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NHS Oxfordshire Clinical Commissioning Group | OXFORDSHIRE COUNTY COUNCIL | healthwatch Oxfordshire

To: Members of the Health Improvement Partnership Board

Notice of a Meeting of the Health Improvement Partnership Board

Tuesday, 27 October 2015 at 2.00 pm

Town Hall, Oxford

Peter G. Clark
Head of Paid Service

19 October 2015

Contact Officer: ***Katie Read, Policy & Partnership Officer***
Tel: (01865) 328272; Email: katie.read@oxfordshire.gov.uk

Membership

Chairman – City Councillor Ed Turner
Vice Chairman - District Councillor Anna Badcock

Board Members:

Ian Davies	Cherwell & South Northants District Council
Cllr John Donaldson	Cherwell District Council
Laura Epton	Healthwatch Ambassador
Emma Henrion	Healthwatch Ambassador
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Voluntary Sector
Cllr Monica Lovatt	Vale of White Horse District Council
Dr Jonathan McWilliam	Director of Public Health
Cllr James F. Mills	West Oxfordshire District Council
Dr Paul Park	Vice Clinical Chair of Oxfordshire Clinical Commissioning Group
Jackie Wilderspin	Public Health Specialist

Notes:

- ***Date of next meeting: 18 February 2016***

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned….."*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on (01865) 815270 or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chairman, City Councillor Ed Turner

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Minutes of last meeting (Pages 1 - 6)

2:05pm
5 minutes

To approve the minutes of the meeting held on 6 July 2015 and to receive information arising from them.

6. Performance Report (Pages 7 - 18)

2:10pm
20 minutes

People responsible: Members of the Health Improvement Board

Performance report presented by: Jonathan McWilliam, Oxfordshire County Council

Treatment of Opiate and Non-opiate users report card presented by: Jackie Wilderspin, Oxfordshire County Council and Andy Symons, Turning Point

A report on progress against the targets of the Health Improvement Board including a report card on the treatment of opiate and non-opiate drug users.

7. Director of Public Health's Annual Report (Pages 19 - 90)

2:30pm
15 minutes

Report presented by: Johnathan McWilliam, Director of Public Health, Oxfordshire County Council

The Director of Public Health will present his Annual Report for 2014/15. It is an independent report for all organisations and individuals.

The annual report summarises key issues associated with the Public Health of the county. It includes details of progress over the past year, as well as recommendations

for future work.

8. Healthwatch Oxfordshire (Pages 91 - 100)

2:45pm
10 minutes

Update provided by: Rachel Coney, Chief Executive, Healthwatch Oxfordshire

A presentation on the purpose and work of Healthwatch Oxfordshire and how this relates to the Health Improvement Board.

9. Healthwatch Ambassadors' Report (Pages 101 - 102)

2:55pm
10 minutes

Report presented by: Laura Epton, Healthwatch Ambassador

A report that updates the Health Improvement Board on the Healthwatch Ambassadors' main areas of focus and highlights key issues and messages from the public. This report particularly focuses on the breastfeeding support service run at the Oxford Baby Café.

10. Healthy Weight Strategy (Pages 103 - 130)

3:05pm
60 minutes

Discussion led by: City Councillor Ed Turner, Chairman of the Health Improvement Board

A discussion to facilitate the revision of the Oxfordshire Healthy Weight Strategy and its multi-agency approach to tackling obesity among children and adults.

The discussion will include:

- An outline of activities in the current Healthy Weight Action Plan
- An overview of activities coordinated by the following organisations that contribute to the prevention of obesity among children and adults (5 minutes each):
    - Oxfordshire County Council
    - West Oxfordshire District Council
    - South Oxfordshire District Council
    - Vale of White Horse District Council
    - Cherwell District Council
    - Oxford City Council
    - Oxfordshire Sport and Physical Activity

    - Oxfordshire Clinical Commissioning Group
    - Oxford University Hospitals NHS Foundation Trust Occupational team
- Gaps in current service provision and next steps for revising the Healthy Weight Strategy.

11. Housing related support

4:05pm
10 minutes

Verbal update from: Natalia Lachkou, Oxfordshire County Council

A verbal update to the Health Improvement Board on the implementation of housing related support services.

12. Forward Plan (Pages 131 - 132)

4:15pm
5 minutes

Presented by: Councillor Ed Turner, Chairman of the Health Improvement Board

A discussion about the forward plan for the Health Improvement Board.

MATTERS FOR INFORMATION ONLY

Oxfordshire's new Children and Young People's Plan 2015-18 is attached for information only, not for discussion.

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HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Monday 6 July commencing at 2.00 pm and finishing at 4.00 pm.

Present:

Board Members:	Councillor Ed Turner (Chairman), Oxford City Council Councillor Anna Badcock (Vice-Chairman), South Oxfordshire District Council Councillor John Donaldson, Cherwell District Council Councillor James Mills, West Oxfordshire District Council Jackie Wilderspin, Public Health Specialist Dr Jonathan McWilliam, Director of Public Health Laura Epton and Emma Henrion, Healthwatch Ambassador (job share)
Officers:	
Whole of meeting:	Val Johnson, Oxford City Council Katie Read, Oxfordshire County Council
Part of meeting:	
Agenda item 8	Natalia Lachkou, Oxfordshire County Council
Agenda item 9	Eleanor Stone, Oxfordshire County Council
Agenda item 10	Eunan O'Neill, Oxfordshire County Council Paula Jackson, NHS England

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Katie Read (Tel 01865 328272; Email: katie.read@oxfordshire.gov.uk)

ITEM	ACTION
1. Welcome The Chairman, City Councillor Ed Turner, welcomed all to the meeting and all members introduced themselves.	
2. Apologies for Absence and Temporary Appointments Apologies have been received from: Councillor Hilary Hibbert-Biles, Councillor Monica Lovatt, Ian Davies and Dr Paul Park.	
3. Declaration of Interest No declarations were received.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Minutes of Last Meeting The minutes of the April meeting were approved.	
6. Performance Report Jonathan McWilliam presented the performance report and provided information on the red indicators for the benefit of new Board members. At 8.5 - the number of opiate users successfully leaving treatment (6.7%) was queried. In real terms this equates to less than 20 users, whilst over 1,000 remain in treatment. **The exact breakdown of opiate users both in and leaving treatment will be circulated to members.** **A full update on performance against the indicators for opiate and non-opiate users and the impact of the new Integrated Drug and Alcohol Treatment Service in place since April 2015 will be presented at the next meeting.** At 9.1 – discussion about obesity in children focused on organisational responsibility. Whilst no individual organisation is responsible for tackling childhood obesity, it was emphasised that a multi-agency approach that commits organisations to certain actions, is essential. The Oxfordshire Healthy Weight Strategy is being refreshed in 2015/16 and is the vehicle for this work. **A revised version of the Healthy Weight Strategy will be discussed at a future meeting.** At 9.2 – members queried the definition of 'physical activity' in the Active People Survey that is used to inform this indicator. **The detail of the relevant question(s) in the survey will be forwarded to members.** At 9.3 – **a report on what all member authorities have done and**	**Jackie Wilderspin** **Jackie Wilderspin** **Public Health** **Jackie Wilderspin** **Val**

plan to do to encourage breastfeeding will be presented at the next meeting. This will be collated by Val Johnson. It was thought useful to have sight of the national picture in relation to performance indicators for Oxfordshire. **Information on Oxfordshire performance in relation to national benchmarks will be circulated.**	**Johnson** **Jackie Wilderspin**
7. Draft Health and Wellbeing Strategy Jonathan McWilliam introduced the draft Health and Wellbeing Strategy that will be presented to the Health and Wellbeing Board on 16 July. **All members of the Board were invited to email any further comments on the draft strategy to the Chairman before the Health and Wellbeing Board on 16th July so that they could be represented in the discussion.** Board members discussed the priorities within the Strategy and questioned whether levels of funding would reflect these, in particular the priority on prevention. It is speculated that Public Health will receive an in-year reduction in government funding, meaning a tighter fiscal situation for prevention. **The Board will be informed of any changes to Public Health funding once these are known.** Promoting the priorities of prevention and reducing inequalities in discussions about strategic plans was considered important. **The Board requested an update on the progress of the Health Inequalities Commission,** which is being established to consider new ways of working to reduce inequalities in health outcomes across Oxfordshire. The Director of Public Health Annual Report also examines the causes of health inequalities and reports on progress made – **the Public Health Annual Report will be brought to the next meeting.**	 **All** **Jonathan McWilliam** **Paul Park** **Jonathan McWilliam**
8. Housing Related Support update Natalia Lachkou provided a verbal update on the re-commissioning of housing related support services. The new single homelessness pathway was published in March and the tender process for commissioning this started in May 2015. Tender submissions are expected by 31 July and interviews with prospective providers will follow. The interview process will involve service users. The new contract is due to be awarded in September 2015 with new services beginning in February 2016. The flexibility of the pathway was queried in relation to potential future budgetary pressures, but given that the tender process has not yet finished, it was considered too early to say. The importance of open dialogue and on-going cooperation between partners was emphasised.	

9. Young People's Supported Housing Eleanor Stone presented the paper on young people's supported housing and outlined the context around availability of long term housing options. The Health Improvement Board was asked to provide oversight of the supported housing pathway and its officer steering group given that the Board's membership includes representation from all district authorities and many strategic decisions require cross-authority agreement. The Board agreed to provide governance for the young people's supported housing pathway and the Joint Housing Steering Group. The proposed outcome measure was considered positive and stretching but there was lack of agreement on whether it could be adopted without further consultation. The Board welcomed the focus on young people's progression out of the pathway and the removal of references to time spent in the pathway. **Board members also expressed interest in how many young people are currently in the pathway. A decision will be taken at the next meeting whether to adopt the proposed target or a different target, with County Council officers to provide information at that meeting to enable a decision to be taken.**	**Eleanor Stone**
10. Health Protection Forum Annual Report Eunan O'Neill and Paula Jackson presented the annual Public Health Protection Forum report which updated the Board on a wide variety of health protection activities during 2014/15. The complex issue of air quality management was discussed. It was emphasised that a multi-faceted approach is required, working in partnership with both public and private agencies. It was agreed that the monitoring of Air Quality Management Areas could be co-ordinated by the Health Improvement Board, but that additional input would be needed from other agencies such as the Environment and Economy Directorate of the County Council. **A paper on the responsibilities of a range of agencies in relation to air quality management and how the Board can influence and monitor activities in this area was requested for the February meeting of the Board.** **The Public Health Protection Forum was thanked for the report and it was requested that updates and exceptions in performance should be reported to the HIB throughout the year.**	**Eunan O'Neill** **Eunan O'Neill**
11. Forward Plan The next meeting of the Board will be on **Tuesday 27th October 2015.**	

From the meeting the following items will be added to the forward plan: • **Update on opiate and non-opiate drug treatment services** • **Healthy Weight Strategy** • **Breastfeeding friendly activities** • **Health Inequalities Commission** • **Director of Public Health Annual Report** • **Air quality management**	**Katie Read**
The meeting closed at 4.00pm	

..... in the Chair

Date of signing .....

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Health Improvement Board
27 October 2015

Q1 Performance Report

Background

1. The Health Improvement Board is expected to have oversight and of performance on four priorities within Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, and ensure appropriate action is taken by partner organisations to deliver the priorities and measures, on behalf of the Health and Wellbeing Board.

2. The four priorities the Board has responsibility for are:

   Priority 8: Preventing early death and improving quality of life in later years
   Priority 9: Preventing chronic disease through tackling obesity
   Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
   Priority 11: Preventing infectious disease through immunisation

Current Performance

3. A table showing the agreed measures under each priority, expected performance and current performance is attached as appendix A.

4. There are some indicators that are reported on an annual basis and some on a half-yearly basis - these will be reported in future reports following the release of the data.

5. For the indicators that can be regularly reported on, current performance can be summarised as follows:

   4 indicators are Green.
   4 indicators are Amber (defined as within 5% of target).
   3 indicators are Red

6. The three indicators that are red are:
   8.4 At least 3650 people will quit smoking for at least 4 weeks by end of 2015/16.
   8.6 The target for opiate users should be at least 7.6% successfully leaving treatment by the end of 2015/16
   8.7 At least 39% of non-opiate users should successfully leave treatment by the end of 2015/16

Sue Lygo
Health Improvement Practitioner
6 October 2015

Oxfordshire Health and Wellbeing Board
Performance Report

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
Priority 8: Preventing early death and improving quality of life in later years											
8.1 NHS England	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	**Expected** 60% **Actual** 59.2%	**A**	**Expected** 60% **Actual**		**Expected** 60% **Actual**		**Expected** 60% **Actual**			
8.2 OCC	Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%	**Expected** 3.75% **Actual** 5%	**G**	**Expected** 7.5% **Actual**		**Expected** 11.25% **Actual**		**Expected** 15% **Actual**		West Oxfordshire locality has fairly small proportion invited to attend (1.8%) this quarter.	
8.3 OCC	At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)	**Expected** 46% **Actual** 42.2%	A	**Expected** 50% **Actual**		**Expected** 58% **Actual**		**Expected** 66% **Actual**		North East Oxfordshire has a lower proportion attending (26.7%) whilst West Oxfordshire has had more attending than invited (150%)	

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
8.4	At least 3650 people will quit smoking for at least 4 weeks (Achievement in 2014/15 = 1955)	**Expected** 913	R	**Expected** 1825		**Expected** 2738		**Expected** 3650			
occ		**Actual** 477		**Actual**		**Actual**		**Actual**			
8.5	The number of women smoking in pregnancy should decrease to below 8% (recorded at time of delivery). (Baseline 2014/15 = 8.1%)	**Expected** <8%	G	**Expected** <8%		**Expected** <8%		**Expected** <8%			
occ G		**Actual** 7.8%		**Actual**		**Actual**		**Actual**			
8.6	The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months (baseline 7.8%)	**Expected** 7.6%	R	**Expected** 7.6%		**Expected** 7.6%		**Expected** 7.6%			Please note that the completion data is from 1/10/14 to 31/12/14 and representations are up to 30/06/2015.
occ		**Actual** 6.2%		**Actual**		**Actual**		**Actual**			
8.7	At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months (baseline 37.8%)	**Expected** **39%**	R	**Expected** **%**		**Expected** **%**		**Expected** **%**			
occ		**Actual** 29%		**Actual** %		**Actual**		**Actual**			
Priority 9: Preventing chronic disease through tackling obesity											
9.1	Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2013/14 this was 16.9%). No district population should record more than 19%					**Expected** 16% or less					
occ						**Actual**					

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
9.2	Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active People Survey)							**Expected** 22% or less			
District council								**Actual**			
9.3	63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual CCG locality should have a rate of less than 50%	**Expected** 63%		**Expected** 63%		**Expected** 63%		**Expected** 63%		For CCG localities in Q1 all are over 50%	
NHS England & CCG		**Actual** 60.9%	**A**	**Actual** %		**Actual** **%**		**Actual**			
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness											
10.1	The number of households in temporary accommodation as at 31 March 2016 should be no greater than the level reported in March 2015 (192 households in Oxfordshire in 2014/15)			**Expected** 192 or less				**Expected** 192 or less			
District Councils				**Actual**				**Actual**			
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 91% in 14/15)	**Expected** 75%		**Expected** 75%		**Expected** 75%		**Expected** 75%			
OCC		**Actual** 84.8%	**G**	**Actual** %		**Actual** **%**		**Actual**			

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
10.3	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 83% in 2014/15 when there were 2454 households known to services). Reported 6-monthly			**Expected** 80%				**Expected** 80%			
District Councils				**Actual** %				**Actual**			
10.4	More than 700 households in Oxfordshire will receive information or services to enable significant increases in the energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners.			**Expected** >700				**Expected** >700			.
Affordable Warmth Network				**Actual**				**Actual**			
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 70 (2014/15)					**Target** < 70					
District Councils						**Actual**					
10.6	A measure will be included in the performance framework to monitor the success of supporting vulnerable young people in appropriate housing following monitoring to establish a baseline.										Baseline to be established and outcome to be discussed in March 2016
OCC											

Priority 11: Preventing infectious disease through immunisation											
No	**Indicator**	**Q1 Apr-Jun**	**RAG**	**Q2 Jul-Sept**	**RAG**	**Q3 report Oct-Dec**	**RAG**	**Q4 report Jan-Mar**	**RAG**	**Locality spread**	**Notes**
11.1 NHS England	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94%	**Expected** 95% **Actual** 95.1%	G	**Expected** 95% **Actual** %		**Expected** 95% **Actual** **%**		**Expected** 95% **Actual**		Oxford City is almost at the target (93.3%). All others are achieving over 95%	
11.2 NHS England	At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94%	**Expected** 95% **Actual** 92%	A	**Expected** 95% **Actual**		**Expected** 95% **Actual** **%**		**Expected** 95% **Actual**		North Oxfordshire and Oxford City have lower rates this quarter – below 92%. All other CCG localities are achieving 94% or higher	
11.3 NHS England	At least 60% of people aged under 65 in "risk groups" receive flu vaccination (2014/15 =)							**Expected** 55% **Actual**			
11.4 NHS England	At least 90% of young women will receive both doses of HPV vaccination. (2014/15 =)							**Expected** Over 90% **Actual**			

Health Improvement Board outcomes for 2015-16 and relevant benchmarks

Outcome measure for 2015-16	England / SEast	Oxfordshire 2014-15
Priority 8: Preventing early death and improving quality of life in later years		
8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years). ***Responsible Organisation: NHS England***	55%	56%
8.2 Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%. ***Responsible Organisation: Oxfordshire County Council***	19.7% (2014/15)	21.2%
8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 55% with all aspiring to 66%.(baseline 53% 2014-15) ***Responsible Organisation: Oxfordshire County Council***	48.8% (2014/15)	53.3%
8.4 At least 3650 people will quit smoking for at least 4 weeks (achievement in 2014-15 to be reported). ***Responsible Organisation: Oxfordshire County Council***	N/A	
8.5 The number of women smoking in pregnancy should decrease to below 8% recorded at time of delivery (baseline 2014-15 8.1%). ***Responsible Organisation: Oxfordshire Clinical Commissioning Group***	11.4% (2014/15)	8.1%
8.6 The 2015-16 target for opiate users should be at least 7.6% successfully leaving treatment (baseline 7.8%) ***Responsible Organisation: Oxfordshire County Council***	7.6% (2014-15)	6.7%
8.7 The 2014-15 target for non-opiate users should be set at 39% successfully leaving treatment (baseline 37.8%). ***Responsible Organisation: Oxfordshire County Council***	39% (2014-15)	20.2%

Priority 9: Preventing chronic disease through tackling obesity		
9.1 Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2014 this was 16.9%) No district population should record more than 19% ***Data provided by Oxfordshire County Council***	Eng 19.1% SE 16.4%	16.9%
9.2 Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active People Survey). ***Responsible Organisation: District Councils through Oxfordshire Sports Partnership***	Eng 28.9% SE 26.5%	23.1%
9.3 63% of babies are breastfed at 6-8 weeks of age (currently 59.7%) and no individual health visitor locality should have a rate of less than 50% ***Responsible Organisation: NHS England and Oxfordshire Clinical Commissioning Group***	Eng 43.8%	62.6%
Priority 10 – no benchmarks		
Priority 11: Preventing infectious disease through immunisation		
11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***	92.7% (2013-14)	95% Rank 1 / 4 in Thames Valley
11.2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 92.5%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***	88.3% (2013-14)	92.1% Rank 2/4 in TV
11.3 – At least 60% of people aged under 65 in "risk groups" receive flu vaccination (baseline from 2014-15 to be confirmed) ***Responsible Organisation: NHS England***	52.3% (2013-14)	51.9% Rank 3 /4 in TV
11.4 At least 90% of young women to receive both doses of HPV vaccination. ***Responsible Organisation: NHS England***	86.7% (2013-14)	92.5% (2013-14)

Report card: Successful Completions of treatment for opiate and non-opiate use.

Oxfordshire Health and Wellbeing Board
Detailed performance report

1. Details

Strategic Priority: Preventing early death and improving quality of life in later years

Strategic Lead: *Jackie Wilderspin, Jo Melling*

PROGRESS MEASURE:

8.5 Percentage of opiate users successfully leaving treatment by the end of 14/15
8.6 Percentage of non- opiate users successfully leaving treatment by end of 14/15

The Drug and Alcohol treatment system was put out to competitive tender by the Public Health team at Oxfordshire County Council during 2014, the new specification for this that was developed in consultation with the CCG, police, service users, families and other key stakeholders. Several large contracts were combined to form the new integrated drug and alcohol treatment service. Turning Point won this contract and the new service become operational in April 2015.

During any system re-design performance may falter - as staff and service users move to the new service provider. Transferring clinically complex service users requires strong clinical governance to ensure service users don't drop out of services or any other health issues. As this new contract was set up all services users were transferred safely, all care plans were reviewed and no service users dropped out of treatment. This was due to a carefully managed transition process with robust governance by Turning Point.

Turning Point has many challenges to overcome to deliver improved outcomes for Oxfordshire service users. They have already recruited more clinicians, nurses and specialists and opened 3 new full time treatment centres. There are now treatment centres running in Didcot, Banbury, Witney and Oxford.

The charts below show the trends in performance for clients seeking treatment for opiate use and non-opiate use. It should be noted that the previous dip in performance, which was during the time that other providers held contracts let by the DAAT prior to this becoming the responsibility of the Public Health team in the County Council. Please note that the data in the table is for the last 12 monthly reports only and does not cover the whole time span illustrated in the chart.

A recovery plan for improving successful completions of treatment has been in place since October 2013. This plan has recently been revised in collaboration with Turning Point and focus on this performance continues with support from Public Health England.

Red

Report card: Successful Completions of treatment for opiate and non-opiate use.

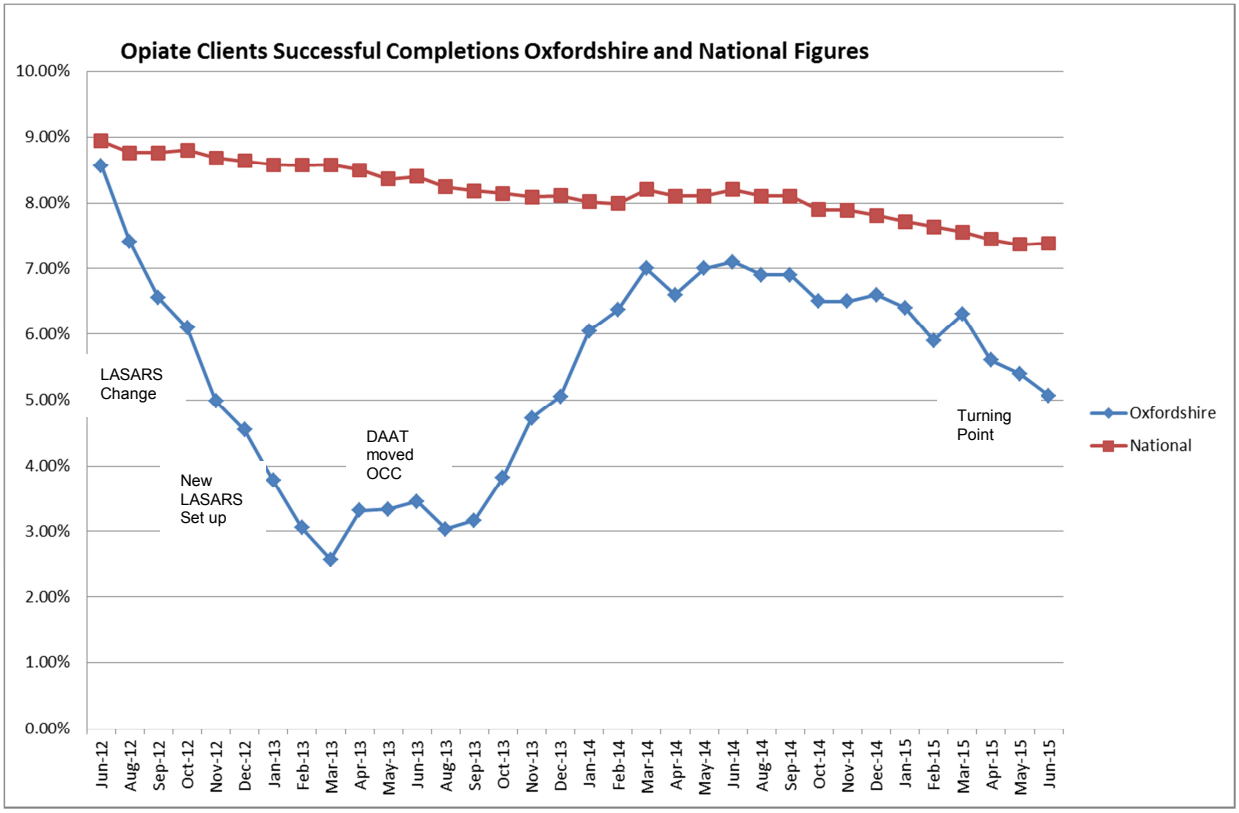
Current indicator RAG Rating

2. Trend Data

Outcome no 8.5 'Opiate' Service Users

An opiate service user is any service user citing at least one primary, secondary or tertiary problem in the list of Opiates.

Opiate Clients Successful Completions Oxfordshire and National Figures

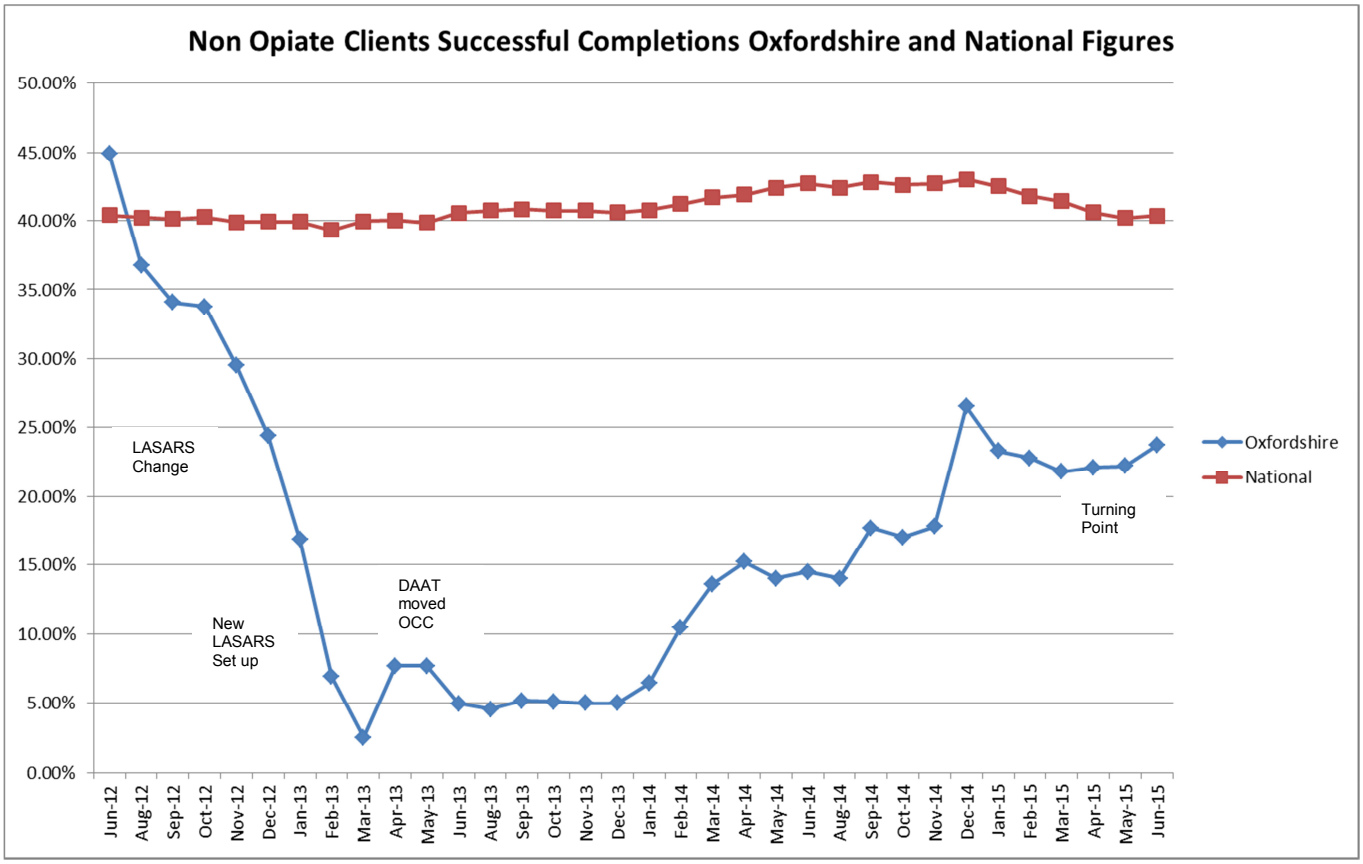


Opiate	Jun-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numbers in treatment - rolling 12 months	1601	1584	1571	1553	1556	1538	1525	1511	1503	1511	1501	1500
Total completions - rolling 12 months	113	110	109	101	101	101	98	89	94	85	81	76
Successful completions as a proportion of number in treatment - rolling 12 months	7.10%	6.90%	6.90%	6.50%	6.50%	6.60%	6.40%	5.90%	6.30%	5.60%	5.40%	5.07%
Direction of Travel From Previous Period	↑	↓	-	↓	-	↑	↓	↓	↑	↓	↓	↓
NATIONAL	8.20%	8.10%	8.10%	7.90%	7.89%	7.81%	7.72%	7.64%	7.56%	7.45%	7.37%	7.39%
Oxfordshire compared to National	-1.10%	-1.20%	-1.20%	-1.40%	-1.39%	-1.21%	-1.32%	-1.74%	-1.26%	-1.85%	-1.97%	-2.32%

Report card: Successful Completions of treatment for opiate and non-opiate use.

Outcome no. 8.6 'Non-Opiate Only' Service Users

A non-opiate service user is any service user citing a primary problem substance of non-opiate, and no secondary or tertiary problem in the list of Opiates or Alcohol.



Non Opiate	Jun-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numbers in treatment - rolling 12 months	110	100	96	88	90	83	86	92	87	86	90	97
Total completions - rolling 12 months	16	14	17	15	16	22	20	21	19	19	20	23
Successful completions as a proportion of number in treatment - rolling 12 months	14.50%	14.00%	17.70%	17.00%	17.80%	26.50%	23.30%	22.80%	21.80%	22.10%	22.20%	23.70%
Direction of Travel From Previous Period	↑	↓	↑	↓	↑	↑	↓	↓	↓	↑	↑	↑
NATIONAL	42.70%	42.40%	42.80%	42.60%	42.70%	43.00%	42.50%	41.80%	41.40%	40.60%	40.20%	40.34%
Oxfordshire compared to National	-28.20%	-28.40%	-25.10%	-25.60%	-24.86%	-16.41%	-19.16%	-18.98%	-19.58%	-18.49%	-17.96%	-16.64%

Report card: Successful Completions of treatment for opiate and non-opiate use.

3. What is the story behind this trend? - Analysis of Performance

- System change. The Service was re-tendered during 2014 and new service started in April 2015
- Performance in terms of successful completions of Oxfordshire treatment services has been poor for some time, historically the treatment services were designed to retain people in treatment and Oxfordshire was very successful at this. A change in national strategy meant a shift in emphasis to moving people through treatment to abstinence. This proved more difficult to manage through the new contracts from 2012.
- Re-tendering of these services is part of the recovery plan and learning from the period of poor performance has been incorporated into the service specification.
- Broad consultation with service users, staff and other stakeholders was carried out as part of the specification process to ensure necessary improvements could be specified.

4. What is being done? - Current initiatives and actions

Recovery plans are in place and Turning Point are closely monitored in order to ensure that actions are in place to improve performance over the next 3 years.

This contract incorporates prevention, harm reduction and treatment services and support for abstinence based recovery. The new contract will reduce the difficulty in navigating the system and will mean service users can access a wide range of treatment options all provided through one contract.

A wider range of treatment options are available from 4 locality hubs in the City, Banbury, Didcot and Witney, with satellite clinics in other towns too. Staff have been able to improve their skills with a comprehensive training programme and recruitment to a larger staff team has been successful.

5. What needs to be done now? - New initiatives and actions

Action	By Whom & By When
¤ A revised recovery plan in the light of new contract arrangements has been drafted in collaboration with PHE	OCC and PHE October 2015
¤ Performance reporting to monitor the impact of transition on the overall performance.	OCC and PHE
¤ Monthly contract management meetings to ensure all actions in the recovery plan are being prioritised	OCC monthly
¤ Continued implementation of the new service development plan alongside the recovery plan.	OCC and Turning Point. Oct 2015
¤ Continued investment in workforce development to improve the skills of staff employed by Turning Point – both new recruits and those transferring from previous providers of the service	Turning Point March 2016

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT VIII

Reporting on 2014/15
Produced June 2015

Foreword

Every Director of Public Health must produce an Annual Report on the population's health.

This is my 8th Annual Report for Oxfordshire.

It uses science and fact to describe the health of Oxfordshire and to make recommendations for the future.

It is for all people and all organisations.

I hope that it is found to be interesting, but, more than that I hope it is found to be useful in shaping the County's services for the future.

I am responsible for its content, but it draws on the work of many - too numerous to name. I thank you all for your help, support and encouragement.

With best wishes,

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
June 2015

The Thrust of This Report and Its Main Messages

This report presents a review of the population's health.

In conducting that review, I have come to two main conclusions. These are:

The overall state of health in Oxfordshire is fundamentally good. Work carried out over the last 8 years is paying dividends. This must be maintained.

And

To continue to improve we need to tackle the remaining and emerging health challenges in a more comprehensive way.

This report points to that way in 6 chapters, and together these form a **6 point plan** as follows:

1. Older People and Population change

This remains our number one challenge. All organisations need to transform services to meet the changing character of Oxfordshire's population to help people achieve a healthier old age.

2. Building better health through housing, roads and planning

The built environment if fundamentally connected to our quality of life and to our health. We need to work together to build consciously for health.

3. Breaking the Cycle of Disadvantage

This report reviews 15 aspects of disadvantage and finds we are improving in areas such as reducing teenage pregnancy and achieving better school results. However new sources of disadvantage continue to arise. All agencies plans need to specifically and persistently combat disadvantage.

4. Mental Health

Services have improved over the last seven years. This needs to continue through seeing physical and mental health as two sides of the same coin and designing new services accordingly.

5. Lifestyles: We are what we eat, drink, smoke and do

We need to widen the scope of our activity to prevent disease. There is scope to do more, particularly through the massive potential the NHS has to offer.

6. Fighting Killer Diseases

Constant vigilance is required. All organisations need to protect their specialist services which guard against diseases like TB and Ebola.

Why Now?

Now is the time to tackle these. Why? We have a strong and established Health and Wellbeing Board led by the County Council and the Clinical Commissioning Group. Public Health is well established in the County Council. The Clinical Commissioning Group, Public

Health England, NHS England and Healthwatch are now reorganised and stable. Our two main NHS trusts are now fully engaged in planning for the County. District Councils are active in the Health Improvement and Health and Wellbeing Boards. The Universities are well engaged in economic development. Plans are in the pipeline to improve our infrastructure and thus the economy with new road and rail links. We are working with the Voluntary Sector in a more constructive way. We are supported by active Scrutiny Committees which are doing their work with vigour.

In these tough fiscal times, it is still a time of opportunity. We must work together if we are to push forward. We really do have the ability to work together in a unique way in Oxfordshire to improve health and help the County thrive.

How will we do this?

This report contains suggestions and makes recommendations for how this might be taken forward. Many other individuals and organisations will have positive contributions to add. This is an ambitious agenda for an ambitious County.

I hope that promoting this debate finds support and that health and wellbeing truly becomes everyone's business.

Chapter 1: The Demographic Challenge

Main Messages in this Chapter

1. **The population is living longer, often with complex health needs and all services will have to change as a result.**
2. **Changes can already be seen in primary care, in improved dementia services and through the Care Act.**
3. **Loneliness is now recognised as an additional risk to health in old age.**
4. **NHS and Social Care services will need to keep on changing to adapt to the demographic challenge.**

We live in rapidly changing times, and the population's needs are changing too. What are the factors driving this change which have an impact on our health? I will concentrate in this chapter on the population change due to the ageing population. **This is the demographic challenge and it remains our most serious health issue.**

An Ageing Population

This is our greatest challenge. It is a well-documented fact that life expectancy continues to rise. A woman in Oxfordshire who reaches her 65th birthday can expect to live around 21 more years on average and reach 87. However, because this is the average, a great many will live far beyond this, into their 90s and 100s.

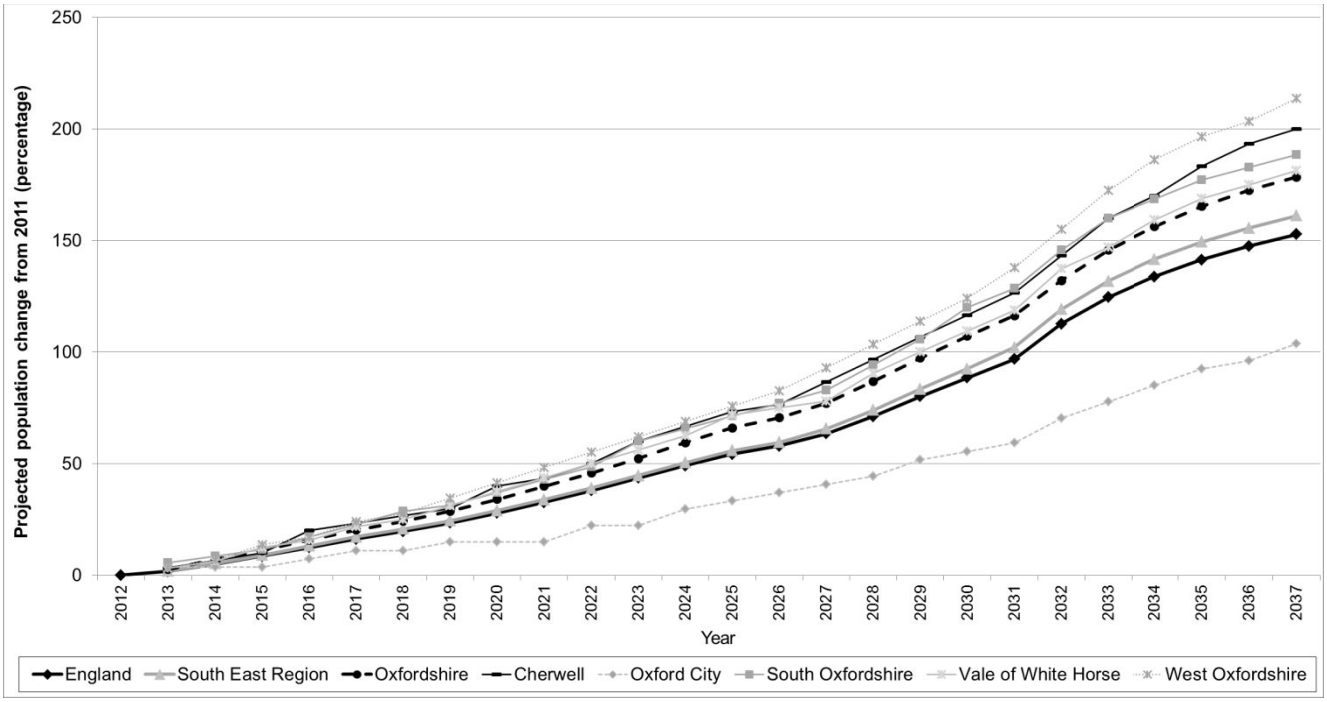
Longer life is of course a blessing, and a healthy, active, productive longer life is an even greater blessing. However, ageing inevitably brings change, and often declining health, some limitations and often loneliness. Learning to adjust to this is a life skill we urgently need to acquire.

The impact of an ageing population is now a daily reality for our health and social services. It manifests as increasing demand on GPs, pressure on hospital beds and social services and delayed transfers of care.

There is, however, some comfort here: a statistic called **'disability-free life expectancy'** which measures the years of healthy life we can, on average, expect. For the period 2009-2011 disability-free life expectancy at birth in Oxfordshire was 67.6 years for males and 69.3 years for females. Trends since 2006-2008 show that disability-free life expectancy is increasing for both sexes.

Disability-free life expectancy in Oxfordshire remains significantly above the national average. Male disability-free life expectancy has consistently been in the top 10% of the 150 upper tier local authorities in England since 2006-2008. Female life expectancy has been in the top 20%.

In terms of numbers, the pattern of ageing is not the same across the County. The chart below shows the projected percentage increase in the over 85s from 2012 to 2037 by District:



Source: Office for National Statistics

It can be seen that the percentage growth in the number of over 85s in the more rural parts of the County is higher than in the City. Growth is highest in West Oxfordshire. This means that demographic pressure is not even across the county and plans will need to reflect this. It is not a case of 'one size fits all'.

The pattern of diseases also changes as the population ages. Patterns of disease in older age are characterised by:

- chronic diseases such as diabetes
- heart problems, stroke and high blood pressure
- physical diseases accompanied by mental health problems such as depression
- physical diseases accompanied by mobility problems
- increasing numbers of people living with dementia.

This means that services need to change to respond, and we are seeing a re-shaping of GP services in response, through personal long-term care plans and care by teams of professionals sharing a single electronic record of care. There is also a move to longer GP appointments for people with multiple diseases and a recognition that dementia is a condition whose course can be improved through prevention, early detection and treatment.

Society as a whole has needed to respond to this change too as it is recognised that the tax-base will struggle to cope – hence we see increases in pensionable working age, increasing national insurance payments and squeezes on occupational pensions.

We have also seen radical change in the way social care is funded and what it covers. **The Care Act** has come into force and it strives to strike a 'fair deal' between people and their lifetime entitlement to social care, their personal wealth and the thresholds for State support. Crucially it has also recognised **the needs of carers** and has enshrined their entitlement to support. The plain fact is that without carers, our present health and social care system would be 'dead in the water' and so carers need to be cared for too.

In terms of health and social care funding, the trend is for these to become more closely aligned. **The Better Care Fund** is an example of this. The NHS continues to have its funding protected while Local Government funding is squeezed. This means that there will need to continue to be a flow of funds from NHS to social care in exchange for shared plans and integrated services.

We will now look at 3 crucial aspects in more detail:

- the exact size of the ageing population going forward
- the challenge posed by dementia
- the problem of loneliness and isolation.

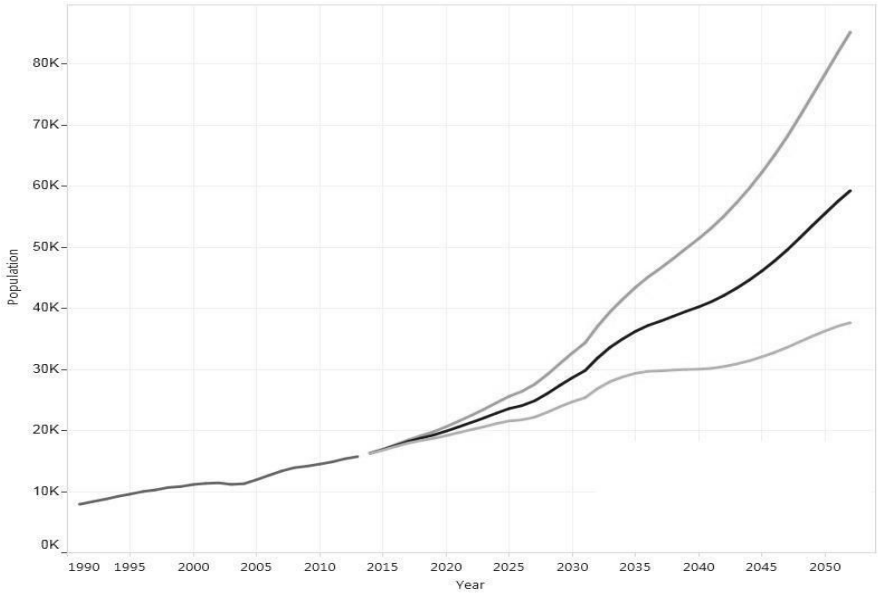
Just how big will the ageing population be?

The answer is uncertain. Any future projection is an educated guess and depends on:

- Life expectancy
- Housing growth
- Movement of people in and out of the County

The chart below shows just how different the population estimates might be, looking at the period 1990 to 2050 for those aged 85 and over. As we get further towards 2050, it becomes less a matter of science as we move into the realms of clairvoyance! Factors such as housing growth and their impact on where older people live are notoriously hard to predict.

Population projection for those aged 85+ in Oxfordshire showing 3 scenarios:



The top line, shows the maximum projected number (and it is truly shocking), the bottom line the minimum number and the middle line the most likely scenario. This gives us a range of growth to 2052 of between 22,000 and 70,000 people aged 85 plus, i.e. the difference between highest and lowest projections is around 48,000 people!

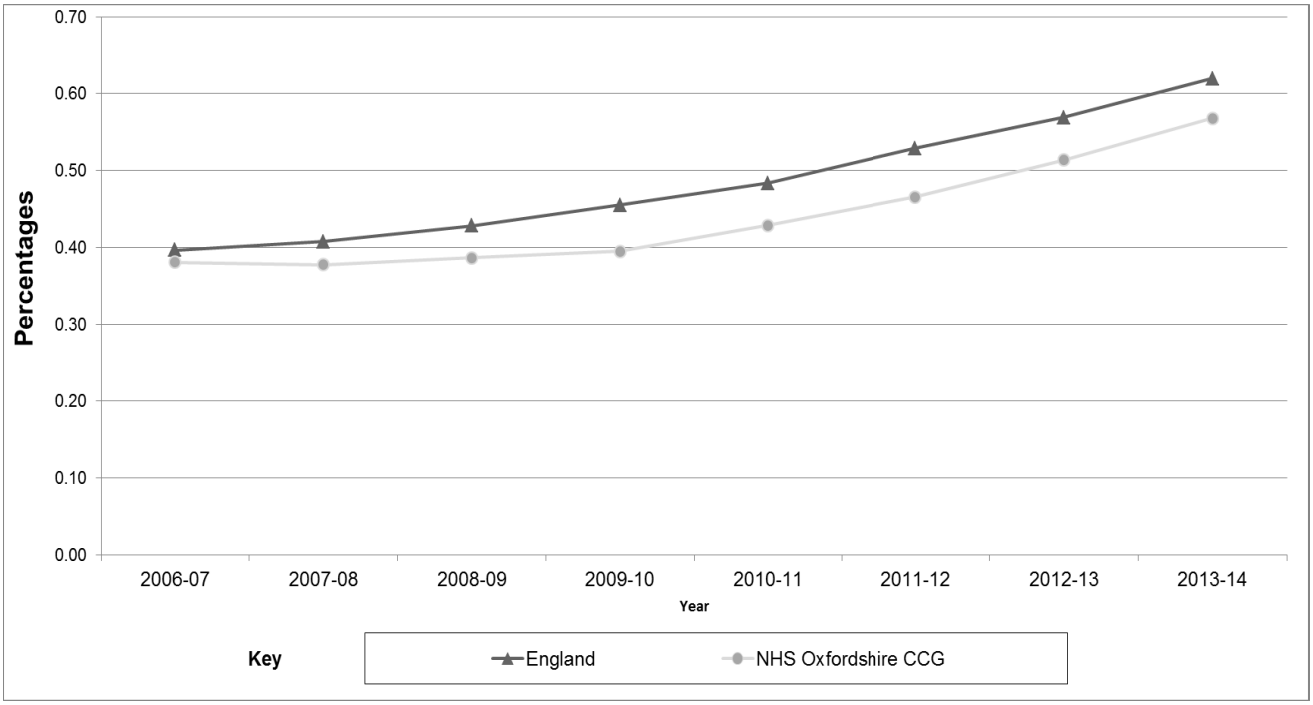
Of course, the projections closest to the present day are the most accurate, and this shows a growth in the ten years from 2013 to 2023 of between 4,900 and 7,700 people (31% increase to a 49% increase). The 'most likely' increase (the middle line) is 6,300 people aged over 85, an increase of 40%.

Looking at the figures for disability-free life expectancy shown above, it can be seen that we can expect many people at this age will have some disability and be in need of complex long term health and social care.

Dementia

The Government estimates that in the UK around 800,000 people are living with dementia and that this costs the economy around £23 billion every year.

The chart below shows the percentage of patients registered with local GPs in Oxfordshire Clinical Commissioning Group diagnosed with dementia from 2006/2007 to 2013/14:



The chart shows:

- A gradual rise in the number of cases known to GPs from 2,500 to 4,000.
- A gradually increasing trend.
- Oxfordshire is broadly in line with national trends.

We need to be careful with this measure. There will be many people with early dementia who are not yet known to general practice or people who are known, but are not recorded as such. The recorded cases may be only 50 % of the total. The upward trend shows in part the increasing awareness of dementia, and the benefits of recording and treating it early. We also need to remember that these patients will be some of the frailest in the County and will also suffer from other chronic diseases.

As a County we have a target for GPs to have recorded 67% of people with dementia by March 2016 using Government estimates of the likely 'true' number of cases in Oxfordshire.

Is Dementia a preventable disease?

The jury is still out. Dementia is really a family of diseases and some may be preventable. There is a growing consensus that a sensible lifestyle may prevent some cases of dementia, especially those resulting from disease of the heart and blood circulation. It is a complex topic, and until a definitive conclusion is reached it seems reasonable to follow the advice summarised by the NHS and leading dementia charities which recommend that the following may reduce one's chances of developing dementia:

- not smoking
- controlling high blood pressure
- reducing your cholesterol level
- controlling your blood glucose if you have diabetes
- exercising regularly
- achieving and maintaining a healthy weight
- eating a healthy, balanced diet with lots of fruit and vegetables and low amounts of saturated fat
- drinking alcohol within the recommended limits.

The list sounds familiar and is good news, as it is in line with general advice for a healthy life and is well covered by the NHS Health Check. It may provide some with the extra motivation they need to adopt a healthier lifestyle – not only will you feel better, and reduce risk of heart attack, stroke and cancer; you may well lower your risk of dementia too.

Health and Social Services and Dementia

Services have undergone significant improvements over the last 5 years.
Noteworthy improvements are:

- The CCG have appointed a GP to lead on improving dementia services and as a result we have a new primary care memory assessment service across 32 practices.
- The existing memory assessment service provided by Oxford University Hospitals Trust has been improved to reduce waiting times.
- Plans are underway to commission a countywide dementia support service to help patients and families throughout the disease, to help plan and navigate a path through services to make care less disjointed. This will be in place in early 2016. This includes younger patients with early onset dementia.
- Adult Social Care services are working on improving the quality and supply of the market for home care and residential care.

Dementia Friendly communities, organisations and individuals

This isn't all about statutory services. Everyone can help. The idea behind 'Dementia Friendliness' is to raise awareness of dementia in individuals and communities and organisations so that they can help and support people suffering from all stages of dementia. This can help at many levels, from a more understanding village shopkeeper to a better signposted city.

Oxfordshire has responded well to this and has worked with the Rural Community Council to establish 57 dementia friendly communities and to train staff to become 'dementia friends'.

Loneliness and older people

Since highlighting this issue two years ago, loneliness is now firmly established as a risk factor for poor health in old age. It occurs in both rural and urban communities, but older people living in greater isolation in more rural parts can be more at risk, especially if local facilities such as shops and post offices are scarce. Age UK have called loneliness the "hidden killer", because it is estimated to increase the risk of death in elderly people by about 10 per cent.

Loneliness has a wide range of negative effects on both physical and mental health. Some of the health risks associated with loneliness include:

- Depression and suicide
- Cardiovascular disease and stroke
- Increased stress levels
- Decreased memory and learning
- Poor decision-making
- Alcoholism and drug abuse
- Faster progression of dementia

The impact of loneliness on mental health is well known, but the impact on physical health is only just being understood.

We can get a handle on loneliness in older people by looking at the census data on people living alone who are aged over 65. The table below gives the figures:

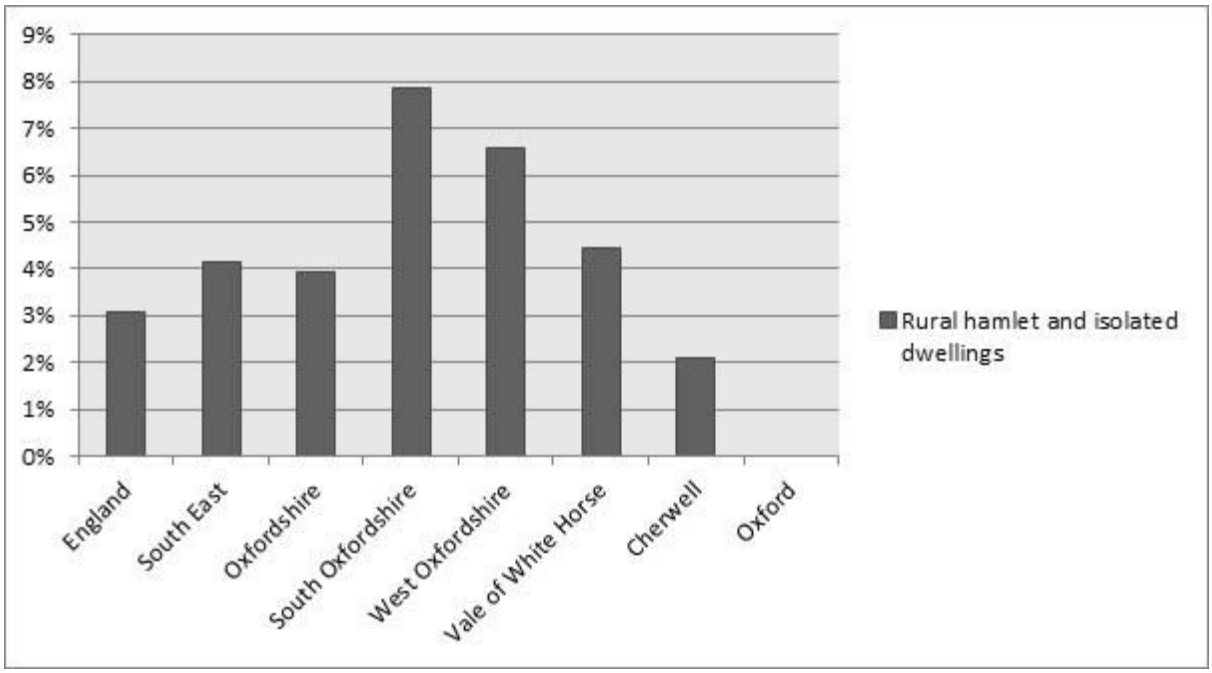
Area	One person households aged 65 and over in 2001	One person households aged 65 and over in 2011	One person households aged 65 and over in 2001 – As a percentage of all households	One person households aged 65 and over 2011- As a percentage of all households
Oxfordshire	31,140	29,852	13%	12%
Cherwell	6,118	5,967	12%	11%
Oxford	7,415	6,049	14%	11%
South Oxfordshire	6,728	6,570	13%	12%
Vale of White Horse	5,738	5,947	12%	12%
West Oxfordshire	5,141	5,319	14%	12%

The data tells us that:

- Living alone in older age is a common finding. In 2011 there were 30,000 people over the age of 65 living alone **– that's about one in every 8 households across the County.**
- The percentage of older people living alone is about the same in rural and urban areas.
- The percentage has been fairly stable on average over the last 10 years at around 12% to 13%.

We can get a handle on isolation from the chart below:

Percentage of People living in a rural hamlet/isolated dwelling by Area



Source: ONS 2011 Census: Population Density

This shows that:

- The proportion of people living in isolated hamlets is around 1/3 higher in Oxfordshire than the England average (around 4% vs. 3%).
- The proportion varies from District to District with South Oxfordshire the highest (almost 8%) followed by West Oxfordshire (around 6.5%).

The data needs to be interpreted with caution – for example the many isolated hamlets in Cherwell will be masked by the much larger populations living in Banbury and Bicester. The data also includes all ages, not just the elderly, but as we have seen, many rural parts of the County have a greater number of older people, and so, isolated hamlets are likely to contain more elderly people. Every small community is different, but elderly people in these settings can be particularly vulnerable to loneliness.

The Impact on Social Care

Dementia, lack of an informal carer and loneliness all act as triggers for needing residential social care services. Tackling these problems early can therefore both increase quality of life and reduce the County's Social Care bill.

With regard to the ageing population, dementia and loneliness, what have we said before and what should we do?

Previous annual reports have recommended:

- The importance of joining up services and plans between health and social care.
- Using the Health and Wellbeing Board as a vehicle for change.
- Improving the sophistication of the use of the existing pooled budgets.
- Improving the lot of carers and making them a priority.
- Working more closely with voluntary organisations to help communities support themselves.
- Supporting volunteering to make it easy for people to volunteer.
- Making loneliness and isolation better understood causes of poor physical and mental health.
- The need to detect dementia early and improve services.
- Work all of the above factors into a single plan for Oxfordshire.

These recommendations all show improvement, but now need to be driven to a new level as this issue is such a high priority for the decades to come.

Recommendations re Population Change

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

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

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

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

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

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

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

8. The Oxfordshire Health Overview and Scrutiny Committee should consider scrutinising progress on these matters as part of its forward planning.

Chapter 2: Health, Houses and Roads

Main Messages in This Chapter:

1. **The built environment and the road network have a clear role to play in health and wellbeing, including stimulating the economy, providing jobs and prosperity, building communities that support health and helping to promote exercise.**
2. **Put together with well-designed green spaces, these will have a powerful, sustainable and long term impact on the health of Oxfordshire.**
3. **It is therefore time to place health considerations into a more prominent place when planning decisions are made.**
4. **We have made a good start on this and are in a good position to do more.**

This chapter is about the relationship between health and wellbeing and planning for the built environment and road and rail projects.

I'm pushing an open door here, as, during 2104/15, County Council planners have welcomed input from the Public Health team with open arms and this has helped to lever new funds into the County.

This gain has been made possible by Public Health being part of Local Government. It helps that the link between health and planning is already enshrined in national planning practice guidance as follows:

"(Local Authorities should) *ensure that health and wellbeing, and health infrastructure are considered in Local and Neighbourhood Plans and in planning decision making*".

This chapter sets out some of the issues for the future as well as reporting on progress made.

Demography and Housing Numbers

According to current plans, the next couple of decades will see the number of houses in Oxfordshire increase dramatically. According to the Strategic Housing Market Assessment (SHMA) published in March 2014, **the current plans for housing growth (set at 2,887 new homes per year) need to be increased dramatically to between 4,678 and 5,328 new homes per year**, i.e. just about doubling the existing plans.

The report comes to this figure by taking current plans and adjusting them to take into account the need for affordable housing, the need to improve housing affordability and the need to support committed economic growth in line with Government expectations.

In summary the SHMA concluded:

"…..up to 93,560 – 106,560 additional homes are needed across Oxfordshire in the period 2011-2031 (between 4,678 – 5,328 homes per annum). "

Of course, this is all highly controversial and is the subject of much current debate about just how many houses there should be, where they should go and how they should be grouped and joined to the road network. However, whatever the result, it seems clear that there will be a significant increase in the population on the back of more house-building for all age groups in Oxfordshire in excess of current projections.

Other trends such as the tendency for more single people wanting to live alone make the picture more complex still.

My aim here is not to dispute the figures but to look at the implications for the health and wellbeing of Oxfordshire in its broadest sense.

More people and a growing economy means more houses, and more people means more travel on our road and rail systems, more need for schools and health services and a need to link the housing with workplaces and jobs.

The current systems to make all this happen are complex and confusing to say the least: a mixture of District and County Councils, developers, appeals, inspectors, businesses and the views of Town and Parish Councils and the views of many local people. New developments are rarely welcomed by locals, and the whole system is fraught with difficulties until an uneasy compromise is reached.

There is currently a disconnection between this planning and the future planning of GP and hospital services and it is a disconnection we should bridge.

I am not a housing expert, but looking at the data with common sense suggests that population change gives us a number of dilemmas:

- An increasing population means that more houses are needed.
- An ageing population means that a wider range of housing choices suitable for older people are needed.
- Loneliness and isolation in old age means that we need to find 'smarter' ways to design communities which will help older people be in contact with others.
- High house prices in Oxfordshire means that we need to build affordable places for the workers we need who attract lower salaries.
- The way populations and available land are distributed across District Council boundaries means that close cooperation between Districts and County is needed.
- Congestion on the roads means that we need to encourage workplaces that are strategically placed and which are near to where potential workers live. Broadband should help with this and will help reduce commutes through working at a distance.
- We need to consider facilities like GP surgeries along with schools and shops when designing new communities.
- We need to consider the impact on hospitals and community health services as a key element of community infrastructure.
- We need to design new communities with care to avoid creating areas where the cycle of disadvantage can thrive.

The link to Health and Wellbeing

But what has this got to do with health and wellbeing? The simple answer is - plenty!

There are strong links between housing and health. 150 years ago, the fledgling science of Public Health cut its teeth on issues of overcrowding, poor sanitation and disease-laden air and water which helped diseases like TB and cholera run rife.

Research shows that people's perception of the good life is tightly bound with their feelings about their homes and local communities, the quality of their commute, and the environmental change this implies. On top of that, 'growth' is linked to prosperity, income and satisfaction at work which all promote good physical and mental health. Good jobs help to lift communities out of disadvantage and help people stand on their own two feet.

For example, the 2012 Marmot review of Spatial Planning makes no bones about it and summarises the position as follows:

'The elements identified as having a significant impact on health, as well as relating to socio-economic status are:

- *Pollution*
- *Green and Open Space*
- *Transport*
- *Food*
- *Housing*
- *Community Participation and Social Isolation*

The link between disadvantage and the quality of the environment in its broadest sense was also made explicit:

'There is a social gradient in health: those living in the most deprived neighbourhoods die earlier and spend more time in ill health than those living in the least deprived neighbourhoods. Such health inequalities are determined by social inequalities, including environmental inequalities; there is a gradient in the distribution of environmental disadvantages: those living in the most deprived neighbourhood are more exposed to environmental conditions which negatively affect health.'

Spatial planning decisions are thought to have a direct influence upon:

- Heart disease
- Respiratory disease
- Mental health (acute and chronic effects)
- Obesity
- Physical injury
- Increased mortality and morbidity

There is also strong evidence to suggest that:

- Providing safe and easily accessible space increases physical activity levels
- Reducing traffic improves air quality
- Green spaces improve mental health

What practical things can we do to build improved health into developments?

A realistic list might be:

- Building health-promoting communities, i.e. those incorporating green spaces and those which encourage exercise, play and socialising. This needs to be part of planning for major new developments. A difficulty here is the creation of 'pepper pot developments' which scatter a few houses here and there. They add to existing communities piecemeal and make an overall plan difficult to achieve.
- Building in proper, purpose-built cycle paths into new road schemes where the terrain is suitable and the demand is high. This could reduce commutes by car and pays back handsomely in terms of preventing heart disease and improving mental wellbeing
- Build according to population need – in particular working with developers to build housing options which are attractive to older people as they age, enabling their larger houses to be freed up for younger families, and to build sufficient key-worker and affordable housing to make sure our hospitals, fire stations and schools are staffed.
- The need to make provision for these factors through developer contributions and the new Community Infrastructure Levy (which in effect 'tax' developers of housing so that essential roads, schools and amenities can be built). This currently does not include GP surgeries as a requirement. This issue is also difficult to handle if new houses are scattered pepper-pot style and again, this can lead to a mismatch between where houses are located and the services they need, which puts further pressure on the roads they need which supply them, which makes congestion still worse.
- All of this will rely on goodwill between Districts and involving the health service in the debate.

I don't want to be naïve or Pollyanna-ish about this. This is incredibly difficult, fraught and sensitive work, and Local Government Councillors and planners wrestle with these issues day in day out, but the stakes seem too high for our future wellbeing not to include health considerations more explicitly.

Recent Developments and Progress Made

Local Transport Plans and Active Transport

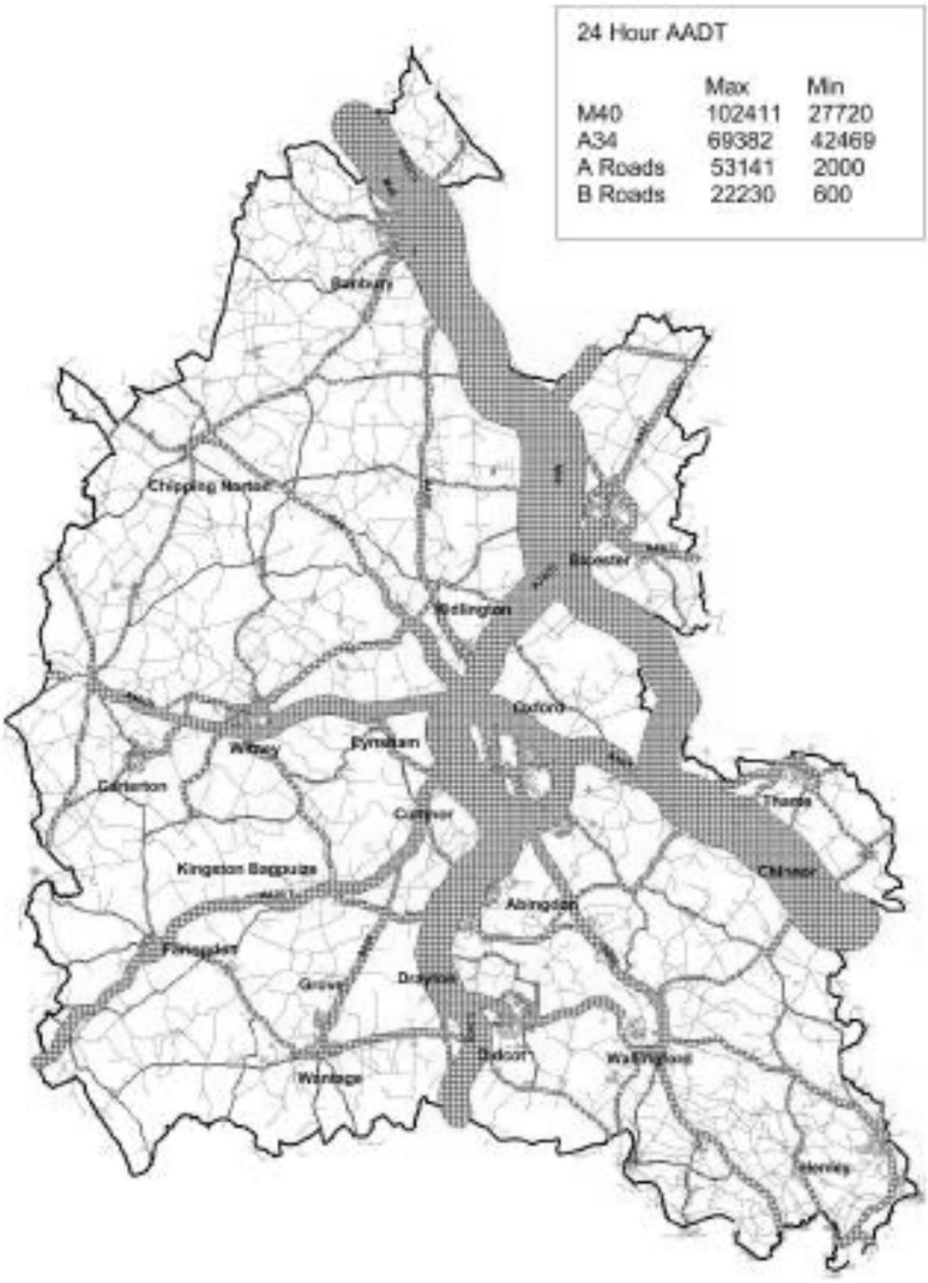
The County is currently completing its fourth Local Transport Plan (LTP4). This plan acts as a blueprint for developments to our road and rail networks, which in turn need to mesh into plans for housing and future workplaces. Its four objectives are:

- To support jobs and housing growth and economic vitality
- To support the transition to a low carbon (dioxide) future.
- To protect and, where possible, enhance Oxfordshire's environment and improve quality of life.
- To improve public health, safety and individual wellbeing.

It is great to see that to some extent, all of these goals are aligned with improving health and wellbeing, and the last explicitly so.

Creative solutions will be needed because, as in many other parts of the country, using Oxfordshire's roads is not always easy. **The map below shows the current road system by frequency of use**. The wider the road, the bigger the volume of traffic it carries. The current road network has real problem areas, some of which have implications for the national economy (and therefore national wellbeing) as well as the local economy.

The A34 is perhaps the most celebrated example. Instead of a North-South motorway connecting ports with the Midlands, we have a half-way-house dual carriageway which at times turns into a ring road and is prone to traffic jams when there is an incident (or a Black Friday shopping event!).



Annual average daily traffic flow bandwidth map – based on automated traffic counts throughout Oxfordshire. (Source: Oxfordshire County Council Transport Monitoring)

With roads and transport come concerns about air quality, which is a fiercely debated bone of contention.

Air Quality

This is a highly technical topic, but the current position on air pollution can be summarised as follows:

1. Outdoor air pollution has decreased markedly over the last 100 years and has continued to decrease over recent decades due to tighter laws and advances in technology. The age of coal burning, "pea-soupers", blackened buildings and leaded petrol is past.
2. However, burning fuel does produce pollutants such as Nitrogen Oxide, Nitrogen Dioxide, Nitrous Oxide and Sulphur Dioxide, which in turn react with the air to form further pollutants including ozone. 'Fine particles' are also produced.
3. These pollutants can cause adverse effects on health, both short term and long term. It may be the fine particles that have the most long term impact but these are hard to measure.
4. This impact is mostly a generic one, i.e. many people will be slightly affected. The impact is very difficult to measure credibly and statistics should be viewed with caution. On the whole levels in Oxfordshire are about the same as the England average.
5. In some ways this could be seen as a trade-off. We all want to have warm houses and to move around, and the cost is a slight impact on health. Of course, having warm houses also has a positive impact on health and so the final balance sheet is hard to tally.
6. Local situations cause local people considerable aggravation and thus, air quality as a health issue is frequently raised as one of a number of objections about a proposed development or to argue for a new development such as a by-pass.
7. The long term view is that air quality gradually continues to improve and that standards and legislation can gradually reduce pollutants. However, as a society, there is always likely to be a balance between the desire for faster travel, warmer homes and air conditioning etc. and a threat to air quality.
8. Greener options such as solar panels and electric cars are becoming gradually more accepted and more feasible and may be the way of the future.
9. This situation needs close monitoring as population numbers rise.

Broadband as Infrastructure Planning

We should also include the development of broadband here, as it allows the idea of 'workplace' to change.

The workplace for an increasing number has either shifted to home or is a flexible arrangement between home and office. Broadband also enables offices to be located in innovative developments such as converted barns up and down the County and makes working patterns much more flexible, taking some of the heat and stress out of the traditional rush hour. For example, this report is being typed at home on a warm Spring evening – unthinkable 10 years ago.

Broadband is also the lifeblood of the hi-tech industries that fuel the Oxfordshire economy and keep its 'knowledge spine' alive.

Oxfordshire has done well in introducing broadband and has leap-frogged the national queue. Of course coverage isn't perfect in some areas, but the overall picture is positive.

A Word about Cycling

I'm often surprised by how much negativity cycling (or cyclists) generate when I discuss the topic. It's a shame because cycling has real, tangible, strong and lasting health benefits.

For example the research shows that:

- Cycling for 60 minutes per week or more reduces cardiovascular mortality by 13% and cancer mortality by 7%.
- Switching from using a car to cycling to work results in an increase in life expectancy of between 3-14 months on average.
- The health benefits of switching to cycling as a form of travel to work result in savings of approximately £1,100 per year per person.
- It is estimated that an 8 fold increase in cycling nationally would result in £17bn in savings to the NHS over 20 years.

Much of the problem arises because we are obliged to mix bikes and cars, or bikes and pedestrians, and they mix together about as well as oil and water. Let's face it, it isn't easy to modify towns and villages laid out in medieval times to accommodate the ever-widening car, the juggernaut and the ever-so-vulnerable cyclist.

All that aside, on balance I would like to say a serious word in support of cycling and the need to encourage it where possible. It seems to me that the practical longer term answer lies in separating cyclists from other road users and building this into selected new transport schemes.

A strong dash of pragmatism will be needed too. Some places are pretty hilly even in Oxfordshire, and, where money is tight, schemes will need to be chosen with care starting with those where demand will be high. Cheaper and sensible solutions are likely to include using parts of footpaths where they are wide enough and promoting selected quieter streets as cycle routes.

Meanwhile we will have to do our best with improving the sticking-plaster solutions that painted-on cycle lanes provide.

The really great thing to bear in mind is that once a cycle path is in place, the pay-back in terms of health goes on increasing for decades.

Recommendations

1. Oxfordshire County Council's Environment and Economy Directorate should continue to embrace input from the Public Health team and this should develop further.

2. The NHS should become a consultee for local planning decisions and the Clinical Commissioning Group should be offered membership on key planning groups.

Planning and health infrastructure should be considered when developer contributions are considered.

3. Housing developments and housing developers should more closely reflect population need, with regard to housing options suitable for people as they age, and the needs of key workers should be given increased strategic consideration.

4. Cycling should be seriously encouraged in new road developments which are likely to attract high usage. Alternative cycle-only commuter routes using features such as rivers and canals should be considered.

Chapter 3: Breaking the Cycle of Disadvantage

Main Messages in This Chapter

1. **Inequalities due to disadvantage taken as a whole appear to have reduced over recent years.**
2. **This is due to persistent targeting of problems for a number of years. This is a good result but the problems have not gone away. Continued effort is needed.**
3. **However areas of disadvantage remain and new areas are emerging.**
4. **This is a serious concern and will require further persistent effort.**
5. **Persisting with work to break the cycle of disadvantage should remain a major priority**

I was recently asked whether inequalities due to disadvantage in the County were increasing or decreasing. This chapter attempts to answer that question.

It is particularly timely as the Health and Wellbeing Board supported the establishment of a Commission to look closely at this issue across the county. It is intended that this section will inform that process.

Overall, we have to remember that disadvantage is a many-headed hydra: it exists in many forms. New types of disadvantage appear all the time as society changes. The answer about whether the 'gap' is widening or not is, 'it depends which aspect of disadvantage you look at'. I provide here an overview of the main forms of inequality due to disadvantage and come to a judgement about whether they are increasing, decreasing or staying the same.

The good news is that we are making a positive impact on many forms of long term disadvantage which are reducing. It is however a mixed picture and we need to make concerted efforts to tackle those that remain or are emerging.

In this chapter I will consider 15 different indicators of disadvantage in turn and reach a conclusion about each.

1. Disadvantage in gender

The bare facts show that women can expect to live longer on average than men, but that men are catching up and narrowing the gap. This is because fewer men are now injured in the workplace due to improved health and safety standards and the decline in the more hazardous industries. Men have also begun to smoke less than previously, and smoking is still the biggest killer. The effect of two world wars used to increase the gap in life expectancy, but this effect is now diminishing as the population ages.

Women on the other hand have tended to take up smoking over the last 50 years, increasing their death toll – the number of younger women smoking is now about the same as in men. Drinking levels in women have also similarly increased. Women also suffer from the relatively common breast cancer which adds to the early death toll, although vastly improved treatment and survival rates mean that many more women now survive this condition.

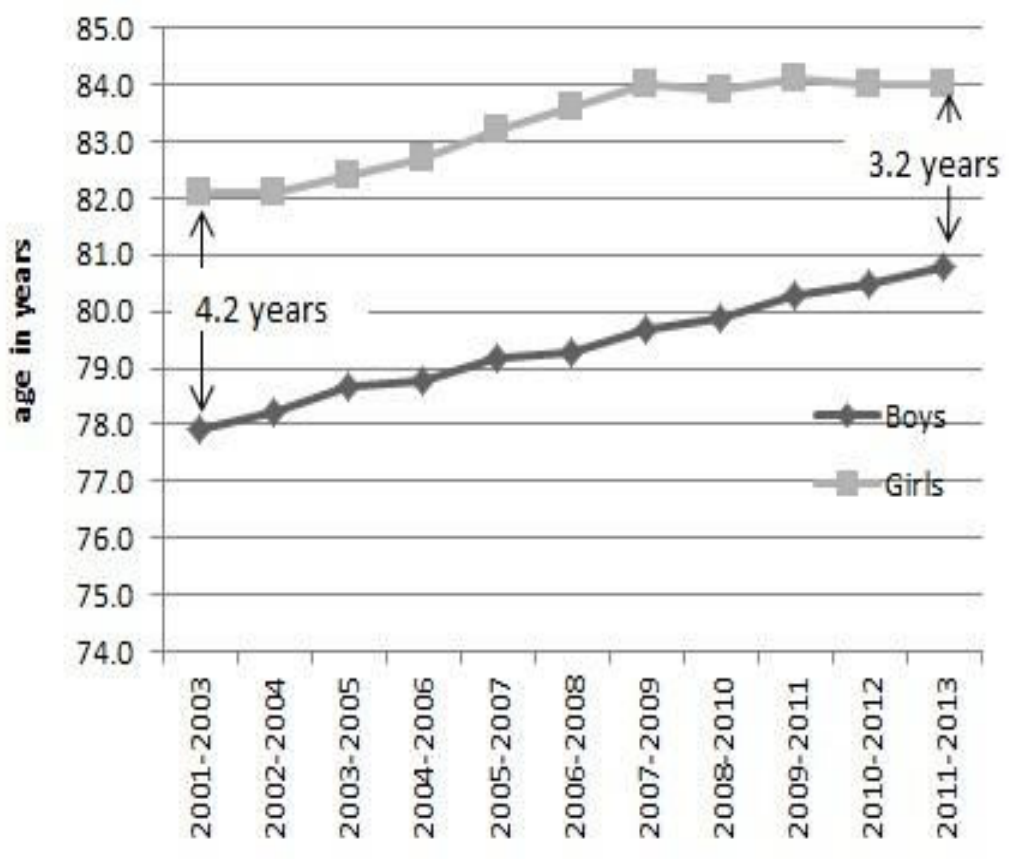
The situation can be summed up as follows:

- The male avoidable death rate fell from 408 deaths per 100,000 in 2001 to 278 deaths in 2013. The ***female rate dropped more slowly*** from 235 to 169 per 100,000.
- Coronary ***heart disease*** is still overall the most common ***single cause of avoidable death***, having ***fallen proportionately more for men than women***.
- Avoidable ***lung cancer*** deaths have also ***dropped for men but risen for women***: lung cancer is the biggest single avoidable killer.

The gap between male and female life expectancy at birth in Oxfordshire has reduced in recent years. The change is due to male life expectancy increasing at a faster rate.

The picture is shown below using a measure of life expectancy from birth.

Male and female life expectancy at birth in Oxfordshire



<u>Conclusion:</u> On the whole disadvantage due to gender inequalities are reducing, mainly because men's prospects have improved. Women need to be cautious with regard to smoking and drinking habits.

2. Inequalities in Health and Wellbeing and Age

I have discussed ageing more thoroughly in Chapter 1. This section deals briefly with the main points with regard to disadvantage.

While ageing is often a rewarding and fulfilling part of the life cycle, it is often accompanied by declining health and mobility and fewer material resources. As mentioned in the previous chapter, the main risk for diseases such as dementia is simply being older. We have also already noted the additional risks posed by loneliness in old age. Ageing is therefore a source of disadvantage. The question is, is it getting better or worse?

Chapter 1 also noted that the period of 'disease-free life expectancy' was also gradually increasing, and this can be seen as a reduction in the overall impact of ageing on health. The fact that dementia is now better detected and treated also reduces a further potential disadvantage.

Conclusion: ***Disadvantage is potentially present in the ageing process, but improvements in health care and its delivery and tackling issues such as loneliness and adopting healthier lifestyles may be reducing this cause of disadvantage as shown by longer 'disease free life expectancy'. Persistence will be required as the population continues to age.***

3. Carers and Disadvantage

We rely on carers of all ages to keep health and social care services functioning and we neglect them at our peril. As mentioned previously, the rights of carers to receive care themselves have recently been enshrined in the Care Act. I have underlined the importance of carers in many annual reports and the summary position last year was that Oxfordshire's performance was good overall. A new Carers' Strategy is currently being developed to enhance services further.

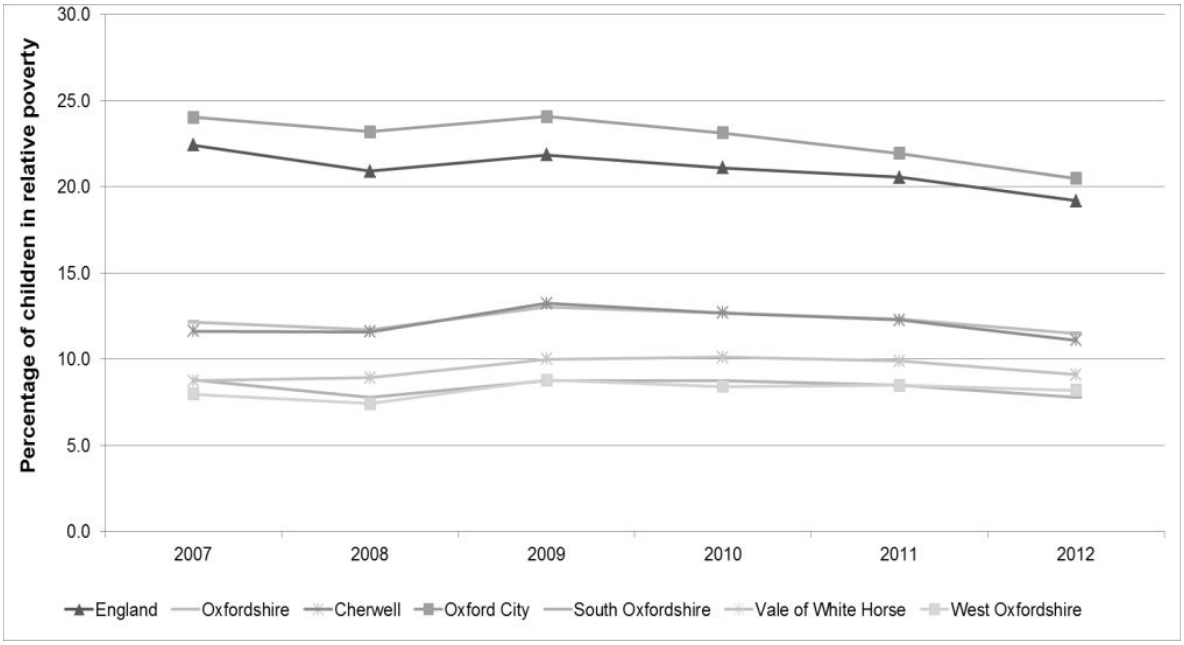
Being a carer can represent a serious disadvantage, and the impact on people's lives needs to be minimised.

Conclusion: ***There is still a way to go, but the recognition of the importance of carers of all ages and the development of services to help them means that on balance this cause of disadvantage is decreasing.***

4. Poverty

The following statistics shed light on the local picture. With regard to child poverty the chart below shows the current picture:

Child Poverty in Oxfordshire and Districts (2007-2012)



Source: Child Poverty Unit

Defining child poverty is difficult and controversial. It is a relative measure based on the average national income. The definition used is: "*children under 16 in families in receipt of out of work benefits OR who are in receipt of tax credits with an income of less than 60% of national median income.*"

The chart shows that child poverty overall in Oxfordshire is low compared to England and is fairly static at around 12%. The England figure is around 19%. This reflects Oxfordshire's overall prosperity and is broadly good news.

However, the City is a clear outlier here compared with the rest of the County, with slightly higher than the national average figure of around 21% in 2012. That is 1 in 5 children in the City were classed as living in poverty by this measure.

This is a significant source of disadvantage in the County and a serious cause for concern, although levels are falling across the board.

Smaller areas around the County in every District will also be affected, but the poverty will be masked by the overall prosperity of the District as a whole. This effect is shown in the table below which shows data from the most recent quarter available in 2013.

Here Banbury Ruscote, Abingdon Caldecott and Witney Central also feature while the majority of the wards are in the City.

Top 10 wards in Oxfordshire for child poverty in 2013:

	Percentage of children in Poverty
Abingdon Caldecott	21.33%
Banbury Ruscote	20.88%
Blackbird Leys	23.20%
Carfax	22.18%
Churchill	20.41%
Cowley Marsh	21.82%
Littlemore	19.01%
Northfield Brook	21.94%
Rose Hill and Iffley	22.05%
Witney Central	20.11%

Conclusion: ***This form of disadvantage overall is reducing. Higher rates tend to occur in persistent pockets of disadvantage. These are a cause for concern.***

5. Employment

Correlations have been found between being in good quality employment and better health. Conversely, unemployment is linked to poorer health.

In the financial year 2013/14 there were 355,000 economically active people in Oxfordshire. This was equivalent to 80.1% of people aged 16-64. The rate of economically active people was just higher than for the South East (79.9%) and higher than England (77.5%). It was higher among men (85.5%) than women (74.4%).

In Oxfordshire 77% of people aged 16-64 were in employment (65% were employees; 12% were self-employed). This proportion has remained fairly stable over the last five years, having peaked at around 80% in 2006. The proportion employed was higher in Oxfordshire than in the South East (75%) and England (72%).

In 2013/14, 3.4% of people aged 16-64 in Oxfordshire were unemployed. This figure represented a reduction from a nine-year high of 6.5% in 2012/13. The rate in Oxfordshire was lower than for the South East (5.4%) and considerably lower than for England as a whole (7.3%).

Employment rates were similar across different parts of the County.

In November 2014, 0.7% of people aged 16-64 in Oxfordshire claimed Job Seekers Allowance .This continued a declining trend since February 2013, when the claimant rate was 1.7%. The rate for Oxfordshire remains lower than for the South East (1.2%) and less than half that of Great Britain (2%).

Conclusion: ***Unemployment in Oxfordshire is generally very low and this source of disadvantage is decreasing.***

6. Housing and Homelessness

The Health Improvement Board, which has representation from all District Councils, keeps a close eye on levels of housing need , people on the edge of homelessness and rough sleeping. A great deal of close partnership working takes place to keep the figures as low as possible.
The main measures it looks at and recent trends are summarised in the table below:

Indicator	Number of households		
	2012/13	2013/14	2014/15
Homeless households in priority need	312	307	325
Total homeless Households	476	517	498
Households in temporary accommodation	216	197	192
Homelessness Prevention	1992	2298	2454
Rough Sleepers			70

Households in priority need are defined as follows:

Local housing authorities have a duty to secure accommodation for households who are in priority need under homelessness legislation. Categories of priority need are pregnancy, dependent children, vulnerable as a result of old age, mental illness or handicap, or physical disability or other special reason, homeless as a result of an emergency such as fire or flood, a child aged 16 or 17, vulnerable as a result of having been looked after, accommodated or fostered, as a result of serving in the armed forces or having been imprisoned or ceasing to occupy accommodation because of actual or threatened violence.

In an Oxfordshire context, District Councils are the Housing Authorities, but it is recognised that working in partnership is required for effective services – the Health Improvement Board oversees this.

The data shows that:

- There are fluctuations in the data from year to year as one would expect. Drilling down into the data shows that levels in the City are higher than for the other Districts.
- The number of households in priority need has been broadly static at just over 300 presentations per year. However if we look back a little further, there is an upward trend from 249 households in 2010/11 to 325 households in 2014/15.
- The total number of homeless households has been broadly static, fluctuating around the 500 mark.
- The number of households in temporary accommodation fluctuates at around 200 per year.
- There has been a gradual increase in the number of households prevented from becoming homeless through 'positive action', from 1992 to 2454. Positive action covers securing accommodation with a housing association or in the private rented

sector as well as a result of the provision of advice, support or other intervention. This is a good achievement.

- The estimated number of rough sleepers is around 70 at any one time. This is the first year when all Districts have counted rough sleeping in the same way so no conclusions about the trend can be drawn.

What are we doing about it - Joint Working in 2014/15

There have been a number of areas of joint working over the 2014/15 year, between the County Council, District Councils, and other statutory partners such as the Oxfordshire Clinical Commissioning Group. This has included:

- Considering the health needs of homeless families placed in temporary accommodation by using a Health Notification Protocol.
- Working together to commission services for young people to support those in housing need.
- Multi-agency work to ensure current services for homeless adults still provide what is most needed.
- Making a successful bid for Central Government funding to support offenders with housing need. This work was led by Cherwell District Council.
- Closer working between the District Council Housing Authorities, Social Care and health services following a Housing and Health event in the City. This work was particularly focussed on preventing delayed discharge from hospital.

Conclusion: ***Overall the balance of evidence shows that the number of households in difficulties in maintaining accommodation and in need of help is broadly static. This form of disadvantage remains a cause for concern.***

7. Education – School Results

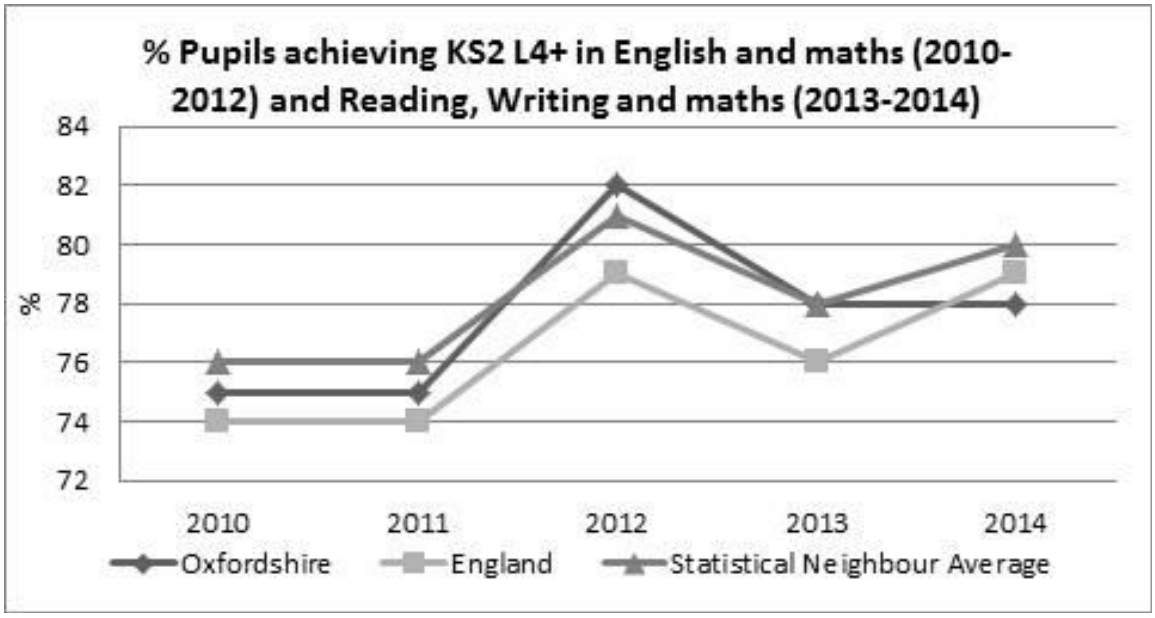
School results give a useful indicator of prospects for children. Poor results can reflect general disadvantage. The accuracy of the data means that these figures can be used to tease out underlying trends.

It has been noted in previous reports that this indicator is not simply about schools. It also reflects the general level of disadvantage among pupils in a local area which is due to many factors beyond the control of schools.

In this section we will look at the actual results at different key stages, focusing on results locality by locality. We will then look at the performance of different ethnic groups.

Results at Key Stage 2 (typically aged 11)

- Pupils are assessed at the end of Key Stage 2, which runs from Year 3 to Year 6. The key performance measure is the percentage of pupils achieving level 4 or above in reading, writing and maths.
- In 2014 78% of pupils in Oxfordshire achieved level 4 or above in reading, writing and maths. This represents a drop below the England average (79%) for the first time in a number of years. Oxfordshire now performs below the national and statistical neighbour averages and ranks 8th out of its statistical neighbour group (down from 5th in 2013).



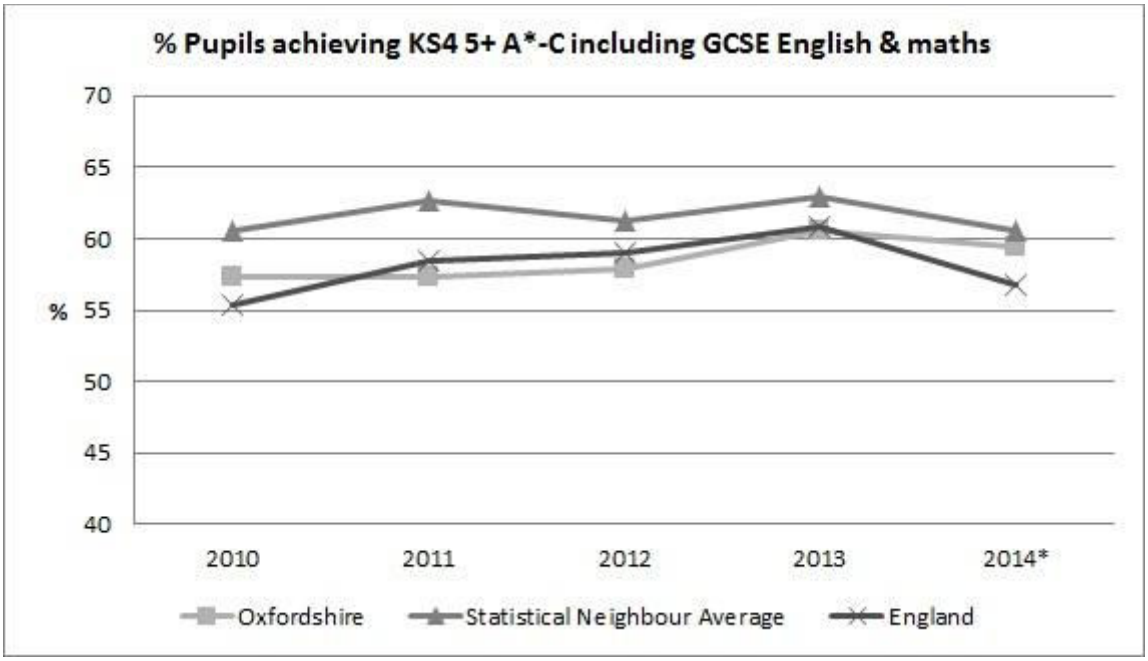
Source: Department for Education

- However, progress between Key Stage 1 and Key Stage 2 was higher across all subjects in Oxfordshire than the national average, with at least a 1% increase in each subject being reported in 2014.
- In 2014 pupils known to be eligible for free school meals in Oxfordshire were 23% less likely to achieve level 4 or above in reading, writing and maths than those who were ineligible. This attainment gap remains larger than the national average (18%).

Oxfordshire's statistical neighbours are: Bracknell Forest, Bath and NE Somerset, Buckinghamshire, Cambridgeshire, Gloucestershire, Hampshire, Hertfordshire, West Berkshire, West Sussex and Wiltshire

Results at Key Stage 4 (typically aged 15)

- The key performance measure at Key Stage 4 is the percentage of pupils achieving five or more A*-C grades at GCSE, including English and maths.
- In 2014, 59.4% of pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE, including English and maths. This was above the England average of 56.8% but just below the statistical neighbour average of 60.6%.
- This is a good result as previous reports have 'flagged' the previous poor performance compared with England as a major indicator of disadvantage.

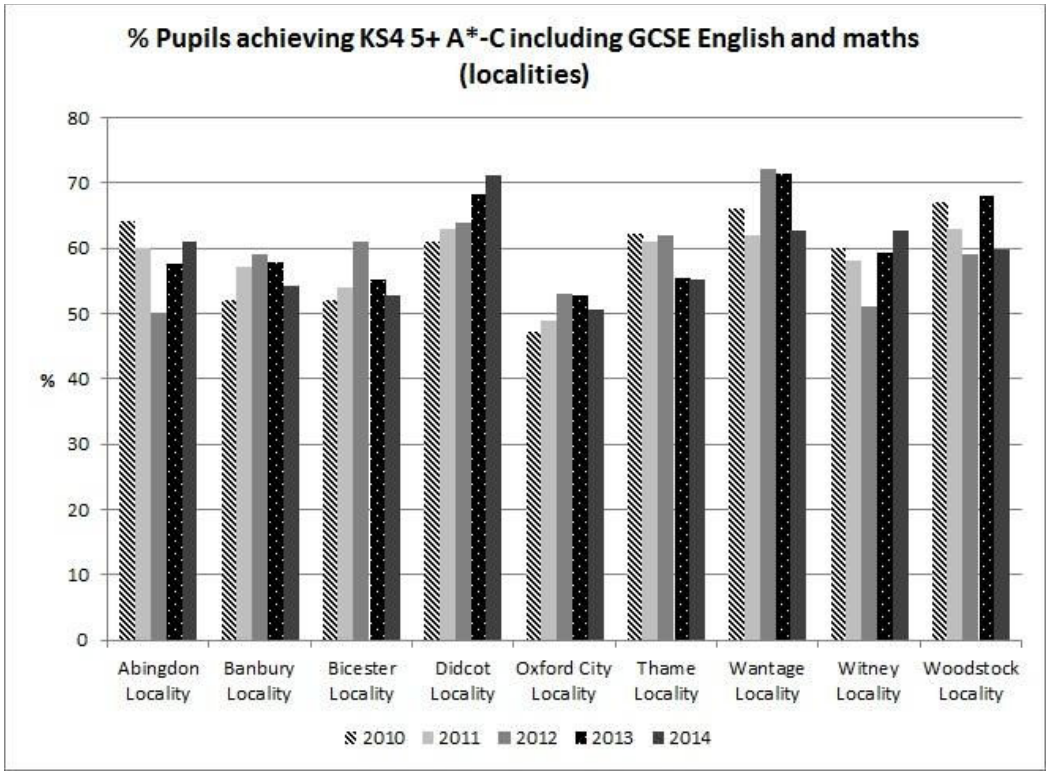


Source: Department for Education

- In 2014 the proportion of pupils at schools in Oxfordshire making the expected progress in English and mathematics was higher than the national average. This is a good result.
- Pupils known to be eligible for free school meals in Oxfordshire schools were 34% less likely to achieve five or more A*-C GCSE grades, including English and maths than those who were ineligible. This attainment gap remains larger than the national average (27%).
- The way in which performance is reported changed in 2014 and is now based on First Entry (i.e. the first time a pupil sits an exam), rather than Best Entry (which can include resits). For this reason previous years' results cannot be directly compared. The trend chart above should therefore be treated with caution.
- Across the County, GCSE performance in Oxford schools has moved out of the bottom quartile for the first time in a number of years. This is a good result and indicates a decrease in disadvantage.

Key Stage 4 results by Locality

Looking at school results at GCSE grouped by locality gives the following picture:



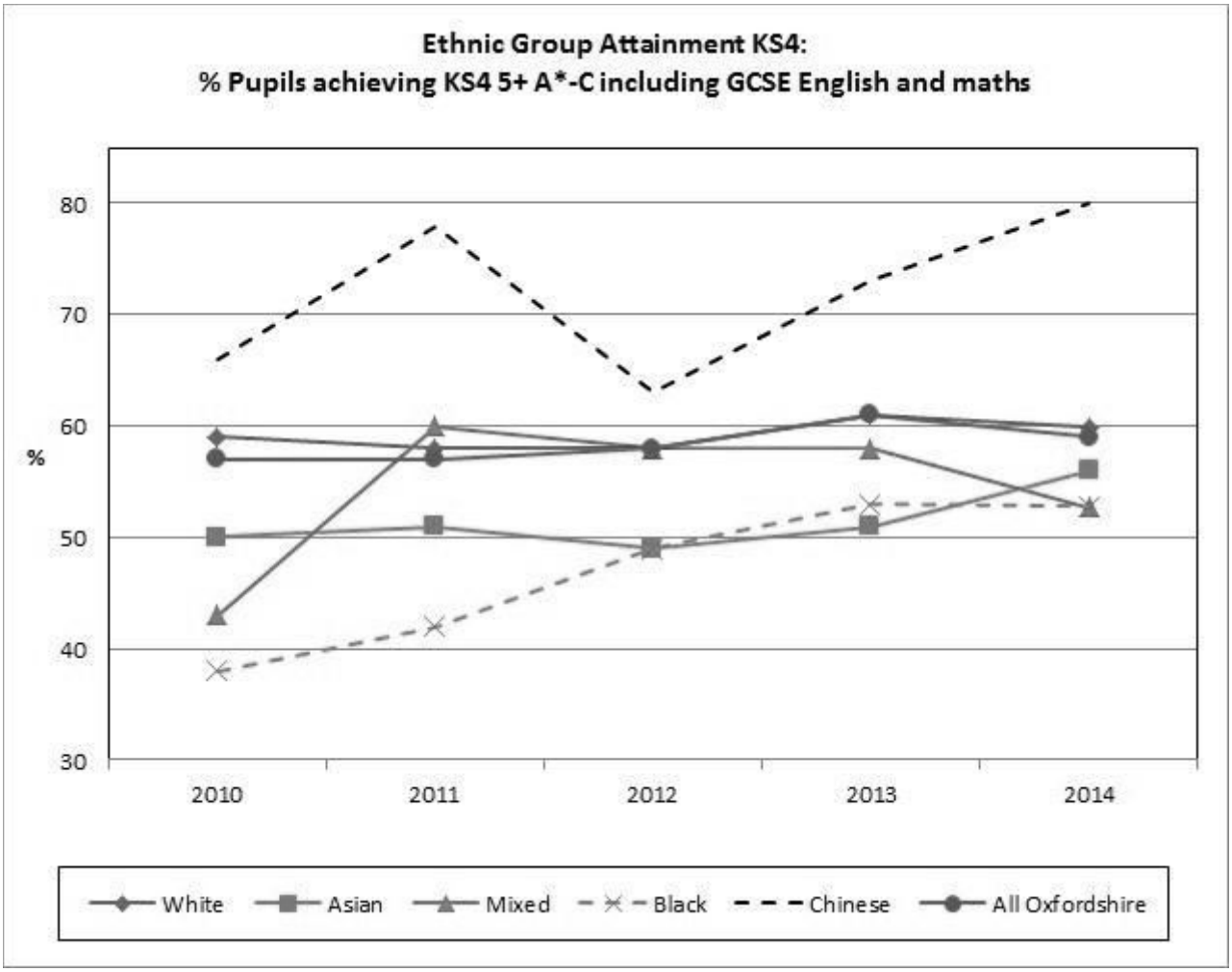
Source: Department for Education

It can be seen that:

- The Didcot locality has been gradually improving and now has average attainment at over 70%.
- Oxford City locality has improved since 2010, but has average attainment levels of around 50%.
- The gap between best and worst has remained broadly constant at around 20 percentage points.

Key Stage 4 results by ethnicity

- In 2014, 60% of White pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE, including English and Maths. This compares with 56% of Asian pupils, 53% of Black pupils and 53% of Mixed ethnicity pupils. ***Caution should be exercised due to the relatively small number of non-White pupils: in 2014 there were 302 Asian pupils, 258 Mixed ethnicity pupils; 125 Black pupils and 30 Chinese pupils. This means that results will fluctuate from year to year and is likely to account for some of the differences shown in the chart below.***



Source: Department for Education

The chart above shows that:

- Results for children from Black and Asian ethnic groups have improved steadily. This is a good result.
- The Chinese population's numbers are small, but perform above the average.
- Results for children of mixed ethnicity fell slightly last year.
- Overall these results show an improvement.

Conclusion: ***There has been recent improvement in this measure which has been a serious cause for concern in previous years. The gap has closed at key stages 4 and between key stages 1 and 2, but have widened at key stage 2. Children from minority ethnic groups are performing better on the whole. Children in receipt of free school meals and areas with the poorest results can be used to focus further effort.***

8. Ethnicity related Disadvantage

There has been an 'across the board' increase in the number of Oxfordshire residents from ethnic minority groups of 57% comparing 2001 and 2011, (46,000 more residents) the increase involving every District of the County.

Over a third of all city residents are from ethnic minority groups and over 10% of all Cherwell residents.

The picture continues to be fluid as populations from parts of the EU migrate in and out of the country.

Ethnicity doesn't necessarily equate with disadvantage, and the needs of different communities will differ widely – the needs of Polish, Lithuanian or Czech economic migrants are unlikely to be the same as a first generation Asian immigrant for example. However, ethnic minorities, especially those who are fleeing persecution and those who do not speak English well, do suffer health inequalities.

The position in schools, which shows improvement, was highlighted above – many schools are now teaching children whose first language is not English and the number of first languages spoken may be over 20 different languages.

In terms of disadvantage, ethnicity presents a number of challenges for example:

Health related disadvantage
Ill health does not affect all equally. For example people from the Asian sub-continent have a higher risk of developing diabetes, and are at risk of diabetes at lower Body Mass Index BMI than are 'white' ethnic minorities.

Language related disadvantage
Particularly among 1st generation migrants, language presents a challenge. It is more difficult to do as well at school or to secure a high paying job if fluency is poor.

Conclusion: ***Ethnicity may be a risk for disadvantage, but it isn't necessarily so. However, the increasing number of migrants does mean that the potential for disadvantage is widening.***

9. Teenage pregnancy

This is a success story in Oxfordshire. Rates have been falling steadily since 2001-2003 from just over 35 per 1000 15 to 17 year olds to around the current rate (2011-13) of 20 per 1000. This easily out-performs England's figures of around 42 per 1000 in 2001-2003 and 28 per 1000 in 2011-2013)

This achievement has been due to careful attention from all services, including sexual health services, schools, school health nurses and targeted services to improve access to contraception such as condoms and the morning after pill.

The five wards with the highest rates per 1,000 females aged 15-17 years in rank order are:

District	Ward
Oxford	Blackbird Leys
Oxford	St Mary's **
Oxford	Iffley Fields
Oxford	Barton and Sandhills
Oxford	Rose Hill and Iffley

** this ward now includes figures for Holywell ward

However, even in the wards with the highest rates, the numbers have fallen over the last decade. And this is overall a good result.

Teenage pregnancy is one of the persistent markers for social disadvantage. Recent improvements in the school health nursing service help to target teenage pregnancy with a holiday time, as well as term time, service in the City, access to the morning after pill in selected pharmacies across the county and contraceptive advice focussed on Banbury and the City. Also an outreach service of two trained sexual health staff goes out to help young people in the most difficult areas to give help and advice.

Continued targeting of the services mentioned above will be needed to continue to keep teenage pregnancy in decline.

***Conclusion:* This is a good result and is a decreasing cause of disadvantage.**

10. Safeguarding and Exploitation

Children who need to be safeguarded and protected from exploitation are by definition disadvantaged.

Improvements made to services over recent have been thoroughly scrutinised by the Oxfordshire Safeguarding Children Board (OSCB), by external review, and by the Council's Performance Scrutiny Committee. The results show the substantial gains made in understanding these issues in Oxfordshire and the work done by all organisations to improve matters. This has been extensively covered elsewhere, but in summary, Oxfordshire has faced up to this issue and improved the local situation.

***Conclusion:* This issue is now well understood and the determined approach in Oxfordshire acts to reduce this cause of disadvantage.**

11. Female Genital Mutilation

Female genital mutilation (FGM) (also referred to as female circumcision) is defined by the World Health Organisation (WHO) as "*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons*".

There are no health benefits to FGM. Immediate effects include severe pain, shock, bleeding and infection. Long term physical effects include chronic infection, difficulties passing urine, kidney failure and damage to the reproductive system including infertility. There may be long term psychological and mental health effects, including depression and anxiety.

FGM is illegal in the UK – both the practice itself and assisting in it.

As well as a legal issue, FGM is an inequality issue. It is linked to cultural practice and behaviours which cross religious, ethnic and language boundaries. No accurate figures of the numbers of women affected in Oxfordshire exist, though there is now regular reporting

of the number of women who have been affected by FGM and who are seen years later in local hospitals, often when they are pregnant.

Much is being done to raise the profile of this practice as a safeguarding issue. The Oxfordshire Safeguarding Children Board has been operating at the forefront of this work. The Oxfordshire FGM strategy is addressing the needs of women who have undergone FGM by providing specialist health services for them. The strategy also includes longer term prevention initiatives.

The role of public health is focussed on prevention, working with communities to help them to raise awareness and start talking about FGM. By this means the community members themselves will start to change expectations.

So far the FGM strategy group has:

- Established a network of trained professionals who work across different agencies to provide the best services for affected women.
- Secured funding for the "Rose Clinic" where specialist help is available for women through pregnancy and childbirth.
- Supported a group of young people who are raising the issue of FGM in local secondary schools. They have already run several workshops and a successful poster competition.
- Worked with a local voluntary group who are developing a website to highlight the stories of those affected.
- A very successful conference was also held with the Department of Health where the development of the work in Oxfordshire was described and celebrated.

The next steps in this work are to:

- Press on for the long term in parallel with enforcement agencies to ensure that children are protected.
- Work with survivors of FGM to help them undertake action research in their own communities and bring about change from within.
- Ensure that professionals are trained and aware, so that a range of organisations can work together to recognise risk, support those affected and prevent FGM in the next generation.

Conclusion: ***This is an example of disadvantage which has come to the fore in recent years. Sound and solid action is being taken, but at present it remains as an area of potential disadvantage.***

12. Inequalities in mental health and mental health services

The chapter on mental health and wellbeing gives a fuller account of this topic. In summary, over the last 5 years there has been a gradual improvement in the way mental health services are viewed, commissioned and provided. There have been 5 'drivers' behind this:

- The move to see mental health problems as common, and to improve basic services to help people combat anxiety and depression.

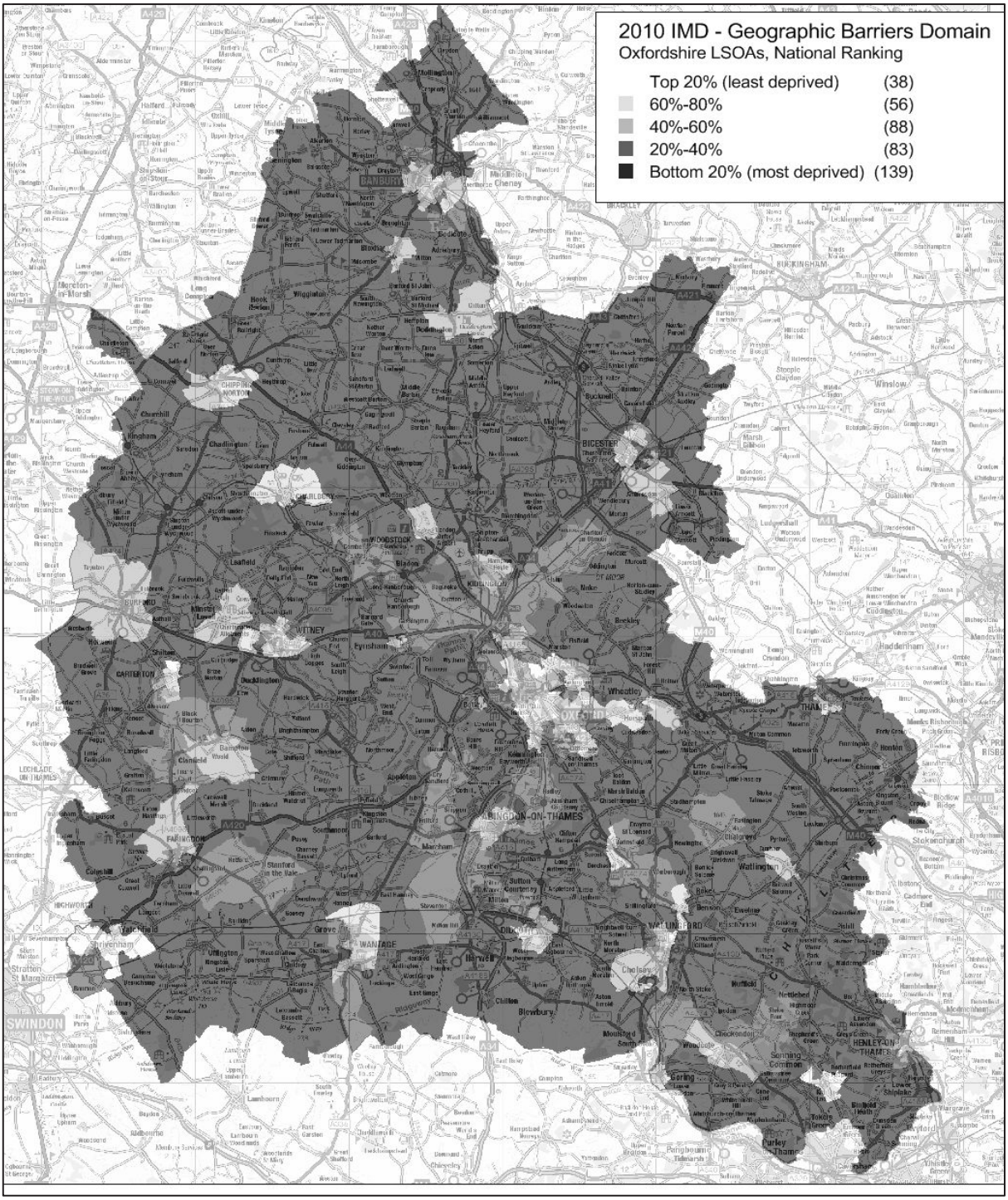
- The move to discuss mental health problems alongside physical health problems and thus reduce stigma.
- The concept of 'parity of esteem' enshrined in the NHS five year plan which seeks to 'level the playing field' and give equal weight to mental and physical health issues and services. This includes acknowledging that mental and physical health problems are not separate, but form a continuum in each individual, and this needs proper attention to achieve recovery.
- The good work done in dementia awareness and dementia services described elsewhere in this report.
- A much improved partnership between the statutory agencies and the voluntary sector.

Conclusion: ***There is a way to go, but this inequality is gradually reducing. See the next chapter for more detail.***

13. Disadvantage in Access to Services: A Rural County

Oxfordshire is a rural County. Services tend to be located in population centres to give access to the greatest number and so, from that point of view, there will always be a disadvantage in living off the beaten track. The most celebrated example of this is the long-running struggle of the Health Overview and Scrutiny Committee to improve rural call-out times for ambulances.

The map below summarises a mixture of data about access (which includes distance to GP, food shops, primary school or Post Office) and shows it as areas on the map. It can easily be seen that the more rural areas have poorer access to services. This can be particularly disadvantageous to older people and compounds the problem of loneliness and isolation:



The darker the area on the map, the poorer access to amenities will be compared to other places in Oxfordshire.

<u>Conclusion:</u> This form of inequality is 'hard-wired' into the fabric of Oxfordshire. As such it neither increases or decreases, but it is a feature of this County which needs to be borne in mind when planning services.

14. Inequalities from place to place

Much of the information mentioned about disadvantage described above can be gathered together and mapped. The measure used is called the index of multiple deprivation (IMD). The IMD measures relative levels of 'social deprivation' across England. It combines a number of indicators into a single score for each small area of the country.

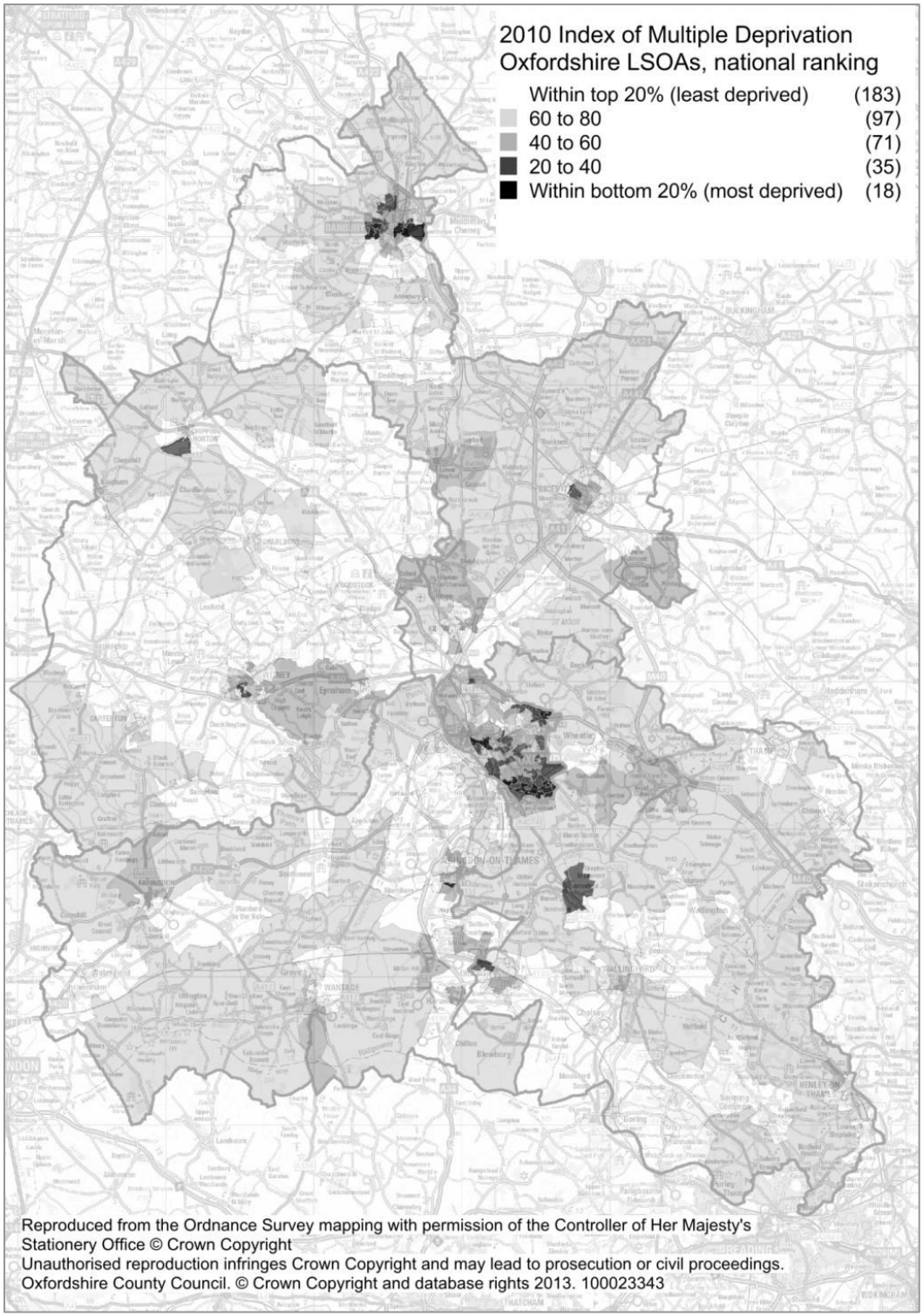
Overall, Oxfordshire is an affluent and prosperous county. According to the 2010 IMD, Oxfordshire ranked as the twelfth least disadvantaged upper tier local authority out of 152 in England. 102 of Oxfordshire's 404 small areas in 2010 ranked among the 10% least disadvantaged nationally; 183 ranked among the 20% least deprived.

In population terms, around a quarter of the County's population is estimated to live in areas that were ranked among the 10% least deprived areas in England. Over two fifths live in areas ranked among the 20% least deprived.

However, the flip side of that is that one of Oxfordshire's small areas ranked among the 10% most disadvantaged in England, (Northfield Brook) and 17 areas are ranked among the 20% most disadvantaged. Relatively disadvantaged areas in the County include parts of South East Oxford, Abingdon, and Banbury.

The small areas in the 20% most disadvantaged are; Northfield Brook, Rose Hill and Iffley, Blackbird Leys, Barton and Sandhills, Banbury Ruscote, Banbury Grimsbury and Castle, Littlemore, Holywell, and Abingdon Caldecott. In population terms, just under 5% of the county's population is estimated to live in areas that were ranked among the 20% most deprived nationally.

These areas are shaded as the darkest on the map in below. 'Social deprivation' is consistently linked to poorer health and wellbeing.



<u>Conclusion:</u> This measure compares one area in the County with all others as a snapshot and so can't be used to measure a trend in disadvantage, i.e. it doesn't say whether disadvantage is growing or declining, but it can tell us about the disadvantage 'hard-wired' into the fabric of the County. However, because of the useful combination of statistics, this remains a valuable way of identifying and targeting areas of disadvantage.

15. Disadvantage in families who are most in need: Thriving Families

Phase 1 of the Thriving Families Programme in Oxfordshire

The national Troubled Families programme was launched in 2011. The Oxfordshire Programme, known as the "Thriving Families Programme", was set the task of identifying 810 families who had 2 or 3 of the following "family problems".

1. Children not attending school.
2. Adults out of work.
3. Families involved in anti-social behaviour or youth crime.

It is also aimed at making long-term savings by reducing the financial burden these issues place on society. The County Council has consistently supported this programme as a priority.

The Results of Phase 1

Over the 3 years from April 2012 the programme in Oxfordshire identified 810 families and demonstrated improvement for them all. This is a very good result.

Of the **810 families** identified:

- **743 families** saw significant improvement in school attendance, to at least 85% attendance over the school year.
- **607 families** entered continuous employment or engaged in work related activities (Apprenticeships, Work Experience, Volunteering, Permitted Work, Work Choice, Non-Mandatory Training Courses) for at least 13 weeks.
- **443 families** previously engaged in anti-social behaviour or youth crime did not commit further offences for at least 6 months.

The features of phase 2 of the programme

The delivery of 100% performance in phase 1 of the programme has led to very strong working relationships with the Troubled Families Unit in the Department for Communities and Local Government. Oxfordshire became an early implementer of phase 2 of the programme in September 2014 ahead of the national roll out in April 2015.

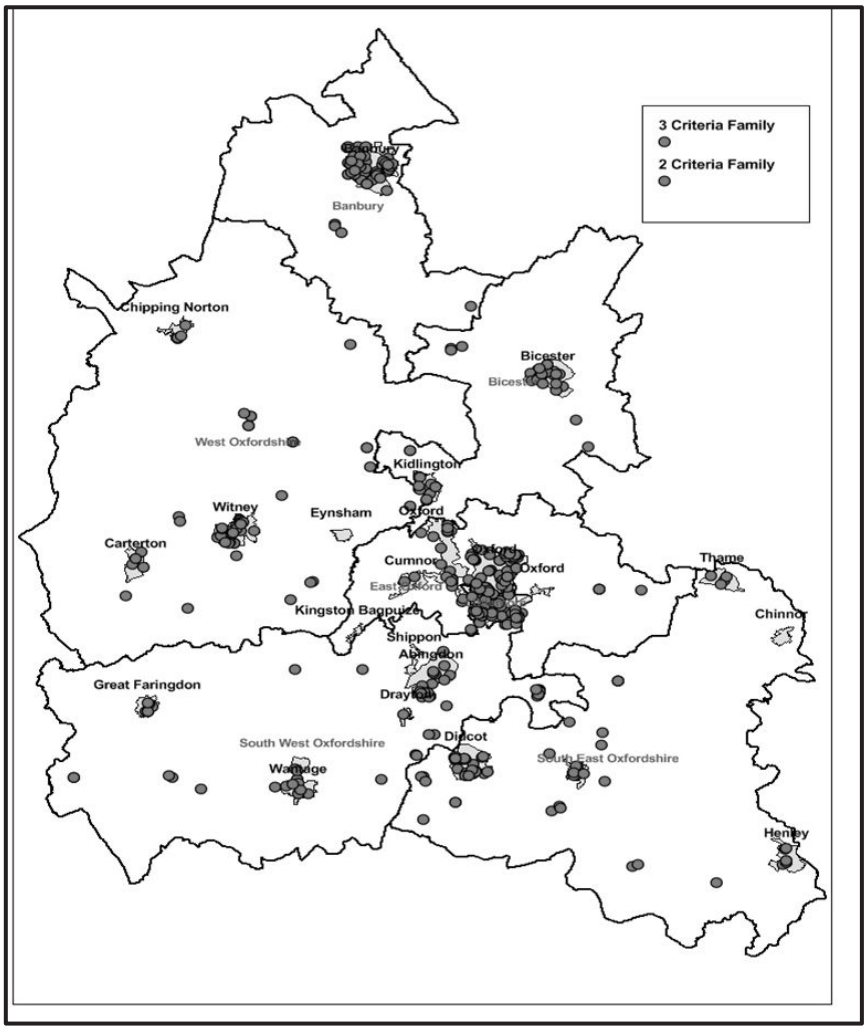
In phase 2 of the programme Oxfordshire have been asked to identify and work with 2,890 families over 5 years from 2015 to 2020 – an ambitious programme.

Results will be sought for 6 family problems rather than just the 3 used in phase one. The issues that have been added are:

- Children on child protection plans or Children in Need plans for neglect.
- Domestic abuse.
- Health issues including substance misuse.

A map of the locations of families identified in phase 1 is shown below. The great thing about the Thriving Families programme is that it achieves coverage of every corner of the

County, which are NOT masked by surrounding better off areas. This means that areas like West Oxfordshire, South Oxfordshire and Vale receive services too where they are most needed.



The Council is also at the forefront nationally in finding new and practical ways to engage the NHS in the initiative through local GPs.

<u>Conclusion:</u> Because the 'Thriving Families' programme is reaching out to all parts of the County, urban and rural, and because it achieves demonstrable results, it is likely that this represents a decrease in disadvantage

What have we said previously about Disadvantage in Oxfordshire

Previous annual reports have highlighted and called for action on many of these topics, including:

- Teenage pregnancy
- Educational achievement
- Breaking the Cycle of Deprivation in families who need help the most
- Dementia
- Mental health

Many of these topics have also been of concern to the County's scrutiny committees. It is good to see that progress is now being made in all of these areas. The key is now to retain and improve on this position and tackle the newly emerging areas.

Other topics previously reported on such as ethnicity still require attention.

Summary of Breaking the Cycle of Disadvantage

At the beginning of this chapter the question was posed, 'Are inequalities due to disadvantage increasing or decreasing in Oxfordshire.'

The table below summarises the information reviewed:

Decreasing Inequalities	Inequalities 'Hard Wired into the fabric of Oxfordshire	Static / Increasing/newly recognised Inequalities
Inequalities in men's health	Geographical inequalities: inequality by place	Ethnicity
Disease free life expectancy	Social isolation and rural access to services	Women and lifestyles
Dementia detection and care		Loneliness in older people
Children in Poverty		FGM
Unemployment		Homelessness
Educational attainment		
Teenage Pregnancy		
Mental Health Services		
Families in Greatest Need		
Breastfeeding (see lifestyles chapter)		
Caring for Carers		

Reducing Disadvantage

Overall there is evidence of reducing disadvantage in a number of important areas in Oxfordshire which have been causing concern for some time. Good examples are school results, teenage pregnancy, helping families who need it most, and mental health services. Why is this? There are probably 3 reasons:

- Persistent policies applied over time which are paying off, e.g. teenage pregnancy and improved school results.
- National policy priorities targeted at areas of inequality with earmarked funding, e.g. dementia services, mental health services and the Thriving Families programme.
- General improvements in healthy lifestyles, e.g. the gradual improvement in men's health.

This points to a formula for success in tackling disadvantage which has 4 components:

1. **Identify,**
2. **Target,**
3. **Fund,**
4. **Persist.**

All of these are likely to be assisted by the relative economic prosperity of Oxfordshire and its high levels of employment.

Stubborn Causes of Disadvantage

Some causes of disadvantage are less likely to diminish however because they are currently 'hard-wired' into the fabric of Oxfordshire. These are the persistent geographical areas in which disadvantage persists, particularly in areas of the City and Banbury, and there are persistent inequalities of access which are a result of the rural nature of much of Oxfordshire. These contribute to isolation and loneliness in older people.

These causes of disadvantage are likely to be stubborn to combat and require a more strategic long term approach.

Increasing Disadvantage

The data shows that there are also areas where disadvantage is worsening and these need to be addressed:

- Our services need to accommodate a more ethnically diverse population.
- Those in the greatest need require help to stay in settled accommodation - this is a basic prerequisite for thriving.
- We need to maintain the good progress we have made to eradicate Female Genital Mutilation.
- Women need to consider their smoking and drinking levels with care so as not to cause the diseases of the future.

If targeting is the key who should we target?

The characteristics suggested by the evidence follow. They apply equally to all areas, urban or rural. They are:

- Loneliness and isolation in older people
- Local areas with low educational attainment
- Children in receipt of free school meals / in areas of high poverty levels
- Families identified by the thriving families programme
- Families and individuals on the brink of homelessness
- Women with regard to lifestyle factors such as smoking and drinking
- Areas in the bottom 20% of multiple disadvantage for England
- Mental health problems as an additional factor alongside other physical health problems

How should we target them?

People sometimes shy away from targeting because they think 'their' area will lose resources.
This isn't necessarily the case and making a difference needn't cost more. Practical targeting is less about big free-standing initiatives and more about 'tweaking' the hundreds of initiatives and services we already have to be more sensitive to the groups described above.

Tackling Disadvantage is in everyone's interest

Ill health, disability and early death are tragic. They are also expensive for state-funded services. They also sap the economy and the workforce and lead to unhappiness in old age. It is in everyone's interest to tackle disadvantage and to promote good health for all, and it can be done right across the County as Oxfordshire's proud record with the Thriving Families programme has shown.

Recommendations

Short term recommendations:

1. The Health and Wellbeing Board should carry out its plans to sponsor a more detailed review of disadvantage, and should use the analysis in this report as a source of information. This analysis should inform the Joint Health and Wellbeing Strategy, Local Authority plans the Clinical Commissioning Group's 5 year plan and the work of the NHS and County Council Systems Leadership Group and Transformation Board.

2. All agencies should maintain current programmes which are successfully reducing disadvantage. These include:

   - Teenage pregnancy
   - The Thriving Families programme
   - Work with schools to improve school results
   - The promotion of breastfeeding
   - Improved dementia services
   - Improved mental health services

3. All agencies should target the causes of disadvantage which are static or increasing. Specifically:

   - The Health Improvement Board should continue its efforts to prevent homelessness through partnership working
   - GPs and the Public Health team should target NHS Health Checks to improve take up by ethnic groups and manual workers
   - Partnership work to eradicate FGM should continue

4. Contract specifications for services being renewed should carefully consider how to target areas in the bottom 20% IMD and areas of high child poverty so as to give a

good service across the county and a specific service to meet the needs of these areas.

5. NHS Trusts and General Practice should consider how to give additional help to those in the target groups listed above when they come for help for any condition. This consideration should be built into the Health and Wellbeing Board's planned work on disadvantage and specific recommendations should be made.

Longer term recommendations:

6. See the recommendations in chapter 2 regarding housing and the design of communities so as to combat isolation, loneliness and to break the cycle of disadvantage in specific areas.

7. The Local Enterprise Partnership, Local Government, Local Employers and Oxford University should continue to work together to secure central government funding to provide the infrastructure to favour continued economic prosperity and high levels of employment.

8. The Health Overview and Scrutiny Committee should consider scrutinising the extent to which reducing disadvantage and inequality are built into the plans of the Clinical Commissioning Group, General Practice and NHS Trusts.

9. Healthwatch should be invited to consider monitoring the inequalities identified in this chapter as part of its on-going work programme.

Chapter 4: Mental Health

Main Message of This Chapter:

Mental Health services have gradually improved over the last seven years. Current plans aim to push this further.

The last six annual reports have called for improvements in mental health services. They were then considered a 'Cinderella service'. Since then we have seen steady improvement and it seems fair to say that Cinderella has now received an invitation to the health ball.

Why is this?

The chapter on inequalities summarised 5 'drivers' which have helped to gradually improve mental health services. To re-cap, these are:

- the move to see mental health problems as common, affecting one in four of us and to improve basic services to help people combat anxiety and depression
- the move to discuss mental health problems alongside the physical and thus reduce stigma
- the concept of 'parity of esteem' enshrined in the NHS five year plan which seeks to 'level the playing field' and give equal weight to mental and physical health issues and services. This includes acknowledging that mental and physical health problems are not separate but form a continuity in each individual, and this needs proper attention to achieve recovery
- the good work done in dementia awareness and dementia services described elsewhere
- a much improved partnership between the statutory agencies and the voluntary sector.

The 'NHS 5 year Forward View' sums up the issue and the ambition well:

> *"Mental illness is the single largest cause of disability in the UK and **each year about one in four people suffer from a mental health problem.** The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked - people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease. Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together.*).

This chapter details some of the recent initiatives taken locally.

- With regard to improving access to therapies, there are now 9,100 Oxfordshire residents in treatment every year with 50% moving towards recovery.
- A criticism of the current system is the length of time it takes to be seen. In response, waiting time standards for access to psychological therapies (counselling,

and help from clinical psychologists and the like) will be in place from April 2016 and the services are working on achieving these.

- This will include a 2 week wait target for intervening earlier in cases of serious mental illnesses such as schizophrenia and bi-polar disorder (formerly known as manic depression).
- An effective 'psychiatric liaison service' between physical and mental health professionals is being designed and will be in place by 2020. This will ensure that people being treated for physical disorders which have a mental health component (e.g. in hospital) will be treated as a whole person. This is beginning with:

    - A 24/7 liaison service in Accident and Emergency.
    - A psychological medicine service in inpatients in the John Radcliffe Hospital and Horton Hospital– focussing on patients with depression, delirium and dementia.
    - A more active service in outpatient clinics.
    - Assessment of the mental health needs of frequent service users to make more appropriate use of services.
    - Planned improvements for services for eating disorders in children.

Another interesting development is Outcome-Based Commissioning (OBC in the jargon, more accurately known as outcome based contracting). This combines agreeing contracts with service providers for achieving defined results instead of just counting the number of treatments given. An example of what would be counted includes whether or not the individual is back in work. It is designed to empower service providers to work together for the long term so that they redesign services so as to achieve real results.

While it sounds good in theory, it is complex to achieve in practice. We are on the brink of putting in place an outcomes-based contract for mental health in Oxfordshire with a value of £35M each year for 5 years initially. The funding comes from pooled NHS and County Council Social Care budgets. The 'preferred providers' for the contract have put together an exciting consortium of partners involving the Oxford Health Foundation Trust and 5 local voluntary sector partners including MIND and Restore. The outcomes set will aim to achieve concrete improvements of improved mental and physical health, improved support for carers, more patients in employment and improved 'social functioning' (e.g. improved personal relationships and better integration into 'society').
Work is also in progress to improve the Child and Adolescent Mental Health Service to improve the transition from children's to adults' services.

Recommendations

1. The Clinical Commissioning Group, Oxfordshire Adult Social Services, Oxford University Hospitals Trust and the associated Voluntary Agencies should ensure that outcome-based contracting really does improve outcomes.

2. The Oxfordshire Health Overview and Scrutiny Committee should consider continuing to monitor these proposals as part of its forward plan.

3. Oxfordshire Healthwatch should consider continuing to closely monitor the quality of mental health services from the perspective of the service user.

Chapter 5: Lifestyles and Health: We are what we eat, drink, smoke and do.

Main Messages In This Chapter:

1. **Our lifestyles have a massive impact on our health and there are many things we can each do to improve it. This is good news.**
2. **Obesity is an epidemic which has not yet reached its peak. Action is needed at all levels, individual, local and national. This is the major pressing lifestyle issue.**
3. **Smoking is on the decline: we need to target groups where rates are highest, in this case, manual workers.**
4. **Tooth decay is gradually declining but inequalities persist. Oxfordshire's new prevention service will help.**
5. **Drug addiction services are improving.**
6. **Legal Highs present an important risk, particularly to younger people. Oxfordshire is active in combatting the threat. Proposed legislation will help.**
7. **Drinking levels have fallen slightly, but the disease and misery caused by alcohol addiction remain.**
8. **Breast feeding has real health benefits. Local breast feeding rates are good. We need to keep this up.**
9. **Our local NHS Health Checks are performing well. We need to work with GPs to improve further still.**

There is an old saying, 'You are what you eat'. But we are also what we smoke and drink and do. This chapter will look at important 'lifestyle choices' to paint the current picture.

Obesity, diet and physical activity

Rising levels of obesity present a major challenge to our health. This is as true today as it was 8 years ago when the importance of the topic was first raised. Next to quitting smoking, staying reasonably slim is probably the best thing you can do for your health.

There is an epidemic of obesity in this country and Oxfordshire is no exception. Nearly one in four people in the UK is obese – being obese reduces life expectancy by an average of nine years. Obesity makes its impact in many ways. It affects general mobility leading to problems with joints and causes long-term diseases such as diabetes, stroke and heart disease, as well as affecting self-esteem.

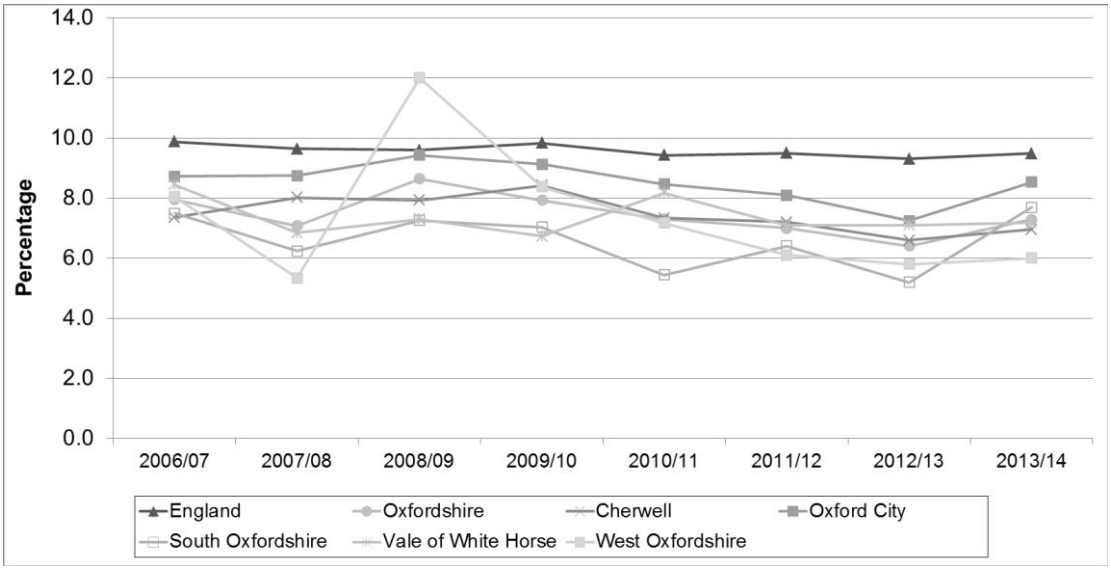
In 2014, Public Health England calculated that NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £50 billion per year.

Obesity does not affect all equally; it is more common in children in areas of disadvantage, in women and in manual workers. It is therefore another aspect of inequality. For example, obesity levels amongst women in unskilled roles are nearly twice that of women in professional roles.

If obesity continues to increase, the knock-on effect on NHS and Local Authority budgets in terms of increasing levels of diabetes, heart disease, stroke, cancer and limited mobility will break the bank.

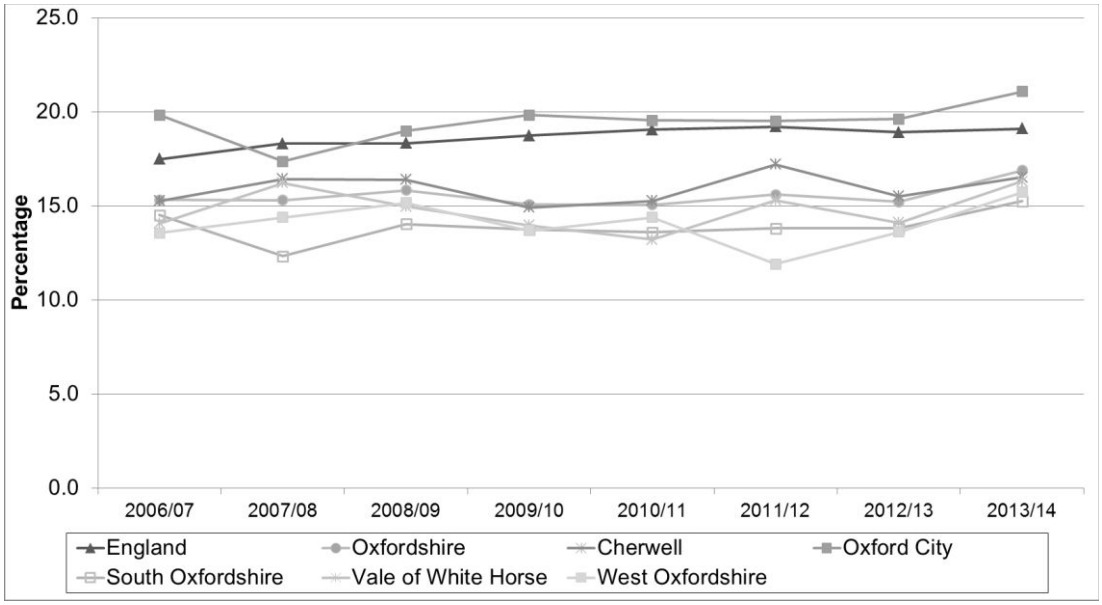
Obesity itself is the tip of the iceberg. **The average adult in this country is now classed as overweight**.

The chart below shows the picture for reception year children. Around 7% of Oxfordshire's children are already classed as obese. This is a dangerous situation as obesity in early life tends to carry through into adulthood.



Source: National Child Measurement Programme (NCMP)

There is some comfort for Oxfordshire in the figures. All Districts, except for Oxford City, have significantly lower levels of obesity than the England average (10%), at around 6% to 8%. Oxford City's figure is almost 9% and this is another inequality. By the time year 6 is reached, we see the following picture:



Source: National Child Measurement Programme (NCMP)

The position has become worse; the County average is around 17%, with all Districts except for the City at around 16%. These figures are again significantly better than the national average which stands at around 19%, but Oxford City's figure is greater than the national average at 21% - a significant inequality.

A similar picture is seen in adults and the figures are shocking. In England around 64% of adults are overweight or obese – that's more than 6 out of every 10 adults. The figure for Oxfordshire is better at around 55%, but that means that over half the adult population is overweight or obese. By the time the current cohort of schoolchildren reach adulthood the figures will be even worse.

What can we do about it? Public Health England Director Kevin Fenton summarises the issue well:

'There is no silver bullet to reducing obesity; it is a complex issue that requires action at individual, family, local and national levels. We can all play our part in this by eating a healthy balanced diet and being more active.'

In short we need a blend of individual, local and national action. It is said that every epidemic has its peak. It happened with the HIV epidemic, it is happening with the epidemic of smoking, but when we turn to obesity, it doesn't look like we have reached the peak yet despite best efforts. Why? The reason is simple: the factors pushing us into obesity are stronger than those promoting a healthy weight. What sort of factors am I talking about? A straightforward list follows:

- Modern lifestyles make it easy for busy people to reach for fast food or takeaways, and while the quality of these is improving, they rely too heavily on fat and are often packed with calories. They tend to push fruit and veg out of the diet.
- We like to use modern gadgets, from cars to computers to TV remote controls. This means we simply don't move about as much, even to change the TV channel, and so we don't burn the extra calories. Over months and years this all adds up.
- Children seem to losing the culture of active play for reasons of safety and maybe because a lot of interaction now takes place on-line.
- Obesity may be becoming the new norm – when 50% or more of adults are overweight, carrying extra pounds starts to look like 'business as usual'.
- The increase in alcohol consumption over recent decades has also contributed. Beer, wine and spirits are essentially high calorie fuel and can tip the balance into overweight.

But there is a further catch. Tacking obesity is like turning the titanic. Anything we do to combat obesity takes time to have an impact. A new tool was launched recently to calculate savings from obesity programmes. Payback on investment is very real, but a programme may take 6 or 7 years to break even. After that the savings made accumulate quickly.

The message is that we need to plan for the long term and avoid stop-start interventions. Organisational change and endless re-structuring of services are the great enemy here. It

is very hard to maintain momentum and funding when organisations continually chop and change.

The solution doesn't lie in preaching and nannying. It's about swinging the pendulum back a bit. We need to make it easier to move around a bit more and change our eating patterns towards the healthy.

It isn't all doom and gloom. There are signs that the rise in obesity is slowing nationally and the prize is worth the effort. Time will tell if we have reached the high tide mark.

On an individual level things are brighter too. A reduction in 10% of body weight (no matter what the starting point) gives the following benefits, even if you do not return into a normal weight category:

- a 20% fall in death rates overall
- a 30% reduction in deaths related to diabetes
- a 40% reduction in obesity-related deaths from cancer (e.g. bowel cancer)
- a 90% decrease in the symptoms of angina
- a significant reduction in blood pressure and cholesterol levels

So, if you are say 15 stone, it's still worth it to lose around a stone and a half. This sounds like a good deal, though those who have tried will tell you it is easier to say than to do and even harder to maintain. The way to do it seems to be to plan for the long term, be a bit more active and eat a bit better.

What have we said previously?

Previous annual reports have called for local action in a number of areas and all of these are being taken forward. They include:

- Bringing together all organisations to pool their efforts within single healthy weight strategy.
- Establishing a successful NHS Health Checks programme.
- Promoting breastfeeding which counteracts obesity.
- Supporting national campaigns such as 5 a day.
- Encouraging play at school through initiatives like working with London Welsh to promote tag rugby and healthy eating.
- Setting up a new 'lifestyles clinic' in the John Radcliffe to which clinicians can refer people for health advice as well as treating their illnesses.
- Targeting young people, e.g. by promoting the 'sugar swaps' campaign which tells young people about just how much sugar food contains and helping them choose healthier drinks and fruit.
- Writing to parents when their children are weighed and measured at school to let them know what the situation is.
- More than doubling the number of School Health Nurses in secondary schools to help schools work on better 'Health at School' policies.
- Working with local GPs to commission services to help weight loss, e.g. through referral vouchers to organisations like Weight Watchers and setting up services to help children lose weight with support from their families.
- Supporting the Oxfordshire Sports Partnership

- Working with the County Council team on long term transport and road planning to include purpose built cycle paths when feasible.
- Beginning to work with District Councils to connect their work on leisure centres and green spaces.
- Working through stop – smoking services to help people not put on weight after they kick the habit.

What do we need to do next?

Essentially, we have to keep pressing on, promoting a healthy weight and building long term infrastructure **now** so that when the tide eventually turns we are ready to capitalise on it. This means we need to keep up what we are doing now but also intensify our work with schools, transport planners and District Councils to put together an improved long term plan.

This plan also needs to focus on disadvantage, putting a little more emphasis on parents and schools in areas where levels of obesity are highest. We need to plan for the long term and not be tempted by 'stop-start' short term plans, short term funding and one-off initiatives.

We need to talk to the NHS, including GPs, to take obesity more seriously and consider investing in a long term NHS funded obesity prevention programme to complement the work of Local Government as this will save the health service money in the long run.

Recommendations with regard to Obesity

1. The Health Improvement Board should review its healthy weight strategy and make recommendations for a range of services, including schools, health visitors, school health nurses, hospitals, general practitioners and highway planners. The key role of District Councils should be emphasised with regard to green spaces, leisure centres, play areas and the licensing of premises.

2. The Clinical Commissioning Group should work with the new General Practice Federations and should consider commissioning innovative ways of preventing obesity using NHS funding as this will prevent health care expenditure in the long run.

3. The Health Overview and Scrutiny Committee should consider scrutinising the District Council role in the fight against obesity as part of its forward work-plan.

Smoking tobacco

For the population overall, smoking is still the biggest risk to health and early death, as it causes many different cancers, chronic lung disease, heart disease and stroke.

The death toll can be seen by looking at deaths attributable to smoking. It is estimated that there are over 2000 deaths in Oxfordshire in a three year period attributable to smoking in the over 35s.

Admittedly Oxfordshire's figure is lower than England's, at around 230 deaths per 100,000 deaths in over 35's in a three year period compared with around 290 deaths per 100,000 for England, but the City's figure is significantly higher and closer to the England figure at around 270 deaths per 100,000.

The good news is that the health message has gained ground over the last 20 years and the overall prevalence of smoking continues to fall nationally, from around 21% of adults in 2010 to around 15% currently.

However the figures mask an important aspect of disadvantage. Around 30% of 'routine and manual workers' smoke in both England and in Oxfordshire – that's double the average.

Considering smoking in children, the figures show smoking levels falling from around 12% throughout the 80s and 90's to around 4% for girls and boys currently with girls smoking fractionally more.

Girls are more likely than boys to have tried smoking (23% of girls, 20% of boys) between ages of 11 and 15 years.

Stop-smoking services

During the last year there has been a decline in the number of people taking up stop smoking services and Oxfordshire's figures have been the lowest in years too. It isn't clear why this is. Some say it's that there aren't as many smokers 'out there', but it may be something to do with people taking up e- cigarettes as an alternative to quitting. It is still too early to say whether these pose a threat to health.

However, we haven't let the grass grow under our feet and the County Council has just let a new and improved contract for stop-smoking services, which we hope will help to turn the corner – time will tell.

How Should We Move Forward?

All organisations should do their bit.

This includes:

- Brief Advice given by GPs and Hospital Doctors and all front line NHS staff.
- Referral systems within hospitals like the innovative Oxford University Hospital Trust's health promotion clinic.
- GPs should take the opportunity to promote NHS health checks and increase the number of people taking up invitations. Brief advice to give up smoking should be given emphatically as part of all consultations.
- Midwives and health visitors and school health nurses should consider how best to take an active role.
- The Health Improvement Board should coordinate this activity.

Recommendations re Smoking

1. The Health Improvement Board should consider reviewing the actions of all the agencies listed above in order to help more people never to start smoking or to quit.

2. The Clinical Commissioning Group and General Practice should consider how to emphatically promote the brief intervention to 'stop smoking' as a consistent part of all consultations.

Tooth Decay

Tooth decay has been falling over the last half century, largely due to better brushing with fluoride toothpastes and more awareness of oral health in general. Also in the past decade more people have been accessing dental services.

The current picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions. However, looking at the national data, we can see that tooth decay is linked with other measures of general social disadvantage and so is a further source of disadvantage 'hard-wired' into the structure of the County.

The most recent national figures (2012) show that approximately 1 in 4 of 5 year old children have active decay in their teeth with an average three decayed teeth in these children. The major sources of the sugar which causes decay in children are found in soft drinks and cereals.

The Picture in Adults

Tooth decay has fallen in adults in England from 46% having active decay in their teeth in 1998 to 28% in 2009. The main sources of sugar in adults' diets come from cereals, soft drinks, jams and sweets.

Older adults are now keeping their own teeth into old age as the norm. The proportion of 65 to 75 year olds with their own teeth increased from just 26% in 1979 to 84% in 2009 - a significant change. As the population ages it will be important that the NHS keeps pace with this change, particularly as the number of people needing more complex dental work rises steadily with age.

What are we doing and what should we do next?

Since the NHS reorganisation, the responsibility for oral health is split 3 ways. The NHS and Public Health England have a responsibility for dentists and more specialised surgery, while Local Government has an emphasis on prevention.

The County Council let an improved contract for prevention in 2014/15 which aims to prevent oral health problems as follows.

Oral health promotion interventions aimed at children

The service will contribute to improving the oral health of children by providing the following child focused services:

- Running an accreditation scheme for preschool settings
- Training a wide range of professionals who work with children about the importance of oral health and the causes of oral diseases
- Working to include oral health promotion into targeted home visits by health and social care workers.
- Providing oral health information and advice for 0-5's, tailored to areas where there is a higher risk of poor oral health.
- Promoting supervised tooth brushing schemes in early years' settings and primary schools based in areas where children are at higher risk of poor oral health.
- Promoting oral health in the primary and secondary school curricula.
- Working with the School Health Nurses to promote a 'whole-school' approach to oral health in education, such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting, oral health information for parents, carers and children, including details on how to access local dental services.

Oral health promotion interventions aimed at adults

The service will improve the oral health of the adult population by implementing the following actions:

- Delivering targeted services for adults at higher risk of poor oral health, including peer (lay) support groups.
- Training professionals who work with adults from disadvantaged populations and those who do not attend the dentist regularly, about the importance and promotion of oral health.
- Providing information about what services are available to the public and how to access them.
- Working with partners to promote oral health and oral health services in residential care homes.

Recommendation for Tooth Decay

1. The Director of Public Health should monitor the new contract for oral health promotion and ensure that it targets disadvantage.

Drug Abuse

There has been a sea-change in national policy about drug abuse.

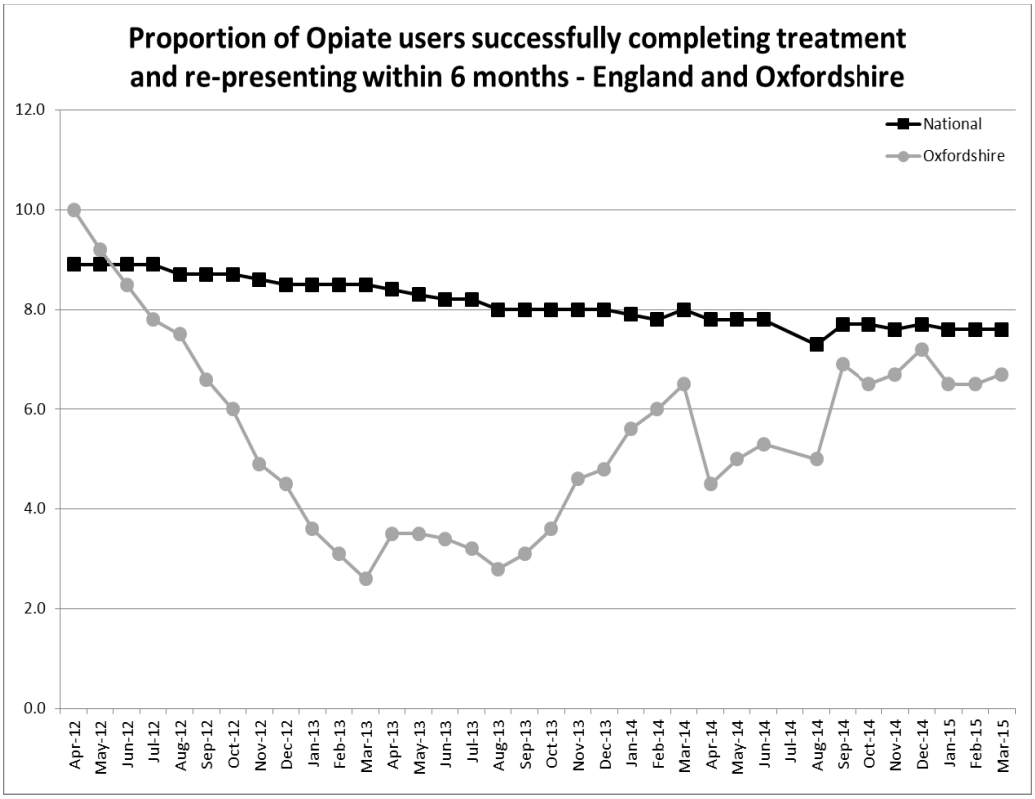
Under the old policy of minimising harm by maintaining narcotics addicts on methadone, Oxfordshire performed well. However, national policy changed a few years ago and is now

focussed on getting people off drugs altogether. Oxfordshire's services weren't designed to cope with this and performance declined dramatically.

The County Council took over responsibility for these services in April 2013 at a critical moment when performance was at a low, and since then has worked hard to re-vamp services to meet the new requirements. This culminated in a new and improved contract being let in April 2015 as well as new education services for secondary schools. We have worked closely with experts from Public Health England to improve the services. The results since then show that services are steadily improving and we are slowly climbing the national league table in terms of performance.

This doesn't mean to say that there is a crisis of drug taking in Oxfordshire, the overall prevalence is generally low, but it does mean that our services needed an overhaul if we to get more people off drugs altogether.

The chart below shows the picture for getting people off opiates such as heroin and methadone. The same picture and trends are also true for non-opiate drug abuse such as cocaine and amphetamines.



The chart shows the decline in performance mentioned above and the recent improvement in the figures which are now close to national averages.

Legal Highs (officially called New Psychoactive Substances)

I reported on this emerging threat to health last year. These are chemicals which are manufactured in labs which have are said to give you a 'high' and which are not strictly illegal. They are available on-line and in a few shops and are attractive to young people. The problem is that they can have a devastating effect on health and are largely unregulated. Deaths due to 'Legal Highs' rose nationally from 29 in 2011 to 60 in 2013.

Legal highs are manufactured to mimic other (illegal) drugs. The main effects of almost all 'psychoactive' drugs, including 'legal highs', can be described using three main categories:

- stimulants
- 'downers' or sedatives
- psychedelics or hallucinogens.

For example there is a growing market for synthetic cannabinoids – chemicals which are sprayed onto inert plant material and smoked. The effects mimic those of cannabis but the strength may be much higher, and they may also cause panic, paranoia and mental health problems.

These chemicals can be manufactured and put on the market very quickly and the number of new ones created is rising all the time. Because the market is difficult to regulate, it is difficult to know what substances or mixtures of substances they contain. This is a dangerous situation. There is a Europe-wide early warning system in place which helps to keep pace with the new drugs and keep track of them. This data shows that in 2008, 13 new substances were marketed and this rose steadily to 81 in 2013.

Recently the government made 5 of these drugs illegal, this helps, but it is swimming against the tide. The intention of the new Government to make all of these substances illegal in the year ahead will be helpful. The ban on 5 substances came into force in April 2015 and was on the recommendation of the Advisory Council on the Misuse of Drugs The Council said that one of the five legal highs, ethylphenidate, had been available over the internet in Britain for four years. Users inject it and it is widely marketed as a "research chemical" or as a component of branded products such as Gogaine, Nopaine, Burst and Banshee Dust. This chemical is one of the most commonly encountered legal highs in Britain and is taken as an alternative to cocaine.

What are we doing about it and what shall we do next?

We have been quick to take up this challenge in Oxfordshire and have prioritised work to disrupt the supply and demand of legal highs through our Alcohol and Drugs Partnership. We have:

- Convened a summit which gave a range of agencies the chance to talk about the work that was already going on and discuss what more was needed.

- Researched which local shops supply these substances and worked to ensure that the supply is drying up.
- Sent information out to young people as the term "legal Highs" may imply "safe" to those who are not well informed. Campaigns at music festivals, through social media, information through schools and colleges and signposting to helpful websites are good routes to get information out.
- Reviewed the training available for front line professionals in schools, youth settings and health services and where the gaps are. For example, people working with homeless people need to know more as use of legal highs is a growing concern.

Recommendations re Drug Abuse and Legal Highs

1. The Directorate of Public Health should continue to lead a partnership of the many agencies involved to continually improve the performance of services for opiate, and non-opiate addiction. Services in primary care should be now be reviewed and updated as a next step.

2. The Directorate of Public Health should continue to lead a partnership to meet the emerging challenge of legal highs as new information becomes available.

3. The Community Safety Partnership, Health Improvement Board and Performance Scrutiny Committee should continue to monitor progress on these topics as a priority.

Alcohol

Previous reports have highlighted the health problems of drinking alcohol excessively.

To summarise, these are:

- Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression.
- In the UK in 2012-13, there were just over 1 million hospital admissions related to alcohol consumption.
- In 2012 there were 8,367 alcohol-related deaths in the UK.
- Males accounted for approximately 65% of all alcohol-related deaths in the UK in 2012.
- Alcohol now costs the NHS £3.5bn per year; equal to £120 for every tax payer.
- The alcohol-related mortality rate of men in the most disadvantaged socio-economic class is 3.5 times higher than for men in the least disadvantaged class, while for women the figure is 5.7 times higher. This is a serious inequality.
- In England and Wales, 63% of all alcohol-related deaths in 2012 were caused by alcoholic liver disease.

- Liver disease is the only major cause of mortality and morbidity which is on the increase in England whilst decreasing in other European Countries.
- Deaths from liver disease have reached record levels, rising by 20% in a decade.
- The number of older people between the ages of 60 and 74 admitted to hospitals in England with mental and behavioural disorders associated with alcohol use has risen by over 150% in the past ten years, while the figure for 15-59 years old has increased by 94%.

Young People and Alcohol

Some good news: drinking alcohol among young people appears to be reducing:

- Since 2003 there has been a downward trend in the proportion of young people who say that they have ever had an alcohol drink.
- Data on alcohol consumption show a decline in risky drinking behaviour.
- The proportion of girls who have ever had an alcoholic drink (39%) is the same as boys.
- Self reports of drinking within the last week are the same for girls and boys.
- The volume of alcohol consumed by girls that drink is similar to that of boys
- The proportion of young adults aged 16-24 that are teetotal has increased in the last decade.

Drinking in adults

Drinking trends are reducing slightly:

- Alcohol consumption in both men and women aged 16-44 has reduced between 2005 and 2013.
- Consumption of alcohol in adults aged 45 and over has remained relatively unchanged between 2005- and 2013.
- There has been a decline in the proportion of adults binge drinking at least once a week, mostly in the 16-44s.
- Trends in alcohol consumption have been more pronounced in men than women, with a larger drop in binge drinking amongst younger men and a larger increase in teetotalism in younger men.

In summary, the picture seems to be:

1. Women's and men's drinking levels are now more on a par.
2. There has been a recent welcome decline in drinking levels among young people and younger adults
3. Diseases - which are partly caused by the drinking patterns of previous decades – are still rising.

What are we doing about it and what should we do next?

The expert view in this controversial subject is that alcohol consumption can best be tackled at national level by controlling the minimum price for a unit of alcohol and controlling marketing.

Local action taken can be summarised as follows:

The Alcohol and Drugs Partnership has prioritised reducing the harm caused by drinking too much alcohol in a Strategy published in 2014-15. Work done recently includes:

- Campaigns targeting young people who may be likely to binge drink, especially in the "party season" around Christmas.
- Promotion of Dry January – a chance to abstain from alcohol for a month and develop strategies for drinking less throughout the year.
- Pharmacy campaigns to enable people to think about how much they drink and to take some action. This work has included training pharmacists to be able to offer brief advice on drinking patterns so they can raise the questions more confidently.
- Helping adults to recognise unsafe levels of drinking as part of the NHS Health Check.
- Continuation of the work being done in the Emergency Department of the Oxford University Hospitals to follow up individuals who have been injured as a result of drinking too much and offer them advice and support.
- Supporting Street Pastor teams across the County as they give practical help as part of the Nightsafe initiatives in the City and market towns.
- Establishing new, streamlined referral routes to treatment services which include the use of a specially designed questionnaire so that GPs can discuss results with patients and make a direct referral for specialist help.

This work has to be maintained, and the focus needs to continue to shift from reactive work with binge drinkers to proactive work targeting those who are drinking regularly but at levels above the daily recommended maximum intake.

Recommendation re Alcohol

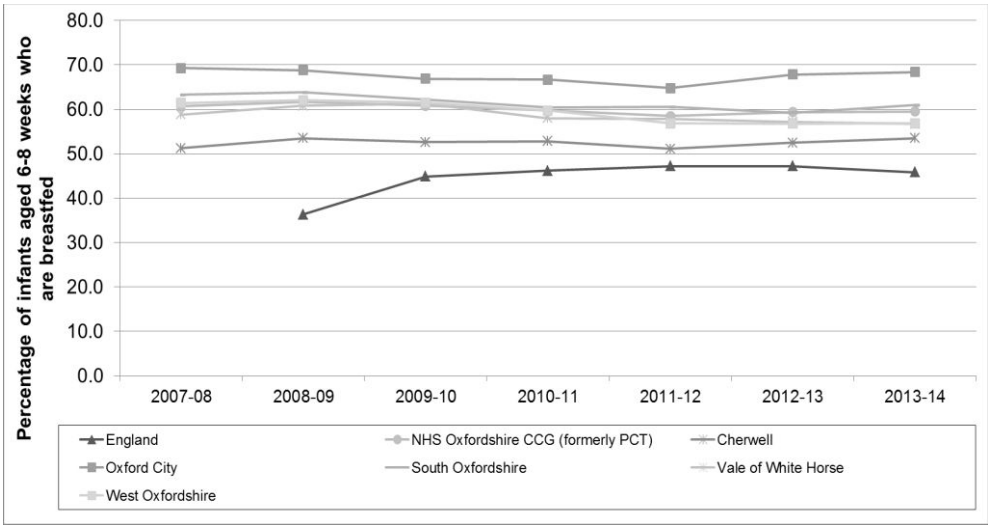
1. Continue to work across agencies to given relevant information and advice to people at risk of alcohol related harm, either through binge drinking on "high days and holidays" or by habitually drinking at harmful levels.

Breast Feeding

Breastfeeding gives children a fantastic start in life. The percentage of mothers breastfeeding across Oxfordshire at 6 weeks is high (60%) compared with national levels (46%). This is a good result. Breast milk is a complete, balanced food and breastfeeding helps to prevent obesity in later life.

We have to remember however that despite best efforts, it is not possible for all mothers to maintain breastfeeding and we need to take care not to stigmatise those in this situation.

However, there are inequalities across Oxfordshire with not all mothers choosing to breastfeed their children. The chart below shows the current picture In 2013/14:



The chart shows that:

- Oxfordshire performs much better than the national average.
- The City overall does particularly well on this measure.
- Cherwell historically performs consistently poorly compared with other Districts.
- The Districts with the lowest rates are gradually 'catching up' and so this indicates a reduction in disadvantage.

What Have We Said Before and What Should We Do About It

This has been a County priority for some years, supported by Health and Wellbeing Board targets.

We have taken steps to promote breastfeeding over the years from targeting poorly performing general practices to promoting breastfeeding as a 'cool' thing to do through the 'Be A Star' campaign.

Looking forward, we need to keep pressing on to try to buck the national trend further. The move of Health Visiting to the County Council will provide a useful opportunity for this when we specify the service in 2017.

Recommendation re Breast Feeding

1. The current range of work should continue and should target areas of disadvantage.

Page 80

NHS Health Checks

I reported fully on the NHS Health Checks Programme (commissioned by the County Council) in last year's report. This section comprises a briefing on what the Programme is and reports on progress.

The NHS Health Check is a national risk assessment and prevention programme required by statute. It is commissioned currently from local GPs.

NHS Health Checks specifically target the top seven causes of preventable deaths: high blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. It also includes the offer of information on dementia to people aged 60 and above.

The Programme requires us to invite all eligible individuals aged 40-74 years old for the check every five years (191,372 people), which means that 20% of this age group are invited per year. The age range is set nationally because it is the most cost-effective group in which to detect preventable disease.

In Oxfordshire, the Joint Health and Wellbeing Strategy set a target for 66% of those invited for NHS Health Checks to turn up for their Checks. If we achieve 66%, based on Public Health England (PHE) modelling using the NHS Health Check Ready Reckoner, we could potentially:

- identify over 700 people who require anti-hypertensive drugs
- discover over 1000 people who require a statin
- detect over 200 cases of undiagnosed cases of diabetes and over 500 cases of kidney disease earlier, allowing people to manage their condition sooner and prevent complications
- refer over 2000 people to a weight management programme
- offer 7500 people a brief intervention to take up more physical activity
- generate over 550 referrals to smoking cessation services
- help reduce the increasing health and social care costs related to long term ill-health and disability

What We Said Before and What We Are Doing About It

Last year we said that we would promote NHS Health Checks to raise awareness, quality assure the way GPs were delivering the Checks so as to increase uptake, and begin to look at alternative ways of deliver the Checks if we were dissatisfied with the approach from general practice.

During the last year we have carried out these tasks to good effect. GPs are responding well and we have worked hard to monitor services and spread good practice.

We have also successfully promoted the Checks in a number of ways, including reaching out to (primarily males) via events at the Kassam Stadium. The Kassam management and Oxford United and London Welsh RUFC have been a fantastic help in this and deserve our thanks.

The result is that the Oxfordshire service is currently one of the top performing Local Authorities in the region, achieving an uptake rate of 53.3% uptake in 2014/15 compared to 45.9% the previous year. As a result, we also delivered 2000 more Checks than in the previous year.

We need now to continue this approach and strive to improve performance further.

Recommendation re Health Checks

1. The Public Health Directorate should:

- Continue to work with GPs to improve the uptake of the offer of a free NHS Health Check.
- Identify and engage with high risk groups to take up the offer of a free NHS Health Check.
- Launch a new results booklet for service users in GP practices. This provides a record for people of their Health Check results and also advice on local public health services.

Page 82

Chapter 6: Fighting Killer Diseases

Main Messages For This Chapter:

1. **We need to make sure our specialist services for fighting major outbreaks of disease such as Ebola stay strong and resilient.**
2. **Infectious diseases do not go away. They simply change and return in new guises. Constant vigilance is needed to stay ahead of the curve. Good teamwork across organisations is essential.**
3. **Local Government has a key role to play in the fight against killer diseases.**

Part 1. Epidemics: Ebola, Flu Pandemics and HIV

No Room For Complacency

Day to day we take our good health for granted and this can lead to dangerous complacency. It is easy to forget the importance of planning for hard times when the going is good.

Recent decades have shown that in reality we live on a knife-edge, and unpredicted and unexpected disaster can strike at any time. **The right response isn't fear and panic, it is systematic and calm planning and organising ourselves NOW so that we can fight back when the need arises.**

In recent times we have seen what new diseases could do through the emergence of HIV, virulent strains of flu and, most recently, Ebola. These crises have been managed because we constantly learn lessons and improve so that the UK response is good.

So far we have been pretty lucky in the UK. The flu pandemic proved to be milder than it might have been, and Ebola seems to be largely contained within West Africa where the effects have been devastating. The UK has played a major role in this containment effort. The military and Public Health England staff have done sterling work.

The need to keep emergency planning and response as a high priority

This means we need to constantly prioritise the work we do in the background day in, day out, to prepare for the worst while hoping for the best.

This is what emergency planning does, and Public Health has a key role to play.

Directors of Public Health work closely with Public Health England and the NHS across the Thames Valley to make sure that our response is up to the mark. Oxfordshire County Council has the lead role for all Councils in the Thames Valley for making sure this is done.

Relationships are good and we compare favourably with other regions.

How Do We Keep This Work Going?

Success depends on several key elements:

- Maintaining a well-qualified and well trained cadre of Public Health specialists in Local Government.
- Constantly building and maintaining long standing relationships with opposite numbers in Public Health England and the NHS,
- Mainstreaming our plans by working with the Police, the military and many other organisations under the auspices of the Thames Valley Local Resilience Forum (LRF).
- Continually learning, planning and practising our plans.

Recommendation re Epidemics, Ebola, Flu Pandemics and HIV

1. The County Council, all Local Government organisations and the NHS should ensure that they maintain this specialist function as a priority and ensure that emergency planning continues to receive the resources it requires.

The remainder of this chapter reviews the most serious infectious diseases affecting the population of Oxfordshire and reviews recent progress.

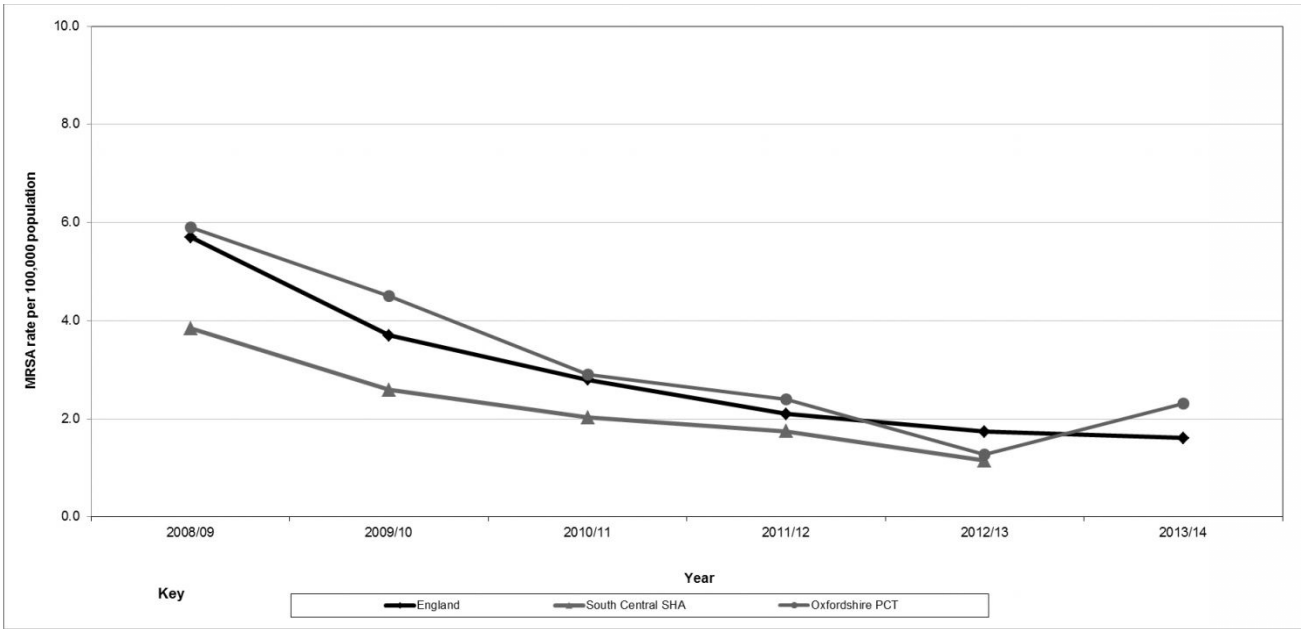
Part 2. Infectious and Communicable Diseases

Health Care Associated Infections (HCAIs)

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through invasive procedures or chronic wounds) it can cause blood poisoning (bacteraemia). It can be difficult to treat in people who are already very unwell so we continue to look for the causes of the infection and to identify measures to further reduce our numbers. MRSA has fallen gradually in Oxfordshire up to 2012/13 in response to the direct measures taken by hospital and community services to combat it. Last year saw a small upturn in numbers. This needs to be monitored closely.

Page 84



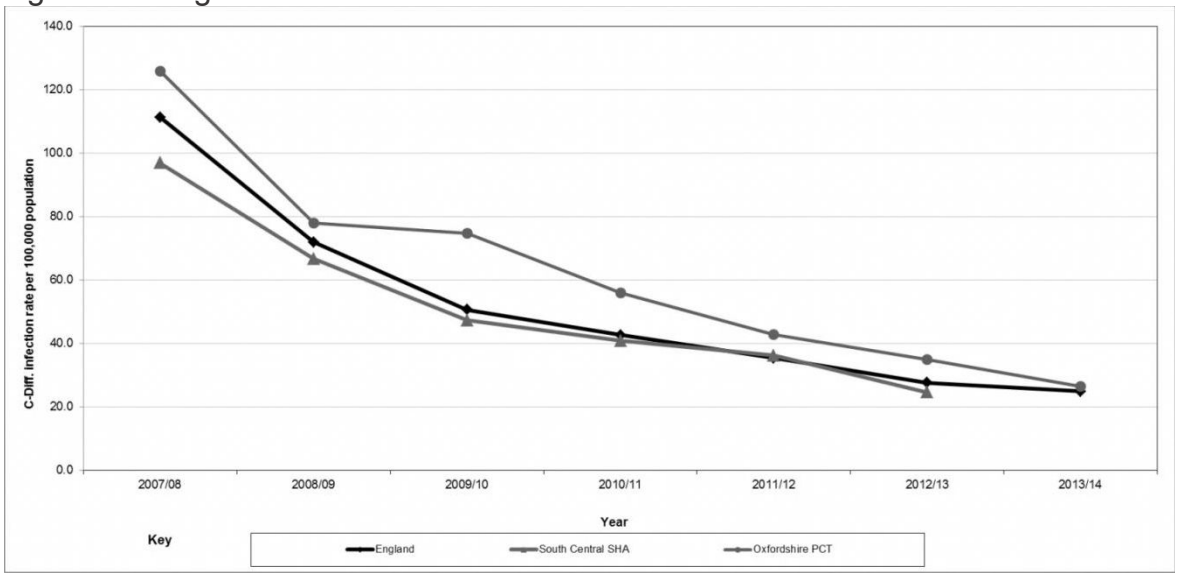
Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 – 2013/14) England, South Central SHA and Oxfordshire

The recent slight increase reaffirms the continued vigilance that is required by all hospital and community services to address this increase.

Clostridium difficile (C.diff)

Clostridium difficile is a bacterium that causes mild to severe diarrhoea which is potentially life-threatening especially in the elderly and infirm. This bacterium commonly lives harmlessly in some people's intestines but commonly used broad spectrum antibiotics can disturb the balance of bacteria in the gut which results in the C.diff bacteria producing illness.

Last year saw good progress in combatting this disease, reaching parity with the England average for the first time.

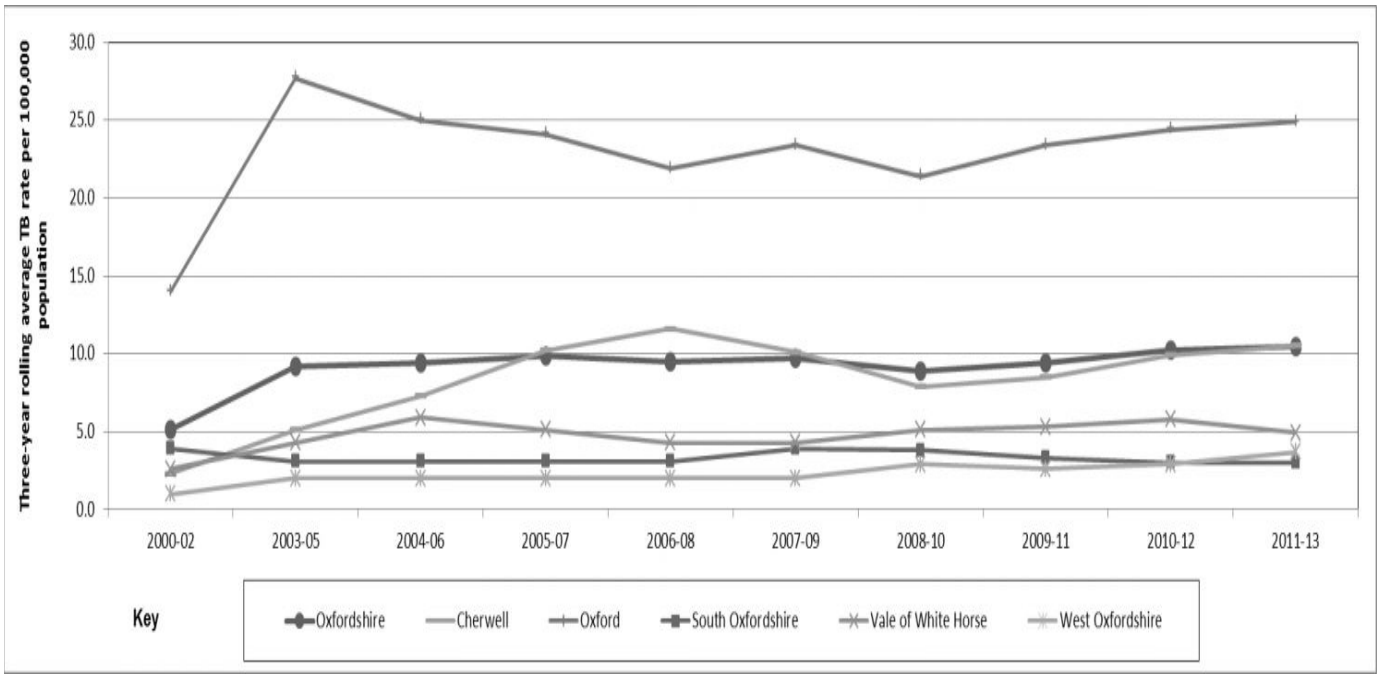


Clostridium difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2012/13) England, South Central SHA and Oxfordshire PCT

Tuberculosis (TB) in Oxfordshire

TB is a bacterial infection caused by Mycobacterium tuberculosis which mainly affects the lungs but which can spread to many other parts of the body including the bones and nervous system. If it is not treated, an active TB infection can be fatal as it damages the lungs to such an extent that the individual cannot breathe.

In Oxfordshire the numbers of cases of TB at local authority level are very low. These are shown below. In terms of numbers of cases, the average figure per District remains below 10. Because numbers are small, a modest outbreak of TB has a big effect on the overall figures. A three-year average is given which, at district level, still remains below 10



Tuberculosis (TB) - Rate per 100,000 population (2004 to 2012) Oxfordshire and districts within Oxfordshire

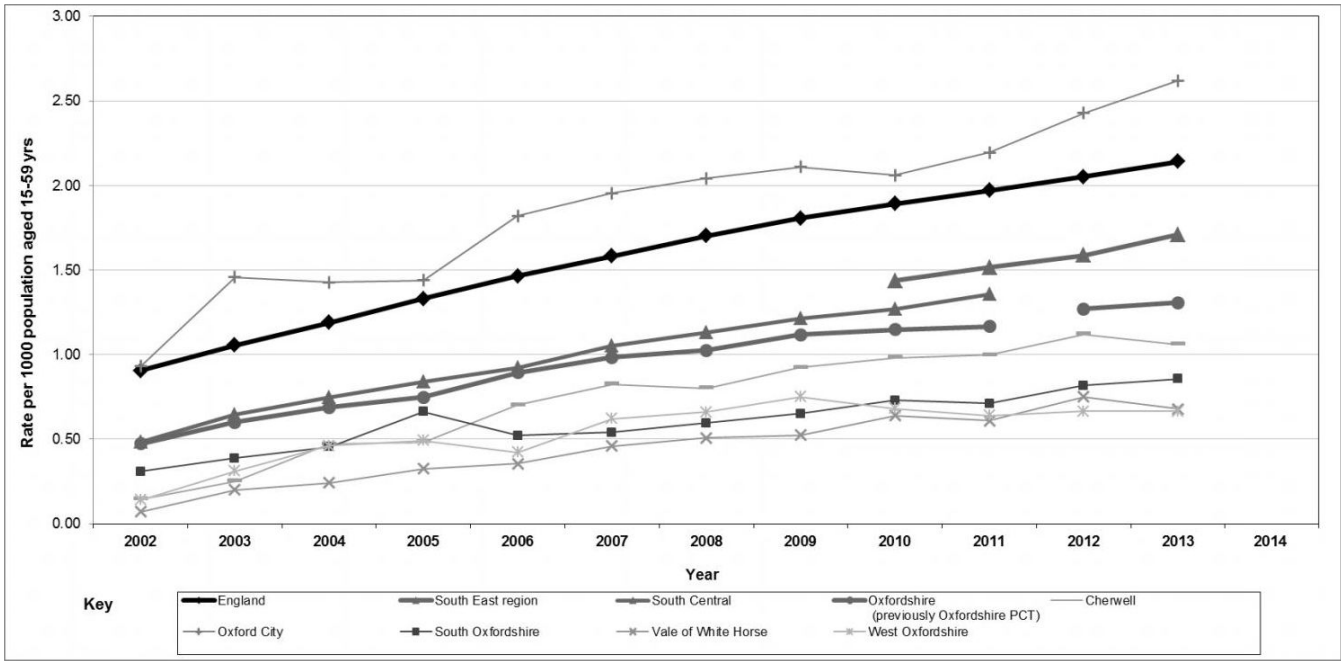
The levels of TB in the UK have been relatively stable over the past seven years. However, despite considerable efforts to improve TB prevention, treatment and control, the incidence of TB in the UK is higher compared to most Western European countries.

The rate of TB in Oxfordshire is lower than National and Thames Valley levels. In the UK the majority of cases occur in urban areas amongst young adults, those coming from countries with high TB burdens and those with a social risk of TB. This is reflected in the higher rate of TB in Oxford and Cherwell compared to other districts in the County. Given the importance of TB as a public health issue, it is one of the key priorities for Public Health England who are working to support local services to address TB in Oxfordshire.

Sexually transmitted infections

HIV & AIDS

Whilst HIV does not raise the public alarm it used to, it still remains a significant disease both nationally and locally. HIV is now a long term condition so we would expect there to be more people living with HIV long term. 2013 data shows that there are 524 people diagnosed with the infection living in Oxfordshire. 279 out of 524 live in Oxford City. This gradual increase is shown in the chart below.



Prevalence of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 yrs England, South East region, Oxfordshire and Oxfordshire districts

Finding people with HIV infection is important because HIV often has no symptoms and a person can be infected for years, passing the virus on before they are aware of the illness. Trying to identify these people is vital. We do this in four ways:

- Through Antenatal screening programmes - there are approximately 7,000 deliveries per year in Oxfordshire and 99% of pregnant women are screened for HIV, this identifies an average of 9 women as being HIV positive per year.

- Through community testing - we have 'HIV rapid testing' in a pharmacy in East Oxford as an initial step. This test gives people an indication as to whether they require a full test. The rapid test takes 20 minutes and gives fast results, although a fast tracking to the sexual health service for a full test is required to confirm diagnosis.

- Through offering a test in sexual health clinics when people attend with other diseases.

- Through prevention and awareness. Educating the local population about safe sexual practices and regular testing in high risk groups. The current contract for services ends on 31 March 2016. The Public Health Directorate are commissioning prevention and awareness services that will meet the changing needs of the local population.

Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments. HIV cannot be cured but the progression of the disease can be slowed down considerably, symptoms can be suppressed and the chances of passing the disease on greatly decreased.

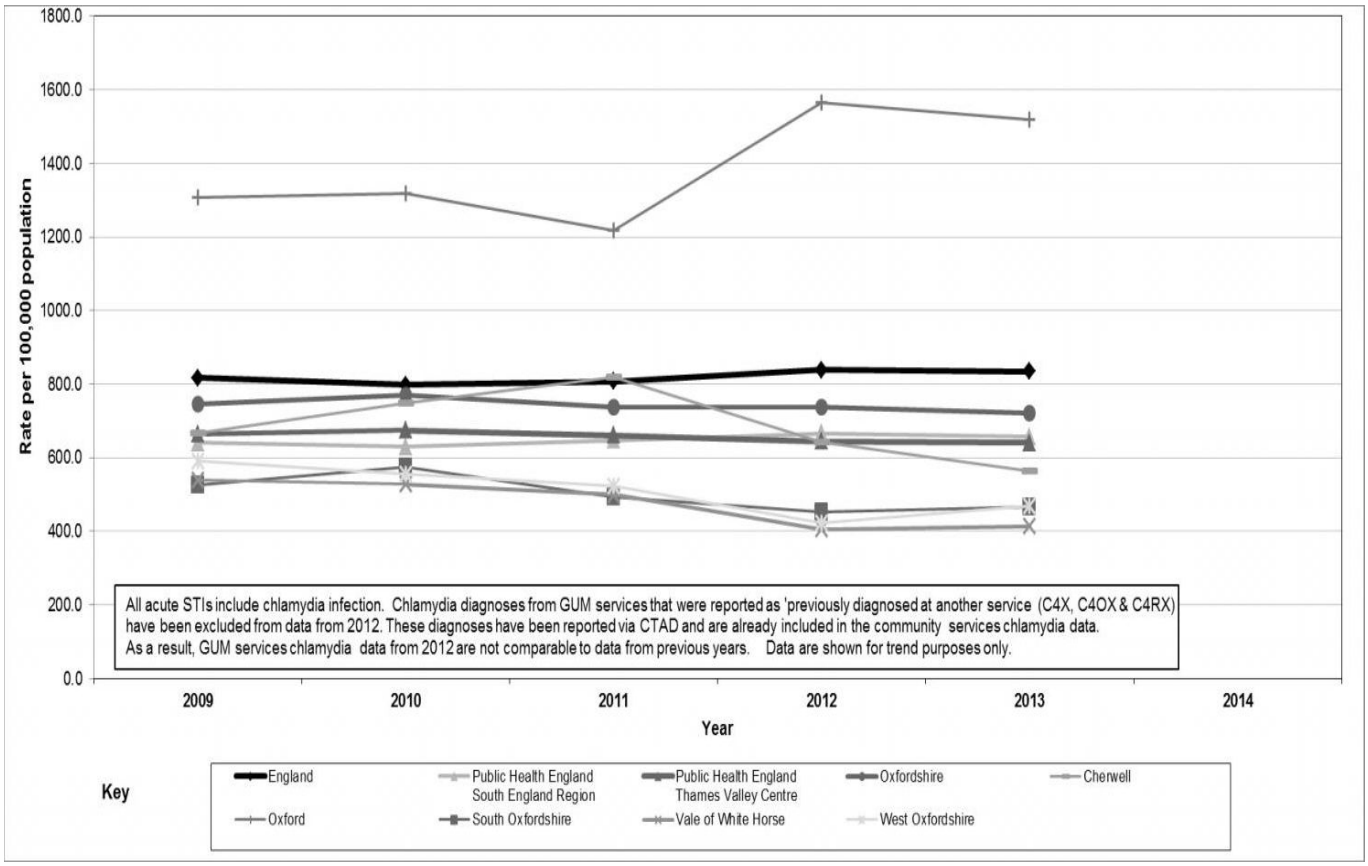
Sexual Health

Sexually Transmitted Infections (STIs) are continuing to increase in England with the greatest number of cases occurring in young heterosexual adult men and women and men who have sex with men. STIs are preventable through practising 'safe sex'. Total rates of STIs in Oxfordshire are below the national average except in the City, which has now slightly improved on 2012 data.

The different types of STI each show a mixed picture which is generally good with County averages below the national average. This is shown in the chart below. Looking at each disease in turn gives the following picture:

- Gonorrhoea – levels are below the national average for Oxfordshire as a whole and all Districts except in Oxford City where rates are high. A detailed piece of work is in progress to find out why this is. The reason may be connected with a more sensitive test for the disease which has been introduced. The situation needs close monitoring.
- Syphilis - is falling and below national average in all areas of the County except in Oxford City.
- Chlamydia –levels are lower than national average, but we continue to have difficulties in persuading young people to come forward for testing, despite best efforts.
- Genital Warts – rates are now lower than the national average which is an improvement. Oxford City is significantly higher (reflecting the younger age group) but the trend is generally stable.
- Genital Herpes – rates are lower than national average except in the City which has higher levels. However the total number of cases in the year is small. Again this reflects the predominantly younger population in the City.

The chart below shows the overall position.



A new sexual health service began in 2014 which brought together STI and contraception services. A report on the first year of operation has shown improvements in public access coupled with better access to the 'morning after pill'. Safeguarding has also been strengthened.

In line with best practice a partnership of local stakeholders was established in February 2015. This group will work together to identify and address priorities locally to make further service improvements.

Recommendations

1. The Director of Public Health, the NHS and Public Health England should remain vigilant, spot the early signs of rising disease levels and continue to take action.

2. The Director of Public Health should report on killer infections and infectious diseases in subsequent annual reports.

3. The new Sexual Health Partnership should steer multiagency action to combat sexually transmitted infection.

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About us

Healthwatch Oxfordshire exists to be the independent watchdog and champion for people who use health* and social care services in Oxfordshire.

Healthwatch Oxfordshire's vision is that people are actively involved in shaping the health and social care services they use in Oxfordshire.

* "health" includes public health throughout

To do this we:

- Gather information about people's experiences of using health and social care services in Oxfordshire and make it available to the public.
- Use this information to make recommendations to relevant local and national organisations about how local services, policies and strategies need to change and improve and, where possible, secure their agreement to make improvements.
- Help hold those in charge of local health and social care services to account for putting our recommendations into practice – and do this in a way that is visible to the public.
- Provide advice and information to help individuals access health and social care services in Oxfordshire.

Responsibilities and powers granted by the 2012 Act

- A duty on service providers to allow authorised Enter and View representatives to observe services on their premises.
- Making reports and recommendations about how local care services could or ought to be improved.
- Local Healthwatch must rely on good relationships, or use the Freedom of Information Act to get information from public bodies.
- A person must acknowledge and respond to reports and recommendations within 20 days or 30 in some exceptional circumstances.
- NHS bodies and local authorities are required to ensure that independent providers respond to requests from us for information within 20 working days.

Cont'd…

- A referral to Overview and Scrutiny must be acknowledged within 20 working days and take into account any information provided.
- A place on the Health & Wellbeing Board and statutory consultee of the health & wellbeing strategy.
- Making recommendations to Healthwatch England to advise the Care Quality Commission (CQC).
- Local Healthwatch have the opportunity to comment on Quality Accounts
- We can escalate issues that can only be addressed at a national level to Healthwatch England, with a request that they take action.

How we hear from people

- Projects funded by grants and delivered by 3rd party organisations who can reach communities we cannot reach by ourselves
- Outreach work with the general public in order to hear unsolicited feedback on any topic of interest
- Major projects using Enter &View- often in partnership (eg Age UK)
- Conferences, workshops and events on particular topics – eg Hearsay!
- Quality and patient experience leads meetings.
- Single issue lobbying
- Building our networks and encouraging others to share their information with us
- Work with the media and wide range of local networks to raise our profile with the public so they bring us their stories

How we influence people

- We publish reports which make clear evidence based recommendations
- We carry out formal letter writing campaigns
- We are selective about what we comment on, so that when we speak we are listened too
- We are an active member of HOSC and H&WBB and other project and programme boards
- We have a regular cycle of “We said, They Did (or didn’t)” reporting in public
- We chair the Oxfordshire Directors’ of Quality and Patient Experience leads meeting
- We use the media
- We lobby behind the scenes.

Work already completed this year

Major projects: Discharge (July publication)

Events: Voluntary sector conference and Hearsay x 3

Outreach programme: 27 days out talking to the public.

Lobbying : Big Plan consultation; Campsfield House

Grant aided reports: Oxfordshire Neurological Alliance; Alice's Report; Dementia Friendly Communities; Homestart and Guideposts.

HWO Ambassadors: supporting lay people on Health Improvement and Children's Trust Boards

CQC inspections: MH Crisis services, local GP practices, local care homes, pass on safeguarding concerns

Current work programme

Major projects:

- Dignity (Nov publication), Child Sexual Exploitation (March-ish publication)

Events:

- Voluntary sector conference and Hearsay follow up in January
- Dignity in Care event with Age UK and the University in November

Enter and View:

- 3 sites of concern before March

Outreach programme:

- 12 events planned between now and Christmas.
- Aim for one event a week and to cover the County's towns over a year

Lobbying issues:

- Community Hospitals
- Needs of veterans and their families
- Quality of consultations.

Current work programme cont'd

Grant aided reports:

- Needs of gypsies and travellers (SEAP)
- Needs of parents and children from conception - age 2 (OXPIP).
- 10 organisations interested in bidding for next round.

HWO Ambassadors:

- Supporting lay people on Health Improvement and Children's Trust Boards and at national networks like HAPIA
- Supporting 6 patient led locality forums

CQC inspections:

- Oxford Health FT
- Local GP practices

Supporting other work:

- JSNA
- Primary care pilot development schemes and Co-commissioning
- Planning for population growth
- Healthy Towns Initiative
- Health Inequalities Commission
- CCG Equality Reference Group
- Oxfordshire Stronger Communities Alliance.

Next steps

- What do you think are the things local patients and social care users are most worried about?
- Do you know a site we should Enter and View?
- Do you know an organisation that would like a grant?
- Can you help us with our outreach programme?

Contact us on:

- 01865 520520
- hello@Healthwatch.co.uk

Report for Health Improvement Board, 27 October 2015
By Laura Epton, Healthwatch Ambassador

My report wishes to raise the concerns expressed by 41 medical professionals and infant feeding professionals in a letter dated 10 August 2015 addressed to members of the Health Improvement Partnership Board [and Oxfordshire Health & Wellbeing Board among others] at the prospect of the closure of the breastfeeding support service delivered by the Baby Cafe.

This report asks the Health Improvement Board to request the OCC and OCCG to consider these concerns as they determine their priorities and funding decisions for 2016/17 given both the value of the service and Health and Wellbeing Strategy's priority to tackle obesity.

Oxfordshire's Joint Health & Wellbeing Strategy for 2015 - 2019 states that increasing the number of breastfed babies is the foundation of an obesity strategy for the county:

Priority 9 - *Preventing chronic disease through tackling obesity* commits to ensuring that 63% of babies are breastfed at 6-8 weeks of age (the current figure is 60.4%).

Oxford's high breastfeeding continuation rate of 68% (measured at 6-8 weeks) would likely decrease without funding of the breastfeeding support delivered by Oxford Baby Café.

Background on the Oxford Baby Café
Below is some background detail on the service delivered by the Baby Café and its impact and value to women and families in the county.

Best Practice
The Baby Cafe model has been recognised as the most effective breastfeeding intervention by the **Centre for Excellence and Outcomes in Children and Young People's Services (C4EO)**. It is also recommended by **UNICEF Baby Friendly Initiative**. All Baby Cafés must adhere to the 12 Baby Café Quality Standards (as outlined by C4EO - http://www.c4eo.org.uk/local-practice/validated-local-practice-examples/baby-caf%C3%A9-breastfeeding-support-service.aspx). This well-evaluated service combines a social model of care and one-to-one breastfeeding support.

Activity
The total footfall per year is on average 3,218 which includes 1,147 individual mothers.

The current service:

- Eight weekly 2-hour drop-in sessions, open to all breastfeeding mothers, pregnant women and their supporters.
- Four monthly antenatal breastfeeding workshops.
- Annual peer support training for 12-15 peer support volunteers.

The Baby Café helps to establish breastfeeding by:

1. Being available at the time of need: out of hospital, five days a week and with a closed Facebook group offering peer and professional advice. Many mothers are discharged from hospital long before the breastfeeding relationship is established.
2. Offering high quality care from trained lactation consultants who provide consistent

advice, information and trouble-shooting to women and families.
3. Offering peer and community support by bringing together families at different stages of the breastfeeding journey and demonstrating that their current difficulties can be overcome.

The service dovetails with the Oxford University Hospitals Trust Breastfeeding Clinic and works closely with midwives, health visitors, GPs and OXPIP.

Funding
The Baby Café service costs approximately £40,000 per year, which equates roughly to £40 per family. Given the long-term health benefits this is excellent value for money. The service is fully funded through the Children's Centre budget until March 31 2016. It is unlikely to be extended as OCC propose to discontinue funding and provision of the 'universal' services of Children Centres.

Healthwatch feedback
Healthwatch Oxfordshire have spoken to mothers over the county as part of their Outreach programme and the praise for the baby café staff has been strong with mothers stating that the encouragement and reassurance they received ultimately helped them to go on breastfeeding for as long as they did; that the support was invaluable and a "life-saver" and that the loss of such an important resource will leave new mothers with no support which they felt could lead to post-natal depression and inability to cope.

Potential impact of reducing the breast feeding support
The letter anticipates a number of implications if the service is closed. These include:
1. Reduced access to prompt expert help, leading to greater distress for parents.
2. Demand transferring to other services.
3. The workload of Community midwives, GPs, health visitors and the infant feeding clinic at the JR will increase.
4. Decreased breastfeeding rates.

As well as lower rates of early years obesity, the health benefits of breastfeeding are well established: lower rates of gastrointestinal and lower respiratory tract infections; prevention of SIDS; and reduced rates of maternal breast cancer.

This report asks the Health Improvement Board to request the OCC and OCCG to consider these concerns as they determine their priorities and funding decisions for 2016/17 given both the value of the service and Health and Wellbeing Strategy's priority to tackle obesity.

Paper for Health Improvement Board - 27th October 2015

Oxfordshire County Council work for the prevention and treatment of overweight and obesity in children and adults

1. Commissioned Services:

a. Prevention

The School Health Nursing (SHN) Service: includes the National Child Measurement programme (NCMP) which measures BMI rates for children in Reception and Year Six. This is fed back to the Health and Social Care Information Centre (HSCIC) and allows trends to be tracked both locally and nationally.

The SHN service provides promotion, advice and support to children about healthy eating and how to achieve a healthy weight.

From the 1st October 2015, Public Health is responsible for the **Health Visiting Service** which leads the delivery of the Healthy Child Programme 0-5. A key aspect of this work is to promote and support breastfeeding, healthy weight, healthy nutrition and physical activity for parents and children in the early years.

b. Treatment

The Council commissions a referral hub (coordinated by Morelife), for GPs to refer obese patients (BMI more than 30). Patients are either offered 12 weeks of Slimming World or Weight Watcher vouchers. There are 1500 vouchers available a year (Sept to Sept). The Slimming World programme is available to young people from age 11 accompanied by a parent.

Patients with a BMI of more than 40 are eligible for the MoreLife specific weight loss service. This is 14 weeks of weekly weigh in sessions and lifestyle advice, with a significant psychological therapy input. They then attend two weekly sessions, followed by monthly sessions, to complete a full year intervention. There are 580 places available for a year (Sept to Sept), again there is significant demand. The Morelife service will see Young People from 16 years and they will tend to offer 1:1 session.

c. Grants

Public Health funded training for children's centre and health staff in 14/15 to deliver **HENRY** (Health, Exercise, Nutrition for the Really Young) programmes across children's centres. Additional funding from Public Health supports the annual licence fee, and a part time co-ordinator of the group delivery and supervision for staff.

We make a contribution to the running costs of play day events, and community playback organised by the **Oxfordshire Play Association** to promote physical activity through active play in the community. These engage many different partners and stakeholders and are very well attended.

London Welsh rugby club were also granted some money to deliver physical activity and nutrition sessions in Primary Schools across the County.

We grant fund the **Oxfordshire Sports and Physical Activity Partnership** who run schemes targeting people who are inactive. Initiatives include Go Active, Get Healthy (for individuals aged16+ who are achieving less than 30 minutes physical activity daily) and Sportivate (6 week programme of sport for 11-25 year olds). A specific programme that PH funding contributes towards is The Workplace Challenge, which aims to increase PA in workplaces and includes active travel.

In 2014/2015 we helped to fund **Cropredy Primary school** to improve consumption of locally grown vegetables using a 'school farm' approach. It provided 80 hours of teaching and project work to encourage children to grow and consume produce grown on the school premises. This helped to address healthy eating, engaging in the natural environment and physical activity.

2. Partnerships and Influencing

Public Health is a member of the Strategic Physical Activity Group which was re-launched in 2015. This compliments the priorities and actions of the healthy weight steering group. This will be explained in more detail by OXSPA

Since PH has been part of the Local Authority it has given the opportunity to work more collaboratively with other Directorates that can have an influence on the wider determinants of healthy weight. This includes:

a. Children, Education and Families

- Working with the School Food Trust and Facilities Management to 'Make School Meals Count' (increase the uptake of school meals in middle and secondary schools) through the delivery of improved marketing and kitchen facilities.
- Attending the Children and Young People's Wellbeing group which covers positive activities for young people
- Children's centre representative on the healthy weight steering group
- Primary school Headteacher representative on the healthy weight steering group

b. Environment and Economy

- Addressing the obesogenic environment with E&E and District Planning departments through the healthy weight steering group
- Linking spatial planning with public health; engaging in commenting on planning applications (e.g. Oxford City's Northern Gateway Masterplan). This includes the development of a formal response template with which to comment (in progress).
- Part of the Smart Cities partnership, and works with the NHS Healthy New Town expression of interest/bids
- Consulting and commenting on Local Transport Plan 4 (LTP4), including a section on the health benefits of cycling.
- Ensure that green infrastructure is maximised

c. Fire and Rescue

- Working in collaboration on their child friendly 'Drago the Dragon' books to incorporate healthy eating and physical activity messages.

d. Social and Community Services

- Partnering with the library service to display campaign material such as information on sugar sweetened beverages

e. Corporate services

- OCC 'Well at Work' initiative which is aimed at raising awareness improving employee health, including physical activity and access to healthy eating choices.

f. Wider partners

Public Health is supporting the development of a **Workplace Wellbeing Network** across the County. This will be private sector led by Unipart, with core members consisting of both NHS Trusts, OCCG, OCC (HR and PH), and BMW. This will provide employers with evidence based health and wellbeing targets to make workplaces a supportive and productive environment. In return for commit resources to improve workplace wellbeing participating employers will benefit from access to pooled resources, services, training and events/campaigns.

3. Information and advice

Public Health has dedicated webpages providing advice, information and signposting on the County Council website

Young people can access information on the OxMe website which PH have been involved in re-designing and re-launching in 2015.

4. Campaigns

The Public Health team actively adopts national PHE campaigns such as 'Change 4 Life', aimed at raising awareness of healthy weight in families. Locally the PH team have implemented the 'Eat Well Move More' campaign using the Oxfordshire Play Association Play Days as a springboard, as well as working with local communities and partnerships to design their own social media including 2 videos - 'Sugar Love' (2014) and 'Can the Can' (due in October 2015) .

Other campaigns to promote physical activity include 'Well at Work' at OCC (health kiosk, step jockey), and a joint campaign with Oxfordshire Sport and Physical Activity Partnership in Pharmacies to encourage individuals to sign up to their Go Active Get Healthy programme.

We have dedicated 'Healthy Oxon' Facebook and Twitter pages, which promote campaigns, programmes of work and latest evidence and policy change.

5. Co-ordination of Steering Group / countywide strategy and action plan

Public Health led the consultation and subsequent development of a countywide Healthy Weight strategy. The approach of this strategy is;

- Influencing choice, addressing social norms and cultural values

- Working with local partners across the County
- Embedding healthy weight into a life course approach

Public Health chairs the multi-agency Healthy Weight Steering Group which has a lead role in overseeing implementation of the countywide action plan. The three main priorities for this year are:

- Focus actions on all children and young people to reduce levels of overweight and obesity
- Explore how workplaces can contribute to working aged adults healthy weight
- Work in collaboration across agencies to ensure the built environment contributes in a positive way towards healthy weight (e.g. connectivity, infrastructure, giving choices where possible, and community safety)

Sal Culmer, Health Improvement Practitioner, Public Health, Oxfordshire County Council.

1. Purpose of this Briefing Note

This note sets out the areas of work that West Oxfordshire District Council is already delivering to prevent obesity and promote maintenance of a healthy weight for its residents.

2. Background

- West Oxfordshire District Council has a strategic priority around enabling its residents to access and maintain physical and mental health and wellbeing lead healthy summarised as:
  Work in partnership to sustain vibrant, healthy and economically prosperous towns and villages with full employment.

- The Council works closely with the CCG, County Council and local GP commissioning group to develop appropriate initiatives and programmes. The Council's Healthy Communities Manager sits on the PH Healthy Weight Steering Group on behalf of the city and district councils and the Strategic Physical Activity group for Oxfordshire.

- The Council is engaged in a range of activities that help people to gain and maintain a healthy weight. They can broadly be categorised as
  - opportunities to be physically activity through structured activity
  - opportunities that stem from medical interventions
  - casual opportunities to be physically active through spatial planning including access to green spaces.

3. Opportunities to be physically active through structured provision

The council is engaged in:

- Full exercise programme through our leisure facilities, including establishing the 'easy-line' fitness facility for people who are not ready or comfortable in a large open fitness suite.
- Financial support for sports clubs who want to improve their facilities and become more accessible to local people.
- The ISO Project, our lottery funded programme, opening up participation opportunities for young people with a range of disabilities. 280 young disabled people accessing this service in the first year.
- Targeted work with vulnerable groups – to enable them to use facilities easily. The Council has introduced a range of concessions and free services to encourage

differing groups to access leisure opportunities – main beneficiaries are vulnerable young people and adults with complex needs
- Financial support for communities who wish to enhance their community facilities, such as village halls, to enable activities to take place.
- Securing developer contributions to create sport, physical activity and leisure infrastructure in suitable locations including indoor and outdoor activity space, leisure centres and play areas.

4. Opportunities that stem from medical interventions

The council is engaged in:
- Exercise on prescription is encouraged and there is a successful programme running in partnership with the Councils leisure management contractor GLL Better.
- Introduced some activities to the most recent cycle of the Reach for Health programme in West Oxfordshire led by Oxford Health. Interested to build on this but contract dissolved.
- There is on-going engagement with GP's across the district including a presentation to GPs in the last year.
- GLL Better's Health Manager has visited Practices with guidance and encouragement.
- GPs also have physical activity on their calendar for a 2016 Practice Learning Time session, which will be led by the Council's health personnel.
- West Oxfordshire GPs have been referring through More Life to weight loss providers, which has proved popular and has had some success (60% of participants experiencing weight loss).
- Pilot council in recent Sport England research exploring how best to build closer relationship between commissioners and second tier local authorities – has resulted in more visibility for both parties and some greater engagement.

5. Casual opportunities to be physically active through spatial planning including access to green spaces.

The council is engaged in:
- Financial support for communities to build appropriate and innovative play provision.
- High level of success in developer contributions to green spaces and play provision.
- Strategic approach to spatial planning within the Council services of *Planning and Strategic Housing* and *Leisure and Communities* with regards to open spaces, in particular play spaces.

South Oxfordshire briefing on the activities delivered by the Participation Team

October 2015

When referring to leisure, many people only associate this with the facilities side of the team and the leisure centres that they are responsible for. The Participation team is the part of leisure dealing directly with the public, offering opportunities for all our residents to take part in sport and physical activity. Outlined below are some of the key areas of our work.

Sportivate is a £56 million Lottery funded London 2012 legacy project that gives more young people the chance to discover a sport that they love.

The programme started by giving 14-25 year-olds, who are not particularly sporty, access to six-to-eight weeks' of free or subsidised coaching in a range of sports. From September 2013, Sportivate extended its age group so that 11-13 year-olds can also take part.

During the six-to-eight weeks those taking part can work towards an event or personal challenge and when the free or low-cost coaching has finished they will be supported to continue playing sport.

Sportivate launched in June 2011 as a four-year programme but, due to its success, additional funding of £10m per year has been invested allowing the programme to run until March 2017.

In South Oxfordshire this year we have engaged 143 youngsters in sports including squash, basketball, golf, boxing and rowing.

In partnership with local clubs and our leisure provider, GLL, we have delivered holiday activities for youngsters aged 5 – 18, enabling them to stay active throughout the school holidays, trying new sports and hopefully going on to join the clubs and take part regularly in the sport of their choice.

The GO Active, Get Healthy Project in South Oxfordshire offers a variety of activities to encourage adults 16 + to live more active lifestyles.

- There are regular activities taking place such as: Nordic Walks, health walks, community tai chi, Pilates, Yoga, stretch classes and open water swimming.
- We work in partnership with our local leisure provider, GLL, to run reduced cost swim campaigns twice a year at all our leisure centres.
- During August we signed up to a national campaign, Love Parks, focusing on communities to take up sports and physical activities in their local parks. Some of these activities included volleyball, Nordic Walking tasters, tai chi in the park and ultimate Frisbee.
- We make sure we use our funding to set up sustainable activities such as the Didcot Park run where anyone can either run or jog a timed 5km loop every Saturday with volunteers organising and marshalling the event.
- We also use our funding to train coaches and volunteers to help us run sustainable activities. We recently funded a table tennis coach who offers coaching to a senior table tennis session at Thame Leisure centre with a group of 12 regular players. This group started as part of a table tennis taster day we offered to older residents.

In South Oxfordshire our Active Women team have run a variety of sessions for either mums to do with their children or on their own (e.g. badminton, powerhoop, yoga, boxfit).

We have set up new activities such as mum and toddler dance, zumba, badminton and we have also tried to provide childcare where possible, for example at Thame Racquets Centre we have set up a project where women can attend 6 exercise sessions on their timetable at £5 each and this includes crèche facilities. Many of our activities have continued as regular sessions and popular activities such as netball groups and boxfit sessions, initially set up by Active Women are now being led by the leisure centres.

Our main success projects have been our involvement in a swimming campaign across both Districts (in South Oxfordshire 176 ladies with children under 16 took part); a zumba course in Wallingford, which has attracted 92 ladies in total, to attend and have now continued as regular classes); and also powerhoop, where we have set up an additional class in Didcot due to it's the popularity.

Active Women have also run a mum and toddler dance session for Didcot Ladygrove children's centre, with a focus on low income families and regularly has eight mums attending.

GO Active Gold

South Oxfordshire and Vale of White Horse District Councils have been awarded £227,000 by Sport England for Go Active Gold, a three year project offering a range of sports and classes in rural areas for people aged 60 plus.

Go Active Gold will target different villages each year to encourage people to do 30 minutes of moderate intensity physical activity each week. Sessions start in January and will be delivered by Go Active Gold 'activators' and local sports and activity coaches.

Members of the local community will also be encouraged to volunteer to help spread the message about what's on offer and set up and deliver some sessions.

Activities will begin in January and will include dance, tai chi, table tennis, golf, bowls, Pilates, yoga, Nordic walking and fitness

Taster sessions in the above will initially be held in Kingston Bagpuize, Steventon, Woodcote, Watlington, Chalgrove, Sutton Courtney and Shiplake.

Through increasing physical activity levels we will improve the physical and mental health and wellbeing of older people, encourage social interaction and create lifelong habits and role models for younger generations.

Vale briefing on the activities delivered by the Participation Team

When referring to leisure, many people only associate this with the facilities side of the team and the leisure centres that they are responsible for. The Participation team is the part of leisure dealing directly with the public, offering opportunities for all our residents to take part in sport and physical activity. Outlined below are some of the key areas of our work.

Sportivate is a £56 million Lottery funded London 2012 legacy project that gives more young people the chance to discover a sport that they love.
The programme started by giving 14-25 year-olds, who are not particularly sporty, access to six-to-eight weeks' of free or subsidised coaching in a range of sports. From September 2013, Sportivate extended its age group so that 11-13 year-olds can also take part.
During the six-to-eight weeks those taking part can work towards an event or personal challenge and when the free or low-cost coaching has finished they will be supported to continue playing sport.
Sportivate launched in June 2011 as a four-year programme but, due to its success, additional funding of £10m per year has been invested allowing the programme to run until March 2017.
In Vale of White Horse this year we have engaged 153 youngsters in sports including water sports, tennis, self-defence, rowing, volleyball and gymfit.

In partnership with local clubs and our leisure provider, GLL, we have delivered holiday activities for youngsters aged 5 – 18, enabling them to stay active throughout the school holidays, trying new sports and hopefully going on to join the clubs and take part regularly in the sport of their choice.

The GO Active, Get Healthy project in the Vale has a varied programme of activities for all adults (16+) to try including short tennis, Pilates and ballroom basics. We try to reduce the barriers to participation as much as possible whether that is reducing the cost, providing local venues or like our Slacklining sessions that allow the whole family to attend. Sessions specifically for our target audience of sedentary adults include Short Mat Bowls, Boccia and Pickleball which has grown to three sessions in Abingdon and recently added a new group in Wantage.

Over the last year we have held campaigns in swimming and golf along with the Annual Football Tournament and Fun Run events. Our jogging programme has proved to be successful with the top three largest recreational jogging groups in Oxfordshire all in the Vale district.

Our Active Women team have run a variety of sessions for either mums to do with their children or on their own (eg badminton, powerhoop, yoga, boxfit). We have set up new activities such as mum and toddler dance, zumba, baby yoga and now have a new 'New Mums' exercise group starting as a result of a successful pilot we did involving exercise sessions, pedometers and home exercise DVDs. Many of our activities have continued as regular sessions and popular activities such as netball groups and boxfit sessions, initially set up by Active Women are now being led by the leisure centres.

Our main success projects have been our involvement in a swimming campaign across both Districts (in Vale 138 ladies with children under 16 took part); a cardio badminton taster sessions at the White Horse Leisure and Tennis Centre in Abingdon where 14 ladies attended (picture attached) and a boxfit session in Faringdon, where 11 women attended – both sessions have continued as regular sessions.

South Oxfordshire and Vale of White Horse District Councils have been awarded £227,000 by Sport England for Go Active Gold, a three year project offering a range of sports and classes in rural areas for people aged 60 plus.

Go Active Gold will target different villages each year to encourage people to do 30 minutes of moderate intensity physical activity each week. Sessions start in January and will be delivered by Go Active Gold 'activators' and local sports and activity coaches.

Members of the local community will also be encouraged to volunteer to help spread the message about what's on offer and set up and deliver some sessions.

Activities will begin in January and will include dance, tai chi, table tennis, golf, bowls, pilates, yoga, Nordic walking and fitness.
Taster sessions in the above will initially be held in Kingston Bagpuize, Steventon, Woodcote, Watlington, Chalgrove, Sutton Courtney and Shiplake.

Through increasing physical activity levels we will improve the physical and mental health and wellbeing of older people, encourage social interaction and create lifelong habits and role models for younger generations.

Another area that falls within the remit of the participation team is The Beacon in Wantage. This is a community building run by members of our team that offers great opportunities for local people to get involved in a variety of activities, including dance classes, fitness classes, weight watchers groups, tea dances and martial arts.
These are run in addition to the cultural and community activities such as concerts, shows and cinema, which also take place regularly.

Cherwell District Council
Healthy Weight Initiatives for Health Improvement Board

Cherwell District Council commissions and directly delivers a range of recreation, sports and arts opportunities with prevention of poor health, both physical and mental, in mind. No single initiative is directed at weight management but the recognition that individuals who are engaged in physical or creative participatory activities that improve fitness and mood will have a positive impact on the wellbeing of that individual and may assist them with attaining and maintaining a healthy weight.

Young Peoples Recreation

- Recreation & Sport Activator Initiative – District wide, engaging 8-16 year olds with free physical activity sessions to encourage healthy lifestyles. Sessions are open access and run in recreational spaces, parks and youth club settings promoting community sport and sign posting young people to clubs and health information.

- Activate Banbury initiative – Working in partnership with Sanctuary Housing & Sport England to target physical activity sessions in Brighter Future wards in Cherwell to engage young people who wouldn't normally get involved in sport. 4 Sessions run every week in Ruscote and Neithrop wards over 8 week blocks all year round, making links to local sports clubs for sustainability.

- Brighter Future's Healthy Eating holiday activities – Working in partnership with The Hill Youth & Community Centre a programme has been developed around healthy eating and cooking to give young people and families a fun way to engage in healthy lifestyles. Programmes run in the Easter, Summer and half term holiday periods.

- Health zones incorporated into both the Banbury and Bicester Play day events to promote healthy lifestyles to children, young people and families. The two events attract over 3,000 people to each event so provide a great audience for health professionals and initiatives to access a target audience.

- Cherwell Play Partnership, Banbury Youth Partnership and Bicester Youth Partnership all keep health items on their agenda's to incorporate this into planned programmes and opportunities across the district.

- Play grants awarded to key play organisations across the district to deliver and promote play opportunities and encourage healthy lifestyle sessions throughout the year.

Sports Development

- Sportivate School programme 11 – 18 year olds

The Sportivate School programme focuses on offering a block of 8 sessions to young people aged 11 – 18 year olds in a variety of sports and physical activity. Examples of programmes are Canoeing, Gym, Dance, Boxing, Squash and Tennis. If young people attend 6 times in an 8 week period they receive an incentive of FREE membership at the attached club or leisure centre for sustained

participation in sport and physical activity. The young people are targeted by teachers as pupils that are currently not engaged in sport in school or out of school hours and offered the opportunity to participate in the programmes and as a result engage young people in sport and activity who previously haven't been. The programme has been very successful with over 500 pupils engaged in programmes last year and many continuing into continued participation especially into memberships at Parkwood gyms.

- Sportivate Programme 18 – 25 year olds

The programme again offers a block of 8 sessions to young people aged 18 – 25 year olds in a variety of sports and physical activity. Again if young people attend 6 times they receive a FREE membership at clubs or leisure centre. Targeted interventions have been developed with local supermarkets (Morrison's, Sainsbury's, Tesco) and young people were targeted to participate in specific Gym, Golf, Boxing and Dance projects. These young people were targeted as people who currently do not participate in sport or physical activity. The programme has been successful with over 2000 18 – 25 year olds being part of the programme last year and 450 young people joining clubs and leisure centres as a result of the interventions for sustained participation. As a result of Sportivate programme 16 new clubs and satellite clubs have been developed to accommodate for demand. This has led to an increased provision of sporting opportunities

- Buddy Scheme

The programme with mind targets people with a mental health disability. They were then paired up with a partner (buddy) who is a specialist trained volunteer from Oxfordshire Mind. Participants then access a programme for 12 weeks with a volunteer to help with confidence. After 12 weeks they have then built up the confidence to access the gym on their own. The programme has seen 46 adults take part in the programme at Spiceball and access the incentive of a link card for 50% membership. The feedback has been excellent with many participants saying how the programme has made them more active as before very sedentary along with programmes being tailored around fitness and needs of each individual. As programme was a success at Spiceball going to be rolled out at Gosford and Bicester after Christmas

- Holiday Programme

The holiday programme although not targeted offers 5 – 15 years olds positive sport and physical activity provision in the school holidays. Young people are offered a range of physical activity opportunities and fundamental movement skills to get young people active. Specific sport coaches then deliver sessions in a range of 14 different sports ranging from Archery to Fencing. Young people are then linked into local clubs to offer sustained participation. In 2015 over 3000 young people took part in the programme.

Healthy Lifestyles

- The two projects that we are involved with are the Go Active, Get Healthy and Active Women ; both projects aim to get people into exercise, we only monitor the amount of times people attend each session. Both projects are not specifically designed for weight management although exercise and weight management normally come hand in hand.

- CDC Healthy Lifestyles Officer has also previously worked with the Morelife project to deliver light exercise classes alongside their weight management meetings, the sessions lasted for six weeks one in Banbury at the Mill and the other in Kidlington at the Secondary

school, both had around 6-10, we had positive feedback from some of the participants where they said that the exercises classes helped them on their weight loss journey.

- Future work on healthy workplace initiatives at CDC
  Promotion of healthy eating and weight management in the Movember (move it more for November) as well as running exercise sessions. This is part of the national health promotion for prostate cancer in men.

Older people

Cherwell District Council contracts Age UK to run a range of recreational activity across the District for older residents; seated exercise, short mat bowls, boccia, Wii Fit, tea dances and cinema; IT support. Again nothing that is specifically directed at weight management

There are regular meetings to monitor the uptake of sessions and to modify the offer to better suit the needs of the numerous groups engaged in the programme.

Social prescribing pilot – Arts development and Health improvement partners have been piloting a social prescribing programme in Banbury to see how individuals respond to being prescribed social / creative activity to reduce their dependence on their GP surgery.

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Oxford City Council
Activities to Promote Healthy Weight

October 2015

OLDER PEOPLE'S SERVICES

Project	Why are we doing it?
The provision of: parks, pitches, play areas, skate parks, swimming pools, street sports, ice- rink and countryside provision.	To facilitate people to become more physically active in order to promote health and wellbeing.
Targeted activities in sports centres and community venues(e.g. swimming and fitness classes)	To increase the number of older people taking part in physical activity in order to preventing long term health conditions
Health Walks	To facilitate people to become more physically active in order to prevent/recover from long term conditions and obesity and to remain physically active for longer into old age.
Dance for Older People	To enable, encourage and empower older people to be physically active, learn new skills and enjoy the social aspect of dancing.
Volunteering in the local area.	Help older people to engage and benefit from volunteer activities. (Age UK supported by Comic Relief).
Community grants for services that directly or indirectly benefit older people.	Increase the numbers of older people who feel they are valued members of the community and to promote healthy lifestyles and activities
Support to Oxfordshire Council for Voluntary Action – to enable them to provide support to voluntary and community groups.	To support and advice voluntary and community groups who provide support to older people e.g. healthy lifestyle activities

CHILDREN, YOUNG PEOPLE AND FAMILIES

Project	Why are we doing it?
The provision of: parks, pitches, play areas, skate parks, swimming pools, street sports, ice- rink and countryside provision.	To promote healthy and active lifestyles for all children and young people.
Targeted activities in sports centres and community venues (e.g. swimming and dance classes).	To increase the number f children and young people taking part in physical activity in order to preventing long term health conditions.
The BONUS Slice Card and free swimming for under 17 year olds.	The provision of affordable activities for families on low incomes. To encourage those who may not be able to afford it to access sports and activities.
Grant funding to sports clubs and associations.	To promote healthy and active lifestyles for all children and young people and their families.
Information dissemination of public health messages	To enable children, young people and families to access the services that they need. To promote

Information in Your Oxford City Council Information to staff and members in Council Matters. Advertise events and campaigns. Working with partners to promote their activities.	healthy life styles and choices.
To deliver or support Educational Programmes in schools and School Leadership Programmes.	To promote financial inclusion and to mitigate the impact of poverty on poor health and diet.
Working with the Back to Work Group to promote life- long learning, training and employment initiatives, especially for particularly vulnerable groups.	To improve life opportunities and promote healthy lifestyles. To promote financial inclusion and to mitigate the impact of poverty on poor health.
To work with and support the Central NEETs Group and delivery of the NEETs Action Plan.	To improve life opportunities. To promote financial inclusion and to mitigate the impact of poverty on poor health and diet.
Youth Ambition Project	Improve health and promote healthy lifestyles. Raising aspirations of young people through access to sports, leisure and cultural activities.
Job Clubs in Blackbird Leys, Rose Hill, Barton and Littlemore	To promote financial inclusion and to mitigate the impact of poverty on poor health and diet.

CITY COUNCIL STAFF

Project	**Why are we doing it?**
Employee Assistance Programme	The Council have contracted OPTUM to provide the free employee assistance scheme. It offers free advice and support for a range of topics, including health and wellbeing support
LA Fitness	The Council offers discounted membership for LA Fitness in Oxford.
Health & Wellbeing Practice Group	This group is formed by people from across the Council who want to promote Health & Wellbeing initiatives. You will see communications from them on a regular basis.
Health & Wellbeing workshops	Corporately there are numerous Health & Wellbeing workshops being delivered which cover a variety of topics aimed at giving delegates a greater understanding of health and wellbeing issues and ways to build personal health and resilience.
Health MOT's	The Council is offering free Health checks to all staff who want to find out a bit more about things like blood pressure and Body Mass Index BMI.

Report for Health Improvement Board

27th October 2015

1. Introduction

This report provides a summary of how the Oxfordshire Sport and Physical Activity Partnership (OxSPA) is working to prevent obesity and promote the maintenance of healthy weight in the county.

2. Background

Following partner feedback Oxfordshire Sports Partnership changed its name in July 2015 to Oxfordshire Sport and Physical Activity. It also refreshed its purpose as:

'Work together to improve people's lives through growing participation in physical activity and sport '

The partners of OxSPA include Oxfordshire County Council- (Public Health), 5 Districts Councils, Governing Bodies of Sport, Sport England (biggest funder), Universities, Further education, schools, voluntary sector etc.

3. How are we doing-big picture

The partners within OxSPA have come together to develop and refresh a Strategic Framework for Physical Activity and Sport 2012-2017. Its two key destinations or goals are to:

3.1 To get 35,000 more adults 16 years plus doing the governments recommendation for weekly physical activity

3.2 To get between 15,000-35,000 sedentary people doing more activity by 2017.

These two goals are measured by the Public Health Outcomes. To date the results have been:

3.1 22,227 more adults doing government's recommendation of physical activity per month from 2012 to 2014

3.2 2,615 more adults no longer sedentary from 2012 to 2014. (Both surveyed by national Active People survey)

4. What has been done to prevent obesity and promote maintenance of health weight?

4.1 Commissioning

OxSPA has run a variety of programmes via a commissioning process. One significant programme for children and young people aged 11-25 years is the Sportivate programme which is led by the Districts in each of their areas.

OxSPA is also responsible for supporting Primary School Primary Schools Physical Education via the Governments Primary Premium. This has led to much better relationships with most Primary Schools within the county and the Chair of the Primary Heads Association has now joined the OxSPA Board.

Both these examples contribute to the Healthy Weight Plans Priority Number 2.

4.2 Partnerships and influence

Since an excellently attended conference on Physical Activity in March jointly organised and run with Public Health OxSPA has set up the Oxfordshire Strategic Physical Activity Group which is aiming to work closely with the Healthy Weight Group and produce and implement a Physical Activity Plan for the county. The group has representatives from each Local Authority, Oxford Brookes University, transport etc.

It is hoped that this can contribute to Priority number 4 in the Healthy weight plan by linking Oxfordshire County Council transport more closely to the sport and leisure sector

A key target market for OxSPA has been workforces and business organisations in the last year and this contributes to Priority number 3 in the Healthy Weight plan. Projects associated with this included Workplace Challenge, Business Games, Health MOTs.

4.3 Information and advice

OxSPA has a dedicated web site and produces a wide variety of promotional and information literature.

Key programmes such as GO Active Get Healthy and Active Body Healthy Mind have advice and support built into them.

4.4 Programmes and products

OxSPA has a wide variety of programmes and products aimed at various target markets and age groups within the county.It may be helpful to focus on one programme in particular

4.4.1 GO Active Get Healthy

GO Active, Get Healthy is a 3 year pilot programme aiming to increase participation in physical activity and sport in those who are inactive. This project has developed, maintained and promoted a 'Physical Activity and Sport Pathway' based on the Department of Health's *'Let's Get Moving'* model.

The programme is funded by Sport England, Oxfordshire Public Health and Oxfordshire Sport and Physical Activity (OXSPA). The programme is led by the core team at OXSPA and delivered by a multitude of partners; Oxford Brookes University, South and Vale District Councils, West Oxfordshire District Council, Oxford City Council, Cherwell District Council, Fusion Lifestyle, GLL and Parkwood Leisure Limited and SOLL Leisure.

Tier One is based on the existing GO Active programme, led by a coordinator in each district. The coordinator ensures there is a varied and interesting range of activities/opportunities available, with particular focus on activities for inactive people

Tier Two supports participants to become more active through motivational coaching and on-going support over 12 months to help elicit behaviour change. Subsidised activities are provided in the form of a voucher booklet and incentives are offered to take part in the full 12 month programme.

Tier One Data (from April 2013 – June 2015)

- **3762 people** have been engaged in tier one of the programme that were doing *30mins or less of activity a week*
- **5715 people** have been engaged in tier one of the programme that were doing *90mins or less of activity a week*
- **14362 people** have been engaged in total in tier one of the programme (*all levels of activity*)

Tier Two Data (from February 2014 – April 2015)

- **432** people have entered the programme
- **87** organisations have signed up to refer (**82.8%** are health)
- **52.1%** came from **health or non-health** referrers
- **55.1%** of people entering the programme go on to take it up
- People were **more likely** to take up the programme if referred by **health** or **non-health** organisations

In terms of the specific targeting examples include:

- ✓ Large number of people entering programme are overweight (self-reported at baseline assessment)
- ✓ MoreLife are a Referrer – 30 referrals to date.
  OxSPA now attending Physical Activity Session 5 to speak with group discuss local opportunities and offer support to group. Good feedback from 1st group
- ✓ Working with Public Health to improve working relationship with Slimming on Referral – refer people to GAGH for support and motivation that is likely to be needed.

In summary the programme is:

- ✓ The programme has been very effective at increasing overall activity levels and these are maintained at 6months
- ✓ The increased activity levels appear to be benefiting perceived health and wellbeing and reducing GP visits even in the short term (3months) and this is also maintained at 6months
- ✓ The programme is effective at recruiting people with disabilities
- ✓ Satisfaction with the programme is high for both referrers and participants
- ✓ The programme is achieving excellent data fidelity and follow up rates and therefore the results have good internal validity for this type of evaluation

4.4.1 Active Body Healthy Mind

This is another OxSPA programme aimed at people with mental health issues and is run in co-operation with MIND and a variety of local voluntary groups. OxSPA was successful in securing significant national funding to run the project over 3 years.

A very pleasing testimonial from one participant is included below:

Have you seen any benefits since taking part in physical activity?
Absolutely! Shortly prior to the opportunity you provided me with I was diagnosed with type 2 diabetes and I was asked, by the nurse, to see if I could do something about that, otherwise permanent medication was going to be the course of action recommended by the nurse. I was given 3 months and I kept an eye on my diet and attended the gym for the free 8 weeks. After 3 months I returned to the Diabetes Nurse and she was over the moon with my results. No blood sugar issues!

5. Conclusion

OxSPA provides a robust and effective means for partners to work together within Oxfordshire on areas of shared interest in sport and physical activity. It acknowledges that partners will work on their own in some areas but that in key areas of work where there is interdependency or they cannot achieve it alone with the resources at hand there is real added value in working together.

Key to the obesity and healthy weight agenda going forward is the impact the Strategic Physical Activity Group can have working co-operatively with the Healthy Weight Group and the willingness of partners to be influenced and in a more tangible way key will the sustainability of the GO Active Get Healthy programme past its initial national funding. A unique chance to get more sedentary people active.

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Health Improvement Board: Tuesday 27 October 2015

Promoting a Healthy Weight Amongst Staff at Oxford University Hospitals NHS Foundation Trust – A report on current and planned initiatives

This report outlines the areas of work which Oxford University Hospital NHS Foundation Trust is delivering to prevent obesity and promote maintenance of a healthy weight in the workforce at The Trust, as well as amongst patients and visitors at OUH.

Background

1. The health and wellbeing of the workforce is high on national and local agendas. NHS England's 'Five Year Forward View' (October 2014)[1] sets out a clear direction for NHS staff. Amongst a number of key objectives, the review highlights the importance of supporting the health and wellbeing of staff. Aimed at reducing sickness absence, the review promises to support new workplace incentives to promote employee health. As a key national driver, the Government recognises that a healthier workforce is a happier, more productive workforce, delivering a better patient experience. Importantly, when making healthier choices, the workforce has the potential to act as 'health ambassadors' to patients and visitors, being ideally placed to promote healthy lifestyles and behaviours, and improve health at the population level by leading by example.

2. Oxford University Hospital NHS Foundation Trust (OUH) employs over 12,000 people, has around 1 million patient contacts per year and as many visitors. It is therefore ideally placed to promote healthy lifestyles and improve health and prevent disease at the population level.

3. The Trust's Staff Health and Wellbeing Strategy and action plan is led by the Deputy Director of Workforce, through the Centre for Occupational Health and Wellbeing (COHWB) and representatives from each Division. The Strategy outlines key priorities for staff wellbeing. From Department of Health and National Institute of Clinical Excellence recommendations, three particular areas of healthy living have been prioritised from 2014 through to 2015/16:

- healthy weight management;
- increasing physical activity;
- building resilience.

4. This is in recognition of inter-relationships between all three and the impact they have on each other in achieving weight management, improved fitness and mental wellbeing.

5. In keeping with these priorities, OUH delivers support to staff members to engage in healthy living to prevent obesity and promote maintenance of a healthy weight in the workforce through a number of channels led by the Health and Wellbeing Group.

[1] NHS Five Year Forward View https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

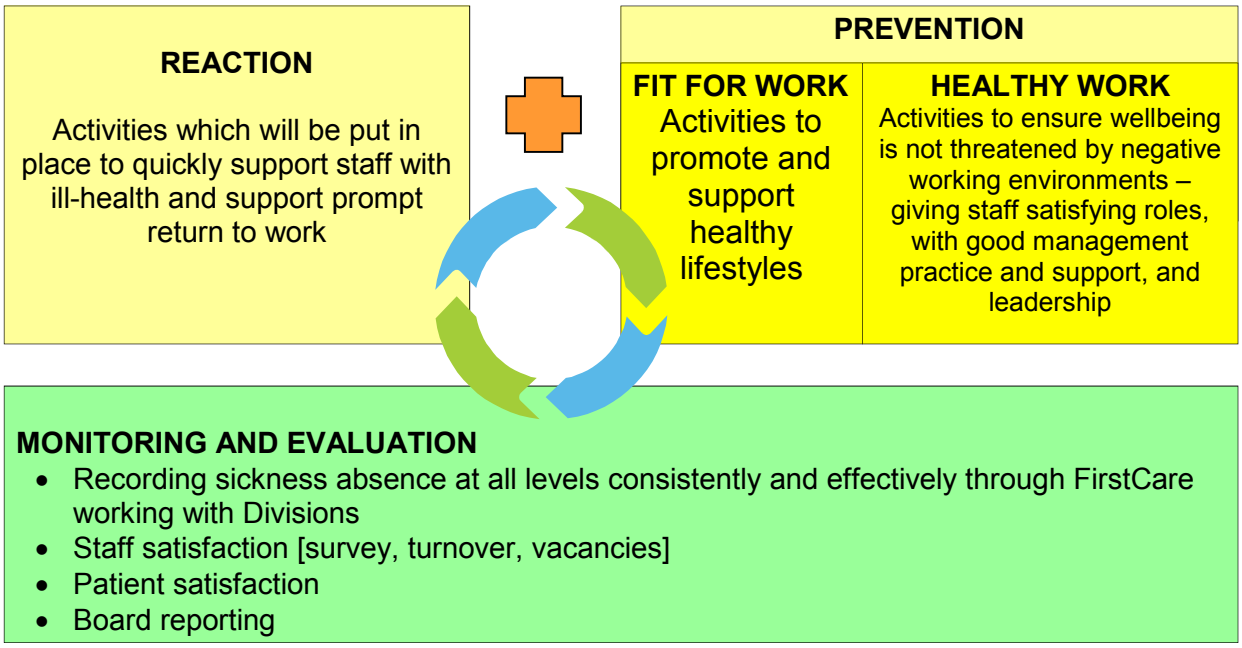
6. On 1 July 2015, OUH introduced a free and confidential Employee Assistance Programme (EAP). This service is delivered by Workplace Options, an independent provider of employee support services. Their staff are specialists in fields such as wellbeing, family matters, relationship issues, debt management, consumer rights and much more. Their webpages and support include a plethora of information on healthy eating, weight management and dietary advice. It is available 24 hours a day, seven days, a week, 365 days a year and is accessible by phone and online. The EAP can provide practical information, factsheets and packs, and resource information on support services in the local area.

7. In 2014 OUH established a Public Health strategy[2] demonstrating an innovative commitment to improving the health of the population of the county, and thereby also reducing the demand on local health services through the prevention of ill health. This is a joint Strategy with Oxfordshire County Council, helping to strengthen links, and builds on existing Public Health work at OUH. The Strategy has three overarching aims which incorporate:

- building capacity to promote healthy lifestyles to patients, visitors, and staff at all opportunities;
- developing a hospital environment that enables and promotes healthy behaviours;
- embedding population health approaches within OUH.

Approaches and initiatives developing year on year aimed at improving staff health

8. OUH approach to embedding health and wellbeing in the organisation is summarised in the diagram below:



[2] Oxford University Hospitals NHS Foundation Trust Public Health Strategy http://www.ouh.nhs.uk/about/trust-board/2015/may/documents/TB2015.58-public-health-strategy-update.pdf

9. In addition, part of the OUH Public Health Strategy was the establishment of the "Here for Health, Health Improvement Advice Centre" which opened August 2014. The Centre, based at the John Radcliffe Hospital, is an original approach to promoting and supporting healthy lifestyles in a hospital setting, focusing on the primary and secondary prevention of ill health, embodying an integrated care approach. It offers a drop-in service freely available to all patients, visitors and staff. The Centre offers lifestyle information and support on a wide range of topics, including: weight management, physical activity, healthy eating, and emotional wellbeing as well as basic health assessments. Services offered include:

- health promotion messages, brief advice, and educational materials about healthy living and health improvement;
- brief assessment of chronic disease risk;
- individual consultation with health promotion specialist and completion of health behaviour change action plan;
- signposting and/or referral to relevant local services to support behaviour change.

Initiatives implemented and in progress to prevent obesity and promote maintenance of a healthy weight in the workforce

Weight management support for staff

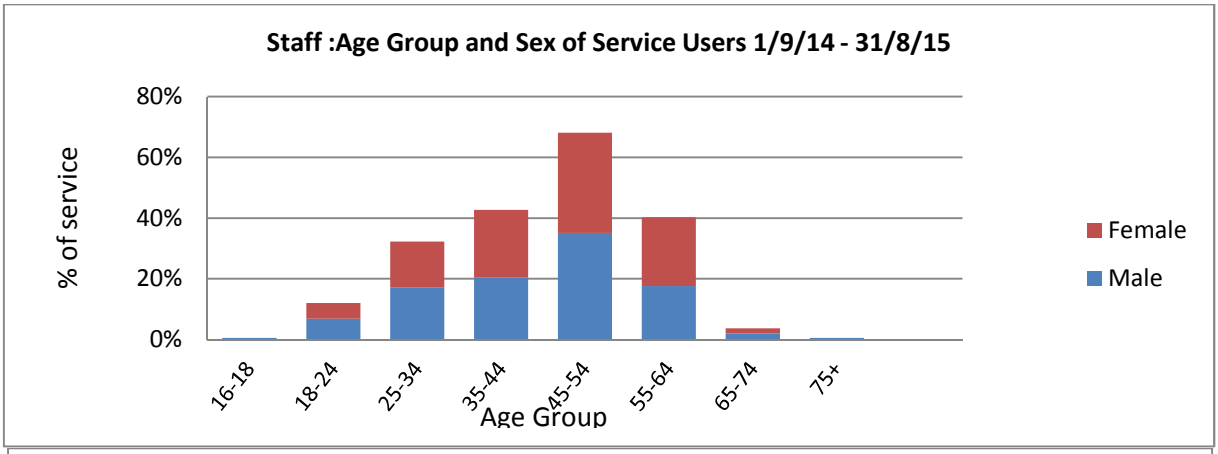
10. MOTs during annual healthy hospital days and an ongoing offer of MOTs by appointment at the Centre for Occupational Health and wellbeing (COHWB).

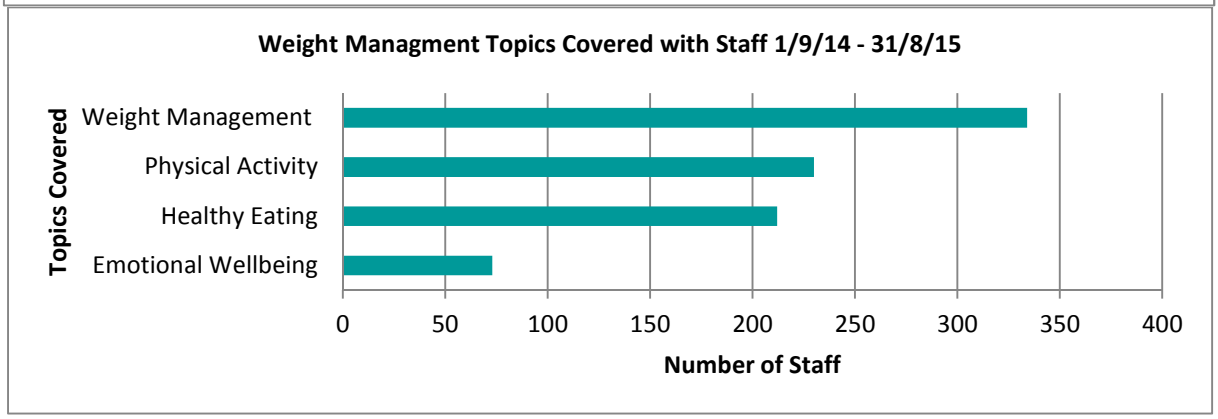
12. Staff health questionnaire for maternity services identified midwives with high BMIs wishing to reduce their weight and model weight management to mothers to be and resulted in a pilot on site group run by MORE LIFE for maternity services with 13 staff signing up to the programme.

13. COHWB has approached slimming world for onsite classes specifically for staff. However Slimming World is reluctant to establish a class specifically for staff at this time.

14. Accessible information with key messaging, for example newsletters information, webpages, leaflets and posters.

15. The Here for Health Centre offers staff the opportunity to drop-in for weight management support through information/advice on topics related to weight, health measurements, behaviour change action planning and referral/signposting to community services where appropriate. Staff are also offered the opportunity to return to the Centre for regular weight checks. During the Centres first year of opening 2,078 individuals accessed the service, of which 857 were staff members. The images below detail the demographics of staff and the topics covered (*note: more than one topic may have been covered with staff member):





16. Advice and support is also offered to patients and visitors through the Here for Health Information Advice Centre and since opening in August 2014, 16 referrals have been made to More life the county weight loss service.

Healthier eating for staff

17. OUH, in line with Department of Health recommendations, is developing a Hospital Food Strategy. The Strategy seeks to improve the nutrition of patients, staff and visitors; create a healthy food environment throughout the hospital; and develop sustainable catering pathways. The Strategy aims to support staff, patients and visitors to maintain a healthy weight by ensuring that all catering outlets reflect this ethos by offering and promoting healthier eating choices.

18. In order to deliver improvements, OUH has established a healthy eating working group involving all food providers.

19. Providing a healthy food environment to staff, patients, and visitors has also been incorporated into the Trust Health and Wellbeing and Public Health Strategies. Our aim is to help the Trust achieve a health promoting ethos signalled by providing healthy food choices.

20. All staff members have been surveyed on the food provision at the Trust and their responses are being used as levers for change.

21. During 2013/14 the online survey was circulated to all OUH staff, asking about healthier eating in the workplace. The survey received 2,355 responses, with all four hospital sites represented. Leading barriers to healthier eating at work were identified as:

- the availability and choice of healthy options, particularly out of hours and outside core meal times, and for those with particular dietary requirements;
- the cost of healthier options relative to less healthy foods;
- time and convenience, with no/short breaks, and healthier foods not as easy to eat 'on the go';
- additional barriers cited were desire and temptation of less healthy options, the need for an 'energy boost', and 'comfort eating' due to stress or having a bad day.

22. The working group has worked with food providers to offer healthier food and drink options at our hospitals, and there are now greater numbers of healthy choices available during main meal times. A key provider (Aramark) has also signed the Responsibility Deal pledge. Food providers have reformulated recipes to provide meals which are lower in fat, salt, and energy. Additional actions providing healthy options and promoting healthy choices for staff, patients and visitors will arise from the Hospital Food Strategy.

23. Healthy Hospital Days have been held across all four hospital sites, promoting healthier eating and an increasing level of physical activity. The hospital restaurants have offered a greater number of healthier food and drink choices, including fruit and vegetables and price promotions, on and around these days.

24. Healthier "vending" is being implemented gradually. The Trust is obliged to follow the external provider's current contractual arrangement and going forward aims to negotiate with them to enhance the healthier eating options.

25. A wide range of information on healthier eating is available to staff through OUH occupational health website, the Here for Health drop-in Centre, EAP, health champions, mobile pop ups and healthy hospital days and Aramark's own promotion material as Provider of food on three sites.

Physical Activity: Opportunities for staff engagement

Staff feedback

26. Staff health and wellbeing surveys began as part of a Go Active pilot with a specific Division which led to much greater involvement in healthier lifestyle Initiatives within their work area

27. During the autumn of 2014 a Physical Activity survey was conducted via Survey monkey with an onsite assessment of facilities. Recommendations were made and an action plan developed

Activities available for staff

28. Range of onsite classes are offered to staff, for example Zumba, Yoga, and Pilates.

29. Active travel initiatives such as cycle to work scheme and OxonBike, walk to work maps are focused on encouraging active travel through such detailed information.

30. Pedometer challenges are offered throughout the year across all four hospital sites and have been very well received with significant numbers of staff engaged in walking more and often using them to eat less in order to lose weight.

31. Discounted gym memberships are offered to staff and referral/signposting to a plethora of local resources is ongoing: for example Brookes Sport, Oxfordshire Sport and Physical Activity Partnership; Walking for Health etc.

Building resilience

32. Trust-wide emphasis on building resilience to facilitate mental wellbeing through:

- A comprehensive training programme for all managers entitled “creating a mentally healthy workplace” commissioned by NHS employers and delivered by the COHWB, which emphasises the importance of physical wellbeing with “move more eat healthier and / or less” messages pervading training;
- COHWB support is provided for individuals with referral options for external support if required;
- HR support and advice through robust policies and procedures to enable managers and staff to build good working relationships, reduce workplace stress and ensure a culture of resilience;
- Staff unions provide a robust overarching together with individual support to staff promoting organisational and individual wellbeing.

Behaviour change

Staff training

33. Health champion training has been building health improvement capacity within the Trust. Health champions are staff trained and supported to deliver brief advice to help others to adopt a healthier lifestyle by sign posting to services, providing information about health and wellbeing including weight management and initiating activities such as health challenges in their work area: examples of health challenges include weight loss challenges amongst teams and pedometer challenges .To date there are 21 trained health champions. They support the Trusts’ goals of becoming a health promoting organisation, improving staff health and wellbeing and positively influencing the health improvement agenda recognising the core principle that effective behaviour change is more likely through peer education.

34. Building resilience training for all staff has been embedded into the learning and development programmes for staff ensuring the key health and wellbeing messages are inextricably linked to working within the Trust.

Individual support

35. COHWB advisors offer individual staff support to lose weight together with health MOTs by appointment to engage staff in healthier behaviour change.

36. Here for Health Drop in Centre offers support to staff to engage in improving their wellbeing through behaviour change guidance.

37. The EAP offers online or telephone support on all personal matters including healthy eating.

Conclusion

38. Oxford University Hospitals NHS Foundation Trust has implemented a number of measures to help support staff in living healthy lives and maintain a healthy weight. These include providing staff with advice, signposting to services and influencing the built environment.

    Going forward, the Trust is energetically committed to supporting staff endeavours to lead healthier lives both in and out of work and seeks innovative measures to further engage staff in looking after themselves whilst working towards making the healthier choice the easier choice whilst at work.

Authors: Anna Hinton, COHWB, and Aine Lyng, Here for Health Improvement Centre; Sam Williamson, Public Health Registrar

October 2015

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Health Improvement Partnership Board
Forward Plan 2015-16

Date	Item
Thu 18 Feb 2016 2-4pm Oxford Town Hall	• Breastfeeding friendly policies • Air quality management • Young people's supported housing
Thu 12 May 2016 2-4pm Oxford Town Hall	• Annual Basket of Housing Indicators • Health Improvement Board Priorities 2016-17
Thu 7 Jul 2016 (tbc)	• Health Protection Forum Annual Report
Thu 20 Oct 2016 (tbc)	
Standing items:	
• Minutes of the last meeting and any matters arising • Healthwatch Ambassadors' Report • Performance Report (including any report cards) • Forward Plan	
Proposals/periodically:	
To be kept under regular review: • Re-commissioning of housing-related support • Welfare reform • Oral Health Needs Assessment • Healthy Weight Action Plan • Oxfordshire Sports Partnership	

19 October 2015

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Oxfordshire

Children & Young People's Plan

2015 - 2018

Contents

Foreword

Welcome to the new Oxfordshire Children and Young People's Plan

In the last year the Children's Trust's membership has been refreshed and reinforced. This puts us in an even stronger position to promote the value and importance of children and young people in the county. We are committed to realising our vision for Oxfordshire to be the best place in England for children and young people to grow up.

This Plan has been developed through discussion with our partners and through public consultation about what the priorities should be for services for children, young people and families in Oxfordshire over the next three years. Our responsibility as a Trust is now to play our part in delivering this Plan by highlighting the importance of these priorities to all partners across the county, monitoring the performance of agencies in delivering services that support the Plan, and working to solve problems and find solutions collaboratively.

It is crucial in times of limited budgets and increased demands on services that the Trust continues to enable partnership working. Only together will we meet these challenges and tackle our Plan's priorities such as improving children's mental health, improving educational attainment especially of vulnerable learners, and preventing neglect and child sexual exploitation.

We know that there have been some significant successes in achieving better outcomes for children in Oxfordshire and that a majority of children, young people and families in Oxfordshire are healthy, safe and thriving at both home and school. Many of the services we commission and provide meet children and young people's needs very well and we must work to ensure that these services continue to evolve and adapt to meet the changing needs of our children, young people and families.

As Chairman and Vice-Chairman of the Children's Trust we look forward to making this new Plan a reality and working with every child and young person to develop the skills, confidence and opportunities they need to achieve their full potential.

Cllr Melinda Tilley

Chairman of the Children's Trust and Oxfordshire County Council's Cabinet member for Children, Education and Families

Dr Matthew Gaw

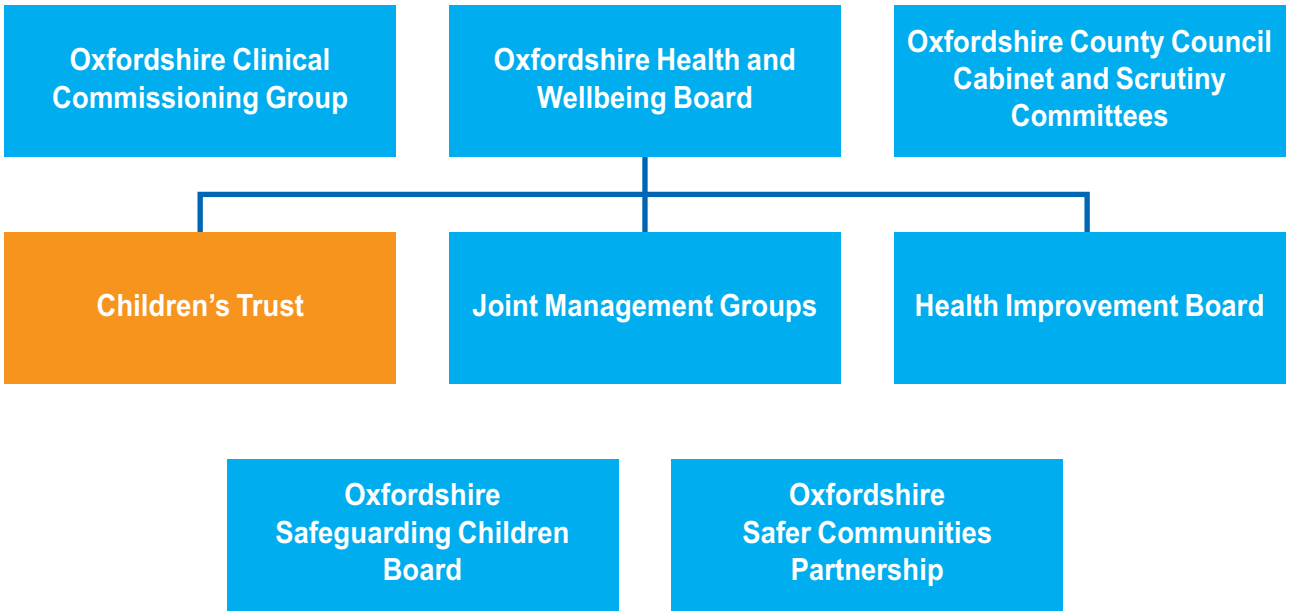
Vice-Chairman of the Children's Trust and GP

Introduction

The Children and Young People's Plan drives the work of the Children's Trust and is jointly authored by all of the Trust's members. It is based on evidence from the Oxfordshire Children's Needs Analysis 2014 and from the Joint Strategic Needs Assessment 2015.

The Children's Trust is a group of stakeholders who have an interest in the health and wellbeing of children and young people in Oxfordshire. It includes representatives from the county council, city and district councils, Thames Valley Police, the NHS, schools, the voluntary sector, and parents.

Our relationship with other partnership boards



The Oxfordshire Health and Wellbeing Board is responsible for improving the health and wellbeing of the people of Oxfordshire through partnership working.

The Children's Trust influences and supports the Oxfordshire Health and Wellbeing Board in its aim to improve outcomes for children, young people, and their families.

The Trust informs and complements the work of other partnerships in the county, in particular: the Health Improvement Board; the Oxfordshire Safeguarding Children Board; the Oxfordshire Safer Communities Partnership; and the Oxfordshire Skills Board. These Boards also have an interest in making sure Oxfordshire is the best place in England for children and young people to grow up.

Our vision

We want Oxfordshire to be the best place in England for children and young people to grow up in, by working with every child and young person to develop the skills, confidence and opportunities they need to achieve their full potential.

We want Oxfordshire to be a 'thriving Oxfordshire'. This means a place where people can work to achieve a decent life for themselves and their family, a place alive with vibrant, active communities, and a place where people can enjoy the rewards of a growing economy and feel safe.

To achieve this, the Trust is focussed on four priorities:

1. Ensuring children have a healthy start in life and stay healthy into adulthood
2. Narrowing the gap for our most disadvantaged and vulnerable groups
3. Keeping children and young people safe
4. Raising achievement for all children and young people

Our approach to achieving this vision

When developing and implementing this Plan, we will focus on:

- Social disadvantage – where disadvantaged and vulnerable groups are targeted
- Helping communities and individuals to help themselves – where we find ways to support people, allowing them to be as independent as possible
- Locality working – where locality approaches are used when they are the best way to make improvements

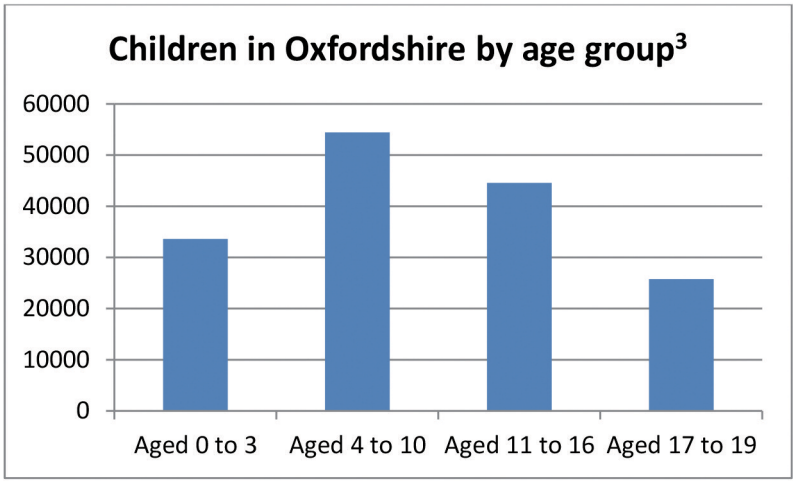
In developing this Plan, the Children's Trust has identified a number of principles that will shape our priorities:

Principle	This means…
Having a 'family' approach	… children and young people are not viewed in isolation and, whenever appropriate, action is taken to address issues that affect the whole family.
Encouraging early intervention	…wherever possible, issues are identified and interventions are made early in order to avoid more acute problems developing down the line.
Getting input from children and young people	…our work reflects the concerns and meets the needs of children and young people. We are always listening.
Promoting working in partnership	…planning and implementation of services is joined up wherever outcomes can be improved.
Smoothing the transition between children's and adult services	…ensuring a coherent and simplified experience for young people moving into adulthood.
Having cost effective services	…where budgets are spent wisely and efficiently.

Children and young people in Oxfordshire

There are 138,000[1] people under the age of 18 in Oxfordshire. They represent 21% of the county's population. The graph below shows how they are distributed by age range.

The birth rate in Oxfordshire is 1.77[2]. This is its highest level since 1973, but the Office for National Statistics anticipates that national fertility rates will remain stable between now and the mid-2030s.



82%[4] of our children and young people are from white British ethnic backgrounds. There are differences across the county though, and in Oxford City 42% of children are non-white British. The largest minority ethnic group in the county is Asian/Asian British at 6.22%, with most coming from Indian or Pakistani backgrounds. This rises to 17.41% in Oxford City. Ethnic diversity is higher amongst young people than in the population in general.

Most children live in households where there are two parents but 18.7%[5] of all households with dependent children have single parents.

Approximately 12.2% of children aged 15 and under live in income-deprived households. This is well below the national average of 21.8%. However, there are wide local variations with Oxford City reaching 22.9% and West Oxfordshire at 8%[6].

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[1] Census 2011

[2] Based on ONS Mid-2013 Population Estimate. The Birth Rate is the total number of births per 1,000 of a population in a year.

[3] ONS Mid-2013 Population Estimate

[4] Census 2011

[5] Census 2011

[6] IMD 2010 data published by DCLG

Progress across the county

Healthy Start

More women see a midwife or maternity health care professional within the first 13 weeks of pregnancy than in previous years.

95% of children aged two to two and a half years old received a Health Visitor review during 2013/14.

The county achieves high coverage rates for the majority of childhood immunisations.

Emergency admissions to hospital of young children with infections have decreased.

Narrowing the gap

Teenage pregnancies are at their lowest figure since records began and lower than the national average.

810 families are on track to be turned around as part of the Troubled Families programme. Oxfordshire is an early starter for Phase 2 of the programme, supporting a further 434 families.

Persistent absence rates from school have improved.

Keeping Safe

Children's social care services are rated as "good" by OFSTED.

More than 3,500 staff across Oxfordshire have received child protection training since 2012.

21 extra dedicated child protection social workers were recruited in 2013/14.

The Kingfisher team, which works with children vulnerable to child sexual exploitation, has won a number of national awards.

The Multi-Agency Safeguarding Hub – home to a multi-agency team which identifies risks to vulnerable adults and children - opened in October 2014.

Raising achievement

More pupils now attend 'good' and 'outstanding' schools than ever before.

Reading at Key Stage 1 continues to improve.

In 2014, 59.4% of pupils achieved five or more A*-GCSEs, including English and Maths – higher than the national average.

In July 2014, 4.4% of young people aged 16-19 years in Oxfordshire were classed as being 'Not in Employment, Education or Training' (NEET), the lowest rate for a number of years.

The successful Oxfordshire Reading Campaign has been extended for another year.

2,600 16-24 year olds started apprenticeships in 2012/13.

Priority one: Ensuring children have a healthy start in life and stay healthy into adulthood

Aim: All children should have access to the wide range of services universally available to protect and promote health. When health problems do occur they should have access to safe and high quality local health services that aim to help them recover as soon as possible.

There is increasing evidence that outcomes across health, education and social care are determined from very early on in life. A healthy start in life begins at conception, runs through pregnancy and on into the first few years of life.

By ensuring that children have a healthy start in life, and that this continues into adulthood, we are helping services move towards the prevention of ill health and helping to reduce unnecessary demand for services in the future.

What we know about getting a healthy start in life[7]

Pregnancy and the first few months

Low birth weight increases the risk of childhood mortality and of developmental problems for the child, and is associated with poorer health in later life. Low birth weight is normally associated with ethnicity but can indicate lifestyle issues of the mother and/or issues with maternity services. Rates in Oxfordshire are higher than the South East average, but below England as a whole.

In 2013/14, 9.3% of mothers in Oxfordshire were recorded as smokers at the time of delivery which is lower than the equivalent proportion in England, 12%.

Breast milk provides the ideal nutrition for infants. Increases in breastfeeding are expected to reduce illness in young children and have health benefits for the infant and the mother. The county's breastfeeding initiation rate is higher than the national figure, as is the breastfeeding rate at six to eight weeks.

Maternal Postnatal Depression affects around 13% of mothers. Compared to children of non-depressed mothers, the children of mothers with Postnatal Depression are more likely to have learning, behavioural and attachment problems.

[7] Much of the 'what we know' information in this Plan is taken from the Oxfordshire Children's Needs Analysis (version 3.3, June 2014) and the Joint Strategic Needs Analysis Annual Summary report 2015.

Teenage mothers are more likely to suffer from Postnatal Depression, and to smoke during pregnancy. They are less likely to breastfeed, and likely to struggle to complete their education and find it difficult to gain employment. The under-18 conception rate in Oxfordshire is significantly lower than the national one and is decreasing broadly in line with the trend for England.

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. In Oxfordshire levels of immunisation for childhood diseases continue to increase.

Into childhood

There are significant health consequences of childhood obesity, including Type 2 diabetes, and it makes conditions such as asthma worse. It can also lead to psychological problems such as social isolation, low self-esteem, and bullying. The percentages of children overweight or obese are lower in Oxfordshire than overall in England or the South East, but there are still a significant number of children in the county who are obese. Nationally, there is a strong positive relationship between deprivation and obesity prevalence for children, and obesity rates are significantly higher for children in ethnic groups including Asian or Asian British, Black or Black British, and Mixed ethnicity.

There is good scientific evidence that being physically active can help us lead healthier lives, whatever our age. In Oxfordshire in 2013 about 90% of children aged between five and 16 spent at least two hours a week doing sport or physical activity at school. This is in line with the national figures.

Engagement in culture, as well as sport, has a positive effect on wellbeing, and a higher frequency of engagement is generally associated with a higher level of wellbeing. Similarly there are also direct benefits of green space to both physical and mental health and wellbeing. Oxfordshire is the most rural county in the South East and 52% of Oxford City's area is open space (not including the colleges).

Hospital admissions caused by unintentional and deliberate injuries in children in the county have declined, and unplanned hospitalisation for asthma, diabetes and epilepsy are at levels below the England average. The number of emergency admissions for children with lower respiratory tract infections is significantly lower than the England average.

Tooth decay in children is a preventable disease. Rates of tooth decay are higher than South East rates in Oxford, Cherwell and West Oxfordshire.

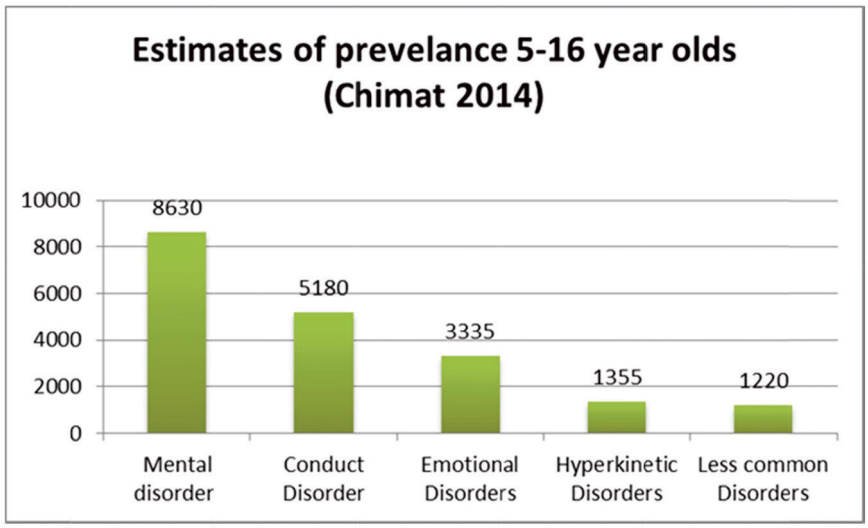
1% of children are thought to have Autistic Spectrum Condition (ASC) (including Asperger's Syndrome). This equates to 1,300 children and young people in the county. In Oxfordshire, the incidence of diagnosed ASC is almost twice the national figure.

Bad housing conditions – including homelessness, temporary accommodation, overcrowding, insecurity, and housing in poor physical condition – are a risk to health. A 2006 study by Shelter found that experience of multiple housing problems increases children's risk of ill-health and disability by up to 25% during childhood and early adulthood.

Moving towards adulthood

One in 10 children and young people aged 5 to16 suffer from a diagnosable mental health disorder – that is around three in every class at school. About half of these (5.8%) have a conduct disorder, whilst others have an emotional disorder (anxiety, depression) and Attention Deficit Hyperactivity Disorder (ADHD). The prevalence increases with age and rises to 20% for the 16 to 24 age group.

Around a quarter of the 11,000 referrals for Oxford Health mental health services in 2013/14 were for Child and Adolescent Mental Health Services (24%).



Young people with mental health difficulties are also likely to have lower attainment than their peers, higher rates of absenteeism from school and higher risk of falling into the NEET (Not in Education, Employment or Training) category.

Analysis of national surveys suggests that peak onset of mental ill health is between eight to 15 years and half of lifetime mental ill health starts by age 14.

Self-harming in young people is not uncommon. Estimates indicate that approximately 2,600 14 to 17 year olds self-harm to some degree in the county. Urban self-harm rates are substantially higher than rural rates. Autistic people have significantly higher levels of self-harm and suicide than their mainstream peers.

The National Youth Survey results show that a large minority of young people in their early teens take part in heavy ‘binge’ drinking. A quarter of 13 and 14 year old students admit they have recently drunk five or more alcoholic drinks in a single session, rising to more than half of all 15 and 16 year olds.

In three of the districts (Cherwell, South Oxfordshire and West Oxfordshire) there has been a declining trend in under 18 alcohol-specific hospital admissions over the four years from 2008/9 to 2012/13. In Oxford and Vale of White Horse numbers have remained fairly stable over the period.

Nationally, fewer young people are smoking but in 2013 8% of 15 year olds surveyed on behalf of the Health and Social Care Information Centre said they smoked regularly. Smoking affects lung growth and can lead to lung function decline which may cause an increased risk of lung disease later in life. 75% of young people who smoke say they want to give up.

Public Health England estimates that the rate of hospital admissions due to substance misuse among 15 to 24 year-olds in Oxfordshire was 56.9 per 100,000 people between 2010 and 2013. The England average was 75.2.

Nationally, young people experience the highest Sexually Transmitted Infection (STI) rates, and Chlamydia is the most commonly diagnosed infection. Chlamydia diagnoses are high in Oxford, but other parts of the county are well below the England rate.

Mental health was a consistent theme in our consultation. Young people value having impartial, emotional support and parents/carers felt that the mental health of the whole family was important to the wellbeing of young people.

Areas of focus for the Trust

- **Mental Health, including:**
  - Maternal and peri-natal (the period immediately before and after birth)
  - Self-harm and suicide
  - Wellbeing, confidence, and body image
- **Substance misuse (including drugs, alcohol and tobacco), including:**
  - Education and prevention
  - Treatments for substance misuse, including those for parents

In considering our areas of focus we acknowledge the work being done by the Health Improvement Board, which also recognises the importance of a healthy early start in life in promoting the health and wellbeing of the county. The Health Improvement Board will lead on the following issues:

- Promoting breastfeeding
- Halting the increase in childhood obesity, including monitoring the Healthy Weight Strategy and Action Plan and the work of the Oxfordshire Sports Partnership
- Preventing infectious disease through immunisation
- The Stop Smoking Service and the percentage of woman smoking in pregnancy.

The Children's Trust will seek information on the progress made by the Health Improvement Board, and will discuss these issues if there are particular areas of concern.

In addition, the Oxfordshire Community Safety Partnership is engaged in related work to divert young people away from crime and anti-social behaviour including Mental Health and the Alcohol and Drug Strategy. As the Trust's focus is on children and young people, we will coordinate with the work of the Partnership to avoid duplication and ensure children and young people are properly considered in its work.

Outcomes for ensuring children have a healthy start in life and stay healthy into adulthood

We want to make sure things are moving in the right direction within our areas of focus, so we will measure progress wherever we can. To do this, we have a set of measurable outcomes that we want Oxfordshire to aim for.

There is a subgroup of the Oxfordshire Safeguarding Children Board called the Performance Audit and Quality Assurance (PAQA) group which does this monitoring for us and they will raise areas of concern to the Children's Trust if progress is not on track.

These measures don't cover every single one of our areas of focus. Even so, we will ensure that we check on progress for each one of the areas over the next three years.

Area of focus	Measure
Mental Health, including: • Maternal and peri-natal (the period immediately before and after birth) • Self-harm • Suicide • Wellbeing, confidence, and body image	Waiting times for first appointment with Child and Adolescent Mental Health Services (CAMHS). 75% of children will receive their first appointment within 8 weeks of referral by the end 2016/17.
Substance misuse (including drugs, alcohol and tobacco), including: • Education and prevention • Treatments for substance misuse, including those for parents	Support all secondary schools to have a school health improvement plan which includes smoking, drug and alcohol initiatives.
Plus monitoring relevant Health Improvement Board measures, including:	
Area of focus	**Measure**
Promoting breastfeeding	63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual health visitor locality should have a rate of less than 50%.
Halting the increase in childhood obesity	Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2014 this was 16.9%) No district population should record more than 19%.
Preventing infectious disease through immunisation	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 and no Clinical Commissioning Group locality should perform below 94%. At least 95% children receive dose 2 of MMR vaccination by age 5 and no Clinical Commissioning Group locality should perform below 94%.

Priority two: Narrowing the gap for our most disadvantaged and vulnerable groups

Aim: Children, young people and families will benefit from effective early and targeted support when they face significant challenges and have greater access to high quality services to prevent gaps developing and to break the cycle of deprivation and of low expectation.

Oxfordshire is overall a very 'healthy and wealthy' place but there are significant differences in outcomes across health, education and social care for some specific groups and in some specific areas of the county.

We know that outcomes for children and families from vulnerable groups and disadvantaged communities can be worse than for their peers and these are variable across the county.

What we know about our disadvantaged and vulnerable groups

Poverty and deprivation

Child Poverty is defined as growing up in a household with low income. Certain groups of people face a much higher risk of living in poverty than others, including lone parents, parents and/or children with disabilities and households where only one adult works.

The most deprived areas of the county are mainly in the urban centres of Oxford and Banbury. However, there are also rural areas that have relatively high levels of deprivation on the geographic barriers index, which assesses the average road distance to important services such as hospitals and schools.

The most deprived communities have the poorest mental and physical health and wellbeing. Children from the poorest 20% of households are three-times more likely to have mental health problems than children from the wealthiest 20%. Parental unemployment is also associated with a two- to three-times greater risk of emotional or behavioural problems in childhood. Nationally, among children in reception and year 6, the prevalence of obesity in the 10% most deprived groups is approximately double that in the 10% least deprived.

Vulnerable groups

Young Carers

At the time of the 2011 Census 1,300 children aged 0-15 years provided some unpaid care in Oxfordshire. Young carers are more likely to have mental health problems, poorer school attendance than average, and are more likely to: be eligible for Free School Meals; be identified as having Special Educational Needs; and have poor educational attainment. In 2013 they were seven times more likely to be Not in Education, Employment or Training (NEET).

Looked After Children

Looked after children – children in the care of social services - experience significantly worse mental health than their peers, and a high proportion experience poor health, and poor educational and social outcomes after leaving care. In Oxfordshire, 6.7% of looked after children have a substance misuse problem, almost double the South East and England average of 3.5%. The emotional and behavioural health of children who have been looked after continuously for 12 months or more in the county is classified as borderline but leaning towards 'cause for concern'.

Disabled children

The mean percentage of disabled children in English local authorities has been estimated to be between 3% and 5.4%. If applied to the population of Oxfordshire this would equate to between 3,946 and 7,102 children experiencing some form of disability.

Estimates from 2010 suggest that around 3,600 children in the county had a learning disability. In 2014 around 2,300 (2.1% of) pupils in Oxfordshire schools had statements of Special Educational Needs (SEN). This proportion has remained broadly similar in the years since 2007. Oxfordshire's rate of SEN-statemented pupils was a little lower than in the South East (2.9%) and England overall (2.8%). In the same year around 16,700 (15.7% of) pupils in Oxfordshire schools were recorded as having SEN but not having statements. Again, this proportion remained broadly similar in the years since 2007, but was slightly above the rates for the South East and England overall (15.1% for both).

Learning disabilities are most common in young boys. Children from poorer families are also more likely to have a learning disability. Moderate and severe learning difficulties are more common among Traveller and Gypsy/Romany children. Profound multiple learning difficulties are more common among Pakistani and Bangladeshi children.

An Anti-Bullying Alliance survey in 2014 found that 70% of the teachers polled heard children using disability terms abusively. Primary school pupils with Special Educational Needs are twice as likely as other children to suffer from persistent bullying. Over 90% of parents of children with Aspergers have reported their child has been bullied in the previous year.

Young Offenders

First-time youth offending rates are lower in Oxfordshire than England, and custody rates are also relatively low. However, 95% of young offenders who are imprisoned have a mental health disorder, and young people in prison are 18 times more likely to take their own lives than others of the same age. 84% of young offenders aged 11 to 17 are boys and over a half of all offences in this group was committed by 16 and 17 year olds.

Thriving families

It is estimated there are 810 families in the county who meet at least two of the national criteria which are tracked as part of the 'Thriving Families' programme. The criteria include:

- Children not attending school regularly or behaving well in school
- Parents in receipt of age-related working benefits
- Anti-social behaviour/ offending within the family

As of 31 August 2014, Oxfordshire has turned around 725 out of 810 families identified.

Equality and discrimination were mentioned by young people regularly throughout the review of this Plan, in particular discrimination regarding young people who are in the care system, or who are "different" such as gay people and goths.

Areas of focus for the Trust

- **Services in deprived areas, including:**
  - The Breaking the Cycle of Deprivation programme – which targets the wards in Oxford City with worst outcomes across a range of indicators
  - The Brighter Futures in Banbury programme
- **Looked after children, including:**
  - Oxfordshire's Placement Strategy – for children in and on the edge of care – which aims, for example, to keep children with their families wherever possible, and increase in-house fostering for harder to place children
- **Care Leavers**
- **Young carers**
- **Disabled children**

The Health Improvement Board also looks at issues relating to this priority, including:

- Controlling the number of households in temporary accommodation
- Preventing households from becoming homeless
- Fuel poverty

The Oxfordshire Safer Communities Partnership supports activity to protect vulnerable children and prevent youth offending, as well as achieve better outcomes for young victims of crime.

We also know that the Education Strategy 2015-18 will have improving provision and raising standards for vulnerable learners as a priority.

The Children's Trust will seek information on the progress made by the Health Improvement Board and the Oxfordshire Safer Communities Partnership and will monitor the Education Strategy, and will discuss these issues if there are particular areas of concern, or where a coordinated interagency approach is needed.

Outcomes for narrowing the gap for our most disadvantaged and vulnerable groups

Area of focus	Measure
Services in deprived areas, including: • The Breaking the Cycle of Deprivation programme – which targets the wards in Oxford City with worst outcomes across a range of indicators • The Brighter Futures in Banbury programme	Reducing inequalities as measured by Public Health measure 1.01i – Children in poverty (all dependent children under 20) – such that the gap between the wards with most poverty and least poverty is reduced.
Looked after children, including: • Oxfordshire's Placement Strategy – for children in and on the edge of care – which aims, for example, to keep children with their families wherever possible, and increase in-house fostering for harder to place children	Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 50.
Care Leavers	Reduce the level of care leavers 'Not in Employment, Education or Training' (NEETs) from 50% (measured at 19th, 20th and 21st birthday of care leaver).
Young carers	Increase the number of young carers identified and worked with by 20% from 1,825 at 1st April 2015 to 2,190.
Disabled children	Reduce the number of children with SEN who have at least one fixed term exclusion in the academic year (down from 5.1% in the academic year 2013/14). Increase the proportion of children with a disability and are eligible for Free School Meals who are accessing short breaks services from 24% in 2014/15.

Plus monitoring relevant Health Improvement Board measures, including:	
Controlling the number of households in temporary accommodation	The number of households in temporary accommodation as at 31 March 2016 should be no greater than the level reported in March 2015.
Preventing households from becoming homeless	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless. Increase the number of households in Oxfordshire who have received significant increases in energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners.
Plus monitoring relevant Oxfordshire Safer Communities Partnership measures, including:	
Prevent youth offending	Reduce the number of first time entrants to the Youth Justice Service from 208 in the calendar year 2014. Reduce the rate of custodial sentencing per 1,000 of the 10-17 year old population.

Priority three: Keeping children and young people safe

Aim: All children and young people to grow up in a safe, healthy and supportive environment and have good access to services at the right time.

Keeping all children and young people safe must be a priority for everyone in Oxfordshire. Children need to feel safe and secure if they are to reach their full potential in life.

Keeping children safe is everyone's business and many different agencies work together to achieve it.

We want children who need help to receive it as quickly and easily as possible.

What we know about keeping children and young people safe

Child sexual exploitation

Child sexual exploitation - a type of sexual abuse in which children, both boys and girls, are sexually exploited for money, power or status - has been an emerging national issue of concern over recent years. Operation Bullfinch is a joint operation by police and social workers within Oxfordshire, which has resulted in the successful prosecution and conviction of seven men for a range of serious sexual offences, and continues to bring prosecutions. The Kingfisher team – a multi-agency team made up of social workers, police and health professionals - has the responsibility of reviewing all suspected child sexual exploitation cases.

Factors linked to heightened risk of child sexual exploitation include children going missing, children with a history of abuse and children in care. During the first half of 2014/15 over 400 children went missing in Oxfordshire, with around 15% of those going missing on more than two occasions.

Domestic abuse

There were 4,820 incidents of domestic abuse reported to the police in 2012/13 in Oxfordshire where there were children in the household. Many incidents will affect more than one child and domestic abuse is under reported to the police, so this is only a partial picture of the number of children affected. Children and young people who are exposed to domestic violence, experience emotional, mental and social damage that can affect their developmental growth.

Teenage relationship abuse is also a concern, and a 2009 national survey by the NSPCC showed that: a quarter of girls and 18% of boys reported some form of physical partner violence; nearly three-quarters of girls and half of boys reported some form of emotional partner violence; and one in three girls and 16% of boys reported some form of sexual partner violence.

Young people said that advice about healthy relationships, friendships, contraception and bullying were issues on which they would like to have consistent advice and guidance.

Female Genital Mutilation (FGM)

It is estimated that in England and Wales nearly 66,000 women have experienced FGM and over 20,000 girls under the age of fifteen are at high risk of FGM. The most recent research was a statistical study conducted by FORWARD in 2007 to estimate the prevalence of FGM in England and Wales. The highest estimated percentages of FGM incidences were in London but with prevalence of over 2% in some cities including Oxford. Due to the impact that FGM has on the health, safety and wellbeing of girls and women, it was identified as a priority by the Thames Valley Police and Crime Commissioner.

Bullying

Statistics on bullying collated from government reports and research by the NSPCC show that almost half (46%) of children and young people say they have been bullied at school at some point in their lives and 38% of young people have been affected by cyber-bullying.

The Oxfordshire Pilot Bullying Survey 2013/14 found that 17% of pupils have been bullied every month or more frequently, 14% every week or more frequently, and 11% most days or more frequently. In line with national trends, the survey also showed that those young people who are “different” from the majority in terms of race, religion, sexuality or experience of long term illness are likely to experience increased frequency of bullying and feeling unsafe.

68% of bullying takes place at school. Bullying in the community is also an issue with 22% saying they have been bullied out of school.

A Department for Education study in 2010 showed that there is a link between bullying and attainment as well as bullying and the likelihood of being ‘Not in Employment, Education or Training’ (NEET). Bullying can have a powerful impact on young people’s future prospects.

Our consultation showed that young people as well as parents/carers are concerned that bullying, particularly online, is rife and that young people need to be further educated to prevent them from becoming victims.

Risky behaviour among adolescents

As we saw in priority one, a large minority of teenagers are engaged in risky behaviour including substance use (including smoking, alcohol consumption, and illicit drug use), engagement in criminal activity, and sexual risky behaviour. A Centre for Understanding Behavioural Change report in 2013 showed that participation in risky behaviour starts at a young age, risky behaviour amongst young people is very persistent and participation in one type of risky behaviour is predictive of later participation in other forms of risky behaviour.

The report also describes risk factors associated with the likelihood of engaging in risky behaviour. For example, substance misuse is more likely to occur among young people who are female, live in a rural area and have experiences of being bullied. And criminal activity is more likely to be associated with young people who are male, play truant or have been suspended and believe they are treated unfairly by their teachers.

Vulnerable parents

It is estimated that parental drug misuse affects between 2,340 and 3,510 children in Oxfordshire. In addition the national figure for children living with alcohol misusing parents is 1.3 million, four times the number of children living with parental drug misuse.

The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include failure to thrive; incomplete immunisation and inadequate health care; a wide range of emotional, behavioural and other psychological problems; early addiction problems and offending behaviour; and poor educational attainment. These can range greatly in severity and may often be subtle and difficult to detect.

Looked After Children

As of March 2014 there were 465 children in care (or 'looked after children') in Oxfordshire. The majority (68%) of looked after children are in a foster placement.

Nearly 50% of looked after children are looked after because of abuse or neglect. Neglect is the ongoing failure to meet a child's basic needs. A child may be left hungry or dirty, without adequate clothing, shelter, supervision, medical or health care. The NSPCC estimates that one in 10 children in the UK have suffered neglect. Family dysfunction is the next most common reason for a child going into care at 17%.

The number of children subject to a child protection plan[8] in Oxfordshire is rising year on year – the figure has risen by 129% since March 2007. The increase was much higher in Oxfordshire than in England overall (73% over the same period).

[8]A child protection plan offers support and services to the family to ensure the child is safe from harm and remains that way. Child protection plans remain in force until the child is no longer considered at risk, moves out of the local authority area or reaches the age of 18.

Protection from abuse, neglect and child sexual exploitation was mentioned numerous times in our consultation. Young people are concerned about the vulnerability of children in Oxfordshire.

Areas of focus for the Trust

- **Neglect**
- **Risky behaviours among adolescents**
- **Bullying**
- **Domestic Abuse**
  Including abuse within teenage relationships
- **Progress of the Multi-Agency Safeguarding Hub**
  a multi-agency team which identifies risks to vulnerable adults and children
- **Female Genital Mutilation (FGM)**
- **Child sexual exploitation (CSE)**

In considering our areas of focus we acknowledge the work being done by the Oxfordshire Safeguarding Children Board (OSCB). Its remit is to secure effective inter-agency arrangements to safeguard and promote the welfare of children and young people. The OSCB has a CSE strategy and action plan which is managed through a dedicated child sexual exploitation sub-group with wide partnership representation.

The Chair of the OSCB is a member of the Trust and will report on progress of the Board's work as required. The OSCB and the Children's Trust have a working protocol that makes clear their respective functions, inter-relationships and roles and responsibilities.

Naturally, the Oxfordshire Safer Communities Partnership is also heavily involved in this area of work, including supporting victims of domestic abuse as well as training practitioners across Oxfordshire, reducing the risk of vulnerability to radicalisation and supporting community safety concerns that are being led elsewhere, such as the Oxfordshire Safeguarding Children Board's child sexual exploitation strategy and the FGM strategy.

The Children's Trust will seek information on the progress made by the Oxfordshire Safeguarding Children Board and the Oxfordshire Safer Communities Partnership and will also aim to focus on areas that support and supplement their work, not duplicate it.

Outcomes for keeping children and young people safe

Area of focus	Measure
Neglect	Set a baseline for and then increase the amount of times the Independent Chair overseeing a child protection plan is satisfied that the objectives of the plans are being progressed by the Core Group. (The Core Group is the group of partners - which can include schools, health, police and social workers etc. - who carry out the work required by the child protection plan). Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan. Increase the proportion of neglect cases where the neglect toolkit is used. (The neglect toolkit is a checklist that professionals use to identify whether a child is being neglected and whether to refer them to children's services.)
Risky behaviours among adolescents; including abuse within teenage relationships	Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (Public Health measure number 2.07ii).
Bullying	More than 70 schools receive direct support to implement effective Anti-Bullying strategies as evidenced by school action plans to tackle and reduce bullying.
Plus monitoring relevant Oxfordshire Safer Communities Partnership measures, including:	
Domestic Abuse	Reduce the assessed level of risk for high risk domestic abuse victims managed through the MARAC (Multi-Agency Referral Risk Assessment Conference).

Priority four: Raising achievement for all children and young people

Aim: To see every single child being successful and reaching their potential, thriving in an outstanding learning environment throughout their education, wherever they live across the county, and to see the gap reduced between the lowest and the highest achievers. We aim for every single school and setting to be rated at least as 'good' and to be moving towards 'outstanding'.

Central to our vision is the aim that every child and young person develops skills and is given opportunities to achieve their full potential. Through raising achievement, children and young people are more likely to get the best start in life and be set up to play an active and positive part in the community as adults.

What we know about raising achievement

Early years

During their early years, babies and young children experience phenomenal growth in brain development, and in their understanding of themselves and the world around them. Children who attend higher quality preschool provision tend to do better throughout primary school, particularly in reading.

In 2014 in Oxfordshire 60% of pupils achieved a good level of development at the age of five, equal to the England average.

Attainment

In 2014, 78% of pupils in Oxfordshire achieved level 4 or above in reading, writing and maths at Key Stage 2 (year 6). This represents a drop below the England average (79%) for the first time in a number of years.

In 2014, 59.4% of pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE (Key Stage 4), including English and maths. This was above the England average of 56.8%.

The number of young people starting apprenticeships in the county increased from 1,610 in 2005/06 to 4,530 in 2012/13.

Children eligible for Free School Meals

There are large gaps in attainment between pupils known to be eligible for Free School Meals and their peers in Oxfordshire. 58% of pupils known to be eligible for Free School Meals achieved level 4 or above in reading, writing and maths at Key Stage 2 (year 6). 72% of these pupils leave school without five GCSEs at A*-C.

Children with Special Educational Needs

The attainment gap is even greater for children with Special Educational Needs, with 35% achieving level 4 or above in reading, writing and maths at Key Stage 2 (year 6). 86% of these pupils leave school without five GCSEs at A*-C.

Young people recognise that not everyone will achieve high academic standards and would like those young people to be encouraged and helped to gain confidence in their strengths and abilities to reach their own potential.

Parents/carers felt that a narrow focus on attainment in exams did not always work in the best interest of a young person and a child's wellbeing can suffer as a result.

Attendance

There is clear evidence of a link between poor attendance at school and low levels of achievement. Of pupils who miss more than 50% of school, only 3% manage to achieve five A* to C GCSEs. Children with low attendance in the early years are more likely to come from the poorest backgrounds.

Evidence shows that pupils who are persistently absent in secondary schools have had poor attendance levels in primary school. In primary schools rates of persistent absence in Oxfordshire are below the national average, but in secondary schools rates are slightly above the national average.

Pupils with Special Educational Needs miss more school through absence compared to those without Special Educational Needs. Looked after children are three times more likely to be persistently absent from school. Persistent absentee rates among Free School Meals pupils are 2.5 times that seen in non- Free School Meals pupils.

At the end of July 2014, 4.4% of young people aged 16-19 years in Oxfordshire were classed as being 'Not in Employment, Education or Training' (NEET). This is the lowest rate for a number of years.

Exclusions

Fixed period exclusions have fallen after peaking in 2010/11 and remain below both the South East and England average.

Quality of provision, including special schools

The number of academies in the county continues to grow, and it is expected that 50% of Oxfordshire pupils will likely to be attending academies by the end of 2015.

More pupils now attend 'good' and 'outstanding' schools than ever before; for example, in 2014, 79% of primary schools were judged good or outstanding, a 20% improvement on 2012. As of March 2015, 83% of special schools in the county were also judged as good or outstanding.

Ensuring that all young people regardless of their abilities or circumstances are able to have the same opportunities as everyone else was mentioned as important by young people in our consultation.

Areas of focus for the Trust

In considering our areas of focus we recognise the on-going work to develop the Education Strategy for 2015-18 as well as the work of the Oxfordshire Skills Board.

The new Education Strategy will build on the ambitions of the previous strategy which included:

- **Early Years, including:**
  - Foundation stage outcomes (for children aged 5)
  - The quality of childcare settings
  - Levels of attainment and quality across all primary and secondary schools
- **Closing the attainment gap, including:**
  - Children eligible for Free School Meals
  - Special schools
  - Children with Special Educational Needs

The Oxfordshire Skills Board, which works closely with the Oxfordshire Local Enterprise Partnership, is charged with understanding and communicating the needs of employers and providers in Oxfordshire relating to business development, employment and skills issues. Its priorities include:

- Creating seamless services to support young people through their learning – from school and into training, further education, employment or business
- Up-skilling and improving the chances of young people marginalised or disadvantaged from work
- Increasing the number of apprenticeship opportunities

The Children's Trust will seek information on the progress made on the Education Strategy, and on the priorities of the Oxfordshire Skills Board, and will discuss issues if there are particular areas of concern.

The Oxfordshire Growth Board is also monitoring developments around: the apprenticeship programme; Information Advice and Guidance to drive better employability skills in young people; and increasing the number of people entering training in Science, Technology, Engineering and Manufacturing (STEM) subjects. The Trust will coordinate with this monitoring work wherever possible to limit duplication.

Outcomes for raising achievement for all children and young people

Area of focus	Measure
Early years, foundation stage outcomes.	62% of children in early years and foundation stage reach a good level of development.
Closing the attainment gap, including: • Children eligible for Free School Meals • Special schools • Children with Special Educational Needs	Improve the Free School Meals attainment gap at all key stages and aim to be in line with the national average by 2015 a) KS2: 19% points b) KS4: 27% points Ensure that the proportion of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average.

Plus monitoring relevant Oxfordshire Skills Board measures, including:	
Area of focus	**Measure**
Up-skilling and improving the chances of young people.	Work place experiences and accredited employability skills training will be widely available to young people. By 2020, 35% of businesses in Oxfordshire will be working with schools and colleges to support young people in their transition into work (up from 12%).
Increasing the number of apprenticeship opportunities.	By 2020, an additional 1,150 apprenticeship places for 16-24 year olds will be created (up from 2,600 in 2012/13).

How the Children's Trust will use this Plan

This Plan will drive the work of the Children's Trust until 2018. However, the Plan will remain under review and will be refreshed annually, if required, to ensure that the areas of focus of the Trust remain relevant and remain the most pressing issues facing children and young people in the county.

The Trust meets six times a year to monitor and feed into the partnership work that is taking place around the issues outlined in this Plan. Through this work it will influence and support the Health and Wellbeing Board in its aim to improve outcomes for children and young people, and their families.

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