Oxfordshire
Clinical Commissioning Group

Oxford City Locality Commissioning Meeting

Date of Meeting: 14.6.18					**Paper No:** **5**	
Title of Paper: **Oxford City Health Inequalities Project**						
Is this paper for	**Discussion**		**Decision**		**Information**	✓

Purpose of Paper:

To inform practices of this project, which is part of the City Locality Plan. Please note the following when considering the following terms:

Primary prevention -
Primary prevention aims to prevent disease or injury before it ever occurs. This is done by preventing exposures to hazards that cause disease or injury, altering unhealthy or unsafe behaviours that can lead to disease or injury, and increasing resistance to disease or injury should exposure occur. Examples include:

- legislation and enforcement to ban or control the use of hazardous products (e.g. asbestos) or to mandate safe and healthy practices (e.g. use of seatbelts and bike helmets)
- education about healthy and safe habits (e.g. eating well, exercising regularly, not smoking)
- immunisation against infectious diseases.

Secondary prevention -
Secondary prevention aims to reduce the impact of a disease or injury that has already occurred. This is done by detecting and treating disease or injury as soon as possible to

halt or slow its progress, encouraging personal strategies to prevent re-injury or recurrence, and implementing programmes to return people to their original health and function to prevent long-term problems. Examples include:

- regular screening tests to detect disease in its earliest stages (e.g. mammograms to detect breast cancer)
- daily, low-dose aspirins and/or diet and exercise programmes to prevent further heart attacks or strokes
- suitably modified work so injured or ill workers can return safely to their jobs.

Tertiary prevention -
Tertiary prevention aims to soften the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy. Examples include:

- cardiac or stroke rehabilitation programmes, chronic disease management programmes (e.g. for diabetes, arthritis, depression, etc.)
- support groups that allow members to share strategies for living well
- vocational rehabilitation programs to retrain workers for new jobs when they have recovered as much as possible.

Action Required:

Practices to read the report and comment on any aspects. Dr Karen Kearley will advise practices on progress at the June meeting.

Author: Dr Karen Kearley, Maggie Dent	**Clinical Lead:** Dr David Chapman

Project Charter

Project Name	**Oxford City Health Inequalities Project**		
(Expected) Start Date	01/09/2018	**(Expected) End Date**	30/09/2019 (for first year projects and review of future programme)
Current Version Number and Date	*V5 June 2018*		
WHAT AND WHY			

Context

Following publication of the Oxfordshire Health Inequalities Commission report, Oxford City Council has pledged £100k funding to be used to tackle health inequalities in Oxford city. Oxfordshire Clinical Commissioning Group (OCCG) has matched funded this sum with a further £100k. A steering group has been convened to manage the planned project for the funding. Members of the group comprise representatives from Oxford City Council; OCCG and Public Health, Oxfordshire County Council. A patient representative has also been invited onto the group and the group agreed to invite other partners as and when required.

Target Areas

Key localities for the project focus are the Leys (Blackbird Leys and Greater Leys) and Rose Hill. There could also be a focus in Barton to compliment existing service provision which is being delivered as part of the Barton Healthy New Town (BHNT) programme. There is also potential learning from the BHNT programme which could be replicated in the Leys and Rose Hill.

Aim

The overall aim is to support residents in the targeted deprived localities of specific identified target groups to access support to improve or maintain their physical and mental wellbeing and deliver savings and better outcomes from services .

Objectives

- To provide health promotion/ prevention information in community settings (primary prevention);
- To conduct register searches in primary care to target patients with specific disease conditions (secondary prevention);
- To work with Oxford City Council tenants, focussing specifically on identified groups of people with mental health issues.

Primary Prevention (in communities)	**Secondary Prevention** (in primary care)	**Work with specific groups** (partnership approaches)
Targeted health promotion campaigns Promoting services e.g. NHS Health Checks and NHS Cancer Screening Promoting and enabling self-help Promoting and enabling healthy lifestyles	Targeting patients at risk of falls & fractures; breathlessness; mental health with long term conditions (diabetes; COPD; heart disease) At high cardiovascular risk (obesity, diabetes, high cholesterol, high blood pressure)	City Council tenants (not just in targeted localities) with serious mental health issues

Linked initiatives

- Social prescribing
- Barton Healthy New Town
- Making Every Contact Count
- Physical Health for people with serious mental illness (OH)
- Health Inequalities Commission Implementation Group

Linked Documents

- Physical & Mental Wellbeing Initiatives in Community Spaces- Oxford (asset mapping)

Relevant Health Inequalities Commission Report Recommendations:

Report number	Recommendation	**Responsible Organisation**	**Comment**
7.	Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities. The CCG should actively consider targeting investment at GP surgeries and primary care to provide better support to deprived groups, to support better access in higher need areas, and specifically address the needs of vulnerable populations.	***CCG***	*This is only part of rec 7 but the rest is not relevant.* *This links to the MH service user/ tenants support part of the project.*
8.	The Health in All Policies approach should be formally adopted and reported on across NHS and Local Authority organisations, engaging with voluntary and business sectors, to ensure the whole community is engaged in promoting health and tackling inequalities. Regular review of progress should be undertaken by the Health & Wellbeing Board (HWB)	***All statutory organisations*** ***HWB***	*This project could be an example of good practice in Health in All Policies but not meet the recommendation fully*
17.	Consideration should be given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, addressing health inequalities in particular, and learning from other areas .	***HWB/CCG***	*There is a bigger project on social prescribing. This work will benefit from some of that other work. Primary and secondary prevention*
28.	A set of Oxfordshire-grounded targets for increasing activity should be developed, targeting people living in deprived areas, older people, and vulnerable groups.	***Districts***	*Outcomes from this project could be part of overall reporting*
29.	Continuing investment and coordination of existing initiatives should be maintained, supported by social marketing and awareness-raising of the benefits of physical activity to targeted populations.	***PH Dept***	*Specific use of social marketing techniques for these target groups*

			will be needed.
30.	The county should : • monitor and increase the number of disabled people participating in regular physical activity • achieve a measurable decrease in inactivity and in parallel an increase in mental well-being measures, measured using the Active People Survey and Health Survey for England datasets • demonstrate and increase a narrowing of the gap between the less socioeconomically privileged groups and the norm .	***Districts***	*These outcomes could be part of the local measures in the target areas. Part of the primary prevention aspect of the project.*
31.	Better data should be collected on smoking rates in different population groups including pregnant women, people with mental health problems, people in manual or routine occupations and other vulnerable groups to ensure that in addition to lowering the overall rates of smoking, the inequalities gap between these groups and others is reduced.	***PH Dept CCG/GPs***	*Not sure if targeted local work will meet this recommendation but outcomes can be reported re. quits*
33.	A targeted project should be developed which aims to reduce drinking in middle aged people living in deprived areas	***PH Dept***	*Delivery in specific areas of City. Primary prevention part of project*
40	The implementation of the Five Year Forward Strategic View of mental health services for the county should explicitly state how it is addressing health inequalities and how additional resources have been allocated to reduce them.	***CCG***	*This could be an example of a local project. OH is addressing physical health of service users at the same time.*
46	Resources should be committed to ensure that prevention and lifestyle advice are embedded in all contacts with statutory service providers and the opportunity taken to include advice about healthier lifestyles and signpost support.	***CCG/NHS***	*Making Every Contact Count. This links to wider initiative through OSP, County council,*

			Barton HNT etc
54.	Support for services and stimulation should be provided to older people, especially those living on their own to avoid isolation and loneliness especially amongst those with dementia and in rural areas	***CCG/OCC***	*This could be a local project to deliver this recommendation*
57.	The current gap in provision of support for older people with mental health needs other than dementia needs to be addressed urgently.	***NHS/OCC***	*This links to the secondary prevention aspect of the project.*
58	Promoting general health and wellbeing through a linked all ages approach to physical activity, targeting an increase in activity levels in the over 50's especially in deprived areas, using innovative motivational approaches such as 'Good Gym' and Generation Games.	***HWB/CCG***	*This links to both primary and secondary prevention aspects of the project.*

Scope and Deliverables

Proposals for two aspects of the project have been developed. These are not mutually exclusive and there will be cross referrals and joint working for early prevention.

- One aspect will focus on addressing potential unmet need for mental health issues experienced by Oxford City Council tenants. The needs/ issues have been identified by the Tenancy Sustainment Team and the ASBiT (anti-social behaviour) team, which have multi contact with tenants, who can be at risk of losing their tenancy due to anti-social behaviour. A Mental Health worker post will be recruited to be sited within the Tenancy Sustainment Team, to support the team and to support tenants to access relevant services to prevent further escalation of mental health issues and risk of losing their tenancy.
- The other aspect will use a model of pro-active population health management. Patients with specific conditions within the postcode areas of the Leys and Rose Hill will be targeted through GP register searches and letters of invite to relevant interventions which can support and improve their wellbeing. The focus will be on falls and fractures; patients with long term conditions and co-existing depression and anxiety, such as diabetes, COPD and heart disease.
- The prject will also include improved referral pathways will be developed for patients to access support services such as smoking cessation and weight management.
- Professionals and community leads will have opportunity to upskill through training elements such as MECC (Making Every Contact Count) and Identification & Brief Advice for smoking and alcohol.
- Two Knowledge Exchange events to be delivered to enhance communication between agencies.

Desired Outcomes / Proposed Benefits

- Improved early intervention to prevent patients going into crisis and potentially losing their tenancy.
- Improved referral pathways and communication between Oxford City Council teams and GPs
- Improved take up of primary prevention services.
- People being better connected in their community to activities and services.

Constraints, Assumptions and Dependencies

Funding

£100k from OCCG is recurrent funding.
Currently, £100k from Oxford City Council is not recurrent.

Recruitment

Appropriately qualified staff are able to be recruited.
Staff recruited can commence employment in an appropriate timeframe for the project.

HOW

Managing Delivery

The project will be overseen and managed by the Oxford City Health Inequalities Project Steering Group. Progress will be reported to the multi-agency Health Inequalities Commission Implementation Group, which is responsible for taking forward the HIC report recommendations and to the Oxford City Locality Forum.

Action	Comment
1. Agree which of the HIC recommendations are relevant	Complete
2. Define terms of reference for steering group and stakeholders/ patient representative	Patient representative has withdrawn from the project.
3. Define the outputs the project will achieve	
4. Consider options for how the work will be delivered (evidence based)	
5. Consider what other partners already deliver which will complement this	Liaison with Mental Health Service provider organisations (Oxfordshire Mind; Elmore)
6. Map links to other work streams e.g. social prescribing, mapping of activities and assets etc	
7. Define referral pathways	
8. Cost the preferred options	
9. Draw up action plan	

Reporting on both proposal outputs/ outcomes		
Group	**Dates**	**By whom**
Health Inequalities Project Steering Group	September 2018 (initial report)	DG/ KK
	December 2018	DG/ KK
	March 2019	DG/ KK
	June 2019	DG/ KK
	September 2019 (final report and evaluation)	DG/ KK
Health Inequalities Commission Implementation Group	September 2018 (initial report)	MD/ JW
	December 2018	MD/ JW
	March 2019	MD/ JW
	June 2019	MD/ JW
	September 2019 (final report and evaluation)	MD/ JW
Oxford City Locality Forum	September 2018 (initial report)	JAH
	December 2018	JAH
	March 2019	JAH
	June 2019	JAH
	September 2019 (final report and evaluation)	JAH

Reporting from Stronger Communities Group to the Health Inequalities Project Steering Group	Dates	By whom
	September 2018	JW
	December 2018	JW
	March 2019	JW
	June 2019	JW
	September 2019	JW

WHO

PROJECT TEAM

Organisation	Name	Job Title
OCCG	Karen Kearley David Chapman	GP, Deputy Clinical Lead, Oxford City Locality GP, Clinical Lead, Oxford City Locality
OCCG Project Managers	Maggie Dent Julie-Anne Howe	Equality & Access Manager, OCCG Locality Co-ordinator, OCCG
OCCG	Zoe Kaveney	Senior Commissioning Manager
Public Health, Oxfordshire County Council	Jackie Wilderspin	Public Health Specialist
Oxford City Council	CAroline Green	Assistant Chief Executive
Oxford City Council	Marie Tidball / Louise Upton	Portfolio Holder for Healthy Oxford
Oxford City Council	Dani Granito	Policy & Partnership Team Manager

Stakeholders and Communications

- Patient/ public representative: Laura Epton (no longer wishes to be part of the group)
- Mental Health providers: Oxfordshire Mind; Oxford Health

WHEN Milestones

Milestone	Start date	End date	Who?
	DD/MM/YYYY	DD/MM/YYYY	
Consider 1st tranche of project proposals	23/05/2018	June 2018	Steering Group
Establish project control and funding payment procedures		June 2018	MD
Establish monitoring and reporting arrangements and dates		June 2018	MD/DG
First projects go live	Sept 2018		Project leads
Consider second tranche proposals (budget allowing)		Sept 2018	Steering Group
Deliver two Knowledge Exchange events		By September 2019	

Risks

Description of Risk and Impact	Mitigating Actions Required
Lack of programme process and systems in place for decision making and managing funding	Establish programme control documentation (ToR steering group, criteria for funding, funding agreements, etc)
Projects do not achieve expected outcomes within project timescales	Establish monitoring and reporting arrangements against KPIs with regular review

Sign Off

I/we confirm that this is an accurate description of the project at the time of writing and commit to delivering against the objectives. I understand that any fundamental change to the project needs to be discussed and agreed between the Project Owner and Project Clinical Lead and notified to PMO/CCG Executive.

Project Owner		**Date**	
Project Manager		**Date**	
Clinical Lead		**Date**	