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OXFORD CITY COUNCIL

DRAFT

To: **Communities and Partnership Scrutiny Committee**

Date: **12th. March 2012** **Item No:**

Report of: **Scrutiny Public Health Panel**

Title of Report: **Select Committee report on Public Health**

Summary and Recommendations

Purpose of report: To present to the Scrutiny Committee the report and recommendations proposed from the Select Committee on Public Health

Report Approved by: Councillors Jones and Sinclair

Policy Framework: Strong and Active Communities

Recommendations for the Scrutiny Committee:

To consider the report produce by the Panel along with the minutes and outcomes from the select committee meeting and agree what recommendations it wishes to make to the City Executive Board

Recommendations for the City Executive Board:

The City Executive Board is asked to support the following recommendations, and to give reasons why not should it choose to decline.

1. That City Executive Board agrees to support the expansion of the "Tweenager" project, costings to be explored further; initially in regeneration areas across the City, utilising Community Centres as well as Leisure Centres wherever possible, and that this be linked to the budget proposal for a 3 year post to deliver greater use of Oxford City Council facilities by schools.

2. That the City Executive Board actively and financially supports a further extension of outreach work and free taster sessions by Fusion within Community Centres and other community facilities, including the provision of information on leisure and well being initiatives. CEB is further asked to explore concessions at leisure centres for those people who wish to progress further following a taster session;

3. That the City Executive Board agrees with the principle of supporting communities to help themselves and explores further through its partnerships the possible establishment of a community health project run by a local community for the benefit of that local community.

Introduction

1. Oxford is an affluent university city with research centres at the forefront of medical science. Yet its health outcomes are significantly worse than the national average. Life expectancy is five years lower in some parts of the city compared with others. Child obesity is on an upward trend.

2 Oxford has areas of significant and stubborn inequality where poor prospects and poor health combine to produce a cycle of deprivation that passes from generation to generation. At the same time, factors such as "junk food" and sedentary lifestyles undermine health and wellbeing across the social spectrum. An aging population and the economic recession contribute to further levels of anxiety and stress. GPs and A&E, meanwhile, are increasingly pressures by the decline in self care and self treatment.

3 Oxfordshire Public Services has prioritised the breaking of the deprivation cycle through the delivery of targeted services and partnership programmes through the Regeneration Framework. In the event of public health becoming a County council responsibility, the City Council will be expected to feed in proposals via its Health and Wellbeing Board representative.

4 Health interventions through advice, education, self help, training and support play a part in efforts to improve outcomes. The task is significant and engaging the right people in the right place in a sustainable way is always a challenge. Local access to community based programmes either formal or informal can provide for better outreach opportunities by providing convenient places for people to engage in activities and be supported.

5 With this in mind, the Communities and Partnership Scrutiny Committee established a small group tasked with setting up a Select Committee to explore some aspect of public health. The Lead Members on this select committee, Councillors Jones and Sinclair, decided to focus effort on identifying a small number of actions which were deliverable and measurable and had a reasonable chance of making a difference. The best way of doing this was through assets over which the Council had some control or significant influence. The initial way forward was to focus on the means by which City Council owned Community Centres are, or can be, used as part of that "local offer" through programmes and activities aimed at well being and health improvement. This necessitated research and face to face meetings with both health professionals and relevant officers from within the City Council.

6 The Select Committee's guiding question was:-

> **"What are the means by which the City Council owned Community Centres are, or can be, used as part of a "local offer" through programmes and activities aimed at well being and health improvement?"**

Meeting of the Select Committee

7 The Select Committee met on 14th December 2011. It heard from the following witnesses:-

Jackie Wilderspin – Assistant Director of Public Health, Oxfordshire PCT;
Val Johnson, - Partnership Development Officer, Oxford City Council;
Dr Peter Von Eichstorff – GP at Bartlemas Surgery and member of the NHS Clinical Commissioning Group;
Lucy Cherry – Leisure Manager, Oxford City Council
Neil Holman – Active Communities Partnership manager, Oxford City Council;
Angela Cristofoli – Communities and Neighbourhoods Manager, Oxford City Council;
Mark Spriggs – Locality Officer, Oxford City Council.

8 Each witness was invited by the Chair of the meeting, Councillor Graham Jones, to consider three questions:-

a. What is the position now?

b. Where are the gaps in service provision?

c. Can any gaps be filled by making better use of the City Council's Community centres? If so, what should be our focus, and if further investment is needed, how can funding be found?

Select Committee Findings

9 The meeting produced a large number and wide variety of suggestions for further consideration. These ranged from the provision of alcohol free bars in Community Centres to upskilling people to take more control of their own health. It also identified a number of gaps in service provision A full list of both is shown at **Appendix A**.

10 Of particular interest was the evidence from Dr Peter Von Eichstorff concerning people's expectations of the NHS and the empowerment of people to take more responsibility for their own health. The Select Committee was also interested in the development of extended partnership working with Fusion, including the provision of sports and leisure "taster sessions" in our Community Centres.

11 Following the Select Committee meeting, Councillors Jones and Sinclair considered the evidence and sought further information on some of the issues that have been raised. They decided to focus on three practical areas where health improvement could be provided and sustained within communities. These include 2 new initiatives and the extension of a successful project which has recently come to an end. In brief these are:-

a. Tackling Obesity

Practical delivery of sustained health improvement in communities through extended partnership working with Fusion (the City Council's leisure partners). A recent successfully run project on health and wellbeing aimed particularly at children and young people called the "Tweenager" project has come to an end. The Committee would like to see this extended to work with young people in Blackbird Leys and other areas with significant levels of childhood obesity.

b. Encouraging Healthy Lifestyles

Local encouragement to active and healthy lifestyles through sports taster sessions provided by Fusion in our Community Centres to encourage target groups into our leisure centres;

c Encouraging Responsibility and Community Advice

Supported programmes and groups through which communities come together to help themselves to take responsibility for their own health and give support and advice where it is needed.

These issues are further explained below

Tackling Obesity - The "Tweenager" project.

Why focus on this?

12 Childhood obesity is fast becoming a major health issue. Witnesses at the Select Committee gave real examples of this trend witnessed through their work:

- Lack of cooking skills in some families leading to poor nutrition and an over reliance on junk or pre-prepared food;
- Poor regulation of children's eating habits and patterns in some families leading to a lack of control on nutrition and calorie intake
- Children purchasing high fat and sugary foods on the way to and from schools and demonstrating poor health choices from either a lack of guidance or knowledge.

These are witnessed more in some communities than others

13 The Select Committee believes that the Tweenager project offers a practical tried and tested delivery of a sustained health improvement in communities.

What is the issue?

The Director of Public Health for Oxfordshire said in his recent Public Health Report: that:-

- Obesity is on the increase in epidemic proportions in affluent western society;
- Once established in childhood it is very hard to shake off in later life
- Obesity reduces life spans by about 9 years;
- Obesity can lead to high blood pressure and long terms conditions such as diabetes, heart disease and stroke and cancer;
- The risk of getting diabetes is 7 times greater in obese women and up to 5 times greater in obese men;
- The risk developing diabetes is 20 times greater for people who are very obese;
- Obesity adds £1 million every year to the costs of the NHS in Oxfordshire alone;
- 10% of all cancer deaths among non smokers are linked to obesity;
- Obesity decreases mobility making independent living harder.

A reduction in 10% of body weight gives the following benefits:-

- 20% fall in death rates overall;
- 30% reduction in death rates related to diabetes;
- 40% reduction in obesity related deaths from cancer;
- 90% decrease in the symptoms of angina;
- A significant reduction in blood pressure and cholesterol levels.

For Children:

- Among children levels of obesity are too high at around 8% of reception year children rising to 15% of year 6 children. This shows that eating too many calories and taking too little exercise gradually increases weight year on year;
- The relatively good county average masks the familiar pattern of social deprivation with levels significantly higher in the City compared to the rest of the County.

In addition, we know :

- For 2010, 15% of the population of Oxford was in the 0-14 age bracket;
- Rates of children participating in at least 3 hours of physical activity at school are worse than the average across England;
- Tooth decay in children aged 5 is slightly worse than the average for England;

- HM Revenue and Customs some 5,000 children were living in poverty in the City. Health inequalities are reflected even in this young age group. There is a risk that unhealthy children grow up to be unhealthy adults.

15 Taking the above into account, the Select Committee considered that investigating a method of early intervention was worthwhile.

How was "Tweenager" chosen?

16 Further discussions took place with Leisure Services Manager Lucy Cherry and Leon Popplewell from Fusion. They provided information about a pilot scheme called the "Tweenager" (Together We Experience Exercise and Nutrition) project which the City Council launched as a pilot scheme in March 2011.

What is "Tweenager"?

17 The project aimed to help approximately 15, 9-11 year olds into healthier lifestyles. Rather than simply telling them they must lose weight they were educated, supported and congratulated them for their efforts. It offered:-

- A 10 week programme, with two workshops each week, based in the Blackbird Leys Leisure Centre. One was physical exercise, the other a fun session focussed on nutrition – for example, shopping for healthy food and preparing healthy meals;
- Free healthy snacks and drinks were provided;
- A simple reward system for regular attendance encouraged children to continue to participate;
- Parents were encouraged to become involved;
- Children were able to use a private diary to record the changes to their Body Mass Index (BMI), changes to body shape and personal targets

18 This project involved partnership working with Go Active, Oxfordshire Sports, Fusion, Change4 Life and the Oxfordshire PCT. Support was also gained from local supermarkets, primarily Tesco. The project was focussed on local schools, with Pegasus Primary School being particularly active.

19 Free places were available for individuals in need with the remainder of the spaces offered to interested children who paid £1.20 per workshop.

20 The scheme was run by an enthusiastic Leisure intern employed within Leisure Services and outcome monitoring was provided by Oxford Brookes University.

What was the outcome?

21 Evaluation at the end of the scheme showed that there were many good and positive outcomes:-

- Although participation was below target, it was felt that the scheme had the potential to grow. 10 children registered for the pilot and registers show 122 individual attendances across the lifetime of the scheme;

- There had been a positive group atmosphere, participants were motivated and some target families had been reached;
- Partnership working was effective and external feedback was positive;
- All children who attended a first workshop returned for a second;
- Oxford Brookes recorded that some children had lost weight and there were positive changes to their BMI;
- Some children continued to use the private diary after the scheme finished;
- Final evaluation note is attached as **Appendix B**

22 The cost of materials and excursions was £880. This covered food, beverages, excursions, marketing, kitchen rent, street sports and a subsidy for some children's contributions. It did not cover accommodation/rent for the main sessions because they were run in Council owned property and were therefore deemed to be given in kind. The approximate overall cost was £2,200, and a breakdown of costs is attached at **Appendix C**)

23 Had the project continued, the intention was to carry out a second project in Blackbird Leys and a third in another area of Oxford. However, it was decided, at the end of the pilot project, that the City Council could not have any further involvement owing to lack of capacity. It would be able to hand over a complete project plan to anyone who wished to take it on, and would support applications for outside funding. Leisure officers have indicated satisfaction with the level of engagement from partners, and that they would be happy to work with them again. Outside funding would be a possibility, but is of course would depend on the application criteria.

Conclusions and Next Steps

24 "Tweenager" is a positive project that provides some practical support to address issues of:

- Childhood obesity;
- Healthy lifestyles that involve the whole family;
- Nutritional education for the family , including "pester power" from children to encourage the family to eat more fruit (for example);
- Encouragement at an early age to take responsibility for your own health by being aware of the value of exercise and nutrition;
- Health inequalities in the City by providing free places for those who could not otherwise afford them;
- Educational attainment and health and well being through the knock on effects of improved physical health.

25 The Select Committee believes that there are clear advantages to the extension of the "Tweenager" project in the City.

26 Our aim would be to:

- Run a second scheme, beginning in one of our regeneration areas;
- Target 20 children of primary school age;
- To build on success of previous project and the partnership working to improve on delivery and outcomes;
- To utilise project plan already in existence so that we are not starting from absolute zero;
- Continued involvement of Oxford Brookes University to monitor outcomes;
- To consider a programme (funded for at least 2 years) across the city using the recently agreed funding for leisure/school partnership activities.

27 Should this be agreed the next steps would be to:-

1. Work with City Leisure and Fusion to re-establish the partnership group to revisit the project plan and come up with a firmly costed proposal;

2. Speak to the schools of choice and formulate target outcomes;

3. Formulate a delivery project for approval by the Board Members.

(PowerPoint presentations giving information on the original Tweenager project are attached as **Appendix D.)**

RECOMMENDATION 1

That City Executive Board agrees to support the expansion of the "Tweenager" project, costings to be explored further; initially in regeneration areas across the City, utilising Community Centres as well as Leisure Centres wherever possible, and that this be linked to the budget proposal for a 3 year post to deliver greater use of Oxford City Council facilities by schools.

Encouraging Healthy Lifestyles – Leisure taster sessions in Community Centres and other community facilities, including schools.

Why focus on this?

27. Exercise is many things to many people from daily walking to daily gym attendance. Getting the healthy lifestyle message across to those who need to hear it is often the real challenge. The select committee heard views from professionals about why some groups engaged in exercise and others didn't. A few mentioned were:-

- The cost of attendance (even after concessions) to leisure centres and activities;
- The fear of what it might be like and whether they would "fit in";
- With so many other daily pressures health, lifestyle and exercise is just not a priority.

It seemed clear that some groups don't see attendance at leisure centres as "a thing for them".

What is the issue?

28 Oxford faces a number of health issues:-

- Many people living in Oxford do not live particularly healthy lifestyles - a quarter of adults smoke; and nearly as many binge drink;
- Just over 20% of adults engage in the recommended amount of physical exercise every week (slightly below the national average). The majority of adults in Oxford do *not* take the recommended amount of exercise;
- Life expectancy in the south of the City is on average 5 years shorter than that in the north of the City;
- Rates of early death (under age 75) from cancer, heart disease and stroke in Oxford, while close to the England average, are still of concern to health providers.
- Health trends in the deprived wards in the City are worse than the average in the County

29 Exercise can reduce risk of major illnesses such as heart disease, stroke, diabetes and cancer by up to 50%, and lower the risk of early death by up to 30%. People who do regular exercise have a lower risk of suffering from chronic disease such as heart disease, type 2 diabetes, stroke and some cancers. They also have up to 30% lower risk of suffering from depression and dementia.

30 The Department of Health's "Health Profile" for Oxfordshire has prioritised tackling obesity, increasing physical activity levels and improving older people's physical activity to help reduce hip fractures as its aims for 2011. Increasing activity levels amongst the population of all ages, old and young, would help towards this aim.

What can we do?

31 The Select Committee believes that the extension of taster sessions run by Fusion in our Community Centres is a viable means to encourage, locally, sustained active and healthy lifestyles. Starting off in a Community Centre or other local community facility, might provide the ideal way into exercise for many people. At the very least, information on sports, fitness and leisure activities around Oxford should be freely available in community facilities and the Community Centres should be encouraged to promote such activities.

What happens currently?

31 Oxford City Council, Oxfordshire PCT and Fusion jointly provide exercise on referral. GPs or other health professionals can refer eligible patients (for example people suffering from excess weight, stable diabetes, stable angina, or mild depression) to the scheme. This allows the participant, in consultation with fitness providers, to work out their own realistic 12 week programme, for which they pay a reduced rate at one of the Council's leisure facilities. Between April 2010 and March 2011 110 people took part in this scheme, and 68% completed it. Figures show that weight loss as a result varied between 2 kgs to 12 kgs (for the very overweight).

32 Active Women, Go Active, and Age UK already offer a variety of heath and well being initiatives across the City, some in our community centres, others in outdoor facilities such as parks.

33 The aim would be to complement current programmes by showing target groups what they can do and what can be achieved in an environment that is both local and welcoming. Links to the Tweenager Project are possible and it and it is hoped the 2 projects could be developed side by side. to gain maximum value.

What would it involve?

34 Indicative costs are:-

Item	**Indicative cost**
Consultation to establish community need and demand	£50 (plus officer time)
One off taster sessions in community centres and signposting to activities provided in our leisure facilities	£50 to £100 per session
Health and well being stakeholder representation at community centres and other community events	£50 for materials (plus officer time)
Expansion of the Streetsports range and programme of activities into community centres (where suitable)	£35 per hour
Dedicated notice boards and leaflet rigs in community centre	£200 to £500 per board (approx cost – depends of numbers type etc)
Joint stakeholder promotion work via web pages, leaflets and community days	£300

Question and answer sessions in community centres delivered by health and wellbeing providers	£100 per session (plus officer time.

35 The following outreach work would involve officer time and commitment:

- Development of a positive partnership between Fusion and Community Associations;
- Joint stakeholder activity programming relationship to avoid duplication of provision and make best use of off peak usage;
- Health and well-being representation at Community association meetings;
- Joint stakeholder development plan;
- Calendar of consultation between key health and wellbeing stakeholders.

36 The pilot scheme was run by an enthusiastic leisure intern. It involved:-

- Approximately 3 months programme preparation;
- 15-20 hours programme management per week of the pilot scheme.

The employment of leisure interns is subject to applications received, and not absolutely guaranteed. With a guaranteed flow of interns, this might be a project that they could pick up. The work could also be linked with the Leisure/Schools Partnership role that is in the budget.

37 To give more of an idea of how much a campaign would cost, in round terms, **indicative** costs for schemes would be:-

For £1,000 invested we could have……	Possibly a programme of 8 taster sessions in 1 Community Centre
For £3,000 invested we could have……	Possibly a programme of 8 taster sessions in 3 Community Centres

38 It is envisaged that the key health and wellbeing stakeholders would be:-

- Fusion fitness and gym instructors;
- Swimming teachers and coaches;
- Sports and community development officers;
- GPs;
- Community Fit For Life organisation;
- Weight Watchers/Slimming World (and similar);
- Age UK;
- Active Women;
- Go Active;
- Community Associations;

- Oxfordshire PCT
- Other groups may be added as the scheme progresses.

What are the challenges for the success of the scheme?

39 It acknowledged that Community Centres are not always ideal venues for the delivery of activities, but they could be used to provide free taster sessions of the sort of activity that could be accessed in leisure centres. Information on condition and access to centres is still needed.

40 Cost – it would have to be made affordable and accessible. The Council and Fusion already has a range of subsidies in place to encourage participation these would have to be considered. It is envisaged that the taster sessions would be free. We would like to see some exploration of a further raft of concessions for those people who join activities as a result of participation in taster session.

41 Measuring success to be sure that the investment produced the outcomes desired

Conclusions and Next Steps

42 The Select Committee believes there is a benefit in extending outreach work by Fusion into Community Centres. It has the potential to encourage participation in healthier lifestyles at the heart of communities and improve outcomes where they are needed.

43 Should the City Executive Board agree the next steps would be to:

1. Focusing in regeneration areas to agree the community health needs;

2. Talk to Community Associations about availability, cost and condition.

3. Ask Fusion to work up and cost a realistic programme of taster sessions and timetable for their implementation which complement needs;

4. Obtain firm costs for the provision of dedicated notice boards in Community Centres and a programme of installation.

RECOMMENDATION 2

That the City Executive Board actively and financially supports a further extension of outreach work and free taster sessions by Fusion within Community Centres and other community facilities, including the provision of information on leisure and well being initiatives. CEB is further asked to explore concessions at leisure centres for those people who wish to progress further following a taster session.

Encouraging Responsibility and Community Advice – A Community Benefit Scheme

Why focus on this ?

44 The committee heard from Peter Voneichstorff, one of two Oxford GP representatives on the emerging Clinical Commissioning Group. This Group currently has commissioning powers delegated from the Oxfordshire PCT and will take the lead commissioning role when and if NHS reforms are enacted. He outlined that the Clinical Commissioning Group is looking for about a 20% reduction in spending to enable the funding of new initiatives and challenges. This means looking at the spending in GP practices and in particular those that spend the most. Inevitably this means practices in our deprived areas will be asked to reduce the most.

45 Index of multiple deprivation data is being looked at to allocate funding but this isn't a perfect tool because it presents some perverse results so work is on going to understand the most effect way to develop services and spending on public health.

46 One of the key aims is to get people out of secondary care and into primary care. This inevitably puts further strain on primary care which has to have the space, resources and services to be able to deliver on this. We must look at the interaction between people and primary care to see if services are appropriate and deliver the best outcomes.

What is the issue?

47 The issues are many and varied but the committee concentrated on those relating to how families and individuals use their Doctor. In most surgeries GPs are presented with all manner of problems they are not able to solve or advise on appropriately, this is more prevalent within areas of deprivation. We have to consider if this is the best use of Primary Care resources and if it isn't how we move individuals and communities towards more appropriate mechanisms. This in itself is a broad ranging issue but the concentration here is on 3 groups:

- "Non-medical" issues;
- Medical issues that can and should be managed by individuals by taking responsibility for their your own health;
- Engaging in preventative care and advice;

One of the reasons suggested for this high health service demand in deprived areas is that maybe there are poor networks. People consult their doctor because they have no where else to go…lay referral does not exist.

These 3 groups are defined below.

48 **"Non medical"** - GPs often find people in their surgeries with issues that aren't "medical". The issue may have some medical consequence in the eye

of the patient but the route of the problem is housing, debt, managing their families, anti-social behaviour, education, family breakdown or any other of the many issues that affect adversely the lives of individuals and families and more so those in deprived communities. Should these people be in front of their doctor?

49 **Taking responsibility** – There are a number of conditions on the increase and therefore more commonly seen as a result of the changing lifestyles and attitudes of people. Some of these conditions, once diagnosed, need to be managed carefully by the patient through self monitoring and/or lifestyle change. A good example of this is diabetes where patients need to take responsibility for managing their condition on a daily basis and adjusting the application of medication accordingly and also consider their lifestyle choices to provide for longer term improvement in their health. How do we encourage and deliver on individual ownership?

50 **Preventative care and advice** – Developments in public health have produced many routine health checks that are successful in making our lives healthier through early detection of disease or early warning of lifestyle changes needed to improve our health. These along with advice on diet, exercise, drinking, smoking etc. should all produce healthier communities. The issue is that some individuals and communities engage with this and others don't. The lack of engagement is more prevalent within our deprived communities where much more targeted outreach work is needed. Why do some people and communities choose not to engage in improving their or their family's health?

<u>What can we do?</u>

51 This report does not try to answer the questions but posses them in order to begin a discussion on what might be done.

52 Things are already happening. There is a "Health Bus" for Rose Hill. This provides mobile NHS nurses for the area. More information is provided at **Appendix E** but in brief it:-

- Focuses on an areas with higher than average health needs;
- Brings health care closer to the community;
- Is mobile, so it is more accessible for people who find it difficult to travel to health centres;
- Is not in a formal health centre setting, so likely to be perceived as less intimidating;
- Offers advice on important health issues for which the patient can self care, such as weight management, smoking cessation, blood pressure and diabetes;
- Offers a "Health MOT" which is a valuable preventative tool;
- Is a supplement to existing health services It does not replace GPs surgeries, but it relieves pressure upon them;

53 One thing that is clear is that no agency or group can provide solutions alone. If we consider who the main contributors might be the list might look like:

- Councils
- GPs
- Commissioning Groups
- Health Workers
- Communities
- The Voluntary Sector

54 If we then went on to consider what those group could contribute in partnership we may come up with a list like:

- Local access to advice and services through varied media
- Improved outreach work to understand and target services locally
- Better "sign posting" to service delivery across disciplines or even shared services or service points;
- The provision of community networks, befriending schemes, community champions and self help partnerships;
- Money, grants, premises;
- Support, encouragement and learning.

55 The list could go on and it is clear that through the community capacity building happening within Housing and Communities at the City Council and services such as the "Health Bus" provided by the PCT some of this partnership work is underway. What the committee would like to concentrate on is what communities can do with our encouragement and help to support each other. To quote Peter Voneichstorff *"…..some of these problems in previous years would have been handled within families, in some areas we almost need a community mum".* The possibility of lay referral through local networks, support groups or retired professionals might bridge the gap between traditional care and self care.

56 The PCT initiative to provide "Health Trainers" was discontinued after a review of their cost effectiveness. Dr Voneichstorff commented that initiatives of this sort usually fail because they are set to train other people to deliver care rather than encouraging collective or individual responsibility for health. They are often set at a distance from communities rather than embedded in local teams. The view expressed was that a more local and directly bookable local service may have been more successful.

57 There are across the country a number of community health projects run by the community and for the community offering activities, services and support that contribute to the betterment of health and well being through local provision, understanding, engagement, ownership and responsibility. They vary in set up and management and are funded through a mixture of grants, fund raising and small community charges. They use a mixture of voluntary and professional staff to deliver services and lay referral. The committee would like the support of the Board Member for Regeneration to explore this

idea further with the Clinical Commissioning Group and the Health and Wellbeing Board to see if such a community benefit scheme could be established in one of our regeneration areas, possibly Barton given the potential for a significant expansion of this community and the opportunity this presents to establish something new within the community.

RECOMMENDATION 3

That the City Executive Board agrees with the principle of supporting communities to help themselves and explores further through its partnerships the possible establishment of a community health project run by a local community for the benefit of that local community.

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Background papers:

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