Gloucestershire Health and Wellbeing Board

Report Title	Finalisation of the Gloucestershire Health and Wellbeing Strategy
Item for decision or information?	Decision and information
Sponsor	Sarah Scott, Director of Public Health
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Organisation	Gloucestershire County Council
Key Issues:	
The Gloucestershire Joint Health and Wellbeing Strategy has previously been presented in draft form. This has now been amended to include options for incorporating climate change into the strategy. There is also the addition of paragraphs in the introduction to reflect the impact of COVID-19 on health inequalities.	
Recommendations to Board:	
• To review and agree the wording for the *Gloucestershire Joint Health and Wellbeing Strategy*	
Financial/Resource Implications:	
None identified	

Gloucestershire Joint Health and Wellbeing Strategy

The Gloucestershire Way

We know that connected and empowered communities are healthy communities. The assets within communities, such as the skills and knowledge, social networks and community organisations, are building blocks for good health.

As part of our commitment to improving health and wellbeing, we seek to develop our relationships and connections with communities and recognise local strengths. Often referred to as a 'strengths-based' or 'asset-based' approach, this requires a different way of thinking and different conversations. We have some excellent examples of where this already happens but we want to build on this.

The Gloucestershire Way will be to build a shared understanding and commitment to working in a strengths-based approach. This will be underpinned with a clear set of guiding values.

Through this shift in ways of working, we will build community strength and resilience with associated improvements in health and wellbeing.

Foreword

Under the Health and Social Care Act 2012, Health and Wellbeing Boards have a statutory duty to develop a Joint Health and Wellbeing Strategy. It requires the Local Authority and Clinical Commissioning Group (CCG) to work together to understand the health and wellbeing needs of their local community, and agree joint priorities for addressing these needs to improve health and wellbeing outcomes and reduce inequalities.

Gloucestershire is generally a healthy county, but that does not mean we should be complacent and there is a great deal of variation across the county. We know that not everyone experiences good health and wellbeing, and this is influenced by a wide range of factors. Evidence suggest that as little as 10% of someone's health and wellbeing is linked to health care – it's our environment, jobs, food, transport, housing, education, and our friends, families and local communities that affect our health and wellbeing most.

This Joint Health and Wellbeing Strategy provides an excellent opportunity to focus on those areas where a collective, system wide approach can help to improve the health and wellbeing of the population of Gloucestershire.

We recognise the significant work that is going on across our districts and networks, and across the range of organisations that operate within them, to maintain and improve the health and wellbeing of our populations. We also acknowledge the considerable work that is being carried out in partnership across the county of Gloucestershire, with many strategies and programmes driving this work forward. We look to build on that work through the systems leadership of the Health and Wellbeing Board. More recently our system has come

together to support our population and each during the outbreak of and recovery from Covid-19. We know that Covid-19 has caused health inequalities to widen and impact negatively on our local population. Therefore the role of the Health and Wellbeing Board and this strategy is key in leading the system in identifying and addressing these inequalities.

The strategy is not about taking action on everything at once, but about setting priorities for joint action and making a real impact on people's lives. It provides a focus and vision from which to plan ahead for the next ten years.

Chair of Gloucestershire Health and Wellbeing Board

Introduction

Our population in Gloucestershire was estimated to be around 637,070 in 2019, representing a rise of approximately 3,512 people since 2018. The health of people in the county is generally better than the England average. Gloucestershire is among the 20% least deprived local authorities in England. Life expectancy for both men and women is higher than the England average.

However, there are notable variations across the county, from rural communities to urban towns. Notably, good health and wellbeing is not evenly distributed across the county and pockets of deprivation do exist particularly in the main urban areas and in some of the market towns. Life expectancy is 8.4 years lower for men and 5.4 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

There was considerable variation in age structure at district level. The proportion of 0-19 year olds is highest in Gloucester and exceeds the national figure for this age group. The proportion of 20-64 year olds is highest in Cheltenham and Gloucester. The Cotswolds, Forest of Dean, Stroud and Tewkesbury all have a higher proportion of people aged 65 and over when compared with the national figure.

Children from poorer backgrounds are more at risk of poorer health outcomes. The level of child poverty is better than the England average with 14.4% of children aged under 16 years living in poverty.

With a large rural geography, transport is a vital factor in accessing services. 40,000 households in Gloucestershire do not own a car or van, making public transport essential to accessing public services. Gloucestershire's Accessibility Matrix shows that in 24 Lower Super Output Areas it is at least a 45 minute walk or public transport journey to a GP.

Housing is unaffordable for those on low incomes in the county with the ratio of house prices to wages being higher in each of the districts compared with the national average, except for Gloucester. Gloucestershire's first Joint Health and Wellbeing Strategy, *Fit for the Future*, was published in 2013. It focused on five objectives with a plan for each in the form of action cards.

The Health and Wellbeing Board has evolved considerably since then. It has undertaken a series of development sessions and formed new ways of working. This has been tested through two key areas; our work on self harm and on Adverse Childhood Experiences (ACEs).

The Local Government Association Prevention System Peer Challenge in February 2018 made nine key recommendations. Alongside the need to refresh the Joint Health and Wellbeing Strategy with greater community input, the recommendations also included the need to set out a fuller vision for health and wellbeing, define 'prevention' clearly, include the wider determinants of health, and make greater use of the voluntary and community sector to provide community insight. This strategy articulates the Health and Wellbeing Board's response to the Prevention System Peer Challenge and sets out a clear vision and priorities.

This strategy has clear links with the approach of the Safer Gloucestershire strategy. Safer Gloucestershire aims to ensure a coherent, strategic approach to the delivery of community safety activity in Gloucestershire. Together with this Joint Health and Wellbeing Strategy this provides a county wide framework for achieving the Vision 2050 ambition of a *'happy, healthy and safe'* Gloucestershire.

Addressing health inequalities

It is important to form a shared understanding about health inequalities across our system. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They do not occur randomly but are largely socially determined by factors beyond the individual's control. These conditions influence our opportunities for good health.

The COVID-19 pandemic brought health inequalities into sharp focus. Pandemics rarely affect all people in a uniform way and emerging national research indicates that the virus is having a disproportionate effect on people from BAME backgrounds and those living in deprived areas, exacerbating existing inequalities and creating new ones.

A PHE review into the disparities in the risk and outcomes from COVID-19 found that mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared to White British.

These analyses did not account for the effect of occupation, comorbidities or obesity which may explain some of the disparity. However, a higher prevalence of obesity, comorbidities, and higher-risk occupations among the most deprived and BAME populations is itself a health inequality issue.

The negative impacts of the lockdown and social distancing measures to control the spread of COVID-19 have been borne disproportionately by those already experiencing inequality. The social and economic impact of the virus and lockdown measures has exposed people on low incomes to greater risk of physical and mental ill-health.

It is clearer than ever that action is needed to improve the lives of those at risk of worse health outcomes in the immediate and long term. This means setting out system wide objectives and measures for improving the health and wellbeing of these groups and working with communities to narrow the health gap.

We know that the social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves and our families collectively have a bigger impact on our health than healthcare alone. However, these conditions are not fixed, but are amenable to change through interventions which address:

- **risk and protective (lifestyle) factors** such as smoking, diet and physical activity,
- **addressing unwarranted variation** in access, experience and outcomes from treatment and care in conditions such as cancer, mental health, cardio-vascular disease (CVD), respiratory disease and diabetes,
- the **wider determinants** of health,
- the **gap in health access and outcomes** experienced between the least and most deprived populations, and other population groups such as inclusion health and protected characteristic groups most likely to experience health inequalities.

2. Systems leadership approach

Health and wellbeing depend on a complex interplay of factors. There is no single intervention or single organisation that in isolation can guarantee good population health and wellbeing. Our systems to support health and wellbeing are complex, therefore we need an approach that recognises this complexity and seeks to influence across the whole system.

Crucially, it recognises the priorities and work of the other system 'players'. Working together enables the systems to move forward together rather than separately and create more impactful change.

Vision 2050

The intention of Gloucestershire Vision 2050 is to set ideas that collectively can transform the county for tomorrow while embracing, retaining, and nurturing the values and assets that are the central strengths of Gloucestershire today. It sets out ambitions for achieving this. One of the ambitions is:

"A healthy, happy and safe county."

This Joint Health and Wellbeing Strategy provides a clear mechanism for being able to deliver the 'healthy, happy' element.

Integrated Care System and the NHS Long-Term Plan

In 2016, NHS organisations and local councils came together to form 44 Sustainability and Transformation Partnerships (STPs) covering the whole of England, and set out their proposals to improve health and care for patients. Gloucestershire has evolved to form an Integrated Care System (ICS), a new type of even closer collaboration. In an Integrated Care System, NHS organisations, in partnership with local councils and others, take collective

responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

The NHS Long-Term Plan sets out key ambitions for the NHS over the next 10 years. The plan signals a clear focus on prevention, recognising that the NHS can take important action to complement the role of local authorities and the contribution of government, communities, industry and individuals.

The plan includes the commitment to a renewed NHS prevention programme. The Integrated Care System will have a key role in helping to deliver this. The Prevention and Inequalities Framework (which is in response to the Long-Term Plan) and this strategy are closely linked.

3. Developing the Joint Health and Wellbeing Strategy

This strategy has been developed through the Health and Wellbeing Board engaging with wider stakeholders, including our communities.

Engaging communities

Engaging with the public and listening to their views about health and wellbeing has been an essential part of developing the strategy. There have been four main stages to this.

Stage 1: Understanding the landscape

There has been a wealth of previous engagement and consultation about health and wellbeing with various populations within Gloucestershire. Findings from a wide range of these were assessed to help build an understanding about what people have already told us. Mental health, loneliness and social and community connections were key themes.

Stage 2: Informing the priority setting

Through workshops and structured interviews, we encouraged residents to consider their top three priorities in maintaining positive health and wellbeing. This helped to inform the priority setting process.

Stage 3: Developing a better understanding of the priorities

This was an opportunity to feed back to communities the priorities that had been chosen and start to understand some more detail about how they viewed these priorities. This gave us better insight into what people view are the strengths and opportunities around the priorities and some examples of positive practice.

Stage 4: Have we got it right?

This final stage involves more engagement to check that the strategy reflects what we have heard throughout the earlier stages.

Priority setting process

The community and wider stakeholder engagement helped to form a list of eleven potential themes for the Health and Wellbeing Board to then prioritise. In addition to these, 'adverse childhood experiences (ACEs)' and 'early years' were added to the list since ACEs is an area in which the Board have recently taken a leadership role in and early years was a cross cutting theme running through many of the community engagement workshops. The Health and Wellbeing Board went through a process of prioritisation taking into account need, impact, effectiveness, inequalities and acceptability. As part of the 'acceptability' criteria, the community and other stakeholder feedback was taken into account as well as a consideration of where the Health and Wellbeing Board could add value. These acceptability considerations carried a heavy weighting in the priority setting process.

4. Our vision

'Gloucestershire is a place where everyone can live well, be healthy and thrive'

5. Our priorities

We have seven Health and Wellbeing Board priorities.

- Physical activity
- Adverse childhood experiences (ACEs) and resilience
- Mental wellbeing
- Social isolation and loneliness
- Healthy lifestyles
- Best start in life
- Housing

Tackling social isolation and loneliness is a shared priority between the Health and Wellbeing Board and Safer Gloucestershire. Each of the seven priorities is at a different stage of development. It is important that the emphasis is maintained on where the Health and Wellbeing Board can truly add value.

The focus needs to be on what it is we can only tackle in partnership. It is important to recognise the need for local areas to be able to adopt bespoke approaches to how they approach the seven priorities.

The Health and Wellbeing Board will maintain a watching brief over the wider health and wellbeing agenda. In addition, it will develop a position statement on economic development, climate change, green infrastructure and transport to recognise the importance of these to health and wellbeing.

Climate change

In May 2019, Parliament declared a climate emergency and government amended the Climate Change Act 2008 for the UK to be carbon neutral by 2050, with an interim target of a 57% reduction in carbon emissions by 2030. All Gloucestershire councils have now declared a climate emergency.

We are now experiencing climate change at a rate that is completely unprecedented, and is likely to accelerate further. This is already impacting on human health, and will certainly have greater impact in the future through the following pathways:

1. through the direct effects of weather, in particular extreme weather events;
2. effects mediated by natural systems such as changing distribution of disease vectors;
3. Effects mediated by social systems such as malnutrition, violence or mass refugee flows.

Action on climate change is evident through local examples such as Carbon Neutral 2030, Gloucestershire County Council Climate Change Strategy, Gloucestershire Local Nature Partnership activity, Gloucestershire Sustainable Energy Strategy, Local Transport Plan and Gloucestershire Air Quality and Health Strategy.

The Health and Wellbeing Board will develop a position statement to recognise the links between climate change with health and wellbeing.

Transport

40,000 households in Gloucestershire do not own a car or van, making public transport essential to accessing public services. Rural communities often have limited access to public transport.

The 2017 Community Survey linked transport and loneliness. Respondents who have a car as their main form of transport were the least likely key group to feel lonely. Consideration to this will be linked to the work on the social isolation and loneliness priority. The Health and Wellbeing Board will develop a position statement on transport and health identifying key systems levers.

Green infrastructure

Green infrastructure is intrinsically linked with the seven Health and Wellbeing Board priorities especially those such as housing or physical activity. The priorities are focused on where the Health and Wellbeing Board can add the greatest value, acknowledging the excellent work already in place and being led across the county on many of the other determinants of health. Health and Wellbeing Board will form a position statement around green infrastructure to highlight links with the priorities and the commitment to the Gloucestershire Green Infrastructure Pledge
https://www.gloucestershirenature.org.uk/green-infrastructure-pledge

Economic development

Economic prosperity (including educational attainment, employment and financial security) and its health benefits are well understood. Figures from the ONS covering July 2017 to June 2018 state that 8,700 people (2.6%) are unemployed in Gloucestershire. 62,000 (16.4%) are economically inactive, including students, retired, those looking after a home, and the temporary and long-term sick. One in five of the economically inactive would like a job.

There is the opportunity for the Health and Wellbeing Board to link with the development of the Local Industrial Strategy to identify key objectives that overlap with economic development and health. Again, the Health and Wellbeing Board will develop a position statement for this area.

6. Understanding the priorities

Priority 1: Physical activity

Increasing physical activity has the potential to improve the physical and also mental health and wellbeing of individuals, families, communities and the county as a whole. Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths globally. In the general population of England, physical inactivity is higher in more deprived local areas and has large education and income gradients. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer, and with improved mental health.

Where are we now?

• People in the UK are around 20% less active now than in the 1960s. If current trends continue, we will be 35% less active by 2030.
• Nearly one in five adults in Gloucestershire are inactive (less than 30 minutes of activity a week).

Where do we want to be?

• The national recommendation is for adults to aim to take part in at least 150 minutes of moderate intensity physical activity each week, in bouts of 10 minutes or more.
• Moderate intensity physical activities, such as brisk walking or cycling, cause adults to get warmer and breathe harder and their hearts to beat faster, but they can still carry on a conversation.
• We want to get 30,000 inactive people in Gloucestershire active and to make being physically active the social norm.

How will we get there?

• For every individual the specific opportunities and barriers to being more active will vary.
• A traditional delivery model with specific interventions to get people active is highly unlikely to have a lasting impact on behaviour on its own.
• Using a whole system, behaviour-change approach to get the least active people in the county moving.
• This will be delivered through We Can Move which is facilitated by Active Gloucestershire and has been developed through extensive research and consultation.
• A theory of change approach will be used.
• The approach recognises that many factors influence attitudes and behaviours. For example the personal (e.g. self-confidence, experience, the social norms within an individual's family, friends and close community), infrastructure including the built and natural

environment (e.g. existence and maintenance of cycle lanes, sports facilities, clubs) and education (e.g. understanding of what's involved) - collectively a set of interlocking 'systems'.

How will this be delivered and monitored?
The We Can Move steering group provides the strategic direction, monitoring and evaluation for delivering this approach to improving physical activity and will report to the Health and Wellbeing Board.

Spotlight on: How the system works together at a local level to deliver change in level of physical activity
Under We Can Move, one of the campaigns is to prevent falls in older adults. The campaign focuses on behaviour intervention (strength and balance exercises). It first involved understanding the impact of current falls prevention interventions. Over 20 stakeholders and 100 older adults in the county were contacted as part of the research. The findings highlighted the lack of awareness of risk factors, difficulties accessing interventions and a need for simplified health style messages that were relatable.

The findings also amplified the need for a social movement due to the importance of peer to peer influence - a network of people who will spread guidance and motivate people to either start strength and balance exercises at home or join a class. We Can Move has embarked on a programme of recruiting this network through existing community groups, coffee mornings and lunch clubs, who will promote the exercises and distribute the material.

The marketing campaign was tested with a network of stakeholders including older adults in the community, professionals, as well as local governing bodies. The final version of the campaign will be promoted through We Can Move partnership with the Clinical Commissioning Group (CCG), Gloucestershire County Council, and community networks. It is anticipated to reach 175 groups locally and 30,000 people over the age of 65.

Priority 2: Adverse childhood experiences (ACEs) and resilience

What are ACEs?
ACEs are specified traumatic events occurring before the age of 18 years. High or frequent exposure to ACEs, without the support of a trusted adult can lead to toxic stress. There is a large body of evidence that shows the adversity we experience as children can affect us into adulthood.

Developing resilience through access to a trusted adult in childhood, supportive friends, positive attachments and being engaged in community activities has been shown to improve outcomes even in those who experience high levels of ACEs. This relies on active, thriving, and resilient communities.

Where are we now?
ACEs are prevalent across the population and recent studies have shown that nearly half of people in England experience at least one ACE, with around 9% experiencing four or more ACEs.

Where do we want to be?

Our vision is a resilient Gloucestershire where communities and organisations are acting on ACEs. We want to build communities and organisations that are aware of, able to talk about and take action on ACEs and resilience. We will build a social movement that recognises the potential lifelong impacts of adversity in childhood and takes action to stop childhood harm.

How will we get there?

We will deliver this through the Gloucestershire ACEs Strategy. The concept of 'viral change' has been used to establish a network of ACEs Ambassadors, effectively mobilising people across the county to implement the ACEs Strategy.

Our strategic objectives are to:

- Raise awareness and understanding of ACEs and resilience with communities and organisations through the delivery of a co-ordinated local campaign.
- Implement training to equip communities and organisations to respond appropriately to ACEs.
- Continue our partnership work with communities and organisations to build resilience through encouraging trusted relationships and developing core life skills.
- Develop relevant resources and information for people identified with ACEs who need signposting to further sources of support.
- Increase our understanding of the distribution of ACEs across Gloucestershire.
- Incorporate ACEs informed approaches into relevant organisational policies, strategies and contracts.
- Evaluate interventions and share good practice and positive outcomes from ACEs work across Gloucestershire, the South West and beyond.

How will this be delivered and monitored?

Gloucestershire ACEs Panel leads on the ACEs Strategy and reports to the Health and Wellbeing Board. Further information is available at www.actionaces.org

The ACEs Strategy explicitly acknowledges the vital role of communities in taking action on ACEs and building resilience; agencies cannot do this work alone. Two community pilots are being developed in Gloucester and Cheltenham. These pilots will provide valuable information through testing out different approaches to building resilient communities acting on ACEs. Early results are encouraging, with a high level engagement from extended families and increased trust and relationship building.

For example, one parent was having escalating problems with their personal situation and that of their children, as well as problems maintaining their property. Via personal support, trust has been established and the parent is now engaged in community activities. They have grown massively in confidence and self-esteem, regularly attend family support sessions and have started volunteering.

Priority 3: Mental wellbeing

Mental health and wellbeing are affected by individual factors, by population characteristics and by socio-economic circumstances. There is evidence to show that poor mental health is

both a cause and a consequence of social, economic and environmental inequalities. Mental health problems are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education and low income or material standard of living, in addition to poor physical health. Most of these risk factors not only contribute to poor mental health but are also often the outcomes of poor mental health, i.e. social isolation can contribute to poor mental health but equally poor mental health can contribute to social isolation.
A focus on mental wellbeing is a vital component of the work our whole system does to improve the health, wellbeing and quality of life of our population.

Where are we now?

• Anyone can be affected by poor mental health at any point in their lives.
• One in four adults experience at least one diagnosable mental health problem in any given year.
• The national mental wellbeing survey measures people's outlook on life satisfaction, feeling worthwhile, happy and anxious. For Gloucestershire, approximately one in five people have high self-reported anxiety scores.
• There are already some good examples of practice in Gloucestershire such as the mental health trailblazer working to integrate mental health support teams into schools and offer earlier intervention for CYP when worries arise.

Where do we want to be?

The ambition is for every resident of Gloucestershire to enjoy the best possible mental health and wellbeing throughout the course of their life.

How will we get there?

We will promote mental wellbeing and prevent mental illness across the lifetime through:
• Promoting good mental health and wellbeing from the earliest age.
• Gloucestershire Wellbeing (GloW) and the Gloucestershire commitment to promoting mental wellbeing through organisations and employers.
• Helping people build the Five Ways to Wellbeing into their everyday lives.
• Preventing suicide and self-harm.
• Creating and sustaining the conditions for good mental wellbeing.

How will this be delivered and monitored?

The Gloucestershire Mental Health and Wellbeing Partnership Board will continue to lead and co-ordinate the delivery of this priority.

Spotlight on: GloW and the Gloucestershire Commitment

Led by the Gloucestershire Health and Wellbeing Board, GloW has been launched as a commitment to taking positive action to improve mental wellbeing for everyone in Gloucestershire.

The aim of the campaign is to increase focus on the contributing factors to mental wellbeing and help organisations and communities recognise where they can make improvements that have a positive impact on our day-to-day wellbeing. By looking to make a difference to

these, we are able to improve the mental wellbeing of Gloucestershire residents, and prevent mental illness in the future.

When we focus on the factors that affect our wellbeing day-to-day, we are in a better position to keep ourselves well and less likely to hit crisis point. At the heart of GloW is the Gloucestershire Commitment, signed by organisations in the public, private and voluntary sectors who want to pledge to be a part of the movement.

This is based on the national Prevention Concordat for Better Mental Health, led by Public Health England – www.gov.uk/government/collections/prevention-concordat-for-better-mentalhealth

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The wide range of partners who have already signed the Gloucestershire Commitment can be seen at www.gloucestershire.gov.uk/glow.

Priority 4: Social isolation and loneliness

Loneliness and isolation are not the same thing. Social isolation is defined as 'an objective state determined by the quantity of social relationships and contacts between individuals, across groups and communities'. Meanwhile loneliness is defined as 'a subjective state based on a person's emotional perception of the number and/or quality of social connections they need compared to what is currently being experienced'. Therefore, it is possible for an individual to be socially isolated without feeling lonely, or conversely feel lonely without being socially isolated.

There is a growing body of research that identifies and quantifies the impact of social isolation and loneliness on individuals and the wider economy. There is clear evidence that social isolation and loneliness are associated with negative health outcomes, which in turn places increased stress on local health and social care services.

Where are we now?

• One in two adult social care users in Gloucestershire have as much social contact as they would like.

• Only one in four (28.5%) of adult carers in Gloucestershire have as much social contact as they would like.

• The Community Wellbeing Survey carried out in July 2017 reported '38% of all respondents feel lonely at times, and loneliness is highest in those with a mental health issue, a long term illness and/or a learning disability. Those with a car as their main form of transport considered themselves less lonely'. However, this was based on a small sample of 606 respondents.

- The links to transport in our rural communities can be a contributing factor to social isolation.

Where do we want to be?

The ambition is to reduce social isolation and loneliness, and enable local people to take an active role in building and nurturing strong social networks and vibrant communities.

How will we get there?

This is a priority that requires a fuller understanding of where the focus is needed. The Health and Wellbeing Board requested a deep dive into this priority, which helped to identify actions.

The Enabling Active Communities Group undertook the deep dive with a number of structured interviews with a wide cross section of individuals, community groups, voluntary and statutory organisations across the county. Based on the feedback received to date, the approach to tackling social isolation and loneliness can be grouped into the following areas of focus:

- Create face-to-face opportunities for people to network, including intergenerational opportunities.
- Recognise and optimise the importance of friends, family and partners.
- Support/empower vulnerable people to join social groups, initially through one to one support.
- Encouraging people to make the time to get to know their neighbours through the creation of community events and welcome packs for new people moving into the area.
- Make more use of the resources around us, i.e. spaces and benches.
- Active design for new housing developments.
- Well designed places and high-quality green spaces where communities can gather can help tackle social isolation and draw people together.
- Creating the conditions for and supporting individuals and communities to solve problems and do more for themselves.
- Adopt an strengths based approach in all we do. How will this be delivered and monitored?
- This is a shared priority between the Health and Wellbeing Board, Safer Gloucestershire and Enabling Active Communities. This is a good example of where districts will work in different ways; but will be able to measure and feedback on activity, outputs and outcomes.

Spotlight on: Wye Valley Area of Outstanding Natural Beauty (AONB) MindSCAPE Project

MindSCAPE was a Wye Valley AONB project, funded by the Big Lottery Fund and delivered by Artspace Cinderford in partnership with the Forest of Dean District Council and Forestry Commission. The project was aimed at improving the mental and physical health of people diagnosed with early onset dementia and their carers. It aimed to reduce social isolation and help them to reconnect with the natural environment.

Fortnightly sessions included activities to engage participants with the outdoors and the natural environment. Training for professionals and family carers was also delivered, enabling people to feel confident carrying out MindSCAPE type activities independently in their own setting. The project contributed towards the Forest of Dean becoming a ‘dementia friendly’ community and has, in partnership with the Forest of Dean District Council and the Gloucestershire County Council Dementia Education Team, trained a team of voluntary ‘dementia champions’.

Over four years there were 96 sessions delivered to 55 participants (29 carers, 26 people with dementia). The combination of arts and the environment is one that isn't otherwise available to this hard to reach and often isolated group, and it has proved hugely rewarding. The creative and relaxed atmosphere in sessions provided participants with a wonderful experience, which they enthusiastically attended on a regular basis. Since the end of BIG Lottery funding, the MindSCAPE group now forms part of the Branching Out project led by Artspace Cinderford and funded by the Arts Council England.

Priority 5: Healthy lifestyles

Collectively it is estimated that 'lifestyle factors' are responsible for 25% of overall health outcomes. Key lifestyle factors include things like diet and physical activity, maintaining a healthy weight, smoking, alcohol consumption and drug use.

From the Health and Wellbeing Board's perspective, the focus needs to be on where programmes require transformative co-ordinated action across a broad range of stakeholders to have impact at a population level. For this priority, initially the Health and Wellbeing Board will focus on healthy weight. Obesity reduces life expectancy by an average of three years, while severe obesity reduces it by eight years. People living with obesity are at increased risk of a range of health issues, including diabetes, heart disease, stroke, cancer, mental ill-health and musculoskeletal problems. Obesity is a health inequalities issue with children living in the most deprived parts of the county being twice as likely to be affected as those living in the least deprived areas.

Where are we now?

- Two thirds of adults in Gloucestershire are overweight and of these approximately 120,000 are living with obesity.
- One in ten (9.9%) 4-5 year olds and nearly one in five (17.8%) 10-11 year olds in Gloucestershire are living with obesity.
- Gloucester City has the highest level of childhood obesity in the South West region (21.2% of 10-11 year olds compared to 16.8% regionally). Of particular concern are escalating levels of severe obesity affecting 5% of 10-11 year olds in Gloucester (compared to 4.2% nationally).
- There are clear inequalities in childhood obesity with higher rates in the most deprived areas. In 2016/17 25.7% of pupils living in the most deprived decile are likely to be obese in Year 6, this compares to 11.2% of pupils living in the least deprived decile.

Where do we want to be?

In line with the national ambition for reducing childhood obesity we will aim to halve the level of childhood obesity among children living in Gloucestershire, and to significantly reduce the gap in the obesity rate between children living in the most and least deprived parts of the county by 2030.

How will we get there?

Traditional approaches focusing on specific interventions to encourage people to alter their eating and physical activity habits are unlikely to reduce childhood obesity at a population level.

Emerging evidence suggests that whole systems approaches, involving a range of joined up actions to address the social, economic and environmental factors affecting eating and physical activity behaviours can be effective.

Evidence on how to operationalise such an approach is still in its infancy. For this reason we will adopt a 'test and learn' approach to shape our local programme. This will include action to:

• Prevent excess weight gain by: creating healthier physical activity and food environments.
• Working with communities, and with Gloucestershire Moves to understand and shift social norms around eating and physical activity.
• Equip those already affected by obesity with skills for sustainable weight loss.

How will this be delivered and monitored?

The healthy weight programme and governance arrangements are being reviewed to include wider representation, and a balanced scorecard and learning framework are being developed. This will link to key areas of work including Gloucestershire Moves, and the service development work being delivered through the Adult Weight Management Board.

Spotlight on: Podsmead Food and Families Project

Community based insight research was conducted in Podsmead and led by HealthWatch during 2018 to understand the factors affecting residents' eating patterns, and their ideas and aspirations around food. A localised 'food system map' has been developed using this insight. This will help to guide local action.

A follow up Food and Families Community Fun Day will be used to scope the skills and experiences of residents on the estate and support the community to enact the improvement ideas put forward last year. This will also seek to identify where support from other partners is needed, for example, in influencing local policy decisions affecting the food environment. A community network will be established to support delivery and capture evidence of impact and wider learning.

Priority 6: Early years and best start in life

Early years describes the journey from pregnancy to an aged 5 child. This life stage, and particularly the first 1,001 days, is accepted to be the most significant in a child's development in influencing their future health, emotional and social wellbeing than any other time in their life.

Where are we now?

On average, there are around 6,700 live births per year in our county. Gloucestershire is set to see an increase in the population aged 0-19 between 2017 and 2021 of 5.4% (7,508 children) with a disproportionate increase in children aged 0-4 years.

- Around one in ten (10.9%) women in Gloucestershire are recorded as smokers when their baby is born.
- Over three quarters of women in Gloucestershire (77%) initiate breastfeeding, although this figure has remained fairly static.

- Less than three quarters (69.2%) of children in Gloucestershire have achieved a good level of development by the end of reception. This is worse than the national average.
- There are clear inequalities in school readiness (good level of development) with 48.9% of pupils with free school meal status achieving a good level of development at the end of reception, this was significantly lower than the average for all pupils.

Where do we want to be?

The ambition is for every resident in Gloucestershire to have the best start in life.

How will we get there?

The key areas of focus include:

- Attachment and responsive parenting
- Childhood poverty
- Healthy lifestyles including oral health
- Childhood immunisations in 0-5 year olds
- School readiness (with a focus on those in receipt of free school meals)
- Vulnerable children
- Breastfeeding
- Smoking in pregnancy and early years
- ACEs

How will this be delivered and monitored?

There is currently no single overarching partnership in Gloucestershire for a co-ordinated approach to achieving this ambition. Further work is required to scope this Health and Wellbeing Board priority and to understand where the Board can add the greatest value. This is a partnership agenda that will need to work with an existing and emerging structure of work programmes and governance, which includes:

- Better Births
- Children and Families Partnership Framework
- Children's Improvement Plan
- Safeguarding Children and the new Working Together guidance
- Child Friendly Gloucestershire
- Mental Health Trailblazer Pilot
- ACEs Partnership

The aim is to achieve better continuity, integration, efficiency, reduced duplication and ultimately improved outcomes.

Spotlight on: Better births

Gloucestershire Local Maternity System (LMS) brings together clinicians and provider organisations, commissioners and service users from across the Integrated Care System Network to plan and deliver maternity and early years care. In response to the National Maternity Review, this delivers our Better Births Maternity Transformation Plan. Some of the successes to date include:

• Redesigning the antenatal education offer to ensure that it meets the needs of women, is based on evidence and includes an integrated approach with the Health Visiting Service so women and families receive continuity of care.

• Piloting of a multi-professional integrated postnatal pathway to ensure that women and families receive a more joined up approach to care between health visiting and maternity services.
• Developing services so that more women have access to the same team of midwives throughout their journey through pregnancy, birth and the early years. This model has been shown to improve a number of outcomes.
• Set up a Maternity Voices Partnership to ensure that the voice of women is embedded in continual service improvement.
• Keeping more mums and babies together in the postnatal period, providing alternative safe options of care avoiding admissions of babies to the neonatal unit.
• Developing a system wide Safety Improvement Plan to deliver high quality care to every woman and family.

Spotlight on: A district level approach - No Child Left Behind

Cheltenham partners recently commissioned a needs assessment that highlighted the extent of child poverty in the town. The assessment told us that 4,300 children and young people are growing up in poverty and that those children, when compared to their more affluent peers are then facing significant challenges such as poorer education attainment, higher rates of exclusion, higher risk of being victims of crime, higher risk of being obese, higher risk of being open to social care, higher risk of self-harm.

In response to the needs assessment, Cheltenham Borough Council and its partners committed to a year of action, called No Child Left Behind, that is:
• Highlighting the issue of children growing up in poverty in Cheltenham and the inequality between them and their more affluent peers.
• Starting to address the inequality gap beginning with a 12 month programme of events and activities.
• A call to action for all sectors to work together to make transformational change over the longer-term.
Partners have looked at the main issues associated with child poverty and devised a year of themed action. Each month focuses on a key area with events, activities and campaigns to engage young people, strengthen communities and help people to understand what they can do if they are experiencing difficulties. Examples of the themes include:
• #OurTown – activity included over 100 people attending a local poverty summit.
• #PositiveRelationships – during this campaign month a series of training and awareness raising sessions were provided for 85 professionals and teachers on how to support young people experiencing domestic abuse.
• #StrongFamilies – a screening of the ground-breaking documentary ‘Resilience: The biology of stress & the science of hope’ to 200 professionals and a plan to relaunch the Inspiring Families project.

Priority 7: Housing and health

The age, condition and affordability of housing have a number of health consequences relating to overcrowding, fuel poverty and excessive cold, respiratory problems, and emotional wellbeing. Poor housing has an impact on the health outcomes for children and older people in particular, including psychological distress and mental disorders, with people

in crowded conditions tending to suffer from multiple deprivation. People who do not have access to affordable housing and may be homeless or at risk of homelessness are more likely to experience worse health outcomes than the general population.

Where are we now?

The ratio of house prices to earnings in 2015 was higher than the national average in every district except Gloucester, indicating that houses are unaffordable for residents on lower incomes. Average rental costs are in line with the regional average but there are wide variations across the county.

The Index of Multiple Deprivation (IMD) in 2015 listed 33 areas in Gloucestershire in the most deprived 10% nationally for 'Barriers to Housing and Services'. The housing aspect of this indicator measures household overcrowding, homelessness, and housing affordability. This accounts for 9.9% of the population in the county.

The IMD also assesses 'Living Environment' deprivation, which includes indoor living environment, housing in poor condition, and houses without central heating. There are 17 areas of Gloucestershire in the 10% most deprived nationally in this domain which accounts for 28,126 people (4.6%).

Where do we want to be?

We want to ensure health and wellbeing are promoted through improvements in the quality, affordability, availability, and suitability of housing. This is all through a partnership approach. Further work is needed to understand what the one or two main housing objectives under this priority should be and where the Health and Wellbeing Board can add the greatest value.

How will we get there?

Subject to further scoping, the main areas could include:

- Housing design and quality
- Housing conditions
- Homelessness and housing for those in vulnerable circumstances
- Housing with care
- Intergenerational living
- Surrounding physical infrastructure
- Surrounding community infrastructure

How will this be delivered and monitored?

There is no one single board which addresses housing and health at a county wide level. Relevant groups and boards include:

- Strategic Housing Programme Board
- Gloucestershire Strategic Housing Group/Strategic Directors
- Gloucestershire Economic Growth Joint Committee
- Joint Core Strategy Planning Delivery Group
- County Planners Group
- County Homelessness Implementation Group (CHIG)

Housing is also linked to the Vision 2050 Boards: Central Gloucestershire Growth Board,

Central Gloucestershire City Region Board, Severn Vale Board and Rural Ambition Board. This list is by no means exhaustive and it does not reflect district level boards. Further work is being undertaken to scope out this priority and fully understand where the Health and Wellbeing Board can most add value to improving housing and health.

Spotlight on: Healthy homes Initiative

The joint housing action plan has provided funding for a number of initiatives to improve people's health and wellbeing. One of these projects is the Citizens Advice Bureau healthy homes team. They can take referrals from health teams who have identified people whose home environment is having a negative impact on their health. Self-referral is also possible as is referral from other statutory and voluntary organisations. Comprehensive benefits advice is provided and, where appropriate, people can be referred in to Warm and Well for energy efficiency improvements or heating systems. They will also be signposted to other support services where appropriate.

This case features a woman aged 75 diagnosed with cancer and undergoing chemotherapy. She was referred to the Citizens Advice Bureau healthy homes team by the cancer support team. She was living on her own, she was very concerned about her health and her mental health was suffering as a result. In her baseline assessment she reported 8/10 for feeling anxious and 3/10 for feeling worthwhile. The caseworker supported her around her finances and identified benefits that she was eligible for but not currently receiving. She was also referred to the Warm and Well service and a grant was provided so her boiler could be replaced. This not only saved her money but improved her home environment and reduced her risk of illness linked to her vulnerable condition following her treatment. A follow up assessment recorded 5/10 for anxiety and 6/10 for feeling worthwhile alongside the expected health benefits of having a warmer home.

7. Our approach to delivering the strategy

To deliver the priorities, we have considered some Health and Wellbeing Board principles for ways of working:

Principles for ways of working

• **A systems leader:** The Health and Wellbeing Board will take a position as a systems leader to enable and facilitate change to improve population health and wellbeing.
• **Prevention focused:** Developing a system wide shared understanding and commitment to prevention and early intervention.
• **Collaborative and community centred:** Taking a strengths based, community centred approach. Ensuring a collaborative approach engaging communities in ongoing conversations about the health and wellbeing priorities, assets and how we measure success.
• **Holistic:** Taking a whole person, whole life, whole population and environment approach to prevention based on 'what matters to you' conversations.
• **Equally valuing physical and mental health:** Ensuring equality in how we think about mental health and physical health and how they are valued.

• **Tackling health inequalities:** Developing shared understanding and commitment to addressing the unfair differences in health status that exist between people due to social, geographical, biological or other factors.
• **Addressing the wider determinants of health and wellbeing:**
Recognising that many poor outcomes in health and wellbeing result from a complex interaction and accumulation of factors and poor life chances over time.
• **Recognising where we add value:** Focusing on actions where by working together we can make the biggest difference to those in the greatest need. Developing a place based approach is a key way of putting into operation the overall vision for health and wellbeing. This strategy gives an overarching set of priorities but recognises the need for a flexible approach to delivery to reflect the differences at local, community levels.

A shared understanding of prevention

The Health and Wellbeing Board has a key role in ensuring that there is a sustained focus on embedding prevention across the health and social care system, taking a place-based approach (looking at communities and neighbourhoods) that goes beyond just thinking about what public sector services provide.

The Local Government Association Peer Challenge recommended that a clear and consistent definition of 'prevention' should be developed, owned and used by all partners. Prevention means different things to different people. The framework of primary, secondary and tertiary prevention is useful for helping to define what we mean by prevention: IMAGE

At a population level, health and wellbeing improvement opportunities that look to prevent the need for treatment services are more cost effective than treating people once they get ill.

Addressing health inequalities

Tackling poverty and inequality is a theme running across all of our health and wellbeing priorities. In line with the NHS Long-Term Plan, we are committed to a more concerted and systematic approach to reducing health inequalities. We remain dedicated to improving outcomes for all, but for those in the worst position fastest.

We recognise that inequalities can be identified according to where people live. This is particularly true in some areas where there are high levels of deprivation and need but there are also inequalities between genders, ethnicities, ages and abilities that we need to tackle. We will take an evidence based approach to reducing health inequalities through our work on each of the priorities.

Our approach to addressing health inequalities

System wide action: Addressing health inequalities is not about single initiatives. It needs to be central to everything we do and therefore is the 'golden thread' through the delivery of this strategy. It requires a whole systems approach, recognising the complexity of the issue.

Intelligence driven and evidence based: We will continue to use the available data and intelligence sources such as IAF indicator 106a and Outcome Framework Indicators, to understand our baseline and set trajectories. However, we need to better understand what is

driving health inequalities. Using Population Health Management, we will continue to develop our local understanding.

We will use the 'Menu of Evidence Based Interventions for Addressing Health Inequalities' to inform our approach.

Community centered / Strengths based: Fundamental to addressing health inequalities, is the strengths based approach. Gloucestershire already has some excellent examples of working in this way but will continue to develop this through the development of The Gloucestershire Way.

Place based: Place based working provides an excellent foundation for addressing health inequalities in our local areas. The recently published PHE/LGA/ADPH guidance on 'Place Based Approaches for Reducing Health Inequalities' will be used to inform the local approach and plans. The Population Intervention Triangle provides a framework for action and will be used as a tool locally.

Proportionate universalism: The concept of applying proportion universalism is a key principle ensuring that universal services are offered with added intensive support for vulnerable groups. This is effective at reaching all of those that need them by ensuring that there are fewer or no barriers.

Working with adults with complex lives

We recognise that some adults in vulnerable circumstances frequently come into contact with many different services including health and social care, community and accommodation based support, mental health services, specialist substance misuse services, domestic abuse services and the criminal justice system. They are more likely to experience a range of health inequalities. We also recognise that the commissioning and provider arrangements for these services can be complex. Often more joined-up, assertive and creative solutions underpinned by a strengths based approach are needed.

8. Delivering the priorities

Whilst all of the priorities need a whole systems approach, it remains important to have an identified lead for each priority. There will be an identified partnership and a named Health and Wellbeing Board member responsible for the strategic oversight of each priority (see table 1).

Table 1: Strategic leadership for each priority

Priority	Partnership Board	Health and Wellbeing Board member lead
Physical activity	We Can Move	Dr Andy Seymour
ACEs and resilience	ACEs Panel	Awaiting confirmation
Mental Wellbeing	GHC NHS FT	Angela Potter
Social isolation	Enabling Active Communities	Mary Hutton / Chris Brierley
Early years / Best start	Awaiting confirmation	Andy Dempsey

Housing	Strategic Directors	Anne Brinkhoff
Healthy lifestyles	Healthy weight programme board	Sarah Scott

9. Measuring success

The overarching framework for measuring success for the Joint Health and Wellbeing Strategy is from the national outcomes framework. A number of high level indicators from the Public Health Outcomes Framework (PHOF) will be viewed to assess health and wellbeing:

- Healthy life expectancy at birth (male)
- Healthy life expectancy at birth (female)
- Under 75 mortality rate from all causes
- Inequality in life expectancy at birth (male)
- Inequality in life expectancy at birth (female)

Table 2 shows the core indicators used relating to the specific priorities and the current position. Further indicators will be identified. Each priority will have a statement of strategic intent providing greater detail on the objectives and performance management. The Health and Wellbeing Board regularly monitors and reviews this strategy.

Table 2: Key indicator set

Priority	Key indicator	Gloucestershire baseline	95% CI	South West	England	Date of baseline	Source
Physical activity	Percentage of physically inactive adults	17.3	16.0 – 18.7	17.5	21.4	2018/19	PHOF C17b
Mental wellbeing	Self reported wellbeing – people with high anxiety score	17.8	15.0 – 20.7	19.6	19.7	2018/19	PHOF C28d
	Self reported wellbeing – people with low happiness score	6.7	4.9 – 8.4	7.3	7.8	2018/19	PHOF C28c
Social isolation / loneliness	Percentage of adult social care users who have as much social contact as they would like	49.9	46.4 – 53.4	46.6	45.9	2018/19	PHOF B18a
	Percentage of adult carers who have as much social contact as they would like (age 18+)	30.8	27.8 – 33.8	28.1	32.5	2018/19	PHOF B18b
Health lifestyles – health weight	Reception: Prevalence of overweight (including obesity)	22.0	21.0 – 23.1	22.0	22.6	2018/9	PHOF C09a

	Year 6: Prevalence of overweight (including obesity)	31.9	30.8 – 33.0	29.9	34.3	2018/19	PHOF C09b