Aug-19	95	A	121	R	Latest national published figure for July DTOC Bed days for Oxfordshire. Trajectory for July 63 . Main causes of delay are: awaiting HART or placement. HART Improvement Plan has system oversight to support delivery with key performance indicators against agreed thresholds and improvement trajectories.
	3.10 Reduce the average number of people delayed when discharged from hospital to care homes	Joint Management Groups	8 people (Dec 2018)	average of 6 at yr end	Jul-19	6.1	G	4.4	G	
	3.11 Validated local position of CCG on average length of days delay for locally registered people discharged from hospital to care homes	Joint Management Groups	2.48 (17/18)	< 2.48	Jun-19	2	G	2.19	G	
	3.12 Reduce unnecessary care home admissions such that the number of older people placed in a care home each week remains below the national average	Joint Management Groups	13.0 (Apr-Dec 2018)	14	Aug-19	11.5	G	12.5	G	
	3.13 Increase the Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Joint Management Groups	77% (Oct-Dec 2017)	85% or more	Oct - Dec 2018	73.7	R	73.7	R	This measure is a national measure of people leaving hospital with reablement between October and December and whether they are at home 91 days later. A lower figure could imply that cases picked up are more complicated.
	3.14 Increase the Proportion of older people (65+) who are discharged from hospital who receive reablement / rehabilitation services	Joint Management Groups	1.4% (Oct-Dec 2017)	3.3% or more	Oct - Dec 2018	1.7	A	1.7	A	This measure is a national measure of the proportion of older people who leave hospital with reablement between October and December. A higher figure suggests greater use of reablement. The latest national figure (2017) is 2.9%The measure is used to monitor the CQC action plan
	3.15 Increase the estimated diagnosis rate for people with dementia	Joint Management Groups	67.8% (Apr-Dec)	67.8%	Jun-19	68.1%	G	67.8%	G	Figure to June
	3.16 Maintain the level of flu immunisations for the over 65s	Health Improvement Board	75.9% (2017/18)	75%	Sept 18 to Feb 19	76.3%	G	76.3%	G	
	3.17 Increase the percentage of those sent bowel screening packs who will complete and return them (aged 60-74 years)	Health Improvement Board	58.1% (Q4 2017/18)	60% (Acceptable 52%)	Q3 2018/19	59.5%	A	58.7%	G	
	3.18 increase the level of Breast screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	Health Improvement Board	74.1% (Q4 2017/18)	80% (Acceptable 70%)	Q1 2018/19	73.9%	A	73.5%	G	

Tackling Wider Issues that determine health [2]	4.1 Maintain the number of households in temporary accommodation in line with Q1 levels from 18/19 (208)	Health Improvement Board	208 (Q1 2018-29)	>208	Q4 2018/19	n/a		141	G	
	4.2 Maintain number of single homeless pathway and floating support clients departing services to take up independent living	Health Improvement Board	tbc	<75%	Q4 2018/19	n/a		89.1%	G	
	4.3 Maintain numbers of rough sleepers in line with the baseline "estimate" targets of 90	Health Improvement Board	90 (2018-19)	>90	Q3 2018/19	n/a		119	R	
	4.4. Monitor the numbers where a "prevention duty is owed" (threatened with homelessness)	Health Improvement Board	no baseline	Monitor only	Q4 2018/19	n/a		307		
	4.5 Monitor the number where a "relief duty is owed" (already homeless)	Health Improvement Board	no baseline	Monitor only	Q4 2018/19	n/a		162		
	4.6 Monitor the number of households eligible, homeless and in priority need but intentionally homeless	Health Improvement Board	no baseline	Monitor only	Q4 2018/19	n/a		15		

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Report to the Health and Wellbeing Board – 26 September 2019

Report from	Children's Trust Board (Chair – Cllr Steve Harrod)
Report Date	21st August 2019
Dates of meetings held since the last report: 20th June 2019	
HWB Priorities addressed in this report • A Healthy Start in Life	
Link to any published notes or reports: https://www.oxfordshire.gov.uk/cms/content/children-and-young-peoples-plan-2018-2021 (Link to current Children and Young People's Plan)	
Priorities for 2019-20	**Be Successful** 1. Have the best start in life. 2. Access high quality education, employment and training that is motivational. 3. Go to school and feel inspired to stay and learn. 4. Have good self-esteem and faith in themselves. **Priority focus for 2019/20: Focus on children missing out on education**
	Be Happy and Healthy 5. Be confident that services are available to promote good health and prevent ill health – early in life and before crisis. 6. Learn the importance of healthy, secure relationships and having a support network. 7. Access services to improve overall well-being. 8. Access easy ways to get active. **Priority focus for 2019/20: Focus on social and emotional well-being and mental health**
	Be Safe 9. Be protected from all types of abuse and neglect. 10. Have a place to feel safe and a sense of belonging. 11. Access education and support about how to stay safe. 12. Have access to appropriate housing. **Priority focus for 2019/20: Focus on domestic abuse**
	Be Supported 13. Be empowered to know who to speak to when in need of support and know that they will be listened to and believed. 14. Access information in a way which suits them best. 15. Have inspiring role models. 16. Talk to staff who are experienced and caring.

1. Progress reports on priority work to deliver the Joint HWB Strategy

Priority	**Be Successful**
Focus	Children missing out on education
Deliverable	See Children and Young People Plan for list of 11 deliverables.
Progress report	An annual review of the deliverables highlighted good progress in a number of areas, however there is still more work to do to meet some of the targets. The Board agreed to retain these targets for 19/20 and introduce two additional targets: 1. Reduce the number of children missing education to 25 by 19/20. 2. Elective Home Education – no children on CP/CIN plans electively home educated by 19/20 (from 3/24).

Priority	**Be Healthy**
Focus	Social and Emotional Wellbeing and Mental Health
Deliverable	See Children and Young People Plan for list of 6 deliverables.
Progress report	Good progress has been made against a number of the targets. The Board agreed to carry forward and continually monitor the early help assessment and CAMHS targets. Two new targets have been introduced: 1. 2 pilot MHSTs operational by December 2019 (national target) 2. All 34 schools in pilot to identify Mental Health Lead

Priority	**Be Safe**
Focus	Domestic Abuse
Deliverable	The Domestic Abuse Strategic Board is responsible for this action and is reviewing and implementing a revised pathway.
Progress report	Good progress has been made on embedding the Domestic Abuse pathway since it was relaunched in July 2018. Going forward this will be measured via the outcome of a peer review audit, alongside a separate report which will evaluate the Domestic Abuse training outcomes.

Priority	**Be Supported**
Focus	Listen to the feedback from young people in Oxfordshire
Deliverable	This deliverable was measured via a survey run by Voice of Oxfordshire Youth (VOXY)
Progress report	Feedback was gathered, via the questionnaire, from over 500 children. A report has been collated on the learning and is being used to update the implementation plan for the forthcoming year. The results of the survey will also form a benchmark to test the next survey against. As a result of the learning the following poster has also been produced - www.oxfordshire.gov.uk/keymessages

2. Note on what is being done in areas rated Red or Amber in the Performance Framework

Indicator Number	RAG	What is being done to improve performance?
1.1b increase the proportion of children that have their first appointment (with CAMHS) within 12 weeks.	R	The average referrals per month to CAMHS has increased by 40% from 499 in 2015-16 to 697 for the months of May 2018 – February 2019. As previously reported we have been successful in our bid to become a Trailblazer for CAMHS Green Paper which means additional funding of £5.4m by 2022. The two (16WTE) Mental Health Support Teams (MHST) to deliver mental health support in Oxford City secondary and primary schools now fully recruited to and mobilisation has started. Infrastructure is being in place in selected schools and a team base has been secured. A new on-line service is operational and 60 children have been identified and are now receiving treatment, which is helping to eradicate the backlog for the Getting Help Pathway. Train to recruit posts for the Getting More Help Pathway are being trained at Reading University as well as the trainees for the Mental Health Teams into Schools pilot. There is still a programme in place transferring patients from the Getting More Help pathway to the new neuro developmental conditions (NDC) pathway. We are anticipating on having a complete picture on the number of children and young people in the NDC pathway by May 2019 and detailed plans to reduce waiting times. Additional funding from NHS England (£95,000) has been awarded to help clear the longest waiters (111 CYP). Healios has got a new contract with OHFT for this additional work and a draft contract is in place. Trajectory is currently being worked on with Healios
2.3 Ensure that the attainment of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average. * Key Stage 2 * Key Stage 4	R	This is a key area of focus identified by the SEND performance board. A detailed action plan is in place and is overseen by the board and the Head of SEND. This has a focus on increasing the level of support in early intervention for mainstream schools and the gathering of evidence for where a pupil is requiring additional support. This action plan has been shared and signed off by Department for Education and the Care Quality Commission.
2.5 Reduce the persistent absence	R	The trust has a detailed review of children's attendance and attainment at its September.

Indicator Number	RAG	What is being done to improve performance?
of children subject to a Child Protection plan		Following the launch of the Learner Engagement services in October, the education service is actively working with schools within a new Learner Engagement strategy overseen by the Learner Engagement Board. The Board has focused on persistent absence through the introduction of a behaviour and attendance helpline for schools; model attendance policy and schools audit, attendance flow chart, re-integration guidance, flexi-schooling guidance. Additionally, Learner Engagement services are working in partnership with CAMHS on their Oxford City pilot and wave 2 bid for the north and the south of the county.
3.14 Reduce the number of looked after children to the average of our statistical neighbours	R	At the end of the year 780 children were looked after against a target of 672 (the average of similar authorities). The number has dropped slightly since the end of December (794) and continues to drop – at May 1st 771. The recent Ofsted inspection rated our children's services overall, and services for looked after children, as 'good', which assures us that we are performing well and keeping children safe. However, the high numbers can mean that children are placed further away, and workload pressures rise. Each current looked after case has been reviewed by a senior manager in the council to determine an appropriate plan is in place. All external places are regular reviewed to ensure that they are appropriate. Within the council's 'Journey of the Child' programme we have a set of projects looking at the sufficiency of placements and how we support looked after children returning home after placements. 60% of children who become looked after do so within a year of them being on a child protection plan. Reducing child protection numbers should have a knock-on to looked after numbers (as has been seen in the Herts Family Safeguarding model).
4.1 Improve the disadvantaged attainment gap at all key stages and aim to be in line with the national average by 2018 and in the top 25% of local authorities.	R	At Key Stage 2, the disadvantaged attainment gap has worsened from 26% in academic year 2016/17 to 29% in 2017/18. This is greater than the national average of 20% for 2017/18. At Key Stage 4, the average point score in Oxfordshire for the 17/18 academic year, for children with Special Educational Needs and Disability but no statement or Education Health and Care Plan was 28 points compared to 28.5 last year (i.e. lower) and a national score of 32.2. This means that Oxfordshire is ranked lowest of all its statistical neighbours. (The disadvantaged attainment gap – looks at the achievement of young people who have had free school meals in the last 6 years, are looked after or are adopted from care). For the gap to be the same as that nationally – an additional 140

Indicator Number	RAG	What is being done to improve performance?
		disadvantaged pupils in Oxfordshire would need to achieve the expected standard. The education service is working in partnership with schools to implement key strategies including school readiness and writing skills in Key Stage 2 to improve this gap for pupil premium pupils.
2.4 Reduce the persistent absence of children subject to a Child in Need plan.	A	Please see comments on 2.5 above. The same strategies and plans are in place to support improvement in both measures.
2.6 Reduce the number placed out of county and not in a neighbouring authority	A	Please see 3.14 above
3.5 Reduce the number of social care referrals to the level of our statistical neighbours	A	This measure is one of a suite of measure to monitor whether we are increasing early help and reducing the need for social care services Although the number of referrals has increased this year, it remains below the national average. At the same time the number of early help assessments has risen and the number of social care assessments has fallen and is below that of similar authorities. This has helped to support a significant fall in the number of children who are the subject of a child protection plan. After over 10 years of growth in child protection numbers (there were 250 children the subject of child protection plans at March 2009) the number this year has reduced by 100. The target to support people early and reduce those needing to come into the social care system is clearly beginning to bear fruit.
4.2 Increase the % of children reaching a good level of development in early years or foundation stage (target 75% for academic year 17/18)	A	Performance remains above the national average, but is just short of the stretched target we set. Performance shows a three-year trend of improvement with a 1% increase from 16/17. The Early Years and Foundation Stage team is working with schools and other settings to secure further increase, particularly linked to disadvantaged learners and school readiness (i.e. narrowing the GAP indicator covered in 4.1 above)

3. Summary of other items discussed by the board

The Board agreed to retain the same priority areas of focus for 2019-20 as there was still some work to do to meet a number of targets and measures. However, it was also noted that good progress had been made in a number of areas.

A presentation was received on School Readiness. A strategy is currently being developed, with input from across the sector. This is planned to be rolled out in September 2019 and officially launched as a conference in November 2019. Data analysis of Good Learned Development is showing that Oxfordshire is about average with its' statistical neighbours. However, the gap between those children eligible for Free School Meals and those claiming them is widening. It was also acknowledged that more work is needed to strengthen the connections between the public and voluntary sectors in this area.

SEND Update:

Work is currently being done, focusing on the five areas of improvement as outlined in the Written Statement of Action (WSoA).

- Area A (effective lines for accountability) - This has mostly been implemented. A SEND Strategy is currently in development, with stakeholders providing input.
- Area B (self-evaluation) – A review is taking place on the processes around the Education, Health and Care timeline. Additionally staff are being consulted on changes and feedback so far is proving positive.
- Area C (Quality of Education, Health and Care Plans (EHCP)) – Although challenging to track, regular monitoring is showing that an improvement has been made.
- Area D (timeliness of the completions of ECHP) – This has improved, however external factors such as; increase in demand and the reforms in the criteria to access the service has resulted in the improvements being slower than expected.
- Area E (High level of fixed term exclusions) – Progress is being made, however this is mixed. The Council's Education Scrutiny Committee has been focussing a 'deep dive' exercise on exclusions.

4. Forward plan for next meeting

The following items are due to be considered in the forthcoming October meeting:

- Children Missing Out on Education
- Corporate Parenting
- Youth Justice Annual Report
- SEND Reform

Report to the Health and Wellbeing Board, (**26th September**)

Report from	Better Care Fund Joint Management Group
Report Date	13th September 2019
Dates of meetings held since the last report: 24th July 2019	
HWB Priorities addressed in this report □ A coordinated approach to prevention and healthy place-shaping. □ Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan). □ An approach to working with the public so as to re-shape and transform services locality by locality. □ Plans to tackle critical workforce shortages. □ A Healthy Start in Life □ Living Well □ Ageing Well □ Tackling Wider Issues that determine health	
Link to any published notes or reports: n/a	
Priorities for 2019-20	The Better Care Fund Joint Management Group will deliver the priorities outlined in Living Longer, Living Better: Oxfordshire's Older People's Strategy. The priority themes identified in this strategy are: i. Being physically and emotionally healthy ii. Being part of a strong and dynamic community iii. Housing, homes and the environment iv. Access to information and care

1. **Progress reports on priority work to deliver the Joint HWB Strategy (priority, aim, deliverable, progress report)**

a. Market Position Statements

Priority	Ensure services are effective, efficient and joined up and that the market for provider organisations is sustainable.
Aim or Focus	To approve the Market Position Statements for publication.
Deliverable	The aim of a Market Position Statement is to bring together information and analysis about the local market so that current and prospective providers understand the local context, what is likely to change and where opportunities might arise in the future. It also supports the Council to carry out its duty, under the Care Act 2014, to maintain an efficient and effective care market for the population of Oxfordshire. This Market Position Statement has been jointly written by colleagues across the Council and OCCG and has been co-produced with providers of services. It sets out our joint commissioning intentions for care and support, and accommodation-based services. The document is designed to help providers shape their business plans to support the council's vision for the future of local public health, social care and specialist housing provision. It also helps providers to identify opportunities they may tender for and how they might best develop services to meet local need and demand.
Progress report	The Market Position Statements were agreed for publication and the good work to engage provider partners in the development of these was noted..

b. Self funder offer

Priority	Support the care of older people
Aim or Focus	To review the plan to develop support for people who fund their own care, as required following the CQC Local System Review.
Deliverable	The project has been established as part of a larger workstream which will see the implementation of the Council's new model of Care and Support Brokerage. The development of a Self-Funder's pathway for the Council is one element of this implementation. The development of the Self Funder Pathway will provide additional advice and guidance as well as financial guidance to enable people who fund their own support to arrange services quickly and with greater confidence.
Progress report	Members of the Joint Management Group reviewed the plan to review support to people who fund their own care, with the following activities planned:

	• Finalise communications strategy • Complete full data analysis of engagement data to better manage expectations of self-funders. • Review of contracts to ensure care act and legal compliance • Follow-up workshops with stakeholders (internal and external) to agree pathway and ways of working. • Ongoing engagement plan • Details of PILOT way of working in hospital setting to be finalised • Work closely with Service Improvement team.

c. Choice in Personal Budgets

Priority	Help people maintain their independence and remain active in later life.
Aim or Focus	To develop support enabling people in receipt of a personal budget in making choices and meeting their needs in a personalized way.
Deliverable	This work is being co produced with people in receipt of a personal budget to develop options that meet their needs in supporting decision making.
Progress report	The group supported the work to date and requested that focus was given to understanding the Personal Assistant market going forward.

2. **Note on what is being done in areas rated Red or Amber in the Performance Framework**

Indicator Number	RAG	What is being done to improve performance?
3.1	R	Oxfordshire University Hospitals are leading the delivery of an improvement plan for the HART service, supported by system partners.
3.2	R	This measure is subject to close monitoring and is supported by the HART improvement plan. The delivery of this improvement plan is overseen by a board comprising senior system leaders. August saw an increase in hours delivered.
3.3	A	The level of hours is not delivering the level of cases as the amount of care provided per person is higher than predicted.
3.6	A	Home care capacity remains a challenge, due to workforce capacity within Oxfordshire. A range of measures to support the capability and capacity within the workforce are underway, and Oxfordshire County Council is leading a review of the homecare commissioning strategy to develop capacity in the medium and longer term as well as working with providers and system partners to prepare for winter.
3.9	R	Main causes of delay are: awaiting HART or placement. HART Improvement Plan has system oversight to support

		delivery with key performance indicators against agreed thresholds and improvement trajectories.
3.13	R	Oxfordshire University Hospitals are leading the delivery of an improvement plan for the HART service, supported by system partners. A lower figure against this measure could imply that more complex cases are support through the HART service.
3.14	A	This measure is a national measure of the proportion of older people who leave hospital with reablement between October and December. A higher figure suggests greater use of reablement. The latest national figure (2017) is 2.9%The measure is used to monitor the CQC action plan

3. **Summary of other items discussed by the group**

a. **Progress with the Older People's strategy delivery plan** were reviewed
b. **Contributions to the Pooled Budget:** were formally agreed.
c. **Winter plan 2019-20 outline** was reviewed
d. **Review of commissioned services paper** was reviewed.

4. **Forward plan for next meeting**

25th September 2019	Better Care Fund Planning template. CQC data profiles CHC and fast track overview Improved Better Care Fund outcomes.

Report to the Health and Wellbeing Board, 26th September 2019

Report from	**Adults with Support and Care needs Joint Management Group**
Report Date	10 September 2019
Dates of meetings held since the last report: 25th July 2019	
HWB Priorities addressed in this report ☐ A coordinated approach to prevention and healthy place-shaping. ☐ Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan). ☐ An approach to working with the public so as to re-shape and transform services locality by locality. ☐ Plans to tackle critical workforce shortages. ☐ A Healthy Start in Life ✓ Living Well ☐ Ageing Well ☐ Tackling Wider Issues that determine health	
Link to any published notes or reports: None	
Priorities for 2019-20	Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems will live independently and achieve their full potential. This includes: • Improving access to mental health support (including psychological therapies, the Emergency Department Psychiatric Service and packages of care following experiencing first episode psychosis or At Risk Mental State) • Reducing health inequalities for people with severe mental illness and people with learning disabilities • Increasing the number of people in employment who have severe mental illness or learning disabilities • Reducing the number of people with learning disabilities and/or autism admitted to specialist in-patient beds, or placed out of county

1. **Progress reports on priority work to deliver the Joint HWB Strategy (priority, aim, deliverable, progress report)**

a. Strategy for Adults of Working Age with Care and Support Needs

Priority	To work with people who receive services and their carers to understand what they want from services that support them over the next five years
Aim or Focus	The Adults' strategy will bring together the vision for services for people who have mental illness, a learning or physical disability, autism, a sensory impairment, a long-term health condition or brain injury. We are developing this in conjunction with people who use these services and their carers
Deliverable	Draft strategy to be brought to Health & Wellbeing Board in December before going out for public consultation
Progress report	• A reference group was established including people who use services, carers and representatives for organisations which support people, which has focused on the development and then the results of the user survey. • The user survey was co-produced by the reference group, ran for four weeks in June, and received over 400 responses. • In June we also attended meeting of groups who support people across the areas covered by the strategy to hear about what is most important about the help and support they receive now and in the future. • The new Working Age Adults Needs Assessment was released in August (http://insight.oxfordshire.gov.uk/cms/new-working-age-adults-needs-assessment-2019). This is a supplementary report to the main JSNA report and provides additional health and wellbeing data on working age adults (aged 18-64) with physical disabilities, learning difficulties and mental health problems. • Based on the user survey and focus groups, a strategy has been drafted. We are reviewing this, following a meeting of the reference group, to ensure that everyone's views are incorporated into the strategy.

b. Market Position Statement

Priority	To inform providers of Adults & Older People's services about anticipated demand and commissioning intentions for care homes, home care, mental health services, learning disabilities & extra care housing

Aim or Focus	By sharing data about the needs of Oxfordshire residents and the Council's commissioning intentions, we help to develop a sustainable market who can provide the services people need.
Deliverable	Market Position Statement to come to the JMGs in July for publication in September
Progress report	Final document has been approved by the JMGs and is now available on the Oxfordshire County Council and Oxfordshire Clinical Commissioning Group websites: https://www.oxfordshire.gov.uk/business/information-providers/adult-social-care-providers/news-and-updates https://www.oxfordshireccg.nhs.uk/key-occg-publications/oxfordshire-market-position-statement-20192022/95101 •

c. Reviews of Outcome Based Contract (OBC) for mental health services and of social work staffing in Integrated Mental Health Teams (IMHTs)

Priority	To provide an independent evaluation of the effectiveness of the OBC to date ensure it is fit for purpose, meeting the right needs, and that the voluntary sector is fairly funded. Alongside that, to ensure that we are meeting our statutory duties regarding social work delivery in the IMHTs and that this can be carried out within the budget available.
Aim or Focus	The OBC for mental health services runs from 1 October 2015 until 30 September 2020. The review will inform extension of the contract to September 2022 and will help determine whether the voluntary sector's contribution to the partnership is fairly funded.
Deliverable	A report of both reviews will go to the Council's Performance Scrutiny Committee and the Oxfordshire Joint Health Overview & Scrutiny Committee.
Progress report	• OBC review: The four workstreams have been completed and chapters sent to the Centre for Mental Health who are collating and summarizing the report. • A draft report is currently being considered. • Social work review: an initial draft has been completed and a more detailed consideration of activity in the teams is currently underway.

2. **Note on what is being done in areas rated Red or Amber in the Performance Framework**

Indicator Number	RAG	What is being done to improve performance?
2.3 Improving access to psychological therapies: The % of people who have depression and/or anxiety disorders who receive psychological therapies	Red	National target 22%. Q1 figure 19.5%. July 22.3%. Local system agreement to maintain the 2018/19 target of 19% for 2019/20, due to prioritizing current resources to support adult mental health teams' core services.
2.4 The proportion of people who complete psychological treatment who are moving to recovery.	Red	National target 50% Q1 51%, July 47.6% - recovery rate is being monitored through teams as the impact of access over performance is known to adversely affect recovery rate.
2.7 The proportion of people on General Practice Seriously Mentally Ill registers who have received a full set of comprehensive physical health checks in a primary care setting in the last 12 months.	Red	Target 60%, Q2 figure 29%. This is a relatively new target and a new enhanced service for primary care to deliver. Target is achieved when all six health checks have been completed therefore performance is expected to improve throughout the year and support is being offered to address data quality issues. Currently Oxfordshire is performing better than its regional counterparts.
2.8 Number of people referred to Emergency Department Psychiatric Service seen within agreed timeframe	Red	Target 95% Q1 JR 79% and HGH 66%, July showed improvement at HGH at 85%. Emergency Department Psychiatric Service is under close scrutiny. Previous analysis shows the targets were only just missed and actions to mitigate issue of overnight staffing within existing resources in place.
2.11 Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by March 2020	Amber	OCCG is contacting practices to promote the Oxford Health Learning Disability primary care liaison service. This supports practices to engage with their LD populations, including encouraging eligible individuals to have annual health checks. Historically the majority of health checks are carried out in Q4. In 2019-20 practices delivered health checks to 74% of the eligible population.
2.15 Reduce the number of people with learning disability and/or autism placed/living out of county	Amber	Small decrease in numbers since last report. Project plan drafted to bring some people back in county; a range of services are being developed to prevent future out of area placements.

3. **Summary of other items discussed by the group**

a. Performance, Activity and Finance Report: At each meeting there is review and discussion of the financial position of the pooled budget and the activity driving it.

b. Finance schedule to the section 75 agreement: The finance schedule for 2019/20, which includes the contributions to the pooled budget and the risk sharing agreement was agreed.

c. Abated clients protocol: The protocol describes what is expected in managing people with social care needs whose assessments are completed by the Adult Mental Health Teams but fall outside of the scope of the Outcomes Based Contract for mental health services, (people referred to as abated) and the decision making regarding the management of the financial impact. The revised protocol was agreed by the JMG.

d. Risk management for people with high-functioning autism: Chris Walkling outlined the concerns from social work operational teams and from primary care clinicians in relation to the risk management of people with high-functioning autism and challenging behaviour in the community. A process to support the clinical risk management of those people has been put in place. Chris was asked to bring a report to the September JMG proposing further work to support this group of people more effectively.

e. Personal Budgets: Rebecca Lanchbury brought a report on increasing choice within people's personal budgets and was asked to bring back an updated proposal based on Group's discussions.

4. **Forward plan for next meetings**

For 25th September 2019:

- Mental Health Outcomes Based Contract Review
- Services for people with high-functioning autism
- Service & Resource Planning

For 28th November 2019:

- Review of Commissioned Services
- SEND report

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Report to the Health and Wellbeing Board, **26 September 2019**

Report from	Health Improvement Partnership Board
Report Date	13th September 2019
Dates of meetings held since the last report: 12th September 2019	
HWB Priorities addressed in this report ☐ A coordinated approach to prevention and healthy place-shaping. ☐ Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan). ☐ An approach to working with the public so as to re-shape and transform services locality by locality. ☐ Plans to tackle critical workforce shortages. ✓ A Healthy Start in Life ✓ Living Well ✓ Ageing Well ✓ Tackling Wider Issues that determine health	
Link to any published notes or reports: Papers for the September meeting were published and can be found here: https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=899&MId=6144	
Priorities for 2019-20	**1. Keeping Yourself Healthy (Prevent)** • Reduce Physical Inactivity / Promote Physical Activity • Enable people to eat healthily • Reduce smoking prevalence • Promote Mental Wellbeing • Tackle wider determinants of health - Housing and homelessness • Immunisation **2. Reducing the impact of ill health (Reduce)** • Prevent chronic disease though tackling obesity • Screening for early awareness of risk • Alcohol advice and treatment • Community Safety impact on health outcomes **3. Shaping Healthy Places and Communities** • Healthy Environment and Housing Development • Learn from the Healthy New Towns and influence policy • Social Prescribing • Making Every Contact Count • Campaigns and initiatives to inform the public

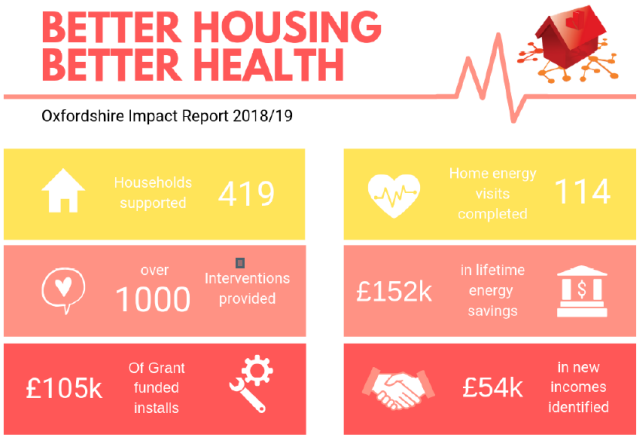
1. **Progress reports on priority work to deliver the Joint HWB Strategy (priority, aim, deliverable, progress report)**

a. Housing Support Advisory Group

Priority	To prevent and reduce the impact of homelessness and rough sleeping
Aim or Focus	The Housing Support Advisory Group report covered 3 topics 1. Performance update on preventing homelessness 2. Process for an independent review of deaths of homeless or recently housed people in 2018-19 3. Transformation of housing support services
Deliverable	Partnership work and joint reporting across all local authorities to reduce and prevent homelessness
Progress report	The full report can be seen here: https://mycouncil.oxfordshire.gov.uk/documents/s48339/Item%209%20-%20HSAG%20Health%20Improvement%20Report%20030919.pdf The performance report highlighted the following: • Between Q1 and Q4 there has been a reduction in the number of households in temporary accommodation from 195 to 141 • In total there were 1,246 prevention duties undertaken across the County in 2018-19. This would involve activities to enable an applicant to stay in their current home or find alternative accommodation in order to prevent them becoming homeless. • In total there have were 630 relief duties provided across Oxfordshire in 2018-19. This is almost exactly half the number of households benefitting from a prevention duty. • Rough sleeping numbers reported are higher than last year and therefore the indicator is rated RED. See below In addition it was noted that the independent review of deaths of people in the homeless pathway is scheduled to report in February 2020.

b. Affordable Warmth Network annual report

Priority	To tackle the wider determinants of health by reducing fuel poverty, especially for those for whom cold homes will exacerbate existing health conditions.
Aim or Focus	The Health Improvement Board agreed the following recommendations: Continue to champion the role housing plays in protecting and maintaining the health of both young, old and vulnerable and ensures housing has a place in the Health and Wellbeing Strategy. Request the AWN to report next year on the progress on tackling inequalities, particularly around young families. Challenge clinical and health and social care partners to explore opportunities to work more closely with the AWN, with success being demonstrated by an increase in referrals from health and social care practitioners to the BHBH service.

Deliverable	To deliver the Better Housing Better Health freephone advice line, helping residents to access services to tackle fuel poverty. Also to raise awareness and embed referral pathways with key health and social care partners
Progress report	 The full report can be seen here: https://mycouncil.oxfordshire.gov.uk/documents/s48263/Item%2010%20-%20HIB%20Report%20on%20Fuel%20Poverty%20and%20poor%20Housing%20Conditions.pdf

c. Whole System Approach to Healthy Weight

Priority	To develop a whole systems approach to healthy weight which incorporates environmental factors, food, physical activity and weight management programmes **Overarching principles to guide this work** □ There is no single solution to tackle obesity □ We need to work collaboratively across traditional sectors and boundaries □ Collective and coordinated action is greater and more effective than its parts □ We need to gain further insght and co-design solutions with our communities □ Universal and targeted action is needed to address health inequalites □ We all need to be confident talking about weight

Aim or Focus	**Where do we want to be?** We will develop, test and implement a whole systems approach to healthy weight across the lifecourse that will focus on 3 key delivery themes, detailed below. 
Deliverable	**In 2019-2021 we will continue with the above and work with partners to:** • Develop a healthy weight system story map for Oxfordshire to identify the scale of the issue, develop a clear rationale for targeted action, and engage stakeholders • Map the current healthy weight initiatives in Oxfordshire to better understand the existing system • Map the drivers of obesity locally and explore opportunities for further action • Review the levers and barriers to implementing restriction zones for new hot food takeaway premises around schools and colleges • Review the levers and barriers to restrict advertising of high fat high sugar foods on bus stops, bill boards and other advertising spaces • Review the levers and barriers to incentivise healthy catering in Oxfordshire • Conduct a range of face to face interviews and surveys to gain insight from a range of stakeholders, including businesses, the voluntary sector, and children and families to understand their needs and priorities • Work with communities to co-produce and pilot potential solutions • Work with partners to develop a seamless pathway of care across the healthy weight pathway • Procure a public health tier 1 and tier 2 weight management service • Review approaches to reduce weight stigma and develop a workforce that is confident talking about healthy weight • Complete an audit of the local policy and strategy related to healthy weight • Test a range of participatory approaches and activities to inspire and engage stakeholders and identify priorities • Conduct a gap analysis detailing the opportunities and actions that will have the greatest leverage of change in the system • Develop a 3-year WSA action plan for Oxfordshire • Test a WSA in 1 or 2 identified areas
Progress report	Work already completed includes: • Engaged with relevant partners to initiate the development of a healthy weight system story map for Oxfordshire for stakeholder engagement and to inform targeted action • Rolled out the Sugar Smart initative across Oxfordshire • Supported 20 schools to sign up to WOW – the year round walk to school challenge • Extended our adult weight management service contract to August 2020 • Completed primary care and client consultations to inform the procurement of future adult and family weight management services

	• Worked in partnership with Active Oxfordshire to raise awareness of the role of physical activity and healthy weight and ensure joined up working • Held the first childhood obesity whole systems workshop with a range of partners to map the current system and gain feedback our proposed approach The full report can be seen here: https://mycouncil.oxfordshire.gov.uk/documents/s48264/Item%2011%20-%20HIB%20Report_Sep%2019_Healthy%20Weight.pdf

The Board also received updates on

- the Diabetes Transformation Programme – demonstrating a significant improvement in delivery of care, attendance at Expert Patient Programmes and take up of the National Diabetes Prevention Programme
- the Making Every Contact Count initiative – reporting a wide coverage of training for front line workers and more training events available. Coverage of community and acute NHS services needs to expand.
- the development of the Domestic Abuse Strategy which will now go out to further engagement. The Domestic Abuse Strategy Group were congratulated on delivering the draft to the timescales requested by the Board.

2. Note on what is being done in areas rated Red or Amber in the Performance Framework

I. MMR immunisations

Members of the Health Improvement Board discussed the recent drop in the number of children immunized against Measles, Mumps and Rubella. The performance report at the meeting on these indicators shown in the table below:

1.13 Increase the levels of Measles, Mumps and Rubella immunisations dose 1	94.3% (Q2 18/19)	95%	N	Q1 2019/20	94.6%	A
1.14 Increase the levels of Measles, Mumps and Rubella immunisations dose 2	92.7% (Q2 18/19)	95%	N	Q3 2018/19	91.7%	A

Dr Nisha Jayatilleke from NHS England presented a detailed "Report Card" on this issue, explaining the work being carried out to improve MMR immunization rates. There have already been some slight improvements and the current performance is rated Amber (this was red in the previous quarter) as shown in the extract from the performance framework above.

The Board was assured by the range of work to improve immunization rates which includes outreach, written reminders, follow up by GPs and in schools and media work

The full report can be seen here:
https://mycouncil.oxfordshire.gov.uk/documents/s48341/Item%207.1%20-%20MMR_report_card_NHSE.pdf

2. **Rough Sleeping**

The performance report highlighted that the target to prevent an increase in the number of rough sleepers in Oxfordshire has not been met. Discussion focused on work to prevent homelessness but also acknowledged the complexity of reducing rough sleeper numbers.

It was agreed that the final report of the Trailblazer project to prevent homelessness will be presented to the next meeting and the timetable for transformation of housing support services should be shortened and reported

back. A further report on rough sleeper numbers will also be requested when figures are published.

4. **Forward plan for next meeting**

July 2019	Workshop on Social Prescribing
21st November 2019	Items for this meeting may include: • Oxfordshire Prevention Framework • Public Health, Health Protection Forum annual report • Mental Wellbeing working group update • Alcohol and Drugs draft strategy • Social Prescribing and GP referral scheme progress report • Trailblazer report on preventing homelessness

Other news

The Chairman of the Health Improvement Board welcomed several new members to the meeting. The current membership of the Health Improvement Board is:

Cllr Andrew McHugh (Chair)	Cherwell District Council
Cllr Louise Upton (Vice Chair)	Oxford City Council
Cllr Lawrie Stratford	Oxfordshire County Council
Cllr Michele Mead	West Oxfordshire District Council
Cllr Maggie Fillipova-Rivers	South Oxfordshire District Council
Cllr Paul Barrow	Vale of White Horse District Council
Ansaf Azhar	Oxfordshire County Council
Dr Kiren Collison	Oxfordshire Clinical Commissioning Group
Diane Hedges	Oxfordshire Clinical Commissioning Group
Jackie Wilderspin	Oxfordshire County Council
Andy McLellan	Healthwatch Oxfordshire Ambassador
Graeme Kane	Cherwell District Council

Jackie Wilderspin, September 2019

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Strategy and Innovation Directorate
NHS England and NHS Improvement
Quarry House
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22 July 2019

Dear Colleagues

COMMUNITY PHARMACY CONTRACTUAL FRAMEWORK

The Department of Health and Social Care has today published **The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan** jointly with the Pharmaceutical Services Negotiating Committee, and NHS England and NHS Improvement.

This agreement translates commitments in the NHS Long Term Plan into a five-year contractual framework, setting out an ambitious programme of work to help more people stay well within the community. The framework sets out the introduction of new clinical services to develop and expand the role of community pharmacy across three key areas: prevention, urgent care and medicines safety, with community pharmacies further integrated as part of local Primary Care Networks in the way they deliver services.

The key messages are:

- The NHS is introducing an expanded clinical role for local pharmacists, beginning a revolution in patient care which could see community pharmacy becoming the first port of call for minor illness and health advice as the NHS begins its delivery of the NHS Long Term Plan.
- The NHS Long Term Plan promises to make better use of the clinical skills of highly trained professionals like pharmacists, working collaboratively with local healthcare teams led by GPs.
- This new, five-year vision puts community pharmacy on a firm footing and offers more certainty to pharmacy owners and a more fulfilling clinical career for community pharmacists and pharmacy technicians.

In summary, the deal:

- Commits almost £13 billion to community pharmacy through its contractual framework, with a commitment to spend £2.592 billion in each of the next five financial years. This significant investment, compared to original government plans, recognises the contribution that community pharmacy has committed to make towards delivery of the NHS Long Term Plan;

- Provides 5-year stability allowing businesses to make long term decisions and to discuss investment with banks and suppliers;

- Signals a move towards a much more clinically focused service;

- Confirms community pharmacy's future as an integral part of the NHS, delivering clinical services as a full partner in local Primary Care Networks;

- Describes new services which will immediately be offered through community pharmacy as well as a programme to develop evidence-based additions to those services. Foremost amongst the new services is the new national NHS Community Pharmacist Consultation Service, connecting patients who have a minor illness with a community pharmacy which should rightly be their first port of call. This begins with referrals from NHS 111 with piloting of expansion to referrals from GP practices, 111 online, UTCs and A+E, and appropriately relieving pressure elsewhere in the urgent care system;

- Underlines the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community. To underpin this, terms of service will be updated so that by April 2020 being a Level 1 HLP will become an essential requirement for community pharmacy contractors.;

- Recognises that an expanded service role is dependent on action to release pharmacist capacity from existing work. The deal rationalises existing services and commits all parties to action which will maximise the opportunities of automation and developments in information technology and skill mix, to deliver efficiencies in dispensing and services that release pharmacist time;

- Continues to prioritise quality in community pharmacy and to promote medicines safety and optimisation. The current programme of Medicines Use Reviews in community pharmacy will be phased out by the end of 2020/21 as the new programme of structured medication reviews is delivered via PCNs;

- Underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme; and

- Commits to working on a range of reforms to reimbursement arrangements to deliver smoother cash flow, and fairer distribution of medicines margin and better value for money for the NHS.

This agreement will come into effect from October 2019 and run through to March 2024.

For further details please read our Community Pharmacy Contractual Framework Briefing. If you have any queries they can be submitted to ENGLAND.CommunityPharmacy@nhs.net.

Yours faithfully

Ed Waller

Director
Primary Care Strategy and
NHS Contracts Group
NHS England and NHS Improvement

Keith Ridge CBE

Chief Pharmaceutical Officer
NHS England and NHS Improvment

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