Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 29 November 2016	**Paper No: 16/79**

Title of Presentation: Health Inequalities Commission Report

Is this paper for (delete as appropriate)	**Discussion**		**Decision**		**Information**	✓

Purpose and Executive Summary (if paper longer than 3 pages):
The Oxfordshire Health and Wellbeing Board commissioned a report on health inequalities in Oxfordshire. The Health Inequalities Commission was formed and over the past year has taken evidence from across a wide spectrum and has now produced a report with recommendations. The OCCG Board is being asked to receive the report and to take time to consider the recommendations which can be taken forward. This consideration will commence at the Board Workshop in December. The paper presented is the Headline Report. The full report can be found on the OCCG website: http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2016/11/Oxfordshire-Health-Inequalities-Commission-Report-28-October-2016.pdf

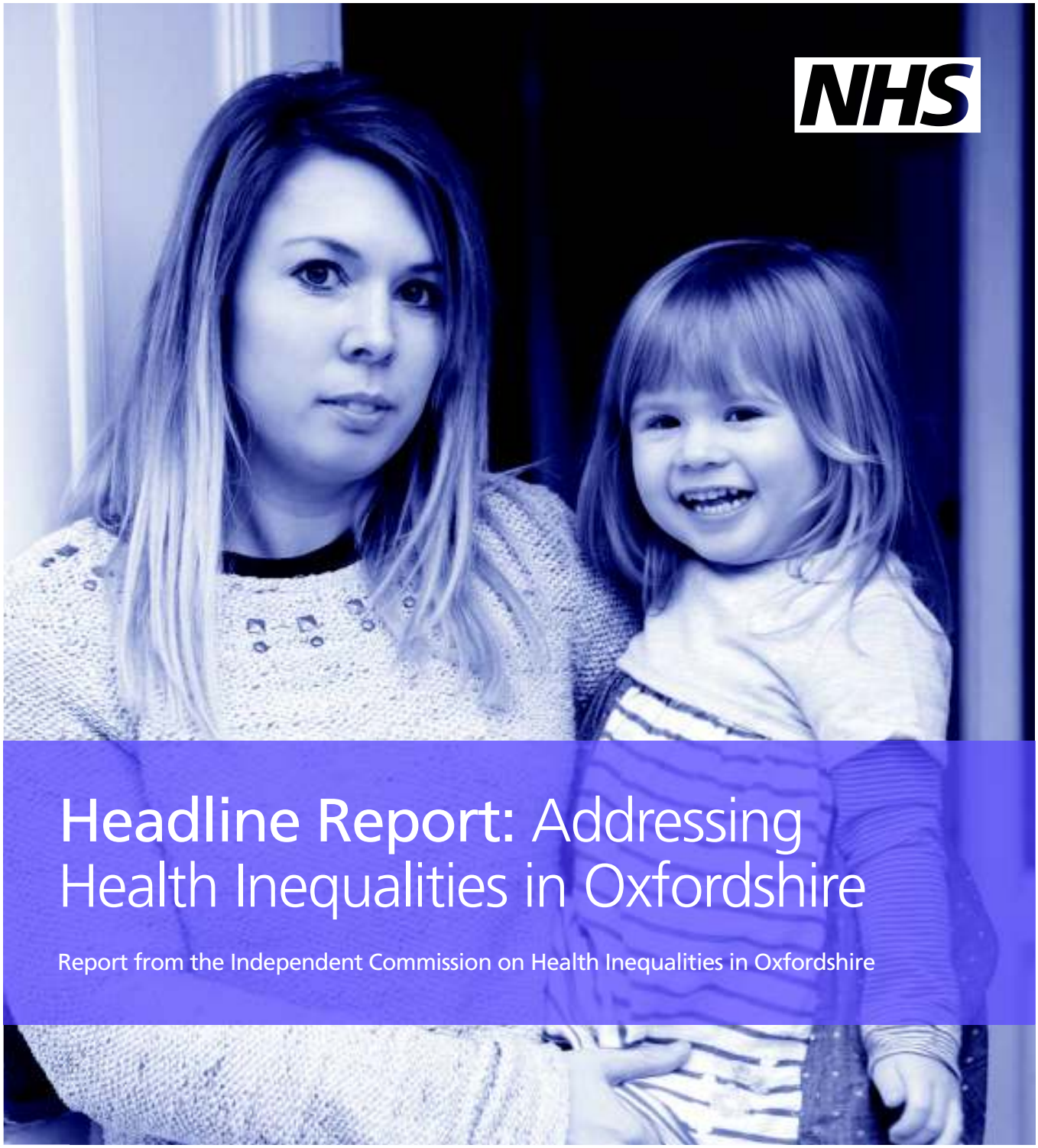
Financial Implications of Paper:
There may be some financial implications arising from the recommendations.

Action Required:
The OCCG Board is asked to receive the report and to consider the recommendations at the OCCG Board Workshop in December.

NHS Outcomes Framework Domains Supported (please delete tick as appropriate)	
✓	Preventing People from Dying Prematurely
✓	Enhancing Quality of Life for People with Long Term Conditions
✓	Helping People to Recover from Episodes of Ill Health or Following Injury
✓	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed (please delete tick and attach as appropriate)	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

Author: Health Inequalities Commission	**Director Lead:** Dr Joe McManners, Clinical Chair



Headline Report: Addressing Health Inequalities in Oxfordshire

Report from the Independent Commission on Health Inequalities in Oxfordshire

Acknowledgements
The Commission would like to thank:

- The members of the Commission Support Group, convened by the CCG, who gave unstintingly of their expertise and advice, providing useful contacts for the commission and its secretariat
- The co-opted members of the group, and members of its wider support network, who provided their support and specialist expertise at various stages of the evidence gathering. These include, but are not restricted to Patrick Taylor, Lonah Hebditch, Mandy Rose, Maggie Dent, Emily Phipps and Jackie Wilderspin
- The members of the public who came along to the evidence sessions to provide their input and views
- The many people from across the statutory, voluntary and private sectors who produced written submissions, gave oral evidence, and attended the evidence gathering sessions
- Professor Paul Johnstone, Clare Laurent and her team at PHE, Sir Michael Marmot and Poppy Jaman
- Allison Thorpe for her secretarial support holding the process together.

Their support and input were invaluable.

Useful resources to support further action on health inequalities
Source: www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers

The Marmot Review, published in 2010, set out evidence for action across the wider determinants of health to reduce health inequalities. To help turn the Marmot recommendations into practical actions, in September 2014 PHE published the first series of evidence papers on the issue. The commitment to support local action on health inequalities has been continued with new Practice Resource papers that include evidence, information and tips on approaches that local partnerships can adopt on four topic areas:

- Opportunities for using social value act to reduce health inequalities in England
- Promoting good quality jobs to reduce health inequalities
- Reducing social isolation across the life course
- Improving health literacy to reduce health inequalities.

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CHAIRMAN'S LETTER

To the Chairman,
Health and Wellbeing Board,

I have pleasure in submitting the report from the Oxfordshire Commission on Health Inequalities.

The Commission was established at the request of the Health and Wellbeing Board, recognising that both the human costs and the economic costs of health inequalities to the NHS and to the county are unacceptable. Nationally, an estimated £5.5bn economic loss is associated with health inequalities and due to lost production, higher benefit payments and lost taxes the costs rise to £31-33bn. The county bears its share of these losses and addressing inequalities will strengthen not only the health of its population but also its economic well being.

Informed by the Marmot Review of 2010, the Commission adopted a life course approach, and makes recommendations to reduce local health inequalities across the social gradient as well as at different life stages. In making these recommendations we have drawn upon local experience and sound evidence for effective action, resonating with local, national and international policy directions including the Five Year Forward View and the Sustainability and Transformation processes and we have not repeated the work summarised in the Annual Reports of the Director of Public Health, the Joint Strategic Needs Assessment and other. We also recognise the importance of advocating national solutions in addition to implementing our local recommendations.

During the evidence sessions in different parts of the county we heard about excellent initiatives which target vulnerable populations and were given many examples of current and emerging good practice that can address health inequalities in Oxfordshire.

Our recommendations are made from the perspective of taking local action which can make a difference in the short and medium term. These recommendations will need the guardianship of the HWB if they are to make a difference to the health of the population of Oxfordshire, particularly its most vulnerable members.

I would like to thank all those who participated in the process of producing this report – most especially the Commissioners and the support team. Without them and the sterling efforts of Allison Thorpe in keeping the show on the road the opportunity to highlight often hidden inequalities might have passed us by.

Professor Sian M Griffiths OBE

INTRODUCTION

1

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged.

But as Sir Michael Marmot has highlighted, health inequalities are not just poor health for poorer people but affect us all – *"It is not about them, the poor, and us the non poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone."* [i]

Addressing health inequalities is a priority for the World Health Organisation [ii] and remains central to the UK government's health strategy, the Five year Forward View [iii], which provides guidance to the NHS.

The open letter from the Secretary of State for Health in February 2016 makes it clear that all communities are expected to have plans in place to narrow the gap and reduce overall inequalities in their health. [iv] Local authorities, strengthened by the recent move of public health departments, have inequalities duties – introduced for the first time by the Health and Social Care Act 2012.

1.1 Background to the Commission Report

The Oxfordshire Commission on Health Inequalities was established at the request of the Oxfordshire Health and Wellbeing Board (HWB). The HWB had recognised that in addition to the human costs, the cost of health inequalities to the NHS is unacceptable. It is currently estimated at £5.5bn nationally, and economic losses associated with health inequalities due to lost production, higher benefit payments and lost taxes have been estimated at £31-33bn.

The economic benefits of addressing inequalities are clearly demonstrated in Appendix 1 which presents costs of illnesses and benefit analyses of interventions. Thus addressing inequalities will strengthen the economic well being of the county as well as the health of its population.

1.2 The Commission's Approach

Informed by the Marmot Review of 2010, the Commission (for membership see Appendix 2) adopted an approach, which would enable it to consider factors, which would make recommendations to:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

The overall aim of the Commission is to make recommendations that will reduce health inequalities. Its approach has been:

- To draw upon local experience and sound evidence for effective action, which resonates with local, national and international policy directions
- To identify activities that can address health inequalities in Oxfordshire, giving robust examples of current and emerging best practice.

The Commission has considered what is currently being done to identify and tackle health inequalities in Oxfordshire, drawing on documentary and oral evidence provided by statutory, voluntary and charitable organisations in the county. This includes the Annual Reports of the Director of Public Health, the Joint Strategic Needs Assessment, the Sustainability and Transformation planning process and other reports already in the public domain. The evidence sessions have been held in public, to encourage and enable input from Oxfordshire residents, and to ensure transparency.

The Commission used a lifecourse model to inform its deliberations. A lifecourse perspective highlights both critical periods of risk and also the accumulation of risk over an individual's lifetime and directs attention to how health inequalities operate at every level of development – pre conception, childhood, working age, and into the latter years of life. [v]

Each consultation session started with a presentation of the relevant available data on health inequalities, provided by the public health team. This Headline report presents the main recommendations of the full report, structured to reflect the process followed.

Recommendations 1-11 focus on the Common Principles *(Box A)* which emerged during the process of the Commission. These principles should inform all policy, resource allocations and practice across the county if health inequalities are not to become further entrenched or grow.

Box A:

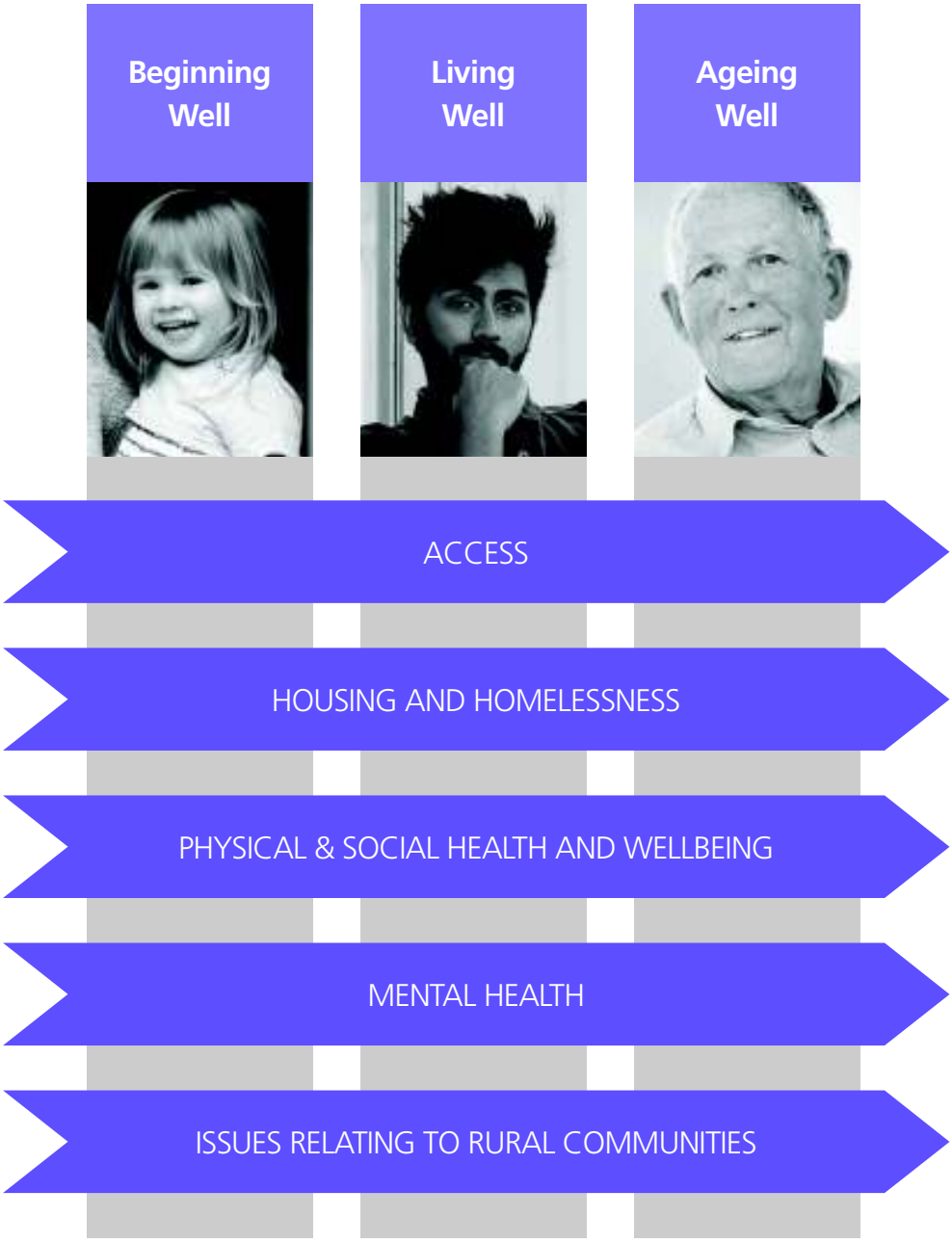
Common Principles to address health inequalities

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

Recommendations 12-40 focus on common themes across the lifecourse, drawing together many of the threads common to the other sessions. *(Figure 1)*.

These recommendations take into account not only geographic communities but also communities of common interest, particularly vulnerable groups most likely to suffer from health inequalities.

Figure 1: Cross cutting themes



Recommendations 41-58 focus on stages of the life course

- Beginning well: pre-pregnancy, the antenatal and perinatal period and childhood
- Living well: the middle years
- Ageing well: the latter years of life.

The difference in life expectancy between rich and poor is well known. Perhaps less well known but equally important… is the inequality in the years lived in good health.

House of Commons Health Committee Report on Public Health, September 2016

SUMMARY OF RECOMMENDED ACTIONS

2

The 2012 Social Value Act is an important piece of new legislation which places an onus on organisations spending public money to do so with an eye to improving social circumstances; spending it for the public good.

2.1. The profound influence and impact of poverty on health needs to be widely recognised and systematically addressed

Poverty and disadvantage lead to poorer health. Mitigating the relationship between poverty and health is essential if we are to address the entrenched inequalities already present within Oxfordshire, and prevent further generations of Oxfordshire residents becoming adversely effected by circumstances beyond their immediate control – the wider determinants of health.

Recommendations		Responsibility
1	Statutory funding bodies need to do more to demonstrate their commitment to reducing inequalities. Their policies and plans should be scrutinised by HWB on an annual basis.	**HWB**
2	Monitoring of the process of commissioning/service design to ensure it has taken inequalities into account in the design of new models of care and innovations such as vanguards needs to be undertaken regularly.	**CCG / OCG**
3	Local indicators on progress towards reducing inequalities should be developed, with regular reporting to the Health and Wellbeing Board. This should be in place by the end of 2017.	**HWB**

2.2. Commitment to prevention needs to be reflected in policies, resources and prioritisation

'While strong local political leadership can bring enormous benefits for public health, there is also the potential for tension between political priorities and evidence-based decision making. Clearer standards should be introduced and monitored transparently to improve accountability and to make sure that services to underrepresented or politically unpopular groups are maintained at an appropriate level.'

Source: House of Commons Health Committee, Public Health Report, September 2016

'An economic perspective is about more than counting the costs associated with poor health. It is about understanding how economic incentives can influence healthy lifestyle choices in the population.'

Source: www.euro.who.int/en/about-us/partners/observatory/publications/studies/promoting-health,-preventing-disease-the-economic-case

Numerous studies have shown that investment in primary and preventive care greatly reduces future health care costs, as well as increasing health [vi vii]. In England only 4-5% of health spend is focused on prevention activities [viii]. The Marmot review recommends this should be at least 7% [ix]. We have no reason to doubt that this also applies in Oxfordshire and that the current level of investment in prevention across all sectors is inadequate.

Investment in prevention by all agencies is essential if progress in improving the health and wellbeing is to continue and to ensure that existing health inequalities do not grow and become further entrenched. This is not just about investment in essential public health services, but more broadly across all investments in the socioeconomic conditions which affect health to ensure that all resources are invested effectively and take account of the opportunities in all contacts with services.

Recommendations		Responsibility
4	1. Greater investment is needed in prevention, innovation and service design both across the health and social care system and more widely to mitigate the impact of poverty and health inequalities. 2. All NHS partners should state clearly their investment in prevention. 3. The current level of spending on public health services through the ring fenced budget should be maintained. 4. The HWB should track increased spending on prevention, [x] and annually report to the public on progress made and outcomes achieved.	**1) CCG** **2) NHS** **3) HWB / Councils** **4) HWB**
5	The needs of disadvantaged groups should be monitored to ensure preventive programmes do not increase the inequalities gap, and that programmes delivered to all raise the health of all, including those who are most disadvantaged. [xi]	**HWB / CCG**
6	Core preventative services such as Health Visiting, Family Nurse Partnership, School Health Nurses and the Public Health agenda should be maintained and developed.	**PH Department in County Council**

2.3 Resource re-allocation will be needed to reduce inequalities

'Cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities.'

Source: House of Commons Health Committee, Public Health post 2013, Second Report of Session 2016-17 [xii]

Ensuring best value from investment is critical to the current and future health and wellbeing of Oxfordshire residents, and the future sustainability of the health and social care system. The evidence submitted to the commission suggests that there are existing unmet needs in Oxfordshire.

Recommendations		Responsibility
7	Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities. 1. 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. 2. The CCG should conduct an audit of NHS spend, mapping health spend generally and prevention activity particularly against higher need areas and groups, setting incremental increasing targets and monitoring progress against agreed outcomes. 3. The ring fenced funding pot for targeted prevention should be expanded in higher need communities, using a systemwide panel of stakeholders to assess evidence and effectiveness, with ongoing independent evaluation of impact, including quantification of impact on other health spend. [1] 4. An Innovation fund/Community development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations.	**1) CCG** **2) CCG** **3) CCG / STP** **4) CCG**

2.4. Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organisations

Whilst there was evidence of good partnership work in pockets in Oxfordshire, the commission was also presented with many examples of where this could be made stronger. Addressing health inequalities in all policies should be given higher priority in Oxfordshire.

'Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.'

Source: www.healthpromotion2013.org/health-promotion/health-in-all-policies

[1] This needs to engage people from the community and voluntary sectors, as well as people working in the statutory sector.

Recommendations		Responsibility
8	1. 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. 2. Regular review of progress should be undertaken by HWB.	**1) All statutory organisations** **2) HWB**
9	The presence of the NHS and of the voluntary sector should be strengthened on the Health and Well Being Board.	**HWB**

2.5. Data collection and utilisation needs to be improved for effective monitoring of health inequalities

'The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, we are concerned that robust systems to address unacceptable variation are not yet in place. The current system of sector-led improvement needs to be more clearly linked to comparable, comprehensible and transparent information on local priorities and performance on public health.'

Source: House of Commons Health Committee Report

Data collection on health inequalities in the county is patchy and not adequately utilised in policy and resource allocation decisions. During the process of consultation we found it difficult to get good data on Black and Ethnic Minority Communities in the county as well as on other disadvantaged groups. [2]

Recommendations		Responsibility
10	The data on health inequalities available through PHE / NHS and other routine sources should be regularly reported to all statutory organisations and made available to the public.	**PH Dept**
11	Gaps in data collection on the health of Black and Ethnic Minority Communities, those with learning difficulties and other vulnerable groups at greater risk of poor health should be addressed and data used to inform resource allocation decisions. This includes encouraging all public sector organisations and organisations who do work on behalf of these organisations to be fully Equality Act compliant.	**HWB**

[2] This is a concern, given that this is one of the protected characteristics covered by the Equality Act. The Commission believe there is a need for focused effort encouraging all public sector organisations (and all organisations and parties who do work on behalf of those organisations) to be fully Equality Act compliant, as this would support good quality data collection that can then be used to inform decision making in a number of areas, including health inequalities.

CROSS CUTTING THEMES 3

When considering evidence across the lifecourse it became apparent that there were common themes which needed to be holistically addressed in efforts to reduce health inequalities.

3.1 Access

Better Access to financial advice

Greater attention needs to be given to the wider arrangements for referring people to benefits advice programmes, as part of a sustained programme of activity which aims to improve financial situations, address debt, and promote financial inclusion.

Recommendations		Responsibility
12	Benefits advice should be available in all health settings, including GPs networked into local areas to support CABs.	**CCG / NHS Partners**
13	A sub group working on income maximisation should be established, and asked to report back to the HWB / CCG within a year.	**HWB**
14	District councils should be approached to seek matched funding, dependent on existing contribution.	**District Councils**

Better access to services

All service providers need to ensure that services are as responsive as possible. For example, discharge arrangements from NHS care need to be appropriately tailored for people who are homeless. Services need to be sensitive to the cultural norms and beliefs of patients from minority ethnic communities.

Recommendations		Responsibility
15	Indicators in the wider NHS performance framework should be utilised as part of routine monitoring for NHS organisations to yield useful, if limited, insights into inequalities and provide a metric that can be measured to assess progress in addressing inequalities.	**District Councils**

3.2 Housing and Health

Better access to secure, affordable, decent accommodation for Oxfordshire residents

There is a growing body of evidence showing a correlation between poor housing and ill health. Warm, dry secure accommodation is associated with better health outcomes.

Recommendations		Responsibility
16	1. Public agencies, universities and health partners should work together to develop new models of funding and delivery of affordable homes for a range of tenures to meet the needs of vulnerable people and key workers. 2. Specifically, public agencies should work together to maximise the potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing by undertaking a strategic review of public assets underutilised or lying vacant.	**1. Public agencies, universities and health partners** **2. Public agencies / HWB**
17	Consideration should 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**

'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses. Rates of fuel poverty in Oxfordshire are unacceptably high.

Recommendations		Responsibility
18	In 2014, 9.1% of households were fuel poor. This should be reduced in line with the targets set by the Fuel Poverty Regulations of 2014.	**HWB**

3.3 Action to reduce the harms of Homelessness

Homeless people experience severe health inequalities with an average life expectancy of some 30 years less than the rest of the population [xiii]. They often suffer from tri-morbidities; the combination of poor physical health, poor mental health and substance misuse, with poor health as both a cause and an outcome of sleeping rough. In general, homeless people experience significant barriers in accessing services to support their health, requiring extra support to access routine and acute services.

Phased changes in the funding allocations for housing related support are expected to have a significant impact on the availability of accommodation for single homeless people across the county. We would encourage the District and County Councils to continue to work together to find a solution, which will ensure this already vulnerable population are not further disadvantaged and to regularly report on progress to the Health and Wellbeing Board.

Recommendations		Responsibility
19	All public authorities are encouraged to continue their collaboration and invest in supporting rough sleepers into settled accommodation, analysing the best way of investing funding in the future. Homelessness pathways should be adequately resourced and no cut in resources made with all partners at the very least maintaining in real terms the level of dedicated annual budget for housing support.	**HWB**
20	The numbers of people sleeping rough in Oxfordshire should be actively monitored and reduced.	**HWB**

3.4 Reduce the health harms associated with rurality

Oxfordshire is a rural county, with approximately 50% of its population living in small settlements of less than 10,000 people. Health services such as major and community hospitals, out of hours GP services and ambulance services can be more difficult for village based residents to access, with limited or non existent public transport. For older people in particular, with limited access to public transport or poor mobility, rural living can have a negative impact on health and wellbeing, and isolation and loneliness diminish their well being.

Recommendations		Responsibility
21	An integrated community transport strategy should be developed. [xiv]	**District and County Councils**
22	A digital inclusion strategy, which explicitly targets older people living in rural communities should be developed and the percentage of older people over 65 with access to online support regularly reported.	**CCG**
23	Reports of isolation and loneliness in older people/people suffering from dementia in rural areas should be collated and monitored on an annual basis with a reduction achieved year on year utilising advice in: www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation	**OCC / CCG**
24	The recommendations from the DPH annual report should be implemented and monitored.	**All Agencies**

3.5 Supporting vulnerable populations

Improving access to services for Refugees

The Commission heard evidence on the health needs of refugees and migrants, including detainees in Campsfield House and agreed that special consideration should be given to the needs of migrant families and refugees. Evidence to the Commission noted that this support needs to be kept under review.

Recommendations		Responsibility
25	Funding for locally enhanced services for refugees and asylum-seekers should be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers.	**CCG**
26	Outreach work in communities with high numbers of refugees, asylum seekers and migrants, should be actively supported and resources maintained, if not increased, especially to the voluntary sector, to improve access to the NHS, face to face interpretation /advocacy and awareness raising amongst health care professionals.	**HWB**

Improving access to Throughcare provision for prisoners

Prisoners, and ex- prisoners are a vulnerable ethnically diverse population, with a constantly moving and increasingly ageing population adding further complexity. A recent study has suggested that offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. [xv]

Recommendations		Responsibility
27	Robust pathways to community services for community rehabilitation (including Community Rehabilitation Companies) [3] on release, particularly for short term offenders, need to be developed.	**NHS / Community Safety Partnership**

3.6 Lifestyle factors: Physical and Social well being

The importance of lifestyle as a contributor to health is well known, and the Annual Reports of the Director of Public Health have sequentially described trends and targets which will not be repeated in this report (see www.oxfordshire.gov.uk/cms/content/oxfordshire-public-health). However, we wish to recommend some specific actions:

Physical activity

The health benefits of physical activity are well documented: providing help with weight control, reducing the risk of chronic disease and improving mental health. In Oxfordshire, 41.6% of people participate in sport at least once a week, but disabled people, people over the age of 55 and people from lower socio-economic groups are less likely to participate.

Recommendations		Responsibility
28	A set of Oxfordshire grounded targets for increasing activity should be developed. Targeting people living in deprived areas, older people, and vulnerable groups.	**HWB**
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**
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.	**PH Dept**

[3] Community Rehabilitation Company (CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation.

Smoking

Smoking is the single greatest cause of preventable illness and premature death in the UK. In Oxfordshire local figures show a current overall smoking prevalence of 15.5% but amongst routine and manual groups this rate rises to 30.6%.

Recommendations		Responsibility
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.	**CCG / GPs**

Alcohol

Alcohol is more affordable and available than at any time in recent history. While most people who drink do so without causing harm to themselves or others, there is a strong and growing evidence base for the harmful impact that alcohol misuse can have on individuals, families and communities in Oxfordshire.

Recommendations		Responsibility
32	An alcohol liaison service should be developed in the OUHT.	**NHS**
33	A targeted project should be developed which aims to reduce drinking in middle aged people living in deprived areas.	**PH Dept**
34	Building on experience from Wantage, Community Alcohol Partnerships should be established across the county to address the problems of teenage drinking, particularly in Banbury as A&E data shows high numbers of under 18s attending the Horton ED for alcohol related reasons. (The partnership model brings retailers, schools, youth and other services together to reduce under age sales and drinking).	**Community Safety Partnership**
35	Support and develop schools interventions including support given to school health nurses as well as services such as those run by The Training Effect to increase capacity of young people to choose not to misuse substances.	**PH Dept**

Drugs

National data shows that people who misuse drugs and their families are most likely to live in socially deprived circumstances at the bottom end of the social gradient. Their needs are a fundamental health inequalities challenge. Yet there is no prevalence data for drug use, as such, as nobody knows exactly how many people are using illegal substances.

This does not detract from the need to maintain and if necessary increase support to drug users and their families to meet their needs. Evidence available on Novel Psychoactive Substances (legal highs) suggests agencies also need support to develop a model of care.

Recommendations		Responsibility
36	Resources in the public health budget should be maintained to provide services and support for drug misusers and their families.	**OCC**
37	School based initiatives should be promoted for all age groups.	**OCC**
38	Policy and action should be targeted to continue to address the rates of: • Successful completion of drug treatment in non opiate users • Parents in drug treatment • people in substance abuse programmes who inject drugs who have received a hep C vaccination • Children facing a fixed period of exclusion due to drugs/alcohol use • NPS use.	**OCC**

3.7 Mental Health

Many people with mental health problems also suffer poor physical health and impoverished social conditions. Addressing their needs will reduce health inequalities within the county. Oxfordshire has one of lowest spends per weighted capita for mental health (FYFV) and did not increase the percentage allocation of funds to mental health in line with total increased allocation in funding. It has a higher than average excess under 75 mortality rate in adults with serious mental illness.

Recommendations		Responsibility
39	The under provision of resources for Mental health services should urgently be addressed.	**CCG**
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**


DONATION
BOX

LIFE COURSE ACTIONS 4

Future health inequalities are, to a large extent, determined from a child's earliest years, including its intrauterine development. This is due to biological factors as well as life circumstances. Early responses to what is happening shape future physical and psychological functioning, supporting children to thrive, learn, adapt and form good future relationships. The first few years of life can be critical for readiness to learn, educational achievement and ultimately wealth and economic status, a strong predictor of future health and wellbeing.

4.1 Maternal Health

Evidence provided on perinatal mental health highlighted a significant gap; whilst Oxfordshire has a local pathway for mental health services, there is no service or access for women with severe mental illness and personality disorders, although such services are being developed in other parts of the region.

Recommendations		Responsibility
41	Perinatal mental health should be a priority with appropriate investment to improve access to perinatal mental health services across Oxfordshire.	**CCG**

4.2 Children's Health and Wellbeing

Evidence presented to the commission suggested that more needs to be done to ensure that children are given the best possible start in life, recognising that family circumstances can and do make a difference to health outcomes.

Nutrition is an important foundation for good health – and challenges exist in ensuring access to affordable healthy food for all families with young children. Evidence provided to the Commission, which drew on The Trussell Trust's 2016 report data, suggests that food bank use is at a record high across the country. We interpolate from national data that 2.5% of the population of Oxfordshire accessed 2 emergency food parcels per person in the last year.

Education is an important factor in future health, and ensuring that children are ready for school entry, are adequately fed during their school days, attend school regularly and their achievement monitored are all important ways in which inequalities can be addressed. We recognise that there is much good work ongoing within the county in these areas.

Recommendations		Responsibility
42	Use of food banks needs to be carefully monitored and reported to HWB.	**District Councils**
43	Child Health Profiles and other relevant routine data should routinely be reported from the perspective of addressing factors which could reduce health inequalities.	**OCC**
44	New and creative ways to work with schools, such as Oxford Academy, should be explored and initiatives funded and evaluated through the proposed CCG fund.	**CCG**
45	The current plans for closures of Children's Centres should be reviewed by March 2017 to ensure prioritisation of effective evidence-based investment and good practice in early intervention for children and to ensure that the change of investment and resource allocation to young children and their families does not disadvantage their opportunities especially for those children and families from deprived areas and identified disadvantaged groups.	**OCC**

4.3 Living Well

At every point in the adults life there is an opportunity to improve health and wellbeing, prevent the development of new conditions, and minimise the impact of pre-existing conditions. Yet at this stage of the lifecourse, engagement with services is often minimal.

Being in work is good for health and economic productivity. The health of the workforce is an asset and programmes within workplaces as well as initiatives to reduce worklessness will contribute to reducing inequalities. The Commission heard of good examples both within the NHS and within the local corporate sector.

Using the workforce race equality standard is a useful measure of discrimination, harassment and access to career progression. The Commission recognised that amongst the adult population some groups were particularly vulnerable to health inequalities, particularly those with learning difficulties.

Recommendations		Responsibility
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**
47	Promoting the health of those in work should be a priority and examples of good practice shared by establishing a county wide network.	**All Employers**
48	The NHS workforce should engage in equity audit and race equality standards should be routinely reported.	**NHS**
49	The needs of adults with learning disabilities within the county should be reviewed in 2017 and targets set to reduce their health inequalities.	**NHS / HWB**

4.4 Ageing Well

With significant improvements in healthcare and lifestyles, an increasingly large percentage of our population is made up of people aged over 65 years old. [xvi] Older people are increasingly likely to require support from adult social care and social isolation becomes an important factor in older people's mental health.

There is much that can be done to maximise the potential of older adults and enable them to live as independently as possible in their own community, i.e. provision of seasonal flu vaccination, falls prevention activity, tackling fuel poverty, and community development projects to reduce social isolation, particularly for people living in rural communities. *(Box B)* More needs to be done to promote integrated health and social care addressing co – morbidities, particularly recognising that depression and low mental health are major predictors of institutionalisation.

Box B:

From DPH annual report in 2016

1. Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Adult Social Care Directorate should continue to plan explicitly for services for an increasing population of frail elderly people. Further integration of health and social care services should include this topic as a priority.

2. The Clinical Commissioning Group and NHS England should work with GP services to consider loneliness as a risk factor for disease and consider how affected individuals could be signposted to use local resources such as befriending services and lunch clubs.

3. The Oxfordshire Clinical Commissioning Group should continue to develop improved services for dementia as a priority.

4. Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospitals Trust and Oxford Health Foundation Trust and NHS England should develop, as a priority, their joint work to collaborate in transforming the local health system. This is in order to provide new models of care closer to home, care focussed on prevention and early detection of disease, improved care for carers, prevention of hospital admission and speedy hospital discharge through improved community services, the modernisation of primary care and the funding of primary prevention services by the NHS.

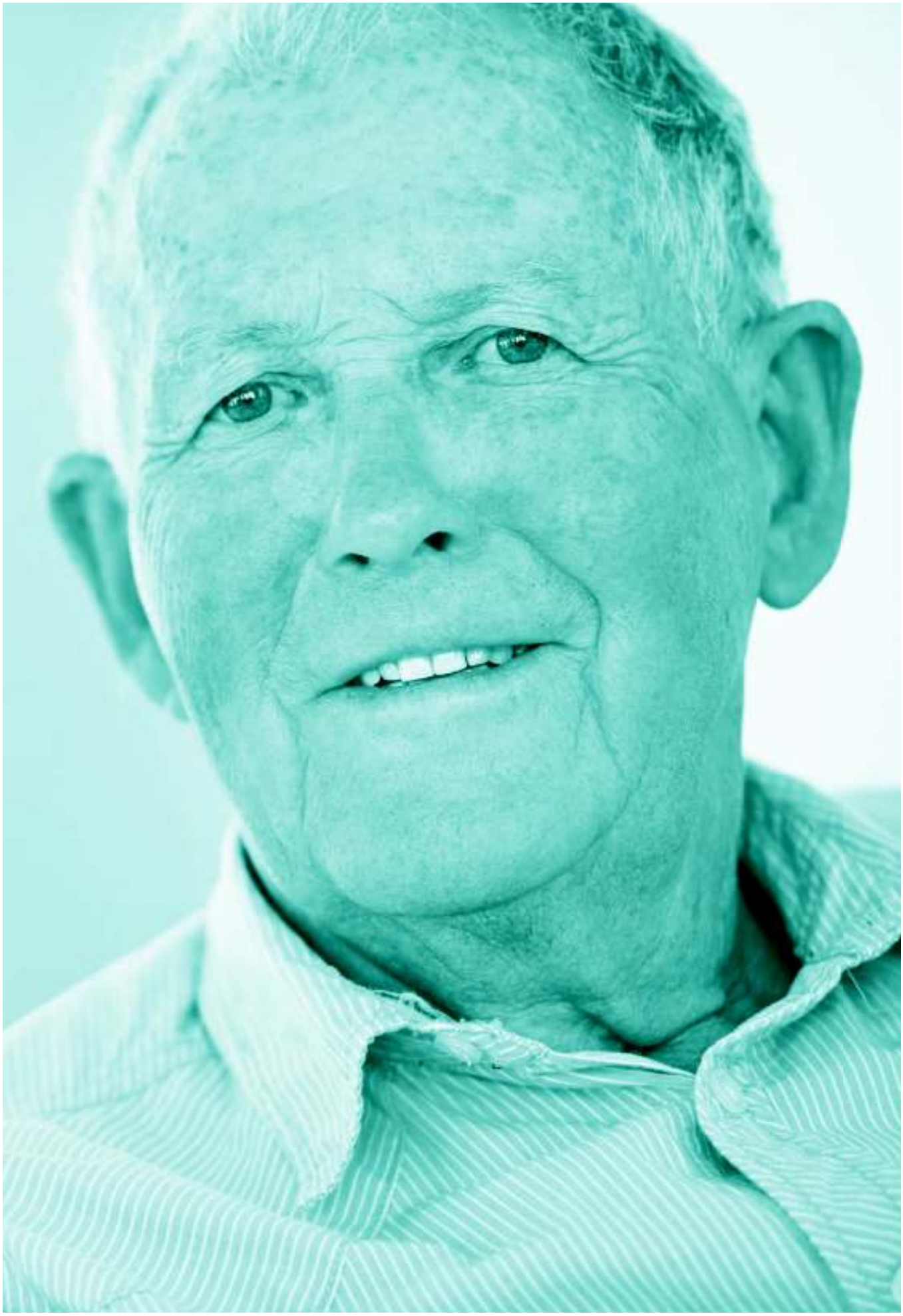
5. Oxfordshire Adult Social Care Directorate should continue to analyse carefully the implementation of the Care Act and feed this information into future service planning.

6. The Director of Public Health should continue to commission NHS Health Checks and ensure that the offering and uptake of these services achieved by local GPs is kept at high levels. Poorly performing practices should be helped to improve the way Health Checks are delivered.

7. Oxfordshire Healthwatch should consider paying particular attention to dementia services and care for carers as part of their forward planning.

8. The Oxfordshire Health Overview and Scrutiny Committee should consider the issues raised in the care closer to home report carefully, and consider the issues raised in the DPH report, to ensure that proposals to re-shape services match demographic need and address health inequalities.

Recommendations		Responsibility
50	Health and social care systems should work together to agree how best to bring together local services to produce a more coherent transition between sectors when addressing inequalities, recognising that co-morbidities are common in this age group, and that many older people are acting as carers for their partners and family members.	**NHS/OCC**
51	Shared budgets for integrated care should be considered and how this fits with the broader care packages available to older people. For example, looking at how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers.	**CCG / OCC**
52	Support for carers, including their needs for respite care and short breaks, should be supported with resources by all agencies.	**NHS / OCC**
53	The recommendations from the 2016 DPH annual report are endorsed and the Commission wishes to ensure they are targeted to reduce health inequalities and progress reviewed by HWB in 2017.	**NHS / OCC**
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**
55	Strategic action should be taken to oversee increased access to support for older people in disadvantaged and remote situations: • Physically through a better coordinated approach to transport across NHS, local authority and voluntary/community sectors • Digitally through a determined programme to enable the older old in disadvantaged situations to get online • Financially, through support to ensure older people, who are often unaware of their financial entitlements, are helped to access the benefits they are entitled to claim.	**HWB / CCG /District Councils**
56	Building on existing experience, support the further development of Alzheimers friendly environments.	**HWB / District Councils**
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**
58	Promoting general health and wellbeing through a linked all ages approach to physical activity, targeting an increase in activity levels in the over 50s, especially in deprived areas, using innovative motivational approaches such as 'Good Gym' and Generation Games.	**HWB / CCG**



NEXT STEPS

5

The Commission has reviewed health inequalities in Oxfordshire and the many positive steps already being taken to care for the more vulnerable members of our community. Our objective has been to highlight that inequalities in health are unfair and unjust and that they need to be taken into account and action taken by all concerned with the health of our population.

The recommendations highlighted in this Headline report are more fully described and developed within the final report which will be presented to the Health and Well being Board in November 2016. Whilst it is easy to say that many of the structural elements of poverty and disadvantage are beyond the control of the county and its services it is also true to say that local action can make a difference. It is also easy to discount recommendations on the basis of poor financial data on costs and benefits of the recommendations, but this rigour is not applied to the commissioning of other routine services commissioned on a historical basis.

We do know that addressing inequalities will save and improve lives for the most vulnerable in our communities and that gains will accrue over the lifetime of children who benefit from positive interventions. We also know that budgets are constrained, and we need to think creatively about how resources can be allocated or even reallocated.

The next steps for the Commission will be to promote the findings of the report and discussion of what can be achieved through local action. The areas for action can be reviewed using the tools produced by PHE to support local action (see above). Progress needs to be regularly reported to councils, NHS partners and the local population through the Health and Well Being Board.

Overall Recommendations		Responsibility
59	The suggested actions should be considered by relevant parties and prioritised, with a report on progress to the HWB by mid 2017.	**HWB**
60	The resources produced by PHE to support local action should be used as part of the formal review process.	**HWB / All partners**

We would like to thank all those who have contributed to the process so far.

November 2016

APPENDIX **1** **6**

Economic impact estimates to support the business case for investment in the social determinants of health – evidence gathered by the King's Fund

Measure of economic impact	
	Cost of illness
The best start in life	Each annual cohort of pre-term and low birth weight babies costs an additional £3bn from birth to the age of 18.
Healthy schools and pupils	
Helping people to find good jobs and stay in work	Workplace injuries cost an estimated £13.8bn in 2010 - 2011 and sickness absence contributes to an overall cost of worklessness of £100bn per year.
Active and safe travel	The overall cost to society of transport-related poor air quality, ill-health and accidents is at least £40bn, with accidents accounting for £9bn.
Warmer and safer homes	Poor housing costs the NHS at least £2.5bn per year due to illnesses related to damp, cold and dangerous homes Treating young people injured by accidents in the home costs almost £150m in A&E treatment Falls and fractures in the over-65s cost £2bn per year.
Access to green and open spaces, and to leisure services	Increasing access to parks and open spaces could reduce NHS treatment costs by £2bn.
Strong communities, well-being and resilience	
Public protection and regulatory services	In 2002 the average local authority incurred around £18–20m in NHS costs and a further £26–£30m in lost productivity and earnings due to obesity.
Health and spatial planning	

Cost-benefit analysis	Social return on investment
Parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested, with savings to the NHS, education and criminal justice systems.	
Every additional four years of education return £7.20 in the value of health and other outcomes for every £1 spent. Anti-bullying programmes can return £15 for every £1 spend in the long-run in terms of higher earnings, productivity and public sector revenue. Smoking prevention programmes in schools can recoup as much as £15 for every £1 spent. Every £1 spent on contraception to prevent teen pregnancy saves £11 in lower terminations, antenatal and maternity care.	
Business in the Community estimates its programmes getting disadvantaged groups back into work returns £3 for every £1 spent. Employee wellness programmes return between £2 and £10 for every £1 spent.	
For every £1 spent on cycling provision the NHS saves £4 in health costs. Getting one more person to walk to school could pay back £768; and to cycle to work rather than by car between £539 and £641 in terms of NHS savings, productivity improvements and reductions in air pollution and congestion.	
the average local authority and return £80,000 in reduced NHS costs, if 10% of injuries were prevented as a consequence. Birmingham City Council's housing programmes (Decent Homes; Supporting People) returned £24m per year for a total outlay of £12m. Quickest paybacks were for reducing cold and reducing falls in elderly people.	
Birmingham's 'Be Active' programme returned up to £23 in benefits for every £1 spent in terms of quality of life, reduced NHS use, productivity and other gains to the local authority.	
Every £1 spent on health volunteering returns between £4 and £10 shared between service users, volunteers and the wider community.	
Investing in a range of practical air quality improvements is likely to return on average a benefit of £620 for every £100 spent.	An assessment of 15 community health champion projects delivered an SROI of between £1 and £112 for every £1 invested.
'high standard' spatial planning is likely to return £50, £168 and £50 for planning interventions that promote walking, cycling and insulating homes respectively for every £1 spend on the planning process.	

APPENDIX **2**

Commission Members

Professor Sian Griffiths OBE (Chair)
Trained as a doctor Professor Griffiths practiced as a service based public health physician at local, regional and national level in the UK. Sian co chaired the HKSAR governments inquiry into the 2003 SARS epidemic whilst President of the UK Faculty of Public Health.

In 2005 she moved to her academic career as Director of the School of Public Health and Primary Care and Founding Director of Centre for Global Health at the Chinese University of Hong Kong.. She remains Senior Adviser on International Academic Development to the Vice Chancellor and Emeritus Professor at CUHK. In the UK she has been Associate Board member for Public Health England since 2014, chairing PHE's Global Health Committee. She is Visiting Professor at the Institute of Global Health Innovation at Imperial College, London, Trustee of the Royal Society of Public Health and chairs the Board of the Centre for Health and Development [CHAD] at Staffordshire University.

Allison Thorpe (project manager and secretariat)
Allison is a freelance researcher/Prince 2 project manager, with extensive experience of working on public health projects at a range of levels within the health system. Since 2010, when she was awarded a Global Research Report Fellowship for TDR/WHO, she has undertaken multiple time limited research projects on a broad range of areas. She is an experienced researcher, who has utilised quantitative and qualitative skills to undertake both academic studies, and more pragmatic outcome focused studies.

Dr Joe McManners
Joe has been a GP for 11 years. For the past 9 years, he has been a partner at a GP practice in Oxford where he has joint responsibility for the running of the practice. He is also a GP trainer.

He was elected Oxfordshire CCG Clinical Chair in February 2014. Oxfordshire CCG is one of the biggest CCGs in the country with a population of 650,000 patients and a budget circa £700 million. Previously he had been the Clinical Director for Oxford City Locality, and a member of the CCG Governing Body. He previously was also Clinical Lead for older people.

He is Vice Chair of Oxfordshire Health and Wellbeing Board.His priorities as Chair of Oxfordshire CCG are; integrating health and social care for local population management, tackling health inequalities and building a sustainable primary care led system.He has a Masters degree in Public Policy in 2005, and is a King's Fund Associate in Clinical Leadership. For 7 years he was a Local Councillor in Oxford City, and for 3 of those years had executive responsibility for housing. In whatever spare time not taken up by work or family, he likes to relax by getting out cycling around Oxfordshire.

Professor Trish Greenhalgh
Trish Greenhalgh is Professor of Primary Care Health Sciences and Fellow of Green Templeton College at the University of Oxford. She studied Medical, Social and Political Sciences at Cambridge and Clinical Medicine at Oxford before training as an academic GP. She has previously worked at University College London (1986-2010) and Barts and the London School of Medicine and Dentistry (2010-2014).

Trish leads a programme of research at the interface between the social sciences and medicine. Her work seeks to celebrate and retain the traditional and the humanistic aspects of medicine and healthcare while also embracing the unparalleled opportunities of contemporary science and technology to improve health outcomes and relieve suffering. Three particular interests are the health needs and illness narratives of minority and disadvantaged groups; the introduction of technology-based innovations in healthcare; and the complex links (philosophical and empirical) between research, policy and practice. She is the author of 250 peer-reviewed publications and 8 textbooks. She was awarded the OBE for Services to Medicine by Her Majesty the Queen in 2001 and made a Fellow of the Academy of Medical Sciences in 2014.

Cllr Ed Turner
Ed Turner is Deputy Leader of Oxford City Council, leading on Finance, Corporate Assets and Public Health.

He has represented Rose Hill and Iffley on the authority since 2002, overseeing a major regeneration project in his ward. Alongside his council role, he is Senior Lecturer and Head of Politics and International Relations at Aston University, Birmingham.

He has published widely on German politics and, more recently, has developed a specialisation in the areas of housing and planning. He has served on three major national reviews of housing policy: the Harman Review, the Technical Housing Standards Review and, most recently, the Lyons Review. As such, he is particularly interested in the relationship between bad housing and poor health, and the role of housing improvement in narrowing health inequalities.

Paul Cann
Paul Cann joined Age Concern (now Age UK) Oxfordshire as its Chief Executive in April 2009.

Paul read English Literature at King's College Cambridge, also holding a Choral Scholarship. After teaching for five years, he joined the Civil Service where he held a range of postings at the Cabinet Office, including working as a Private Secretary to successive Cabinet Ministers, including the Minister for the Arts. A subsequent spell in the private sector included working for 'The Independent' newspaper. He joined the charity world in 1992 as Director of the British Dyslexia Association and subsequently of the National Autistic Society. He was a Trustee of the disability charity Contact a Family for five years, a charity which supports carers and people with special needs or disabilities.

From 2000 to his arrival at Age Concern Oxfordshire he was Director of Policy and External Relations at Help the Aged, where he had responsibility for research, policy, international strategy, media and external relations. He brought together research and policy, and was particularly involved in Help the Aged's work on pensioner poverty, social exclusion and care issues. As Director with responsibility for international affairs, he helped to reshape the charity's international programme and increased Help the Aged's own profile and activity. From 2004-07 Paul held a Visiting Fellowship at the Oxford Institute of Ageing.

In 2008 Paul was awarded the medal of the British Geriatrics Society for an outstanding contribution to the well-being of older people. In 2009 he was appointed an Associate Fellow of the International Longevity Centre and also in that year a Charter Member of the charity Independent Age. He co-edited 'Unequal Ageing (Policy Press, 2009), which examines in turn the injustice and inequalities experienced by older people in income, housing, health, and many other aspects of daily life. Paul chairs the Public Policy Panel of the national charity Age UK. He and Age UK Oxfordshire are founding members of the national Campaign to End Loneliness. He is a Board member of NDTi, an agency promoting social inclusion across all ages and stages.

Richard Lohman
Richard Lohman has been a director on the board of Healthwatch Oxfordshire and its predecessor 'Oxfordshire LINK' since 2008.

Richard is a registered and qualified social worker with a Masters in Advanced Social Work with Adults. He was a founding member of Unison's National LGBT Committee and has 15 years NHS experience serving people undergoing homelessness. Richard is the Healthwatch representative on the Faculty of General Dental Practitioners Lay and Patient panel.

Andrew Stevens
Andrew joined the NHS in 1982 as a national general management trainee. After posts in North Wales and Manchester, he spent two years in a public and patient engagement role as Secretary of the Community Health Council in Swindon.

Andrew moved to Hampstead Health Authority in 1988 and undertook a variety of senior planning-related roles in the hospital and community sectors. He project-managed the Royal Free's first wave NHS Trust application before becoming the Trust's Director of Business Planning.

Andrew joined what was then the Oxford Radcliffe Hospitals NHS Trust (ORH) in 1999. He was the ORH lead for its merger with the Nuffield Orthopaedic Centre, which resulted in the creation of the Oxford University Hospitals NHS Trust (OUH). Andrew heads up the Trust's planning, commissioning, IM&T and media and communications functions. He also leads the Trust's developing public health activities. He was the lead executive for the OUH's NHS Foundation Trust application process and for the implementation of the Trust's Electronic Patient Record.

Tamsin Jewell
Tamsin has worked with and for a wide range of organisations from charities like Crisis and Oxfordshire Mind to large international bureaucracies like UNAIDS. Social work trained, her career spans social and development work in the UK and internationally, with a focus on health – both mental and physical – forced migration and human rights. Tamsin has been at Elmore Community Services since April 2015.

Dan Leveson
Dan is currently Associate Director of Strategy and OD at Oxford Health NHS Foundation Trust.

He has a long history of working in international development and health, working for Oxfam GB and Goal, managing emergency and post conflict humanitarian programmes in Afghanistan, Ethiopia, Bosnia-Herzogovena, various countries in West Africa and the Democratic Republic of the Congo.

Cllr Hilary Hibbert-Biles
Hilary has been a County Councillor since 2005. She has been a member of the planning committee at both District and County. Hilary has been the vice chairman of the County Council 2009-2010 and the Chairman of the County Council 2010-11. She has also held the post of Cabinet Member for the Environment.

She is also on the Health Improvement Board as well as the Health & Wellbeing Board and the Childrens Board (now called the Childrens Trust). She was a West Oxfordshire District Councillor from 2002-2014 holding cabinet positions covering health, housing, leisure and tourism, children and young people.

She enjoys spending time with her family and gardening. Hilary is married with two daughters and two grandchildren.

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