Oxfordshire Prevention Framework

What is it?
How could you use it?
A Prevention Framework – what is it?

• This Prevention Framework is to go alongside the Joint HWB Strategy

• The aim of producing this framework is to
  • Improve quality of life by creating and promoting health and wellbeing
  • Reduce health inequalities
  • Save our public services from the spiralling costs of treating avoidable illness and ongoing needs and improve the efficiency and wellbeing of the workforce.

• There is a role for everyone – and the framework is designed to help us all see our own and each other’s roles

• We need to use this as a vehicle for tackling inequalities
Where does the Prevention Framework fit in?

Joint Health and Wellbeing Strategy

- Joint Strategic Needs Assessment
- Prevention Framework
  - Priorities for prevention
  - Outline of evidence of effectiveness
  - Assets
- Priority setting
- Identifying inequalities
- Action planning, implementation and monitoring

Focus on need:
- Use Population Health Management methodology where appropriate

Involve stakeholders:
- e.g. use Health and Care Planning Framework for stakeholder participation
## Our proactive approach to prevention

<table>
<thead>
<tr>
<th>PREVENT illness</th>
<th>REDUCE the need for treatment</th>
<th>DELAY the need for care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing illness and keeping people physically and mentally well, e.g. being active, breathing clean air, having social connections</td>
<td>Reducing impact of an illness by early detection e.g. cancer screening, and preventing recurrence e.g. lowering blood pressure or cholesterol to prevent another stroke</td>
<td>Soften the impact of an ongoing illness and keep people independent for longer</td>
</tr>
</tbody>
</table>

(primary prevention) (secondary prevention) (tertiary prevention)
Prevent, Reduce, Delay in Care Pathways – an example for frailty

For every model of care, this 5-step pathway may be considered, with a particular emphasis on the upstream step of prevention. Here is an example for frailty but these 5 steps could be applied to all conditions:

**Prevent**
- Improve resilience
- Strength and balance training
- Optimise medication

**Proactive**
- Proactive monitoring at home
- Define the cohort thru risk stratification
- Common assessment – Comprehensive Geriatric Assessment
- Medication review e.g. STOPP START
- Care planning
- Care coordination in neighbourhoods

**Responsive**
- Acute deterioration requiring out-of-hospital intervention:
  - Hospital at home / EMU / visiting service
  - Timely communication with ambulance crews

**Managing in Hospital**
- Requiring hospital management
- Quick turnaround in ED or AAU
- Front door frailty services
- **Home First** – MDT response including 3rd sector
- Integrated across health and social care and across primary, community & acute

**Returning Home**
- Discharge
- Step down reablement
- Support in the community
- Integrated approached across health and social care
The structure of the document is based on what we want to prevent and root causes of those factors.

**What do we want to prevent?**
- The top 4 causes of death for under 75s in Oxfordshire are: **cancer**, **cardiovascular disease**, **respiratory disease** and **liver disease**.
- Half of these are considered to be preventable.
- A higher proportion of these deaths is in areas of **deprivation**.

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**The Wider determinants of health**

- **Contributors to health outcomes**
  - Health Behaviours 30%
    - Smoking 10%
    - Diet/Exercise 10%
    - Alcohol use 5%
    - Poor sexual health 5%
  - Socioeconomic Factors 40%
    - Education 10%
    - Employment 10%
    - Income 10%
    - Family/Social Support 5%
    - Community Safety 5%
  - Health Care 20%
    - Access to care 10%
  - Built Environment 10%
    - Environmental Quality 5%
    - Built Environment 5%

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**We have to concentrate action on all fronts**
Details on the factors causing preventable ill health are set out in tables with this format:

<table>
<thead>
<tr>
<th>Name of the preventable risk factor</th>
<th>National Recommendations for Action (including as recommended by the Public Health England menu of preventive interventions and the NHS Long Term Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local challenge</td>
<td>List what will be prevented if action is taken</td>
</tr>
<tr>
<td>Outline how we will know we are successful</td>
<td></td>
</tr>
</tbody>
</table>

These tables set out details for these factors:

- **Mental Wellbeing – an enabling factor**
  - Lifestyles
    - Obesity
    - Alcohol
    - Smoking
    - Physical Inactivity
  - Socio-economic factors and the built environment
    - Healthy Place Shaping
    - Social Isolation / Loneliness
    - Low Income and Debt
    - Better Housing, Better Health
  - Healthcare factors
    - The First 1000 Days
    - Implementing the NHS Long Term Plan
    - Prevention through GP practices and Primary Care networks
    - Prevention across our county wide organisations
Priority Checklists

We have devised 3 priority checklists to set out the range of work that can be done on that priority topic. They can be used to tick off what YOU could do as part of the joint effort on that priority.

Each checklist is set out under the headings of
- Healthy Lifestyles
- Socio-economic factors and the built environment
- Health and other Services

Tackling Health Inequalities is EVERYONE's role as they work on that priority topic.

You can set out other checklists for different priorities if that helps.
Some local inequalities issues

Wards which have some areas in the worst 20% nationally for multiple deprivation
- Banbury Grimsbury and Hightown (Cherwell)
- Banbury Ruscote (Cherwell)
- Barton and Sandhills (Oxford)
- Blackbird Leys (Oxford)
- Northfield Brook (Oxford)
- Rosehill and Iffley (Oxford)
- Abingdon Caldicott (Vale of White Horse)

More early deaths from heart disease and stroke
More respiratory disease
More childhood obesity
More children with tooth decay
Fewer active people
Higher use of emergency services

The table shows how long, on average, someone might expect to live without disability or long-term conditions in the most and least deprived areas of Oxfordshire (JSNA 2017):

<table>
<thead>
<tr>
<th></th>
<th>Most deprived 10%</th>
<th>Least deprived 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>60.7 years</td>
<td>70.8 years</td>
</tr>
<tr>
<td>Women</td>
<td>60.9 years</td>
<td>70.5 years</td>
</tr>
</tbody>
</table>

Poorer physical health outcomes for people with severe mental health problems, learning disabilities and autism

People from some minority ethnic communities have
- Increased risk of diabetes
- Increased risk in pregnancy and childbirth
The Prevention Framework will be tackling inequalities

We can do this through

1. **Focus on a place with poor outcomes**
   - This needs a multi-faceted approach with enabling initiatives e.g. Making Every Contact Count

2. **A priority theme with identification of particular groups who are affected e.g. loneliness.**
   - Not necessarily a geographical focus. Find groups at risk e.g. carers

3. **Focus on a condition, such as those causing early illness or death**
   - This approach should incorporate initiatives to Prevent, Reduce, Delay and use available information to identify those at greatest risk e.g. JSNA or Equity Audit.
So how do we turn the Prevention Framework into action plans?

Here are some suggested steps and worked examples
1. What is your overall priority?
   - Use the Prevention Framework analysis of local priorities

2. What is your aim?
   - Use the Prevention Framework to identify causes of your priority issue

3. Find out about health inequalities
   - Use the JSNA to identify those with worst outcomes

4. What will work?
   - Check the Prevention Framework evidence of what works.

5. How will you know it has worked?
   - Monitor what happens, measure the impact, and review your actions accordingly.
Worked examples

• We have suggested 3 priority areas for illustration, but there will be others that you want to work on. The 3 we are using as examples are:
  • Healthy Place Shaping
  • Preventing premature death
  • Tackling Loneliness

The following slides show a worked example from each of these 3 checklists using the flowchart to set out how a specific action can be developed for each priority.

Note: each action will be one contribution to the bigger picture.
**Priority: Preventing Cardiovascular Disease**

Use the checklists to note what YOU and YOUR ORGANISATION can do to contribute to this priority.

**Healthy Lifestyles**
- Reduce the number of people who smoke
- Tobacco Control measures
- Promote Healthy Eating
- Reduce obesity
- Enable Active Travel
- Promote physical activity
- Reduce alcohol consumption
- 5 ways to Wellbeing
- Lifestyle advice for people with long term conditions e.g. Cardiovascular disease

**Socio-economic factors / Built Environment**
- Healthy Place Shaping
- Walking routes
- Safe cycle routes
- Clean air
- Warm homes
- Leisure and community facilities
- Green and Blue spaces

**Health care and other services**
- Making Every Contact Count
- Workplace wellbeing
- Social prescribing
- NHS Health Checks
- Weight management services
- Case finding for atrial fibrillation and high blood pressure
- Identifying high risk groups
- Alcohol Care Teams in hospitals
- Access to psychological therapies

**Tackle Health Inequalities:**
- Identify people or groups with poor outcomes and improve them
Example 1. Preventing cardiovascular disease

1. What is your overall priority?
   - Prevent Cardiovascular disease

2. What is your aim?
   - Address risk factors including high blood pressure, high Body Mass Index, high cholesterol

3. Find out about health inequalities
   - Equity Audit shows that men from some ethnic minority groups do not attend for their NHS Health Checks which assess these risk factors.
   - Data shows early illness and death from cardiovascular disease is more likely for these men.

4. What will work?
   - Consider how to provide NHS Health Checks at times and venues that men can attend.
   - Also make sure access to lifestyle support is easy for them to access e.g. smoking cessation

5. How will you know it has worked?
   - Monitor uptake of NHS Health Checks at new services and access to lifestyle services e.g. smoking cessation.
   - Repeat Equity Audit
   - Report back to the community and maintain dialogue.
Priority: Healthy Place Shaping

Use the checklists to note what YOU and YOUR ORGANISATION can do to contribute to this priority.

Healthy Lifestyles
- Social prescribing
- Physical activity
- Health walks
- Safe cycling routes
- Cycle friendly employers
- Healthy schools
- Sports clubs
- Gardening & allotments
- Access to healthy food
- Access to lifelong learning and cultural engagement
- Licensing policy and practice
- Workplace wellbeing schemes

Socio-economic factors / Built Environment
- Green Spaces / waterways
- Community hubs
- Community development / activation
- Good quality, well-designed houses
- Pedestrian zones
- Clean air
- Age Friendly communities
- "Good work"
- Community Employment plans
- Workplace wellbeing
- Transport plans
- Industrial strategy
- Oxfordshire 2050 and Local Plans
- Safe Communities
- Reduce impact of noise
- Road safety

Health care and other services
- One Public Estate / co-location of services
- Neighbourhood models of service provision
- Voluntary sector capacity and investment
- Co-production and community involvement, building on community assets
- Care Closer to Home
- Personalised care
- Leisure and recreation services
- Community Centres
- Dementia Friendly services and communities
- Befriending services

Tackle Health Inequalities:
- Identify people or groups with poor outcomes and improve them
1. What is your overall priority?
Improve Air Quality

2. What is your aim?
- Reduce asthma and prevent respiratory disease in children
- Promote active travel to schools – walking, cycling, scooting, Park and Stride

3. Find out about health inequalities
Children in towns and cities, including areas of deprivation.
Children in cars where traffic is slow moving and air quality is very poor e.g. the school run

4. What will work?
Introduce and enforce “No Idling Zones” and “School Streets” outside schools and in congested areas to get drivers to turn off their vehicle engines.
Promote “WOW” in primary schools to encourage children to choose to walk, cycle, park and stride to school.

5. How will you know it has worked?
Monitor air quality and traffic flows.
Monitor uptake of WOW and School Streets projects and include feedback from children and parents
Monitor disease prevalence.

Example 2. Use Healthy Place Shaping to reduce the risk of respiratory disease
Priority: Loneliness and Social Isolation

Use the checklists to note what YOU and YOUR ORGANISATION can do to contribute to this priority.

Healthy Lifestyles
- Making Every Contact Count
- Promote Physical Activity
- Promote 5 ways to Wellbeing
- Access to information on local initiatives
- Employer support to workforce to prepare for retirement

Socio-economic factors / Built Environment
- Healthy Place Shaping
- Community activation
- Community asset based approaches
- Age Friendly communities
- Dementia Friendly communities
- Community Safety
- Co-production and community involvement
- Transport to help people be active and engaged

Healthcare and other services
- Social prescribing
- Befriending services
- Vibrant, proactive and well supported voluntary and community organisations
- Volunteering opportunities
- Support for Carers
- Appropriate digital services
- Intergenerational work
- Helping people be independent at home
- Accident prevention at home / Safe & Well

Tackle Health Inequalities:
- Identify people or groups with poor outcomes and improve them
**1. What is your overall priority?**
Promote the “5 Ways to Wellbeing” to reduce the risk of social isolation

**2. What is your aim?**
Focus on “Connect” to enable people to engage with others in their community

**3. Find out about health inequalities**
People moving into new houses on housing developments near to existing settlements. These houses may be released gradually and people move in a few at a time.

**4. What will work?**
Produce and hand out a “Welcome Pack” for all new householders, including details of local community facilities, clubs, services and activities and also how to volunteer or start something new.

**5. How will you know it has worked?**
Feedback from residents as they settle in.
Participation in local activities.

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**Example 3. Tackling the risk of social isolation**
Summary

• The Prevention Framework is an iterative document and we need to keep working on it. Feedback is welcomed and the Oxfordshire Wellbeing Network meeting will also contribute

• Targeting inequalities is at the heart of all this

• Each organisation has a role to play and can make a contribution to the bigger picture.

• There are (will be) named Prevention Champions in each organisation.

• We already have some ways of developing a coordinated approach
  • Some groups or working arrangements already exist e.g. on specific topics such as the Whole Systems Approach to Obesity; Active Oxfordshire, Alcohol Partnership; or in areas of inequality such as Stronger Communities in Oxford, Brighter Futures in Banbury.
  • New ways of coordinating other work may need to be started

• Measuring progress and the impact on narrowing health inequalities is essential