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

To: Members of the Health Improvement Partnership Board

Notice of a Meeting of the Health Improvement Partnership Board

Thursday, 21 November 2019 at 2.00 pm

Old Library, Town Hall, Oxford

Yvonne Rees
Chief Executive

Date Not Specified

Contact Officer: ***Julieta Estremadoyro, Partnership Board Officer***
Tel: (01865) 326464; Email: commissioning.partnershipboard@oxfordshire.gov.uk

Membership

Chairman – District Councillor Andrew McHugh
Vice Chairman - District City Councillor Louise Upton

Board Members:

Ansaf Azhar	Director of Public Health, Oxfordshire County Council
Cllr Paul Barrow	Vale of White Horse District Council
Dr Kiren Collison	Clinical Chair of Oxfordshire Clinical Commissioning Group
Cllr Maggie Filipova-Rivers	South Oxfordshire District Council
Daniella Granito	District Partnership Liaison
Diane Hedges	Chief Operating Officer, Oxfordshire Clinical Commissioning Group
Graeme Kane	District Council Director Representative
Det Chief Insp Clare Knibbs	Domestic Abuse Lead, Thames Valley Police
Andy McLellan	Healthwatch Oxfordshire Ambassador
Cllr Michele Mead	West Oxfordshire District Council
Cllr Lawrie Stratford	Cabinet Member for Adult Social Care & Public Health, Oxfordshire County Council
Jackie Wilderspin	Public Health Specialist, Oxfordshire County Council

Notes:

- ***Date of next meeting: 20 February 2020***

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

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Notice of Any Other Business

14:05
5 minutes

To enable members of the Board to give notice of any urgent matters to be raised at the end of the meeting.

6. Note of Decisions of Last Meeting (Pages 1 - 14)

14:10
15 minutes

To approve the Note of Decisions of the meeting held on 12th September 2019 and to receive information arising from them.

Matter arisings:

1. Verbal update on the timescale for the Housing Transformation Workplan by Nerys Parry and Gillian Douglas
   To receive an update on the timetable for Transformation of services for supported housing as requested at the last meeting.

2. Health messages - working together on communication – Update by Graeme Kane
   To receive an update from local authorities on working together to promote health through their communication channels.

7. Performance Framework (Pages 15 - 20)

14:25
20 minutes

Performance Framework report presented by Ansaf Azhar

To receive an update on performance, note the variation in outcomes reported for some

indicators and discuss any Red and Amber rated indicators.

Report Card on smoking at time of delivery – to be confirmed

8. Healthwatch Ambassador report

14:45
10 minutes

Report presented by Andy McLellan

To receive updates from Healthwatch Oxfordshire on topics relevant to the Board.

9. Oxfordshire Prevention Framework (Pages 21 - 94)

14:55
20 minutes

Report presented by Kiren Collison, Ansaf Azhar and Jackie Wilderspin

To give an overview of the Prevention Framework and discuss how it can be put into action.

SHORT BREAK

3:15
10 minutes

10. Housing and Homelessness - Trailblazer report on preventing homelessness (Pages 95 - 102)

15:25
15 minutes

Presentations by Paul Wilding and Nerys Parry

To discuss the findings of the Trailblazer project for preventing homelessness.

11. Mental Wellbeing working group update (Pages 103 - 116)

15:40
15 minutes

Report presented by Jannette Smith

To get a progress report including reports of actions from partners since they signed up to the Mental Health Prevention Concordat.

12. Alcohol and Drugs draft strategy (Pages 117 - 122)

15:55
15 minutes

Report presented by Kate Holburn

To discuss the content of a revised draft strategy for Oxfordshire.

13. Active Oxfordshire - reducing physical inactivity

16:10
15 minutes

Report presented by Annie Holden and Paul Brivio

To receive an update on work to encourage more physical activity for people with long term conditions.

14. Forward Plan (Pages 123 - 124)

16:25
5 minutes

Presented by Jackie Wilderspin

Discussion and suggestions for future items.

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HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on 12th September 2019 commencing at 14:00 and finishing at 16:00

Present: **Board members**	Cllr Andrew McHugh, Cherwell District Council Cllr Louise Upton, Oxford City Council, Jackie Wilderspin, Public Health Specialist, Oxfordshire County Council Ansaf Azhar Director of Public Health, Oxfordshire County Council Cllr Paul Barrow, Vale of White Horse District Council Cllr Maggie Filipova-Rivers, South Oxfordshire District Council Daniella Granito, District Partnership Liaison Diane Hedges, Chief Operating Officer, Oxfordshire Clinical Commissioning Group Graeme Kane, District Council Director Representative Andy McLellan, Healthwatch Oxfordshire Ambassador
In attendance	Paul Swan, Transformation Programme Manager, Long Term Conditions, Oxfordshire Clinical Commissioning Group Kate Austin, Health Improvement Practitioner, Oxfordshire County Council Katharine Eveleigh, Health Improvement Practitioner, Oxfordshire County Council Matt Neal, Household & Community Project Manager, National Energy Foundation Sarah Carter, Strategic Lead Domestic Abuse, Oxfordshire County Council Nerys Parry, Chair, Housing Support Advisory Group Donna Husband, Head of Public Health Programmes Jannette Smith, Health Improvement Principal, Oxfordshire County Council Dr. Nisha Jayatilleke, Consultant in Public Health, NHS England
Officer:	Julieta Estremadoyro, Oxfordshire County Council
Apologies:	Cllr Lawrie Stratford Cabinet Member for Adult Social Care & Public Health, Oxfordshire County Council Dr Kiren Collison Clinical Chair of Oxfordshire Clinical Commissioning Group Det Chief Insp Clare Knibbs Domestic Abuse Lead, Thames Valley Police Cllr Michele Mead, West Oxfordshire District Council Val Messenger Deputy Director of Public Health, Oxfordshire County Council

ITEM	ACTION
1. Welcome Cllr McHugh welcomed everybody to the meeting.	
2. Apologies for Absence and Temporary Appointments Apologies received as per above.	
3. Declaration of Interest There were no declarations of interest at this meeting.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Notice of Any Other Business None	
6. Note of Decisions of Last Meeting The notes of the meeting held on 16th May 2019 were signed off as a true and accurate record. Actions update: <u>From Item 2 – Apologies for Absence and Temporary Appointment</u> *The Chair to write to Anna, Monica and Jeanette to thank them for their contribution to the HIB –* ***Completed*** <u>From Item 6 – Note of Decisions of Last Meeting</u> 1. *All members to involve their communication teams in sharing health promotion campaigns -* ***Ongoing*** 2. *Jackie to Circulate to NHS England the letter to "all working groups of Health Improvement Board and organisations delivering priority work -* ***Completed*** <u>From Item No. 7 – Performance Framework</u> *Val to request a Report Card from NHS England regarding the falling levels of measles, mumps and rubella immunisations. –* ***On the agenda*** <u>From Item No. 12 – AOB</u> *Jackie to arrange a workshop on social prescribing:* Jackie explained that the workshop was proposed in the context of Primary Care Networks (PCNs) receiving money to employ social prescribing link workers. It was thought that this was a good opportunity to have a workshop involving members of the board and other stakeholders.	

Jackie liaised with various people and organisations and it was concluded that it was not the right time yet. There were PCNs that were in the process of recruiting, and others were talking to the voluntary sector that was doing work on social prescribing. Since then, it has become clear that the money that PCNs will receive from NHS England is not enough to cover for full employment, training and supervision of these workers. The conclusion was to keep a watching brief and hold the workshop when appropriate. Diane added that it would be useful to have common principles for implementing social prescribing across the county and Ansaf said he is keen to be involved as there is potential for addressing wellbeing issues, not just demand management.	
7. Performance Framework and Report Card on MMR vaccination Ansaf referred to the document *Performance Report (*page 9 in the agenda pack). Ansaf acknowledges that the performance indicators are better than the national average. However, in Oxfordshire, there are seven wards in the 20% most deprived in England so it is important to also know about groups with poorer than average outcomes. Ansaf was particularly concern about the level of smoking in pregnancy (1.12). In the county-wide figures appear as amber but there may be substantial variation among wards that are not reported in the figures. He suggested a Report Card considering the data coming from the most deprived areas. Group members agreed that variations in outcomes should be reported wherever possible. **Action: Jackie to request a Report Card from NHS England regarding smoking in pregnancy** **Action: Jackie to work with colleagues who provide the data for the report to see if it is possible to report on the variations (e.g. where the best and the worst places in the county are)** Ansaf made references to the other amber and red categories in the report. Some of these would be considered by the Health Protection Forum. **Action: Eunan O'Neill to ensure the Public Health Health Protection Forum discusses poor performance of immunisation and screening programmes.** **Action: Diane to provide Ansaf with the OCCG comprehensive Flu Plan Report looking at more details on the level of flu immunisation for at risk groups under 65 years old.**	**JW** **JW** **EON** **DH**

Dr Nisha Jayatilleke– MMR Vaccination uptake in Oxfordshire. – Nisha presented the Report Card on page 15 in the agenda pack. She highlighted that although in Q3 the figures were rated RED (89.4%), the numbers have improved (91.7%) and there are measures in place to progress further. She went through the actions in the document (page 16 to 17 in the agenda pack). She also commented on the HPV vaccination that has been carried out through schools directed towards girls. There is a 90% uptake. The vaccine is going to be offered to boys too from September 2019, delivered in schools. *Nisha responded to concerns about data systems, refusal to vaccinate and public information. In response to the last issue she requested that HIB members should look for opportunities spread the immunisation message. The NHS website has very simple, factual information about the scheme that can support that work. The material is available at:* *https://www.nhs.uk/conditions/vaccinations/mmr-vaccine/* Cllr McHugh asked the group members if they were happy for him and Graeme to take follow up actions outside the group to promote health messages. They were focusing on the Flu Programme during September/October and are developing a calendar of activities with the intention to use Facebook for dissemination. Cllr McHugh congratulated Nisha on a great report.	**ALL**
8. Introduction to the new Healthwatch Ambassador Andy McLellan introduced himself and his role as Healthwatch Ambassador. Andy commented on the main Healthwatch achievements of the last year. He referred to the last Annual Report (2018-2019) available at: https://healthwatchoxfordshire.co.uk/our-reports/annual-reports/ Healthwatch has taken a more strategic approach about the impact of their work. They focus on listening to members of the public and passing information to partner agencies (OCCG, OUH, OCC and Oxford Health, as well as other providers). Their work emphasises co-production, helping the public to make sure that their voices are heard in the developing of their services that affected them. Additionally, during 2019/20, mental health would be a main theme that will run all their activities. Councillor McHugh welcomed Andy and reminded him that he came as critical friend to the HIB and his feedback on the work of the HIB would be always welcome.	

9. Housing Support Advisory Group Report Nerys Parry, Chair of the HSAG, referred to the document *Housing Support Advisory Group report to HIB* (page 9 in the agenda pack) and provided the following commentaries: <u>Performance Indicators (point 2 of the Report):</u> The introduction in April 2018 of a new statistical system (H-CLIC) has produced some data recording issues. All data needs now to be verified by the Ministry of Housing Communities and Local Government (MHCLG) which explains the delay in receiving local reports. At present, there are 12 months of verified data allowing for comparison and benchmarking. The Homelessness Reduction Act 2017 (HRA) built on the national Trailblazer Programmers. The Oxfordshire Trailblazer aimed to intervene in different settings to prevent homelessness. There are dedicated workers in hospital settings at the JR and the Horton hospitals. There is presence in the criminal justice system, in probations teams. At social care level, there are worker identifying very early signs of homelessness. The programme will come to an end in October. **Action: Nerys to share the final report of the Trailblazer programme with members of the Board** Nerys reported a change in balance across the county, with more households being prevented from becoming homeless than needing support after being made homeless. This was a welcome development. In relation to households regarded as Intentionally Homeless, Nerys clarified that councils are reluctant to take that decision and always are trying to find alternative options for families. <u>Independent review of deaths in the homeless pathway (Point 3 of the report)</u> In the wake of several deaths of homeless or recently housing people in the last year, an independent consultant has been appointed to review the working of the systems in place to help people experiencing homelessness. A final report is expected in November. <u>County-wide transformation Service (Point 4 of the report):</u> Cherwell District Council (on behalf of all partners) has successfully bid to the Ministry of Housing, Communities and Local Government to fund a county-wide transformation post. The post holder will design a new strategy that will lead to a new recommissioning of housing support services by April 2022. Board members welcomed the report that has given a good overview of the whole new system of working and reporting. It was agreed that housing is an important health issue and getting housing right is a good prevention issue. A question was posed about the transformation work timetable, Nerys pointed out that this is a complex piece of work that involved multiple partners, so the initial timetable had been set on that basis. The aim is to change models, and this is a	**NP**

challenge for all the agencies involved. A request was made that Nerys share the timetable with members. It was noted that the indicator on the number of people sleeping rough is RED. Nerys offered to give an update on this when the next data is available. Cllr McHugh congratulated Nerys on a great report. **Action: Nerys to bring the timetable for the Transformation of Services to the next HIB meeting and update the members on Rough Sleeping numbers when more data is reported.**	**NP**
10. Affordable Warmth Network Update Matt Neal and Kate Eveleigh referred to the document *Report on Fuel Poverty and poor Housing Conditions* (page 27 in the agenda pack). They reported on behalf of the Affordable Warmth Network (AWN) Among the AWN actions has been the delivery of the Better Housing Better Health, a freephone advice line, helping over 400 residents and linking with key health and social care partners as well as with landlords and tenants as detailed in the report. <u>The AWN requested the HIB to:</u> • *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.* *Members agreed with the recommendations.* Cllrs McHugh congratulated the presenters on a great report and highlighted how central housing is to health and wellbeing. Members welcomed the ambition to increase referrals from health and social care as this would help AWN to target their work to those in greatest need.	
11. Whole System Approach to Healthy Weight Jannette Smith, Health Improvement Principal, Oxfordshire County Council referred to the report on *the Whole System Approach to Healthy Weight (*page 47 in the agenda pack) A short video produced by Public Health England was shown at the beginning of the presentation: https://youtu.be/SLu9AOpfsjs	

The video is included in the webpage: https://www.gov.uk/government/publications/whole-systems-approach-to-obesity Jeanette explained the three phases of their work and their plans for 2019-2021. (page 51) She explained that current work aims to build the picture and enable them to identify priorities. Various elements of the work include analysing data on obesity and overweight people, the number and location of fast food restaurants and fast food advertising on billboards in order to understand the drivers of overweight and obesity in Oxfordshire. In Phase 2, they want to engage with stakeholders to design a multiagency plan and start with test cases. Phase 3 is the rolling out of the project to the whole county. They are looking at 3 years plan initially. Recommendations: *Public Health requested that each organisation on the Health Improvement Board identify appropriate representatives who can be involved with this important area of work. This will include working within a Systems Network to develop a Whole Systems Action Plan for Healthy Weight in Oxfordshire.* **Action – All HIB members to go back to their organisations to provide an appropriate representative for the working group.** **Action: Danie to contact her network of colleagues across the districts and copy members of the HIB.** **Action: Diane to liaise with OCCG representatives.** During discussion on this item it was agreed that through a Whole System Approach the whole environment can be tackled to promote healthy behaviours. There was a question on how to change attitudes when being overweight has become the norm. It was also agreed that the solution to obesity has to start with prevention in children to avoid a future problem. Helpful initiatives might include closing roads around schools to encourage children to walk and cycle more. The trials are going to start in the City with the aim to rolling this to all schools. Cllr McHugh congratulated Jeanette on a great report.	**All** **DG** **DH**
12. Diabetes Transformation overview and progress report Paul Swan referred to the document *Diabetes Transformation in Oxfordshire,* (page 53 in the agenda pack). The Report focused on prevalence of diabetes in Oxfordshire and the NHS Diabetes Prevention Programme (NDPP).	

The NDPP programme started June 2017 and to July 2019. 97% BOB GPs practices referred patients to the programme. The programme has 8 NICE Care Processes that aim to reduce the risk of diabetes. The expectation is that improvement in care processes completion will have positive effect on improving treatment target achievement. Additionally, structured patient education is recommended. In this way, people can improve the knowledge and skills to manage their long-term condition. Cllr McHugh pointed out that the main cause of Type 2 diabetes is obesity and that this can be reverse with a change of diet and sensible exercise programme. The message should be that it is not a life sentence. Ansaf added that The National Diabetes Prevention Programme (NDPP) takes action to support people in avoiding the developed of Type 2 Diabetes. It works a pre-diabetes stage. Louise mentioned an initiative called Cities changing diabetes promoted by the charitable arm of Novo Nordisk (more information at: http://www.citieschangingdiabetes.com/home.html). An initiative to form a group in Oxford has started. She invited Paul to join them. **Action: Cllr Upton to provide details of this initiative and meeting to Paul Swan**	**LU**
Jackie praised the quality of information in the report. She asked: 1) Do we know how many people are prevented from having diabetes as result of this interaction with the NDPP? 2) Do we know whether there is equity of access? For instance, diabetes is more prevalence in some Asian communities. Are these equitable represented in the educational programmes? In response to questions on outcomes of the NDPP, Paul explained that it is too soon to receive data from NHS England but there will be a full evaluation in due course. Paul also confirmed that they have been working with providers to ensure that people from all ethnic communities are accessing the structured education programmes. Cllr McHugh congratulated Paul for the great report. *Note received from Paul Swan after the meeting:* *1. DAFNE stands for 'Dose Adjustment For Normal Eating'. Link to programme website: http://www.dafne.uk.com/* *2. Paul thought that the Board may be interested in some feedback from diabetes patients at patient engagement events they have held. There are a number of themes patients raised, but Paul thinks that the following three could be areas the Board (council partners/other services) could help with:* *a. Peer support for and between people with diabetes.* *b. Support to help people make lifestyle changes – particularly those discussed in the meeting: healthy diet, healthy weight, more physical activity.*	

c. Increased public awareness of diabetes and its impact on the lives of people living with both Type 1 and Type 2 diabetes	
13. Making Every Contact Count Kate Austen referred to the document *Progress Report – Oxfordshire Making Ever Contact Count (MECC)* (page 61 in the agenda). Kate provided an explanation on the definition of MECC. It involves opportunistic conversations about health. The programme aims to train people in the skills and confidence to look for cues to start conversations about healthy choices with people in everyday situations and then being able to confidently signpost them to further sources of support and information. Kate confirmed that Talking Therapies workers have been trained as MECC trainers – 11 workers have been trained so far. They will now be delivering training to others through a variety of training courses to suit different organisations. **Requests to HIB (Next Steps):** *1. The Health Improvement Board was asked to note the content of the report and to continue to support the principles and roll out of MECC across Oxfordshire.* *2. The Health Improvement Board was asked to support the IAPT MECC training pilot detailed above by encouraging partners and colleagues in their organisations to participate in the MECC training sessions.* *Places for all training courses can be booked via the Oxfordshire Training Hub at https://oxfordshiretraining.net/event/making-every-contact-count-mecctraining/* *The HIB supported the above requests.* **Action: Danie to distribute the information regarding the MECC training among her contacts.** Diane noticed that there was little information on the involvement with Oxford University Hospitals (OUH) and Oxford Health (OH) in attending training. Kate confirmed that it would be good to increase their participation. Cllr McHugh congratulated Kate on a great report.	**DG**
14. Domestic Abuse update Sara referred to the document *Update on Domestic Abuse Strategy* (page 67 in the agenda pack) in which they look at the 1st year delivery plan. She also referred to the document *Oxfordshire's Domestic Abuse Strategy 2019-2024* (page 71). She explained that in terms of the 5 year strategy, they took the approach of having 4 strategic aims and has worked with the stakeholders and operative people on what the outcomes should been achieved in the 5 years period.	

They had a consultation process with people working in different agencies, other providers in the community and survivors of domestic abuse. The strategy is in draft form and Sarah asked for feedback on this, either at the meeting or through the consultation portal: https://consultations.oxfordshire.gov.uk/consult.ti/Oxon_DA_Strategy/consultationHome Sarah referred to the document *Summary of the Oxfordshire Domestic Abuse Strategic Board meeting* (page 105) and highlighted the piece of work that OSCB is requesting on the impact of domestic abuse for children in Oxfordshire, reviewing the services available and identifying any gaps. At the same meeting, it was proposed the implementation of a Domestic Homicide Review (DHR) Group, which would meet twice a year Cllr McHugh congratulated Sarah on meeting the deadlines suggested by the HIB. There was a question on whether the data dashboard is going to be the measure of progress. Sarah replied it will be but clarified she has not brought the dashboard to the HIB because the actual data mentioned there is so small that individuals can be identified. They are working on this. Cllr McHugh commented that he is keen to see data about the time delay between a domestic abuse complaint and the magistrate's court appearance and has brought this matter to the Thames Valley Policing and Crime Panel. There is evidence that the longer the gap the lower the chance of an effective prosecution.	
15. AOB Forward Plan During the meeting it had been noted that the Preventing Homelessness Trailblazer Report could come to a future meeting or be circulated to members. It was agreed that Domestic Abuse reports could now be every 6 months rather than at every meeting due to the good progress that has been made. The meeting concluded at 16:36	

A report to the Health Improvement Board, November 2019

A matter arising from the notes of the meeting in Sept 2019

Health messaging – Oxfordshire's councils

Oxfordshire's six councils each undertake external and internal communications related to health and wellbeing. Public health returned to local government in 2013 having previously been part of the remit of councils up to 1974. When the Government made the decision to transfer public health back to local government it said it did so with a view to the ability of councils to shape services to meet local needs, to influence wider determinants of health and to tackle health inequalities. Local authorities are democratically elected stewards of their local populations' wellbeing.

Oxfordshire County Council was the authority to take on responsibility for public health. Since 2013 the county council has undertaken public health communications formerly undertaken by the NHS on a wide range of subjects. Oxfordshire's district councils have often linked in to this work – however this has been on an ad hoc basis. Districts – with their responsibilities in spheres such as leisure, community development and housing - have always undertaken wellbeing messaging particular to their geographical areas and their services.

During the Autumn, communications teams from Oxfordshire's six councils shared with each their PR plans as regards health and wellbeing. The table below represents a list of such work – partners in the NHS are already involved in a large number of them.

The intention is to try to align this work better without creating undue bureaucracy and process. As a result it is hoped that such work will reach more people and be more powerful due to its joined up nature, particularly on social media.

Each campaign/round of communication is led by an identified organisation. The existence of the new table provides partner comms teams with an initial notification of what is coming up for their individual forward planning purposes. It will then be for the lead partner in any campaign to share materials (wording, images, graphics, branding) in good time ahead of "go live" for any campaign so that individual councils are ready to share/retweet at the designated moments and consider internal communications to reach staff reflecting the messaging. Councils would be free to change the geographical focus for messaging to instil local relevance without altering core messages. It is hoped that this will create greater consistency. The plan can be refreshed by communications teams every month via email and phone calls.

Graeme Kane
Cherwell District Council
On behalf of all Oxfordshire local authorities

Date	Subject/Campaign	Detail/channels	Lead organisation
November 11-15	Alcohol Awareness Week	Case study based news highlighting Turning Point's new wellbeing services. Digital FB/Instagram ads and Digital ads coming from DrinkCoach	OCC public health
November 18-24	HIV Testing Week	Digital advertising support for the Terence Higgins Trust (THT) campaign	Terence Higgins Trust (THT) lead with OCC public health /Oxford University Hospitals (OUH)
November throughout	Mouth Cancer Action Month	Oxfordshire Community Dental Services CIC – holding clinics/events around Oxfordshire. OCC public health plan to support with digital messages and quote for the news release	Community Dental Services supported by OCC public health
December 1	World Aids Day	As above with HIV Testing week	OCC PH/THT/OUH
January throughout	Winter warmth	Campaign plan/press release/case study helping to improve health related issues to do with the home. Grants for heating, insulation etc. Keeping homes in better condition especially for 75+ age and the vulnerable. This will help with delayed transfer of care	OCC PH team Fits in with Winter plan OCC PH and Adult Social Care (ASC)/Oxford Health (OH)/CCG

January until March Q4 NHS HC NHS Health Check programme is a year round campaign	Have a healthcheck	January, radio campaigns, case study, press release two events. One at Templars Square, Cowley one at Oxford United with lots of PR. Petrol pumps more digital adverts, myth busters	OCC PH team
September to December	Flu campaign	Part of the overall Winter Plan encouraging care home workers to get flu jabs	OCC PH and ASC/CCG/OH
March	Under my skin	Play going around schools in Oxfordshire talking to year 8 and 9 about self- harm. News release	OCC public health commissioned Pegasus Theatre
March 11	No smoking day	Support with digital messages, provide quote for their press release. Potential case study	Provider Led – SmokeFreeLife Oxfordshire
January – Feb	Wellbeing map – discover healthy activities near you	Social media	CDC
January – Feb	Get Fit for Free	Social media video campaign	CDC
Winter & 23 Feb	Fuel Poverty Awareness Day	Social media	CDC

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Health Improvement Board
21 November 2019

Performance Report

Background

1. The Health Improvement Board is expected to have oversight and of performance on four priorities within Oxfordshire's Joint Health and Wellbeing Strategy 2018-2023, and ensure appropriate action is taken by partner organisations to deliver the priorities and measures, on behalf of the Health and Wellbeing Board.

2. The indicators are grouped into the over-arching priorities of:

    - A good start in life
    - Living well
    - Ageing well
    - Tackling Wider Issues that determine health

Current Performance

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

4. For all indicators it is clear which quarter's data is being reported on. This is the most recent data available.

5. Some areas of work will be monitored through achievement of milestones. These are set out on pages 4-5 of this report. For Q1 and Q2 achievement progress is shown for Whole Systems Approach to Obesity, Making every Contact Count, Mental Wellbeing and Social Prescribing.

6. The latest update for some indicators relates to 2018/19; therefore, RAG rating for those indicators refers to 2018/19 targets. Performance for indicators included in this report can be summarised as follows:

    Of the 11 indicators reported in this paper:
    8 *indicators are* ***green***
    6 *indicators are* ***amber***
    2 *indicators are* ***red***

    - 2.16 Reduce the Percentage of the population aged 16+ who are inactive (less than 30 mins / week moderate intensity activity).
    - 2.19i Increase the level of Cervical Screening (Percentage of the eligible population women aged 25-49) screened in the last 3.5)

Health Improvement Board Performance Indicators 2019/20

	Measure	Baseline	Target 2019/20	National or Locally agreed	Update	Latest	RAG	Notes
A good start in life	1.12 Reduce the level of smoking in pregnancy	8% (Q1 18/19)	7%	L (N target >6% by 2022	Q1 2019/20	6.8%	G	Oxfordshire CCG level
	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	Variance 78.9% for a practice in Oxford City and 100% in 25 practices across the county (experimental stats).
	1.14 Increase the levels of Measles, Mumps and Rubella immunisations dose 2	92.7% (Q2 18/19)	95%	N	Q1 2019/20	91.7%	A	Variance less than 80% in three practices (two of which in Oxford City) to 100% in 17 practices (experimental stats).
	1.15 Maintain the levels of children obese in reception class	7.8% (17/18)	7%	L	2018/19	7.6%	G	Children who are obese and does NOT include those overweight (but not obese) These are Initial results which are not yet available at District level (likely to be December).
	1.16 Reduce the levels of children obese in year 6	16.2% (17/18)	16%	L	2018/19	15.7%	G	
Living Well Age 16	2.16 Reduce the Percentage of the population aged 16+ who are inactive (less than 30 mins / week moderate intensity activity)	21% (May 2018)	18.6%	L	May-19	20.3%	R	Cherwell 24.1%; Oxford 15.4%; South Oxfordshire 19.4%; Vale of White Horse 17.6%; West Oxfordshire 26.9%
	2.17 Increase the number of smoking quitters per 100,000 smokers in the adult population	>2,337 per 100,000 (2017/18)	3,468 per 100,000	L	Q1 2019/20	3460	A	Estimated rate per 100,000 based on number of actual quitters for the quarter (475)
	2.18 Increase the level of flu immunisation for at risk groups under 65 years	52.4 (2017/18)	55%	N	Sept 18 to Feb 19	51.4%	A	
	% of the eligible population aged 40-74 years invited for an NHS Health Check (Q1 2015/16 to Q4 2019/20)	97% (2018/19)	99% at year-end (84%, 89%, 94%, 99%)	L	Q2 2019/20	90.5%	G	CCG Localities: North East 85.8; North 88.9; Oxford 93.4; South East 98.6; South West 88.3; West 85.2
	% of the eligible population aged 40-74 years receiving an NHS Health Check (Q1 2015/16 to Q4 2019/20)	49% (2018/19)	50.5% at yearend (41.6%, 44.1%, 47.1%, 50.5%)	L	Q2 2019/20	44.6%	G	CCG Localities: North East 40.5; North 49.7; Oxford 40.4; South East 48.0; South West 46.3; West 41.8

	Measure	Baseline	Target 2019/20	National or Locally agreed	Update	Latest	RAG	Notes
Living Well	2.19i Increase the level of Cervical Screening (Percentage of the eligible population women aged 25-49) screened in the last 3.5)	68.2% (all ages) Q4 2017/18	80%	N	Q4 2018/19	68.3%	A	Variation in districts for 2018/19 data - Cherwell 71.3%; Oxford 53.7%; South Oxfordshire 75.8%, Vale of White Horse 73.9%, West Oxfordshire77.4% (Source|: PHE Public Health Outcomes Framework)
	2.19ii Increase the level of Cervical Screening (Percentage of the eligible population women aged 50-64) screened in the last 5.5 years		80%	N	Q4 2018/19	76.6%	A	Variation in districts for 2018/19 data - Cherwell 75.8%; Oxford 70.4%; South Oxfordshire 78.8%, Vale of White Horse 77.4%, West Oxfordshire79.5% (Source|: PHE Productive Healthy Ageing Profile)
Ageing Well [1]	3.16 Maintain the level of flu immunisations for the over 65s	75.9% (2017/18)	75%	N	Sept 18 to Feb 19	76.3%	G	
	3.17 Increase the percentage of those sent Bowel Screening packs who will complete and return them (aged 60-74 years)	58.1% (Q4 2017/18)	60% (Acceptable 52%)	N	Q4 2018/19	63.5%	G	FIT testing replaced FOBt testing in programme in June. The simpler test kit is likely to improve uptake nationally; preliminary local data is reflecting this (PHE)
	3.18 increase the level of Breast Screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	74.1% (Q4 2017/18)	80% (Acceptable 70%)	N	Q4 2018/19	77.5%	A	Cherwell 78.1%; Oxford 70.3%; South Oxfordshire 77.8%; Vale of White Horse 80.5%; West Oxfordshire 79.8% (Source: PHE Productive Healthy Ageing Profile 2018/19 year data)
Tackling Wider Issues that determine health	4.1 Maintain the number of households in temporary accommodation in line with Q1 levels from 18/19 (208)	208 (Q1 2018-29)	>208	L	Q1 2019/20	153		Officially released by Government 13 December. It is unlikely that the figures will change.
	4.2 Maintain number of single homeless pathway and floating support clients departing services to take up independent living	tbc	<75%	L				Q1 & Q2 to be provided for the next meeting
	4.3 Maintain numbers of rough sleepers in line with the baseline "estimate" targets of 90	90 (2018-19)	>90	L				Reported for Q3 following the official count
	4.4. Monitor the numbers where a "prevention duty is owed" (threatened with homelessness)	no baseline	Monitor only	-	Q1 2019/20	373	-	Officially released by Government 13 December. It is unlikely that the figures will change.
	4.5 Monitor the number where a "relief duty is owed" (already homeless)	no baseline	Monitor only	-	Q1 2019/20	149	-	Officially released by Government 13 December. It is unlikely that the figures will change.
	4.6 Monitor the number of households eligible, homeless and in priority need but intentionally homeless	no baseline	Monitor only	-	Q1 2019/20	13	-	Officially released by Government 13 December. It is unlikely that the figures will change.

1. These measures will be revised in the year, once the older People's Strategy is finalised

Health Improvement Board – Process Measures 2019/20

Measure	Quarter 1			Quarter 2		
	Process	**Progress**	**Rag**	**Process**	**Progress**	**Rag**
Whole Systems Approach to Obesity	Review the National guidance appropriate to Oxfordshire and the NHS Long Term Plan	PHE WSA National Guidance published in July and reviewed. NHS LTP reviewed for adult and childhood obesity. Developed a working group and action plan to take forward the recommendations	G	Identify and engage stakeholders	Stakeholders identified and 50% engaged. HIB agreed in September for all board member organisations to nominate a representative(s) that we can work with which is currenlty being followed up.	A
Making Every Contact Count	Transformation of Oxfordshire MECC Systems Implementation Group	The group has been changed from a task and finish group to currently meeting every two months until further review. Updated terms of reference for the group have been put in place.	G	Promoting MECC approach and training within stakeholder organisations	Various member organisations have been promoting MECC and encouraging the uptake of training. Detailed updates were reported at the September 2019 meeting. More recent specific examples include the Oxford Health Public Health Promotion Resource Unit (PHPRU) including a link to the Wessex MECC eLearning when they send an email to every new user of their service. There are also now 3 MECC Trainers within Age UK Oxfordshire (AUKO) and Action for Carers Oxfordshire. MECC Training is planned to be rolled out to their 150 staff through 3 levels of training from 2020.	G
Mental Wellbeing	Sign Mental Wellbeing Prevention Concordat	All HWB organisations, OMHP and Active Oxfordshire signed the Concordat.	G	Establish a working group for mental wellbeing	All organisations nominated representatives which public health have engaged with the discuss next steps. Working group established in August and meet twice to develop the framework.	G

Measure	Quarter 1			Quarter 2		
	Process	**Progress**	**Rag**	**Process**	**Progress**	**Rag**
Social Prescribing	1. Oxford City - Develop measurable outcomes. Install 'Elemental' social prescribing platform to track the patient journey; 2. SE Locality - All 10 Practices know the Community Navigators and their role and proactively refer patients. Proactive referrals made from the hospital discharge team to the Community Navigators.	1. OxFed (Oxford City service) is no longer going to install Elemental software. 2. SE Locality service developed across all GP Practices.	G	Cherwell and West Oxfordshire - GP Practices identified and targeted for each phase of the scheme roll out; Practices in areas of inequality identified and targeted.	Phased roll out of service across Cherwell and West Oxfordshire on target. 20 Practices signed up out of 26 Practices. Targeting areas of inequality- 5 Banbury town Practices signed up.	G

There is a caveat within the report explaining that the indicators reported on will not be officially released by Government until 13th December. However, it is unlikely that the figures will change.

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:

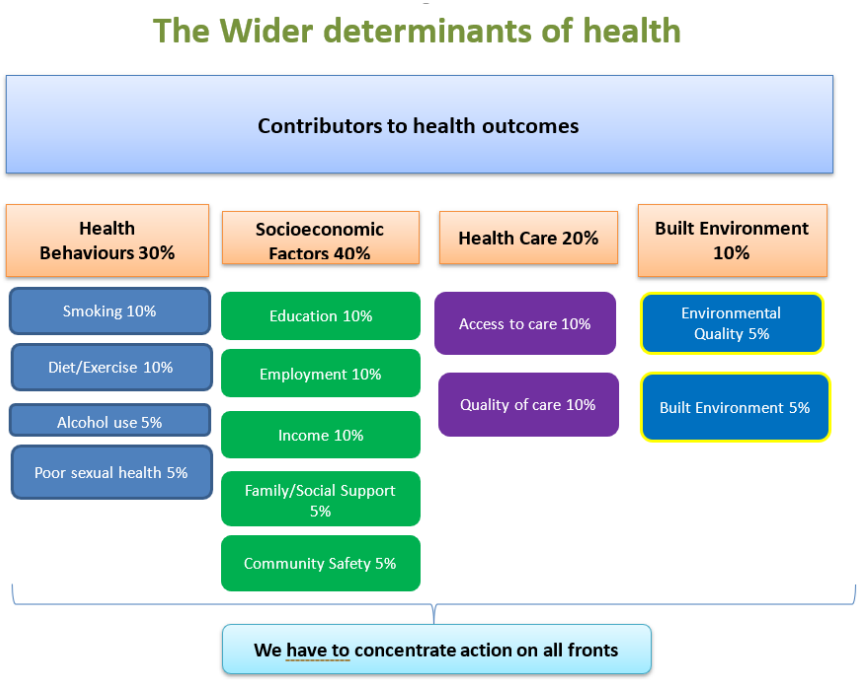
- What are our local prevention priorities?
- What are we already doing?
- How can we fill the gaps?
- How can we close the inequalities gap?
- How are we going to resource this work?

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.

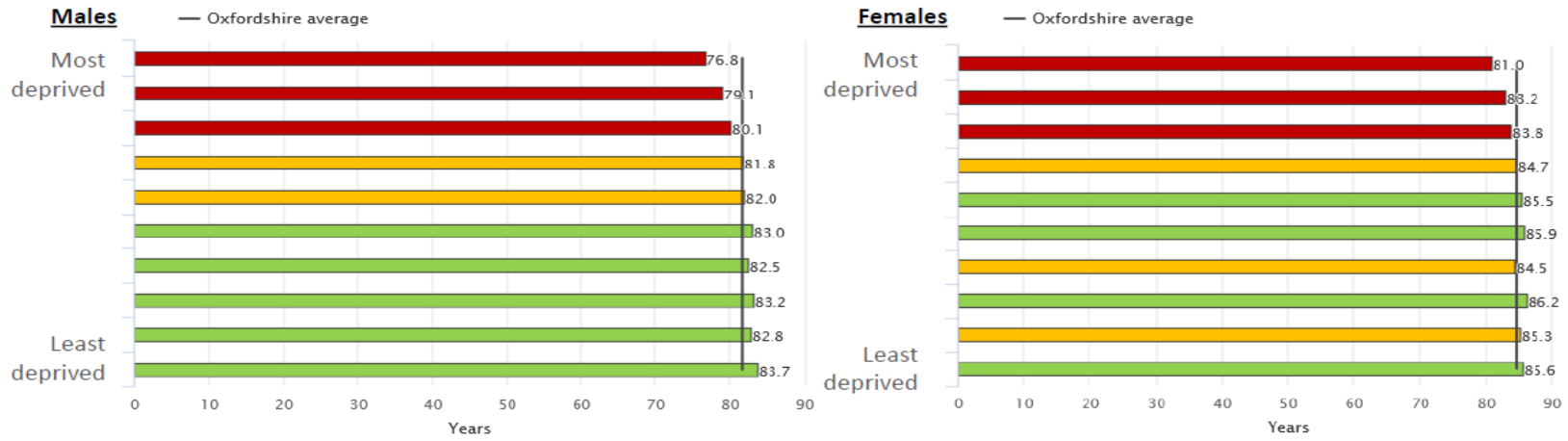
Health Inequalities

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

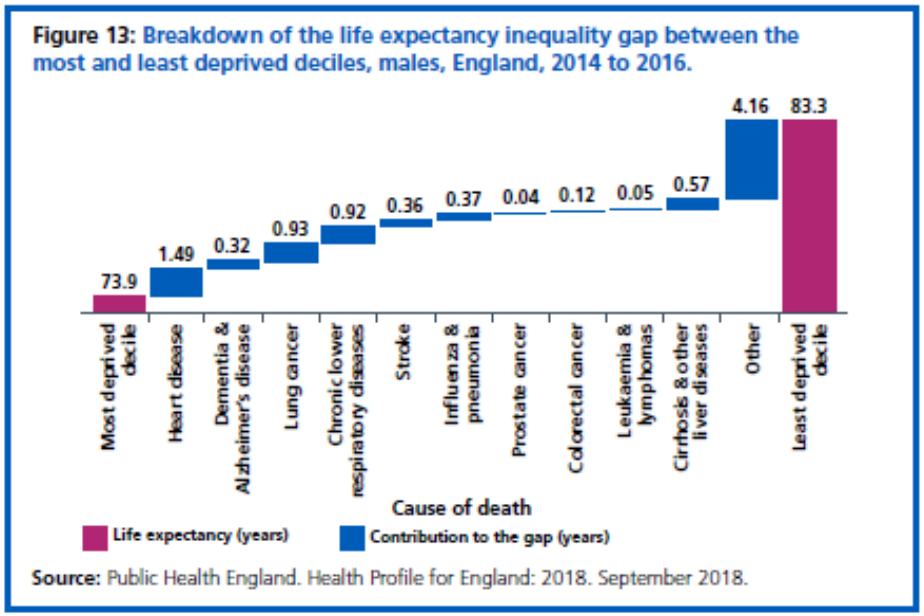
Oxfordshire Life Expectancy at birth by LSOA deprivation deciles: males and females, 2015-17



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

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**.

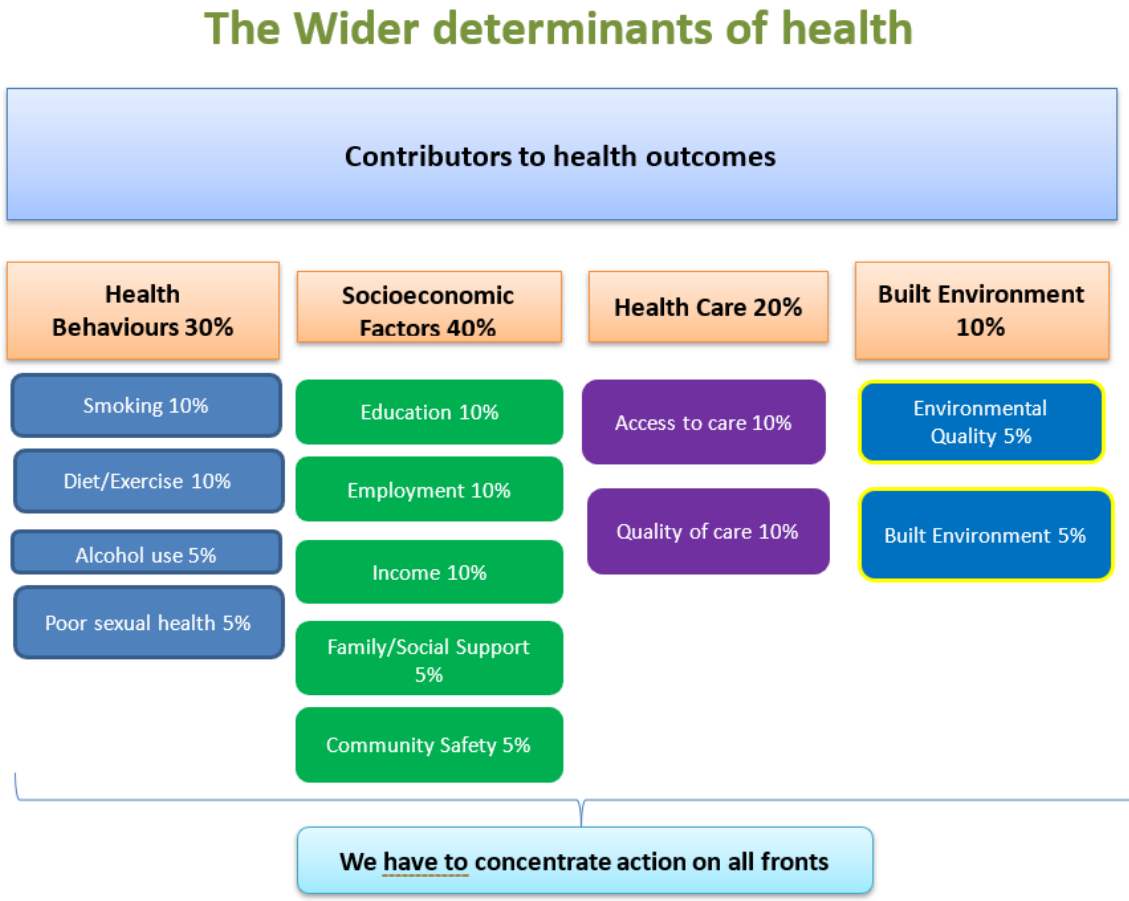
PREVENT illness	**REDUCE** the need for treatment	**DELAY** the need for care
Preventing illness and keeping people physically and mentally well, e.g. being active, breathing clean air, having social connections (**primary prevention)**	Reducing impact of an illness by early detection e.g. bowel screening/smear 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.

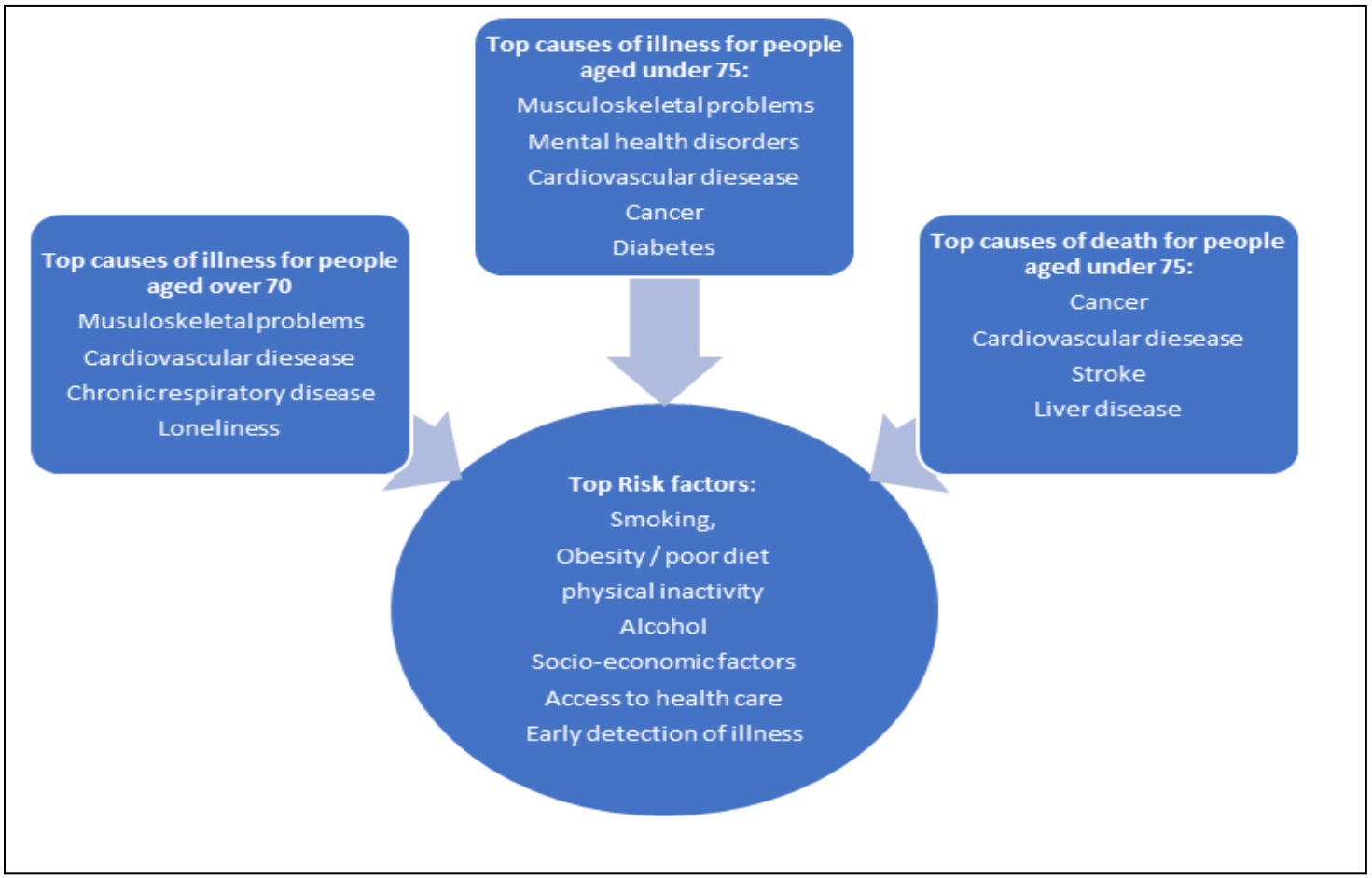
- Ensure that a system wide view is applied to decisions on **how all resources are allocated** to address prevention and inequalities priorities.

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)

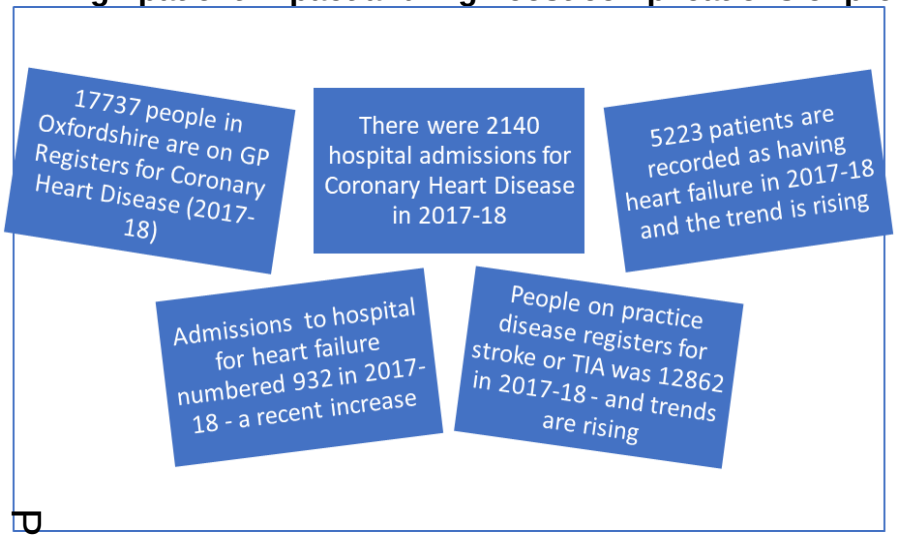
Cardiovascular disease and stroke	The largest cause of premature mortality in areas of deprivation
Respiratory disease	Increased incidence and mortality in areas of deprivation
Type 2 diabetes	The risk is up to six times higher in certain Black, Asian and Minority Ethnic (BAME) groups
Maternity	Women 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 colspan="2">Describe the local challenge</td><td>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:

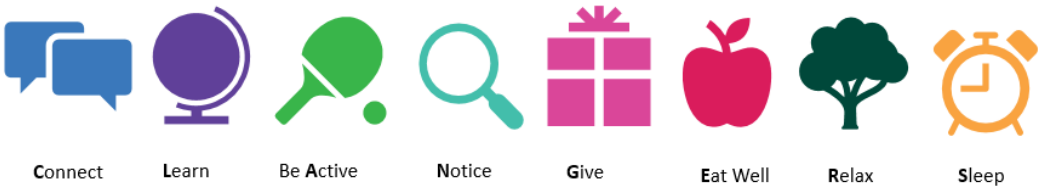
- **Mental ill-health** is concerned with disorders (such as depression, anxiety, schizophrenia, personality disorder) that are used to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions.
-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

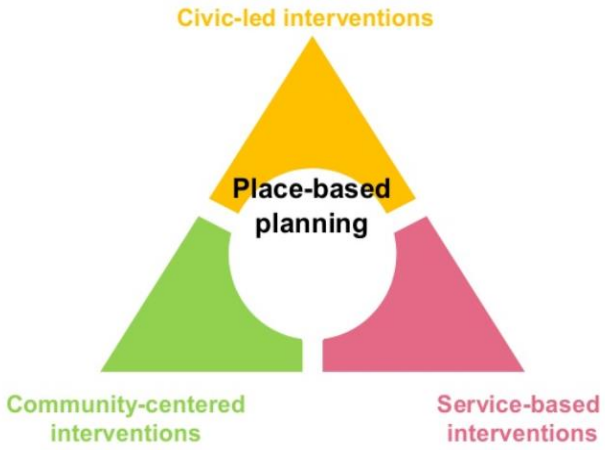
- Increase knowledge and capabilities of the Health Care Professional network across Oxfordshire through MECC, social prescribing pathways and training/development programmes around Moving Medicine for primary and secondary practitioners.
- Co-ordinated local and national campaigning to promote active 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)
How will we know we are successful?	• 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
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**		

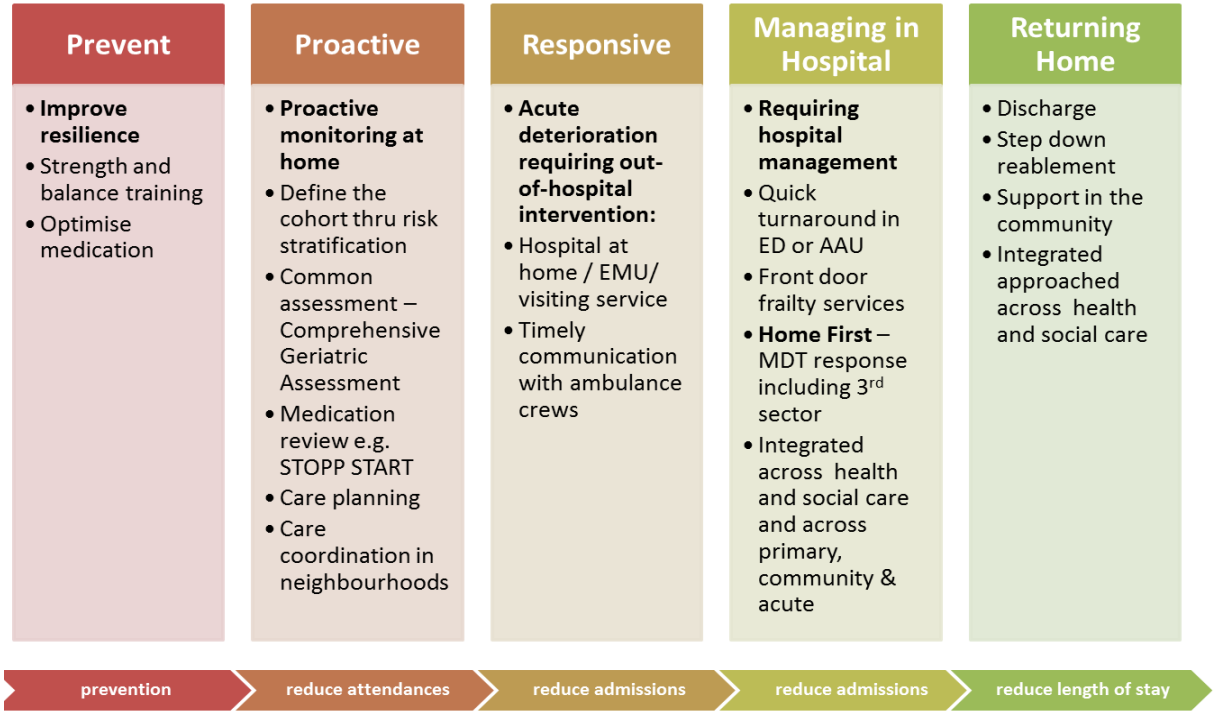
The development of an effective care plan and responding to deteriorations in out-of-hospital settings may reduce the need for hospital care.

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.

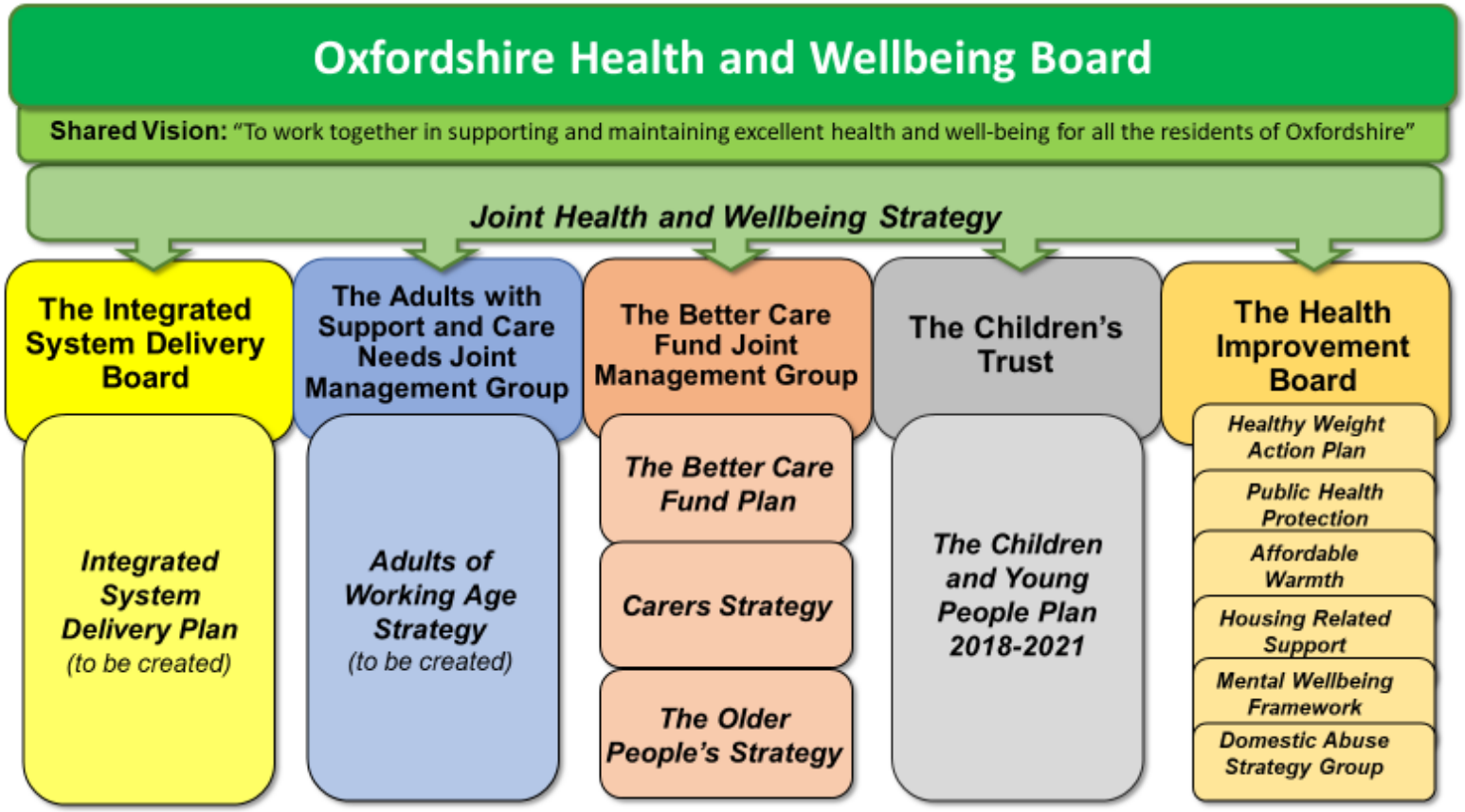
Every step may have input from integrated teams involving primary care, community health, public health, mental health, hospital services, domiciliary care and the voluntary sector.

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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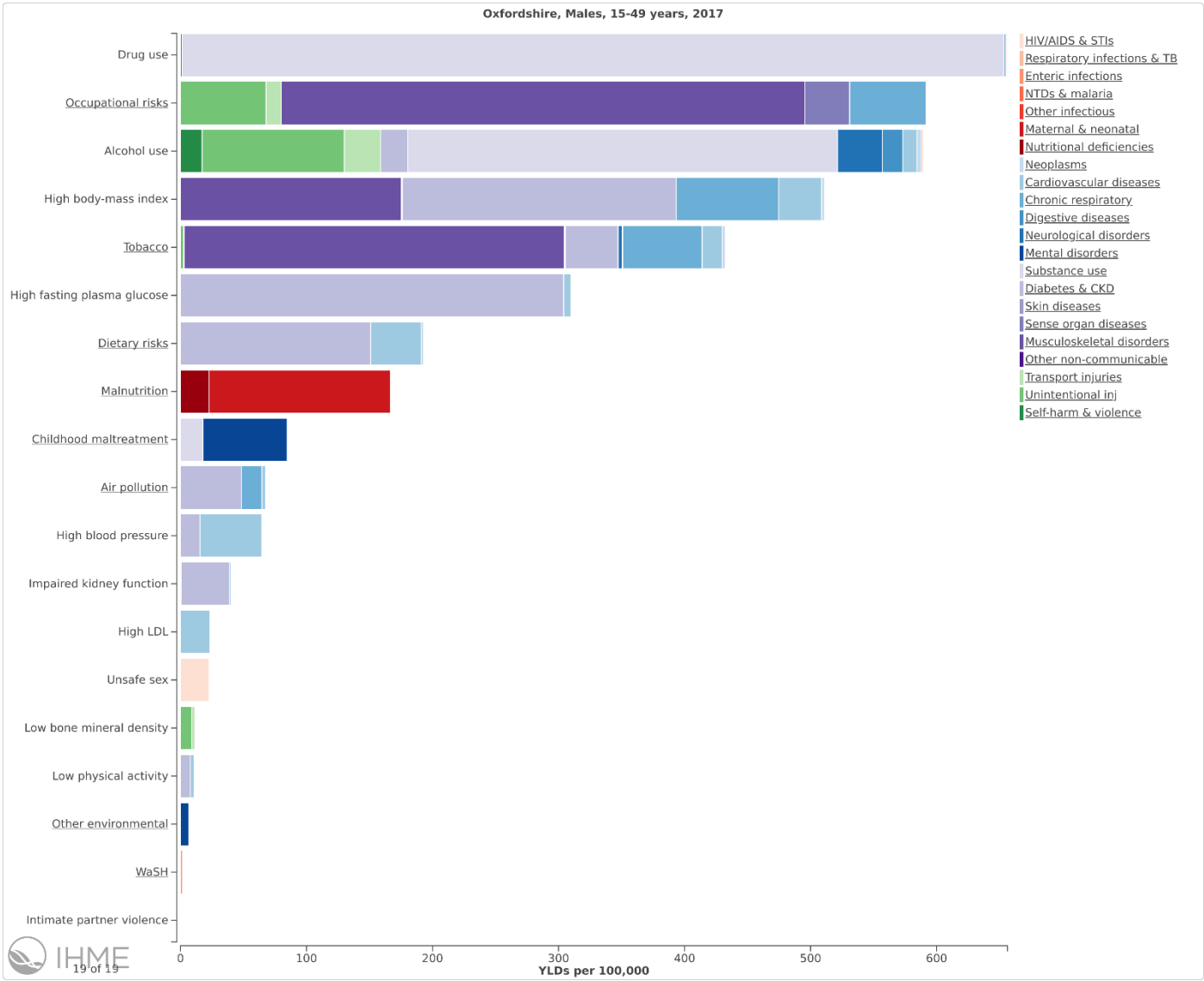
Annex 1 Top causes of disease

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

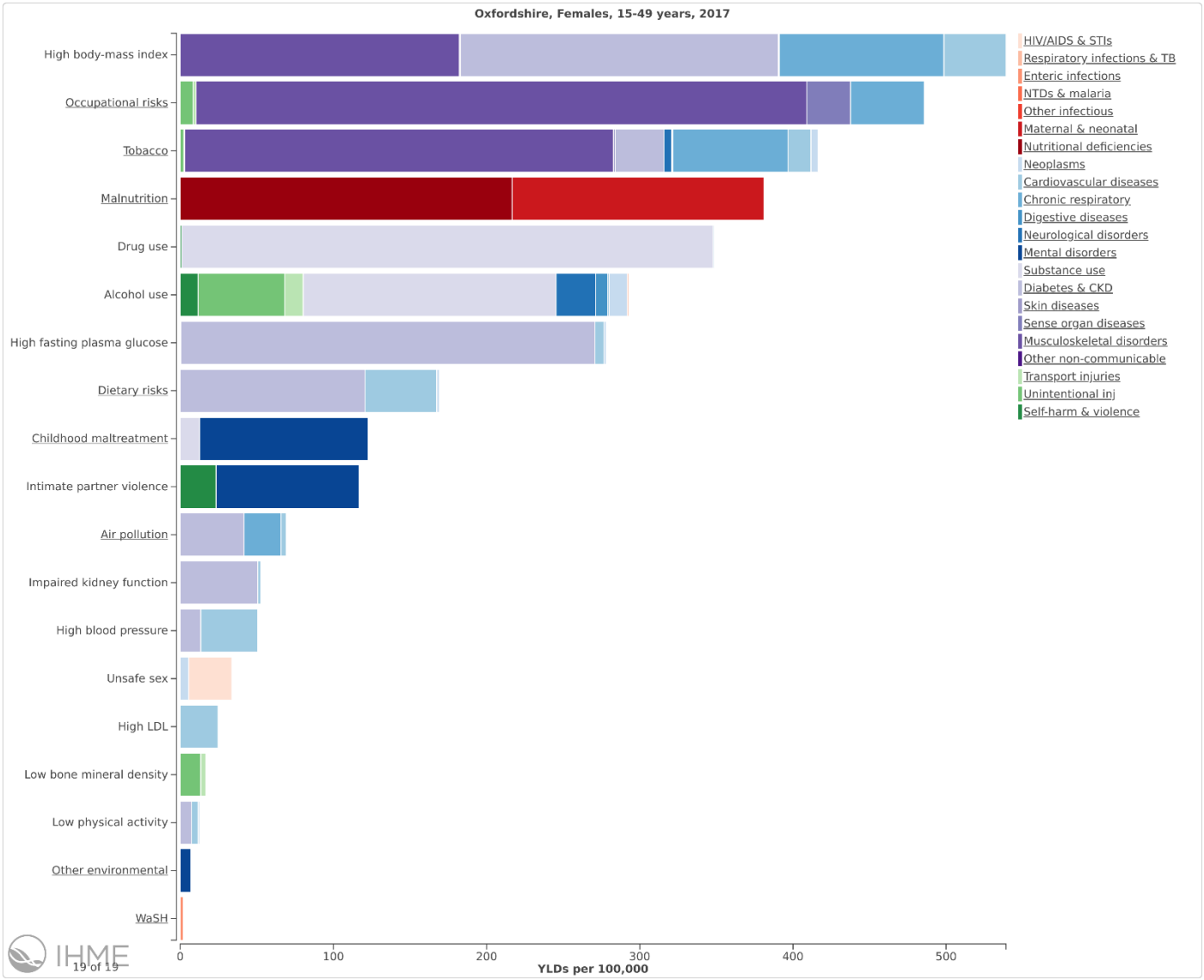
1 Musculoskeletal disorders
2 Mental disorders
3 Substance use
4 Neurological disorders
5 Unintentional inj
6 Skin diseases
7 Chronic respiratory
8 Other non-communicable
9 Maternal & neonatal
10 Diabetes & CKD
11 Digestive diseases
12 Sense organ diseases
13 Transport injuries
14 Respiratory infections & 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

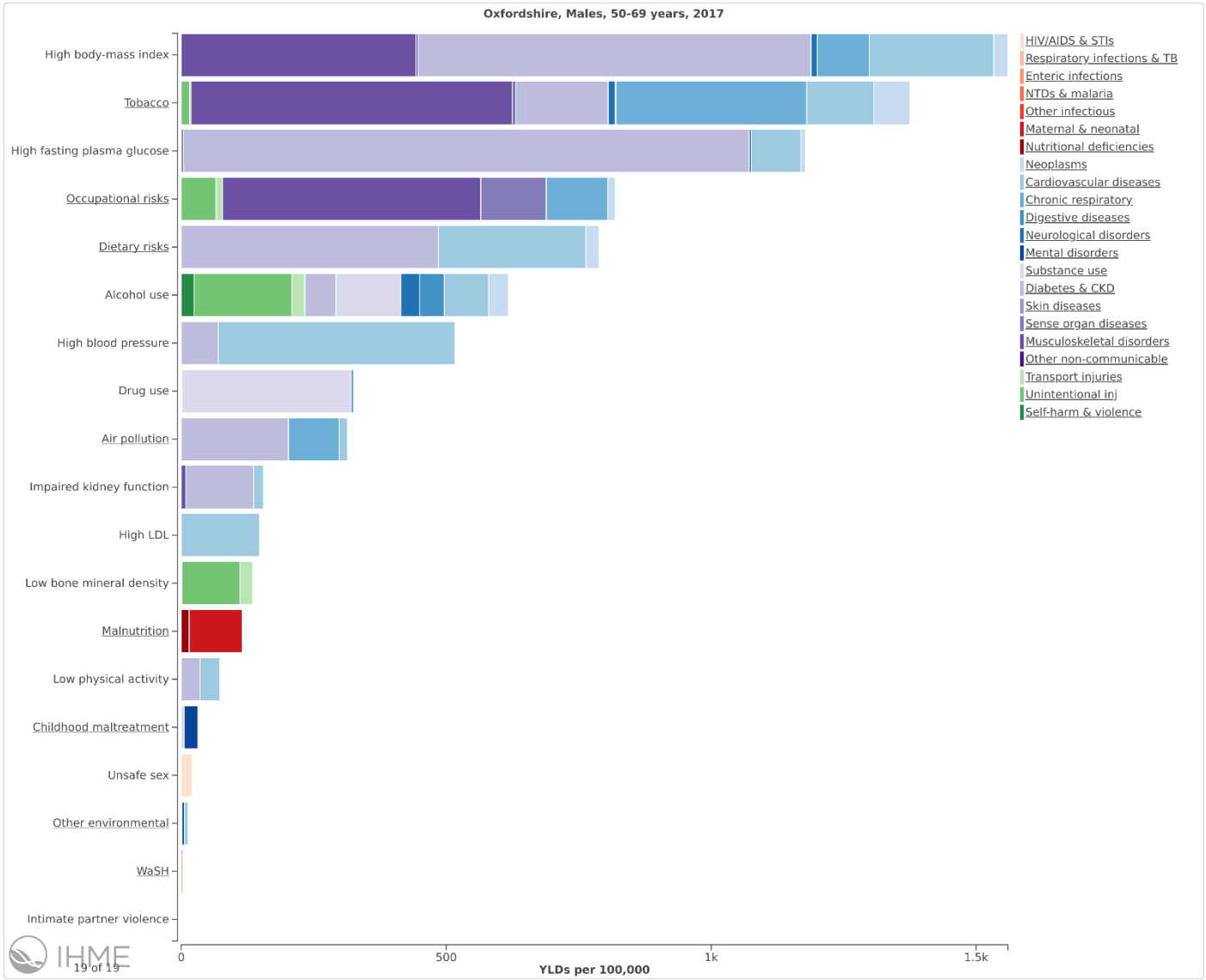
1 Musculoskeletal disorders
2 Mental disorders
3 Neurological disorders
4 Other non-communicable
5 Skin diseases
6 Chronic respiratory
7 Unintentional inj
8 Substance use
9 Maternal & neonatal
10 Digestive diseases
11 Diabetes & CKD
12 Sense organ diseases
13 Nutritional deficiencies
14 Neoplasms
15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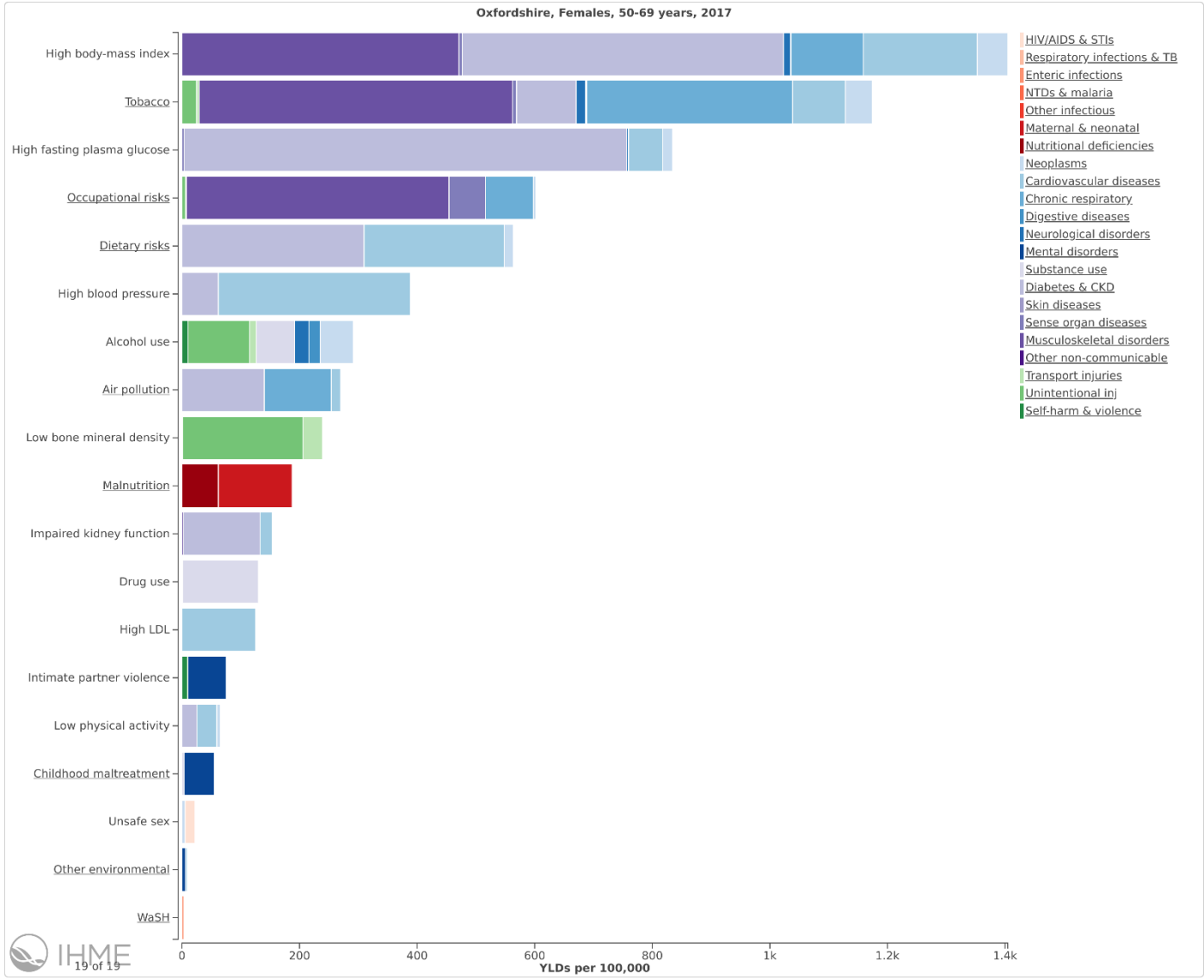
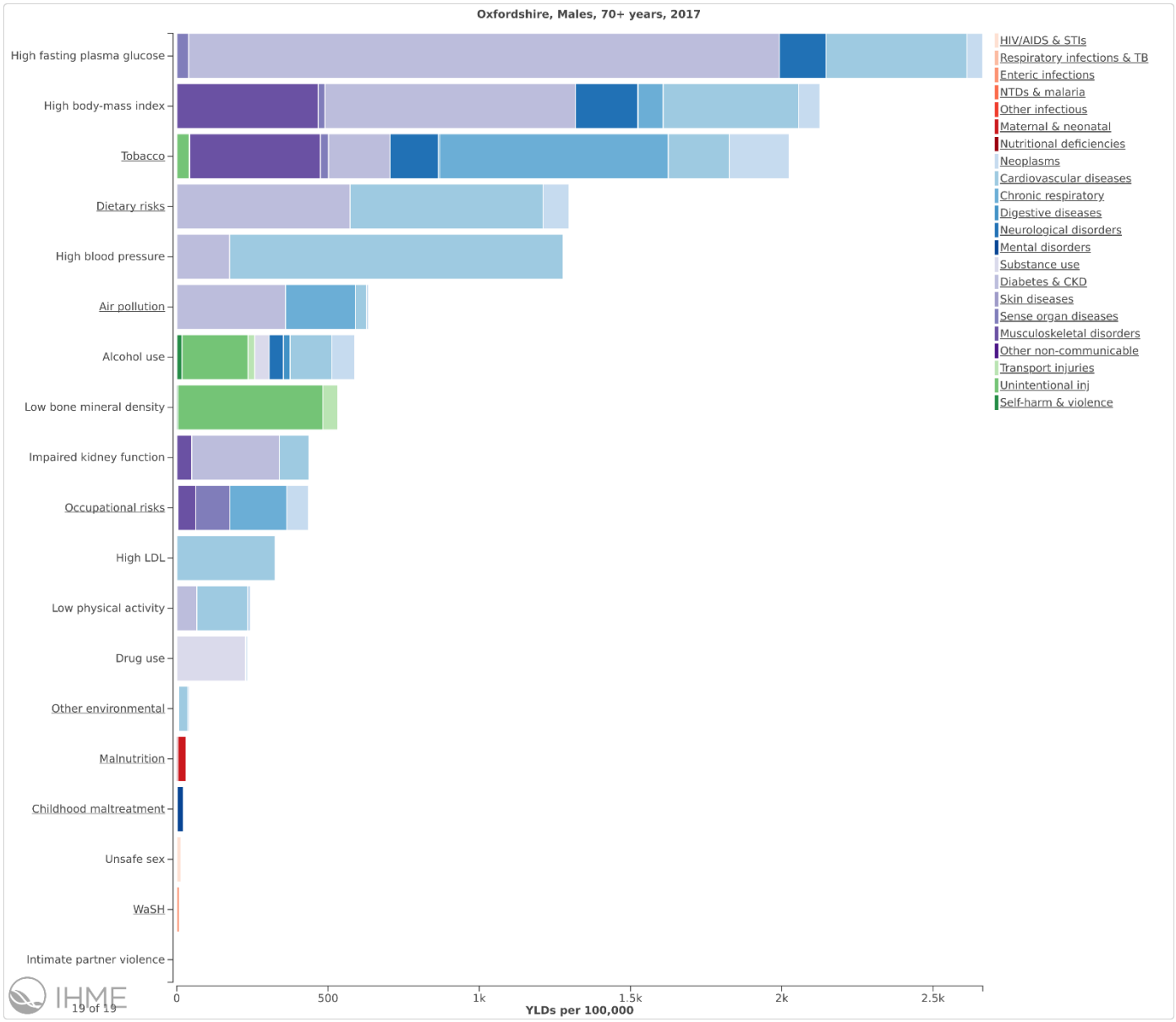
16 Respiratory infections & TB
17 Nutritional deficiencies
18 Enteric infections
19 Self-harm & violence
20 NTDs & malaria
21 Other infectious
22 HIV/AIDS & STIs



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

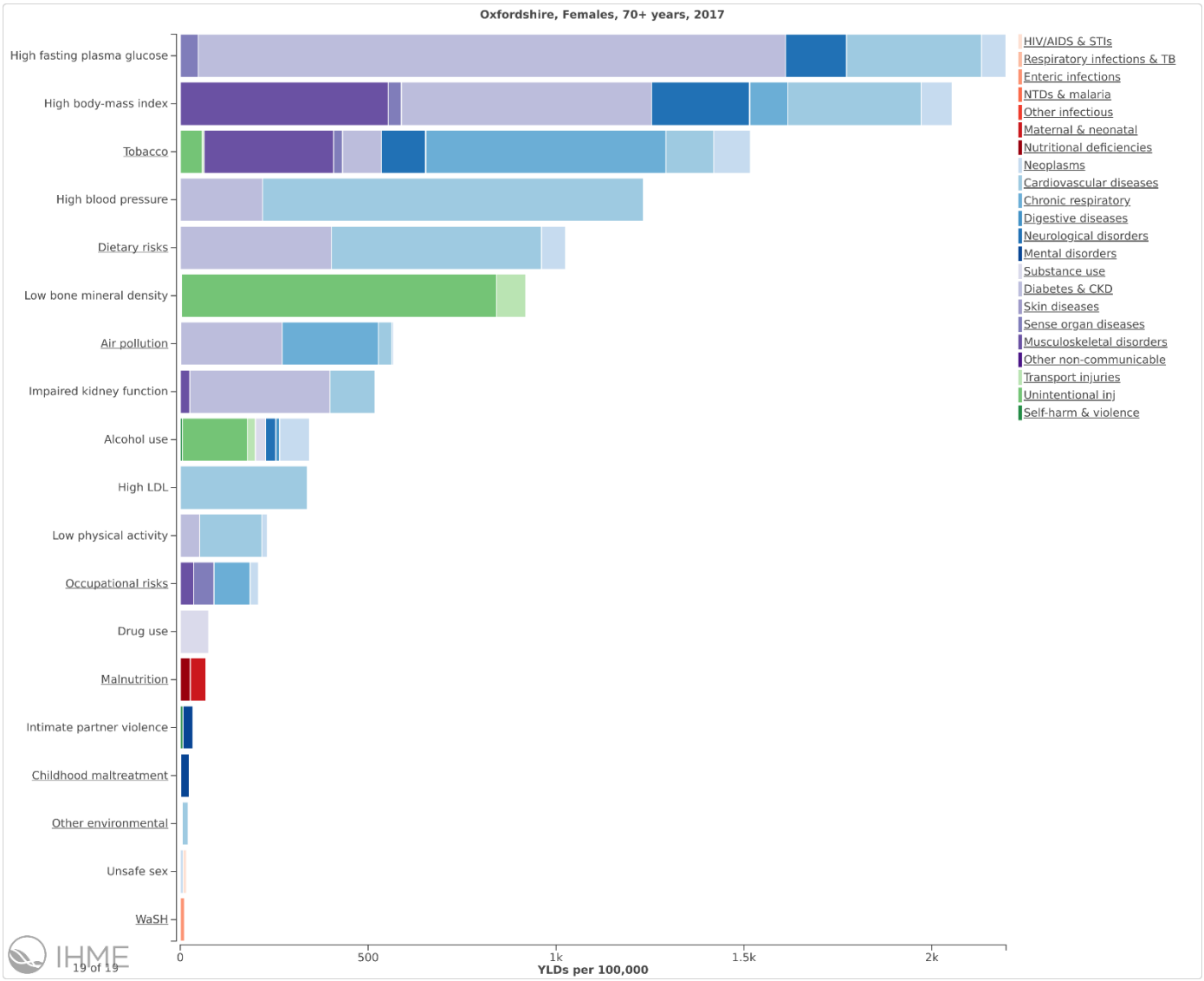
1 Musculoskeletal disorders
2 Sense organ diseases
3 Cardiovascular diseases
4 Chronic respiratory
5 Diabetes & CKD
6 Unintentional inj
7 Neurological disorders
8 Neoplasms
9 Mental disorders
10 Other non-communicable
11 Skin diseases
12 Digestive diseases
13 Transport injuries
14 Substance use
15 Enteric 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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To:	**Health Improvement Board**
Date:	**21 November 2019**
Report of:	**Housing Needs Manager, Oxford City Council**
Title of Report:	**Impact of Oxfordshire Homelessness Prevention Trailblazer in Health**

Summary and recommendations	
Purpose of report:	To update the Board on the impact of the Trailblazer Programme in Health
Report Author:	Paul Wilding, System Change Manger (Homelessness Prevention), Oxford City Council
Recommendation(s):That the Board resolves to:	
1. **Note the impact outlined in the report** 2. **Request a further report which shows how the extension of the embedded housing worker intervention in Health positively impacts on the time and resources of staff within the county hospitals.**	

Appendices:
Appendix One – Trailblazer case studies in Health
Appendix Two – Trailblazer data from Health

INTRODUCTION

1. The Oxfordshire Homelessness Prevention Trailblazer was a multi-agency programme aiming to tackle systemic issues in the public sector which can increase the risk of homelessness to individuals throughout the county. The two year programme ran from September 2017 to August 2019. It received £790,000 from the Ministry of Housing, Communities and Local Government, and a further £100,000 from the Oxfordshire local housing authorities, providing a total of £890,000. The county-wide Trailblazer programme has been managed by a small team based at Oxford City Council.

2. The broad objectives of the programme were to explore options for intervening as early as possible to prevent people at risk of homelessness reaching a crisis point. The first six months was spent researching homelessness in Oxfordshire and planning the programme. This included analysis of homelessness data, a qualitative stakeholder consultation exercise and piloting system interventions. A full evaluation of the programme will be published in November 2019.

PROGRAMME DESIGN

3. The design of the programme interventions was informed by stakeholder consultation which included workshops involving front-line housing staff, people with experience of homelessness and professionals from health, criminal justice and children's social care. People with lived experience expressed a sense of hopelessness about their situation and difficulties in accessing services, but reflected positive experiences of being supported by other people with lived experience. Professionals within the systems felt there was a significant need to improve connections and relationships across statutory and non-statutory services. Awareness of the housing options available to individuals and the local housing authorities' role in this process was low. As a result, early indicators of homelessness were not being acted upon.

4. Three strands of work were developed. These were the embedding of housing workers within the health, criminal justice and children's social care settings (provided by Connection Support), a community navigator service to connect people at risk of homelessness to the services they needed (provided by Aspire), and a homelessness champions network to raise the profile of housing in stakeholder organisations. The rest of this report concentrates on the embedded housing worker intervention in Health.

IMPACT OF TRAILBLAZER

5. Two embedded housing workers were based in the health system, and spent their time in all of the county's general hospitals and mental health hospitals. The embedded workers provided specialist housing knowledge to support and/or upskill health professionals in order to speed up the discharge of patients who were medically fit but where a Housing issue was preventing a safe discharge. They also acted as connectors between the Health and Housing systems across Oxfordshire.

6. The embedded housing workers in Health received 422 referrals, which led to 217 positive housing outcomes. In 137 cases, the outcome was unknown, 44 cases resulted in unsuccessful prevention of homelessness, and 24 people were homeless at the point of referral, and remained homeless. The high volume of cases where the outcome is unknown is a result of many referrals resulting in the provision of one off advice to a health professional. These are not always easy to follow up due to the fast paced nature of the hospital environment, and the changing shift patterns and turnover of staff.

7. This is a particularly good outcome given that 152 referrals related to people who were already homeless. Although the objective of the programme was to intervene early with people to prevent homelessness, health staff did not distinguish between people at risk of homelessness, and people who were already homeless. A consequence of dealing with people who were already homeless was the establishment of a stepdown house. This was for people who needed to receive some form of medical treatment, but who did not require being admitted as an in-patient (e.g. a rough sleeper who needed a dressing to be changed regularly). Dr Logan Mills, a junior doctor in the John Radcliffe, undertook some research into the presentation of rough sleepers. He found that rough sleepers who were seen by an embedded housing worker were almost half as likely to represent as one who wasn't.

8. A comparison of delayed transfer of care (DTOC) data for cases where Housing was listed as the reason for delay for the period Trailblazer was operating, and the year prior to the programme shows a significant decline in delayed discharge. There were 944 fewer DTOC days, which represented a 50% reduction. There was a greater reduction in Oxford Health (66%) than Oxford University Hospitals (38%). More detail on the DTOC data can be found in Appendix Two.

9. During the period of Trailblazer there were other interventions taking place to reduce DTOC, so these outcomes are not solely attributable to Trailblazer. However the Adult Mental Health team attribute much of the reduction to the role played by the embedded worker based with them who gave the team the knowledge and confidence to resolve Housing issues for their clients. They say that as a result of Trailblazer they no longer have to place people who are sectioned out of area (which has included placing people as far afield as Aberdeen). It is now common for their to be available bed spaces at the start of the weekend for this client group, which was not the case prior to Trailblazer. Staff in the mental health hospitals are now able to carry out the work, previously undertaken by the embedded housing worker. Appendix One contains two case studies which demonstrate the impact of the embedded workers.

TRAILBLAZER LEGACY

10. Although the programme ended in August, Oxford University Hospitals NHS Trust has funded the embedded housing worker intervention until the end of March 2020. During Trailblazer, the work of the embedded housing workers was monitored in terms of their impact on patients. However in order to build a case for funding the workers beyond this year, there is a need to monitor the impact of the embedded workers on the hospital staff. A monitoring proposal was submitted by the Trailblazer programme team to the commissioning manager which would enable this to be done.

11. Work undertaken during the programme will leave a legacy in Health. Discharge protocols are in place for the effective management of patients with housing issues. This is supported by simple procedures designed by the embedded workers which are available in all relevant departments across the county hospitals. This content is also available on the hospital intranet. A Housing eLearning course, designed for non-Housing professionals is available on the OSCB website to allow staff to refresh their knowledge and to induct new starters. The homelessness champions network referred to in paragraph 4 will be continuing for another year, which allows relevant hospital staff to access training and support with housing issues.

12. The general hospitals are the one environment within the programme in which it is considered that ongoing specialist housing support is required. Within children's social care, criminal justice and the mental health hospitals Trailblazer has supported a change in approach which has led to a prioritisation of housing issues. It has been harder to achieve this in the general hospitals because in the other systems, there is often one individual who has the lead responsibility for the service user for the duration of their journey within that system (e.g. a social worker or resettlement officer). As such there is a concern that if the embedded housing worker intervention ends, the improvements in discharging patients will be lost.

13. A member of the discharge liaison hub summed up the impact that the embedded housing workers have had:
"The embedded housing workers save us considerable time which we are able to spend supporting ward staff and patients with routine and complex discharges. EHWs can efficiently unpick a patient's current housing situation and liaise with councils by directly contacting the relevant teams/team members using their extensive knowledge and experience. My team, who do not deal exclusively with housing issues have less direct, immediate knowledge and will spend significantly more time unpicking and dealing with the same issue. Having the support of a specialist in this challenging area allows us to use our time and our own specialist skills to support the wards, who turn to us for the very same reason – more efficient

resolution of issues which are to us often everyday but are to the wards very challenging and time consuming, taking them away from bedside care."

Appendix One – Case Studies

Case Study One

A woman who was vulnerable because of a learning disability was admitted to hospital in a state of distress following the death of her partner. The patient was a social tenant and had been advised by her landlord that she should not return to the property because they had concerns over her ability to manage the tenancy on her own. The hospital staff believed that the patient did not have the right to return to her home so she remained in hospital whilst a resolution was found. This resulted in the individual becoming a DTOC case.

The patient was referred to the embedded worker who advised hospital staff about the tenant's legal rights and confirmed that she was able to return home. The embedded worker identified sources of support, including tenancy sustainment services and money management, and worked with hospital staff to make the appropriate referrals.

As a result of this intervention, the patient was discharged to her home with ongoing support in place to help her maintain her tenancy. This reduced the delay in her discharge and the hospital bed was made available at a time of peak demand.

We have estimated that the total cost of this prevention was somewhere in the region of £700 based on the time cost of the professionals involved. Using the New Economy Manchester model Unit Cost Database we have also estimated that the potential total cost to the public purse if no action had been taken was approximately £8,250. This is based on an additional delayed discharge of 14 days and the individual relinquishing her social tenancy resulting in a homeless approach to a local housing authority. As such the public sector has foregone having to expend somewhere in the region of £7,500.

Case Study Two

In this example the embedded worker was able to draw together professional expertise to prevent the homelessness of a young man who was admitted to a hospital under section. He had built up significant rent arrears with his social landlord and had been threatened with an eviction notice.

A referral was made by a Community Psychiatric Nurse (CPN) highlighting the rent arrears but also that financial exploitation had been taking place. The CPN had very little understanding of housing issues or benefit entitlements so the embedded worker supported them to start unpicking the case. With the agreement of the man in question the embedded worker called a multi-agency meeting to include the individual, the CPN, the individual's tenancy manager and members of the rents team.

A repayment plan was put in place, a benefits check was undertaken and the financial exploitation was considered. The man felt extremely vulnerable and feared it would happen again so the embedded worker requested the support of a Police Community Support Officer (PCSO) and Turpin & Miller for legal advice. Trailblazer agreed to pay off some of the arrears using the allocated prevention pot but only on the agreement that the individual would adhere to the remaining payment plan.

At the point of discharge the individual was supported to return home by the CPN, his tenancy manager and the PCSO. The individual felt supported in his home and not at risk from further exploitation. All benefits were put in place and the repayment plan was adhered to. The individual is no longer at risk of eviction and the CPN is better aware of both housing and benefit legislation and procedures.

It is estimated that the costs of this prevention was around £1,250. Using the New Economy Manchester model Unit Cost Database we have also estimated that the potential total cost to the public purse if no action had been taken was approximately £9,250. This is based on an additional mental health care provision, the individual being evicted from their social tenancy and a homeless approach to a local housing authority. As such the public sector has foregone having to expend somewhere in the region of £8,000.

Appendix Two – Trailblazer data from health

Delayed Transfer of Care (DTOC)

The DTOC data has been obtained from the Oxfordshire Clinical Commissioning Group (CCG) and highlights the amount of DTOC that has taken place over the past 2 years as a result of a known housing and homelessness issue.

That data has been split between the two NHS trusts in Oxfordshire to highlight the varying degrees of impact. Overall we have seen 26 fewer DTOC cases where 'housing' has been given as a reason for delay when compared to the year before Trailblazer. This accounts for 944 fewer days of DTOC since the introduction of the EHWs.

There has also been a significant reduction in the use of hub beds for DTOC patients with housing issues. There has been a big drive across both trusts to reduce the use of hub beds, particularly in instances where there was no plan for move on (not a Trailblazer initiative). In 2017/18 the average hub bed stay for an individual where housing has been given as a DTOC reason was 62 days. In 2018/19 this was reduced to 29 days.

Oxford University Hospitals NHS Trust

2017/18	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	18	432	0	24.00
Housing (inc Hub)	10	95	607	70.20
Multiple Reasons	14	485	0	34.64
Multiple (inc Hub)	3	139	207	115.33
TOTAL	**45**	**1151**	**814**	
2018/19	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	16	388	0	24.25
Housing (inc Hub)	8	85	249	41.75
Multiple Reasons	4	193	0	48.25
Multiple (inc Hub)	3	51	69	40.00
TOTAL	**31**	**717**	**318**	
Reduction on previous year	**14**	**434 (38%)**	**496 (61%)**	
2019/20 (April to July)	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	1	1	0	1.00
Housing (inc Hub)	0	0	0	0.00
Multiple Reasons	2	191	0	95.50
Multiple (inc Hub)	0	0	0	0.00
TOTAL	**3**	**192**	**0**	

Across OUH we saw a 38% in the number of DTOC days (434 less) as a result of a known housing issue when the data for 2018/19 was compared to the previous year. However, there remains a relatively high number of cases where housing is provided as a reason for delay. Because of the broad definition of this category it is likely that a number of these cases actually relate to individuals that are single homeless with no fixed address.

The data connected to 2019/20 indicates that there appears to be a continued reduction in the number of DTOC cases being seen across the trust (3 cases in 4 months). However, the cases that still result in a delay appear to be complex cases owing to the length of DTOC.

Oxford Health NHS Trust

2017/18	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	12	454	0	37.83
Housing (inc. Hub)	1	88	55	143.00
Multiple Reasons	4	227	0	56.75
Multiple (inc. Hub)	0	0	0	0.00
TOTAL	**17**	**769**	**55**	
2018/19	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	2	33	0	16.50
Housing (inc. Hub)	0	0	0	0.00
Multiple Reasons	3	226	0	75.33
Multiple (inc. Hub)	0	0	0	0.00
TOTAL (11 months of data)	**5**	**259**	**0**	
Reduction	**12**	**510 (66%)**	**55 (100%)**	
2019/20 (April to July)	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	2	29	49	39.00
Housing (inc. Hub)	0	0	0	0.00
Multiple Reasons	0	0	0	0.00
Multiple (inc. Hub)	1	20	0	20.00
TOTAL	**3**	**49**	**49**	

The numbers above suggest that housing DTOC cases have been almost eliminated across the Oxford Health NHS trust, save for a few complex, intractable cases that have resulted in lengthy delays. The 510 less days of DTOC in 2018/19 represents a 66% reduction on the previous year.

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Report on the Prevention Concordat for Better Mental Health to the November 2019 Health Improvement Board

Definition

Mental health and mental wellbeing are terms that tend to be used interchangeably. Mental wellbeing is understood as how people feel and function, both on a personal and a social level, and how they evaluate their lives.[1] Mental health is described as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community.[2]

The Health and Wellbeing Board (HWB) has adopted the understanding of mental wellbeing as being separate to mental health (Appendix 1).

Prevalence

In Oxfordshire, the average wellbeing scores for life satisfaction, "things you do are worthwhile", and happiness are slightly higher in 2017/18 compared with 2016/17, and the anxiety mean has increased each year since 2013/14.

In 2017/18 there were 62,214 adult patients recorded with a diagnosis of depression in Oxfordshire. Since 2013/14, prevalence of depression has increased from 6.6% to 10.3% among the adult population (18+ years). The proportion of all school pupils with social, emotional and mental health needs has increased over recent years in Oxfordshire and in England. In 2018 there were 2,512 children with identified social, emotional and mental health needs at schools in Oxfordshire.

It is possible that increases in mental health diagnoses are partly due to increased awareness and reduced stigma, although it remains likely that a significant proportion of people with depression are undiagnosed.

During 2017/18, the rate of emergency hospital admissions for intentional self-harm in all ages in Oxfordshire was 178.8 per 100,000 population, significantly lower than the rate in 2016/17. Self-harm admissions are increasing in young people (aged 10-24 years) in Oxfordshire. Numbers recorded for 2016-17 increased to 619 (552 in 2015-16). Oxfordshire's rate for 2016/17 is significantly higher than the England average (as it was in 2014/15).

There were 164 deaths by suicide between 2015 and 2017,131 of which were male. Oxfordshire's suicide rate is not significantly different from national and regional figures.[3]

Policy context

The Prevention Concordat for Better Mental Health and the associated guidance was published by Public Health England (PHE) in August 2017.[4] It aims to galvanise local cross-sector action and increase public mental health approaches to support the

[1] New Economics Foundation (2012) Measuring Wellbeing. London: New Economics Foundation
https://www.mentalhealth.org.uk/blog/what-wellbeing-how-can-we-measure-it-and-how-can-we-support-people-improve-it#_ftn1
[2] http://www.who.int/features/factfiles/mental_health/en/
[3] https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA_2019_Ch5_Health.pdf
[4] https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-planning-resource

prevention of mental health problems and the promotion of good mental health across the whole system.

The approach is outlined in the Prevention Concordat for Better Mental Health: planning resource infographic (Appendix 2)[5] and is structured to guide local prevention and planning arrangements. The consensus statements of the Concordat (Appendix 3) describe the shared commitment of partner organisations to work together via the Concordat to prevent mental health problems and promote good mental health.

A Mental Wellbeing Framework Oxfordshire is being developed to outline what partners have committed to do, build on existing action and identify opportunities for collaboration and innovation. The wellbeing framework is being developed alongside the Suicide and Self Harm Prevention Strategy for Oxfordshire to ensure a joined-up approach to mental health and mental wellbeing.

Progress on the Prevention Concordat for Better Mental Health in Oxfordshire
The recommendation for Oxfordshire to sign up to the PHE Prevention Concordat for Better Mental Health was made to and agreed by the Health Improvement Board (HIB) in May 2018. The HWB approved the sign-up to the Concordat as a Board in November 2018.

The completion of the application for the Concordat was led by Public Health, Oxfordshire County Council, based on the information gathered in a HIB mental wellbeing mapping workshop in March 18 and subsequent comments from key partners. The application for the has two key sections: A summary of what is currently being done at a strategic level and a plan of what will be achieved over the next 12 months.

Oxfordshire Mental Health Partnership and Active Oxfordshire partnered with the HWB to sign-up to the Concordat and the completed application was submitted to Public Health England (PHE) on the 1st March 2019. The application was accepted and PHE published the Oxfordshire commitment on the Prevention Concordat (Appendix 3).

All Concordat partners were contacted following the agreement from the HWB to nominate a representative for the Concordat. All these partners were consulted with between April-August 2019 and asked to consider the potential scope of the Concordat for Oxfordshire and their organisations hopes and aims. All partners identified an officer to work with Public Health to develop an Oxfordshire Mental Wellbeing Framework, agree a partnership approach to build on existing action and identify any gaps and opportunities for collaboration and innovation.

Additional partners outside of the initial signatories have been engaged and have signed up to the Concordat to increase the scope of the project. These include Age UK, Oxfordshire Carers, Rethink Mental Health and RAF Benson.

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640669/Prevention_Concordat_for_Better_Mental_Health_Planning_Resource_Infographic.pdf

A task and finish group to develop the framework has been created with the nominated representatives of each organisation which now includes:

- Oxfordshire County Council
- Oxfordshire Clinical Commissioning Group
- Healthwatch Oxfordshire
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Oxford City Council
- Cherwell District Council
- South Oxfordshire District Council
- West Oxfordshire District Council
- Vale of the White Horse District Council
- Connection Floating Support
- Elmore Community Services
- Oxford Health NHS Foundation Trust
- Oxfordshire Mind
- Response
- Restore
- Active Oxfordshire
- Age UK
- Rethink Mental Illness
- Oxfordshire Carers
- RAF Benson

All partners met as group for the first time in September 2019. Initial workshops have identified what a framework for Oxfordshire should include and the priorities for action. The group has begun to map the current mental wellbeing initiatives in Oxfordshire to identify good practice, and gaps and opportunities for collaboration and innovation.

The feedback from the engagement questionnaire and the focus groups for the development of the Suicide and Self Harm Prevention Strategy for Oxfordshire, as well as existing community insight collected by the Concordat partners is being used to inform the development of the wellbeing framework for the Concordat. Additional stakeholders have also been identified to ensure the framework fully represents all of Oxfordshire residents.

A high-level draft of the proposed framework is included below for information and early comment. The final framework will be presented to the HIB in Feburary 2020 for sign off. The HIB will be asked to provide oversight on progress against the framework and the delivery of relevant partnership plans and strategies.

Draft Mental Wellbeing Framework for Oxfordshire

Draft Wellbeing Framework Nov 19.pp

Recommendations

1. Review the draft proposed Mental Wellbeing Framework for early comment
2. From March 2020 provide oversight on progress against the framework and the delivery of relevant partnership plans and strategies

Jannette Smith, Health Improvement Principal, Oxfordshire County Council
Jannette.smith@oxfordshire.gov.uk

Appendix 1 Definition of mental wellbeing

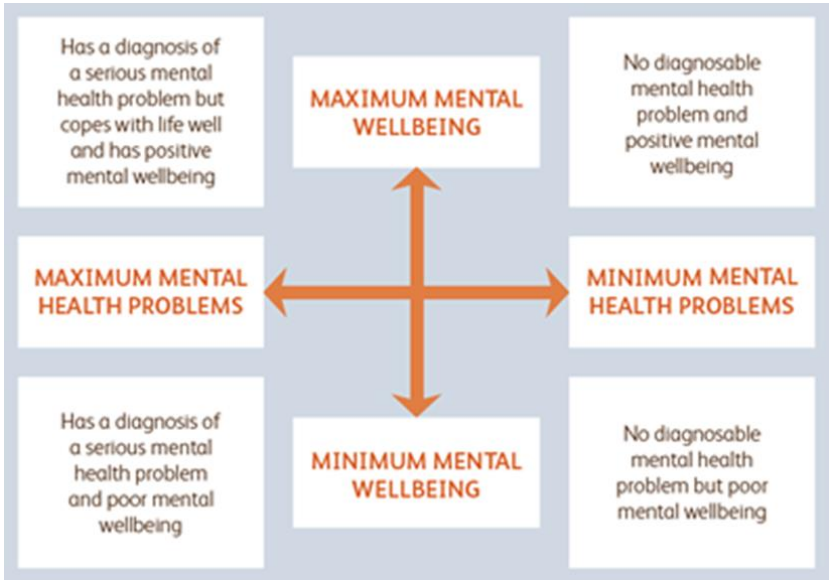
Mental health and mental wellbeing tend to be terms that are used interchangeably. There are two schools of thought about the relationship between mental health and mental wellbeing. The first is that mental wellbeing is on a continuum with mental wellbeing at one end, leading through to mental ill health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

- **Mental ill-health** is concerned with disorders (such as depression, anxiety, schizophrenia, personality disorder) that describe clinically recognisable symptoms or behaviour[6]

- **Mental health** is described as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community[7]

- **Mental wellbeing** can be understood as how people feel and function, both on a personal and a social level, and how they evaluate their lives as a whole[8]

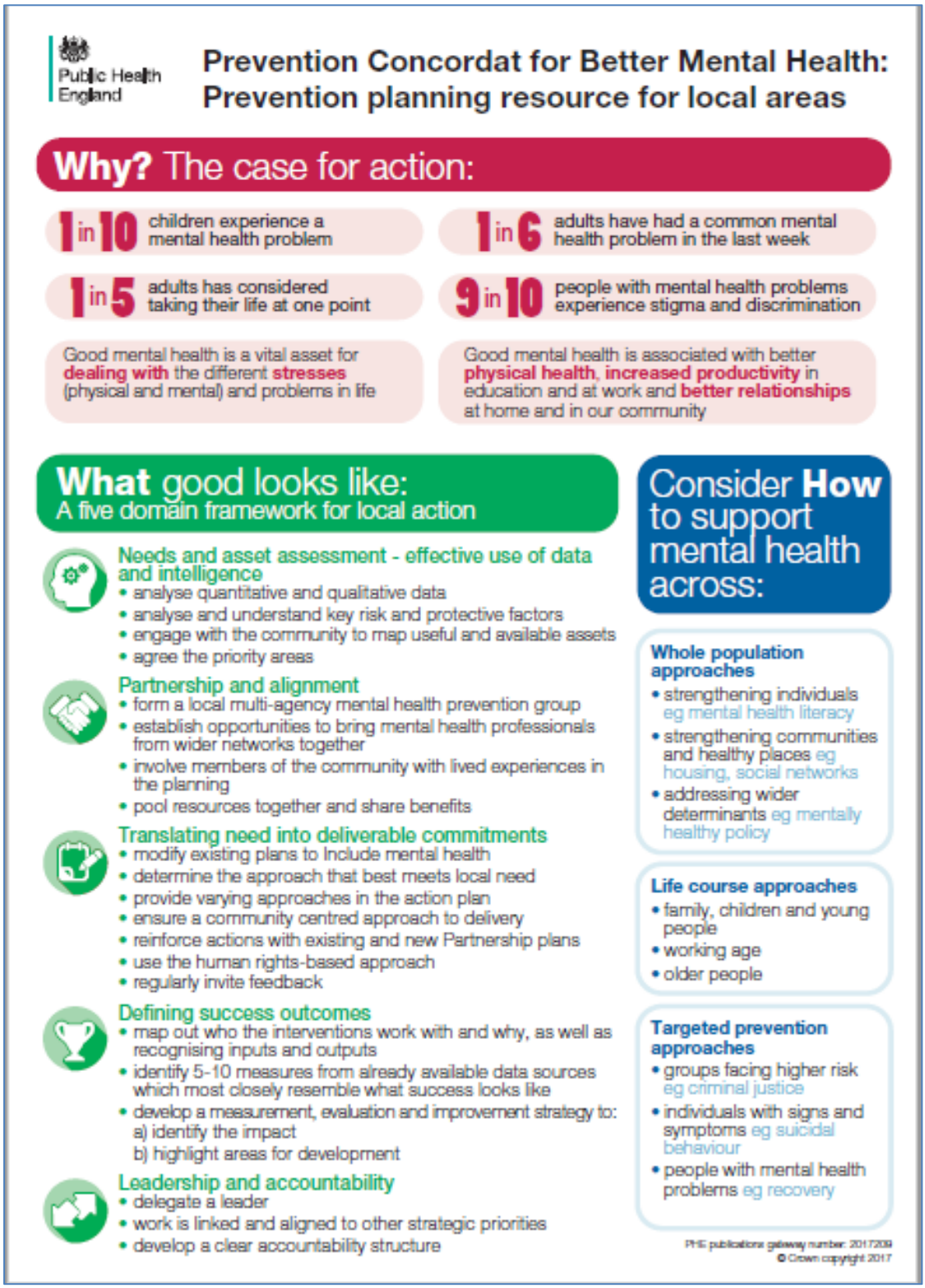
The figure below shows the dual continuum model which recognises that a person with mental health problems can simultaneously be experiencing positive mental wellbeing, and vice versa.[9]



The Health and Wellbeing Board has adopted the understanding of mental wellbeing as being separate to mental health.

[6] http://www.who.int/classifications/icd/en/bluebook.pdf
[7] http://www.who.int/features/factfiles/mental_health/en/
[8] New Economics Foundation (2012) Measuring Wellbeing. London: New Economics Foundation https://www.mentalhealth.org.uk/blog/what-wellbeing-how-can-we-measure-it-and-how-can-we-support-people-improve-it#_ftn1
[9] K Tudor Mental health promotion: Paradigms and Practice 1996

Appendix 2 Prevention Concordat for Better Mental Health: planning resource infographic



Public Health England

Prevention Concordat for Better Mental Health: Prevention planning resource for local areas

Why? The case for action:

- **1 in 10** children experience a mental health problem
- **1 in 6** adults have had a common mental health problem in the last week
- **1 in 5** adults has considered taking their life at one point
- **9 in 10** people with mental health problems experience stigma and discrimination

Good mental health is a vital asset for **dealing with** the different **stresses** (physical and mental) and problems in life

Good mental health is associated with better **physical health**, **increased productivity** in education and at work and **better relationships** at home and in our community

What good looks like:
A five domain framework for local action

Needs and asset assessment - effective use of data and intelligence
- analyse quantitative and qualitative data
- analyse and understand key risk and protective factors
- engage with the community to map useful and available assets
- agree the priority areas

Partnership and alignment
- form a local multi-agency mental health prevention group
- establish opportunities to bring mental health professionals from wider networks together
- involve members of the community with lived experiences in the planning
- pool resources together and share benefits

Translating need into deliverable commitments
- modify existing plans to include mental health
- determine the approach that best meets local need
- provide varying approaches in the action plan
- ensure a community centred approach to delivery
- reinforce actions with existing and new Partnership plans
- use the human rights-based approach
- regularly invite feedback

Defining success outcomes
- map out who the interventions work with and why, as well as recognising inputs and outputs
- identify 5-10 measures from already available data sources which most closely resemble what success looks like
- develop a measurement, evaluation and improvement strategy to:
  a) identify the impact
  b) highlight areas for development

Leadership and accountability
- delegate a leader
- work is linked and aligned to other strategic priorities
- develop a clear accountability structure

Consider How to support mental health across:

Whole population approaches
- strengthening individuals eg mental health literacy
- strengthening communities and healthy places eg housing, social networks
- addressing wider determinants eg mentally healthy policy

Life course approaches
- family, children and young people
- working age
- older people

Targeted prevention approaches
- groups facing higher risk eg criminal justice
- individuals with signs and symptoms eg suicidal behaviour
- people with mental health problems eg recovery

PHE publications gateway number: 2017209

Appendix 3 Consensus statement

Mental Wellbeing in Oxfordshire: Prevention Concordat for Better Mental Health

This consensus statement describes the shared commitment of the organisations signed below to work together via the Prevention Concordat for Better Mental Health, through local and national action, to prevent mental health problems and promote good mental health.

The undersigned organisations agree that:

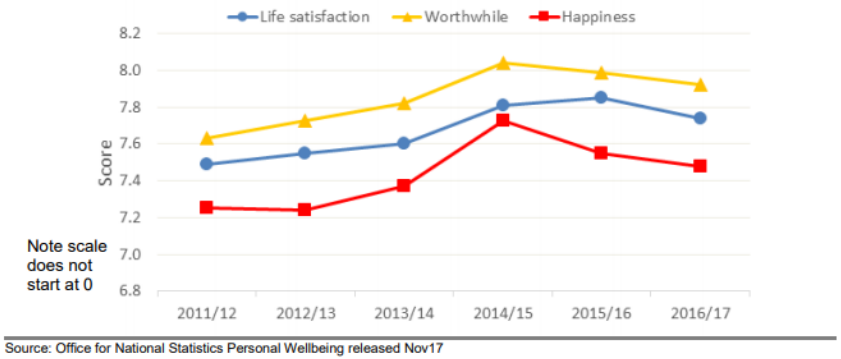
1. To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focused leadership and action throughout the mental health system; and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.
2. 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.
3. We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.
4. 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.
5. 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.
6. We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.
7. 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

Appendix 4 Application form extract

Prevention Concordat for Better Mental Health - local action across the 5 domains

What we currently do that promotes better mental health	
Leadership and Direction	The Joint Health and Wellbeing Strategy for Oxfordshire includes mental health in its priorities and identifies the role of the wider determinants of health such as employment and housing. Three of the partners on the Health and Wellbeing board (HWB) are signed up to 'Time to Change' which is .., (Oxfordshire County Council, including Fire and Rescue, Oxford City Council and Oxford Health NHS Foundation Trust). The board papers endorsed by the Health and Wellbeing Board and its sub board the Health Improvement Board provide a vision for the wellbeing approach to better mental health. The Health Improvement Board monitors three mental wellbeing indicators and has also undertaken to review local activity and interventions that support positive mental wellbeing. This work was informed by a workshop held in March 2018. Attached is a summary of activities for those who attended the workshop.  Mental wellbeing workshop - discussi The Oxfordshire Children's and Young Peoples Plan 2018-2021, which involved children and young people in its creation, includes a priority around "Happy and Healthy" which identifies prevention and wellbeing. The Plan informs the work of the Children's Trust which is a partnership of 12 organisations. Work of the Children's Trust includes social and emotional wellbeing and mental health as one of its three priorities.
Understanding local need and assets	Oxfordshire has completed local authority led Joint Strategic Needs Assessment with a mental health prevention focus. In Oxfordshire, the chosen indicators "feeling worthwhile, happiness and life satisfaction" scores are slightly lower in 2016-17 compared with 2015-16 and the anxiety score is higher.

Figure 15 Trend in average wellbeing scores in Oxfordshire for (a) life satisfaction, (b) things you do that are worthwhile and (c) happiness



Source: Office for National Statistics Personal Wellbeing released Nov17

[22] ONS Personal well-being in the UK: April 2016 to March 2017

In 2016-17 there were around 56,800 GP registered patients with depression, 9.7% of patients. The rate has been above the English average for the past 5 years.

During 2015-16 the number of emergency admissions for intentional self-harm in Oxfordshire was 1,373, this was similar to the number recorded in 2014-15 (1,387). There were 15 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2011-12 to 2015-16).

Between 2014 and 2016, there was a total of 156 deaths registered as suicides in Oxfordshire. The rate of suicides was not significantly different to England.

Through the Oxfordshire Mental Health partnership there is collaborative analysis of local information and intelligence sharing.

Healthwatch Oxfordshire regularly gains feedback and information from members of the public across Oxfordshire. For example gathering views via targeted and geographical research, web based feedback on specific services, and participative community based inquiry. This includes people's views of mental wellbeing, underlying factors, and use of mental health and other services.

The Oxfordshire County Council Public Health team leads on real time surveillance of suicide data and provides post-vention support. Exploration of capturing data on suicide attempts and serious self-harm is also underway to add further insight into where and how prevention should be targeted.

	There is engagement with communities to gain insight into their needs and assets. Currently the OCCG are leading on a consultation into developing the Older Peoples strategy. Young people are engaged through the Children in Care Council and Voice of Oxfordshire's Youth. People with lived experience of suicide are represented on the suicide prevention multi-agency group, following involvement with a workshop run on behalf of the National Suicide Prevention Alliance (NSPA).
Working together	The Health and Wellbeing Board works across, Districts and City Council, the County Council, the Clinical Commissioning Group, HealthWatch Oxfordshire and local NHS trusts. The Oxfordshire Mental Health Partnership has six partners made up of local mental health charities and the local mental health NHS Trust. There is a local multi-agency group for suicide prevention which is coordinated by the County Council and includes representatives from the mental health partnerships, CCG, Coroner's, criminal justice, transport, third sector support services, employer unions The HIB also oversees the work of the Joint Management Group for Adults, which includes working with pooled budgets, for those adults with mental health needs. Schools can engage with Mental Health and Wellbeing in Schools network, whose aim is to provide formal and informal professional development for all school staff and governors, as well as building up a network of people who can collaborate across the area sharing best practice and ideas. The Perinatal Mental Health group is represented with a range of professionals and organizations and also includes a representative for people with lived experience.
Taking action	GPs and Schools have received Mental Health First Aid training and some of the partners provide the training to their staff. The mental health partnership have offered and delivered Psychological Perspectives in Education and Primary (PPEP) care to colleagues across the County. Some GPs practices have received post-vention training following a suicide of a patient and Connect 5 training has been delivered by TVP in collaboration with Papyrus to a range of front line workers in the South of Oxfordshire.

	The health and wellbeing boards (HWB) priority "Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential" has outcomes listed and is monitored by the Health Improvement Board. The HWB strategy identifies that resources have been pooled for mental health. The Oxfordshire Mental Health partnership pools its resources, financial, knowledge and skill based. As employers the partnership organisations have employment support which includes free counselling and mental health support. Many run awareness campaigns internally, as well awareness campaigns externally about dementia. There are local community based opportunities to engage in the arts, the natural environment, volunteering opportunities, delivered by local charities, such as OYAP, Fusion Arts, Artscape. There is a County arts and health group that promotes the role of arts in improving mental wellbeing. Local schools choose to deliver mental wellbeing interventions, such as Bladon Primary School and The Cherwell School. Active in the County is Oxfordshire Schools Mental Health and Wellbeing Network. Schools have also been offered opportunity to see a play raising awareness of self-harm and how young people can access support. Examples of organisations raising awareness include Oxford Health NHS Trust Stamping out Stigma campaign and Oxfordshire County Councils 5 Ways to Wellbeing campaign, which worked in partnership with Mind.
Defining success	The Health and Wellbeing Strategy includes the following outcomes for mental health * reduce out of county placements, * improve access to crisis support, other than the Emergency Departments, * increase those with severe mental illness in employment and settled accommodation, and * increase those reporting feeling safe.

What we plan to do in the next 12 months	
Leadership and Direction	1) Public health within Oxon CC will coordinate the production of an Oxfordshire Mental Wellbeing Framework, which will inform the work of the partner organisations and other stakeholders from 2019 onwards. 2) The Framework will involve representatives from each partner organisation which will further develop the shared vision for prevention and promotion, that all members of the Health and Wellbeing Board organisations have signed up to.
Understanding local need and assets	Local statistics related to mental wellbeing will be reported to the HIB alongside the life satisfaction measure, from the Office of National Statistics. The following topics will be proposed to the board. Use of green and blue spaces and engagement with volunteering and community groups. As part of the creation of the Framework existing local data will be collected and review data already available from communities which gives insights into their needs and assets. The existing Local Authority led Joint Strategic Needs Assessment with a mental health prevention focus will be refreshed to include some analysis and recommendations. The Framework project group will consider including the following a. Mental Health Equity Audits across the partnership b. Collaborative analysis of local information and intelligence sharing c. Shared prioritisation and resources d. Mental Health Impact Assessments to integrate mental health prevention into partnership plans and strategies
Working together	The framework will involve working together in collaboration across a number of organisations and will indicate agreed prevention priorities, shared plans and strategies. The Framework project group will review when and how local communities are involved as well as include those with lived experience and co-production if plans and initiatives

Taking action	The Framework will be signed off by the HIB, who will then provide oversight on progress against the Framework. Delivery of relevant partnership plans and strategies.
Defining success	Success will be within 12 months 1) a task and finish group that involved all the key partner organisations, to produce a signed off Mental Wellbeing Framework for Oxfordshire. 2) At least one progress report on the delivery of the framework. 3) Achieving the agreed year 1 outputs and outcomes defined in the Framework across all partners 4) Additional partners signing up to the Framework, outside of the Health and Wellbeing Boards membership.

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Drug and Alcohol Partnership Strategy briefing document

Aim of the paper:
To inform the Health Improvement Board about the review of the Oxfordshire Drug and Alcohol Partnership Strategy and proposed priorities for the next 4 years.

Background
Substance misuse is an issue that affects a broad spectrum of people across the population. The impact on society can be seen in a number of ways, ranging from the night time economy, child exploitation and reduced health outcomes for individuals. Alcohol and drug consumption is linked to other social determinants of health, and disproportionality affects disadvantaged populations.

As a system, we can work together to identify priorities and coordinate our effects to reduce the impact on broader society, and the harm caused to individuals.

Oxfordshire's Drug and Alcohol Partnership Strategy is a way of drawing together the challenges and impact posed by alcohol and drug consumption, recognised across the system. The strategy being developed will:

- Provide data to articulate the current burden of substance misuse
- identify partnership working groups who input to the priorities and agree action plans based on these
- define a governance structure for reporting progress on action plans
- state agreed partnership priorities which reflect the current challenges posed by D&A consumption.

The Drug and Alcohol Partnership is a virtual partnership, that allows the development of an overarching strategy, and is led by Public Health. Partnership working groups use the priorities identified in the strategy to develop joint actions across agencies, addressing challenges being experienced in their areas of work.

An annual report of the outcomes and achievements will be presented to the Safer Oxfordshire Partnership Working Group, and to the Health Improvement Board. This is coordinated by the Public Health team.

Strategic Context
The use of drug and alcohol is known to have an impact on people's long term health, their health outcomes, and to have inequalities of health outcome.
The Drug And Alcohol Partnership Strategy is being developed in the context of the priorities and objectives of key strategic health bodies.

This strategy will support the **Health and Wellbeing Board's vision**:
To work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire.

As alcohol and drug use can be seen across a broad spectrum of communities, it will contribute to the **following Health Improvement Board Priorities**
Keeping Yourself Healthy (Prevent)

- Promote Mental Wellbeing
- Tackle wider determinants of health
    - Housing and homelessness

Reducing the impact of ill health (Reduce)

- Alcohol advice and treatment
    - Identification and brief advice on harmful drinking
    - Alcohol liaison in hospitals
    - Alcohol treatment services

Shaping Healthy Places and Communities

- Making Every Contact Count
- Campaigns and initiatives to inform the public

The **Oxfordshire Prevention Framework 2019-2024** has been developed with these priorities in mind, adopting the principle of :

- **Prevent** illness
- **Reduce** the need for treatment
- **Delay** the need for care

The use of alcohol and drugs impacts on several preventable risk factors identified in the prevention framework, but there are also specific recommendations for alcohol,:
• ***Joint ambition for addressing alcohol related harm*** *across the partnership*
• ***The Alcohol Care Team (ACT)*** *in the hospital trust is expanded, Fibrosis scanning 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*** *1ry Care increased.*
• ***Increase accessibility*** *to alcohol services to the whole population, including those drinking at harmful but not hazardous levels.*

<u>Developing the Drug and Alcohol Partnership Strategy</u>
Oxfordshire has benefited from a Drug And Alcohol Partnership Strategy for several years, producing outputs such as a joint approach to “Legal Highs”. The periodic renewal of the strategy provides the opportunity to assess current needs, reflect on legislative developments, review current challenges, and consider the synergy with partners priorities.

The process of reviewing the strategy has been led by Public Health, and started with a review of the available surveillance and activity data. As well as using the JSNA, in the last year Public Health have undertaken a Drug and Alcohol Needs

Assessment, which has been used to identify priorities for the strategy. The key findings from this were:

Prevalence:

- Rates of alcohol dependence and opiate and/or crack use in Oxfordshire are estimated to be lower than national rates.
- Overall national rates of drug use among young adults aged 16-24 has declined from 1996 to 2017/18. However, there has been an upward trend in Class A drug use among young adults from 2011/12 to 2017/18. - 8.4% reported that they had taken a class A drug in the preceding year, near double the equivalent rates for adults.
- Rates of alcohol dependence and opiate and/or crack use in Oxfordshire is highest among young males
- Nationally, drug use rates amongst 44-59 has increased over time. (This may be reflective of cannabis use.)

Health:

- More than half of individuals who seek drug and alcohol treatment services have concomitant **mental health** treatment needs
- Individuals with alcohol dependence or substance misuse face substantial associated health inequalities, including higher rates of **premature morbidity and mortality**.
- Nationally 80% of alcohol dependent and near 1000% opioid dependent users also smoke.
- "Alcohol specific" admissions in Oxfordshire are higher than local comparators, but "alcohol related" admissions are lower.

Unmet need

- The estimated **'unmet need**' in Oxfordshire is 87% of alcohol-dependent adults (82% nationally) and 40-60% of crack and /or opiate users.

Inequalities:

- Cherwell and Oxford City are the two districts in Oxfordshire with the highest levels of population growth, socioeconomic deprivation, urban living and homelessness. These districts therefore constitute the highest risk areas for substance misuse.
- Young white males who live in socioeconomically deprived urban areas have the highest rates of alcohol and drug misuse in Oxfordshire.

Social impact

- Substance misuse has a high social cost from associated **public order** & **criminality** in Oxfordshire.

Safeguarding

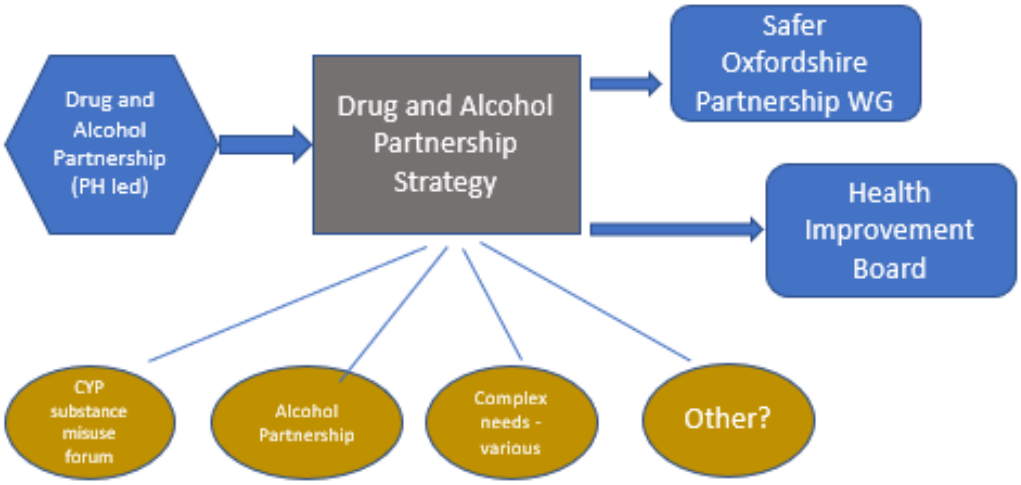
- Alcohol and/or drug misuse is ubiquitous among **sex workers**
- Approximately 1 in 5 presentations to alcohol misuse treatment services, and 1 in 4 presentations to drug misuse treatment services, reported **living with children.** Alcohol and drug use were identified as risk factors in assessments by children's social care, at higher than national rates.

Other information sources were used when collating priorities, including a comparison of local vs national drug data. Also, a Homelessness Health Needs Assessment has also been undertaken this year, which has informed our understanding of this population.

Following review of this information, a proposed set of priorities were identified, and are being discussed at partnership forums. Feedback from these forums has informed the priorities as they are presented in this paper, but as the discussions are ongoing these are subject to change. Once agreed the partnership strategy will be used as a framework to agree relevant actions for that partnership.

Governance

The proposed governance for this strategy is defined below. The Drug And Alcohol Partnership Strategy is a virtual partnership, led by Public Health, and reports to the Safer Oxfordshire Partnership working group, and the Health Improvement Board.



Existing partnership groups include the CYP Substance Misuse Forum, and the Alcohol Partnership Group. There are other issues for which substance misuse has an impact, such as housing and homelessness . The strategy will be shared with relevant groups, and feedback collated by Public Health. There is always the opportunity to share this strategy with further groups as appropriate, and where current issues require this.

Proposed priorities

In line with the prevention strategy, the priorities for this strategy have been expressed in the categories of

Prevent illness / poor social outcomes

Reduce the need for treatment

It has been clear from discussions with partners that there are some **cross-cutting principles** which will relate to the priorities:

Joint working: Having commitment from all partners across the health and social care system, the voluntary sector, education and other agencies as required, is vital to ensuring there is a common understanding of the issues faced due to alcohol and drugs, and the approach being taken by different organisations. This facilitates the development of a joint working approach, and developing a common solution and commitment to action. Also, data sharing is a vital part of being able to identify issues and solutions.

Target Inequalities : This is an accepted theme for prevention work, and will have a different focus in each area of work. Therefore this should be recognised as an important focus for all actions, based on knowledge on inequalities related to that work area.

Prevent

1. Focus on reducing the impact of drugs and alcohol on children and young people. This may, for example, be through tackling child drug exploitation, or ensuring all children have access to Protective Behaviours training.
2. Preventing the harm caused by alcohol or drugs, for example through effective age restrictions to purchasing alcohol, or tackling county lines for drug supply.

Reduce:

1. Reduce the impact of alcohol by addressing the unmet need for services in Oxfordshire. This has been recognised as a national issue, but also as a high local priority, and can be achieved through collaboration between services, innovative extension of services, and raising awareness of when to ask for help.
2. Reduce the harm that can be caused by drugs and alcohol, for example in the night time economy, ensuring people are kept safe, or through violence reduction work.
3. Focusing on vulnerable groups where drug and alcohol are impacting their health and social outcomes. For example, having specialist support for the homeless, or sex workers.

Next steps

Following further discussions with other partners, this strategy will be finalised and shared. The working groups will work with this to agree joint actions, and metrics to measure the impact.

The finalised partnership strategy, with action plans, can be presented to the Health Improvement Board in May 2020

Recommendation:

The board is asked to agree the approach outlined in this paper, and to comment on the proposed priorities.

Kate Holburn
Public Health, Oxfordshire County Council

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Health Improvement Board
Forward Planning

Forward Plan

Meeting Date	Other papers that could be scheduled	Standing items
21st November 2019	Oxfordshire Prevention Framework Mental Wellbeing working group update Alcohol and Drugs draft strategy Active Oxfordshire, reducing physical inactivity Trailblazer report on preventing homelessness	Minutes of the last meeting Performance Dashboard Forward plan Healthwatch Ambassador Report
February 20th 2020	Healthy Place Shaping – Active and Healthy Travel Tobacco Control Alliance Director of Public Health Annual Report Public Health, Health Protection Forum annual report Social Prescribing and GP referral scheme progress report	
Dates in 2020-21 to be confirmed		

Regular Reports from working groups	When to schedule	Note
PH Health Protection Forum	Once a year	Meets quarterly. Last reported Nov 2018 Report due Feb 2020
Affordable Warmth Network	Once a year	Last reported Sept 2019
Housing Support Advisory Group	Twice a year	Last reported Sept 2019
Domestic Abuse Strategy Group	Twice a year	Last report Sept 2019
Tobacco Control Alliance	Tbc	Reported in Nov 18
Mental Wellbeing Working group	At least annually	Report in Nov 19
Healthy Weight – whole systems approach	At least annually	Last reported Sept 19
Active Oxfordshire	Tbc	Update Nov 2019
Healthy Place making	tbc	County wide Master Class events planned for 2019-20
Social prescribing	Tbc	Update as appropriate
Making Every Contact Count	Twice a year	Information item Sept 19
Alcohol and Drugs partnership annual report	Annually.	Draft strategy to be discussed Nov 2019