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, 17 September 2026 at 2.00 pm

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

If you wish to view proceedings online, please click on this Live Stream Link.

Martin Reeves
Chief Executive

Date Not Specified

Contact Officer: ***Georgia Williams***
email: Georgia.Williams@Oxfordshire.gov.uk

Membership

Chair – District Councillor Georgina Heritage
Vice Chair - District Councillor Rachel Crouch

Board Members:

Cllr Bethia Thomas	Vale of White Horse District Council
Cllr Rachel Crouch	West Oxfordshire District Council
Cllr Kate Gregory	Cabinet Member for Public Health & Inequalities, Oxfordshire County Council
Cllr Georgina Heritage	South Oxfordshire District Council
Cllr Mark Lygo	Oxford City Council
Cllr Rob Pattenden	Cherwell District Council
Ansaf Azhar	Director of Public Health, Oxfordshire County Council
Kate Holburn	Consultant in Public Health/Deputy Director, Oxfordshire County Council
Sarah Rayfield	Deputy Director, Oxfordshire County Council
Mish Tullar	District Partnership Liaison
Katharine Howell	Healthwatch Oxfordshire Ambassador

Notes: Date of next meeting: 3 December 2026

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

Time – 14:00

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

6. Note of Decision of Last Meeting

To approve the Note of Decisions of the meeting held on 25th June 2026 and to receive information arising from them.

Time - 14:05 to 14:10

7. Performance Report (Pages 5 - 12)

Presented by Kishan Patel, Public Health Registrar, Oxfordshire County Council

Time: 14:10 – 14:20

8. Report from Healthwatch Ambassador (Pages 13 - 16)

Presented by Katharine Howell, Healthwatch Ambassador

Time: 14:20 – 14:30

9. MECC Update (Pages 17 - 24)

Presented by Lucy Price, Health Improvement Practitioner, Oxfordshire County Council & Emma Hagues (Oxford University Hospitals).

Time: 14:30 – 14:55

10. Break

Time - 14:55 – 15:00

11. Social Prescribing (Pages 25 - 44)

What is the current landscape of social prescribers, who provides this, what are the main challenges/referrals they support. Presented by Jess Wilsher & Chloe Nott (Oxfordshire MIND)

Time: 15:00 – 15:25

12. Citizens Advice Bureau (Pages 45 - 54)

Impact and benefits – moving to a prevention focus. Presented by Paul Wilding, Cost of Living Manager and Pat Coomber-Wood & Mick Morris (Citizens Advice West Northants and Cherwell)

Time: 15:25 – 15:50

13. AOB

Time: 15:50– 16:00

Health Improvement Partnership Board

Thursday 17 September 2026

Performance Report

Background

1 The Health Improvement Partnership Board has agreed to have oversight of delivery of two priorities (priorities 3 and 4) within Oxfordshire's Joint Health and Wellbeing Strategy 2024-2030, and ensure appropriate action is taken by partner organisations to deliver the priorities and shared outcomes. An important part of this function is to monitor the relevant key outcomes and supporting indicators within the strategy's outcomes framework. This HIB performance report has therefore been edited to reflect the relevant measures and metrics from the outcomes framework.

2 The indicators are grouped into the overarching priorities of:

3 Healthy People, Healthy places
- 3.1 Healthy Weight
- 3.2 Smoke Free
- 3.3 Alcohol related harm

4 Physical activity and Active Travel
- 4.1 Physical Activity
- 4.2 Active Travel
- 4.3 Mental Wellbeing

Current Performance

3 The table report below show the agreed measures under each priority, the latest performance available and trend in performance over time. A short commentary is included to give insight into what is influencing the performance reported for each indicator.
Where data is available at sub-Oxfordshire level, this is indicated with * for District and ‡ for MSOA level.

4 All indicators show which period the data is being reported on and whether it is new data (*refs numbers are highlighted*), or the same as that presented to the last meeting.

Of the 23 indicators reported in this paper:
6 indicators have NEW DATA *(Reference Numbers are highlighted in the report)*
These are: ***3.11, 3.14, 3.15, 3.16, 3.17, 4.21***
1 indicator(s) without rag rating.
17 green indicator(s).
4 amber indicator(s).
1 red indicator(s).

4.12 Percentage of physically inactive children - (less than average of 30 minutes a day)

Additional measures proposed for Mental Wellbeing

Two additional measures are currently being explored to strengthen monitoring of mental health and gambling-related harm. Subject to data availability and suitability, these measures will be incorporated into the 2026/27 reporting cycle.

Live Well Priorities

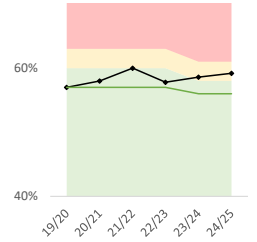
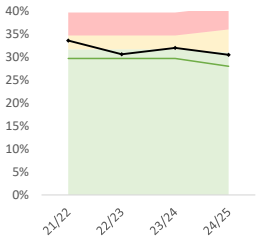
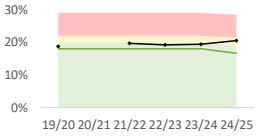
New data is indicated by highlighted references number.

Targets set by local Public Health

All metrics are reported at county level. Available at District * and MSOA ‡ level

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3	**Healthy People, Healthy places**							
3.1	**Healthy Weight**							
3.11	Adults (aged 18 plus) prevalence of overweight (including obesity) *	Annual	56.0%	24/25	59.2%	A	Most recent figures Oxfordshire (24/25) show a slight increase in adult excess weight of 0.6%. However, Oxfordshire's rates remain below England (65%) and are in the lower range amongst it's 10 most similar local authorities (ranging between 56% - 69%). As part of a whole systems approach to excess weight a detailed action plan focuses on prevention, environment, support and wider strategy. A new all age healthy weight service came into effect in September 2024. Wider system work aiming to make changes on a broad scale (such as restriking High Fat Sugar and Salt advertising is required at District Council level to progress this indicator.	
3.12	Year 6 prevalence of overweight (including obesity) * ‡	Annual	28.0%	24/25	30.5%	G	Oxfordshire performs well against the England average generally, but there are some areas in Oxfordshire where children have experienced excess weight over a long period. A new all age healthy weight service launched in September 2024 with a focus on addressing inequalities associated with weight is in place although has struggled to see the number expected. To increase referrals a new proactive follow up will start from January 2026. Beezee Oxfordshire will contact (text, call) families with children identified as overweight through the National Child Measurement Programme (NCMP). New NCMP Co-ordinator recruited to lead this work. Another new option that has launched in October 2025 - Beezee Youth an online programme for children aged 13-17 years old. Work to support more healthy environments continues; latest pilot includes healthier vending in leisure centres to launch Jan 2026.	
3.13	Reception prevalence of overweight (including obesity) * ‡	Annual	16.6%	24/25	20.5%	A	Our whole systems approach to healthy weight and specific programmes including You Move and the new, all age weight management service Beezee, commencing September 2024 continue. In October 2025: Health, Exercise and Nutrition for the Really Young (HENRY), was launched. An evidence-based approach, designed for families with children aged 0–3 years and Nurturing healthy beginnings, Nutrition in Early Years Training for early year settings is being offered from November 2025. A deep dive into healthy weight, including Early Years will be presented to HIB in the New Year	
3.14	Achievement of county wide Gold Sustainable Food Award	Annual	Gold	2026	Gold	G	Oxfordshire stood out for its strong partnership between local government, public health, and food insecurity teams. Key initiatives included the **FEAST European project**, which used community-centred research to address barriers to healthy eating and led to the development of innovative digital tools, alongside the pioneering **OxFarmtoFork** platform, which helps connect local producers with buyers. Progress and impact will continue to be monitored through the recently refreshed Oxfordshire Food Strategy Steering Group.	Not applicable

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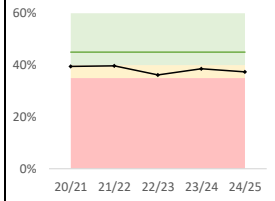
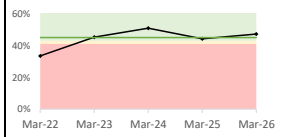
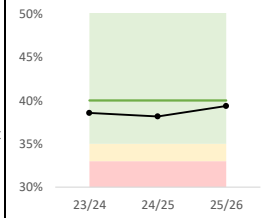
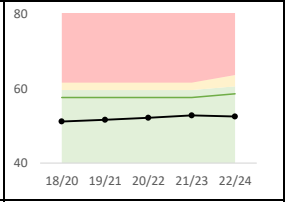
Targets set by local Public Health

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3.15	Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption recommendations *	Annual	45.0%	24/25	37.4%	A	Work to support Oxfordshire's healthy weight agenda continues through initiatives that improve access to healthier food choices, including engagement with food retailers, healthier vending machine provision in leisure centres, and the promotion of healthier food advertising policies. District-led Food Action Plans remain in place, supported by strengthened system leadership through the Food Strategy Steering Group. Programmes for children and young people continue to promote healthy eating behaviours from an early age, such as eating five portions of fruit and vegetables a day, helping to establish lifelong healthy habits.	
3.16	Of those residents invited for a NHS Health check, the percentage who accept and complete the offer.	Annual	42.0%	25/26	47.2%	G	In 2025/26, there was a slight decrease in the number of NHS Health Check invitations issued compared to the previous year. However, uptake improved, with a higher proportion of residents accepting the offer, reaching 47.2%.	
3.17	Healthy Start Voucher uptake	Annual	40.0%	25/26	39.0%	G	**NB: Due to a known issue affecting NHS source data, locally derived data is being used to calculate this measure until the national data source is restored.** Continued promotion of Healthy Start through updated marketing resources and a community influencer campaign, with local parents sharing healthy snack and meal ideas on social media to demonstrate how Healthy Start funds can be used, including tips for families with fussy eaters. A progress report is due in August 2026. The Low Impact Families Tracker will be used to support Healthy Start promotion across city and district councils. In addition, the Healthy Start Oxfordshire online training for frontline professionals was refreshed in June 2026.	
3.18	Under 75 mortality rate from cardiovascular disease (Rate / 100k) (New name) *	Annual	57.6	2022-24	52.5	G	This outcome has remained similar in the current reporting period (22-24) compared to the previous period (21-23) which is a trend seen across the South East and the UK. However, the Oxfordshire data remains better than regional, national and similar authority comparators. Local activity to address this outcome sits within theme specific work on tobacco control, or whole systems approach to obesity, or physical inactivity or alcohol harm. Specific updates will be provided as per Health Improvement Board annual work plan.	

Live Well Priorities

New data is indicated by highlighted references number.
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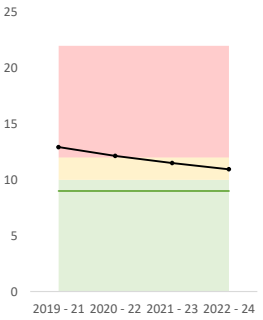
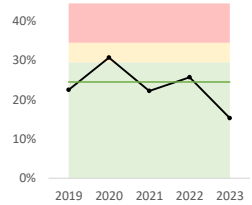
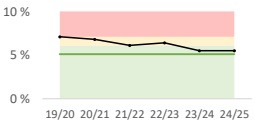
Targets set by local Public Health

Key
Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3.2	**Smoke Free**							
3.21	Smoking prevalence in adults (18+) - self-reported current smokers (APS) (3 years rolling average)	Annual	9.0%	22-24	9.1%	G	Data note: The 2024 Annual Population Survey (APS) returned to using face-to-face interviews as its main method. Based on this new data, the ONS recalculated its adjustment factor and revised all smoking estimates from 2020 to 2023. As a result, single-year smoking indicators for those years were updated in the APS 2024 release. The Oxfordshire Tobacco Control Alliance oversees works to reduce smoking in Oxfordshire. The Alliance has developed a new strategy and action plan for the next 5 years, working in partnership to build on the effective work of the last 5 years, with the aid of a comprehensive new Health Needs Assessment for smoking. This action plan includes work by: NHS trusts, Trading Standards The Fire Service Schools New Local Stop Smoking Service, Smokefree Oxon provided by Solutions4Health. The additional grant funding from government is helping to target work to priority groups whose prevalence rates are highest. This includes outreach work and alternative support option of Allen Carr Easyway, continued work with Swap to Stop in mental health settings and funding Trading Standards work to tackle illegal tobacco supply.	
3.22	Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers *	Annual	23.3%	2023	15.3%	G	Data Note - Due to sample size issues in APS, Data for 2024 is report across 3 years replacing the previous one-year metric until further notice. Oxfordshire's prevalence (18.3%) is statistically no different to both South East (18.8%) and England (19.2%). The new Local Stop Smoking Service, Smokefree Oxon, targets work with routine and manual workers as one its priority groups. The Public Health team track this work at quarterly monitoring meetings with the Smokefree Oxon provider, Solutions4Health. Outreach to places of work and in the community is planned with a new workplace wellbeing service which will deliver Very Brief Advice and make referrals/signpost to Smokefree Oxon. Campaigns in March 2025 for No Smoking Day and Stoptober focused on priority cohorts including routine and manual workers.	
3.23	Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS) (New method) *	Annual	20.0%	23/24	22.6%	A	A Tobacco Dependency Service (TDS) funded by NHSE/ICB specifically supports adult inpatients with mental health conditions to quit smoking. The newly commissioned Local Stop Smoking Service ***Smokefree Oxon*** has key quit targets for people with mental health needs in the community. They are working with mental health partners, pharmacies and GP surgeries to ensure they can engage and support this group. **Data note: The 2024 results are not comparable with previous years because of changes to both the questionnaire and the mailing strategy.**	No data available for trend chart
3.24	Smoking prevalence in pregnancy *	Annual	5.1%	24/25	5.5%	G	Trend comparisons with earlier years should therefore be interpreted with caution. Most pregnant women who smoke, and their household members continue to be supported via the new maternity in-house tobacco dependency advisor service. The new national incentive quit scheme has been rolled out across the county and is showing small but increasing numbers of take up.	

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Targets set by local Public Health

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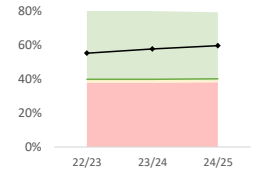
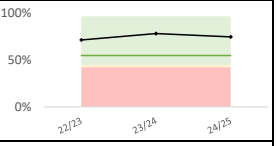
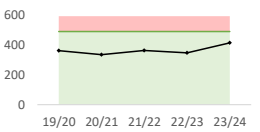
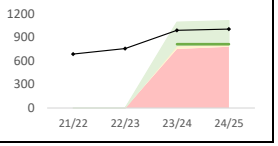
Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3.3	**Alcohol related harm**							
3.31	Alcohol only successful treatment completion and not requiring treatment again within 6 months	Annual	40.0%	24/25	59.4%	G	The latest performance remains significantly above both the set target and the national average of 34.1%, and continues to increase from previous years. This is achieved through strong partnership and multi-agency working, extensive community-based engagement and outreach, providing holistic person-centred care, individualised goals, and supported by access to residential treatment where necessary.	
3.32	Alcohol treatment progress	Annual	55.0%	24/25	75.0%	G	Latest performance is above both the set target and the national average (52%), demonstrating delivery against national and local strategic aims to ensure people receive effective support, engagement and treatment.	
3.33	Admission episodes for alcohol-related conditions (Narrow) Rate / 100K *	Annual	490	23/24	414	G	Oxfordshire rates are below the south east average (429). There is significant ongoing partnership and multi-agency work to prevent the number of people drinking to hazardous levels, and significant investment and activity in community services to ensure people receive the support they require to prevent escalation of need.	
3.34	Alcohol only numbers in structured treatment	Annual	810	24/25	1002	G	In line with national strategic aims, extensive partnership working and targeted outreach to communities experiencing health inequalities have supported continued growth in the number of people in treatment over the past year.	

Live Well Priorities

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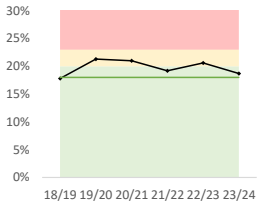
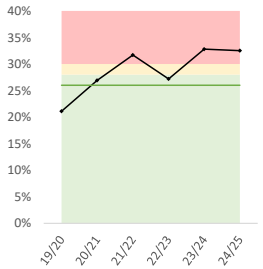
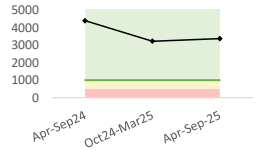
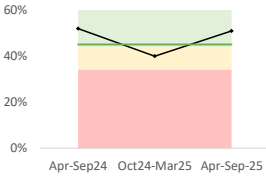
Targets set by local Public Health

All metrics are reported at county level. Available at District * and MSOA ‡ level

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
4	**Physical activity and Active Travel**							
4.1	**Physical Activity**							
4.11	Percentage of physically inactive adults (Less than 30 minutes a week)	Annual	18.0%	Nov 23/24	18.7%	G	Adults in Oxfordshire are less likely to be physically inactive than the England average, with 18.7% of adults classed as inactive compared with 22% nationally. Inactivity is more common among older adults, people living in more deprived areas, those reporting a disability, pregnant women or those with a child under one, carers, and people who are overweight. Oxfordshire's Whole Systems approach seeks to address this through targeted initiatives such as You Move, Move Together and upskilling professionals, alongside a Physical Activity Health Needs Assessment to identify further opportunities for action. **It should be noted that data about physical activity is based on the Active Lives Survey which is not considered statistically robust at local authority level.**	
4.12	Percentage of phyically inactive children (less than average 30 minutes a day)	Annual	26.0%	Academic Yr 24-25	32.5%	R	Around 1 in 3 (33%) of children in Oxfordshire are 'inactive' (active for less than 30 mins daily) and higher than the England and South East averages of 28% In September 2024 You Move was expanded to include 'early years', by providing Jabadao training to Early Years professionals and partnering with Home Start. A Healthy Movers programme (supporting children and families via settings to move more), launched in January 2025, engaging nearly 1,000 children and 90 families, to date, showing early improvements in physical activity. A play sufficiency assessment is underway aiming to enhance play opportunities across Oxfordshire. The Physical Activity Health Needs Assessment, will offer further recommendations. **It should be noted that data about physical activity is based on the Active Lives Survey which is not considered statistically robust at a local level nevertheless it is the best data we have.**	
4.13	Uptake of Move together	Biannual	1000	Apr-Sep-25	3370	G	**Move Together** is part of the Whole Systems Approach to Physical Activity, jointly funded by public health and Thames Valley ICB to support people with long term conditions (LTC). The target of an increase in 1000 steps per day was surpassed with participants on average achieving more than 3,000 additional steps. Referral criteria have been refined to ensue only those people who are inactive are referred into the programme.	
4.14	You move programmes	Biannual	45.1%	Apr-Sep-25	51.0%	G	**You Move** is part of the Whole Systems Approach to Physical Activity commissioned by Public Health, ICB and District Councils, supporting children and their Families meeting eligibility criteria i.e. the predominant group is families of children in receipt of free school meals. The programme delivers heavily subsidised or free physical activity. Over half (51%) of YM participants (returning a survey) reported an increase in activity levels between registration and 6-month follow up. This was based on a low 9.1% questionnaire return rate. Work to increase questionnaire return is being tackled by incentivisation and direct follow up with families.	

Live Well Priorities

New data is indicated by highlighted references number.

Targets set by local Public Health

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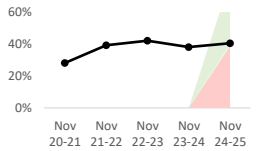
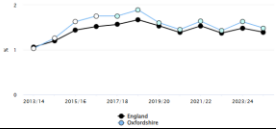
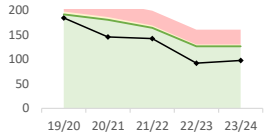
Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
4.2	**Active Travel**							
4.21	Active travel - Percentage of adults (16+) undertaking active travel at least twice in the last 28 days. *	Annual	42.0%	24/25 Nov	40.6%	G	New metric: Oxfordshire County Council's cycling and walking activation programme comprises a range of measures to enable people to walk, wheel and cycle more. These activities in conjunction with improvements to active travel infrastructure seek to deliver an increase in physical activity. Oxfordshire County Council continues to invest in active travel infrastructure, while supporting residents to make greater use of these opportunities through behaviour change programmes. This includes the Community Outreach Active Travel (COAT) programme, which has a particular focus on communities experiencing greater health inequalities, and the BetterPoints rewards platform, which incentivises walking, wheeling and cycling. Together, these initiatives support increased physical activity, reduced car dependency and improved health and wellbeing outcomes	
4.3	**Mental Wellbeing**							
4.31	The percentage of patients aged 18 and over with depression recorded on practice disease registers for the first time in the financial year.	Annual	-	24/25	1.5%		In 2024/25, the rate of newly diagnosed depression in Oxfordshire was 1.5%, representing 10,098 recorded diagnoses. This rate is not statistically different from the England average (1.4%). The most recent data indicate no significant change in trend, suggesting that diagnosis levels in primary care have remained broadly stable. Oxfordshire's rate lies within the central range of national variation.	
4.32	Emergency hospital admissions for intentional self-harm in all ages (Rate / 100k) *	Annual	126.3	23/24	97.3	G	For further insight, see the paper on Adult and Older Adult Mental Health in Oxfordshire which was presented at the Oxfordshire Joint Health Overview & Scrutiny Committee on the 12th September 2024	

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Your voice on health and care services

Healthwatch Oxfordshire (HWO) report to Health Improvement Board (HIB)
17th September 2026
Presented by Healthwatch Oxfordshire Research and Projects Officer, Katharine Howell

Purpose / Recommendation

- For questions and responses to be taken in relation to Healthwatch Oxfordshire insights.

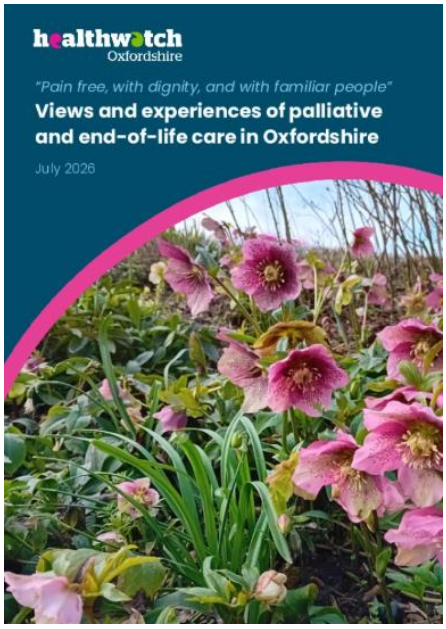
Background

Healthwatch Oxfordshire continues to listen to the views and experiences of people in Oxfordshire about health and social care. We use a variety of methods to hear from people including surveys, outreach, community research, and work with groups including Patient Participation Groups (PPGs), voluntary and community groups and those who are seldom heard. We build on our social media presence and output to raise the awareness of Healthwatch Oxfordshire and to support signposting and encourage feedback. We ensure our communications, reports and website are accessible with provision of Easy Read and translated options.

Key Issues

Since the last meeting in June 2026:

- We published a research report on **Views and experiences of palliative and end-of-life care in Oxfordshire**, based on what we heard from 110 local residents about their hopes and fears around death, and experiences of palliative and end-of-life care services.
  - We heard that many people had **clear and consistent priorities** about what mattered to them most at the end of life: being close to loved ones, feeling safe and comfortable, and receiving good quality care. Most people said they would **prefer to die at home or in a hospice** rather than in a care home or hospital. Although many people had thought about or discussed their wishes, not everyone had made formal plans and some people said they were **unsure about how and when to have end-of-life conversations**.



- People told us about positive aspects of palliative and end-of-life care, including having **control over decisions**, **management of symptoms and pain**, being treated with **dignity and compassion**, and receiving support that recognised both **the patient as a whole person** and those close to them.
- However, some people had experienced challenges including **difficulties accessing support** and services, **gaps in communication**, **lack of coordination** between different health and care providers, **poor communication**, and **inadequate quality and continuity** of care.
- People suggested improvements including around **information** and **access to support and services**; **communication** and encouraging **earlier conversations** about end-of-life wishes; strengthening **coordination** between services; strengthening **staff capacity and skills**, and increasing **support for families**. Throughout, we heard about the importance of care and support that builds on people's existing networks, assets and communities, that is culturally appropriate, and that takes into account the wishes of people who are dying and their loved ones, supporting them to live and die well.
- We welcomed **responses to our recommendations** from system partners, including commitments from Oxford Health to create a map of what services are available in different areas and at what times, and to establish a 'key coordinator' for each person receiving end-of-life care; and from Oxford Health, Oxford University Hospitals and Oxfordshire Community Council to work with diverse communities to ensure that care is culturally appropriate.

- We finalised our report bringing together insight from **850 people** across 14 **rural areas** (Deddington, Cropredy, Heyford, Yarnton, Chipping Norton, Charlbury, Long Hanborough, Freeland, Chalgrove, Sonning Common, Faringdon, Stanford in the Vale, Shrivenham and Watchfield) for Oxfordshire County Council as part of the **Marmot focus on health inequalities**.
  - Key themes include gaps around transport, housing and provision for young people, the wealth of community groups supporting health and wellbeing in rural areas and the precarity of these groups and organisations due to challenges including funding.
  - The report will be published shortly, ahead of the September meeting of the Health and Wellbeing Board.

- We ran **skills training workshops for aspiring community-based researchers**
  - Building on the success of our new co-produced Community Research: How-to Guide, in July 2026 we delivered two practical skills workshops, giving participants the opportunity to put the guide into action.
  - During two interactive, hands-on training sessions at Rose Hill Community Centre, 15 aspiring community-based researchers worked through the 9 steps of community research helping to develop the skills, knowledge and confidence to carry out research within their own communities, and supporting each other to develop their own ideas for community research projects.
  - Together, we are now working to plan and develop ongoing support for community researchers as they put what they have learned into action.
  - We will be running a second cohort of community research training sessions for grassroots community members in October.

All reports are available to read via our website, together with Easy Read, provider responses, and examples of the impact of our research.

Enter and View reports and visits continue. Once complete, all reports and provider responses are available on our website.

- Since the last meeting we made an Enter and View visit to the Minor Injuries Unit at Abingdon Community Hospital.
- We were also delighted to hear that feedback we'd shared with Oxford Health following our **Enter and View** visit had helped shape plans for a major refurbishment project **at Abingdon Community Hospital's Emergency Multidisciplinary Unit**.

Other activity:

- We held a **public webinar** on Palliative and End-of-Life Care, 15th September – with speakers from Oxford Health and Oxford University Hospitals. Recordings of this and previous webinars are available to watch on our website.
- We took part in the **Director of Public Health's Annual Report launch event**, supporting community involvement in the event where partners from across the county came together to share learning, **celebrate community-led action** and strengthen collective efforts to **reduce health inequalities**.
- In **Quarter 1 (April to June)** we engaged directly with approximately 419 people across the county through being on the streets, attending events, hospital stands, community gatherings and Patient Participation Group meetings. Our focus during this time was around hearing from women about their experiences of using maternity services. We have also had great days out talking to people at Play Days across the county.
- We have been participating in Neighbourhood Health workshops, to highlight the need for pathways for patients and residents to be part of the design of this shift towards care closer to home.
- Our most recent **Board Open Forum** was on **Wednesday 16th September** online.

- **Future of Healthwatch**

  Healthwatch Oxfordshire continues an independent charity to be here to listen to people using health and care services and ensuring their voices are heard by decision makers – sign up to our news bulletin to hear about our work.

  The recent publication of the Health Bill https://bills.parliament.uk/bills/4124 includes removal of statutory function of Healthwatch as an independent voice. We are working closely with health and social care system to explore future iterations for our charity.

Health Improvement Board

Thursday 17th September 2026

Oxfordshire Making Every Contact Count (MECC) Update and Strategy Development (2026 – 2031)

Purpose / Recommendation

1. The Health Improvement Board is asked to:
   (a) note the progress made so far in Oxfordshire to embed Making Every Contact Count (MECC)
   (b) approve the proposed direction of the five-year Oxfordshire MECC strategy, and note the opportunities of MECC to improve population health and reduce health inequalities

Executive Summary

2. This report provides an overview of the progress made to date on implementing the Oxfordshire MECC programme and sets out the proposed direction for the development of a five-year Oxfordshire MECC Strategy for 2026–2031. The strategy will provide a shared vision and clear priorities for embedding MECC sustainably across the county to support prevention, improving population health, tackling health inequalities and strengthening opportunities to connect residents with support that addresses the wider determinants of health. The strategy will also support the continued commitment to MECC during Local Government Reorganisation. The Health Improvement Board is invited to note progress made to date and approve the proposed direction for the strategy to inform its continued development.

Background

3. Making Every Contact Count (MECC) is an evidence-based approach to health improvement, which involves responding appropriately to cues from others to have opportunistic conversations about health and wellbeing. These conversations happen in everyday life – for example, this could be at work, on the bus, at school pick up time, or in a shop. MECC can take place anywhere where there is contact between individuals, and not just in health-related settings.

4. The MECC approach is recommended by a range of health organisations, policies and strategies as a key driver for improving health outcomes in a population and supporting upstream prevention. These include the Local Government Association[1], the NHS 10 Year Health Plan[2] through acting as an enabler to preventative interactions, NHS England[3] and the Office for Health

[1] Local Government Association https://www.local.gov.uk/case-studies/making-every-contact-count
[2] NHS 10 Year Health Plan 10 Year Health Plan for England: fit for the future - GOV.UK
[3] NHS England https://www.hee.nhs.uk/our-work/population-health/our-resources-hub/making-every-contact-count-mecc

Improvement and Disparities[4]. Whilst MECC is recommended nationally, Oxfordshire is responsible for rolling out the local MECC programme across the county. Public Health work collaboratively across the South East and Thames Valley with other regions' MECC leads to share best practice and connect MECC programmes.

5. Across Oxfordshire, MECC is rolled out in the form of training delivery to professionals, volunteers and the wider Public Health workforce, using various formats including face-to-face and online. The training typically covers five lifestyle behaviours: healthy eating and maintaining a healthy weight; physical activity; smoking; alcohol and mental wellbeing. It also supports awareness of wider factors that influence health and wellbeing, such as housing, employment and social connections. People who receive MECC training are not expected to be health experts. The training helps them to build the confidence and skills to recognise opportunities for brief, everyday conversations about health and wellbeing. These conversations can support people to consider positive behaviour changes, improve their physical and mental wellbeing, and access further support through appropriate signposting.

6. A sustainable cascade approach is utilised locally by training staff in different organisations to become MECC trainers themselves and roll out the training, this is delivered through a Train the Trainer programme. Training in Oxfordshire is co-ordinated by Oxfordshire County Council's Public Health team and is delivered by a range of trainers across organisations within the county.

7. MECC supports the shared vision of the Oxfordshire Health and Wellbeing Strategy[5] (2024-2030) to improve health and wellbeing across the county through a life-course approach. MECC aligns particularly with the strategy's core principles of preventing ill health, tackling health inequalities and closer collaboration, by enabling staff and volunteers to have meaningful, brief, and opportunistic conversations that support healthier behaviours, early intervention and access to local support.

8. MECC also has a key role in delivering the Oxfordshire Marmot Place[6] ambitions through supporting knowledge and action on the wider determinants of health and reducing health inequalities at both an individual and population level. By helping to address equity of access to services and support through signposting, MECC enables behaviour change alongside reaching residents who may have not otherwise engaged in a healthy conversation or even considered accessing a preventative support service[7].

9. In Oxfordshire, there is a MECC Partnership which drives MECC activity across the county and oversees the county's action plan for MECC. Over recent years, partners have worked collaboratively to implement MECC

[4] Office for Health Improvement and Disparities About us - Office for Health Improvement and Disparities - GOV.UK
[5] Oxfordshire Health and Wellbeing Strategy - 2024-2030
[6] About Oxfordshire a Marmot Place | Oxfordshire County Council
[7] NHS MECC Consensus Statement

across Oxfordshire, expanding the network of trained staff and volunteers and embedding MECC principles within local organisations. As part of ongoing work to consider the sustainability of the MECC programme in Oxfordshire, stakeholders have expressed a strong desire for an overarching MECC strategy to support the MECC programme of work going forward. In response, a five-year Oxfordshire MECC Strategy for 2026-2031 is being developed on behalf of the partnership, to provide a strategic framework for the future delivery of MECC and to support sustainability of the programme.

Key Issues

10. There is currently no countywide unified strategy for MECC beyond the existing partnership action plan. Whilst significant progress has been made in implementing and delivering the Oxfordshire MECC programme, the absence of a shared long-term strategic vision and reliance on membership of the partnership presents a risk to the consistency, co-ordination and future development of MECC across organisations, services and communities in Oxfordshire. Commitment and co-ordination is likely to also be affected by the disruption from organisational reform both within the NHS and local government.

11. The Oxfordshire MECC programme has previously benefited from implementation funding of £200,000 secured in April 2022 from the Oxfordshire Clinical Commissioning Group (OCCG and now NHS Thames Valley Integrated Care Board). A fixed-term two-year co-ordinator role within Oxfordshire County Council's Public Health team was then appointed in 2022 using part of this funding to support the strategic roll out of MECC across the county. Public Health also provided further funding to extend the MECC co-ordinator role part-time, with most of these funds now utilised and the fixed-term co-ordinator post coming to an end in August 2027.

12. At a recent workshop, the Oxfordshire MECC Partnership expressed feedback that the dedicated MECC co-ordinator role is essential to maintaining partnership momentum, enabling collaboration across organisations and ensuring effective delivery of the Oxfordshire MECC programme. This feedback reinforces the continuation of the MECC co-ordinator role as a key enabler to embedding and delivering MECC across the county. The future resourcing and delivery of MECC will be reviewed as part of wider Public Health workforce and service planning.

MECC Strategy Direction

13. The Oxfordshire MECC Strategy is being co-developed with stakeholders through a range of engagement activities. These have included an Oxfordshire MECC Partnership workshop in June 2026, where partners discussed the future direction of MECC and identified areas for action, as well as a needs assessment survey and a monthly working group.

14. The proposed direction and key components of the strategy agreed with the MECC Strategy Working Group are outlined in the table below. The strategy

is also expected to include context-setting sections covering the national context, the Oxfordshire MECC picture, evidence-base, and where we are as a partnership. The structure will continue to be refined through stakeholder engagement and partnership input.

Proposed Structure	Purpose
Our Vision	To establish a shared long-term vision for MECC in Oxfordshire across the next five years. Current key themes include embedding sustainability, fostering a preventative culture and empowering people to improve their health and wellbeing, ultimately reducing health inequalities and improving health outcomes for all.
Guiding principles	To set out the key principles that will underpin delivery of the strategies vision and aims.
Priority areas	Key areas for collective action over the next five years to achieve the strategy's vision and aims. Themes being explored include aligning the Oxfordshire MECC strategy to wider regional work across the Thames Valley in consideration of Local Government Reorganisation, post-training support, MECC within the future workforce, and ensuring MECC is targeted and inclusive.
Enablers	The conditions required to support successful strategy delivery, including areas such as collective responsibility, senior commitment and sustainable resourcing.
Monitoring and governance	How delivery of the strategy will be overseen, monitoring of progress and evidence of impact.

Update on recent MECC activity

15. Key areas of activity that have been completed or are ongoing, since the previous MECC report was presented at the Health Improvement Board on 13th June 2024 are outlined below:

Activity	Action
1. Training delivery	• Development of Oxfordshire specific MECC training in 2024. • A total of 1368 people across Oxfordshire were trained in MECC during the previous financial year (2025-2026)[8]. • 15 people completed the MECC Train the Trainer course[8]. • Attendees covered a range of sectors including the voluntary and community sector, education, healthcare and local authority, working across priority communities and areas at greatest risk of experiencing health inequalities. • A super trainer course was also held in April 2025 to

[8] Please note the numbers stated are likely to be an underestimation as we know that MECC training is being delivered by organisations across the county which are not reported.

	expand capacity and sustainability of Train the Trainer delivery, with 7 people attending. Attendees included representatives from healthcare, the voluntary and community sector, district councils, and Oxfordshire County Council teams.
2. Grant programme and financial support	• Provision of grants to over 20 organisations and teams (10 ongoing in the current financial year) to support them to embed MECC sustainably. • Financial support for reimbursing time and venue costs to enable accessibility of training for smaller organisations and the voluntary sector. • Grant recipients have adapted MECC training content to suit the nature of different audiences.
3. Future workforce	• Embedding MECC into the future workforce, through training Public Health Registrars and the incorporation of MECC training into Oxford Brookes University undergraduate programmes including nursing and paramedics.
4. Communication and narrative	• Strengthened communication and narrative around MECC, through development of the Oxfordshire MECC website, updates to Thames Valley MECC link, and the creation of new resources including lanyard cards, posters and a trainer's newsletter. • MECC Month of May yearly campaign rolled out across the partnership. • Roll out of the MECC South East Communications toolkit.
5. Evaluation and impact	• Here for Health, Oxford University Hospitals Value for Money evaluation[9] indicates possible economic impact of Behaviour Change Frameworks such as MECC. • The Local Policy Lab (2024) evaluated MECC training programmes in Oxfordshire, highlighting the effectivity of Oxfordshire's MECC training in building participants confidence to support people to make healthy lifestyle choices, which were sustained three months after. • The Local Policy Lab (2026) project explored appropriate evaluation methods to identify the possible wider impacts of MECC beyond training, providing a recommendation for a three-stage evaluation approach, focusing on implementation, qualitative story-telling and co-designing monitoring indicators. • Increased efforts to collate case studies capturing the benefits of MECC in practice. • Libraries had a total of 19,099 MECC interactions in financial year 2025/2026, an increase in 83% from the previous year. Mental health and wellbeing was the most discussed topic (34% of all MECC conversations).

[9] Hospital-Embedded Prevention Across Oxfordshire University Hospitals: Evaluation of a Large UK- Based Behaviour Change Service

6. Embedding MECC	• Increased representation within the Oxfordshire MECC partnership and the number of MECC champions. • 119 MECC trainers across Oxfordshire delivering training both internal and external to their organisations. • Many organisations and services progressing MECC as mandatory training for new staters. • MECC is embedded across a range of organisation's cultures in Oxfordshire. • Development of resources to support implementation of MECC in Oxfordshire, including lanyard cards, flyers, badges and pens.

Budgetary Implications

16. Oxfordshire County Council's Public Health team are currently holding the remaining pot of funding received from the previous Oxfordshire Clinical Commissioning Group (OCCG now NHS Thames Valley Integrated Care Board) on behalf of the Oxfordshire MECC Partnership, totalling £25,400. This has been committed by the partnership towards future grants, resources and contingency.

17. The Oxfordshire MECC Partnership and trainers across organisations have provided staff time and resource towards supporting training delivery.

18. Oxfordshire County Council Public Health has provided funding for the extension of one part-time (0.5FTE) two-year fixed-term MECC co-ordinator post until August 2027.

Comments checked by:
Stephen Rowles, Strategic Finance Business Partner
Stephen.rowles@oxfordshore.gov.uk

Equalities Implications

19. A key focus of the Oxfordshire MECC programme is to tackle health inequalities. The programme focuses on embedding MECC within organisations and services that are located in or serve people living in areas of inequality in Oxfordshire or who support groups in the community who are more likely to experience inequalities. Organisations supporting people across the life course are encouraged to get involved in the MECC programme such as early years settings and services aimed at older adults. Where possible, organisations/services that support particularly vulnerable people (e.g. people who are homeless and vulnerable migrants) are also encouraged to engage with MECC, as these groups are more likely to experience poorer health outcomes compared to the rest of the population.

20. It is anticipated there will be no groups who would be disadvantaged by the Oxfordshire MECC strategy.

Sustainability Implications

21. There are no direct sustainability implications associated with the development of the Oxfordshire MECC Strategy. These will continue to be assessed throughout the development and implementation.

Legal Implications

22. There are no specific legal implications arising from this report. The report provides an update on the work being carried out across Oxfordshire to embed Making Every Contact Count (MECC), which, in turn supports the delivery of the objective to improve health and wellbeing across the county.

    Comments checked by:
    Janice White, Principal Solicitor: ASC, SEND and Education

Risk Management

23. There is a risk that MECC will not be implemented consistently without shared commitment and co-ordination across partners. This risk is being mitigated by developing the strategy through a partnership-led approach, with stakeholder engagement at the centre. A MECC Strategy Working Group has helped to identify shared priorities and actions, supporting collective ownership across the partnership.

24. Changes across the wider health and local government landscape, including local government reorganisation and future funding uncertainties could impact the sustainability of future MECC activity. The development of the Oxfordshire MECC Strategy provides an opportunity to establish the foundations of a clear long-term vision, strengthen partnership working and the role of MECC in supporting prevention under the new landscape. It will also enable the embedding of MECC within existing systems, policies and the future workforce to support sustainability. Whilst existing local authority structures will change, the key principles of MECC incorporated within the strategy will be applicable across all three unitary areas and provide an opportunity to embed a consistent prevention-focused approach across the new structures[10].

Communications

25. The Oxfordshire MECC strategy is being developed in collaboration with the Oxfordshire MECC Partnership. This includes a strategy partnership workshop, a MECC Needs Assessment survey incorporating feedback from the partnership, trainers and organisations engaged with MECC, and a dedicated MECC Strategy Working Group which meets monthly to guide the development of the strategy. Represented members of the partnership include:

    - Active Oxfordshire

[10] Local government reorganisation in Oxfordshire - GOV.UK

- Adult Social Care, Oxfordshire County Council
- Age UK Oxfordshire
- Carers Oxfordshire
- Cherwell District Council
- Citizens Advice
- Community Pharmacy Thames Valley
- Early Years, Oxfordshire County Council
- Farmability
- Fire and Rescue Service, Oxfordshire County Council
- Good Food Oxfordshire
- Libraries, Oxfordshire County Council
- Oxford Brookes University
- Oxford City Council
- Oxford Health NHS Foundation Trust
- Oxford Hub
- Oxford University Hospital NHS Foundation Trust
- Oxfordshire Mind
- Public Health, Oxfordshire County Council
- South Central Ambulance Service
- South and Vale District Council
- West Oxfordshire District Council

Key Dates

26. The draft Oxfordshire MECC Strategy (2026-2031) is expected to be completed by the end of December 2026 (Q3 of financial year 26-27).

27. Implementation of activities outlined within the strategy will then be delivered accordingly in collaboration with the Oxfordshire MECC Partnership.

Report by: Fiona Ruck, Public Health Principal
Lucy Price, Health Improvement Practitioner

Contact: fiona.ruck@oxfordshire.gov.uk
lucy.price@oxfordshire.gov.uk

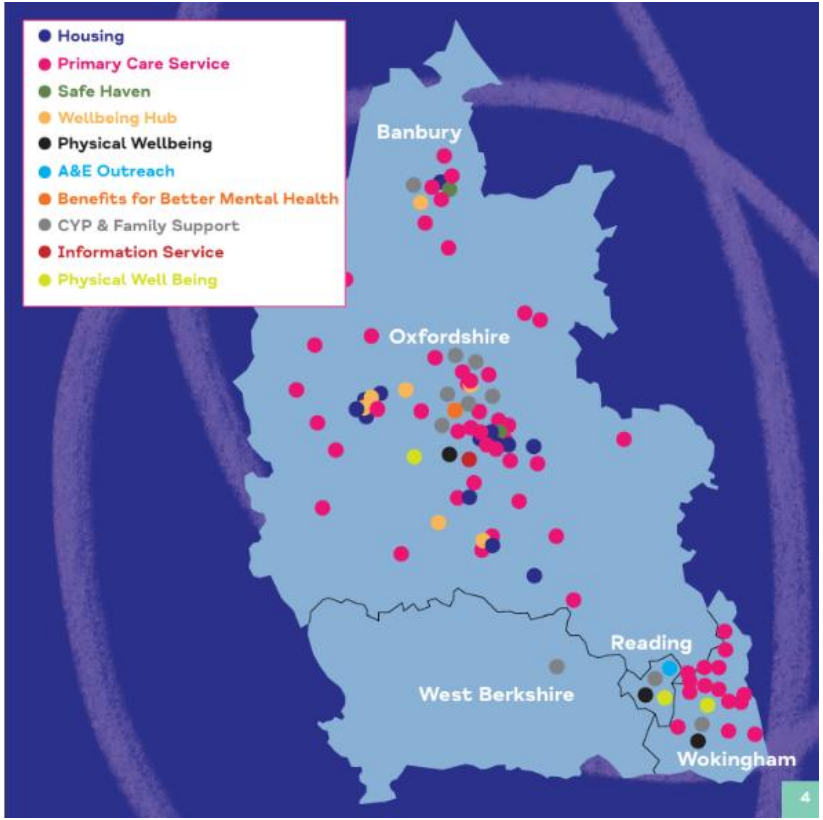
September 2026


Oxfordshire
mind

Oxfordshire Mind: who we are and what we do

- Local independent mental health charity Oxfordshire & Berkshire
- Mind Federation member
- Established almost 60 years ago
- Service delivery & campaigning
- Housing & Wellbeing including city & district hubs
- Social prescribing

"Local support. Human connection. Real Change."



Social prescribing in Oxfordshire: from pilot to established model

2018 Primary Care Wellbeing pilot begins – City & South West Oxon

2020 PCNs/ARRS enable direct PCN contracts & expansion

2022 Provision for children & young people begins

2023 Mind Federation Supported Self Help service begins

2025 First INT work

PCN = primary care network
ARRS = additional roles reimbursement scheme
INT = integrated neighbourhood team

What does social prescribing look like in practice?

‘a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs. They subsequently connect them to non-clinical support and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and well-being and to strengthen community connections.’

Oxfordshire Mind Primary Care Wellbeing Service

- Support from a professional Oxfordshire Mind worker
- Accessible support embedded with primary care
- Time to understand the whole person
- Agree goals & build self-management
- Practical support and connection to community/statutory services
- Clear boundaries & onward referral where specialist support is needed

Who we support

- Very even representation across age groups
- More women than men
- Ethnicity profile very close to the census data from 2021 for Oxfordshire
- Similar deprivation profile to Oxfordshire when looking at IMD score of service user profiles – small but significant group living in most deprived areas

22% under 30 · 25% aged 60+

Even spread across age groups

13.2% vs 14.4%

Ethnic minority background: service users vs Oxfordshire (2021 census)

4.6% vs 2.6%

In the 30% most deprived areas: service users vs OCC population data

What people bring to us

At initial assessment, we record the presenting needs (up to three) that a client identifies as being important. From April 2023 onwards, the most commonly identified primary needs, in order, were:

1. Managing symptoms of anxiety or panic
2. Coping with stress
- Improving mood or motivation
- Needing a space to talk
- Support with bereavement and loss
- Living with a physical health issue impacting wellbeing
- Managing symptoms of trauma

How the intervention works and how we complement primary care

- Embedded alongside GP practice teams
- Familiar and accessible route into support
- Non-clinical wellbeing / social prescribing
- Triage, assessment and onward referral
- Reduces pressure on primary care by addressing wider needs
- Builds confidence, knowledge & self-management

“They are real assets to us and your organisation.”

Beyond the presenting problem: wider determinants of health

Mental health is universal, mental health problems rarely exist in isolation

Housing

Income / benefits

Employment

Physical health

Social connection

Relationships

Community

Bereavement

The most impactful social determinants for driving population-level mental health inequalities	The most important factors for assessing the impact of the determinant
Financial situation	Financial insecurity
Housing and household conditions	Safety
Identity-based mistreatment	Violence
Employment	Earning a liveable income
Social connections	Loneliness and social isolation
Access to mental and physical health support	Availability of support

Mental Health Foundation 2025 Delphi Study

Housing and wellbeing

OCC's Housing and Health Needs Assessment identified three different groups of housing which can negatively impact health and wellbeing:

- **Unhealthy and unsafe homes:** cold, damp or in a poor state of repair
- **Unsuitable homes:** where the home environment does not meet the needs of an occupant, e.g. overcrowding, loneliness, unmet care needs.
- **Precarious homes:** financial risks around affordability including risks of homelessness.

"It is good that you can help with everything that is going on- like housing etc."

Employment, income, poverty and wellbeing

- Working age adults in poverty are more likely to report poor health which gets worse with age and low-incomes are linked with higher rates of anxiety (1) .

- The ONS found in 2022 (2) that the prevalence of moderate to severe depressive symptoms was higher among: adults who were economically inactive because of long-term sickness, unpaid carers for 35 or more hours a week, disabled adults, adults in the most deprived areas of England, young adults aged 16 to 29 years and women.

"James was such an incredible support to me during a rough patch in my mental health due to work stress."

Loneliness and social connection

- Loneliness continues to affect many, with 24% of those aged 16+ in Great Britain saying they feel lonely “often, always or some of the time” – 26% said they experience it occasionally .
- Those aged 16–29 were most likely to feel alone (31%) when compared to those aged 70+ (16%).
- The connection between mental health and loneliness is clear. In the same study, 55% of those with moderate to severe depressive symptoms reported feeling lonely, compared to just 16% of those with mild or no symptoms.

'I'm so glad I had someone I could talk to, otherwise I don't talk to anyone. Thank you very much.'

Physical health and wellbeing

- Mental and physical health are deeply connected. According to the APMS, around a third (32.9%) of adults in England with a physical health condition also have a common mental health problem – compared to just 12.6% of those without (1). Despite this, emotional support is rarely offered as routine treatment for people with long-term physical illness.

- In England, people living with severe mental illness are twice as likely to report poor physical health (2), and 5 times more likely to die before the age of 75 compared to those without a diagnosis (3).

"Very pleased and an invaluable service. So many helpful links and signposts that I was not aware of. It has felt like a safe space to talk over my mental health issues and concerns about my future, whilst now living with a Chronic illness."

What difference does it make?

- 78% showed improvement in SWEMWBS score of at least 1 full point

- Average change was an improvement of 4 points

- Consistently high levels of satisfaction (% choosing “agree” or “strongly agree”)
  - Did you get the help you needed to understand your mental health? **91%**
  - Did you get the help that mattered to you? **91%**
  - Did you have confidence and trust in staff working with you? **95%**
  - Were your concerns taken seriously? **97%**

Who would people ask for help in future?

- At the end of a client's support, we ask them where they would seek support if they had a similar issue in future.
- 71% of those who responded since 1st April 2023 said they would return to a Wellbeing Worker at the practice.

"The service has really helped me to not feel so overwhelmed by my problems and to help break down my thought processes. This has helped to make them more manageable. I do feel in a completely different place. In the future, if I needed more support, I would contact my GP initially and then ask to be referred to the WB service again"

- People report feeling better equipped to manage future difficulties
- Practical tools support longer term self-management

Social prescribing as prevention and early intervention

- Accessible support can reach people earlier
- Provides help before needs escalate
- Builds self-management and resilience
- Can engage people who may not otherwise access mental health services
- Connects people to the right support at the right time

"I would never have accessed a 'mental health service'... Seeing someone in my GP practice... was just what I needed."

What have we learned? Challenges and limitations

- Sustainability depends on funding and commissioning
- Provision has changed with local demand… and PCN finances
- Referral pathways and capacity matter
- Clear boundaries and onward routes are important
- Provision for children & young people is particularly valued where alternatives are limited
- Consistency of access remains an important consideration

From individual support to neighbourhood health

- Learning from primary care wellbeing project & social prescribing can inform neighbourhood working plans
- Integrated Neighbourhood Teams (INT) work from 2025: community-based support and home visits
- Focus on people with complex/wider needs
- Connecting people with local community resources
- Extending support beyond the GP practice

Opportunities for Oxfordshire

- Building on an established, effective, local model
- Strengthen prevention & early intervention
- Embed wider determinants of health into wellbeing support
- Connect primary care, neighbourhood and community provision – with mental health & wellbeing throughout
- Improve equity of access county-wide
- Consider prevention across the life course

What could happen next?

How do we build on what is already working and create the conditions for it to work consistently across Oxfordshire?

- Consistent equitable access
- Sustainable commissioning & funding
- Opportunities for joined up primary / community / neighbourhood working
- Focus on prevention & early intervention

Informed by impact & service user experience data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Health Improvement Board

17 September 2026

Cost of Living Programme 2026-29: Supporting the Living Well Priority of the Joint Health and Wellbeing Strategy

Purpose / Recommendation

1. **HIB members are asked to:**
    - note the contribution that the Cost of Living Programme 2026-29, funded through the government's Crisis and Resilience Fund (CRF), makes to the Living Well priority of the Joint Health and Wellbeing Strategy and to the Board's own areas of focus;
    - endorse the continuing alignment of Cost of Living programme delivery and Health Improvement Board priorities, particularly Healthy Weight, physical activity, mental wellbeing, health protection, housing and homelessness, and affordable warmth; and
    - agree to receive six-monthly updates on Cost of Living programme delivery and outcomes, including take-up among groups with poorer health outcomes, to inform the Board's prevention work.

Executive Summary

2. This report has been prepared for the Health Improvement Board (HIB) to set out how the programme, worth £5.56 million in 2026-27 and £5.12 million per annum in 2027-29, supports delivery of the Living Well priority within the Joint Health and Wellbeing Strategy, and how individual elements of the programme map onto the Board's own areas of focus.

3. Financial hardship is a well-evidenced driver of poor health: it is associated with higher rates of long-term conditions, poorer mental health, delayed help-seeking and reduced ability to self-manage illness. The Cost of Living programme is therefore directly relevant to the Board's prevention agenda. Several elements of the programme, including the Hospital Discharge fund, Better Housing Better Health, Healthy Snacks in Schools, the LIFT dashboard, food infrastructure and Community Co-ordination, map closely onto existing Health Improvement Board work.

Background

4. Nationally, the cost of living remains the most pressing issue for households: the ONS recorded CPI inflation of 3.0% in the twelve months to February 2026, still above the government's 2% target, and its January 2026 survey found 88% of adults cite the cost of living as the most important issue facing the country. The Joseph Rowntree Foundation's Winter 2025 tracker found 7.1 million low-income households (60%) had gone without essentials in the previous six months, including over 2.6 million unable to afford to keep their home warm.

5. Locally, the Oxfordshire Data Hub's analysis of the 2025 Indices of Multiple Deprivation shows that, despite the county's relative affluence, 11 of 428 Lower Super Output Areas remain among the two most deprived nationally, concentrated in the Leys, Banbury, Littlemore and Rose Hill, and parts of Abingdon Caldecott and West Witney. The council's 2025 Residents' Survey found 57% of respondents felt worse off financially than the year before (up from 46% in 2024), and that people with a disability or infirmity were more likely to feel worse off (63%) than those without (53%).

6. These pressures bear directly on the objectives the Board is working to deliver. Food insecurity, fuel poverty and debt are associated with poorer management of long-term conditions such as diabetes and cardiovascular disease, worse mental health, and reduced ability to attend appointments or engage with screening and prevention programmes, all central to the Living Well objectives set out below.

Key Issues

7. In December 2025 the government announced the Crisis and Resilience Fund (CRF), replacing the Household Support Fund (HSF) which had been the main funding source for the council's Cost of Living programme since 2021. Unlike the HSF, which was renewed annually (and in some years every six months), the CRF is a three-year fund running from 1 April 2026 to 31 March 2029, providing greater certainty and enabling longer-term support programmes.

8. The Department for Work and Pensions (DWP) remains responsible for the CRF. Oxfordshire's allocation is £4.82 million per annum, plus a separate £440,000 in 2026-27 to support low-income households who use oil for heating.

9. The report to Cabinet, 'Cost of Living Programme 2026-29', which was approved by Cabinet at its meeting of 21 April 2026, set out the programme structure, informed by new government guidance and a resident consultation held in autumn 2025.

10. This report to the Health Improvement Board draws on the 21 April 2026 Cabinet report, on the CRF guidance published by DWP, and on the Oxfordshire Joint Health and Wellbeing Strategy, to set out the relevance of the Cost of Living programme to the Board's work.

11. The Joint Health and Wellbeing Strategy sets out a shared vision 'to work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire.' Alongside A Good Start in Life, Ageing Well and Tackling Wider Issues That Determine Health, Living Well is one of four priorities the Board and its sub-groups are asked to deliver.

12. The Living Well aim is that 'adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services.' Its strategic objectives are to:
    - prevent the development of long-term conditions by helping people to live healthy lives, live in healthy places and avoid the need to go to hospital;
    - identify ill health early, through comprehensive screening programmes, good access to services and targeting those least likely to attend;

- value mental health equally with physical health;
- deliver sustained and improved experience for people who access services;
- ensure services are effective, efficient and joined up; and
- nurture healthy communities that enable people to participate, be active, give and receive support.

How the Crisis and Resilience Fund Connects to Health Outcomes

13. DWP's guidance describes the CRF's purpose as being ‘to both provide a safety net for those on low incomes who encounter a financial shock and to invest in building local financial resilience... reducing crisis need,’ structured around three outcomes: effective crisis support; improving individuals' financial resilience; and bolstering the local support landscape.

14. The guidance explicitly recognises health as a determinant of financial resilience, listing ‘physical disability, learning disability, mental health condition or wellbeing’ and caring responsibilities among the factors authorities should consider, and noting that ‘insufficient food is a crisis need negatively affecting health and wellbeing’ and that priority debt increases ‘health and homelessness risks.’

15. The guidance also supports closer working between welfare and health services. It identifies GP surgeries and Family Hubs as appropriate locations for Community Co-ordination activity and co-location, names health visitors among the professionals whose referrals should inform targeting of support, and confirms that authorities may use their public health duties under section 2B of the National Health Service Act 2006 to support people with no recourse to public funds where this is appropriate for improving public health. These provisions give the council a clear basis for aligning Cost of Living delivery with the Board's own public health and prevention work.

Cost of Living programme: Contribution to Live Well

16. Table 1 sets out how the main areas of Cost of Living programme spend for 2026-29 map onto the Living Well strategic objectives. The subsequent paragraphs in this section (17-25) provide a brief explanation of the funded activity referenced in the table. At Appendix One, a full breakdown of the Cost of Living programme is provided.

Table 1: Living Well strategic objectives and Cost of Living programme activity

Living Well strategic objective	Contributing Cost of Living activity	2026/27 budget
Value mental health equally with physical health	Advice Services; Period Poverty; Residents Support Scheme	£2,165,000
Prevent long-term conditions; avoid the need for hospital	Hospital Discharge; Better Housing Better Health; Healthy Snacks in Schools	£140,000
Identify ill health early; target those least likely to attend	LIFT Dashboard; Local Co-ordination	£320,000
Deliver sustained, improved experience for service users; joined-up services	Local Co-ordination; District Delegations	£680,000
Nurture healthy communities	Food Co-operatives; Community Larders; Food Infrastructure; Hygiene Essentials	£348,000
Holistic care for people with additional needs	Migrant Food; Better Housing Better Health	£50,000
	TOTAL:	£3,703,000

17. Hospital Discharge (£15,000 p.a.) funds the multi-disciplinary Out of Hospital team, supporting people whose discharge is delayed by a housing barrier, and helping residents with energy costs for essential equipment or medicine, directly supporting the objective to ‘avoid the need to go to hospital’ and enabling people with disabilities to remain independent.
18. Better Housing Better Health (£25,000 p.a.), commissioned by Public Health, provides advice and practical support with energy efficiency and energy costs, addressing a well-established driver of respiratory and cardiovascular ill health and directly supporting the Board's Affordable Warmth and Housing and Homelessness areas of focus.
19. The LIFT Dashboard (£140,000 p.a.) uses locally held benefits data to run targeted campaigns, including pension credit and Free School Meals take-up, supporting the objective to ‘identify ill health early... and target those least likely to attend’ by reaching households before they reach crisis point. LIFT has already generated £1.5 million in additional income for residents.

20. Advice Services (£300,000 p.a.) fund Citizens Advice and four independent providers, supporting an estimated 6,000 additional people a year with debt and benefits advice, directly relevant to the objective to 'value mental health equally with physical health,' given the well-evidenced links between debt and mental ill health.
21. Food Co-operatives, Community Larders and Food Infrastructure (rising to c.£369,000 p.a. combined by 2028-29) deliver the Oxfordshire Food Strategy, including utilising school kitchens as community assets, training and workshops on community cooking, and embedding the Making Every Contact Count approach, supporting the Board's Healthy Weight Whole Systems approach.
22. Healthy Snacks in Schools (£100,000 p.a.), following a successful pilot at The Oxford Academy, has been extended to a further three schools in the county's most deprived areas; an evaluation found improved behaviour for learning and a sharp fall in exclusions, supporting both healthy weight and mental wellbeing outcomes for children and young people.
23. Period Poverty (£15,000 p.a.): products are discreetly displayed in libraries within the 'Health and Wellbeing' section alongside signposting to debt advice, drug and alcohol treatment and domestic abuse support; 90% of participants in the original pilot reported a positive impact on their wellbeing and dignity.
24. Community Co-ordination (£180,000 p.a.) is a new area of CRF-eligible spend focused on the 20% most deprived wards (in Oxford, Banbury, Witney and Abingdon), building referral pathways between welfare and other local services, directly supporting the Board's Social Prescribing area of focus and the CRF guidance's emphasis on co-location with health settings. This funding is channelled through the city and district councils.
25. Migrant Food (£25,000 p.a.) supports migrants in hotel and dispersed accommodation with specific dietary requirements linked to medical conditions such as diabetes or pregnancy, addressing a targeted health inequality.
26. The Residents Support Scheme (£1.85 million p.a.), the council's application-based crisis scheme covering food, energy and household items, is the only element of the programme DWP requires local authorities to deliver and forms the safety net beneath the more preventative activity above; 1,173 successful applications have been made in the first quarter of 2026/27.

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Alignment with Health Improvement Board Areas of Focus

27. Table 2 maps Cost of Living programme activity directly against the Board's own stated areas of focus, drawn from the Joint Health and Wellbeing Strategy.

Table 2: Health Improvement Board areas of focus and Cost of Living programme links

HIB area of focus	Cost of Living programme link
Healthy Weight (Whole Systems approach)	Food Co-operatives; Community Larders; Food Infrastructure; Healthy Snacks in Schools; HAF Programme
Reduce physical inactivity	HAF Programme (physical activity and enriching activities); Family Hub Programme
Mental Wellbeing and Prevention Concordat	Advice Services; Period Poverty; Residents Support Scheme
Public Health, Health Protection (immunisation, screening, air quality)	LIFT Dashboard targeted campaigns; Hospital Discharge
Housing and Homelessness	Better Housing Better Health; Hospital Discharge; District Delegations
Social Prescribing (Tackling Wider Issues)	Community Co-ordination (Local Co-ordination)
Affordable Warmth (Tackling Wider Issues)	Better Housing Better Health; Winter Warmth (Libraries); Oil heating costs support
Domestic Abuse services (Tackling Wider Issues)	Residents Support Scheme; Period Poverty signposting in libraries

Governance and Reporting

28. Cabinet delegated authority to agree new areas of CRF expenditure to the Director of Public Affairs, Policy & Partnerships, in consultation with the Cabinet Member for Public Health and Inequalities. DWP requires an annual delivery plan and six-monthly management information returns.

29. To strengthen join-up with the Board's prevention agenda, it is proposed that the Cost of Living programme reports to the Health Improvement Board six-monthly, alongside its DWP reporting cycle, covering take-up, outcomes and emerging need – particularly among groups with the poorest health outcomes. An appropriate dataset can be agreed with Public Health colleagues to show how the Cost of Living programme addresses health inequalities.

Budgetary implications

30. There are no new budgetary implications for the Health Improvement Board arising from this report. The Cost of Living programme is funded through the government's Crisis and Resilience Fund (£4.82 million p.a., plus £440,000 in 2026-27) and the council's existing £300,000 recurrent budget provision for advice services. Appendix One shows a full break down of the Cost of Living programme budget form 2026-29.

Legal implications

31. The Crisis and Resilience Fund has been provided to local authorities to support low-income households dealing with a financial shock, and the development of individual and community financial resilience. Whilst the funding is subject to its own grant conditions, local authorities have a wide discretion on how the funding is used, provided it is within the scope of the Guidance (which sets out the Fund's objectives and Key Principles) and the Grant Determination.

32. The Guidance explains local authorities can use the funds to deliver support using specific statutory powers, such as s17 Children Act 1989, s18 / 20 Care Act 2014, or s2B National Health Service Act 2006, in accordance with those provisions. However, if the funds are used when the Authority is exercising its discretion under s1 Localism Act 2011, payments fall within the definition of Public Funds and those subject to No Recourse to Public Funds (NRPF) are ineligible for support.

Equalities implications

33. The Cost of Living programme supports positive interventions in respect of residents and households likely to experience worse outcomes than the average. To this extent, it has a positive impact in respect of equalities. However in the Cabinet report referenced above, the programme has committed to undertaking a full Equalities Impact Assessment which will identify whether there are groups who are missing out from the benefits of this work.

Sustainability implications

34. There are no significant impacts in respect of environmental sustainability in this programme. The programme supports the Better Housing Better Health work, which provides advice and financial support to residents on energy use and energy efficiency measures. Funding for the Food Infrastructure work includes the development of sustainable approaches to food support.

Risk Management

35. The main risk from a health perspective is uneven take-up, particularly given that Free School Meals holiday support to all eligible households, previously the largest single area of spend, has come to an end under CRF rules, with the Family Hub programme and an expanded Holiday Activities and Food (HAF) programme intended to provide alternative, more targeted support. The Board may wish to monitor whether this transition affects families it is already working with through its Healthy Weight and Good Start in Life work.

36. The council's 2025 Residents' Survey found people with a disability or infirmity are more likely to report worsening finances than those without; monitoring of Residents Support Scheme take-up by these groups will be a priority for the programme, and the Board is well placed to advise on appropriate channels for reaching them.

Communications

37. Consultation undertaken in Autumn 2025 found residents prioritised support for families with young children, older people, carers, people with disabilities, and those with mental and physical health needs. Stakeholders called for 'wrap-around support,' integrating food aid with budgeting, mental health and employment advice, seen as key to reducing stigma and improving uptake, and for cooking skills and community kitchen provision.

38. These themes are reflected directly in the 2026-29 programme design: cooking skills will be delivered through the food infrastructure project, and wrap-around support is built into the Community Larders and Food Co-operatives offer.

Report by Director of Public Affairs, Policy & Partnerships
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September 2026

Appendix One – Cost of Living programme budget 2026-29

1. The cost of living programme for 2026-27 comprises CRF funding from government of £4.82 million, an additional CRF award of £440,000 to support people using oil for heating, and council budget provision for advice services of £300,000, totalling £5.56 million per annum. For 2027-28 and 2028-29, after the support for oil heating drops out, it will be £5.12 million. Table 3 below sets out the proposed expenditure agreed by Cabinet for the 2026-29 programme.

Table 2 . Cost of Living expenditure

Area of Expenditure	2026/27	2027/28	2028/29
CRISIS SUPPORT			
Residents Support Scheme	£1,850,000	£1,850,000	£1,850,000
Healthy Snacks in School	£100,000	£100,000	£100,000
Hospital Discharge	£15,000	£15,000	£15,000
Period Poverty	£15,000	£15,000	£15,000
Better Housing Better Health	£25,000	£25,000	£25,000
Migrant Food	£25,000	£25,000	£25,000
Oil heating costs	£440,000		
RESILIENCE SERVICES			
Advice Services	£300,000	£300,000	£300,000
LIFT	£140,000	£140,000	£140,000
HAF Programme	£500,000	£500,000	£500,000
Food Co-operatives	£88,000	£97,000	£102,000
Living Essentials Grants	£115,000	£116,000	£117,000
COMMUNITY CO-ORDINATION			
Local Co-ordination	£180,000	£180,000	£180,000
Hygiene Essentials	£60,000	£50,000	£40,000
Food infrastructure	£50,000	£50,000	£50,000
Winter Warmth (Libraries)	£1,500	£1,500	£1,500
MIX OF ACTIVITY			
Support for Early Years	£250,000	£250,000	£250,000
District Delegations	£500,000	£500,000	£500,000
Family Hub Programme	£500,000	£500,000	£500,000
Community larders	£150,000	£150,000	£150,000
OTHER			
In-year expenditure	£75,500	£75,500	£79,500
Admin	£180,000	£180,000	£180,000
TOTALS	£5,560,000	£5,120,000	£5,120,000

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