Health Improvement Board, 22nd November 2018

Draft Performance Dashboard, Discussion paper

Introduction

At the meeting of the Health Improvement Board in September 2018 the priorities for the work of the Board were agreed. These are grouped under the headings of Keeping Yourself Healthy (Prevent), Reducing the impact of ill-health (Reduce) and Healthy Place Shaping and Healthy Communities.

A summary of these Health Improvement Board priorities is included at Annex 1.

The role of the Health Improvement Board includes monitoring delivery of these priorities. This paper sets out a proposed framework to enable that monitoring through a set of outcome indicators and process measures related to the priority areas of work. It is also proposed that progress in reaching the target outcomes will be reported to the Health and Wellbeing Board on a regular basis.

The work to deliver the changes required will be done by a range of sub-groups who report back regularly to the Health Improvement Board. These reports include updates on performance for each meeting and more detailed narrative reports at least once a year. Details of how they will report are set out in the forward plan elsewhere on the agenda for this meeting. The principles for how these working groups deliver their work were agreed at the last meeting and are included in Annex 2 as a reminder.

In addition, it is suggested that the Board members could keep an overview of population health through a Surveillance Dashboard of key indicators (a small sub-set of the indicators reported through the JSNA). This will enable us to be aware of population level indicators such as life expectancy, prevalence of particular conditions or wider determinants of health. This will enable the Board to identify any changes or issues that might be of concern.

Recommendations: The Health Improvement Board are asked to

1. **Discuss and comment on the proposed Performance Framework detailed in Tables 1 and 2 of this paper and reach agreement on a final list to be monitored.**
2. **Agree the outcome indicators to be reported regularly to the Health and Wellbeing Board (some or all of the list in Table 1).**
3. **Ask officers from partner organisations and working groups to contribute to a final version of this Performance Framework so that it can be in operation by the next meeting of this Board in February 2019**
4. **Discuss the proposal on having a Surveillance Dashboard for information in addition to the Performance Dashboard.**

Performance Framework: Table 1. Outcome Measures

The measures listed in this table relate to the priorities of the Health Improvement Board. Target outcomes will be set for each area of work and progress towards the target will be reported at each meeting. Some of these outcomes are already proposed below. Where possible these outcomes will also include specific improvement of health inequalities issues. Some or all of these measures will also be reported to the Health and Wellbeing Board as they monitor delivery of the Joint Health and Wellbeing Strategy.

	Priority area	Indicator	Oxfordshire Baseline and variation (with date)	Proposed target (by when)	(a) Working Group and (b) responsible organisation
	PREVENT				
1	Physical inactivity	Active Lives Survey: Percentage of the population who are inactive (less than 30 mins / week moderate intensity activity)	<u>Active Lives Survey</u> 105,700 physically inactive people in Oxfordshire (May 2018) which is 19.1% of adult population of Oxfordshire Variation • Cherwell 22.3% • Oxford City 16.3% • South Oxfordshire 18.2% • Vale of White Horse 17.4% • West Oxfordshire 22.3%	An annual 0.5% reduction in inactivity across the county. Therefore reduce to 18.6% *by May 2019 /and to 18.1% by March 2020* [1] *Also a "Stretch" target of reducing to 20% in Cherwell and West Oxon by 2020 to be agreed, subject to discussion with the Local Authorities/CCG and Public Health*	(a) Active Oxfordshire working with all partners including Public Health and the CCG through a Physical Inactivity Task Force (b) Active Oxfordshire with LAs, PH and CCGs

[1] Further specific targets on reduction in number of inactive people to be defined. These could include a focus on people with disabilities, long term conditions, low mental wellbeing, children and young people or people on low incomes.

2	Smoking prevalence	**a.** Number of Smoking quitters per 100,000 adult population **b.** Smoking in pregnancy – percentage smoking at time of delivery	a. Baseline is 2337 quitters / 100,000 population (2017/18) b. Baseline is 8% women smoking at time of delivery.	a. Target is to increase this rate to more than 2337 / 100,000 by Mar 19 b. Target is to reduce this by 0.5% to 7.5% by the end of 2018-19	(a) Tobacco Control Alliance (b) Public Health, County Council and Maternity Services
3	Housing and homelessness	a. Households in temporary accommodation **b.** Single homeless pathway and floating support clients departing services to take up independent living **c.** Rough sleeping **d.** Prevention Duty owed (threatened with homelessness) **e.** Relief Duty Stage (already homeless) **f.** Total number of households eligible, homeless and in priority need but intentionally	Baselines to be reported and outcome targets to be set d. Baseline - total number of cases where positive action was successful in preventing homelessness. tbc e. Baseline -.total number of successful cases in relieving homelessness. tbc f. Baseline tbc	Housing Support Advisory Group to advise on all baselines and outcomes for this section	(a) Housing Support Advisory Group (b) District and County Councils

		homeless			
4	Immunisations	a. Measles, Mumps and Rubella dose 1 b. Measles, Mumps and Rubella dose 2 c. Flu immunisation for at risk groups under 65 yrs d. Flu immunisations for 65+	a. Baseline 93.5% (Q1 18-19) b. Baseline 90.1% (Q1 18-19) c. Baseline 52.4% (2017-18) d. Baseline 75.6% (2017-18)	a. 95% b. 95% c. 55% d. 75%	(a) Public Health, Health Protection Forum. (b) NHS England
	REDUCE				
5	Childhood Obesity	Children overweight or obese in Reception and Year 6	a. Baseline: In Reception year 7% children were obese (2017-18) b. Baseline: In Year 6, 16.8% children were obese (2017-18) Variation in Year 6 pupils: Cherwell 18.8%; Oxford 21.3%; South Oxfordshire 12.9%; Vale of White Horse 16%; West Oxfordshire 14.7%	a. Maintain at 7% b. Target to reduce to 16%	(a) Whole System approach to obesity Working Group (b) Public Health, County Council
6	NHS Health Checks	a. NHS Health Checks invite % (over 5 Years)	a. Baseline 98.8% in 2017/18	a. Achieve at least 97% eligible population invited	(a, b) Public Health, County Council

		b. NHS Health Checks uptake % (over 5 years)	b. Baseline 50.2% in 2017/18	by the end of 2018/19[2] b. Achieve 50.5% uptake by the end of 2018/19	
7	Cancer screening	Percentage of those sent bowel screening packs who will complete and return them (aged 60-74 years) Cervical Screening - percentage of the eligible population (women aged 25-64) screened in the last 3.5/5.5 years Breast screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	Baseline 56% (Q3, 2017-18) Baseline 68.2% (Q4, 2017-18) Baseline 74.1% (Q4, 2017-18)	National Target 60% National Target 80% National Target 80%	(a) Clinical Commissioning Group (b) NHS England

[2] From 2019/20, following a consultation, Public Health England (PHE) are planning to change the way total invitations for health checks is reported. They will use GP Practice Populations as the denominator instead of ONS population data. We have started to report in this new way. As a result these reports cannot be compared with last year's data. The outcome target appears to be lower than the baseline as a result of this change but this doesn't represent an actual reduction in performance. Future reports will be needed to show overall progress.

Performance Framework Table 2. Process measures

The areas of work set out in this table show our ambition to deliver new or revised programmes. Because of the developmental nature of this work progress will be measured by milestones rather than outcomes. Therefore this table will be developed to give clear process measures which can be monitored by the Health Improvement Board. Where outcome measures can be set in the course of that work they will be added to Table 1 above.

	Priority area	Project or initiative	Proposed target (by when)	Who is responsible?
	PREVENT			
	Whole Systems Approach to Obesity	Implement Whole Systems Approach to Obesity in 2019 (published by PHE and Leeds Beckett University)	No outcome target proposed Monitor progress through updates at HIB	Partnership working group to be established. Led by Public Health, County Council
	REDUCE			
	Diabetes Transformation	Equitable access to structured education for all patients Multi-disciplinary teams in primary care to give early specialist advice Multi-disciplinary foot teams in hospitals	To be advised	Clinical Commissioning Group
	Domestic abuse	Progress against 9 recommendations from the Domestic Abuse Review and devising 5-year strategic plan 2019-2024.	To be advised	Joint Management Group of local authorities; Oxfordshire County Council

	Healthy Place Shaping and Communities			
	Healthy Place shaping	Process measures are to be finalised. The following are suggestions to consider: a. Process against 10 Healthy New Town principles in Putting health into Place[3] (final publication to be launched March 2019). b. Plan for Health in All policies to be considered c. Proposed introduction of Health Impact Assessment into planning policy to be considered d. Evidence of effective system wide working	To be advised	Working arrangements to be confirmed
	Social prescribing	Process measures to be included	CCG to advise	Clinical Commissioning Group
	Making Every Contact Count	Process measures to be included	Oxfordshire MECC Network to advise	
	Campaigns	Plan for joint campaigns to be agreed and implemented with process measures to be included here	Communications teams to advise	

[3] *https://www.england.nhs.uk/publication/putting-health-into-place/*

Proposal for a Health Improvement Board Surveillance Dashboard

It is proposed that Health Improvement Board could receive updates on a range of indicators for surveillance purposes i.e. not linked to performance and not used to monitor progress on a project. These indicators would be high level population health measures which are unlikely to be influenced by any specific initiatives or projects, but which show the general health of the population. This dashboard could also highlight inequalities issues by reporting the best and worst affected groups or areas of the county. This will be useful information to enable targeting of initiatives to tackle health inequalities.

Additional reports could be brought to the Board on request, but the proposal is that ongoing surveillance is conducted on a set of core indicators, agreed by the Board at the start of each year.

This dashboard could also be laid out to give more information on the HIB priorities to "Prevent and Reduce" but with some overarching indicators added. Additional surveillance will continue to draw from the JSNA and the Basket of Inequalities Indicators[4]

Some suggested indicators are included in the draft below, for discussion:

	Priority area	Oxfordshire Baseline (with date) (from the JSNA Annual Report 2018[5]
Overarching indicators		
1	Life expectancy at birth	Between 2013-15 and 2014-16, Life Expectancy for males and females in Oxfordshire each increased. • Male Life Expectancy increased from 81.2 to 81.4 (+0.2 years) • Female Life Expectancy increased from 84.3 to 84.6 (+0.3 years) Between 2001-03 and 2014-16, the gap between male and female Life Expectancy decreased from 4.1 years to 3.2 years.
2	Gap in life expectancy between best and worst wards	Life expectancy by ward data for Oxford shows a significant increase in **male life expectancy** in the more affluent North ward and no change in male life expectancy in the more deprived ward of Northfield Brook. The gap in male life expectancy between these two wards has increased from 4 years in 2003-07 to 15 years in 2011-15. **Female life expectancy** in these wards has

[4] http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

[5] https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202018%20FINAL%20Apr18%20FULL.pdf

		remained at similar levels with a gap of just over 10 years.
3	Disability Free Life Expectancy (DFLE) This is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply.	Data for the combined years 2009 to 2013 shows that for males there was a 10-year gap between the most and least deprived areas for Disability Free Life Expectancy. For females, the gap was just under 10 years.
4	Preventable deaths. The basic concept of **preventable mortality** is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.	For the 3-year period, 2014 to 2016, total deaths of people aged under 75 from the four causes of: cardiovascular diseases, cancer, liver disease and respiratory disease in Oxfordshire was 3,396. Of these **1,959** (58%) were considered preventable
	Prevent	
5	Physical inactivity for children and young people	New data on physical activity rates for children are due soon
6	Mental wellbeing Every year since 2011, the ONS has asked a sample of UK adults aged 16 to answer 4 personal wellbeing questions: • overall, how satisfied are you with your life nowadays? • overall, to what extent do you feel the things you do in your life are worthwhile? • overall, how happy did you feel yesterday? • overall, how anxious did you feel yesterday?	Adults: In Oxfordshire, the average wellbeing scores for: life satisfaction, "things you do are worthwhile" and happiness, are slightly lower in 2016-17 compared with 2015-16 and the anxiety mean is higher Children: no local data
7	Air quality	District Councils to advise
8	Immunisations	To be considered
Reduce		
9	Obesity Percentage of adults (aged 18+) classified as overweight or obese (PHOF 2.12)	An estimated 55% of people aged 16 or over in Oxfordshire are classified as overweight or obese. This is below the national average
10	Diabetes prevention	Up to 58 per cent of Type 2 diabetes cases can be delayed or prevented through a healthy lifestyle. National survey data (HSE 2015) shows the prevalence of diabetes is higher for men

		than women and significantly higher in those who are overweight or obese
11	Alcohol a. Admission episodes for alcohol related conditions (Broad definition) (Male and female) Alcohol profile b. Admission episodes for alcohol specific conditions aged under 18 (Male, female) Alcohol profile	2016/17 baseline: 1684 per 100,000 people (England 1804 / 100,000). Oxfordshire is significantly better. 2014/15 – 16/17 baseline: 40.7 per 100,000 Population (England 34.2 / 100,000). Oxfordshire is significantly worse
12	Domestic abuse	**To be advised**
13	Fuel Poverty Using the Low Income High Costs (LIHC) indicator, a household is considered to be fuel poor if: • they have required fuel costs that are above average (the national median level). • were they to spend that amount, they would be left with a residual income below the official poverty line.	Between 2014 and 2015, an additional 1,600 households in Oxfordshire were classed as being "fuel poor" taking the total to 25,915 households in fuel poverty in the county. There was an increase in the proportion of households defined as "fuel poor" in each district of Oxfordshire Oxford is one of 9 (out of 67) local authority districts in the South East to be significantly worse than the national average on fuel poverty (2015). The greatest increase in the estimated number of fuel poor households was in Cherwell (+13%), similar to the regional average (13%)

Next steps

Subject to the discussion at the Health Improvement Board in November the Performance Framework and Surveillance Dashboard will be finalised for use by the Board at the meeting in February 2019.

Recommendations: The Health Improvement Board are asked to

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Jackie Wilderspin, November 2018

Annex 1 Priorities of the Health Improvement Board (agreed in September 2018)

1. Keeping Yourself Healthy (Prevent)

- Reduce Physical Inactivity / Promote Physical Activity
    - Promote activity in schools to make it a lifetime habit
    - Promote active travel for all ages
    - Provide excellent leisure services including access to green spaces and the countryside

- Enable people to eat healthily
    - Starting with breastfeeding
    - Sugar Smart
    - Access to healthy food for all

- Reduce smoking prevalence
    - In community groups with higher smoking rates
    - In pregnancy

- Promote Mental Wellbeing
    - 5 ways to Wellbeing / CLANGERS (Connect, Learn, be Active, Notice, Give, Eat healthily, Relax, Sleep)
    - Adopt the principles of the Mental Wellbeing Prevention Concordat

- Tackle wider determinants of health
    - Housing and homelessness
    - Air Quality

- Immunisation
    - Routine childhood immunisations
    - Seasonal immunisations, such as influenza
    - Immunisations for vulnerable groups such as Pregnant women (including whooping cough) or ‘at risk’ groups, such as pneumococcal

2. Reducing the impact of ill health (Reduce)

- Prevent chronic disease though tackling obesity
    - Weight management initiatives
    - Diabetes prevention

- Screening for early awareness of risk
    - NHS Health Checks
    - Cancer screening programmes (e.g. Bowel, cervical, breast screening)

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

    - Alcohol treatment services

- Community Safety impact on health outcomes
    - Domestic abuse

3. Healthy Place Shaping and Healthy Communities

- Healthy Environment and Housing Development
    - Learn from the Healthy New Towns and influence policy
    - Ensure our roads and housing developments enable safe walking and cycling
    - Ensure spatial planning facilitates social interaction for all generations – giving opportunities for people to meet who might not do so otherwise

- Social Prescribing
    - Referral from Primary Care to non-medical schemes e.g. for physical activity, social networks, support groups

- Making Every Contact Count
    - In NHS settings
    - In front line services run by local authorities e.g. libraries, Fire and Rescue, leisure centres
    - In local communities and through the voluntary sector

- Campaigns and initiatives to inform the public
    - Through workplaces including the Workplace Wellbeing Network
    - The media, including social media, or community initiatives using local asset

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Annex 2 Principles for working groups

- Develop working groups that involve a range of relevant individuals and organisations who are equipped and active in delivering the agenda.
- Gain a clear understanding of population health needs and inequalities issues from the latest Joint Strategic Needs Assessment, and identify “at risk cohorts” whose outcomes could be improved.
- Define the outcomes to be achieved for the population segments.
- Devise and deliver targeted interventions to meet the outcomes agreed for segments of the population identified.
- Apply knowledge of effective and cost-effective interventions to be sure we are leading initiatives that are affordable and will have a positive impact.
- Ensure the proposed priorities reflect (or can be incorporated into) each partner’s own organisational priorities.
- Report regularly to the Health Improvement Board on progress, performance and tackling inequalities.