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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

Thursday, 20 October 2016 at 2.00 pm

King's Centre

Peter G. Clark
County Director

12/10/2016

Contact Officer: ***Katie Read, Policy & Partnership Officer***
Tel: 07584 909530; Email: katie.read@oxfordshire.gov.uk

Membership

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

Board Members:

Cllr Jeanette Baker	West Oxfordshire District Council
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
Cllr Monica Lovatt	Vale of White Horse District Council
Dr Jonathan McWilliam	Director of Public Health
Dr Paul Park	Vice Clinical Chair of Oxfordshire Clinical Commissioning Group
Jackie Wilderspin	Public Health Specialist

Notes:

- ***Date of next meeting: 23 February 2017***

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 **07776 997946** 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, Councillor Anna Badcock

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decision of Last Meeting (Pages 1 - 6)

2.05pm
5 minutes

To approve the minutes of the meeting held on 7 July 2016 and to receive information arising from them.

6. Performance Report (Pages 7 - 10)

2.10pm
15 minutes

People responsible: Members of the Health Improvement Board

Performance report presented by: Jonathan McWilliam, Public Health, Oxfordshire County Council

A report on progress against the targets of the Health Improvement Board in Quarter 1. A new target is required for 10.4 (fuel poverty). This will be discussed under item 9 – a briefing from the Affordable Warmth Network.

7. Housing Related Support update

2.25pm
15 minutes

Verbal update from: Natalia Lachkou, Oxfordshire County Council

A verbal update on next steps for commissioning housing related support services.

8. Government's Childhood Obesity Plan (Pages 11 - 24)

2.35pm
15 minutes

A verbal update from: Donna Husband, Public Health, Oxfordshire County Council

A discussion about the Government's recent Plan for Action to tackle Childhood Obesity (attached for reference).

9. Affordable Warmth Network briefing (Pages 25 - 30)

2.50pm
15 minutes

Report presented by: Dale Hoyland, National Energy Foundation

A briefing on the outcomes of the British Gas Energy Trust funded 'Better Housing, Better Health' project and a discussion about future funding for this project and an appropriate performance measure for the Affordable Warmth Network going forward.

10. Health Protection Forum Annual Report (Pages 31 - 38)

3.05pm
10 minutes

Report presented by: Eunan O'Neill, Public Health, Oxfordshire County Council

A report on the activity of the Public Health, Health Protection Forum during 2015-16.

11. Air Quality Management Annual Report (Pages 39 - 42)

3.15pm
15 minutes

Report presented by: Ian Halliday, Oxford City Council and Claire Spendley, Chair of Oxfordshire Air Quality Group

An overview of what is being done to tackle poor air quality across the County, including the role of Local Authorities and the Health Improvement Board.

12. Bicester Healthy New Town (Pages 43 - 64)

3.30pm
15 minutes

Report presented by: Ian Davies, Cherwell District Council

A progress report on Bicester's participation in the NHS England Healthy New Town Programme and action being taken to address air quality issues in Cherwell and Bicester in particular.

13. Alcohol and Drugs Partnership Annual Report (Pages 65 - 86)

3.45pm
10 minutes

Report presented by: Jackie Wilderspin, Public Health, Oxfordshire County Council

An update on the work that has been going on to address the priorities within the Alcohol and Drugs Strategy. This includes a review and update on the latest trends for alcohol and drugs related harm.

14. Director of Public Health Annual Report (Pages 87 - 174)

3.50pm
15 minutes

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

The Director of Public Health will present a draft of his Annual Report for 2015/16 which will be presented to the County Council in November for approval.

It is an independent report for all organisations and individuals that 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.

15. Forward Plan (Pages 175 - 176)

4:05pm
5 minutes

Presented by: Councillor Anna Badcock, Chairman of the Health Improvement Board

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

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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Thursday 7th July commencing at 2.00 pm and finishing at 4.00 pm.

Present:

Board Members:	Councillor Ed Turner (Vice-Chairman), Oxford City Council Councillor Jeanette Baker, West Oxfordshire District Council Councillor Monica Lovatt, Vale of White Horse District Council Councillor Hilary Hibbert-Biles, Oxfordshire County Council Councillor John Donaldson, Cherwell District Council Jackie Wilderspin, Public Health Specialist Val Messenger, Deputy Director Public Health (substituting for Dr Jonathan McWilliam) Emma Henrion, Healthwatch Ambassador (job share)
Officers:	
Whole of meeting:	Val Johnson, Oxford City Council Katie Read, Oxfordshire County Council Heather McCulloch, West Oxfordshire District Council
Part of meeting:	
Agenda item 6	Donna Husband, Public Health, Oxfordshire County Council Sally Culmer, Public Health, Oxfordshire County Council
Agenda item 8	Eleanor Stone, Oxfordshire County Council
Agenda item 9	Phil Ealey, South Oxfordshire and the Vale of White Horse District Councils

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 Vice-Chairman, City Councillor Ed Turner, welcomed all to the meeting.	
2. Apologies for Absence and Temporary Appointments Apologies were received from: Councillor Anna Badcock, Dr Paul Park and Ian Davies. Val Messenger substituted for Dr Jonathan McWilliam.	
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 February meeting were approved.	
6. Healthy Weight Action Plan Sally Culmer and Donna Husband provided an overview of the discussion held at the HIB healthy weight workshop and the action plan arising from this. The Board welcomed the action plan, but requested that **more specific responsible parties / individuals were named in the plan, to ensure that actions are taken forward and there is appropriate accountability.** Members discussed how district council leisure and planning functions could contribute to healthy weight, in particular looking at how s.106 funding is spent and how contracts with leisure providers can be utilised to ensure there is healthy food in vending machines. In some areas action on healthy vending can be taken more quickly than others due to contract review dates. **An update on what action has been taken by District Councils to address healthy vending in leisure centres will be provided each time the Healthy Weight Action Plan is reviewed by the Board.** The opportunity to work with foodbanks and third sector organisations to educate people on healthy eating was considered. The City Council is leading on a project to map local initiatives working with people in food poverty, including cookery courses. **The City Council will work with Public Health and the District Councils to co-ordinate a county-wide mapping project.**	**Donna Husband** **Donna Husband** **Val Johnson**

The Board agreed to review the Healthy Weight action plan in six months and requested that it include a RAG status to indicate progress. Information on the national context, e.g. the sugar tax and national obesity strategy, is also to be brought to a future meeting.	**Donna Husband**
7. Housing Related Support The Vice-Chairman provided a verbal update on the next steps for commissioning housing related support services. Health Improvement Board members have been involved in a number of workshops focusing on the future commissioning of housing related support services in light of a £1.5m budget reduction by 2019/20. Partners have been working together to consider a commissioning plan for the next 3 years. It is likely that this will include local elements and services which are focused on those with the greatest needs. Criteria for accessing services are also likely to be more restrictive, but partners are working together to ensure there is no sharp drop in service provision from 2017/18. The impact of national changes to housing benefit is yet to be understood, as well as ongoing welfare reform. Current providers of housing related support will receive an update on the direction of travel for these services as soon as possible. Each council will discuss proposals for a joint approach to housing related support in September / October. **There will be another update on the future of housing related support at the next meeting Board meeting.**	**Natalia Lachkou**
8. Young People's Supported Housing Pathway Eleanor Stone proposed a new indicator that reflects changing pressures, but enables the Board to monitor performance within the young people's supported housing pathway. The Board endorsed the proposed target: it is based on past performance where 68% of young people achieved a positive move-on from the pathway. However, as the term "positive move-on" can be interpreted differently across the pathway and the housing team is introducing a second indicator that will monitor "positive and planned move-on" and include destination data. This term is being defined with providers to ensure a consistent approach to recording. It will run alongside the current indicator in year 2 of the pathway. **The proposed indicator (68% positive move-on) will be reported on a quarterly basis and the new indicator (positive and planned move-on) will be reported at the end of the first year.** Members considered it important to know the breakdown in performance within the pathway, i.e. not just the overall percentage of positive move-on,	**Eleanor Stone**

but the performance within each package. **Performance will be reported by package type and include some narrative to explain the figures achieved.**	**Eleanor Stone**
9. Performance Review 2015-16 Jackie Wilderspin presented the Q3 and Q4 performance report: At 8.1 – Bowel screening data is yet to be reported. At 8.3 – Oxfordshire's performance on the uptake of NHS Health checks is just below the national average. The wide variation in performance across CCG Localities was queried. The GP surgeries that are underperforming are tracked, but where there is a significant variation in the number of invitations sent by surgeries, this is likely to be reflected in the numbers of people taking up their invitation. Members discussed whether there is data to show that those taking up Health checks are the people in most need. Whilst there is work to target certain groups, national evidence suggest that the lowest uptake is amongst males in the younger age group, although there is little evidence that this increases health inequalities. Patient Participation Groups were highlighted as a useful resource for spreading information about Health checks. At 8.4 – The figure for smoking quit rates was corrected from 1,562 to 1,923. At 8.6 & 8.7 – The figures for re-presentations of opiate and non-opiate users are under target – the Board received a report card on this earlier in the year. At 11.2 & 11.3 – The figures for immunisation are under target, although outreach workers have been employed to reach the remaining children – this is usually a very small number overall. At 9.3 – The figures in Q3 & Q4 for the number of babies breastfed at 6-8 weeks were confirmed as correct. Phil Ealey, Chairman of the Housing Support Advisory Group, presented an annual report on the basket of housing indicators: There has been an increase in homelessness during the last 5 years; the loss of private sector tenancies has become the main cause of homelessness. The number of homeless people in priority need has fallen, despite this rising trend. Oxfordshire has seen a significant increase in rough sleeping, predominantly in Cherwell and Oxford City, but joint working around single homelessness and housing related support services has been positive.	

There are a number of additional pressures facing housing teams in the short / medium term – partners are working together to horizon scan and plan. **A short briefing on these pressures will be circulated to members of the Board.**	**Phil Ealey**
The update on Housing Related Support at the next meeting will include context on future pressures and horizon scanning.	**Phil Ealey / Natalia Lachkou**
10. Draft Health and Wellbeing Strategy 2016-17 Jackie Wilderspin introduced the draft revision of the Health and Wellbeing Strategy for 2016-17 before being presented to the Health and Wellbeing Board for approval.	
The baseline for smoking quit rates will be corrected as per the 2015-16 Q4 performance figure.	**Jackie Wilderspin**
It was felt that keeping targets for reducing obesity at the same level for 2016-17 is quite ambitious, given the rising levels of obesity nationally.	
The target for the young people's housing pathway will be updated to reflect the indicator agreed by the Board at this meeting.	**Jackie Wilderspin**
The measure for the Affordable Warmth Network will be confirmed within the year and is likely to differentiate between the number of material changes to housing and contacts made with households regarding advice on benefits take-up. Members were made aware that grant funding for the Affordable Warmth initiative has now ended and work to secure new sources of funding is ongoing. This affects whether a target for the project can be set for 2016-17.	
District council members requested that information about the project is circulated for them to explore opportunities to support parts of the initiative in different ways.	**Kate Eveleigh**
An update on the status of the Affordable Warmth project will be provided at a future meeting.	**Kate Eveleigh**
Members discussed whether a holistic indicator on mental wellbeing should be included and how outcome measures for this could be developed. The Strategy includes targets about mental health that are monitored elsewhere.	
The Public Health team will take advice from Public Health England and follow national guidance to benchmark measures around mental wellbeing.	**Val Messenger**
11. Forward Plan	
From the meeting the following items will be added to the forward Plan: • Status of Affordable Warmth Network	**Katie Read**

• Update on Housing Related Support, including context on wider housing pressures. • Healthy Weight Action Plan Members also agreed that an additional public meeting of the Board is needed to review the findings of the Health Inequalities Commission after it reports in the Autumn. **A public Health Improvement Board workshop will be arranged for November 2016 to discuss the Health Inequalities Commission final report.**	**Katie Read**
The meeting closed at 3.30pm	

..... in the Chair

Date of signing .....

Health Improvement Board
October 2016

Q1 Performance Report 2016/17

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 2015-2019, 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 (at Q1) can be summarised as follows:

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

6. The indicators that are red are:

   8.3 Take-up of invitation for NHS Health Checks should exceed national average (51.7%) and aspire to 55% in year ahead. No CCG locality should record less than 50%. Q1 reached 35.1% but public health is confident that the annual action plan will see an improvement in the near future for NHS Health Checks.

   8.7 More than 26.2% (30% by end year and aspire to 37.3% long term) of non-opiate users should successfully leave treatment and not represent within 6 months (baseline 37.8%) – Q1 is at 20.8% (slightly lower than Q4 2015/16).

Sue Lygo
Health Improvement Practitioner October 2016

Priority 8: Preventing early death and improving quality of life in later years

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
8.1	At least 60% of those sent bowel screening packs will complete and return them (aged 60-74 years) - and adequately screened	60%	0%		0%		0%		0%		Data received for Q4 2015/16 indicates this is now at 59.9%. Data received 6 months in arrears.
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%.	15%	5.0%		0.0%		0.0%		0%		Q1 - all localities (except West Oxfordshire (2.6%) have similar proportions to Oxfordshire overall.
8.3	Take-up of invitation for NHS Health Checks should exceed national average (2015-16 = 51.7% nationally) and aspire to 55% in year ahead. No CCG locality should record less than 50%.	>51.7% (Aspire 55%)	35.1%		0.0%		0.0%		0%		Q1 - some variance between localities. West Oxfordshire 76%, North Oxfordshire 48%, All others lower than Oxfordshire figure.
8.4	Number of people quitting smoking for at least 4 weeks should exceed 2015-16 baseline by at least 10% (15-16 baseline = 1923)	> 2115 by end year	551		0		0		0		Currently on-target to meet 2115 by end year. However, due to past trends, have classed this as amber.
8.5	Mother smoking at time of delivery should decrease to below 8% - Oxfordshire CCG	<8%	7.8%		0.0%		0.0%		0.0%		
8.6	Number of users of OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.	> 4.5% 5% end year (Aspire 6.8% long term)	4.6%		0.0%		0.0%		0.0%		This has improved and achieves the new target. It is not as high as the aspiration for the end of the year.
8.7	Number of users on NON-OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.	> 26.2% 30% end year (Aspire 37.3% long term)	20.8%		0.0%		0.0%		0.0%		

Priority 9: Preventing chronic disease through tackling obesity

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
9.1	National Childhood Measurement Programme (NCMP) - obesity prevalence in Year 6. No district population should record more than 19%	<=16%									
9.2	Reduce by 0.5% the proportion of people who are NOT physically active for at least 30 minutes a week (baseline for Oxfordshire 21.9% Jan14-15)	Reduce by 0.5% from baseline (21.9%)	23.4%								Updated PHOF Aug 2016. This has been classed as "amber" rather than “red” as it remains significantly better than England (28.7%)
9.3	Babies breastfed at 6-8 weeks of age (County) No individual CCG locality should have a rate of less than 55%)	63%	62.2%		0.0%		0.0%		0.0%		Seeking to obtain these data at locality level (SL)

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
10.1	The number of households in temporary accommodation on 31 March 2017 should be no greater than level reported in March 2016 (baseline 190 households)	≥190			0				0		
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.2% 2015-16)	75%	84.9%		0%		0%		0%		
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.	80%					0%		0%		

10.4	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	Needs a new target					0		0		
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 90 (2015)	≥90				0		0		0	
10.6	At least 70% of young people leaving supported housing services will have positive outcomes in 2016-17, aspiring to 95%	<=70% Aspire 95%					0%		0%		

Priority 11:**Preventing infectious disease through immunisation**

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
11.1	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 years and no CCG locality should perform below 94%	95%	95.0%		0.0%		0.0%		0.0%		Seeking data at locality level
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 years and no CCG locality should perform below 94%	95%	93.4%		0.0%		0.0%		0.0%		Seeking data at locality level
11.3	Seasonal Flu <65 at risk (Oxfordshire CCG)	≥ 55%							0.0%		
11.4	HPV 12-13 years (Human papillomavirus) 2 doses	≥ 90%							0%		

HM Government

Childhood Obesity

A Plan for Action

August 2016

DH ID box
Title: Childhood Obesity: A Plan for Action
Author: HM Government 10800
Document Purpose: Policy
Publication date: 08/2016
Contact details: Childhood.Obesity@dh.gsi.gov.uk

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Introduction

Today nearly a third of children aged 2 to 15 are overweight or obese[i,1] and younger generations are becoming obese at earlier ages and staying obese for longer.[2] Reducing obesity levels will save lives as obesity doubles the risk of dying prematurely.[3] Obese adults are seven times more likely to become a type 2 diabetic than adults of a healthy weight[4] which may cause blindness or limb amputation. And not only are obese people more likely to get physical health conditions like heart disease, they are also more likely to be living with conditions like depression. [5, 6]

The economic costs are great, too. We spend more each year on the treatment of obesity and diabetes than we do on the police, fire service and judicial system combined.[7] It was estimated that the NHS in England spent £5.1 billion on overweight and obesity-related ill-health in 2014/15.[8]

The burden is falling hardest on those children from low-income backgrounds. Obesity rates are highest for children from the most deprived areas and this is getting worse.[9] Children aged 5 and from the poorest income groups are twice as likely to be obese compared to their most well off counterparts and by age 11 they are three times as likely.[10]

Obesity is a complex problem with many drivers, including our behaviour, environment, genetics and culture. However, at its root obesity is caused by an energy imbalance: taking in more energy through food than we use through activity. Physical activity is associated with numerous health benefits for children, such as muscle and bone strength, health and fitness, improved quality of sleep and maintenance of a healthy weight.[11] There is also evidence that physical activity and participating in organised sports and after school clubs is linked to improved academic performance.[12,13]

Long-term, sustainable change will only be achieved through the active engagement of schools, communities, families and individuals.

We aim to significantly reduce England's rate of childhood obesity within the next ten years. We are confident that our approach will reduce childhood obesity while respecting consumer choice, economic realities and, ultimately, our need to eat. Although we are clear in our goals and firm in the action we will take, the launch of this plan represents the start of a conversation, rather than the final word.

[i] A child's BMI is based on 'weight for height' defined as weight in kilograms divided by the height in metres squared (kg/m2). To take into account growth patterns by age and gender, a children's BMI is compared with BMI centiles on published growth charts. Children with a BMI above the 98th centile are considered clinically obese. For population monitoring those above the 95th centile are classed as obese.

Introducing a soft drinks industry levy

Our children are consuming too many calories - and, in particular, too much sugar.[14] Teenagers in England are the biggest consumers of sugar-sweetened drinks in Europe.[15] The Scientific Advisory Committee on Nutrition (SACN) recently concluded that sugar consumption increases the risk of consuming too many calories, the risk of tooth decay, and that consumption of sugar sweetened beverages is associated with increased risk of type 2 diabetes and linked to higher weight in children.[16] A single 330ml can of a soft drink with added sugar (which can contain as much as 35g of sugar), may instantly take a child over their maximum recommended daily intake of sugar.

As a first major step towards tackling childhood obesity, we will be introducing a soft drinks industry levy across the UK. In England, the revenue from the levy will be invested in programmes to reduce obesity and encourage physical activity and balanced diets for school age children. This includes doubling the Primary PE and Sport Premium and putting a further £10 million a year into school healthy breakfast clubs to give more children a healthier start to their day. The Barnett formula will be applied to spending on these new initiatives in the normal way.

This is a levy on producers and importers, and not on consumers, and is designed to encourage producers to reduce the amount of sugar in their products and to move consumers towards healthier alternatives. We have given producers and importers two years to lower the sugar in their drinks so that they won't face the levy if they take action. Many manufacturers have already taken steps to reduce the overall levels of added sugar in their drinks, but the levy will create stronger incentives for action.

Alongside this plan, HM Treasury are consulting on the technical detail of the soft drinks industry levy over the summer, and will legislate in the Finance Bill 2017.

Taking out 20% of sugar in products

Evidence shows that slowly changing the balance of ingredients in everyday products, or making changes to product size, is a successful way of improving diets.[17,18] This is because the changes are universal and do not rely on individual behaviour change. We will therefore launch a broad, structured sugar reduction programme to remove sugar from the products children eat most. All sectors of the food and drinks industry will be challenged to reduce overall sugar across a range of products that contribute to children's sugar intakes by at least 20% by 2020, including a 5% reduction in year one. This can be achieved through reduction of sugar levels in products, reducing portion size or shifting purchasing towards lower sugar alternatives.

This programme will be led and run by Public Health England (PHE) and will apply to all sectors of industry – retailers, manufacturers and the out of home sector (e.g. restaurants, takeaways and cafés) – and to all foods and drinks that contribute to children's sugar intakes, including those aimed at very young children. The programme will initially focus on the nine categories that make the largest contributions to children's sugar intakes: breakfast cereals, yoghurts,

biscuits, cakes, confectionery, morning goods (e.g. pastries), puddings, ice cream and sweet spreads.[ii] Work will then move on to cover the remaining relevant foods and drinks, including any products that may be out of scope of the soft drinks industry levy, for example, milk-based drinks. The sugar reduction programme will also work to reduce the sugar content of product ranges explicitly targeted at babies and young children.[iii]

PHE will advise Government on setting sugar targets per 100g of product and calorie caps for specific single serving products. The 4-year, category-specific targets for the nine initial categories will be published in March 2017. Progress will be measured on the basis of reductions in the sales weighted average sugar content per 100 grams of food and drink, reductions in portion size so that these contain less sugar, or a clear sales shift towards lower sugar alternatives. [iv]

To ensure that the achievement matches expectations, progress will be reviewed by PHE who will publish interim reports on progress every 6 months. This will include reviewing reductions achieved through analysis of sales data and food composition data along with plans for further reductions. Some companies have led the way in addressing sugar reduction and it is important that existing work is recognised. Therefore, PHE will use 2015 data as the baseline for this reduction programme.

PHE will provide an assessment at 18 and 36 months (September 2018 and March 2020) on the approach adopted by industry. Government will use this information to determine whether sufficient progress is being made and whether alternative levers need to be used by the Government to reduce sugar and calories in food and drink consumed by children. If there has not been sufficient progress by 2020 we will use other levers to achieve the same aims.

Sugar reductions should be accompanied by reductions in calories and should not be compensated for by increases in saturated fat. Work to achieve salt targets should continue alongside the sugar reduction programme. From 2017, the programme will be extended to include setting targets to reduce total calories in a wider range of products contributing to children's calorie intake and across all sectors, including the out of home sector. Work on saturated fat will be further reviewed in light of SACN recommendations due in 2017.

Supporting innovation to help businesses to make their products healthier

We want to encourage the next generation of innovation in science and technology to allow industry to create healthier, more sustainable products. To support this, Innovate UK ran a collaborative research and development (R&D) competition worth £10 million for research to

[ii] Excludes soft drinks as these will be covered by the soft drinks industry levy.

[iii] Excluding breast-milk substitutes.

[iv] The sales weighted average refers to the average sugar levels across a food category, and is calculated by weighting the contribution of individual products according to volume sales.

stimulate new processes and products to increase the availability of healthier food choices for consumers and open up new markets. The recently formed Agri-Food Technology Council provides leadership in areas such as health and nutrition and consumer acceptability, and the Food Innovation Network is bringing together food businesses, researchers, and innovation support to enable greater take up of world-leading R&D.

Developing a new framework by updating the nutrient profile model

To help families to recognise healthier choices, we need a new way to determine which food and drink products are healthier and which are less healthy. The restrictions on food and drink advertising that are already in place to protect children are based on a tool called a 'nutrient profile'. Each food and drink is assigned a score based on working out how much sugar, fat, salt, fruit, vegetables and nuts, fibre and protein it contains.

The current nutrient profile is over 10 years old and does not reflect recent scientific advice such as the SACN report or new products introduced. Having a strong, effective model will be crucial for underpinning all areas of this plan: giving clear guidance on how products will be treated will encourage companies to make their products healthier so they can avoid potential sanctions. Therefore, PHE is working with academics, industry, health Non-Governmental Organisations (NGOs) and other stakeholders, to review the nutrient profile model to ensure it reflects the latest government dietary guidelines. This should ensure that an updated profile focuses on the most unhealthy products, rather than adversely affecting products which are consumed as part of a healthy diet.

Making healthy options available in the public sector

We need to harness the true potential of the public sector to reduce childhood obesity. The public sector in England spends over £2 billion on food and catering services annually, with just under half, £1 billion, being the cost of food and ingredients.[19] These buildings, services and spaces should set an example to children and families.

Every public sector setting, from leisure centres to hospitals, should have a food environment designed so the easy choices are also the healthy ones. Therefore, we will continue to work with local authorities and the Local Government Association to support them to tackle childhood obesity. This will include encouraging local authorities to adopt the GBSF standards, particularly in leisure centre vending machines. We will also ensure that there is full uptake of the Government Buying Standards for Food and Catering Services (GBSF) in central government departments

Ukactive, whose members manage a large proportion of the fitness and leisure centres in England, are committed to making the environment in those places healthier by considering ways to provide and promote healthy options and restrict the sale of unhealthy food and drink.

The Department of Health is building on this requirement by collaborating with PHE, NHS England and the Behavioural Insights Team to trial behavioural interventions in NHS hospitals. These interventions will measure changes in purchasing behaviour and the impact on revenue from sales.

Continuing to provide support with the cost of healthy food for those who need it most

We are re-committing to the Healthy Start scheme, which provided an estimated £60 million worth of vouchers to families on low income across England in 2015/16. These can be exchanged for fresh or frozen fruit or vegetables and milk. The scheme also provides free vitamins to support intake during pregnancy and early years. Last year over 1.7 million vouchers were issued every four weeks and an average of 480,000 children in low income families were benefiting from the scheme in each month of the year.

Helping all children to enjoy an hour of physical activity every day

There is strong evidence that regular physical activity is associated with numerous health benefits for children.[v] The UK Chief Medical Officers' recommend that all children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes every day. Many schools already offer an average of two hours of PE or other physical activities per week. However, we need to do more to encourage children to be active every day. Every primary school child should get at least 60 minutes of moderate to vigorous physical activity a day. At least 30 minutes should be delivered in school every day through active break times, PE, extra-curricular clubs, active lessons, or other sport and physical activity events, with the remaining 30 minutes supported by parents and carers outside of school time.

Given the considerable new funding that the soft drinks industry levy will make available for school sports, the Government is keen that schools are supported as much as possible in how they spend the available funds for maximum impact. During inspections, Ofsted assess how effectively leaders use the Primary PE and Sport Premium and measure its impact on outcomes for pupils, and how effectively governors hold them to account for this. Physical activity will be a key part of the new healthy schools rating scheme, and so schools will have an opportunity to demonstrate what they are doing to make their pupils more physically active.

Schools will continue to have the freedom to consider spending the Primary PE and Sport Premium on specific interventions but to help schools understand what help is available, PHE will be developing advice to schools for the academic year 2017/18. This will set out how schools can work with the school nurses, health centres, healthy weight teams in local authorities and other resources, to help children develop a healthier lifestyle.

[v] Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers, July 2011.

Furthermore, we will make available a new interactive online tool which will help schools plan at least 30 minutes of physical activity every day. This will help schools identify gaps in the existing opportunities for children to be active and will recommend a number of solutions they can choose, for example after school clubs, initiatives such as the daily mile, creating an active playground or having an active lesson.

Improving the co-ordination of quality sport and physical activity programmes for schools

We have asked the County Sports Partnerships to work with National Governing Bodies of sport, the Youth Sport Trust and other national and local providers to ensure that from September 2017, every primary school in England has access to a co-ordinated offer of high quality sport and physical activity programmes, both local and national. As part of this, National Governing Bodies will offer high quality sport programmes to every primary school.

Whilst children spend a significant amount of time in school, keeping children active is a shared responsibility and parents and carers need to play their part. The Sport England Strategy 'Towards an Active Nation' (2016) has already set out a major new investment of £40m into projects which offer new opportunities for families and children to get active and play sport together. This investment will focus on helping children acquire a basic level of competence in sport and physical activity as well as supporting them to have fun, regardless of their level of ability.

We will continue investing in walking and cycling to school. Walking or cycling to school provides a healthy way to start the day. The Government has committed to producing a Cycling and Walking Investment Strategy. The first strategy will set out plans for investing £300m to support cycling and walking. It will set a clear target to increase the number of children walking to school as well as continued support for Bikeability cycle training for children.

Creating a new healthy rating scheme for primary schools

Schools are a vital part of our plan, and have opportunities to support healthier eating, physical activity and to shape healthy habits. Schools also have unique contact with parents and can signpost them to information and advice on keeping their children healthy. From September 2017, we will introduce a new voluntary healthy rating scheme for primary schools to recognise and encourage their contribution to preventing obesity by helping children to eat better and move more. This scheme will be taken into account during Ofsted inspections.

The scheme will help schools to demonstrate to parents that they are taking evidence-based actions to improve their pupils' health. Building on existing schemes where appropriate, the criteria for the rating scheme will be developed in consultation with schools and experts but will cover the school's approach as a whole. We will seek to actively involve parents in the rating process so they can be confident their children are attending schools which provide healthy food and opportunities for physical activity.

We are also keen to celebrate schools that can demonstrate healthy approaches towards tackling obesity amongst their pupils, and therefore we will run an annual competition to recognise schools with the most innovative and impactful projects.

Ofsted already evaluate a school's success in promoting and supporting pupils' knowledge of how to keep themselves healthy, including through exercising and healthy eating. Inspectors expect to see pupils making informed choices about eating and physical activity and the school's culture promoting this aspect of pupils' welfare. This evaluation informs inspectors' judgement on pupils' personal development, behaviour and welfare.

Once the new rating scheme is operational it will be referred to in the school inspection handbook, and Ofsted inspectors will be able to take account of the scheme as an important source of evidence about the steps taken by the school to promote healthy eating and physical activity.

In addition, in 2017, Ofsted will undertake a thematic review on obesity, healthy eating and physical activity in schools. The review will provide examples of good practice and recommendations on what more schools can do in this area.

Making school food healthier

We have already done a lot to improve school food: many school canteens are unrecognisable from those 20 to 30 years ago. The School Food Plan, published in July 2013, has helped bring about whole school improvements in food. The new School Food Standards came in to force from January 2015. They have been widely welcomed but since then new advice on sugar and nutrition has been published. Therefore the Department for Education (DfE), supported by PHE, will update the School Food Standards in light of refreshed government dietary recommendations

The majority of schools are subject to the School Food Standards. However, some academies and free schools are not. We are keen to encourage all academies to make a clear commitment as part of tackling childhood obesity. Therefore, the Secretary of State for Education will lead a campaign encouraging all schools to commit to the standards.

Breakfast clubs can contribute to improved attainment, attendance and overall health.[20] This is why the Government recently announced that £10 million a year of revenue from the soft drinks levy will fund the expansion of healthy breakfast clubs. This programme will ensure that more children benefit from a healthy start to their school day.

Clearer food labelling

In order to make healthier choices, families need to be presented with clear information about the food they are buying. The UK has led the way, working with industry to implement a voluntary front of pack traffic light labelling scheme, which now covers two thirds of products

sold in the UK. However, an issue of increasing concern to families is understanding which sugars they should be cutting out of their diet. Current sugar labelling shows the total sugar content of foods but the new maximum intake recommendations are based on the specific sugars[vi] that are easily over-consumed, not all sugars.

The UK's decision to leave the European Union will give us greater flexibility to determine what information should be presented on packaged food, and how it should be displayed. We want to build on the success of our current labelling scheme, and review additional opportunities to go further and ensure we are using the most effective ways to communicate information to families. This might include clearer visual labelling, such as teaspoons of sugar, to show consumers about the sugar content in packaged food and drink.

Supporting early years settings

The early years are a crucial time for children's development. One in five children are already overweight or obese before they start school[21] and only one in ten children aged two to four meets the UK Chief Medical Officers' physical activity guidelines for this age group.[vii,22,23]

PHE have commissioned the Children's Food Trust to develop revised menus for early years settings by December 2016. These will be incorporated into voluntary guidelines for early years settings to help them meet current Government dietary recommendations. This will include practical ideas and suggestions, alongside the sample menus.

In early 2017, we will launch a campaign to raise awareness of these guidelines amongst both early years practitioners and parents and we will update the Early Years Foundation Stage Framework to make specific reference to the UK Chief Medical Officers' guidelines for physical activity in the early years (including active play).

Harnessing the best new technology

Consumer power and choices are important drivers of the food environment and, potentially, in ending the childhood obesity crisis. We need accessible, simple information on how much sugar, fat and salt your weekly shop contains. We need to capitalise on the power of technology to support healthier choices. The uptake of Change4Life's Sugar Smart app[24] shows the potential of digital applications in this regard. We will therefore work with PHE, Innovate UK, the third sector and commercial players to investigate opportunities to bring forward a suite of applications that enable consumers to make the best use of technology and data to inform eating decisions. We will also ask PHE to build on work which is underway around digital based weight management support for adults and explore similar approaches for children and families.

[vi] Public health advice recommends limitation of 'Free sugars' consumption, which includes all refined sugar added to foods, plus sugars naturally present in ingredients such as honey, syrups and unsweetened fruit juices.

[vii] The recommended level of moderate to vigorous physical activity for children under 5 is 180 minutes a day, spread through-out the day. [CMO (2011) UK Physical Activity Guidelines]

We recognise that this is a fast-paced industry and advances are constantly being made. We want to provide a national forum to engage the country's best innovators with the childhood obesity cause. To support this, PHE will hold an annual digital technology 'hackathon', bringing together leading developers and programmers to produce innovative solutions to address childhood obesity.

Enabling health professionals to support families

We are asking health care professionals to build on the good work they already do by always talking to parents about their family's diet, working towards making it the default to weigh everyone, referring people to local weight management services, clubs and websites if they ask for more advice.

Health professionals should feel confident discussing nutrition and weight issues with children, their families and adults. To support this ambition, Health Education England (HEE) and PHE have launched a suite of resources aimed at supporting the health care and wider workforce to "Make Every Contact Count". These resources include training on influencing behaviour change and initiating difficult conversations about health and wellbeing, as well as targeted training for Health Visitors and School Nurses given their unique positioning which enables them to identify weight issues in children early on.

We will review where content on nutrition, physical activity, healthy weight messaging and weaning advice in materials for visits by midwives and health visitors can be strengthened so new families get the best advice to ensure a focus on healthy weight. We will also explore how evidence-based healthy weight messaging can be introduced at other contact points, such as childhood immunisation programmes.

HEE has also reviewed and updated the existing materials about obesity and nutrition available via the E-learning for Health platform and encourage all those working in the NHS to undertake relevant training as part of their Continuing Professional Development, so that they feel confident about raising weight issues, nutrition and physical activity as an issue.

We will continue to explore what more can be done across the health sector and work with our partners to develop approaches to prevent and reduce childhood obesity.

Conclusion

With nearly a third of children aged 2-15 overweight or obese[25], tackling childhood obesity requires us all to take action. Government, industry, schools and the public sector all have a part to play in making food and drink healthier and supporting healthier choices for our children. The benefits for reducing obesity are clear – it will save lives and reduce inequalities.

The actions in this plan will significantly reduce England's rate of childhood obesity within the next ten years. Achieving this will mean fewer obese children in 2026 than if obesity rates stay as they are.[26] We are confident that our approach will reduce childhood obesity while respecting

consumer choice, economic realities and, ultimately, our need to eat. Although we are clear in our goals and firm in the action we will take, the launch of this plan represents the start of a conversation, rather than the final word. Over the coming year, we will monitor action and assess progress, and take further action where it is needed.

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Health Improvement Board Briefing - October 2016

Background

This paper has been produced following the HIB request at their last meeting, by the Oxfordshire Affordable Warmth Network (AWN) on behalf of the four district and the city councils that provide its principal funding.

It provides

- discussion of the Fuel Poverty outcome measure, as well as the latest draft figures (please see appendix 1);
- an outline and initial evaluation of outputs from the British Gas Energy Trust funded 'Better Housing, Better Health' project, including information about how this could be supported once current project funding runs out.

Fuel Poverty in Oxfordshire

The fuel poverty indicator for Oxfordshire, based on the recently adopted Low Income, High Cost (LIHC)[1] definition is 9.1% (an increase from 8.7% the previous year), the average across England is around 10.8% (DECC 2014). This data is also available at district and Lower Super Output Area (LSOA) levels. The lowest level of fuel poverty for an LSOA in Oxfordshire is 1.8% and the highest is 25.5%. The range is much reduced from the previous year's figures (where the ward in Oxford with the highest fuel poverty percentage was in excess of 33% of households in fuel poverty). However, the variance between areas, even neighbouring wards are pronounced, and further build the case for very localised targeting wherever possible.

Oxfordshire local authorities and partners tackle fuel poverty, primarily through the Affordable Warmth Network (AWN) as the county-wide coordinated approach. The county's local authority involvement here shouldn't be understated: they form key members of the Steering Group which govern the day-to-day deliverables, strategic direction, funding bids and fill much of the shortfall in funding provision for energy efficiency improvement (through making available fuel poverty grants, flexible home improvement loans, etc). Core funding for annual running costs is also provided by the four district councils, Oxford City Council and via a grant from Oxfordshire County Council. National Energy Foundation, a local charity, provides the administrative work and expertise in delivering the work of AWN as outlined in an Action Plan. NEF also markets the assistance that is available through outreach, front-line staff training, production and dissemination of content through various media, and coordination of related marketing (for example, council mail-outs to selected residents, and referral routes through key partners, for example GP surgeries). In addition to the input by local authorities, other key partners include Citizens Advice, Oxfordshire Clinical Commissioning Group with visiting membership from Oxford Diocese, Oxon Fire and Rescue Service, Age UK, Carers Oxfordshire, Low Carbon Hubs and Oxford Brookes University.

[1] Under the Government's Low Income High Costs (LIHC) indicator, a household is considered to be fuel poor if they have required fuel costs that are above average (the national median level) and were they to spend that amount, they would be left with a residual income below the official poverty line.

The offer to Oxfordshire residents by the AWN includes:

- Sourcing and provision of funds to provide free or reduced loft insulation, cavity wall insulation, solid wall insulation, new boilers; measures to tackle cold and damp.
- Promotion of and signposting to local authority enforcement as appropriate of poor housing conditions to reduce excess cold, damp and mould in the private sector housing.
- Provision of advice around keeping your home warm, through better knowledge and behaviours, including a free helpline around what additional national and local financial help is available.
- Support accessing full benefit entitlements, by referrals to Citizens Advice and AgeUK.
- Development of projects to improve communications between existing and new partners, such as health and social care colleagues.

Revision of Oxfordshire's Fuel Poverty Target Measure

It is recognised that we need to move on from reporting of activity, towards setting a target to aspire to that would contribute to reducing fuel poverty in the county. The government LIHC measure of fuel poverty is influenced by many external factors for which we have no control (such as the market price of energy, level of employment and resulting wages, health vulnerabilities to cold / damp housing conditions). However, our current measure is a proxy that contributes to the alleviation of fuel poverty:- in taking steps to remove cold and damp homes, this will help in preventing or ameliorating the impact on the health and wellbeing of residents. It is currently not possible to guarantee that the residents assisted are in fact fuel poor or that the interventions will entirely lift people out of fuel poverty. However, through the use of various sources of information, expert local knowledge, working with appropriate partners, we are confident that we are targeting our work such that residents *are* likely to be at risk of fuel poverty, and that interventions *are* significant and impactful so as to be able to bring that household out of fuel poverty, hence being our measure for the HIB.

It is suggested that the Network adopts an annual target of:-

1430 residents helped per year, over the next 4 years where building based measures account for 25% of those interventions by the final year.

In light of the limited resources, uncertainty and reliance on the Government's plans for ECO (where a significant proportion of grant funding for building based measures come from , we feel it is realistic to attempt to maintain current levels of activity over the next four years, as long as the current partners are able to fund and resource the AWN. We have included the 25% building based element in order to be aspirational and work towards a more sustainable model of reducing fuel poverty. Over the past two years, the average number of building based measures was 16% of the overall activity. Building based measures rely significantly on the availability of funds.

Better Housing, Better Health (BHBH)

The Oxfordshire AWN was successful in being awarded approximately £200,000 from British Gas Healthy Homes Trust (http://www.britishgasenergytrust.org.uk/) to deliver a year-long project to tackle cold homes and health. This project element was called 'Better Housing, Better Health', and includes funding for grants, staff time to provide a single point of contact for health and social care partners and a named case-handler for residents, to assist them through the process, make the award, and a Citizens Advice caseworker for additional capacity for undertaking benefit entitlement checks / switching energy tariff.

BHBH is a pilot health and housing referral scheme provided by the National Energy Foundation in partnership with local authorities across Oxfordshire and Oxfordshire Clinical Commissioning Group. The scheme aims to reduce pressure on health services and improve health and wellbeing for those living with a cardiovascular disease or respiratory illness (these criteria could be amended for future continuation of the project), who are most at risk from the health impacts of cold homes. Through practical energy efficiency improvements and advice, the scheme aims to:

- Contribute towards the local implementation of the Government's NICE guidelines (NG6: Excess winter deaths and illness and the health risks associated with cold homes) and fuel poverty strategy, in particular by providing a single-point-of-contact health and housing referral service for people living in cold homes.
- Help to prevent avoidable excess winter deaths. In 2012-13, 510 people died as a result of cold weather across the two counties where our pilot project launched.
- Reduce fuel poverty.

The pilot scheme runs until December 2016 and covers:

- Grants of up to £2,500 (a higher grant would be beneficial in some cases) for energy efficiency measures for owner eligible occupied homes. Measures include insulation, damp works, new heating systems and boilers, draught proofing and replacement external doors or windows. Note that these have already been fully assigned.
- Support with finding installers and facilitating the installation
- Free surveys to identify potential risks to health in owner occupied and privately rented homes where someone has a qualifying medical condition.
- Support with benefits checks, fuel debt mediation and switching energy tariff or supplier, for anyone in need of support, provided by a Citizens Advice caseworker.

The project has achieved great health and wellbeing outcomes as highlighted in the following infographic: Note that the figures below relate to an initial 100 measures installed across 66 Oxfordshire properties this year. The financial savings to the NHS / CCG (and wider society savings) are calculated using BRE's Housing Health Cost Calculator.

Project Funding

This project has been so successful that the initial grant element awarded from British Gas Energy Trust for capital energy-efficiency improvements was allocated within the first few months. There is currently a waiting list now operating for new referrals to the service. In order to continue the momentum, we seek the HIBs assistance in sourcing £700k of funding to run the scheme for another year, which will help at least 200 households. This should achieve annual savings to the CCG in excess of £1million and to wider society of over £2.5million.

Please note that this project could be scaled in a number of different ways:

- Amending the geographical coverage (targeting to LSOA's with high fuel poverty or health inequalities for example)
- Expanding the eligibility criteria, perhaps to include other medical conditions
- Imposing benefits restrictions
- Working with a wider/narrower remit of healthcare professionals
- Increasing/decreasing the maximum grant amount available to each applicant

Progress of AWN in 6 months: April to end September 2016

"Offers and resource"

Range of factsheets produced to complement existing resources

Free cavity wall and loft insulation offered, utilising ECO grants

Community group talks given / events attended

Front-line staff training sessions delivered

Assistance to switch to a cheaper energy tariff provided

Better Housing, Better Health project grant fund awarded

Energy monitors available free-of-charge

Residents directly assisted via Helpline

'Keeping Kids Cosy' project launched following successful bid, focussing on families struggling with rising energy bills

"Communication and Promotion"

Community outreach offered

Easy Save booklet and factsheets

Successful funding bid used for additional outreach resources: thermometer cards and banner stands produced

Editorial in Community Care Guide publication to key health venues

Winter Warmth Pharmacy campaign planned

Appraisal and updates of council websites and communications

Easy access to grants, both locally initiated and national

"Community Engagement"

Outreach activity has directly advised over 1000 residents face-to-face so far

Assistance offered for community group thermal imaging projects, targeted towards fuel poor regions

"Partnerships"

New referral sources from health and social care used to target vulnerable residents

Cross referrals between CAB, Age UK and NEF.

Attended roadshow of AgeUK Community Information Network events

Bid to deliver switching tariff events for the Big Energy Saving Network

Service featured in Home Safety Checks undertaken by Oxfordshire Fire & Rescue Service

Health Improvement Board Briefing update October 2016 meeting

Appendix 1: **Health Improvement Partnership Board – Update from Oxon Affordable Warmth Network, Q1/Q2**

	Local authority works *	NEF / AWN project elements	Citizens Advice Bureaux	AgeUK Oxfordshire
# HHSRS excess cold resolved	**37**			
# HHSRS Damp & Mould resolved	70			
# HMO Licence conditions for EPC complied with (Oxford City only)	TBC			
# Boilers installed	16	33		
# More efficient heating system	6	1		
# Loft Insulation	6	TBC		
# Double glazed windows	1	TBC		
# Cavity Wall Insulation	2	TBC		
# Solid Wall Insulation	0	TBC		
# Uptake of benefit			TBC	TBC

* LA data currently only includes Cherwell DC, Oxford City Council, South Oxfordshire DC and Vale of White Horse DC, and is provisional.

A Report to the Health Improvement Partnership Board
20 October 2016

Public Health Protection Forum business 2015/16

Purpose
This document will report on the activity of the Health Protection Forum for 2015/16

1. **Introduction**
   1.1 Oxfordshire County Council (and the director of public health (DPH) who acts on behalf of the local authority) has a critical role in protecting the health of its population. This role is to act as a watchdog, ensuring that all organisations working within Oxfordshire coordinate their activities and provide high quality services to protect the population.
   1.2 If organisations fall short of the required standards the DPH has a duty to help them ameliorate the situation. It is therefore a leadership role rather than a managerial role.
   1.3 In order to carry out this role the DPH works in partnership with the relevant organisations via the Public Health Protection Forum which reports to the Health improvement board and hence to the health and wellbeing board.
   1.4 Most problems are dealt with directly by the Public Health Protection Forum, but should persistent difficulties arise these will be escalated to the Health Improvement Board and Health and Wellbeing Board as required.
   1.5 The Public Health Protection forum therefore facilitates the DPH in fulfilling the statutory function of protecting the health of the population of Oxfordshire.

2. **Role of the Health Protection Forum**
The group report on the following issues
- Prevention
- Planning and preparedness
- Relationships and accountabilities
- Monitoring of local data
- Reporting of local issues which may affect the health of the local population

3. Membership of the forum
Membership of the forum includes;
- Director of Public Health, Oxfordshire County Council (Chair)
- Oxfordshire County Council Portfolio Holder for Public Health
- Consultant in Public Health/Public Health Medicine with responsibility for Public Health Protection/emergency planning – Oxfordshire (Deputy Chair)
- Director of Public Health England Centre – Thames Valley (or nominated deputy)
- District representation of Environmental Health colleagues
- Associate Director Medicines Management, Quality and Innovation, Oxfordshire Clinical Commissioning Group

- Head of Public Health Commissioning, NHS England Thames Valley
- Consultant in Public Health Screening and Immunisation, NHS England Thames Valley
- Consultant in Health Protection/CCDC with responsibility for Health Protection in Oxfordshire – Public Health England
- Specialist advisors will be invited as necessary

4. **Meetings**
The forum met three times in the financial year 2015/16. There were no extraordinary meetings held in this time.

5. Activity Reporting
The following activity was reported to the forum during the year 2015/16

6. Topical Infections (Lead Role Public Health England)
6.1 In 2015/16 Zika was of concern internationally with the observed increase and spread through South America. This had caused concern for individuals who may have travelled to affected regions. The mosquito responsible for the transmission of the virus is not found in the UK and the risk to UK residents is still considered low.

6.2 There has been an increase in the numbers of Middle Eastern Respiratory Virus (MERS) observed. Surveillance systems are closely monitoring the incidence of new cases and in England, the local health teams are vigilant to monitor for any potential cases locally.

6.3 There were twelve influenza like illness (ILI) outbreaks notified to Thames Valley Health Protection Team in Oxfordshire during the influenza season 2015/2016. This is a decrease on the previous season when there were 14 outbreaks. Eight of these were in nursing or residential care homes, one was in the Immigration Removal Centre, Campsfield House and three further outbreaks were in schools.

6.4 One care home had two outbreaks, the first influenza A and the second a more limited outbreak of influenza B. These were the only two confirmed influenza outbreaks in care homes, which is a much lower number than last influenza season when eight ILI care home outbreaks in Oxfordshire had a confirmed virology result. The one other confirmed influenza outbreak was a combined influenza A and B outbreak in Campsfield House.

7. Healthcare Acquired Infections (Lead Role Oxfordshire CCG)
Clostridium Difficile (C. Diff)
7.1 In 2015/16 there were 157 reported cases of C. Diff which is an increase on the previous year (134). This reflects the challenge in addressing C. Diff.

Methicillin Resistant Staphylococcus Aureus (MRSA)
7.2. In 2015/16 there were 15 reported cases of MRSA which is a decline in performance in 2014/15 (9 cases). This is a return to the same number of cases that was observed in 2013/14.

7.3 Oxfordshire CCG continues to work with providers in primary and acute care to address the increase in the reported cases of healthcare acquired infections.

8. Environmental Health Issues (Lead Role District Councils)

8.1 During the year there have been discussions about local Air pollution at the Board. An Air Quality Management Area (AQMA) is declared if the levels of NO_2 exceed 40µg/m^3. In Oxfordshire the following areas are declared AQMAs:

- Henley on Thames
- Wallingford
- Watlington
- Abingdon
- Botley
- Marcham
- City of Oxford
- Chipping Norton
- Witney
- Banbury
- Bicester
- Kidlington

8.2.1 It is acknowledged that environmental health does monitor air quality and propose action plans in the AQMA areas, however there is no one single solution to resolve the levels of pollution in AQMA areas and it will require a multifaceted, multi-organisational approach to resolve.

8.2 The forum will be piloting a new dashboard at the next meeting in October. This will contain data on different activity monitored by environmental health officers in the Districts and City Councils.

9. Immunisation Programmes (Lead Role NHS England)

Influenza Vaccine

9.1 Influenza activity levels were lower than the last flu season as reflected in the lower number of confirmed outbreaks. Moderate levels of influenza activity were seen in the community in the UK in 2015 to 2016, with influenza A(H1N1)pdm09 the predominant circulating virus for the majority of the season peaking late in week 11 of 2016 and influenza B peaking afterwards. Nationally the impact of A(H1N1)pdm09 was predominantly seen in young adults. The flu vaccination activity for 2015/16 season in Oxfordshire is detailed below

Children's vaccinations 2015/16 Season

9.1.2 In the 2015/16 season

2 year old children in Oxfordshire vaccinated 43.7% (last year 44.8%, Eng. 35.4%)
3 year old children in Oxfordshire vaccinated 44.2%% (last year 48.5%, Eng. 37.7%)
4 year old children in Oxfordshire vaccinated 38.3% (last year 37.1%, Eng. 30.0%)

The offer was extended this year to children aged 5 and 6 years old for the first time. The model of delivery in Oxfordshire was through GP practices.

5 year old children in Oxfordshire vaccinated 32.6% (Areas with similar model of GP delivery Eng. 28.6%)
6 year old children in Oxfordshire vaccinated 28.2% (Areas with similar model of GP delivery Eng. 25.2%)

Adult vaccinations 2015/16 Season
9.1.3 Adults aged >65 in Oxfordshire vaccinated 72.4% (last year 75.6%)
Adults aged < 65 at risk in Oxfordshire vaccinated 45.9% (last year 51.9%)
Pregnant Women in Oxfordshire vaccinated 49.5% (last year 51.3%)

9.1.4 There has been continued mixed performance in vaccinations for the past season, despite concerted efforts there is still poor uptake for individuals aged under 65 at risk. In the next flu season adults suffering from liver disease, neurological conditions and learning difficulties will again be priority groups for vaccination.

9.1.5 For the 2016/17 season the model for flu vaccinations in 5 & 6 year old children will change to a school based delivery. This will bring the model in line with the other areas within Thames valley that had better uptake in vaccinations by delivering in schools instead of GP practices. The offer will also be extended to children aged seven.

10. Other Childhood vaccination programmes (Lead Role NHS England)
10.1 The performance of other childhood vaccinations is still generally achieving the 95% national targets and performance is better than other areas in Thames Valley. The DPH and forum maintain vigilance to ensure that this good performance does not drop. However, vaccinations of note

Measles
10.1.2 There has been another slight uptake in MMR vaccine in children aged 2 years. Oxfordshire has passed the 95.0% uptake target achieving 95.4%. However the vaccination rate for MMR vaccination at 5 years is 92.5% (last year 92.1%). The numbers that are not taking up the vaccine at 5 years are small. The area team are continuing to work on addressing this with local GP practices.

In 2015/16 there was one reported case of Measles in Oxfordshire.

Rotovirus
10.1.3 The uptake of this vaccination in 2015/16 93.5% which was in an improvement on the previous year's uptake of 88.6%. This improvement is a result an action plan to improve performance on immunisation activity in GP practices.

11. Adult Vaccinations (Lead Role NHS England)
Shingles

11.1 Cohort for vaccination is now 70, 78 & 79 year old adults. Oxfordshire CCG 91.3% of GP practices had submitted data. The table below provides information on activity data from 1/9/13- 31/8/15

	% of practices responding		% of patients immunised aged 70		% of patients immunised aged 79		% of patients immunised aged 78	
Year	**13/14**	**14/15**	**13/14**	**14/15**	**13/14**	**14/15**	**13/14**	**14/15**
OXFORDSHIRE	**95.1**	**91.3**	**52.7**	**63.2**	**56.5**	**64.9**	**55.6**	**63.3**
Thames Valley Total	**97.9**	**95.3**	**53.1**	**63.1**	**56.2**	**63.7**	**55.8**	**63.6**

The performance in Oxfordshire is improved on the previous year as the programme becomes more established and recognised in the local target population. The area team will continue to develop the programme and improve uptake.

12. Screening Programmes (Lead Role NHS England)

Antenatal Screening Programmes

12.1 Programme activity continues to meet targets, except for avoidable repeats for blood spot test. The avoidable repeat of blood spots continues to be an issue with different matters arising as others are resolved. Commissioners have developed an action plan with the providers to reduce the number of repeat tests.

Bowel Screening

12.2 Screening is offered to people aged 60-74 years of age. The most recent annual data in 2014/15, 59% of people took up the offer of screening. This was higher than the national target of 60%. Latest data for Q2 2015/16 uptake was 57.1%.

12.2.1 In 2015/15 NHSE and Cancer Research UK ran a bowel cancer screening awareness campaign in Oxfordshire. This was part of a national campaign to try to improve uptake. The complete data for 2015/16 will be available later in the year.

Breast Screening

12.3 This programme is available to women aged 50-70 every three years. Latest data was that 96.8% of eligible women have received a screening examination in the previous 36 months of Q3 2015/16.

Cervical Screening

12.4 This programme is available to women aged 25-64. The percentage of those that took up the offer in 2015 was 73.4% (76.6% in 2014). Uptake activity continues to just fall short of the national 80% target, despite continued efforts over the years. The difficulty in improving uptake is seen wider than Oxfordshire with the decrease in uptake is also being seen Nationally (74.2% 2014 down to 73.5% in 2015).

Aortic Abdominal Aneurism Screening

12.5 This programme is available to men aged 65 to 74 over 10 years. Locally the activity did not meet the national target (75%) with an uptake of 72.5% (77.9% in 2014/15). This was due to staffing issues with the provider during the year. Commissioners have been given assurances that these issues have now been resolved and the activity should improve to above target levels in this year.

13. HIV and Sexually Transmitted Infections NHSE (Lead Role NHS England & Oxfordshire County Council)

HIV

13.1 The prevalence of HIV in Oxfordshire continues to increase in line with the improved survival rates for HIV which has become a more chronic condition with the improved effectiveness of treatment. Currently there are 457 people diagnosed with the infection living in Oxfordshire. Of these 457 people, 231 live in Oxford City. It is estimated that there are an additional 96 people undiagnosed with HIV in the County.

13.1.2 Early diagnosis of HIV is important as it improves the prognosis of treatment, reduces the cost of treatment and lowers the risk of transmission. Latest data for 2012-14 reveals that 36 cases of late diagnoses occurred in Oxfordshire.

Sexually Transmitted Infections (STIs)

13.2 The diagnosis for all STIs has remained similar in 2014 and is still lower than national averages.

Gonorrhoea

13.2.1 In response to concerns about recorded increase in diagnoses of Gonorrhoea an audit was conducted on positive cases with secondary testing of positive cases. This audit was reported to the Sexual Health Action Partnership and concluded that the increase seen in gonorrhoea was due to false positive testing results. A new testing procedure is now in place with a secondary validation testing to confirm a positive case of gonorrhoea.

Chlamydia

13.2.2 The current detection rates are still less than the projected levels that are determined by PHE and we are RAG rated red because of this. A “deep dive” of the provision of services conducted with PHE concluded that the range of services available were not insufficient. The latest evidence suggests that the universal offer which is part of the national programme is not most effective for populations with low prevalence.

14. Blood Bourne Viruses

There were no major incidents locally to report.

15. Recommendations

The board are requested to consider the contents of this report on the health protection activity in the year 2015/16.

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Oxfordshire Air Quality Group Annual Report - Health Improvement Board

National Context

1. The health effects of air pollution have been widely publicised and it is now recognised by the government as the country's second-biggest health threat, after smoking.
2. There is now categorical evidence that long-term exposure to everyday air pollutants contributes to cardiovascular disease (CVD, including heart diseases and stroke), lung cancer, and respiratory disease (which includes asthma and chronic bronchitis).
3. Public Health England estimated the mortality burden attributed to long term fine particulate air pollution exposure in Oxfordshire to be 5.6% of the population, equivalent to 276 deaths (Age 25+) and equivalent to 2944 life years lost[1]. It should be noted that there is considerable uncertainty attached to this estimate. By contrast, there were 26 fatalities on Oxfordshire's roads in 2014[2].
4. The UK is currently failing to comply with its obligations under the Ambient Air Quality Directive 2008. As a result, the European Commission has launched legal proceedings against the UK for its failure to cut excessive levels of nitrogen dioxide (NO_2). This leaves the UK Government open to potential fines of up to £300m.
5. Under Part 2 of the Localism Act under the Government could require responsible authorities to pay all or part of an infraction fine.

The role of District Councils

6. The Environment Act 1995 requires district councils to carry out periodic review and assessment of air quality within their area. The air quality objectives applicable to Local Air Quality Management (LAQM) in England are set out in the Air Quality (England) Regulations. Short and long term objectives are set for a number of pollutants including nitrogen dioxide and particulate matter.
7. District councils are required to designate an Air Quality Management Area (AQMA), if any of the air quality objectives are not being achieved.
8. Once an AQMA has been designated the district council should prepare an Action Plan that sets out how it will achieve the air quality standards or objectives for the area that it covers.
9. District councils report annually to the Department for Environment, Food and Rural Affairs (Defra) on the results of monitoring in their area and progress with the implementation of their Action Plans. A new format for reporting, the Annual Status Report, was introduced in 2016.

[1] *Public Health England Estimates of Mortality in Local Authority Areas Associated with Air (April 2014) Pollution* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332854/PHE_CRCE_010.pdf

[2] *Oxfordshire County Council Road Traffic Accident Casualty Data Summary 2014* https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/roadsandtransport/safety/CasualtyReport2014.pdf

The role of County Councils

10. Where a district council is preparing an Action Plan, the county council is obliged to submit measures related to their functions (i.e. local transport, highways and public health) to help meet air quality objectives in their local area.
11. Oxfordshire County Council developed Local Transport Plan 4 (LTP4) which contains a commitment to improve public health and wellbeing by increasing levels of walking and cycling, reducing transport emissions, reducing casualties, and enabling inclusive access to jobs, education, training and services.

Air Quality in Oxfordshire

12. Air quality across Oxfordshire is considered to be generally good as the county is largely rural in nature. In the more densely populated areas of the county, and those which experience high traffic flows such as Oxford, Banbury and Bicester, increased levels of air pollution are of concern. In these areas, road traffic is the most significant source of pollutant emissions.
13. Air quality is regularly monitored at many locations across Oxfordshire. At some locations air quality is at levels where legal intervention is required by Local Authorities. There are currently 13 AQMAs in Oxfordshire, where the annual mean objective for nitrogen dioxide is being exceeded (four in Cherwell, one covering the whole of Oxford city, three in South Oxfordshire, three in Vale of White Horse and two in West Oxfordshire). The table below summarises monitoring results from 2014 and 2015.
14. The figures in the table below are the average annual concentrations of Nitrogen Dioxide measured by diffusion tube in each of the AQMAs in 2014 and 2015. In those AQMAs with more than one diffusion tube the worst i.e. highest result has been used. The Government objective level is an annual mean concentration of nitrogen dioxide of 40 $\mu g/m^3$.

Air Quality Management Areas in Oxfordshire

District	**AQMA**	**NO_2 $\mu g/m^3$ 2014**	**NO_2 $\mu g/m^3$ 2015**
Oxford	Whole of city	65	67
West	Witney town centre	47	
	Chipping Norton town centre	58	
Cherwell	Banbury Hennef Way	79	78
	Banbury town centre	42	41
	Bicester town centre	47	46
	Kidlington Bicester Road	44	41
South	Watlington village centre	49	41
	Wallingford town centre	41	34
	Henley-on-Thames town centre	59	47
Vale	Abingdon-on-Thames town centre	45	45
	Marcham village centre	50	48
	Botley A34	53	48

15. Most AQMAs in Oxfordshire are relatively small geographical areas, typically in urban centres. However, in the case of Oxford the whole of the city has been declared an AQMA.
16. The figures above highlight that 2015 saw generally lower levels across the county however it is too early to say whether or not this is indicative of a downward trend or whether other factors have influenced these results such as the favourable meteorological conditions seen in the winter of 2015.

What is being done?

17. The District Councils have either developed, or are in the process of developing Air Quality Action Plans for the AQMAs in their areas.
18. As the cause of all the AQMAs is road traffic, the actions focus on reducing emissions from vehicles and can be grouped into the following themes:
    a. Influencing the development of the Local Transport Plan and area specific strategies to ensure that impacts on air quality are considered at an early stage;
    b. Reducing emissions from transport, for example through the introduction of Low Emission Zones;
    c. Promoting more sustainable forms of transport, particularly electric vehicles;
    d. Encouraging modal shift to more active forms of transport such as walking and cycling;
    e. Education and awareness raising around air quality to promote behavioural change; and
    f. Ensuring that air quality is given due consideration as part of the planning process.
19. Opportunities to draw down funding from a variety of sources to implement measure to improve air quality in Oxfordshire have been taken where possible.
20. Further details of specific action by district can be found in appendix 1.

What could the Health Improvement Board do?

21. Defra's Local Air Quality Management Policy Guidance (PG16) recommends that local Directors of Public Health and 'Health and Wellbeing' boards should work closely with local authorities. Working in partnership will increase support for measures to improve air quality, with co-benefits for all. Defra recommends that the following local action is taken:
    a. Ensuring the Joint Strategic Needs Assessment has up to date information on air quality impacts on the population; and
    b. Working closely with local authority health and air quality officers – e.g. have regular update meetings on key, emerging issues.
    c. That Directors of Public Health/ H&W Boards sign off on air quality Annual Status Reports and Action Plans prior to submission to Defra.

22. Introduce policies that encourage a shift from motorised transport to walking and cycling as this is expected to reduce total vehicle emissions, including particulate pollution. If this could be achieved in towns and cities, then we could expect local improvements in air quality leading to health improvements, as well as additional health benefits through increased physical activity through walking and cycling.

Appendix 1.
Recent Actions

The launch of the Oxfordshire air quality website (https://oxfordshire.air-quality.info/) in 2015 was a great success and allows users to see real-time air quality data in a visual map based format whilst providing a raft of air quality data and information for Oxfordshire all in one place. The webpage comes complete with a children's section and quiz.

In addition to this the Districts have been working closely with the County Council and as a result the County have approved an air quality appendix to their Local Transport Plan 4, the key themes are;

- Encouraging walking and cycling
- Restricting diesel vehicles in town centres through the introduction of clean air zones
- Working more proactively with the district councils on action planning
- Introducing low or zero emission mass transit vehicles

South specific actions:

- Adoption of new district wide air quality action plan.
- Low emission strategy for the district was produced and is currently undergoing public consultation.

Vale specific actions:

- Draft developer guidance to be integrated in to the local planning process.

Cherwell specific actions:

- Development of a comprehensive and workable air quality action plan to improve air quality in partnership with other organisations that will assist in the implementation of the measures.

Oxford City Council specific actions

- Launched Oxford Park and Pedal which has seen over 100 cycle parking spaces introduced at two of our park and ride sites.
- Ran the Test Drive the Future event to introduce the public to a range of electric vehicles (EVs) and the financial and environmental benefits of going electric. The event provided an opportunity to test drive vehicles, and outlined the options for driving an electric car 'pay as you go' through one of Oxford's car clubs.
- Commissioned a study into options for a Delivery and Servicing Plan for its city centre premises. Consideration and implementation of the options is now underway.

Oxfordshire Health Improvement Board

20 October 2016

Bicester Healthy New Town Programme

Report from Ian Davies
Director of Operational Delivery Cherwell District Council

Purpose of report

To provide Oxfordshire's Health Improvement Board with a progress report on Bicester's participation in the NHS England Healthy New Town Programme (HNT), and an update on action being taken to address air quality issues in the town. It is acknowledged that Barton, Oxford is also part of the national HNT programme and whilst this report provides an overview of the Bicester HNT programme only, the Health Improvement Board may wish to receive a similar report on Barton at a future meeting.

1.0 Recommendations

The Health Improvement Board is recommended:

1.1 To note Bicester's participation in the NHS England Healthy New Town Programme and the progress of Bicester's Healthy New Town Programme as at October 2016.

1.2 To note action that is being undertaken to address air quality issues in Cherwell and Bicester in particular.

2.0 Introduction

2.1 In June 2015, the NHS issued a prospectus to invite bids to participate in a Healthy New Towns (HNT) Programme. The initiative was aimed at putting health at the heart of new neighbourhoods and towns by future-proofing new communities for the health and care challenges of this new century – obesity, dementia, new models of digital health, by designing in health and modern care from the outset.

2.2 The objectives of the programme were:

- Designing in healthy living (developing new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent;
- Capitalising on new home-based care and technologies to support older people at home;
- Sharing infrastructure across public services to make smarter use of taxpayer investment;

- Making learning available to other national programmes as well as other local areas and to show what is possible when we radically rethink how health and care services could be delivered, freed from the legacy constraints.

2.3 The NHS was seeking long-term partnerships from across the country covering housing developments that meet the following criteria:

- Are in areas identified for future population growth or housing need (e.g. in regional or local plans);
- Are in the pre-application, pre-master planning or master planning phase;
- Are planning schemes of at least 250 homes (with no upper limit on the size of a development);
- Have the active backing of the relevant local authorities even if subsequent planning decisions are outstanding;
- Applications from local authorities, housing associations and the construction sector (as well as other key stakeholders who could form a broader coalition or partnership, including the Local Planning Authority).

2.4 Led by Cherwell District Council, representatives from a range of local health sector organisations, local government, the voluntary sector and A2Dominion - the NW Bicester lead developer, submitted a partnership based expression of interest (EoI) and then, following long-listing from the 114 EoIs nationally, a presentation for a day's 'Dragon's Den' shortlisting event was held on 3 February 2016. On 1 March 2016, the NHS announced 10 shortlisted bids to become part of the Programme, of which Bicester and Barton were included.

3.0 Report Details

The Bicester Healthy New Town Partnership

3.1 The lead partners who presented to the NHS and have shaped the proposal so far are:

Ian Davies - Director of Operational Delivery, Cherwell District Council
Rosie Rowe - Head of Provider Development (Out of Hospital Care), Oxfordshire Clinical Commissioning Group
Dr Nick Scott-Ram - Director of Commercial Development, Oxford Academic Health Science Network
Louise Caves - Strategic Partnerships Manager, A2 Dominion Housing Group
Jenny Barker - Bicester Delivery Manager, Eco Bicester Project Team, Cherwell District Council

3.2 The wider Bicester partnership contains the following additional organisations:

NHS England South, Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Trust, Oxfordshire County Council, Bicester Town Council, Oxford Brookes University, Oxford University, Age (UK) Oxfordshire, Healthwatch Oxfordshire, Bicester Locality Patient Forum, North Oxfordshire Community Partnership Network, ISIS Innovation, ONEFED GP Federation, Health Education Thames Valley, Oxfordshire Sport and Physical Activity, Oxfordshire Local Enterprise Partnership and the Oxfordshire Health and Wellbeing Board.

3.3 The partnership already has an 'engine of innovation' in the Eco Bicester Living Lab set up by Bioregional and Oxford Brookes University to provide support for research and innovation and the Digital Health Network led by Oxford University, ISIS Innovation and the Oxford AHSN to improve health outcomes through providers of innovative digital technologies and health services.

The Bicester Healthy New Town Bid

3.4 The bid focuses on Bicester - a market town that is planned to near double in size, including the innovative national exemplar Eco Town development at North West Bicester led by A2Dominion. The HNT Initiative provides the opportunity to develop further the innovations at NW Bicester and to identify the impacts they have on public health and be replicated across the later phases of large scale planned growth for the town, other areas of the town and elsewhere in the county and country. Bicester will have 26,000 homes that will be available across the whole town, of which 13,000 will be new homes including 6,000 in the exemplar Elmsbrook at NW Bicester Eco development. The first phase of this is the 393 home Elmsbrook site, with the first occupations taking place from summer 2016.

3.5 At Elmsbrook there is a built environment which will be **a catalyst for Healthy Living** through:

- Its **integrated design**, featuring highly energy efficient, adaptable homes that support independent living within a well-designed public realm, where 40% of the site will be multi-functional green active space supported by a network and hierarchy of safe cycle and walking routes with accessible public transport.
- Digital, community and travel connectivity functions which are hard wired into the design. Digitally enabled communities with smart tablets called Shimmy's in every home to encourage healthy lifestyles with real-time energy, travel and community information.
- A community and physical infrastructure to promote and actively engage residents to live **healthy lives** as the norm.

3.6 The scale of development in Bicester is such that lessons from early developments such as NW Bicester can be used to inform further town development and innovation in the built environment and community buildings. This learning will be relevant countywide and nationally as the level of housing delivery increases to meet the country's need. The Healthy New Town Programme at Bicester is focusing on the whole town and how the new housing can improve the health and wellbeing of all residents.

3.7 Bicester was identified in NHS England's 5 Year Forward View as a Garden Town offering opportunities to deliver innovative health and social care to its rapidly growing population. The scale of the development creates opportunities to:

- Improve **access** to health and social care services;
- Facilitate **early detection and prevention** through active monitoring and management;
- Assist the **management of long term conditions** to improve outcomes;
- Help individuals **remain in their own homes and communities**.

3.8 These objectives will be achieved through:

- Delivering a **greater number of services locally** than traditionally available in general practice;
- Using **new technologies** within the home, health and social care settings;
- **Enhanced integration** between health and care, housing, transport, and other public services, and of services (between primary and secondary care, mental and physical health, health and social care, and preventative and treatment services);
- Using a **place based approach** to funding of health and social care services and expanding outcome based contracts currently in place;
- Developing **workforce initiatives** that deliver health and social care in innovative ways.

3.9 The Bicester HNT Programme has developed three multi-agency work streams – the built environment, community activation and new models of health and social care. It is these which are the main focus for delivering innovation and change.

3.10 Digital Innovation is a key enabler for all three work streams and is led by Oxford Academic Health Science Network. This includes new digital technologies and health related applications to promote self-diagnosis, self-monitoring and self-care. To consider the optimum approach to matching the needs of the Bicester HNT with the technology opportunities available and how such technologies could be introduced. This is to include the joint development of A2D's Shimmy tablet and the public need to adopt an inclusive and healthy lifestyle.

Bicester HNT Vision and key objectives

3.11 The aim of the Bicester Healthy New Town Programme is to enable people who live or work in Bicester to live healthier lives and to prevent ill health in the future. The two key **priorities** for the programme are:

- To reduce the number of people who are overweight or obese in order to prevent future health problems;
- To reduce the number of people who feel socially isolated in order to improve mental wellbeing.

The programme aims to improve both the physical and mental health of everyone in Bicester – the existing community as well as those moving to the town.

3.12 The following is an explanation of the three work streams with the key objectives which have been developed for each:

Built Environment: making the best use of Bicester's built environment to encourage healthy living – led by Cherwell District Council. This includes the healthy living aspects for all ages of the urban and built environment of new developments in Bicester, with learning from what's being implemented at NW Bicester – energy efficient and life time adaptable homes, cycle ways, walkways, sustainable transport, public transport, urban design especially physical connectivity and accessibility, multi-activity open space, green corridors and community assets.

- Going for Green - to maximise the use of Bicester's green spaces for healthy living;
- To create a 'walkable and cycleable community' with a comprehensive walking and cycling network;
- To develop planning policies which support the creation of a healthy environment.

Community Activation: helping local people to live healthier lives with the support of community associations, schools, and employers. This is led jointly by A2Dominion and Cherwell District Council and revolves around people based activities and the social support infrastructure. It therefore includes the voluntary sector, new and emerging local groups, education and learning opportunities, healthy lifestyle activities and programmes, social inclusion programmes, carers etc.

- To build better connected communities with the creation of a network of volunteer community activators;
- To support schools, nurseries, colleges and families to get young people more active and eating healthily in order to increase their physical and mental wellbeing;
- To encourage local workplaces to promote health and wellbeing at work.

New Models of Care: Creating care closer to home: led by Oxfordshire CCG, this includes adopting the care closer to home principle plus full social and health care service integration and remodelling by providers and commissioners. Exploration of new models of care and patient activated self-care where appropriate.

- To create a 'primary care home' with integrated community health and social care supporting GP clusters to care for people with complex care needs;
- To deliver new care pathways for long term conditions which minimise hospital based outpatient care (focusing first on diabetes);
- To plan to meet future care needs through the provision of primary and community care from health campuses in the town.

3.13 Workshops with Bicester Healthy New Town partnership members and local experts were held on 26 May and 28 July 2016 in order to develop further detail of the activities of these work streams and priority areas for focus. A further workshop attended by 70 local Bicester stakeholders on 6 October 2016 was held to engage local community leaders and organisations with the programme, to check that its priorities reflected local concerns, and to enable them to shape further development of the programme. This was a most valuable exercise which greatly assisted in identifying the current activity, initiatives and relevant organisations to be engaged in the HNT programme and to finalise the draft action plan contained at Appendix 1.

3.14 Evaluation of the programme and its impact is being guided by a Local Evaluation Advisory Group comprising interested local academics from Oxford University and Oxford Brookes University. Their research expertise in public health, the built environment, primary care, public engagement, and digital innovation is helping to develop an evaluation framework that will identify which elements of the programme work, for whom, and why so that this learning can be shared more widely.

Air Quality Issues in Bicester

3.15 Air quality is a matter which has been identified previously by the Health Improvement Board as having relevance to its remit. It is also of relevance to creating a healthy new town in Bicester and hence, the latest position is detailed here.

3.16 As part of its statutory duties Cherwell District Council has conducted a review and assessment of air quality in Cherwell against national air quality objectives. This review confirmed the air quality objective for nitrogen dioxide was being exceeded at four locations in the District and Air Quality Management Areas (AQMAs) were subsequently declared for these areas. The AQMAs are at:

- Hennef Way in Banbury
- Horsefair/North Bar in Banbury
- Bicester Road in Kidlington
- Kings End/Queens Avenue in Bicester

3.17 A draft Air Quality Action Plan (AQAP) for Banbury, Bicester and Kidlington to improve air quality in these areas has been produced for the purpose of consultation. As road transport sources are the cause of the problem in each AQMA, the AQAP has been developed in consultation with Oxfordshire County Council as the local Highways Authority.

3.18 The action plan has to be realistic and reflects the current priorities and resources available to the Council and the highways authority. At this stage, all possible actions have been put forward for consideration and so some of the proposals are preliminary or relatively broad and will require further work before they can be quantified in terms of costs and benefits. Appendix 2 contains relevant extracts from the draft AQAP with specific detail about Bicester.

3.19 Particularly relevant and a challenge here is the need to consider the effects of new development with increased traffic movements on air quality and how this plan can contribute to new developments. Commuters in Bicester travel relatively long distances to work and therefore reducing travel by car, managing traffic congestion and maximising the opportunity to shift from car dependency to sustainable modes of transport are the key challenges which are recognised in the draft plan. This approach is also consistent with the Bicester HNT programme which therefore supports the AQAP.

3.20 The Air Quality Action Plan is currently the subject of public and stakeholder consultation. Statutory consultees include the local Highways Authority, Defra (on behalf of the Secretary of State), Highways England, Environment Agency, Public Health England, Oxfordshire Public Health, and Neighbouring Authorities.

3.21 Bodies representing local business interests, Parish Councils and other relevant local interest groups are also being consulted on the draft AQAP. Information has been placed on the website and a press release issued to inform the wider community. Residents within the AQMAs have been sent a letter with details of the consultation and where to find relevant information.

3.22 Cherwell DC is establishing a Steering Group to consider the proposals further and the first meeting is arranged for October 2016. The Steering Group will also

consider responses to the wider consultation which will take place from mid-September until the end of December 2016.

3.23 The final Air Quality Action Plan for the District with the proposed actions relevant to each AQMA is planned to be submitted for consideration by Cherwell District Council executive at its meeting on the 6 March 2017.

4.0 Conclusion and Reasons for Recommendations

4.1 The scale and nature of Bicester's development has provided an excellent opportunity to be enhanced through the NHS England Healthy New Town programme. NHS England has recognised this in its shortlisting of Bicester to participate along with the offer of a range of support including financial.

4.1 A wide multi-disciplinary and multi-sector partnership group form Bicester and Oxfordshire has responded very positively to this initiative and good progress has been made to turn intent into action.

4.2 The risk of poor air quality in Bicester and three other sites in Cherwell has been identified and a draft action plan developed to improve this.

Document Information

Appendix No	Title
1.	Bicester Healthy New Town Progamme Action Plan
2.	Draft Cherwell Air Quality Action Plan Extracts
Background Papers	
Report Author	Rosie Rowe, Bicester Healthy New Town Programme Director
Contact Information	Rosie.rowe@cherwell-dc.gov.uk

APPENDIX 1

Bicester Healthy New Town Programme: Draft Delivery Plan October 2016-March 2017

The following briefing identifies an outline plan of activity for the next six months. These initial ideas will be discussed with stakeholders in October to amend, refine, and add to them as well as to identify actions that need longer term planning for delivery in 2017-18.

Item	Deliverable by 31 December 2016	Deliverable by 31 March 2017	Lead Agencies
Built Environment			
1. Going for Green - maximising the use of Bicester's green spaces for healthy living	- Design to be developed for Community Notice Board to include information on Bicester cycle paths and links to green spaces - Produce a guide to the green spaces in the town including walking and cycling information	- New cycling map showing links to green spaces to be launched on website/Bicester app and in leaflets and on Community Notice Board - Develop movers/new residents information pack encouraging cycling/walking/volunteering	Cherwell District Council and Bicester Town Council
2. Creating a 'walkable and cycleable community' with a comprehensive walking and cycling network	- Wayfinding scheme – procurement of signage design and commencement of installation. Signage to provide information about walking and cycling distances between key destinations in Bicester - Consultation on the master plan for Bicester to include questions to understand barriers to cycling and walking -	- Agreed how use of cycling and walking routes to be monitored	Cherwell District Council
3. Develop planning policies that support the creation of a healthy environment	- Training session for planners re: developing healthy environments with public health experts	- Training session for planners re: developing age friendly environments - Round table with town planners to embed active design principles and policies to support healthy environments - to be included in Master plan, Local	Cherwell District Council and Oxford County Council (Public Health)

		Plan and Local Transport Plan - Agree approach and protocol to enable Public Health, Sport England and Age UK to review and influence development proposals to ensure that they deliver active and inclusive environments to support health and wellbeing	
Community Activation			
4. Building better connected communities with the creation of a network of volunteer community activators	- Local Stakeholders Workshop to secure input into and engagement with HNT programme from local community leaders - Input into pilot of AMI site to support befriending and peer to peer support - Plan for how voluntary sector will engage with the programme - ***SPARK fund*** set up and local organisations offered opportunity to seek seed corn funding to assist delivery of the HNT objectives - Participate in Parish Liaison meeting and Knowing your Communities events, Older People's Day Information Fair (30 Sept) and Health Fair (14 Oct) to engage local community with plans - Bid submitted for Innovate funding to test new way of digital engagement with local authorities on use of green spaces/leisure facilities	- Plans confirmed for how voluntary sector are to engage with the programme - £20K of SPARK funding allocated to support community groups - Pilot of peer to peer function on AMI site to have started - Review 'gift survey' with IMB in Elmsbrook - Planning of the public launch of HNT programme in late April/early May to be well advanced	Cherwell District Council
5. Activation of schools, nurseries and colleges, and families to get young people	- Engagement offer developed for schools/nurseries/colleges to engage with the programme	- Round table of school reps held to confirm plans for school engagement with the programme	Cherwell District Council and Bicester Schools Partnership and OXSPA

active and increase their physical and mental wellbeing	- Attend Schools Partnership Council to seek support	- Round table of nursery and pre-school providers to confirm plans for their engagement with the programme - Bid submitted to be one of 10 place based sites for Sports England funding	
6. Activation of workplaces to promote health and wellbeing at work	- Engagement offer developed for workplaces/local employers to engage with the programme	- Local employers signed up to engage with the HNT programme - Discussions held with local retailers re: offering healthy food options - Provide brief intervention training to mulit-sector group	Cherwell District Council and OXSPA
New Models of Care: Creating care closer to home			
7. Creating a 'primary care home' with integrated community health and social care supporting GP clusters to care for people with most complex care needs	- Community services, primary care and social care to identify workforce needs for new models of care - Develop pilot to test use of a 'care bank' to support complex patients at high risk of admission over the weekend	- New model of care for how primary care and community services can be further integrated and the potential future role of Bicester community hospital to be out for public engagement - Primary, community and social care to have tested new ways of working to promote more coordinated care - Run pilot and evaluate impact of 'care bank'	Oxfordshire Clinical Commissioning Group (OCCG)
8. Delivery of new care pathways for long term conditions which minimise hospital based outpatient care (focusing first on diabetes)	- Pilot to test virtual diabetes clinics to have started - Liaison with Digital Health Oxford to identify opportunities to link up with digital innovators - Agreed how shimmy tablet in NW homes can link to health information and advice	- Diabetes pilot of new pathway for managing longterm conditions to be fully mobilised	OCCG

9. Planning to meet future care needs through the provision of primary and community care from health campuses	- Local Plan to be updated with primary care estates requirements to meet population growth - Case for contribution to health infrastructure to be updated for use by planners	- Round table held with local residents to identify how digital innovation can support their health and care needs and promote wellbeing - *Hackathon* held with local digital innovators to identify opportunities for meeting these needs	Cherwell District Council and OCCG

APPENDIX 2

Extracts from and Summary of Current Air Quality Action Plan in the Cherwell District

Introduction

Oxfordshire County Council's Joint Strategic Needs Assessment (JSNA) provides information about Oxfordshire's population and the factors affecting health, wellbeing, and social care needs. Air quality is included in Section 4.2.8 of the 2016 JSNA under the "Wider Determinants; Environment" section and recognises:

- Poor air quality is known to have negative impacts on health.

- In the more densely populated areas of the county, and those which experience high traffic flows, increased levels of air pollution are of concern. In these areas, road traffic is the most significant source of pollutant emissions.

- There are currently 13 AQMAs in Oxfordshire, where the annual mean objective for nitrogen dioxide is being exceeded (four in Cherwell, one covering the whole of Oxford, three in South Oxfordshire, three in Vale of White Horse and two in West Oxfordshire).

- Trends in air quality across some of Oxfordshire's long-standing AQMAs show signs of improvement, with reductions in concentrations of nitrogen dioxide over recent years. However, new AQMAs are still being identified.

- Air Quality and Mortality Estimates In 2010 the UK Committee on the Medical Effects of Air Pollutants estimated that removing all man-made, particulate matter air pollution could save the UK population approximately 36.5 million life years over the next 100 years, and would be associated with an increase in UK life expectancy from birth, of six months on average.

- The calculated attributable proportion of deaths associated with air pollution, among those aged 25 and over in Oxfordshire, was 5.6% in 2010. However, given the uncertainties this could, in fact, be somewhere between 0.9% and 11%. For 2013 it was estimated that 5.3% of all-cause mortality among people aged 30 and over in Oxfordshire was attributable to particulate air pollution from man-made sources. This value has fluctuated between 5.1% and 5.6% over the years between 2010 and 2013 but it is not possible to tell whether or not changes are statistically significant.

- The national and regional averages in 2013 were 5.3% (England) and 5.2% (South East). Meanwhile, the proportion of mortality attributable to man-made air pollution in the districts ranged from 5% (in West Oxfordshire) to 5.6% (in Oxford) with the other three districts at 5.3%.

- The quantification of mortality burden associated with long term nitrogen dioxide concentration exposure is not currently available.

Cherwell District's Air Quality Priorities

Cherwell District Council has identified four areas where air quality does not meet national air quality objectives for nitrogen dioxide (ie above 40). The locations of these four Air Quality Management Areas (AQMAs) can be found on our website at www.cherwell.gov.uk/airqualitymanagement. There are two in Banbury, one in Bicester and one in Kidlington. These concentrations are largely related to road traffic emissions.

AQMA No.1 in Hennef Way exceeds the annual and hourly mean objectives for nitrogen dioxide.

AQMA No.2 between Oxford Road to Southam Road, Banbury, including a section of High Street exceeds the annual mean objective for nitrogen dioxide.

AQMA No.3 on a section of Bicester Road, Kidlington to the north of the Water Eaton Lane controlled junction exceeds the annual mean objective for nitrogen dioxide.

AQMA No.4 between the mini roundabout in Kings End through Queens Avenue to the Field Street mini roundabout, including St Johns, exceeds the annual mean objective for nitrogen dioxide.

The latest monitoring indicates nitrogen dioxide concentrations are trending downwards in most places. This includes within the AQMAs, although concentrations in the AQMAs remain above the national air quality objective levels for nitrogen dioxide.

The four AQMAs which have been identified are where people are exposed to sufficiently poor air quality to require legal intervention under the Environment Act 1995, hence the Cherwell action plan.

These AQMAs are localised areas representing the worst affected places. The main source of pollutants in these AQMAs is traffic emissions. Traffic emissions aren't

localised i.e. journeys originating and terminating within the AQMA so measures to address emissions district-wide are collated as general measures.

The AQAP measures presented in this report are intended to be targeted towards the predominant sources of emissions within Cherwell District's area. A summary of sources is shown in the table below.

Summarised NO_2 concentrations in AQMAs apportioned by source

AQMA	NO_2 Concentration	% NO_2 by Source				
		Background	Cars	LGVs	HGVs	Buses
1 (Hennef Way)	59.8 µg/m^3	32%	39%	17%	10%	2%
2 (Banbury)	40.9 µg/m^3	32%	39%	13%	10%	6%
3 (Kidlington)	41.1 µg/m^3	35%	41%	9%	6%	9%
4 (Bicester)	46.0 µg/m^3	27%	50%	8%	2%	13%

[a] 2015 Concentrations above 40.0 at relevant exposure reported in ASR 2016

It is anticipated that most general measures to reduce emissions will also contribute to reducing $PM_{2.5}$ emissions from vehicles.

Where local measures to reduce pollutant concentrations are identified, these measures have been related to that specific AQMA.

Key Priorities

The key priorities for action are:

- Priority 1 – Strengthening local policy to improve air quality and its role in protecting health;
- Priority 2 – Reducing NOx emissions from cars in all AQMAs;
- Priority 3 – Ensuring new developments encourage and facilitate low emission and alternative transport;
- Priority 4 – Ensuring transport infrastructure delivery takes account of air quality improvement potential within AQMAs;
- Priority 5 – Raising awareness of poor air quality and encouraging improvement actions by vehicle users and fleet managers.

The following represents the Cherwell Air Quality Action Plan draft actions applicable to all its AQMAs.

Air Quality Action Plan General

Measure No.	Measure	EU Category	EU Classification	Lead Authority	Planning Phase	Implementation Phase	Target Pollution Reduction in the AQMA	Progress to Date	Comments
G.1	Explore Local Plan including Low Emission Vehicle uptake measures incorporated into all new developments	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	CDC	2016/17	2017	medium		
G.2	All major developments to include emission statements and mitigation strategies within an appropriate air quality assessment submitted at the application stage.	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	CDC	2016/17	2017	medium		

Air Quality Action Plan General

Measure No.	Measure	EU Category	EU Classification	Lead Authority	Planning Phase	Implementation Phase	Target Pollution Reduction in the AQMA	Progress to Date	Comments
G.1	Explore Local Plan including Low Emission Vehicle uptake measures incorporated into all new developments	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	CDC	2016/17	2017	medium		
G.2	All major developments to include Emission statements and mitigation strategies within an appropriate air quality assessment submitted at the application stage.	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	CDC	2016/17	2017	medium		
G.3	Damage cost calculations to be included in air quality assessments to show the financial impact of developments.	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	CDC	2016	2016	low	n/a	

Measure No.	Measure	EU Category	EU Classification	Lead Authority	Planning Phase	Implementation Phase	Target Pollution Reduction in the AQMA	Progress to Date	Comments
G.4	Major developments in or within 100 metres of an AQMA will be air quality neutral	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	CDC	tbc	tbc	low	n/a	All major developments within 100 metres of an AQMA will be air quality neutral to avoid impacting the local background NOx contribution.
G.5	Travel plans submitted with development proposals will make reference their contribution to the mitigation strategy and progress will be reported to CDC for 5 years post development completion.	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	OCC / CDC	tbc	tbc	low		Travel plans should address air quality specifically and be reported in such a fashion they can be included in the Annual status report.

Measure No.	Measure	EU Category	EU Classification	Lead Authority	Planning Phase	Implementation Phase	Target Pollution Reduction in the AQMA	Progress to Date	Comments
G.6	Air Quality actions to be included in the Local Transport Plan	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	OCC	2015	2016	medium	LTP4 (2016 update) includes an annex on actions to address air quality	Ongoing measure development and updates to LTP4 to represent changes in air quality. Maintain close links between OCC and CDC.
G.7	Air Quality included in the Public health framework Joint Strategic Needs Assessment	Policy Guidance and Development Control	Air Quality Planning and Policy Guidance	OCC	2015	2015	low	JSNA includes statement on air quality	JSNA includes air quality. To maintain, update and progress actions as part of the annual review process.
G.9	Include low emission vehicles in taxi licensing policy to encourage their take up and use within the district.	Policy Guidance and Development Control	Other Policy	CDC	2016	2017	low		Taxi licensing policy is currently being revised.

Measure No.	Measure	EU Category	EU Classification	Lead Authority	Planning Phase	Implementation Phase	Target Pollution Reduction in the AQMA	Progress to Date	Comments
G.10	Low emission plant, vehicle, delivery and fleet requirements to be included in sustainable procurement section of CDC procurement policy.	Policy Guidance and Development Control	Sustainable procurement guidance	CDC	2016	2017	low		
G.11	Low emission plant, vehicle, delivery and fleet requirements to be included in sustainable procurement section of OCC procurement policy.	Policy Guidance and Development Control	Sustainable procurement guidance	OCC	2016	2017	medium		

The following represents the specific air quality actions relevant to Bicester

AQMA No.4 Bicester Air Quality Action Plan

Measure No.	Measure	EU Category	EU Classification	Lead Authority	Planning Phase	Implementation Phase	Target Pollution Reduction in the AQMA	Progress to Date	Comments
4.1	Bicester Park and Ride Bus service	Alternatives to private vehicle use	Bus based Park & Ride	OCC	2015	2016	medium	Delivered	Potential to include alternative vehicle charging at this site to encourage low emission vehicle transport
4.2	Priority parking for lift share permit holders in CDC owned car parks	Alternatives to private vehicle use	Car & lift sharing schemes	CDC	tbc	tbc	low	tbc	Lift share permit system and assign priority parking for permit holders.
4.3	Bicester wide car club	Alternatives to private vehicle use	Car Clubs	OCC	2016	tbc	low	tbc	A2 dominion administers a car club for the Elmsbrook development. Assess feasibility for wider Bicester area.
4.4	Promote Oxford Parkway station for journeys into Bicester	Alternatives to private vehicle use	Rail based Park & Ride	OCC	tbc	tbc	low	tbc	Oxford Parkway alternative to travel to Bicester.
4.5	Low emission delivery plans	Freight and Delivery Management	Delivery and Service plans	OCC	tbc	tbc	low	tbc	Assess feasibility to introduce low emission delivery vehicle requirements.
4.6	Bicester active travel i.e. walking and cycling campaign	Promoting Travel Alternatives	Intensive active travel campaign & infrastructure	CDC	2016	2017	high	tbc	Healthy town to encourage active travel i.e. walking and cycling

Measure No.	Measure	EU Category	EU Classification	Lead Authority	Planning Phase	Implementation Phase	Target Pollution Reduction in the AQMA	Progress to Date	Comments
4.7	Identify school journeys on this route to monitor and promote school travel plans	Promoting Travel Alternatives	School Travel Plans	OCC					
4.8	Wayfinding campaign	Promoting Travel Alternatives	Other	CDC	2016	2017		tbc	Wayfinding campaign to signpost walking and cycling routes around Bicester.
4.9	Central corridor works in LTP	Traffic Management	Strategic highway improvements, Re-prioritising road space away from cars, inc Access management, Selective vehicle priority, bus priority, high vehicle occupancy lane	OCC					

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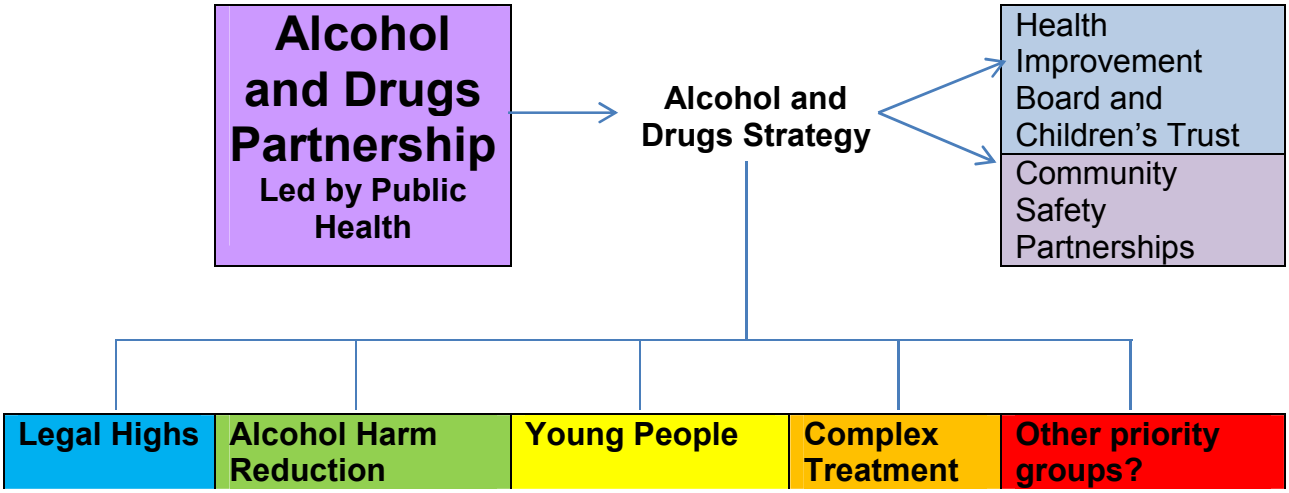
Alcohol and Drugs Partnership Annual Report 2015-16
Executive Summary

The Alcohol and Drugs Partnership in Oxfordshire was set up during 2014 to enable partnership working on prevention, early intervention and treatment of substance misuse issues across the county. It is clear that much more can be achieved across this spectrum of work when organisations work together. This is in addition to the work that each organisation already delivers as "business as usual", such as the commissioning function of the Public Health team and law enforcement by the police.

The governance set up for the delivery of the strategy is illustrated in this diagram:



The Annual Report gives an update on the work that has been going on to address these priorities. It is set out by theme and each section has been written by the leads of the working groups. A review and update on the latest trends for alcohol and drugs related harm is also included in the report.

The conclusions reached show that although progress has been made on each of the priority areas, there is still more to be done. Working groups have outlined their ambition for the year ahead within their reports and it is hoped that this work will continue to develop and make a difference. Local perspectives are needed to enable this. Highlights from each of the work areas are laid out below.

Priority 1: Reduce/ stop the demand and supply of New Psychoactive Substances (NPS) or "Legal highs" in Oxfordshire

There has been progress in the following areas:

a. The local supply of NPS has been disrupted through the work of Trading Standards and Thames Valley Police. Head shops in the City have closed and a prosecution is being brought. Internet sales of NPS still continue.
b. The use of NPS in Oxfordshire is being explored. Recording of use of NPS from the Emergency Department, homeless hostels, mental health services and other sources has been initiated. Indications are that the use of "Spice" is causing the most profound health and behaviour problems.

c. Training was delivered jointly and was attended by those working with young people and also those working with homeless people. Emphasis was on dealing with behaviours caused by NPS use.
d. Campaigns included outreach at festivals including Cowley Road Carnival, Henley Regatta, Rock in the Park. Feedback was given to the Safety Advisory Group for Cowley Rd Carnival.
e. The Working Group has shared good practice, kept up to date with national developments and set an action plan for 2016-17.

Priority 2: Work together on alcohol harm reduction projects

Successful work in 2015-16 included

a. Commissioning and delivering a series of training sessions for Identification and Brief Advice on alcohol – enabling a range of practitioners to raise the issue with clients and advise on how to reduce alcohol intake.
b. A major conference on Alcohol was held in December 2015 with over 140 delegates attending.
c. Officers in Fire and Rescue have been trained to give brief advice on smoking and alcohol use where appropriate – as a fire prevention initiative and for health improvement.
d. The Dry January campaign targeted women to help them think about how much they are drinking. A competition was run by Heart FM and the winner was rewarded with a Pamper Day.
e. Work in Community Safety with Thames Valley Police aims to reduce selling to people already intoxicated, and scoping a Club Angels project.

Priority 3: Reduce the number of young people engaging in risky behaviours and continue to improve the approach to early intervention

Recent work on this theme has included

a. Initiatives to reduce alcohol related attendance at A&E by young people, including referral of those young people to support services (and MASH when appropriate) and information on services for young people to self-refer.
b. More work with young people whose parents misuse substances, including a play worker based in Early Intervention Services.
c. Training on the impact of New Psychoactive Substances for School Health Nurses, teachers and others who work with young people.
d. Improving links between services, such as The Training Effect who deliver programmes in secondary schools linking with CAN (the young people substance misuse service) and School Health Nurses.

Priority 4: Improve the way we commission services to provide better pathways for people with complex needs, with a focus on recovery from addiction

This work has concentrated on closer working between substance misuse services and mental health services. This has resulted in

a. Joint working protocol between Oxford Health and Turning Point for Dual Diagnosis.
b. Identification of 4 key areas for working with complex needs: consistency of key worker, early identification of a dual diagnosis, communication, involvement in social and physical activity.

Jackie Wilderspin, April 2016

Oxfordshire Alcohol and Drugs Partnership

Annual Report 2015-16

Reporting to:

Health Improvement Board
Children's Trust
Safer Oxfordshire Partnership
All partners

OXFORDSHIRE COUNTY COUNCIL

Jackie Wilderspin, Public Health

Introduction

The Alcohol and Drugs Partnership in Oxfordshire was set up during 2014 to enable partnership working on prevention, early intervention and treatment of substance misuse issues across the county. It is clear that much more can be achieved across this spectrum of work when organisations work together. This is in addition to the work that each organisation already delivers as "business as usual", such as the commissioning function of the Public Health team and law enforcement by the police.

The main feature of the work in 2014-15 was the development of an Alcohol and Drugs Strategy for the county. This was discussed and adopted by the Oxfordshire Safer Communities Partnership, the Health Improvement Board and The Children's Trust. The strategy set out 4 priority areas of work and an intention to continue to monitor the situation in Oxfordshire so that emerging priorities can be identified and addressed early. The priorities are:

1. Reduce/ stop the demand and supply of New Psychoactive Substances (NPS) or "Legal highs" in Oxfordshire.
2. Work together on alcohol harm reduction projects.
3. Reduce the number of young people engaging in risky behaviours and continue to improve the collaborative working approach to early intervention.
4. Improve the way we commission services to provide better pathways for people with complex needs, with a focus on recovery from addiction.
5. Share intelligence and data across organisations to better understand the needs of specific and vulnerable groups of the population.

The Executive Summary of the Alcohol and Drugs Strategy is included in Appendix 1

This report gives an update on the work that has been going on to address these priorities. It is set out by theme and each section has been written by the leads of the working groups. A review and update on the latest trends for alcohol drugs related harm is also included in the report.

The conclusions reached show that although progress has been made on each of the priority areas, there is still more to be done. Working groups have outlined their ambition for the year ahead within their reports and it is hoped that this work will continue to develop and make a difference.

Contents of this report

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- Priority 1: Legal Highs (New Psychoactive Substances) page 3
- Priority 2: Alcohol harm reduction page 7
- Priority 3: Young people page 11
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Appendix 1: Alcohol and Drugs Strategy Executive Summary page 20

Priority 1: Reduce/ stop the demand and supply of New Psychoactive Substances (NPS) or "Legal highs" in Oxfordshire

What we wanted to achieve in 2015-16

a. Disrupt and reduce / stop supply of New Psychoactive Substances (NPS)
b. To understand the prevalence of use of NPS in Oxfordshire
c. Train and inform staff to enable them to identify use of NPS and respond appropriately
d. Campaigns and information on NPS that makes it clear that "legal" does not mean "safe".
e. Share best practice and learn from others, building networks of people involved in this work.

Why this was important

The Alcohol and Drug Strategy set out the following information:

> 'Traditional' illicit drug use is going down but the impact of the internet has changed the marketplace and made different substances more accessible to a wider audience than ever before. "Legal Highs" or New Psychoactive Substances (NPS) are presenting a unique and new set of challenges to public facing services. As NPS are not yet covered by the Misuse of Drugs Act (1971), it makes restricting the sale and distribution of these products very difficult.
>
> Limiting the harm caused by these substances in a treatment setting is very difficult for clinicians as the chemical content varies widely and their effects on the human body are not well understood.
>
> Due to the nature of NPS there is a current lack of data at both a national and a local level. In Oxfordshire attendance at the emergency department due to NPS use cannot be reported accurately as there are issues in identification and classification of the substances.

Achievements in 2015-16

a. <u>Disrupt and reduce / stop supply of NPS</u>

Trading Standards and police operations have succeeded in stopping the supply of NPS through a "head shop" on Cowley Road and in bringing a case to prosecution. This will be heard in the Crown Court in the summer of 2016. Partners have helped to strengthen the prosecution case. Regular reports show that there is now no local supply through retail outlets, though internet supply remains.

The Psychoactive Substances Act will come into force in 2016 though the April date for enactment has been postponed. Preparations are being made for enforcement and the emphasis will shift from Trading Standards to the police to control supply. All Police areas in Oxfordshire now have appointed nominated officers to lead on

NPS. There is a proposal has been made that will eventually provide data on where NPS is a factor in more serious police incidents.

NPS remains part of the current syllabus for annual Police Use of Force refresher training and TVP have done some work recently with the ambulance service to create a training package for front line crews on NPS.

b. Understand prevalence of use of NPS in Oxfordshire.

A pilot scheme to collect local data was established and has been running for a year. Quarterly reports are requested from a range of local agencies including Forensic wards at Littlemore Hospital, hostels for homeless people in Oxford and the Accident and Emergency Dept.

A summary of the local data is given below.

- Data collected from some local homeless organisations, A&E and Forensic Mental Health services (not all submitted data during the whole time period).
- Between May 2015 and January 2016 there were 50 recordings of NPS use (most were through A&E).
- Many recordings of individuals smoking “Spice” (Synthetic Cannabinoids); particularly true among homeless population.
- Other named substances include MDMA, Mkat and Synthetic Cannabis, among others.
- Most users were thought to smoke their substance of choice and did so daily; swallowing was also recorded with only two recorded as injecting.
- The majority of cases indicated frequency of use as daily with many being more frequent than once daily.
- Sex of the user was not recorded; where age group was recorded most were less than 45 years, with around a third of these less than 25 years.
- Effects noted (usually two or three in each individual) were paranoia, erratic behaviour, incoherence, drowsiness, stumbling, slurred speech, emotional behaviour, vomiting, anxiety and low blood pressure.
- Possible harms as a result of taking NPS were also recorded – falling (not in full control), neglecting personal hygiene, arrest and lack of motivation.
- Whilst most did not report where an item was purchased, residents within homeless shelters were likely to have obtained from another resident or ex-resident.

Note: This information gives only a brief overview of use of psychoactive substances during this time period in Oxfordshire. Information was collected from a small group of organisations where instances of psychoactive substances were suspected. It id possible that news of impending legislation affected service users’ willingness to be as open about their NPS use as they had been previously.

It was agreed that future campaigns and training for front line workers, including School Health Nurses, should focus on the synthetic cannabinoids as these are

causing the most concern for health and behaviour. This is indicated by this local data and also national trends.

c. Train and inform staff to enable them to identify use of NPS and respond appropriately

A training event was organised and run in November 2015. This was a joint training event between Turning Point, CAN, The Training Effect and Oxford Health. The morning was organised so that all delegates could hear presentations about impact of NPS on behaviour and then attend workshops. The workshops were designed for professionals working with young people and those working with adults, especially homeless people.

Attendance at this training event was high and feedback was very good. In particular the trainers had concentrated on highlighting the behaviours associated with NPS use rather than on the "types" of NPS. It is likely that in future the needs of those working with adults will probably be met through the training programme being run by Turning Point but more combined training events will be run for those working with young people.

d. Campaigns and information on NPS that makes it clear that "legal" does not mean "safe".

Outreach and information campaigns at festivals during the year had mixed success. The presence of Turning Point and CAN at Cowley Carnival was successful and resulted in good contact with the public. Attendance at Henley Regatta and Rock in the Park did not lead to contact with the target audience. Applications to attend other major festivals in the county were made too late or were declined.

Approaches have been made to some licensing authorities to request changes to the conditions of the licenses granted to festivals, or changes to guidelines issues by Safety Advisory Groups.

Feedback from A&E and mental health services was given to the debriefing session for Cowley Road Carnival which showed no increase in NPS related harm. This set a helpful precedent for health service data being used in this way.

e. Share best practice and learn from others, building networks of people involved in this work.

Each meeting of the Legal Highs Working Group has included updates and sharing of best practice among partners. This has included

- Presentation on the Public Health England NPS toolkit for commissioners
- Briefing on the NPS Act 2016
- Intelligence on substances causing concern
- Sharing leaflets and other health promotion materials
- Preliminary results from a survey of school pupils in Oxfordshire by the Training Effect.
- Information on toxicity of substances has been made available to emergency department clinical staff.

The Legal Highs working group

Councillor Hilary Hibbert-Biles,	Cabinet Member for Public Health
Richard Webb &	
Paula Bonham-Samuels	Trading Standards
Insp Neil Applegarth	Thames Valley Police
Fred Toon	Youth Offending Service
Carrie Hartwell	OUHT Emergency Dept
Jude Deacon and Jayne Moore	Forensic Mental Health Service
Naomi Evans	Service Manager, Adult Mental Health Services
Shawn Fox	City of Oxford College
Sam Clarke	Oxford Health
Leigh Rusling	CAN young people substance misuse service
Jackie Wilderspin	Public Health
Merlyn Mistry	Public Health
Sally Gill	Public Health England

Priorities for 2016-17

a. Review action plan in the light of new legislation and set priorities for 2016-17 (April meeting)
b. Run training events for professionals working with young people
c. Campaigns at festivals and targeting young people

Priority 2: Work together on alcohol harm reduction projects

What we wanted to achieve in 2015-16

Alcohol is used by a large majority of the population and, on the whole, is not contributing to any harm. However, for significant numbers of people it is linked to harm to their own health, crime and risk to children and young people. The alcohol working group action plan targeted each of these areas:-

a. **Harm to own Health**
   - Provision of Identification and Brief Advice (IBA) training for front-line staff and professional across Oxfordshire;
   - The promotion of the Dry January campaign targeting middle aged women. Oxfordshire is well under the national average for alcohol related mortality in males, but females are statistically similar to the national averages in most measures. Therefore females were the focus of alcohol campaigns this year.
   - Alcohol Conference for professionals with presentations from a wide range of specialists in the alcohol field including the blue light project.

b. **Crime – including violent crime and public order**
   - Exploring test purchasing initiatives with Thames Valley Police to target excessive intoxication in the night time economy.

c. **Risks to Children and Young People**
   - Alcohol Conference to include presentations on foetal alcohol syndrome;
   - Work with the local hospitals to improve pathways for young people into support services.

Why this was Important

Some local statistics paint a positive picture compared to national averages, 13.75% of people aged over 16 years do not drink, compared to the national average of 16.5%, and 3 of the districts rank amongst the lowest number of abstainers nationally.

However, reducing the harm caused by alcohol is a key priority for organisations in Oxfordshire who have agreed to raise awareness of healthy drinking habits and reduce the burden on hospital services. Oxfordshire has a rate of alcohol related hospital admissions in under 18s of 41.9 per 100,000, which is similar to the national average of 40.1 and more than three times that of the lowest in the country (13.7 per 100,000 in 2013-2014 data).

Oxfordshire is well under the national average for alcohol related mortality for males, but females are statistically similar to the national averages in most measures. This includes deaths directly caused by alcohol, liver disease and admissions to hospital for conditions related to alcohol consumption, including accidents. Admission episodes for alcohol-related malignant neoplasm conditions (cancers) are significantly worse than the national average. Therefore public health messages need to be targeted at females to reduce this inequality.

Achievements in 2015-16

a. Identification and Brief Advice (IBA)

Training in how to identify opportunities to talk to people about their drinking and offer relevant brief advice is the an effective intervention. This can be delivered by a range of professionals in the health service and other settings. Six training sessions were commissioned by Public Health in the last year. The training was offered in locations across the county and have been well attended by a range of professionals. The events have had very positive feedback from delegates, with most rating the sessions very highly in terms of effectiveness and impact. Approximately 88 delegates attended across the 6 sessions, from a range of partners including Adult Social Care, Early Interventions Services, Mental Health organisations, charities, housing providers, Primary Care, Pharmacies, Oxford University Hospitals Trust.

In addition a 'Train the Trainers' session was provided to Oxfordshire Fire Service to enable ongoing partnership work with Public Health. This was a bespoke session combining IBA for alcohol with smoking cessation. The methods of delivery for both topic areas are very similar, so combining them is an innovative approach that allows the best use of resources to provide training and knowledge to delegates in an effective way. The session was also very well received.

b. Alcohol Conference

Public Health held a highly successful Alcohol conference in December 2015, with over 140 delegates attending. The day included a number of guest speakers, including a keynote address from Professor Kevin Fenton, the National Director for Health and Wellbeing at Public Health England. The speakers covered a range of topics including the national picture, treatment for alcohol users, treatment resistant drinkers and foetal alcohol syndrome. Speakers from the local Alcoholics Anonymous and ALANON groups outlined their personal involvement with the organisation and ran workshops to give insights into how their meetings work.

Participants came from a wide range of Council departments, partner organisations and local services including Community and Residential Treatment Services, Housing services and services for the homeless, Oxford University Hospitals Trust, Oxford Health NHS Foundation Trust, Medical Centres and GP Surgeries, Pharmacies, Thames Valley Police, Oxford Brookes University, Community Dental Services, Public Health England, Mental Health services and charities, Oxfordshire Domestic Abuse Service, Oxford Jobcentre Plus and criminal justice services.

The conference was very well received with 90% of who filled in the evaluation questionnaire stating that they found the event to be relevant to their learning needs, and 93% felt it increased their knowledge and understanding of alcohol use and the associated risks. Key learning messages included the importance of reduction as well as abstinence, not giving up on unmotivated drinkers and raised awareness around foetal alcohol syndrome.

c. Alcohol Liaison

Public Health commissioners are working in partnership with Oxfordshire Clinical Commissioning Group (OCCG) to take preventative action in hospital based early intervention and advice. A business case is being developed to explore the development of an alcohol liaison role within the Oxfordshire University Hospitals Trust (OUH).

d. Oxfordshire Fire and Rescue

Public Health has developed a strategy with Oxfordshire Fire and Rescue (OFRS) that identifies a number of joint working initiatives to assist in tackling alcohol harm reduction. This includes OFRS providing brief advice and a signposting service for smoking cessation as well as identifying alcohol or substance misuse through their Home Fire Risk Checks.

e. Campaigns

The focus of Dry January this year was on women, particularly those aged 35 and over and who may be drinking regularly at home. The campaign was conducted on social media, Healthy Oxon Facebook and Twitter channels and through a radio he campaign promoted the health benefits of taking part in Dry January and then continuing to have 2 alcohol free days a week. The campaign also promoted use of the DrinkAware App to record drinking, and sign up for Dry January to go 'booze free for 31 days'.

The radio campaign included advertisements and also a competition which promoted Dry January and the benefits of going alcohol-free and offered a spa-break prize. 116 people entered the competition and the web page accompanying this was live for 18 days and achieved 578 page impressions.

Additional publicity for Dry January focussed on a local Fire and Rescue Team who were in training for a charity cycle ride from John O'Groats to Lands' End in 2016. The team members participated in Dry January, along with another team of firefighters. This proved to be a successful way of boosting social media presence and providing positive role models for the campaign. Firefighters reported improvements to their own health, weight and fitness.

f. Criminal Justice

In addition to the main focus of the work on harm reduction, Thames Valley Police are working with partners on a project that is targeting tackling excessive intoxication in the night time economy.

g. Street Angels

An initial scoping exercise has been investigating the possibility of working with "Club Angels" in the City. Club Angels are volunteers who base themselves in pubs and clubs to help anyone who has drunk too much and to reduce sexual harassment The idea was warmly received by the members of Pubwatch in Oxford City. The scheme has not yet been set up but partners continue to work on it.

h. Super-Strength alcohol

A piece of work in Ipswich saw the police work with local stores to encourage them to sign up to removing super-strength drinks from sale. This had the effect of reducing availability of cheap strong lager to street drinkers and has reduced associated anti-social behaviour in Ipswich. Partners considered setting up a similar scheme locally. However, a scoping exercise was conducted, which suggested no further work was required at present.

Who is part of the Working Group?

Partners in this area of work have included the agencies listed below. Meetings have been convened as needed to take work forward and it is hoped to have more regular partnership meetings in the year ahead.

- Public Health Commissioners, Oxfordshire County Council
- Oxfordshire Fire and Rescue Service
- Oxford University Hospitals Trust – Community Safety Practitioner and others
- All five District Councils
- Thames Valley Police
- Adult Drug and Alcohol Treatment Services
- Young People's Drug and Alcohol Treatment Services
- Oxfordshire Clinical Commissioning Group.

Priorities for 2016-17

1. Commission IBA training sessions across Oxfordshire, with sessions made accessible to all partner agencies This may include combined IBA training for alcohol and smoking. This innovative approach will aim to attract a wider audience and reduce costs of delivery and attendance.
2. Targeted alcohol campaigns including Dry January and the new One You campaign.
3. Improve pathways with Accident and Emergency and maternity departments and local treatment services.
4. Continue to explore the potential to support a local Club Angels initiative.
5. To consider a scoping exercise into the need for a local 'Blue-light project in Oxfordshire working with treatment resistant drinkers;
6. Explore the potential to work with DrinkAware to support their pilot targeting Identification and Brief Advice for alcohol, targeting men and using pharmacy led interventions.

Priority 3: Reduce the number of young people engaging in risky behaviours and continue to improve the collaborative working approach to early intervention

What we wanted to do in 2015-16

The overall aim of this strand of work is to help ensure children have a healthy start in life and stay healthy into adulthood and keeping all children and young people safe.

The specific objectives for 2015-16 included:

- Improve the way services work together to ensure that appropriate information, support and help is available when needed.
- Build on current initiatives for children with drug or alcohol-misusing parents, keeping safeguarding as a paramount concern.
- Increasing understanding of drug and alcohol use among young people in Oxfordshire, including New Psychoactive substances.

Why this was important

The Alcohol and Drugs Strategy sets out data and information which highlights the risks faced by many young people. It is important to get a better overview of the situation in Oxfordshire and to enable the services that are already commissioned to work together to ensure children and young people are kept safe. Partnership work is essential to achieve this.

Achievements in 2015-16

a. Work with A&E departments at JR and Horton.

Information on attendance at A&E highlights attendance of people aged under 18. In response to this there have been developments in engaging young people who present at A& E with drug or alcohol problems. The provider of alcohol and drugs services for young people, CAN, and the paediatric leads in the Oxford University Hospitals Trust are involved. New information to be given to young people include contact numbers for relevant services. A drop down prompt on the A&E forms completed by doctors will enable them to make referrals to MASH. .

b. Work with the Early Intervention Service and Young People's Substance Misuse

Bi monthly meetings are held between Early Intervention Service (EIS), CAN and commissioners in Public Health to monitor and improve engagement with young people through the Hubs. This gives a holistic approach to supporting young people who may have a range of issues.

In addition the agencies have worked together on a plan to ensure that children whose parents have substance misuse issues are identified and kept safe. A new play worker for younger children in this group has been employed by CAN and is working closely with EIS staff.

c. Work with School Health Nurses

As reported in the section on New Psychoactive Substances (NPS) above, a training session was held in November 2015. This was jointly delivered by CAN, The

Training Effect (TTE), Turning Point and Oxford Health. Workshops focussed on how to deal with the behaviours resulting from NPS use. The event was very well attended and evaluated.

Of note for this area of work with young people was the number of school health nurses that attended and who were therefore able to make links with the service providers. As a result of these developing relationships a pathway of referral from TTE to the school health nurses and on to CAN and other Early Intervention Services is being discussed. This will respond to the need shown in the TTE school surveys and by the Risk Avert programme.

d. Work with other teams in Young People's Substance Misuse

It is important for all agencies with a role in preventing and intervening in substance misuse issues for young people to work together. To this end the Commissioners from Public Health regularly met colleagues from the Youth Offending Service (YOS) and the Child and Adolescent Mental Health Services (CAMHS) commissioners. This enabled everyone to discuss developments and plans going forward. This will be furthered in the next meeting of the Young People's working group.

Members of the Working Group
Although there has only been one formal meeting of the working group, a range of partners have been involved in taking this work forward. They include

- CAN, young people substance misuse service
- The Training Effect
- Oxford Health – CAMHS and School Health Nurses
- Early Intervention Service
- Community Safety Practitioner in the Emergency Dept at OUHT
- Public Health Commissioners at Oxfordshire County Council
- CAMHS commissioners at CCG and County Council

Priorities for 2016/17

1. Reconvene the Young People's Substance Misuse Working Group to ensure good communication and effective work by all agencies working with young people and children.

2. Conduct focused needs assessments in areas of identified need, which may include young people's services. this may also include a review of referral routes to services in the light of changes in the Early Intervention Service.

3. Support a scoping exercise into the need for a Community Alcohol Partnership scheme (CAP) in Banbury;

Priority 4: Improve the way we commission services to provide better pathways for people with complex needs, with a focus on recovery from addiction

What we wanted to achieve in 2015-16
Improvements in the way we commission services to provide better pathways for people with complex needs, with a focus on recovery from addiction.

Why this was important
The 2014 assessment of need in Oxfordshire related to substance misuse identified that a group of people with complex needs, including those with mental health problems or housing need, require additional and joined up services in addition to drug or alcohol treatment services to have the best chance of achieving recovery from addiction.

What we did and how progress was measured

a. Improve the health offer to those with a dual diagnosis/complex needs who access the homeless pathway in Oxfordshire.

We set out to do this by:-

- Working jointly with Oxfordshire Clinical Commissioning Group to look at Luther St patient profiles and their access to a range of health interventions, particularly those with a dual diagnosis
- Understanding the current support offered to those with a dual diagnosis/complex needs who access the homeless pathway
- Undertaking a focus group to engage with service user on how to improve outcomes and better meet the needs of those with complex needs
- Working with existing services to understand any barriers that service users and staff currently face accessing/referring to provision that already exists
- Identifying gaps in current accessibility, service configuration or commissioned service provision to make recommendations
- Being a key partner in the redesign and recommissioning of the homeless pathway

b. Improve the pathway between substance misuse and mental health services for those with a dual diagnosis in crisis and those not.

We set out to do this by:-

- Undertaking a review of the pathways between the main mental health and substance misuse providers
- Task Oxford Health and Turning Point to develop a dual diagnosis joint working protocol for Oxfordshire within an agreed timeframe
- Improving staff understanding of needs of people of all ages who misuse substances and present in mental health crisis

- Understanding approaches adopted in other areas to Oxfordshire and implement relevant good practice
- Improving communication and collaboration between services working with complex need
- Participating in the evaluation of the Making Every Adult Matter (MEAM) pilot and reviewing its effectiveness

Achievements in 2015-16

Good foundations have been made to take forward complex needs as a work stream in the following key areas:-

- Effective partnership working with Oxfordshire Clinical Commissioning Group (OCCG) has been established, which has resulted in the development of a Joint working protocol that is in development between Oxford Health and Turning Point for Dual Diagnosis.
- Focus groups with the Supporting People user Group were held, highlighting 4 key areas for working with complex needs:- consistency of key worker, early identification of a dual diagnosis, communication, involvement in social and physical activity.
- Public Health substance misuse commissioners were involved in the redesign and commissioning of Housing Related Support services.
- Turning Point representation on the OCCG led complex needs work stream is established.
- Strategic membership on the MEAM executive group now includes drugs and alcohol commissioners.
- Public Health substance misuse commissioners are key members of the crisis care concordat; led in Oxfordshire by the CCG.

However, despite the foundations there have been delays to two significant areas of work which means they have not been completed. These are:-

1. The development of the joint working protocol for dual diagnosis between Oxford Health and Turning Point.
2. Delivery of substance misuse awareness training to those working in acute settings who come into contact with people in a mental health crisis.

Who is part of the working group

Public Health and Oxfordshire Clinical Commissioning Group have been working together on this area of the drug and alcohol strategy.

Priorities for 2016-17

1. Finalise and launch the dual diagnosis joint working protocol between Oxford Health and Turning Point

2. Set up a commissioning partnership group with the following remit:-
    - Define the cohort that this group is representing
    - Monitor the implementation of the dual diagnosis protocol
    - Ensure the competency of the workforce in working with this group

- Map all complex needs services to reduce duplication and review pathways
- Ensure a shared strategic vision for this client group including setting out principles for working with those with complex needs
- Promote a culture of communication and collaboration amongst providers to respond to the needs of this group

3. Undertake a focus group to explore how to effectively support those with complex needs accessing the homeless pathway

4. Ensure that substance misuse training is scheduled and delivered to those working in acute settings who come into contact with people in mental health crisis that misuse substances

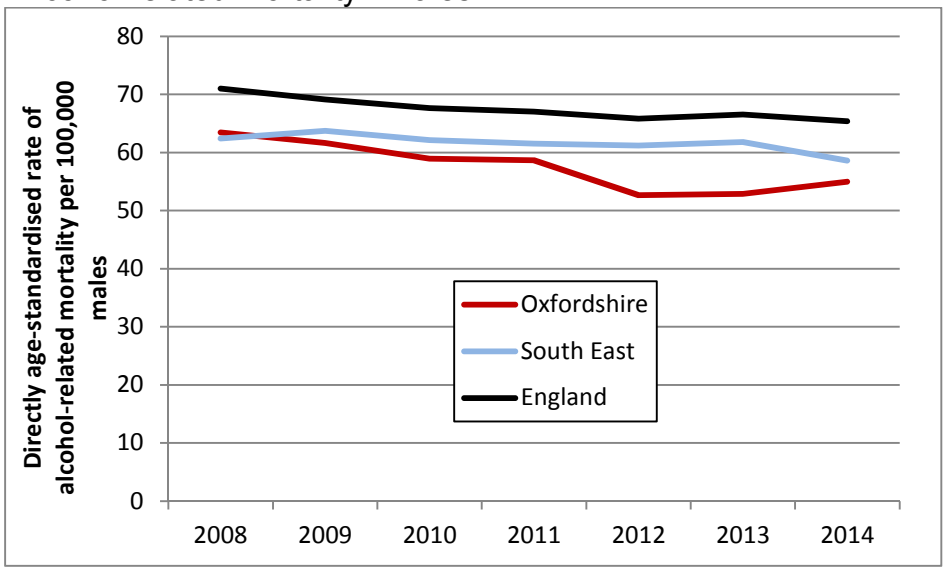
The work for 2016-2017 will be supported by the Public Health. An important publication - 'Co-existing alcohol and drug misuse with mental health issues; guidance to support local commissioning and delivery of care' – is due to be published by the end of March 2016.

Priority 5: Share intelligence and data across organisations to better understand the needs of specific and vulnerable groups of the population

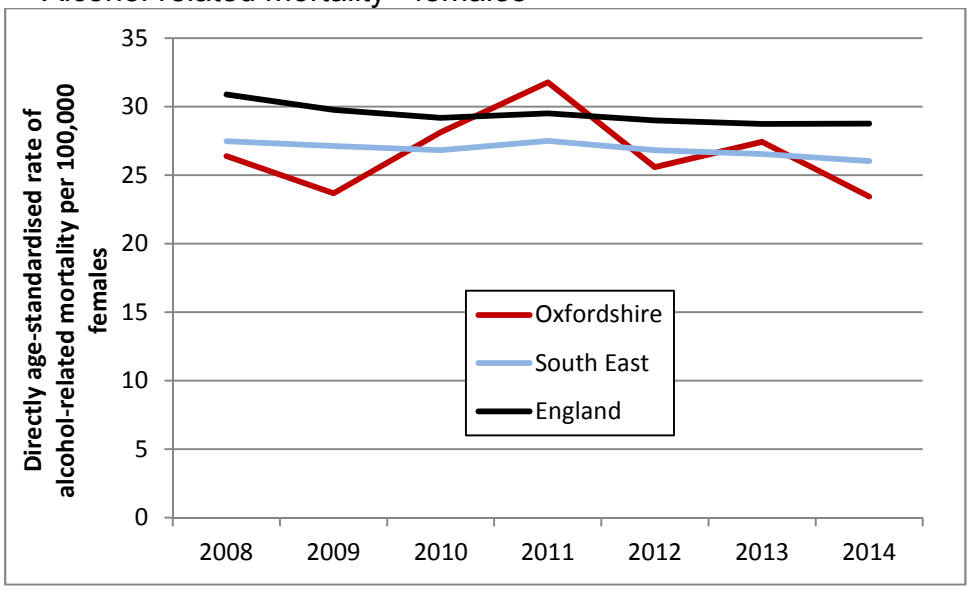
A review of the data presented in the Alcohol and Drugs Strategy has been carried out and the following conclusions have been drawn:

1. In 2014 there were an estimated 7900 **deaths related to alcohol use**[1] in England. The trends for both men and women are shown in the 2 charts below

Alcohol-related mortality - males



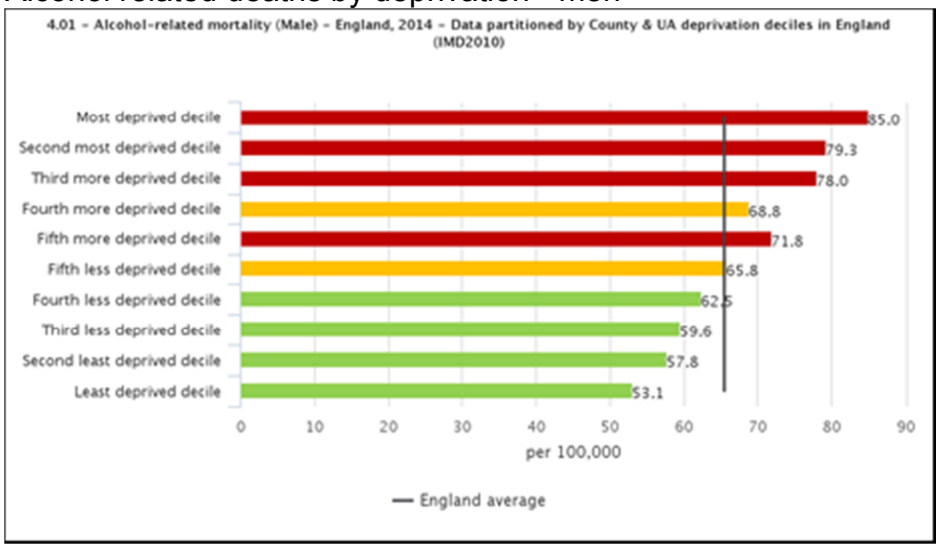
Alcohol-related mortality - females



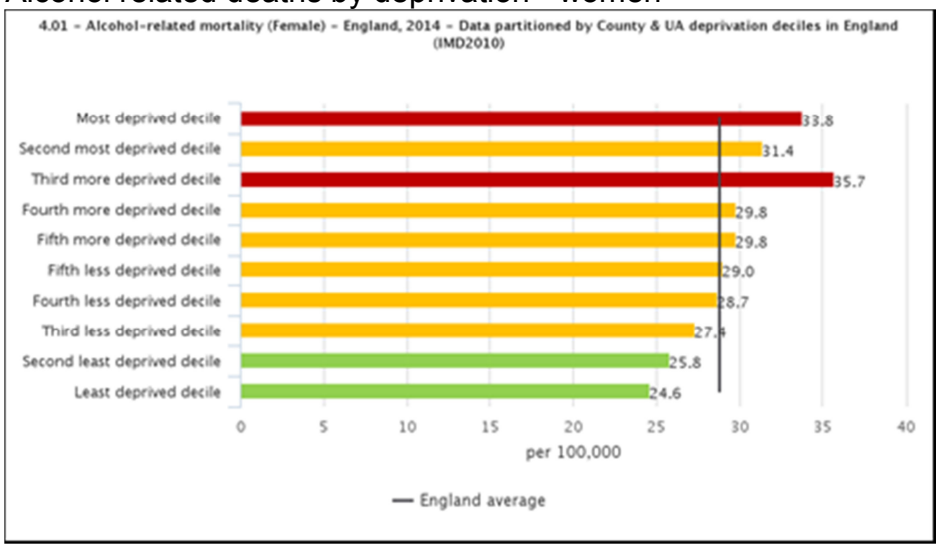
[1] Alcohol-related mortality (males and females) - Deaths from alcohol-related conditions, all ages, directly age-standardised rate per 100,000 population (standardised to the European standard population).

2. **Alcohol-related mortality by socio-economic class** is not analysed at a local level, but new figures have been published at national level. The charts below show the alcohol related deaths split for England by most/least deprived groups. The chart for men shows a greater difference between the best and worst off than for women. (Source: alcohol profile tool)

Alcohol related deaths by deprivation - men



Alcohol related deaths by deprivation - women

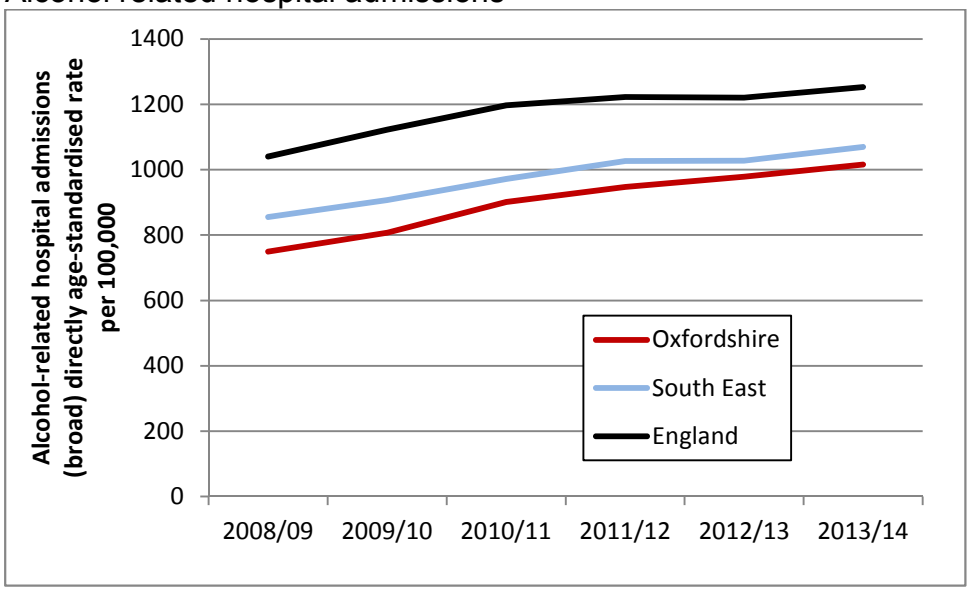


3. In 2013/14 there was a continuing upward trend (3.9% increase on previous year) for **alcohol-related hospital admissions**[2] in England. The annual increase was greater for women (+4.8%) than men (+3.3%) and it remains

- [2] Alcohol-related hospital admissions (broad) - Persons admitted to hospital where primary diagnosis or any secondary diagnoses are an alcohol-attributable code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population European standard population.

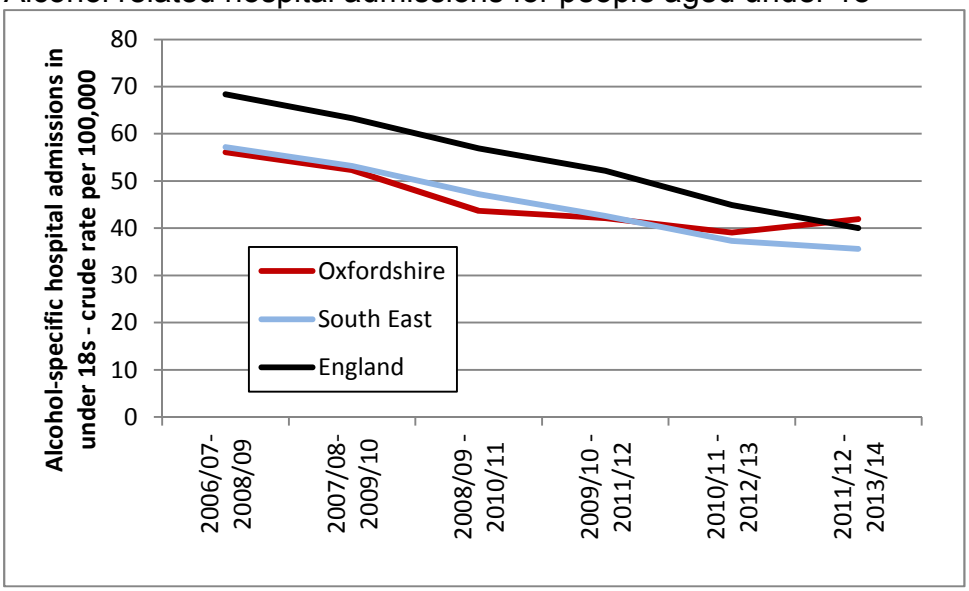
the case that rate of admissions among most deprived is 77% higher than rate in least deprived areas.

Alcohol related hospital admissions



4. **Alcohol related hospital admissions in under 18s**[3] was not updated with 2014/15 data. However, the latest alcohol profiles shows the lowest rate in England was 13.7 whilst Oxfordshire was 41.9 (count 175 young people) so the Oxfordshire rate is still three times that of lowest.

Alcohol related hospital admissions for people aged under 18



Source of data: http://fingertips.phe.org.uk/profile/local-alcohol-profiles

- [3] Alcohol-specific hospital admissions under 18s - Persons admitted to hospital due to alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population

Conclusion and Reflection on Priorities

Overall the reports from working groups and partnership arrangements on the priorities set out in the Alcohol and Drugs Strategy show some progress over the last year. For example, there have been successful training initiatives across agencies, successful campaigns which build on national high profile campaigns and growing success of service providers working together to join things up for clients.

There is still more to be done, as illustrated by the data in this update and the more detailed analysis set out in the strategy. This includes

1. New Psychoactive Substances
    a. The NPS Act will be introduced soon (though the April date has been postponed). There is concern that, as substances currently "legally" available will soon be outlawed, suppliers may flood the market in an attempt to off-load them. Agencies need to be ready to work together to ensure good communication among themselves and provision of clear information to potential users
    b. Over the year local information has given concern over behaviours among users of synthetic cannabinoids. There is a need for campaigns and training in response to this.
    c. It is clear that the potential dangers of use of NPS are still not widely known. This needs to be addressed whether these substances are dubbed "legal" or not.
2. Alcohol
    a. The data shows that alcohol related hospital admissions for adults are still rising, especially for women. This continues to be a concern as alcohol use exacerbates a range of conditions.
    b. The national guidelines for alcohol consumption have been amended by the Chief Medical Officer and now 14 units a week is the recommended maximum for both men and women. Local publicity is needed to help people understand what this means for them.
    c. Binge drinking figures have not been updated but there are still concerns about the harms to health and the community safety implications of this.
3. Children and Young People
    a. The data show that the trend for alcohol related admissions of young people is continuing to fall. This is good news. However, more local data for Banbury has raised concerns about under-age drinking. This needs to be explored more fully and the possibility of setting up a Community Alcohol Partnership in Banbury is being explored.
    b. There are likely to be disruptions to referrals and access to a range of services in the face of organisational change. This has to be prevented.
4. People with complex needs
    a. As set out in the section above, more work is needed to translate good relationships between partners into working protocols.
    b. Changes to services providing housing related support are being made and there are reports of increased numbers of rough sleepers. The contribution of drugs and alcohol treatment services needs to be

Appendix 1: The Alcohol and Drugs Strategy, 2015-18
Executive Summary

Alcohol and/or drug misuse is a broad issue that affects many different parts of society including health, crime, personal relationships, community safety, workplace productivity and the economy. It brings a burden of social and financial cost. Many of the consequences can be prevented or reduced. This strategy sets out priorities which have to be addressed by a range of partners in order to bring about change.

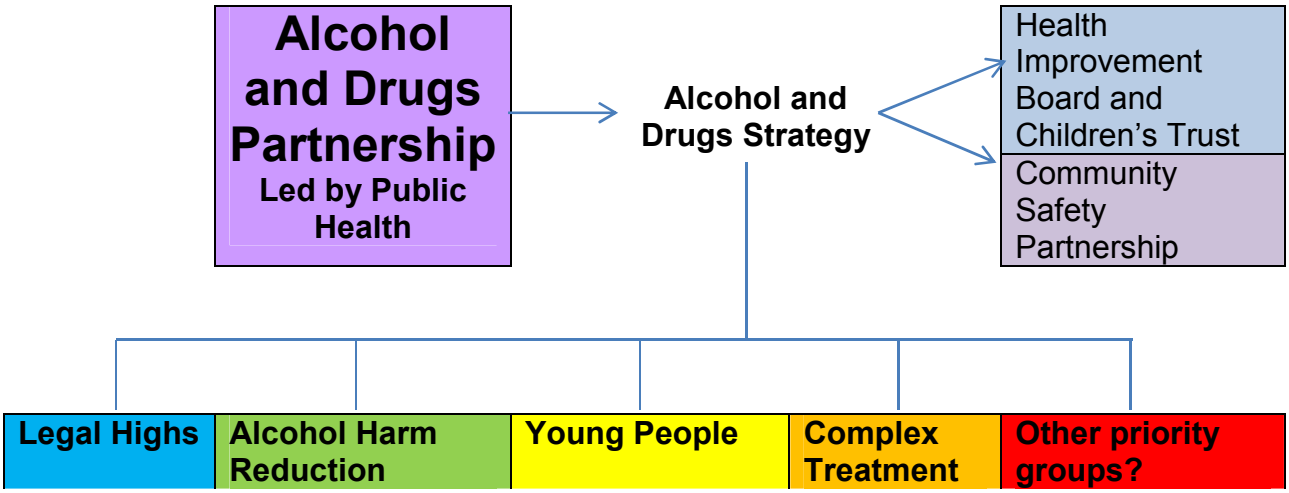
An assessment of need in Oxfordshire has highlighted the following:

- Alcohol related hospital admissions for adults continue to rise in Oxfordshire, demonstrating the harm to health to people who regularly drink at harmful levels. In addition to this there are people who binge drink and are at risk of accident, injury or crime as well as ill-health.
- The number of people receiving treatment for addiction to illicit drugs in the county is good, showing that they feel able to engage with treatment services. However, the numbers completing treatment and remaining abstinent compares badly with other parts of the country.
- There is a growing threat from New Psycho Active Substances (so called "legal highs") as availability increases and little seems to be known about the potential impact on health.
- A group of people with complex needs, including those with mental health problems or housing need, require additional and joined-up services in addition to drugs or alcohol treatment services.

Priorities identified are:

6. Reduce/ stop the demand and supply of New Psychoactive Substances (NPS) or "Legal highs" in Oxfordshire.
7. Work together on alcohol harm reduction projects
8. Reduce the number of young people engaging in risky behaviours and continue to improve the collaborative working approach to early intervention
9. Improve the way we commission services to provide better pathways for people with complex needs, with a focus on recovery from addiction.
10. Share intelligence and data across organisations to better understand the needs of specific and vulnerable groups of the population.

The governance set up for the delivery of the strategy is illustrated in this diagram:



DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT IX

Reporting on 2015/16
Produced: July 2016

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Foreword

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

This is my 9th 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.
July 2016

Chapter 1: The Demographic Challenge

Main messages in this chapter:

- **The demographic challenge is about all ages, not just older people.**
- **However the growth in the number and proportion of older people in the population remains the biggest challenge to health and to services.**
- **Services will need to change to respond to the challenge – doing nothing is not an option.**
- **The change is not even across the County – service change will need to be tailored to different localities – there is no 'one size fits all' solution.**
- **The demographic challenge affects all of us now. Its effects can be felt on our busy roads and through plans for housebuilding in the County.**
- **Because of its relatively 'old' population profile, Oxfordshire will be affected more and sooner than elsewhere.**
- **The nature of the population will change too- for example the population will become increasingly diverse.**
- **New patterns of disease and new forms of inequality will follow and we need to be ready to tackle these.**
- **Shifting from a focus on treatment to a focus on prevention will be key.**

In this chapter I want to focus on health and change in our population and what this means for services and what it may mean for each one of us as individuals.

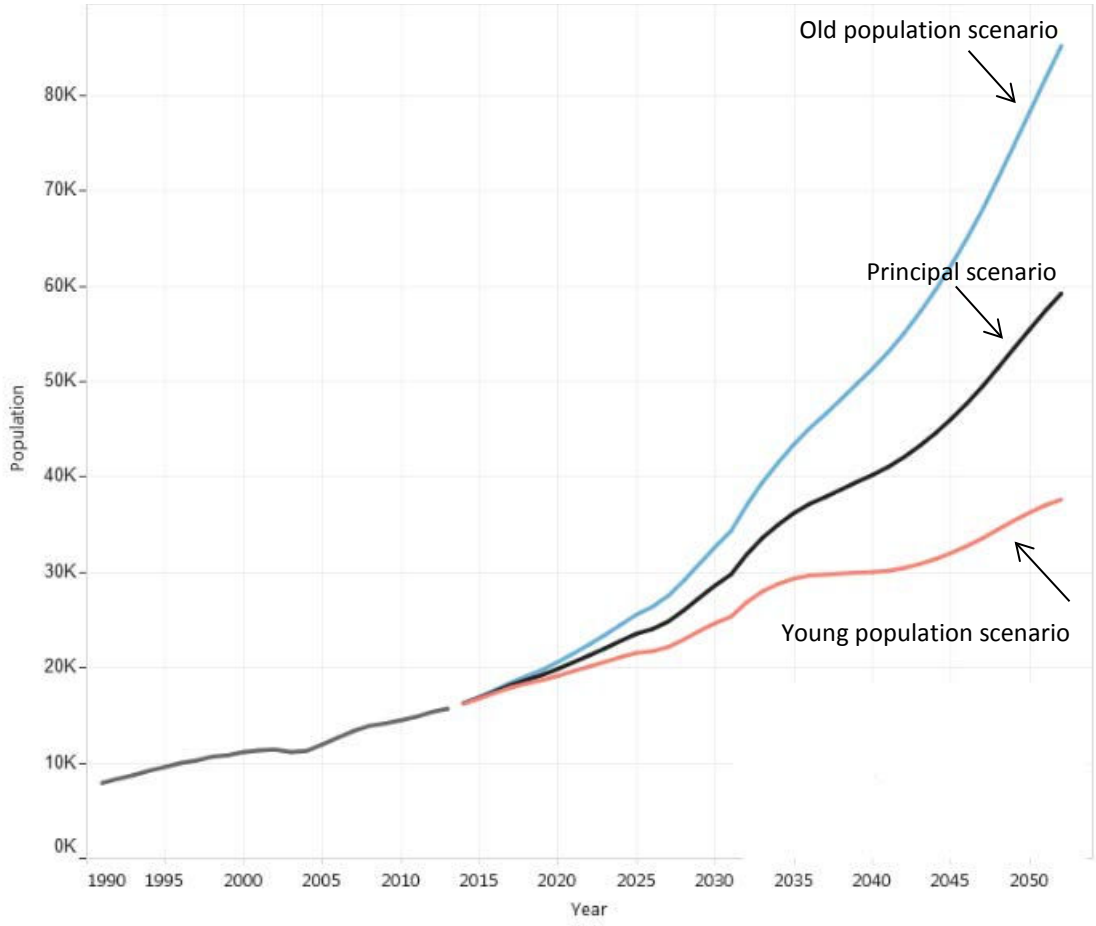
The demographic challenge isn't just about older people – there are issues for all age groups and for the changing composition of the population itself, particularly linked to changes in ethnic group composition. In this chapter I will look at each of these factors in turn.

The overall conclusion is that the demographic challenge is a real game-changer for services and that there is no 'do nothing' option: change is inevitable.

The ageing population

Everyone knows that the population is ageing, and this remains by far and away the biggest challenge to all current services and is the biggest health issue in the County. The chart below shows the picture well for those aged 85 and over in Oxfordshire, looking forward as far as 2050.

Change in Oxfordshire's older population (age 85+)



Source: ONS population estimates/ Oxfordshire County Council Research & Intelligence long-range projections (autumn 2014)

It shows that:

- The 85 plus population is set to increase by around 7,800 people between 2014 to 2026.
- That is an increase of 48% - a huge increase.
- There is uncertainty about the absolute numbers, as no one is sure how long people will live for in the future. The top line shows the maximum growth scenario, the bottom line the minimum and the middle line the most likely. The most dramatic projection to 2050 shows that there may be 75,000 people aged 85+ living in Oxfordshire compared with around 16,000 at present.
- If this even comes close to being an accurate projection it will completely change the nature of society, and services, as we know them.

The ***proportion*** of older people differs from place to place across the County and this will be significant in terms of the shape of future services.

The balance between those contributing relatively more to the tax-base (i.e. those of working age) compared with those who are over 75 affects affordability of services going forward. I know that older people make a significant contribution to the economy through taxation, but not at the same rate as those in pre-retirement years. A higher proportion of older people means that services funded from taxation will become progressively more stretched.

This isn't a static situation. ***An 'ageing population' means that both the number and proportion of older people in the population are changing.*** This is a crucial point. If all ages were increasing at the same rate it would mean that we would all have less space to live in but factors such as the tax-base for funding services would stay the same, i.e. services can be 'more of the same but more of them'. It is a more affordable scenario. ***However, if the proportion of older people also changes it affects the balance of diseases that need to be treated, the availability of carers and the range and shape of services that need to be offered.***

This means that staying as we are simply isn't an option and things must change – it is a simple and inevitable fact.

The table below shows the proportion of the population aged 65+ in the County as a whole and in Districts using 2014 data.

Number of people aged 65 and over in Oxfordshire and its districts

Area	Number of people aged 65+	% of area's population
Cherwell	24,500	17%
Oxford	17,800	11.3%
South Oxfordshire	27,300	19.9%
Vale of White Horse	24,400	19.5%
West Oxfordshire	21,600	19.9%
Oxfordshire Total	*115,600*	17.2%

Source: ONS mid-year population estimates, 2014

The table shows that:

- Overall, around 17% of the population are aged over 65.
- In South Oxon, Vale and West Oxon the figure is higher than 19%
- In the City the figure is markedly lower at around 11%.

Looking even more closely at the proportion of over 65s shows that some wards top the 25% mark for people aged over 65, and Burford hits over 32%. The table below sets out the Oxfordshire wards topping 25% of residents aged 65+.

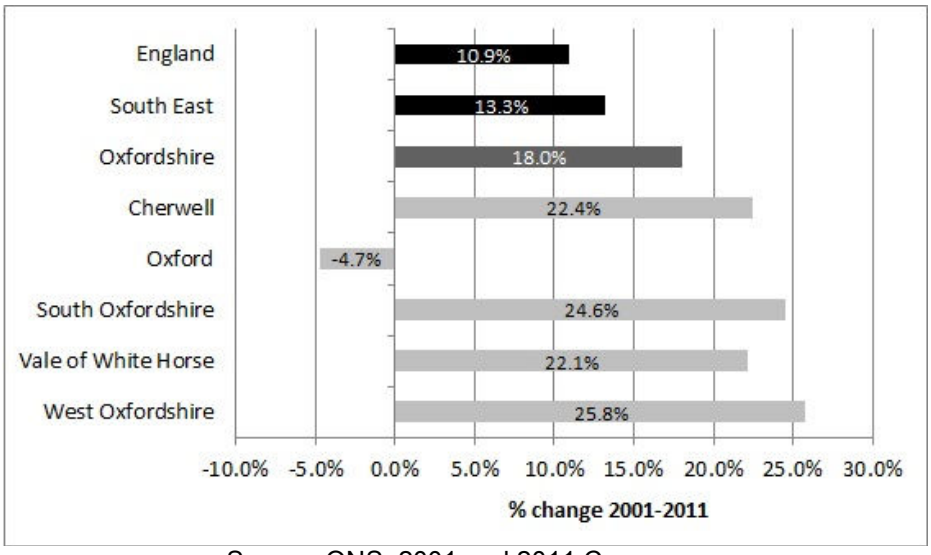
Oxfordshire wards where older people make up more than a quarter of the population

Ward and District	Number aged 65+	% of ward's population
Burford, West Oxfordshire	630	32.5%
Goring, South Oxfordshire	1654	28.7%
Henley North, South Oxfordshire	1560	27.8%
Greendown, Vale of White Horse	654	27.3%
Sonning Common, South Oxfordshire	1478	27.1%
Ascott and Shipton, West Oxfordshire	544	26.9%
Cropredy, Cherwell	715	26.1%
Deddington, Cherwell	692	25.9%
Woodstock and Bladon, West Oxfordshire	1080	25.7%
Blewbury and Upton, Vale of White Horse	542	25.7%
Adderbury, Cherwell	745	25.2%
Milton-under-Wychwood, West Oxfordshire	525	25.2%
Kennington and South Hinksey, Vale of White Horse	1141	25.0%

Source: ONS mid-year population estimates, 2014

Not only is the proportion of older people different in different places, the proportion is also changing at different speeds. The table below shows how the number of people aged 65+ has already increased dramatically in the County and four out of five Districts between 2001 and 2011.

% change in the number of older people in Oxfordshire and its districts (2001- 2011)



Source: ONS, 2001 and 2011 Censuses

It shows that this affects Oxfordshire more than the national and regional pictures – the national and regional increases are around 11% and 13% respectively compared with a huge 18% for Oxfordshire as a whole and topping 22% in Cherwell, South Oxfordshire, Vale and West Oxfordshire.

The City is very different – more younger residents means that the number of 65+ residents fell by almost 5% in the same period.

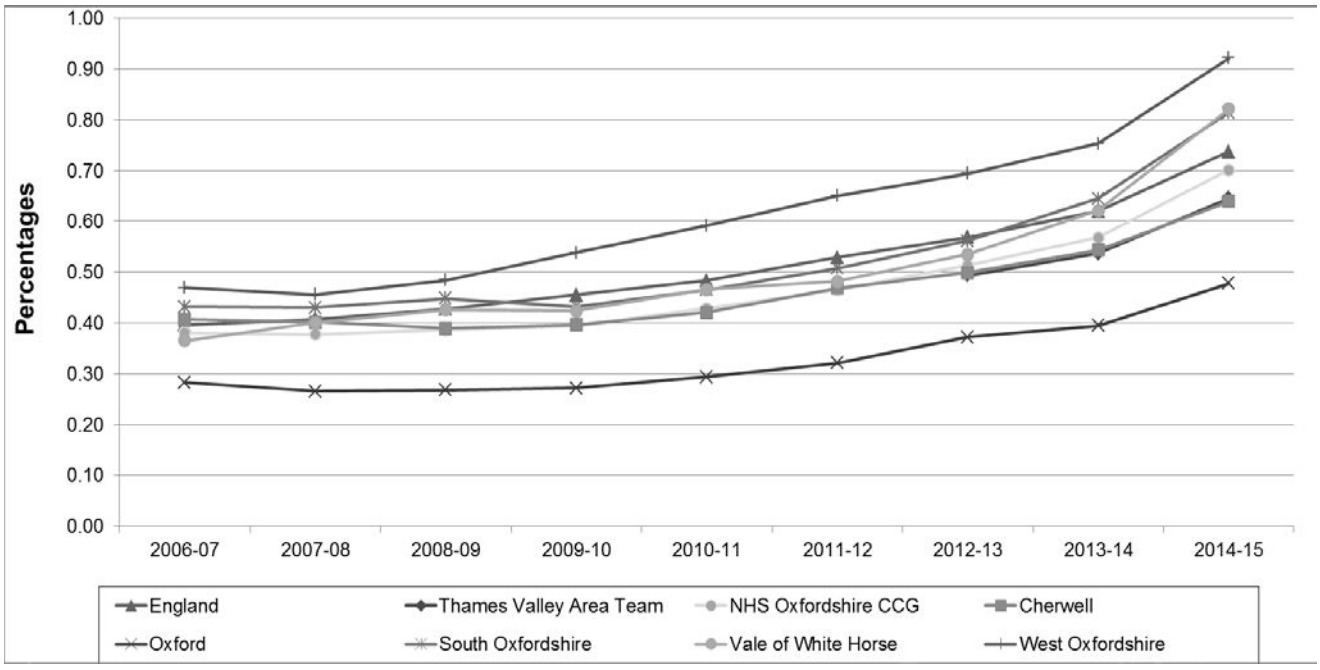
This means that the need for change to services will hit Oxfordshire harder and faster than elsewhere in the country. This puts more pressure on the 'Oxfordshire £' and means that our services will be hit harder and sooner than elsewhere, making the case for change even more compelling.

The differences between different Districts also show that **the right range of services for the future will not be 'one-size fits all'**. Taking into account journey times and distances from health facilities and hospitals means that each locality will need a tailor-made service.

An ageing population means that patterns of disease are changing.

This applies to many chronic diseases such as diabetes, but most topically to dementia. Previous reports have looked at the good developments in detecting and treating dementia in the County and the potential for preventing dementia from a healthy diet, keeping the mind active and exercising more. Upward trends in the detection of dementia are shown in the chart below.

Percentage of patients with a recorded diagnosis of dementia in the GP registered population - 2006/07 to 2014/15



It should be noted that this measures the percentage of dementia in a population – the figure for the City is low because the percentage of older people is lower than elsewhere – it is the rising trend in detection that is important and this should be welcomed.

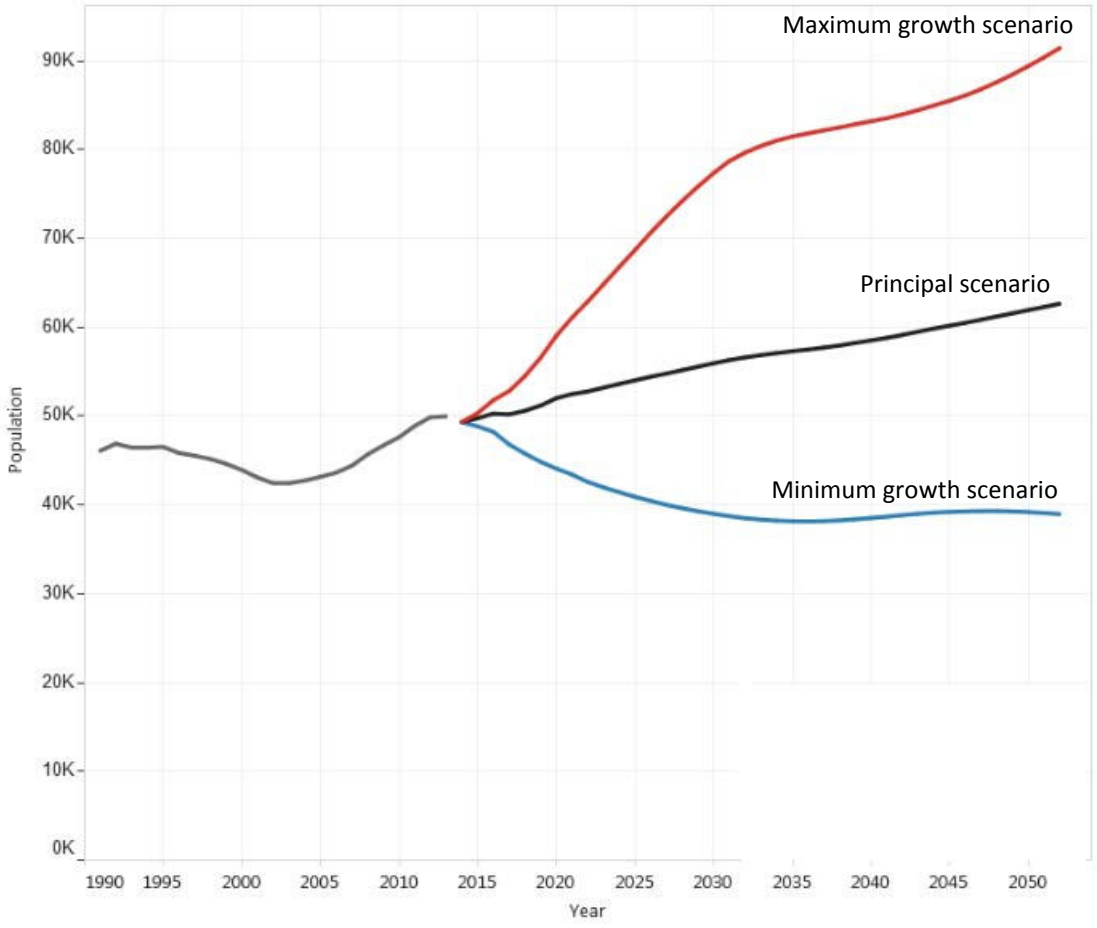
The Demographic Challenge and younger age groups

Population growth due to new housing will tend to swell the number of younger families in the county. The **long range population projections** take into account ambitions for **93,560-106,560**

new homes between 2011 and 2031, as set out in Oxfordshire's Strategic Housing Market assessment

According to the County Council's principle population projection (the most likely scenario), the number of 0-5s in the population is set to increase from 49,600 in 2014 to 54,400 in 2026 (a rise of around 10%). However, there is considerable uncertainty around these figures, as is clear from the chart below. The actual number will depend on a range of factors, including future birth rate, migration patterns, and housing developments on the ground.

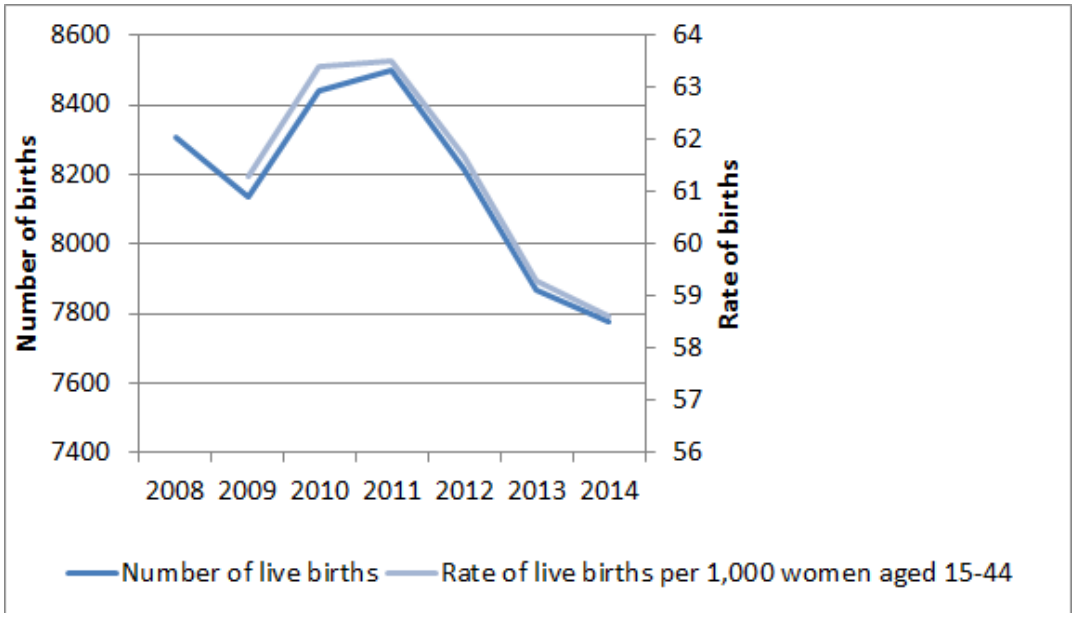
Change in Oxfordshire's population aged 0-5 (inclusive)



Source: ONS population estimates/ Oxfordshire County Council Research & Intelligence long-range projections (autumn 2014)

The impact of growth due to future housing developments is demonstrated by comparing this growth with the underlying local birth rate which has been falling steadily for the last few years as shown in the chart below. In 2014 there were 7,775 live births to Oxfordshire mothers, representing a rate of 59 babies being born per 1,000 women aged 15-44 each year.

Number and rate of live births in Oxfordshire (2008-2014)



Source: Office for National Statistics Birth Statistics

The expected growth in young families in the County will have obvious implications for provision of health care, midwifery services, health visiting services and school provision and a much wider range of services. All of this will need to be funded from a shrinking tax base.

This is a further reason why change is inevitable.

We will simply have to find new ways to provide services.

If we didn't have growth from housing and more people moving into the County, would the population grow or shrink?

A statistic called the total fertility rate (TFR) or completed family size (CFS) gives the answer. It adds up the number of children women will have in their reproductive lifetime on average. A figure over 2.1 children per woman means the population size is steady – i.e. people replace themselves through childbirth.

A figure lower than 2.1 means the population will fall and over 2.1 means the population will grow, all else being equal. Of course this is an average. Women having 3 or 4 children make up for those having none or one.

The current figures are:

- Oxfordshire: 1.75
- England: 1.83

This means that if nothing else happened, the Oxon population would naturally fall, and it would fall faster than the England rate.

This shows that population growth stems from housing and net migration into the County.

More People in the Same Space Means Inevitable Change

As we have seen, the net population of Oxfordshire is set to increase and to carry on increasing.

Simply having more people in Oxfordshire will impact on services, travel, housing stock house prices and the nature of the local workforce.

The implications of having more people living in Oxfordshire are:

- **There will be more pressure on existing services and increased demand for new services and new ways of delivering services.**

- **It will be more difficult to travel around the County** if things remain as they are. Travelling to Oxford hospitals for tests or outpatients (and finding a parking space) can already be challenging and may become more so. New options will have to be found which are more local or use online technology.

- **Mobile services like home care and district nursing will need to be organised** to cope with traffic congestion and the areas professionals can practically cover in a day will shrink.

- **The housing stock will need to change to meet the needs of an ageing population** as well as for young families. This means that we will need to develop more options like extra care housing. Older people may demand a different model of housing, and may well wish to group together for mutual support and to reduce the costs of care. It is possible that more people will want to trade in their existing home as they age for a place in purpose-built communities which provide company, care and medical support as seen in other countries.

- The debate about prevention may well change considerably. In the future **preventative services may become a matter of economic necessity**. People may well take prevention of disease and the imperative to adopt a healthier lifestyle more seriously as a means of self-defence and an economic tool. Once the link is firmly made in people's minds between piling on the pounds and a less-rewarding and less wealthy old age, we may see a sea-change in the way in which diet and exercise are viewed by people in their 40s 50s and 60s. **In the future, prevention of disease and investing in a healthy lifestyle may well be taken as seriously as pension planning is now.**

'We' are not the same 'We' as we were…….

In looking to the future it is important to note that the population structure is changing in other ways too. In a very real sense, collectively, 'we' are not the same type of population as 'we' were twenty years in the past or will be twenty years from now. Our habits, beliefs, and use of technology will all change patterns of health, sickness and expectations.

Add in change due to changing ethnic mix and we are looking at completely new scenarios. These issues are picked up in detail elsewhere in the report. In summary the main impacts are as follows:

Re changing lifestyles:

The major changes may well be about diet and activity. Both increasing obesity and decreasing activity as independent factors result directly in more chronic disease, diabetes and cancers. Alcohol consumption leads to a wide range of diseases and cancers and fuels obesity. The trend for alcohol consumption to creep up as we get older is a cause for concern. Any alcohol intake increases the risk of cancer as the Chief Medical Officer has recently pointed out, but the greatest effect in terms of numbers might be seen through the high calorie content of alcohol as a factor in middle-age weight gain.

Re the changing face of health and care technology:

A summary of recent trends shows the following:

- more can be done locally and remotely to diagnose, monitor and treat disease and care needs

- drugs to combat heart disease and cholesterol have helped to reduce deaths from heart and circulatory disease. New drugs now in the pipeline may help.

- new treatments are developed all the time fuelling both expectation and cost of services. The cost of new health technology and drugs outstrips baseline inflation rates. Recouping the research and development costs that go into new treatments makes them very expensive initially.

Re the changing ethnic mix of the population:

- The figures are given in full in chapter 3. I want to focus here on the impact of changing ethnicity on ageing. The ageing population will increasingly be ethnically diverse. This means that the pattern of disease will change. For example, people from parts of Asia and the Indian sub-continent are more prone to develop diabetes and its complications at lower levels of obesity. We haven't yet seen the impact of this, but it will become a more significant factor.

- In 2011, the ethnic mix of over 65s for the whole County was: 94% White British, 4% White Non-British and 2% Black and other Minority Ethnic Groups.

- This contrasts with the picture seen in the City which has a more diverse population. Around 7% of City residents aged 65+ are Asian, Black and other Minority Ethnic Groups – 5 percentage points more than the County average. This trend will continue and will be seen in all parts of the County.

The Demographic Challenge: Putting It All Together

We have seen that many factors in the population are changing – it is not just about change in older people.

We have looked at the implication of simply having more people. Other factors will change as well, for example:

New patterns of Inequalities may emerge

It is likely that new forms of inequality will emerge. For example we may start to see:

- ***Inequalities of support and companionship –*** having supportive networks and a peer group to lean on is like cash in the bank. We know that isolation and loneliness lead to all manner of worse health outcomes. The people who have supportive networks will simply do better and those who do not will be more at risk.

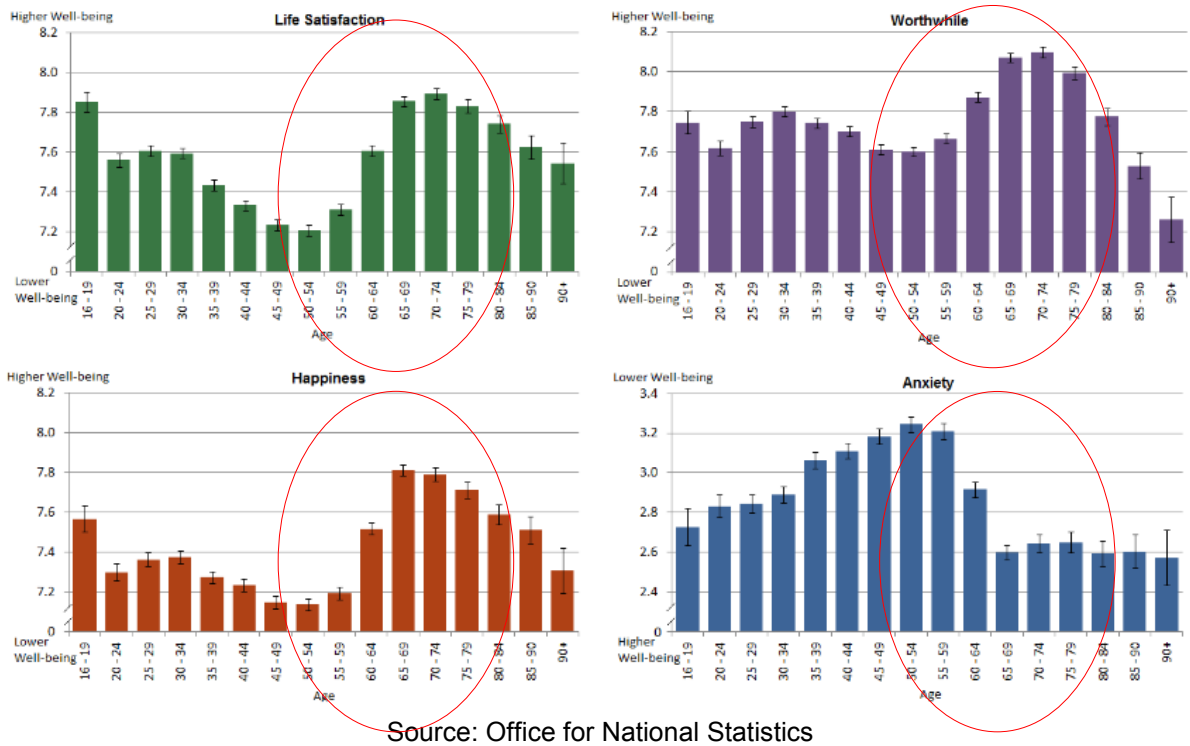
- ***Inequalities of take-up of lifestyles which prevent disease*** may be another key inequality to emerge. Those who make a series of small changes to their daily lives – simple things about more exercise, better diet and drinking less – will tend to have better health en masse than those who do not. Again, it is like cash in the bank – an inequality may emerge between those who create their own personal plan for improving their lifestyle and those who do not– it's like backing yourself in life's race to improve your odds of a healthier life.

- ***Inequalities in health knowledge.*** If you don't know something might be bad for you, you can't make the choice to do something about it. Simple messages like '5 a day' do hit home and do change people's behaviour in the long term. We can see this for sure when supermarkets start to market '5 a day' products because there is a demand for them. This isn't about preaching and nannying – it's about informing local people about health issues so that they can make their own decisions within their means. Everyone can make small positive changes – taking the stairs more often or eating the odd apple instead of a chocolate bar – but not if they don't know it might be a good idea.

But it isn't by any means all bad news – the up-side of older age

UK data asking people about their levels of satisfaction with life, happiness and anxiety shows some surprising and hopeful results for older people. The results are shown below in 5 year age bands from age 16 onwards below.

Average personal wellbeing ratings in the UK, by age (pooled data for 2012-2015)



Source: Office for National Statistics

The results show:

- All measures of happiness and wellbeing dip in the 30s, 40s and 50s and then leap up around retirement age.
- Anxiety levels do the opposite – they are high in adults of working age and then fall dramatically.
- As older age increases, life satisfaction and happiness do fall, but anxiety does not increase.

Factors stated by people in the survey as reasons for poorer mental wellbeing in the over 50s are (in order): financial difficulties; having long term illness or disability; being unemployed or retired; being divorced or separated; having a mortgage and living in an urban area.

I don't pretend to be able to interpret these statistics, but they do seem to give something of a clue about the recipe for increasing the odds of a contented old age which seem to be something like: enough money to get by, positive relationships, being in generally good health, a lack of day to day worries and having a sense of purpose.

When will the demographic challenge kick in? The future is already upon us.

The effects of these changes have already begun – we all know it – you just have to look around you to see:

- At some times of day it is hard to make journeys on our major roads
- Hospital parking is more difficult
- GP services have changed radically – for most people there is no such thing as 'my own Doctor'
- The health and social care sectors are short of cash
- The retirement age is getting later
- Pensions are under pressure
- Half of adults are now overweight
- Health scares have changed – once it was all about heart disease and ulcers, now it's dementia and diabetes
- Some parts of the County are now multi-ethnic communities
- So many things are done on-line with new technology
- Radical service changes are being formulated as we speak.

So, all in all, the inescapable conclusion is that it isn't about whether services and our approach to disease changes; it's about how we must change.

What Can We Do to Meet the Demographic Challenge Head-on?

Mixing common sense and clinical evidence suggests that we should do the following 8 things:

1. **Do more to prevent disease from starting in the first place**
2. **Re-shape health and social care**
3. **Use housing growth to build communities which encourage good health**
4. **Level up inequalities**
5. **See mental and physical health as a continuum, not as two separate things**
6. **Help carers, community groups, voluntary groups, volunteers and faith groups to bridge the gap between statutory services and what people can do for themselves**
7. **Join up services better to give a better start in life**
8. **Protect people from 'unseen threats' such as infectious disease, emergencies and disasters**

The chapters in this annual report deal with many of these points.

Chapter 2 reports on building health communities through the Healthy Towns Initiative
Chapter 3 takes a close look at disadvantage and inequalities, focussing on children
Chapter 4 looks at how we can prevent more disease from starting
Chapter 5 focusses on current mental health issues
Chapter 6 reports on infectious diseases and emergencies

With regard to re-shaping services, the NHS is about to embark on a major service consultation about the future shape of health services in the County. It will be vital to engage the public in this, as every one of us has a part to play in the changes that are inherent in the demographic challenge.

What did we say last year and what has happened?

Last year the recommendations focussed on the need for the NHS to plan for the increasing number of older people in the population, the rise in dementia and to take account of loneliness as a risk factor for older people's health. The need to integrate health and social care was also highlighted, as was the need to further improve NHS Health Checks.

This to a large extent has happened – the NHS is currently preparing a major public consultation on service change which will take these factors into account. This is scheduled for the Autumn.

Progress on NHS Health Checks is covered in chapter 4.

Recommendations

1. The major NHS service consultation about 'care closer to home' should be debated thoroughly and the views of the public and partners taken into account. The extent to which the proposals meet the need to re-shape services to meet the demographic challenge should be a major consideration.

2. The Health Overview and Scrutiny Committee and Healthwatch should consider the consultation carefully and take the issues covered in this chapter into account in their responses.

3. The County Council and the Clinical Commissioning Group should consider the factors in this chapter in shaping plans to integrate health and social care and should do more to prevent disease from starting.

Chapter 2: Building Healthy Communities

Main messages in this chapter

- **If we are to meet the demographic challenge we need to get health issues into local planning of housing, communities and transport schemes.**
- **The Healthy New Towns initiative gives this work an excellent boost in Oxfordshire.**
- **The challenge will be to apply the lessons learned to local planning across the board.**

What can we do to plan, design and build healthier places.

Last year I looked in detail at the intertwined relationship between health, housing, transport, environmental factors and community planning.

In particular I focussed on the complexities of getting health issues into the local planning system with network of Councils, developers, developer contributions, appeals etc.

This year I want to be a little more positive and look at some local work that may help to point the way forward - the Healthy Towns initiative.

This is an important step towards meeting the demographic challenge head on.

In general, the penny seems to have dropped that if we are to combat the demographic challenge we have to think differently about community planning and be more sophisticated about building in healthy features such as cycle paths and community spaces as well as making provision for homes that adapt as one ages, and homes that can be afforded by the lower paid hospital and care workers we depend on.

This is more easily achieved in new developments where we start with a blank sheet of paper – trying to add things like cycle routes to existing medieval road layouts is another matter altogether…….

The Healthy Towns initiative

This idea is being showcased in a Government initiative called the NHS Healthy New Towns initiative via a number of pilot sites. It is about putting 'health' at the forefront of the design of new communities.

We are the only County in the country to have two sites chosen to become part of this, which is a real achievement. The 'Healthy Towns' initiative is led by the NHS in close collaboration with Local Government. District, City and County Councils have all been involved, as has the local NHS and the Public Health team. There is also the bonus of expert help from Government Departments and a grant from the NHS.

In a nutshell the Healthy New Town Programme aims to make it easier for people to make healthier choices for themselves and their families.

Being part of the NHS Healthy New Towns Programme puts Oxfordshire on the map as one of the leaders in getting health into planning.

We have two NHS Healthy New Town sites in Oxfordshire, one in Bicester and one in Barton Park. The sites were selected from an original 114 applications and were announced in March 2016. Bicester has 26,000 new homes that will be available across the whole town, of which 13,000 will be new homes including the exemplar Elmsbrook at NW Bicester Eco development. Barton Park has 885 residential units planned. The two sites are very different but there is much we can learn from these differences as well as sharing the learning from the similarities.

The Barton Park programme is developer and City Council led, with housing to be built alongside the existing Barton area which is an area of significant social disadvantage. Integration of both parts of Barton will be essential to spread the benefit of this new approach.

The idea is to design communities where:

- walking to school or cycling to work become the default option
- public spaces are dementia-friendly from the outset
- health services are joined up with other local services, using digital technology to promote health
- houses can be adapted to meet the needs of people as they age.

It is worth dwelling on some of the details in the **Barton Park** initiative which include the building of a new school which is expected to link with the existing school in Barton. The school will also have community space which will provide an area for social activities, clubs, groups and activity sessions to keep people active and to reduce isolation and encourage mental wellbeing. It is hoped that these will link to the existing community facilities such as the Barton Neighborhood Centre. Being a part of the school also means that a community 'hub' is created where there is an opportunity for more contact between a wide range of people.

There will also be a civic area which will include shops and further opportunities for social contact with others.

The football pitch provision is planned to be upgraded. It is expected that some of the pitches will be artificial turf and so available to play on for longer during the year. The pitches will mean that pupils at the school will be able to keep active and play sports, but they will also provide a community facility for local clubs to use.

There are also plans for upgrades to the allotments which will serve the whole community, both existing and new. Working on allotments will help people to be active, enjoying the fresh air and socialising with others, as well providing the means for healthy food to be grown.

Green routes are planned where people can walk through attractive areas for pleasure or to reach facilities and services in other areas of the development. Some sections will also link to footpaths leading out to the open countryside, which will make it easier for people to be active and enjoy the outdoors without having to travel in the car to get there.

It is planned that there will be play areas where children can be active outside in open spaces. A 'trim trail' will be created which will link to the existing green area in Barton. It is also expected that there will be upgrades to the GP practice in the existing Barton area which will serve both the existing and new communities.

The development will be designed to 'fit in' with the area, with the use of design materials local to Oxford where possible. It is planned that the streets will be designed so that choosing to cycle or walk is easier than choosing to drive. Cycling and walking instead of using the car boosts physical health and mental wellbeing and makes socializing easier which reduces isolation.

The programme at **Bicester** is focusing on the whole town and how the new housing can improve the health and wellbeing of all residents**.** This is based on a broad partnership of around 21 organisations and, along with the developer, includes Local Authorities, health service commissioners, universities, businesses and many more. The plans include:

- options for people to choose healthier ways to travel through cycling, walking or using these in combination with public transport
- more opportunities for social interaction with others
- green space such as parks and walkways and cycle networks which will give people safe and attractive areas to walk or cycle through and will make these methods of transport more appealing.
- Homes designed so that people can live independently for as long as possible. The houses will have features such as good insulation to prevent them from becoming damp, to keep people warm and well and to reduce the amount of money that they will need to spend on heating bills.
- It will be easier for people to eat healthily by ensuring that there are adequate cooking facilities in people's homes, with easy access to shops and plans to provide opportunities to grow food locally.
- Some of the community facilities and services will be located in shared buildings or in the same area so that resources can be shared and they are easier for people to get to them and use them.
- Well-designed community spaces that are attractive and easy to access will give people more opportunities to have contact with others to help reduce isolation and improve mental wellbeing.

Technology will be key in NHS Healthy New Towns. The Elmsbrook Eco development in Bicester will consist of 393 houses which will be installed with digital tablets known as 'Shimmy's'. The tablets will enable households to have access to a range of information. This could include community information such as opening times of services, dates of local events, contact details of services and can carry reliable health information and messages. The Shimmy could also have a feature to let people know 'live' travel options e.g. when the next bus will be, how long it would take to walk to their destination and the routes they could take to make it easier for people to choose travel options that don't automatically mean getting in the car.

There will also be an element of home energy efficiency on the Shimmy where people could monitor temperatures and the amount of energy that they are using in their homes. There are also plans to improve access to health care through the Shimmy such as appointment booking, remote consultations and electronic monitoring of people's vital signs.

That's all well and good, but will it happen and is it generalizable?

This is the big question and the proof of the pudding is in the eating. We will have to wait and see which of these features can be achieved and which make a real difference.

Fancy developments with some Government funding are fine, but what about the 1000's of other developments being proposed across the County? No-one knows the answer, but the Healthy Towns initiative could mark a turning point. Health is now on the map in terms of local planning, and there are many ideas coming from the Healthy Towns development that could be built in to other areas.

Of course the market will have an influence – if these developments prove to be popular, there could be a commercial incentive for developers to build them in elsewhere.
The key is to realise that that we need this type of development if we are to cope with the demographic challenge.

Also the ideas may only be really viable in medium and large size developments. If we continue with 'pepper-pot' developments of a few houses here and there it may be difficult to spread the benefits.

The NHS is alive to the issue of getting health into planning. Proposals for changes to health services are likely to look towards more efficient use of public buildings – the same goes for changes to library services, schools and other public amenities.

The NHS's Sustainability and Transformation Plan is talking about finding ways to work with Local Government in Oxfordshire, Buckinghamshire and Berkshire on local planning as a matter of course.

Various options for Unitary Local Government are currently being debated in the County. It is clear that a Unitary approach would make this sort of planning easier as planning, road building, housing , environmental health, social care and public health functions would all be run by one organisation.

There is far to go and this journey has just begun, which is just as well as we will need to pull together in this way if we are to tackle the demographic challenge while managing a tightening public purse.

What did we say last year and what has been done about it?

Last year's report introduced the topic of 'getting health into planning' and looked at the health issues such as the effect of pollution and the importance of cycling in some detail. The recommendations were all about taking this work further and the Healthy New Towns initiative means that good progress has been made.

Recommendations

1. The Healthy New Towns initiative should be monitored closely and lessons learned should be generalised within the current and future planning system.

2. The NHS through its Sustainability and Transformation Plan should carry out more detailed work with Local Authorities to get health issues into local planning as a routine activity.

Chapter 3: Breaking the Cycle of Disadvantage

Main messages in this chapter

- **Disadvantage and Inequalities remain a major issue for the Public Health of Oxfordshire.**
- **There has been a further modest reduction in disadvantage overall and this is to be welcomed.**
- **We await the findings of the independent Commission on Health Inequalities for Oxfordshire– it will be published later in the year.**
- **There has been steady progress against last year's recommendations.**
- **Because children's services are changing we need to establish a firm baseline of indicators now so that we can measure any future changes. A basket of indicators is set out here.**
- **It is vital that this topic is kept under close review**

We are in between two important developments:

1. Last year this report reviewed thoroughly all aspects of disadvantage in the County and drew the conclusion that, overall, useful progress had been made but there was more to be done,

2. By next year the Health and Wellbeing Board's Independent Commission on Health Inequalities will have reported, having sifted the evidence with a fresh pair of eyes which should help to point the way forward.

This year therefore I want to do 3 things:

1. Review progress on last year's recommendations in detail

2. Report on new data which has emerged during the year

3. Concentrate on children and young people by proposing a set of indicators to monitor changes to children's services in the future

Detailed review of last year's recommendations

Because this topic is so important to improving health, I am going to repeat the detail of last year's recommendations and formally review progress on each one:

The recommendations came in two parts – short term and long term:

Review of Short term recommendations made last year:

Each recommendation from last year is set out in full and is followed by a progress report:

Recommendation 1 said:

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.

Progress report:

Good progress has been made. The Health and Wellbeing Board has sponsored an independent Commission on Health Inequalities and the work is due to report in the Autumn. It has taken evidence from a wide range of sources and has had access to local data.

The NHS's 5 year plan is being implemented through a 'Sustainability and Transformation Plan' (STP), which is including prevention and health inequalities as a major concern to be addressed. The NHS has determined that this plan should cover Oxfordshire, Buckinghamshire and the West half of Berkshire.

Making plans is all well and good – it will be important to make sure this is followed by real action.

Recommendation 2 said:

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.

Progress Report

Satisfactory progress has been made on all of these programmes – many will form part of the NHS's Sustainability and Transformation Plans (STP) mentioned above.

Further information on school results, teenage pregnancy and the Thriving Families programme are included later in this chapter.

Recommendation 3 said:

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 Female Genital Mutilation should continue.

Progress report:

The Health Improvement Board is currently grappling with the issue of homelessness through a multi-agency sub-group. We await the results, but the problem is being pursued in detail.

NHS Health Checks were reviewed to make sure that there are no inequalities in the invitations sent out to people. Next year will see plans come forward to increase uptake in priority groups where disease levels are higher such as manual workers and ethnic minority groups.

Work to prevent Female Genital Mutilation (FGM) has continued successfully as planned. A study has been set up to work with communities with high levels of FGM to find out more about why the practice might be sustained in a UK context. There is currently a dearth of factual information about this because of the sensitivity of the topic. The more we know, the more we can prevent FGM at source. Community researchers have been trained to work with their own communities to tackle the factors that motivate people to consider FGM.

The project will be completed in late 2016 and the findings reported to the FGM partnership group and the Children's Safeguarding Board.

Recommendation 4 said:

Contract specifications for services being renewed should carefully consider how to target areas in the bottom 20% 'Index of Multiple Deprivation' 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.

Progress Report:

The issue of placing 'smarter' NHS contracts for services so that areas of high social disadvantage can be targeted has been proposed as part of the 'prevention' plan as part

of the NHS's Sustainability and Transformation Plans (STP). We wait to see developments. This is important and we need to keep a watching brief on progress.

Recommendation 5 said:

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.

Progress Report:

This is another strand of what is proposed in the NHS's Sustainability and Transformation Plans (STP). Again, the proof of the pudding will be in the eating and we need to keep monitoring progress.

Longer term recommendations from 2014/15:

Recommendation 1 said:

Recommendations regarding housing and the design of communities so as to combat isolation, loneliness and to break the cycle of disadvantage in specific areas should be progressed.

Progress Report:

The Healthy Towns initiative described in Chapter 2 has given a real boost to this strand of work.

Making real progress on the mixture of housing stock available, designing communities which encourage social contact and building new developments that can be adapted easily as residents age, will probably require a resolution to the current 'unitary debate' going on in the County at present.

The real change is that these topics are now 'on the agenda' as mainstream issues whereas they were given scant regard in previous decades.

Recommendation 2 said:

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.

Progress Report:

We work well together as partners in Oxfordshire on these topics and our County remains one of those which contributes positively to the national economy. Making real progress on this topic will also require resolution of the 'unitary debate'. The intense debate in the County about devolution and unitarisation has had the beneficial effect of bringing

forward ambitious thinking about how to attract national funding to drive the economy forward.

Recommendation 3 said:

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.

Progress report:

The Health Overview and Scrutiny group has considered issues of inequity in specific services – the committee has had its plate full in considering major health service plans, CQC and Healthwatch reports, changes to community hospitals and other urgent issues. The time for the Health Overview and Scrutiny Committee to consider inequalities in the round will be when the NHS puts forward its Sustainability and Transformation Plans (STPs) in the Autumn and the Commission on Health Inequalities publishes its findings later in 2016.

Recommendation 4 said:

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

Progress Report:

Healthwatch have continued to champion topics related to inequalities during the year and have helped give voice to those who might otherwise go unheard, including through the Health and Wellbeing Board and the Health Scrutiny Committee. Healthwatch have also been able to contribute constructively to the Commission for Health Inequalities while preserving their neutrality. Their commentary on the published report will be valuable.

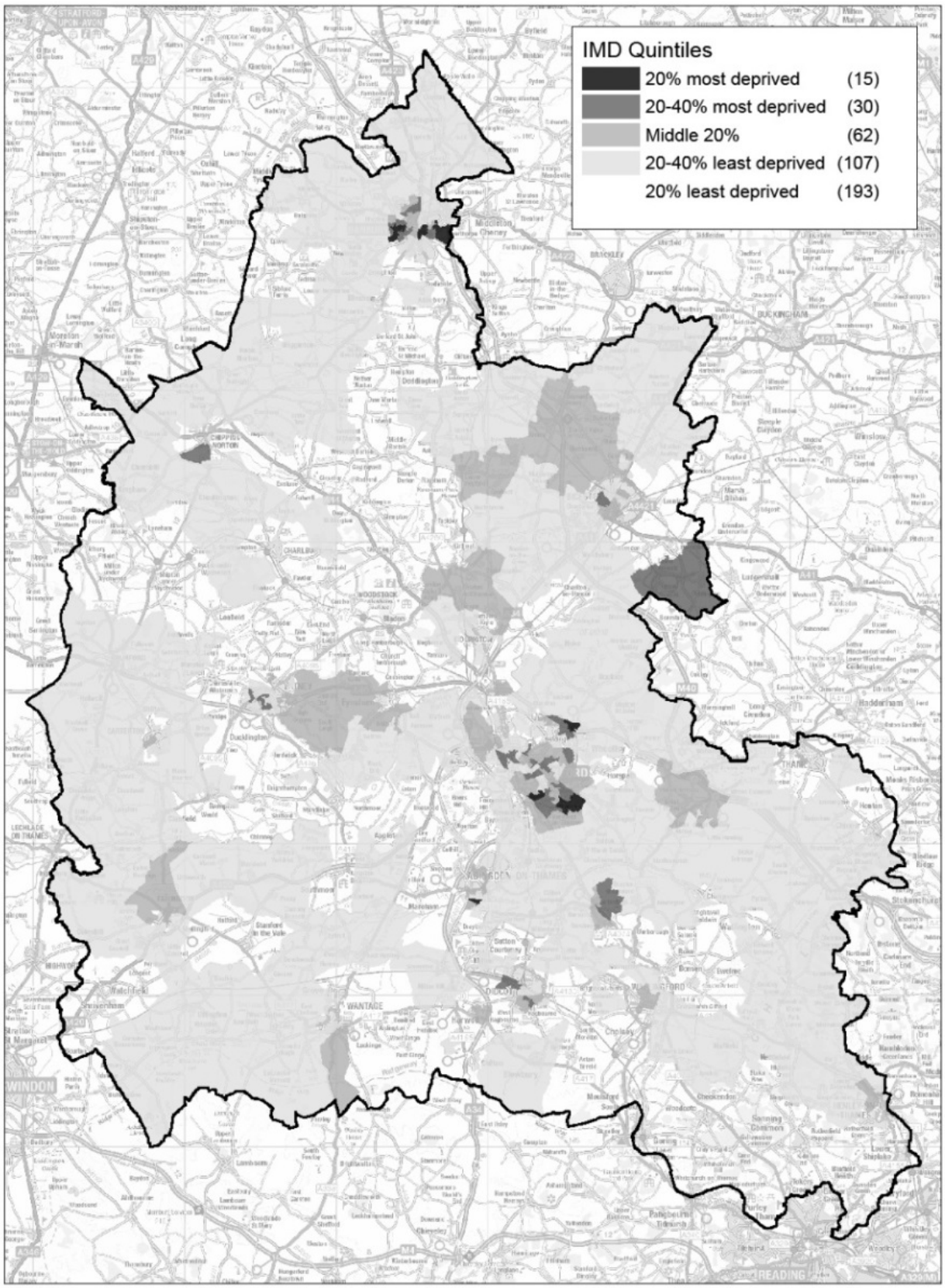
Breaking the Cycle of Disadvantage part 2: Update on data produced during the last year

Measuring overall geographical disadvantage – the 'Index of Multiple Deprivation' (IMD)
The best overall measure of disadvantage in the County – the 'Index of multiple deprivation' (IMD) has been updated.

This measure uses 37 indicators spanning seven broad types of disadvantage. These indicators are used to calculate an overall Index of Multiple Deprivation (IMD). The indicator looks at 407 small areas within Oxfordshire and compares them with national figures.

Overall, Oxfordshire has relatively low levels of disadvantage. It is the 11th *least* deprived of 152 upper tier local authorities in England (up from 12th least deprived in 2010). ***However, as we know, there is significant variation across different parts of the county.*** The map below tells the story – the areas in Oxfordshire which fall within the 20% most disadvantaged in England are shaded the darkest and the areas which fall within the least disadvantaged 20% of areas are not shaded at all.

Overall map of multiple disadvantage in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

The map shows that:

- Most of Oxfordshire's 407 small areas are less disadvantaged than the national average.
- 110 are among the least deprived 10% nationally.
- Overall, nearly half (46%) of the county's population lives in areas that are among the least disadvantaged 20% in England.
- More than four in five residents (82%) live in areas that are less disadvantaged than the national average.
- Of course this does not mean that there is no disadvantage in those areas – individual communities such as Berinsfield for example are 'masked' by being included in larger more affluent areas, and many rural communities can tell the same story.
- 13 areas are among the 10-20% most disadvantaged (down from 17 in 2010).
- Two areas are among the 10% most disadvantaged in England. These are in Oxford City, in parts of Rose Hill and Iffley ward, and Northfield Brook ward. In 2010 only Northfield Brook was among the 10% most disadvantaged areas.

The most disadvantaged areas are concentrated in parts of Oxford City and Banbury with one in Abingdon. They are set out in detail in the following table, along with their national 'ranking' – a sort of league table of all 34,844 small areas in England, where the lower the number, the greater the disadvantage.

Small areas in Oxfordshire among the 20% most disadvantaged nationally

Small Area	Ward	District	Deprivation Decile	Rank position in England (where 1 is the most deprived and 32,844 is the least disadvantaged)
Oxford 016E	Rose Hill and Iffley	Oxford	10% most deprived	2,578
Oxford 018B	Northfield Brook	Oxford	10% most deprived	3,078
Cherwell 004A	Banbury Grimsbury and Castle	Cherwell	10-20% most deprived	4,701
Cherwell 004G	Banbury Grimsbury and Castle	Cherwell	10-20% most deprived	6,520
Cherwell 005B	Banbury Ruscote	Cherwell	10-20% most deprived	6,173
Cherwell 005F	Banbury Ruscote	Cherwell	10-20% most deprived	6,299
Oxford 005A	Barton and Sandhills	Oxford	10-20% most deprived	4,722
Oxford 005B	Barton and Sandhills	Oxford	10-20% most deprived	5,319
Oxford 016F	Rose Hill and Iffley	Oxford	10-20% most deprived	6,182
Oxford 017A	Blackbird Leys	Oxford	10-20% most deprived	5,225
Oxford 017B	Blackbird Leys	Oxford	10-20% most deprived	3,785
Oxford 017D	Northfield Brook	Oxford	10-20% most deprived	6,523
Oxford 018A	Blackbird Leys	Oxford	10-20% most deprived	4,293
Oxford 018C	Northfield Brook	Oxford	10-20% most deprived	3,553
Vale of White Horse 008C	Abingdon Caldecott	V White Horse	10-20% most deprived	5,936

Source: DCLG English Indices of Deprivation 2015

In general, the areas of Oxfordshire that were identified as the most deprived in 2010 remain the most deprived. However, in Oxford City, one area in Holywell ward, and another in Littlemore, have moved out of the 10-20% most deprived. However, one in Rose Hill has moved *into* the 10-20% category.

In Banbury, one area in Ruscote ward has moved out of the 10-20% most deprived.

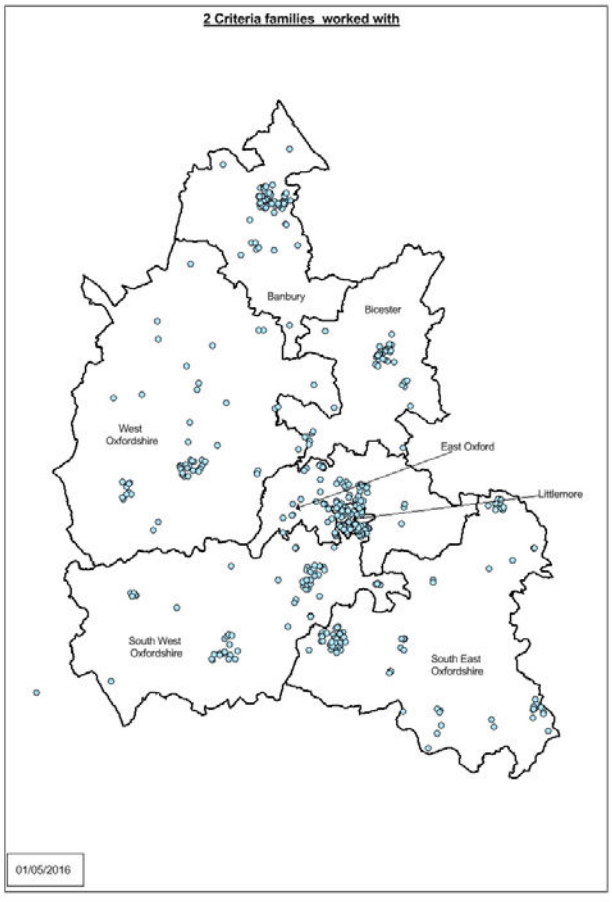
Conclusion: Breaking the cycle of disadvantage in Oxfordshire is all about targeting services to level the experience of all up to the best. Disadvantage in small areas of the County remains the biggest challenge, and services need to be designed to focus on them.

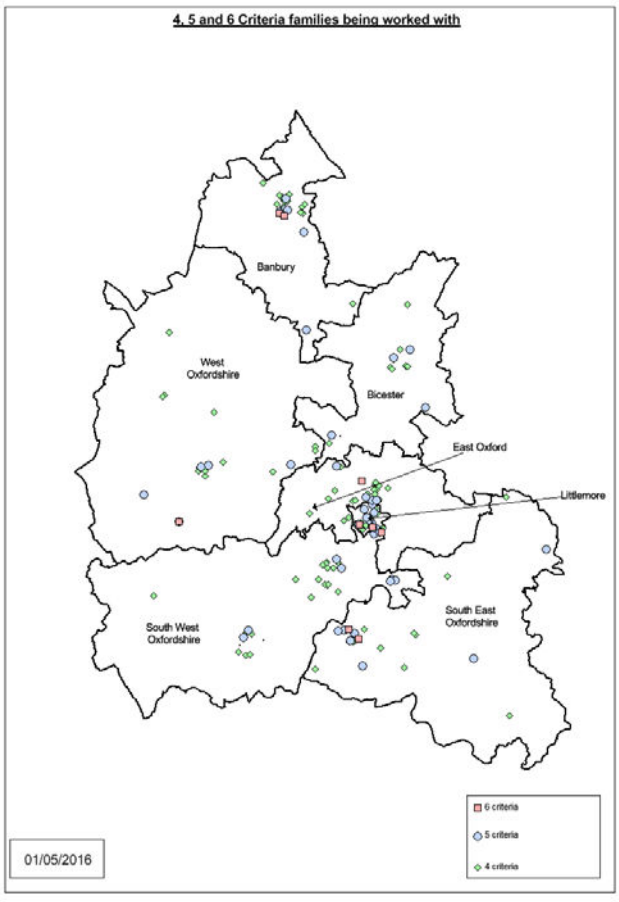
We can get more insight into the spread of individual high-need families by looking at the 'Thriving Families' data below.

Thriving Families Data (The national Troubled Families programme)

This national programme measures 6 indicators of high need in whole families and then focusses services to help them, aiming to break the cycle of disadvantage, get children back into school, adults into work and save the state money.

The families identified can be mapped depending on how many of these 6 criteria they meet. The maps are revealing. I have included 2 of the maps below, one for families with any 2 factors and one map for families with higher needs with 4, 5 or 6 factors:





Comparing the 2 maps shows:

- Families with any 2 of the 6 criteria are spread across the County in rural and urban areas, with clusters in more populated areas.

- Families with 4, 5 or 6 criteria, and therefore greater need, show less 'scatter' and are more concentrated in urban areas, especially Oxford and Banbury.

These maps illustrate well the practical difficulty of planning services on the ground in Oxfordshire – yes, there are needs across the whole County, ***but*** they are focussed on the main population areas and do cluster in the bigger towns.

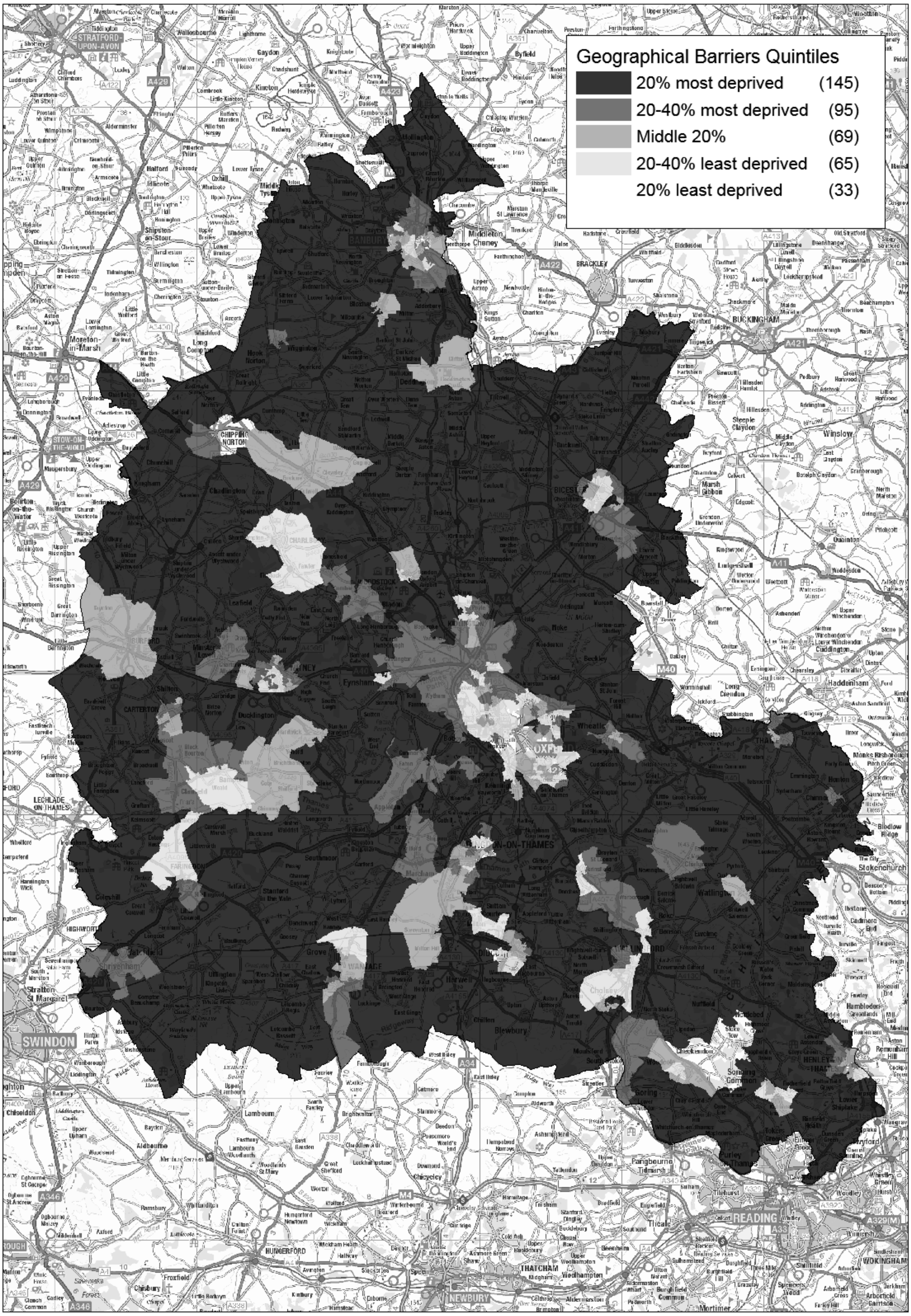
Conclusion: Because the 'Thriving Families' programme is reaching out to all parts of the County, urban and rural, and because it achieves demonstrable results, it is likely that this represents a decrease in disadvantage.

However, the true cycle of disadvantage is passed down from one generation to the next. This will be more likely to happen in communities where many disadvantaged people live together. So, to break the cycle we do need to focus efforts on such communities.

Rural Disadvantage

The other major cause of disadvantage in the County stems from its rural nature. This means that some areas have more difficulty in accessing services as well as having a high proportion of older people. This is shown in the map below in a measure called 'geographical barriers. It takes into account the many challenges posed by rurality in terms of accessing services. It was updated in 2015.

This index is based on road distances to post offices, primary schools, GP surgeries, and general stores or supermarkets.


Geographical Barriers Quintiles
20% most deprived (145)
20-40% most deprived (95)
Middle 20% (69)
20-40% least deprived (65)
20% least deprived (33)

The map shows that **the majority of Oxfordshire's 407 small areas are more deprived than the national average**. 85 are among the 10% most deprived nationally and are concentrated outside the main urban centres. A further 60 small areas are in the 10-20% most deprived nationally.

The implications of this were discussed in chapter 1. This is where the demographic challenge will be felt the most and services will need to be re-designed to meet the needs of these communities.

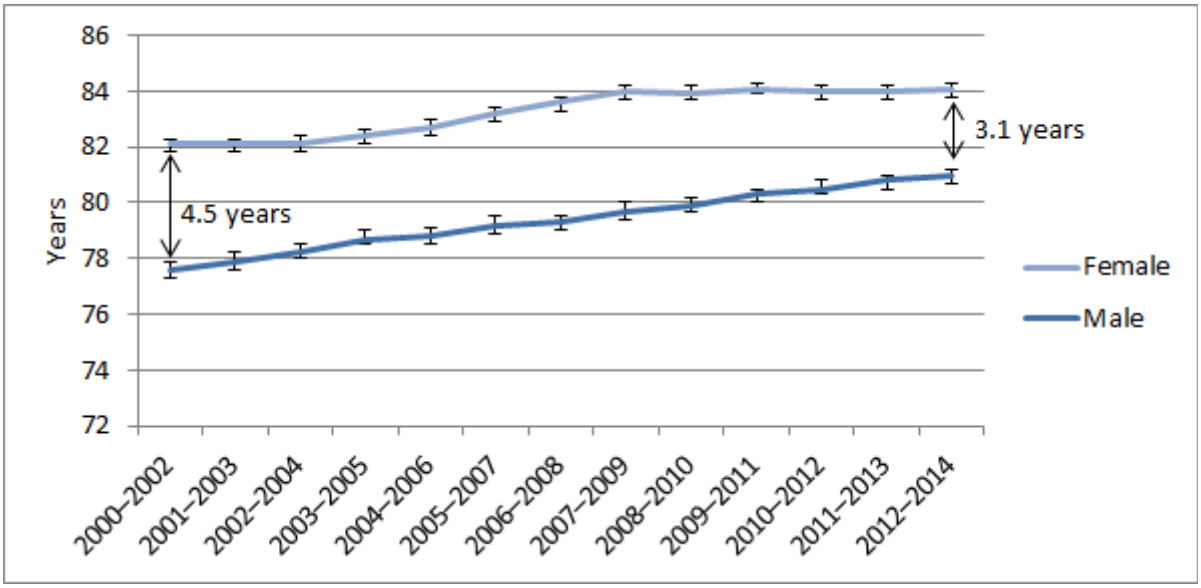
Conclusion: The rural nature of Oxfordshire presents a real challenge to providing services fairly across the County and this form of disadvantage needs to be monitored closely.

Reduction in the 'life-expectancy gap' between males and females.

Life expectancy at birth predicts the average number of years a person born could expect to live if they were to experience their local area's death rates in the future. It is an estimate, but a useful general indicator of life chances in general.

Male life expectancy continues to edge upwards to 81 years, closing the gap on females. Males lag behind by 3.1 years – it was 3.2 years last year. Female life expectancy however seems to have plateaued at 84 years on average. It is still too early to suggest why this might be.

Male and female life expectancy at birth in Oxfordshire, 3-year rolling data for 2000-02 to 2012-14



Source: Office for National Statistics. *NB the vertical axis starts at 72 years, not 0 years.*

For the 2012-14 period, life expectancy for both sexes was higher in Oxfordshire than the national average. *Male* life expectancy was also higher than the regional average (whereas *female* life expectancy was similar to the regional average).

Conclusion: we need to keep this indicator under review, especially as it may indicate a levelling off female life expectancy.

Healthy life expectancy

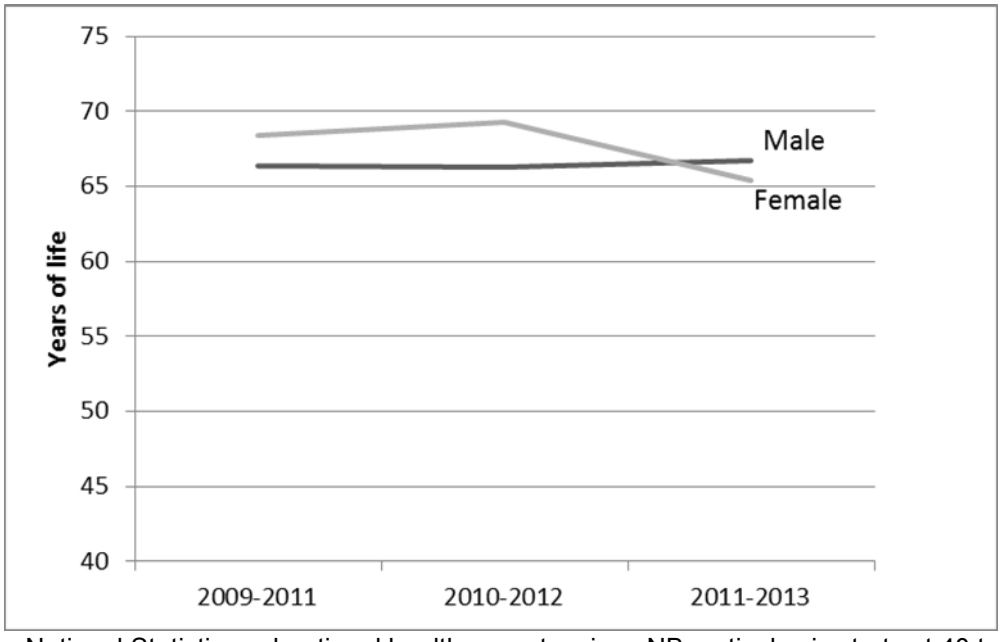
The question then arises, 'so how long can I expect to live in good health'. To answer this we have **healthy life expectancy** figures. Nationally, overall life expectancy has been increasing faster than healthy life expectancy in recent years***; this means people may have more years living in ill-health in the future.***

Males do better than females this time – males can expect nearly 67 years of good health on average and the figures are steady year on year, whereas the figure for females is just over 65 and has fallen slightly and is now lower than for men.

Again, no one is sure quite why this is, but it is important to keep a watching brief.

Healthy life expectancy in Oxfordshire is above the national average for both sexes and close to the Regional average.

Healthy life expectancy at birth in Oxfordshire (2009-11 to 2011-13)



Source: Office for National Statistics subnational health expectancies. NB vertical axis starts at 40 to aid legibility.

Conclusion: This data sounds another note of concern for women's health as a whole and we need to monitor the situation closely

Changes in the ethnic minority population

It is worth reviewing the changes in the ethnic minority population again, as this shows a need to provide a wider range of services in the future if disease is to be prevented and detected early. Comparing the last two censuses, Oxfordshire's Black and Minority Ethnic (BME) communities numbered 59,800 in 2011, - just over 9% of the population. This was nearly double the 2001 proportion of just under 5%, and resulted from growth across all of the county's BME communities.

People from Asian backgrounds constituted the largest BME group, numbering 31,700, or almost 5% of the county's population (up from 2.4% in 2001). Most came from Indian backgrounds (1.3% of the population) or Pakistani backgrounds (1.2%).

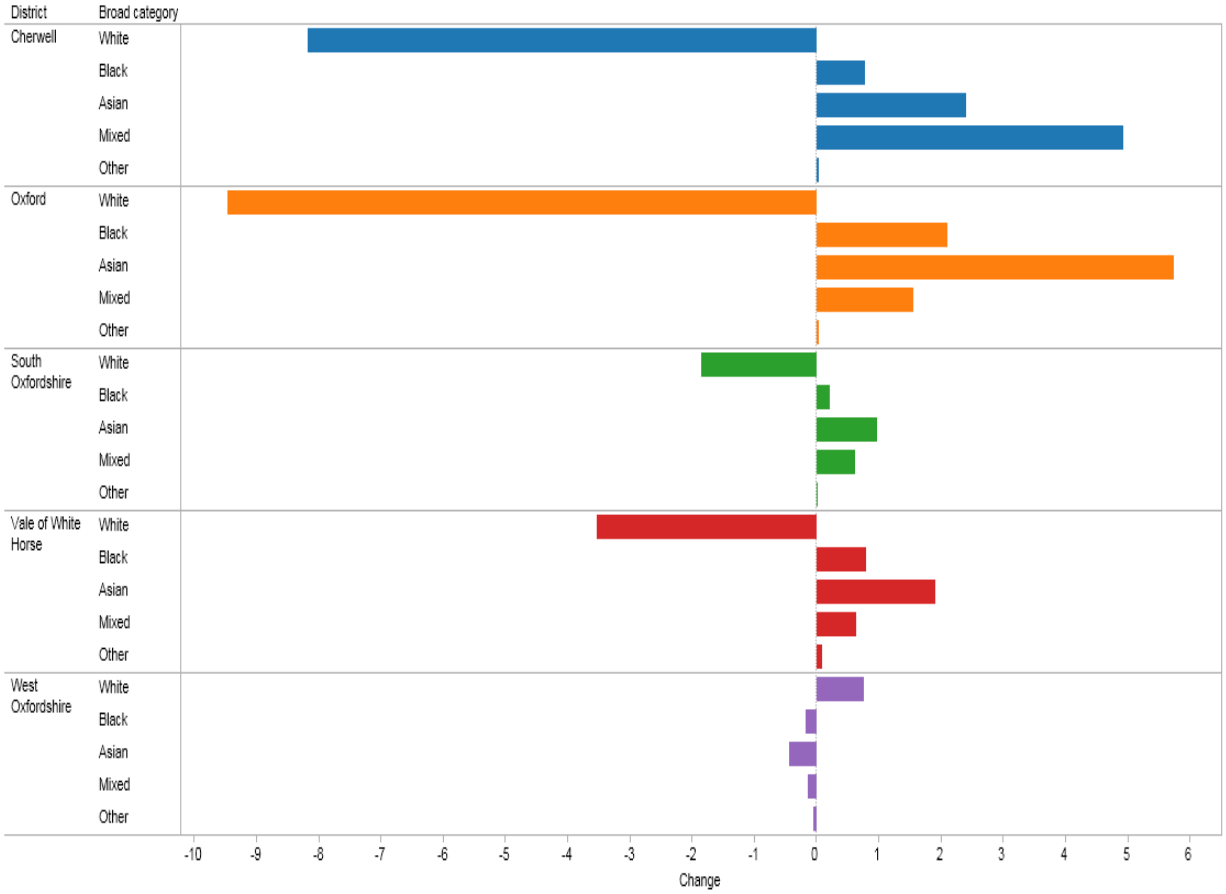
There were 13,200 people from mixed ethnic backgrounds, accounting for 2% of the population (up from 1.2% in 2001).

The number of people from all Black ethnic minority groups was 11,400, or 1.8% of the county's population (up from 0.8% in 2001).

The chart below shows the percentage increase or decrease in the main BME groups between the censuses. The chart shows that:

- Oxford and Cherwell saw the largest increases in the proportion of the population made up by BME communities between 2001 and 2011.
- There was a 6% increase in the proportion of people from Asian backgrounds in Oxford, the largest increase of any of the broad categories.
- Cherwell saw a 5% increase in the proportion of people of mixed ethnic backgrounds.
- Vale and South Districts showed modest rises.
- The proportion of the population made up by ethnic minorities fell slightly in West Oxfordshire.

Change in the proportion of the population made up by ethnic groups



Source: Oxfordshire Insight, data taken from 2001 and 2011 ONS Census surveys

Conclusion:

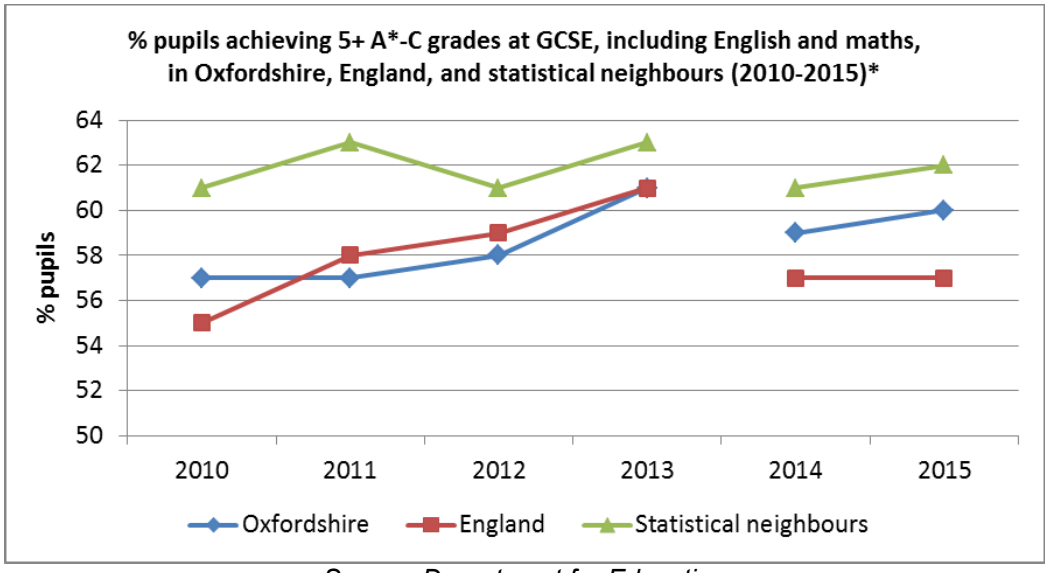
The increasing diversity of Oxfordshire's population remains a key factor in tackling disadvantage through targeting services.

School results at GCSE (typically children aged 15)

These are important measures of the life-chances of children and I report on them each year.

2015 was a good year overall, with **60% of pupils achieving five or more A*-C grades at GCSE, including English and maths. This was above the England average of (57%).**

This is very good news because the chart shows an increase in good results above the national figures. There is further to go as the results were below the average across Oxfordshire's statistical neighbours (similar Counties) by 2 percentage points.

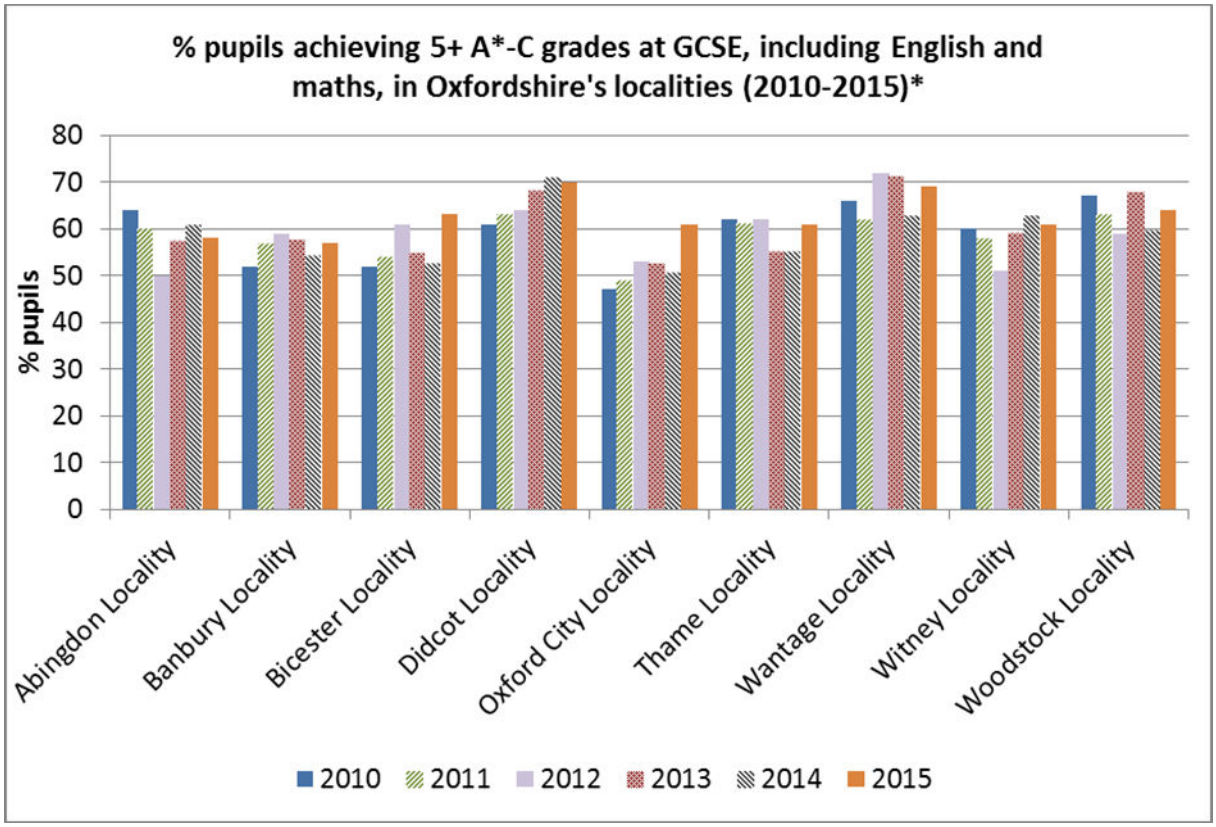


Source: Department for Education
**Before 2014 the measure was based on best entry; from 2014 it is based on first entry*
***NB vertical axis starts at 50 to aid legibility.*

However, this good news must be tempered when we look at results for ***children eligible for free school meals*** which we can use as a rough measure of poverty - 31% of pupils known to be eligible for free school meals achieved five or more A*-C grades at GCSE, including English and maths, compared with 62% of other pupils (a gap of 31 percentage points). This was slightly worse than the England average by 2 percentage points, but it was higher than our statistical neighbours by 1%.

School results at GCSE by locality

There is some good news here too. The chart below tells the story with results at GCSE shown by locality for the last 6 years. ***Compared with last year, results were more even across the board and there was a very welcome improvement from schools in Oxford City which have been worryingly low for some time.*** Oxford's performance in achieving 5 GCSE's at grades A* to C just passed that in schools in Banbury and Abingdon. Scores ranged from 57% in the Banbury and 58% in Abingdon, to 69% in Wantage, and 70% in Didcot.



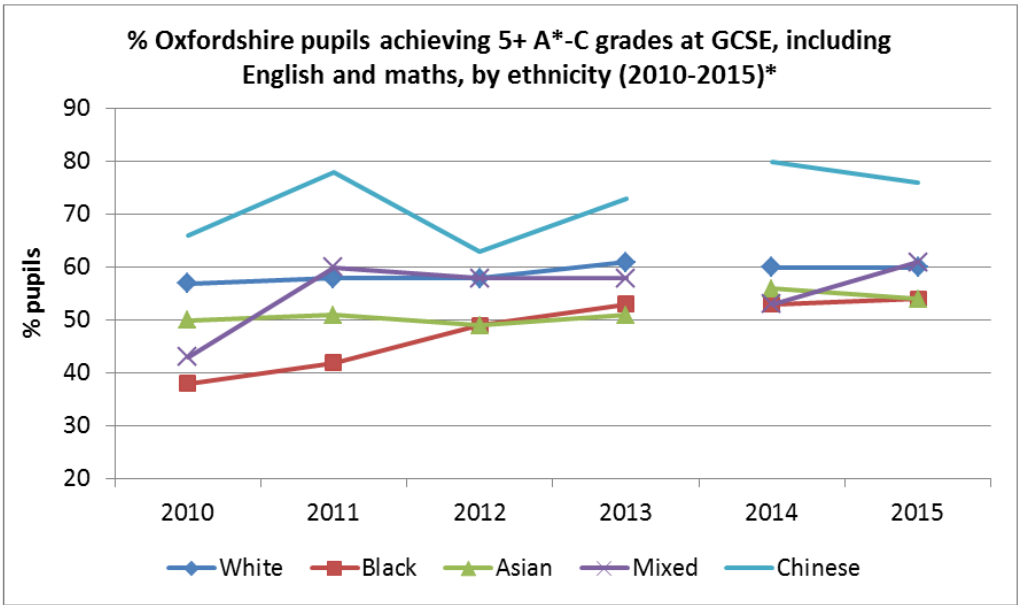
Source: Department for Education
**Before 2014 the measure was based on best entry; from 2014 it is based on first entry.*

GCSE results by ethnic minority
The chart below compares performance between the different ethnic groups in Oxfordshire. The results show:

- Chinese pupils continued to outperform those from other ethnicities.
- On average, GCSE attainment among pupils from White and Mixed ethnicities was similar to the Oxfordshire average.
- Attainment among pupils from other Asian and Black ethnicities was below the Oxfordshire average, but children from Black ethnic minority groups show gradual improvement.

We should interpret these figures with some caution due to the relatively small numbers of non-White pupils: this is likely to account for some of the fluctuation from year to year.

*



Source: Department for Education
**Before 2014 the measure was based on best entry; from 2014 it is based on first entry*
***NB vertical axis starts at 50 to aid legibility.*

Conclusions:

The overall standard of attainment in Oxfordshire's state schools is improving and inequalities are reducing.

The inequality gap between pupils from different ethnic groups is closing overall and this is to be welcomed.

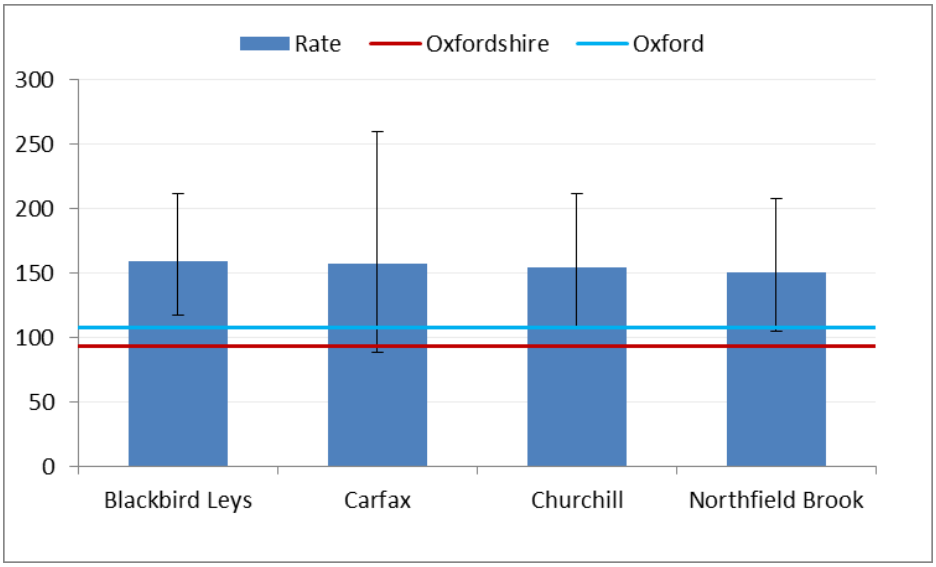
The performance of children receiving free school meals remains a matter of concern.

Deaths from Cancer by District and wards.

Looking at death rates gives us another insight into how disadvantage plays out in the County.

The chart below shows characteristic findings for Oxfordshire:

Oxfordshire wards with the highest cancer mortality (indirectly age-standardised ratios)



Source: Public Health England

The chart shows that:

- Disadvantage has very tangible results – in this case higher death rates from cancer in Oxford City than in the rest of the county.
- The bars on the chart show the death rates for the highest areas in the County. Death rates in the most disadvantaged wards are 50% higher than the County average.
- This pattern of the results of disadvantage is mirrored in many statistics about death and disease and underlines the reasons for tackling disadvantage head on.

Health and disadvantage among carers

The population's health and our services depend on carers. Being a carer can have its rewards, but it is also a significant disadvantage in terms of everyday freedoms and life choices as set out in previous annual reports.

From the 2011 census we already knew that:

- 61,000 people in Oxfordshire said they provided some level of **informal care** to a relative or friend.
- This is just over 9% of the County's population – slightly lower than the national average.
- The proportion of carers by District mirrors the age structure of each District – a higher proportion of older people means a higher proportion of carers.
- Figures for Districts are: Oxford City 8%, Cherwell 9% and 10% in West, South and Vale.
- 72% provided between 1 and 19 hours of care per week, and 18% provided more than 50 hours.
- Most carers are aged 50-64. In this age group 1 in 5 are carers.
- Females provide 58% of care and males 42%.
- 1,300 children aged 0-15 were carers.

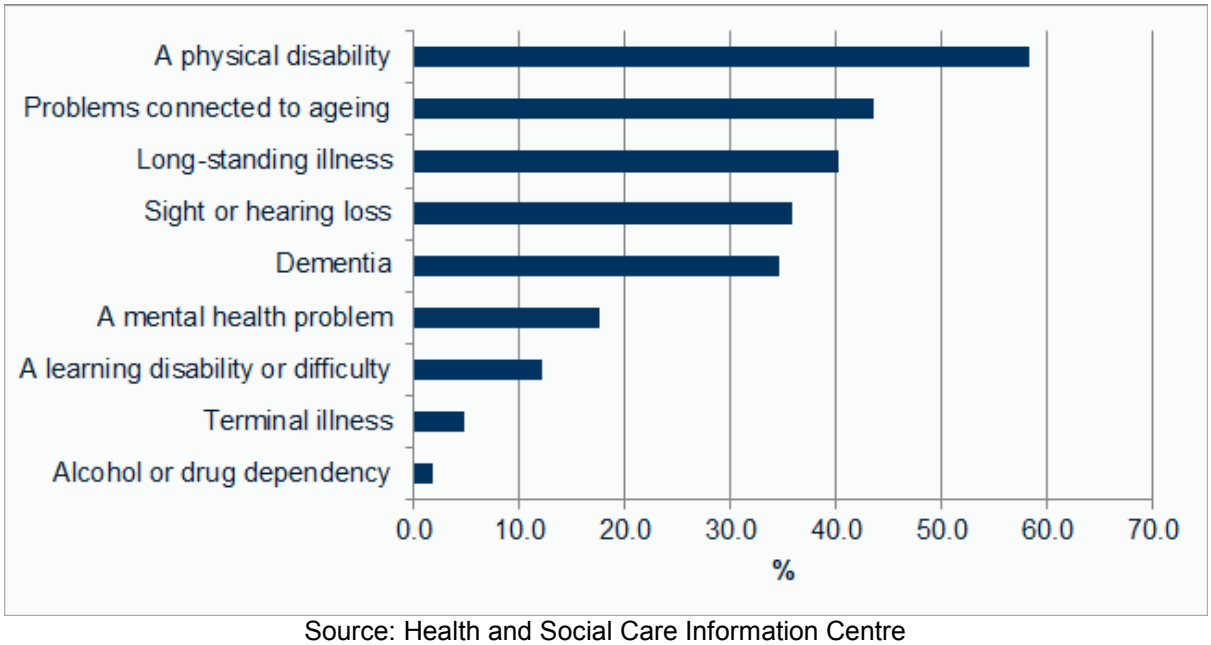
17,200 carers have had their needs assessed by Oxfordshire County Council's social care team during the year, some of whom will also have received a service from the council.

New data was produced as part of a national survey of carers giving a more accurate and up to date picture up to September 2015. The Personal Social Services Survey of Adult Carers in England is carried out every two years covering 18s and over, and it took place for the second time in 2014-15 and 715 carers in Oxfordshire responded. The results show that:

- About three quarters were living with the person they cared for.
- More than one in three had been caring for more than ten years.
- Slightly under half of respondents (44%) reported providing 100 or more hours of care per week.
- Nearly two thirds of the carers who responded (65%) were retired.
- 16% of respondents said they were not in employment *because of* their caring responsibilities.
- Only one in five respondents to the survey in Oxfordshire said they were able to spend their time as they wanted, doing things they value or enjoy.
- 14% said they didn't do anything they value or enjoy.
- Seven in ten respondents said they did not have as much control over their daily life as they want.
- 15% said they had little social contact and felt isolated.
- Most respondents said they had found it easy to find information and advice about support, services and benefits. Nearly 90% had found the information and advice they had received helpful.
- More than three quarters of carers who had received support or services from Social Services said they were satisfied with what they had received. A little under half said they were very or extremely satisfied. These satisfaction levels were broadly similar to regional and national averages.
- These findings overall are broadly in line with the national picture.

For over half of the carers in Oxfordshire who responded to the survey, the person they cared for had a physical disability. The full results are shown in the table below:

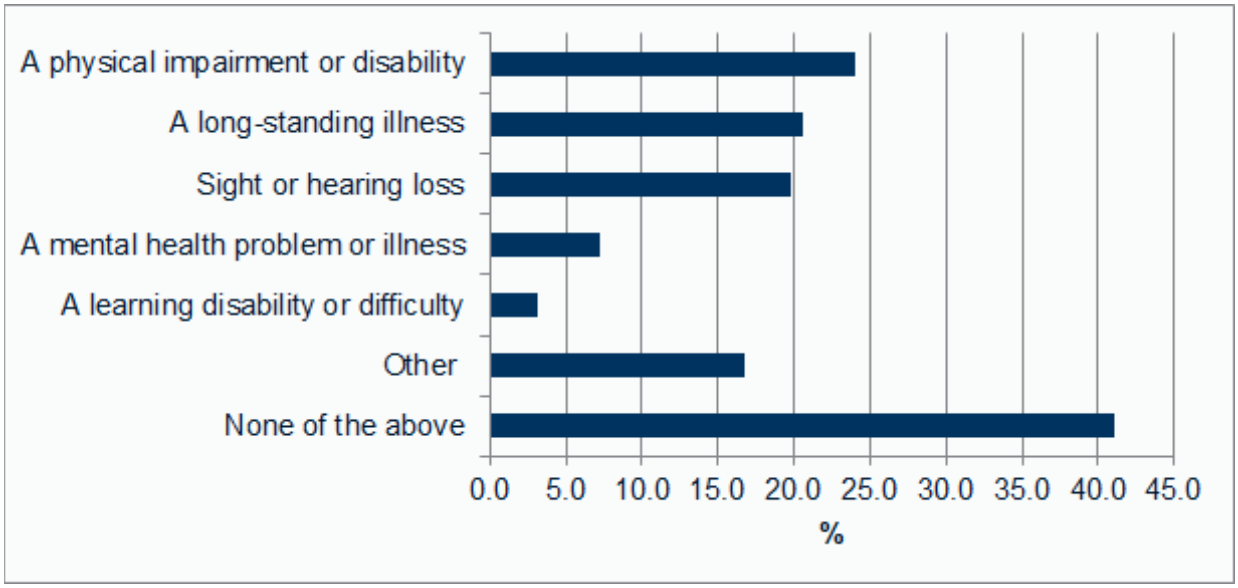
Carers in Oxfordshire, by health condition of the person they care for (2014/15)



Source: Health and Social Care Information Centre

Over half of the carers surveyed reported having a health problem themselves, commonly a physical impairment or disability, a long standing illness, and/ or loss of sight or hearing. The full details are given below:

Health conditions of carers in Oxfordshire (2014/15)



Source: Health and Social Care Information Centre

Conclusion:

This new information highlights the crucial role played by carers.

It also shows the down-side of caring and the limitations it imposes on life choices.

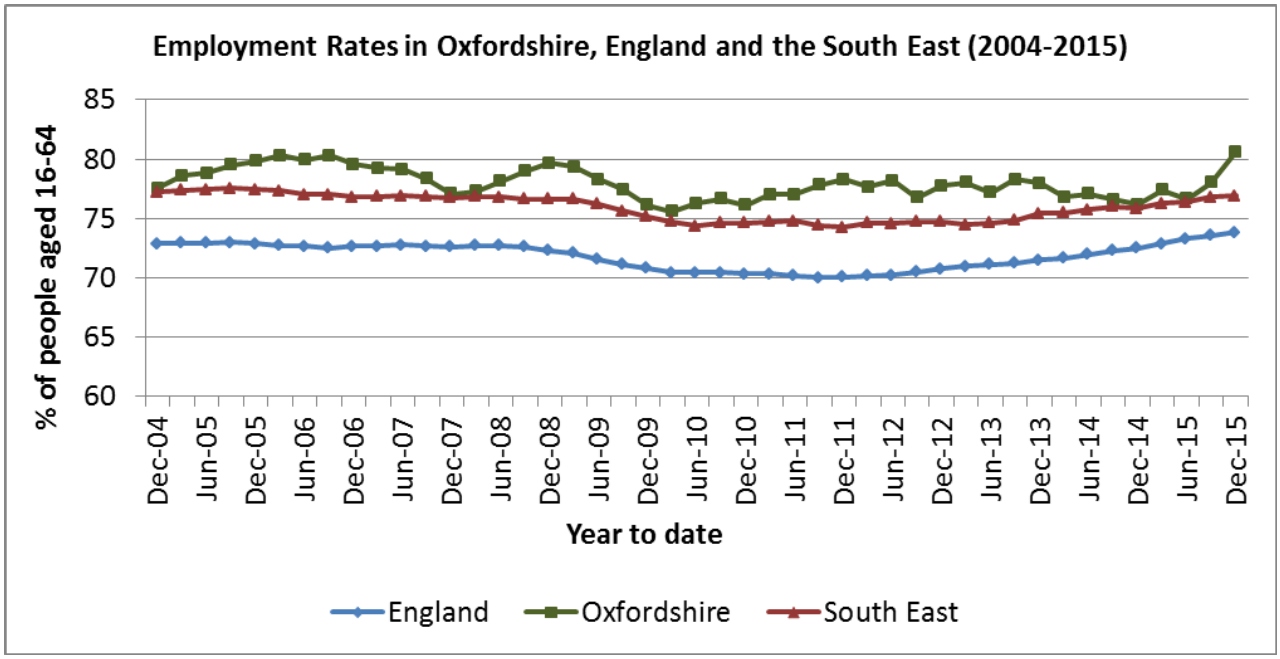
Our services perform well in terms of looking after carers and this is taken as a serious responsibility. We need to ensure that this position does not slip and that it is improved if possible – our carers and our services depend upon it.

A Good Year for Employment

Being in work is good for both physical and mental wellbeing and is crucial for the economy. During last year employment rates rose so that data for the 2015 calendar year show that in Oxfordshire:

81% of people aged 16-64 were in employment, numbering 342,000. Again, this was significantly higher than both the England average (74%) and the South East average (77%). The proportion of men aged 16-64 in employment (86%) was significantly higher than the proportion of women (75%). 70% of people aged 16-64 in Oxfordshire were working for an employer, whilst the remaining 10% were self-employed.

The chart below shows the picture.

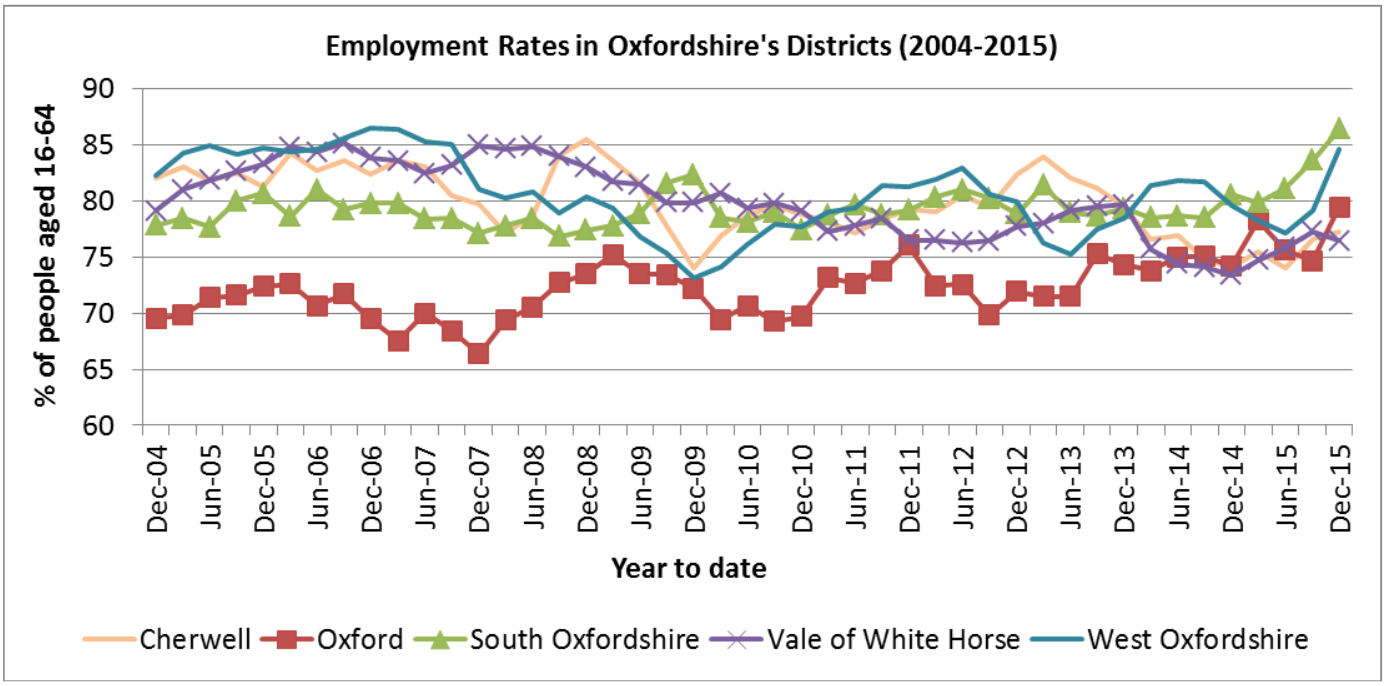


*Source: Annual Population Survey. *NB Vertical axis starts at 60 to aid legibility.*

Employment varies by District

- Employment rates in Districts have varied over the last 10 years with rates in the City gradually rising from 70% to 80%.
- In 2015 employment rates rose in all Districts, but rose more sharply in South Oxfordshire, West Oxfordshire and the City.
- **Overall, disadvantage due to lack of employment is reducing, and inequalities between Districts have reduced over the last 10 years.**
- **This is a good result.**

The chart below tells the story.



*Source: Annual Population Survey. *NB Vertical axis starts at 60 to aid legibility*

Unemployment rates fell slightly during 2015

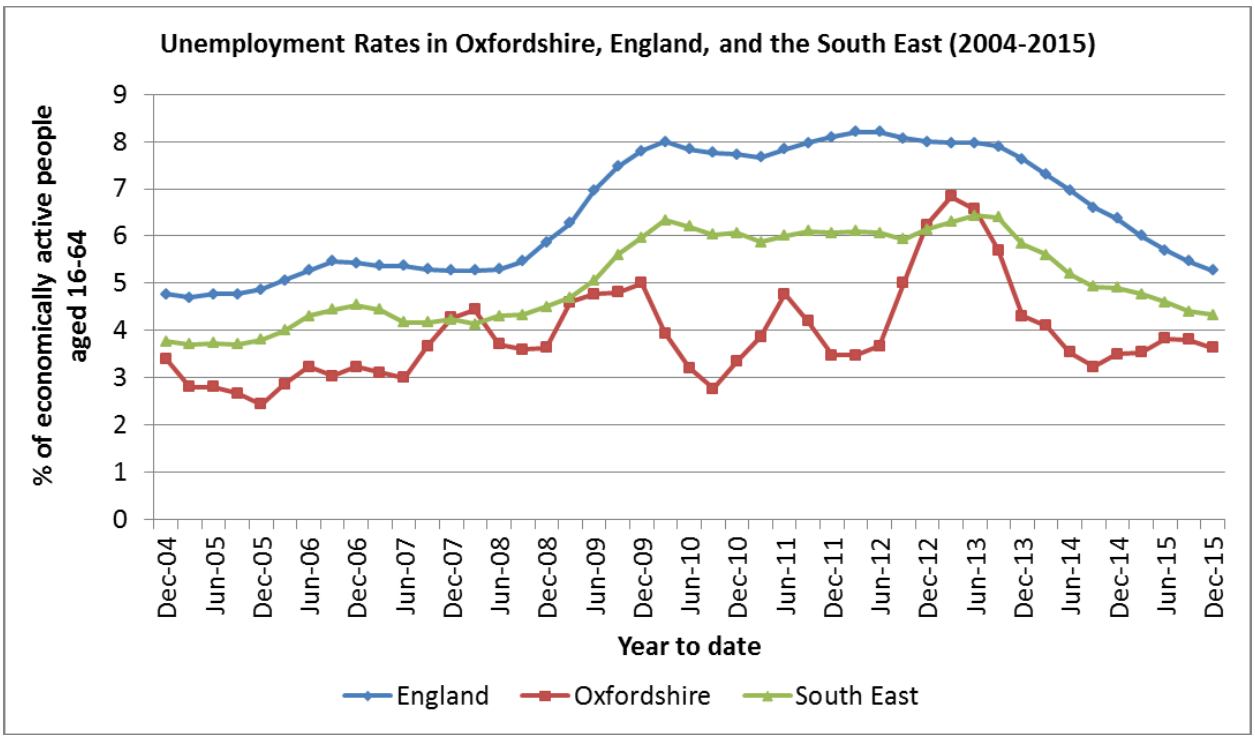
3.6% of economically active people aged 16-64 were unemployed, numbering 12,700 – a modest reduction over the year. This unemployment rate was significantly lower than the England average of around 5%.

As of March 2016, less than 1% of people aged 16-64 were claiming benefits due to unemployment. Claimants are more likely to be men than women.

These are good results.

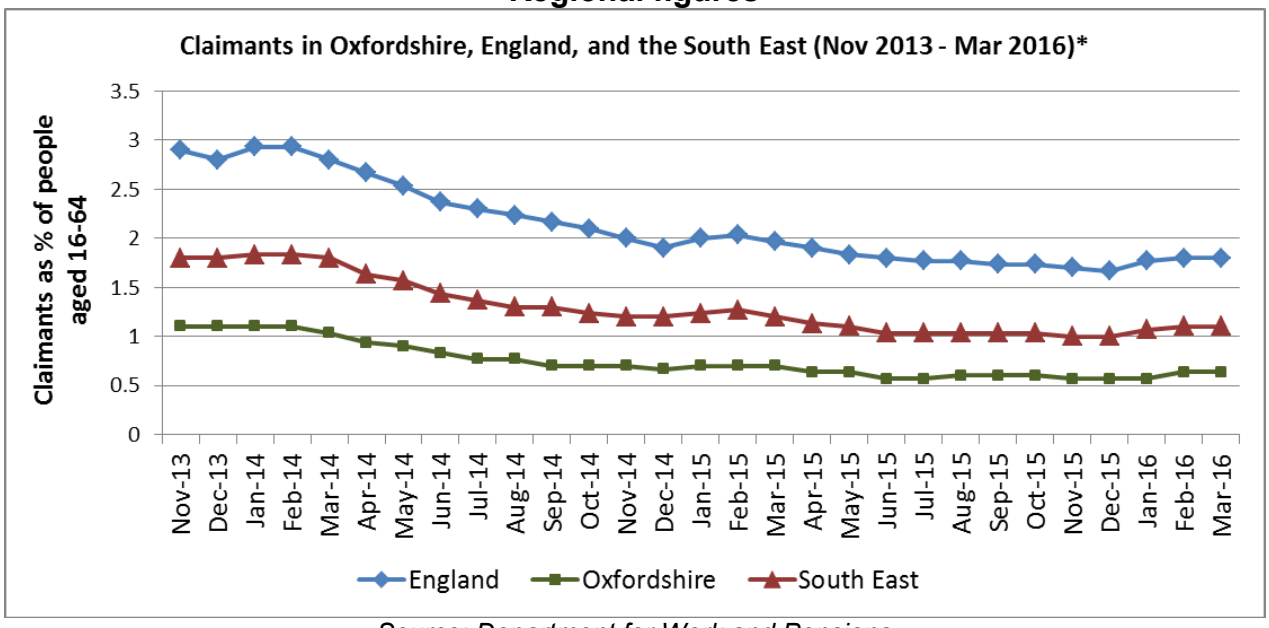
The charts below show the picture and illustrate that Oxfordshire performs better than national and regional figures.

Unemployment rates comparing Oxfordshire with national and regional figures



Source: Annual Population Survey

Unemployment Related Benefit Claimants comparing Oxfordshire with National and Regional figures



Source: Department for Work and Pensions

** This is part of an experimental statistics series running from November 2013, which includes data on all Job Seekers Allowance claimants and all out of work Universal Credit Claimants. Ideally only those Universal Credit claimants who are out of work and required to seek work should be included in the Claimant Count, but it is not currently possible to produce estimates on this basis. The Claimant Count therefore currently includes some out of work claimants of Universal Credit who are not required to look for work; for example, due to illness or disability.*

Breaking The Cycle Of Disadvantage Part III: A Basket of indicators for Disadvantaged Children

Given the proposed changes to children's services in the County, I am keen to monitor the trends in children's life chances using reliable indicators so that we can assess any overall future impact.

The dilemma here is that the data we can rely on tends to come at County level, or District level at best. It will be important to find ways to dig into this data in future years to look more closely at these issues more locally - this is work that the Children's Trust might take on. As we look more locally the numbers will be smaller and will tend to vary, so data from service performance and informed opinion will come into play too. That said, it is important to establish a good baseline now, and that is what I am trying to do here.

The point of setting a baseline now is to draw a line in the sand that can be used to see if things are getting better or worse in future reports.

The indicators I have chosen look at outcome measures that together try to give a picture of children's life-chances in Oxfordshire.

The indicators are:

1. Percentage of children (under 16 years) in Low-Income Families
2. Under 18 conception rate per 1,000 female population aged 15-17 years
3. Teenage mothers (ie teenage conceptions which do not result in termination)
4. Percentage of Infants aged 6-8 weeks who are being breastfed
5. Percentage of 2 year olds who have received one MMR vaccination
6. School Readiness: the percentage of children achieving a good level of development at the end of reception
7. Percentage of pupils achieving 5+ A*-C grades at GCSE, including English and Maths
8. 16-18 year olds not in education employment or training
9. Percentage of children in Reception Year (4-5 year olds) who are obese
10. Percentage of Year 6 children (10-11 years) who are obese
11. Households accepted as homeless
12. Households in temporary accommodation

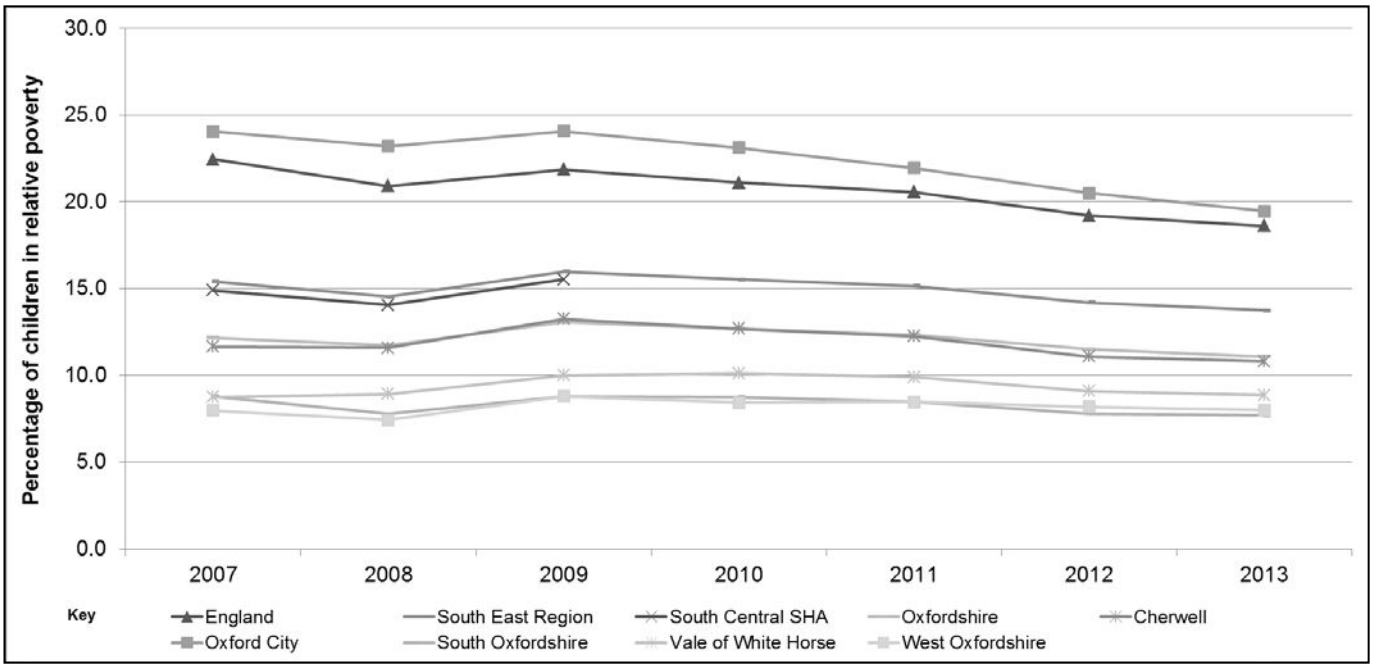
I will look at them one by one and pick out the key features.

Indicator 1. Child poverty

Features of the baseline data:

- The overall trend is downwards, in line with national trends.
- The County average is well below the national average.
- Only Oxford City has more children in poverty than the national average.
- Other Districts are well below the national average and are broadly comparable.

Percentage of children (under 16 years) in Low-Income Families Local Measure (2007 to 2013 - calendar years)



Source: Child Poverty Statistics (extracted from Public Health England; Public Health Outcomes Framework)

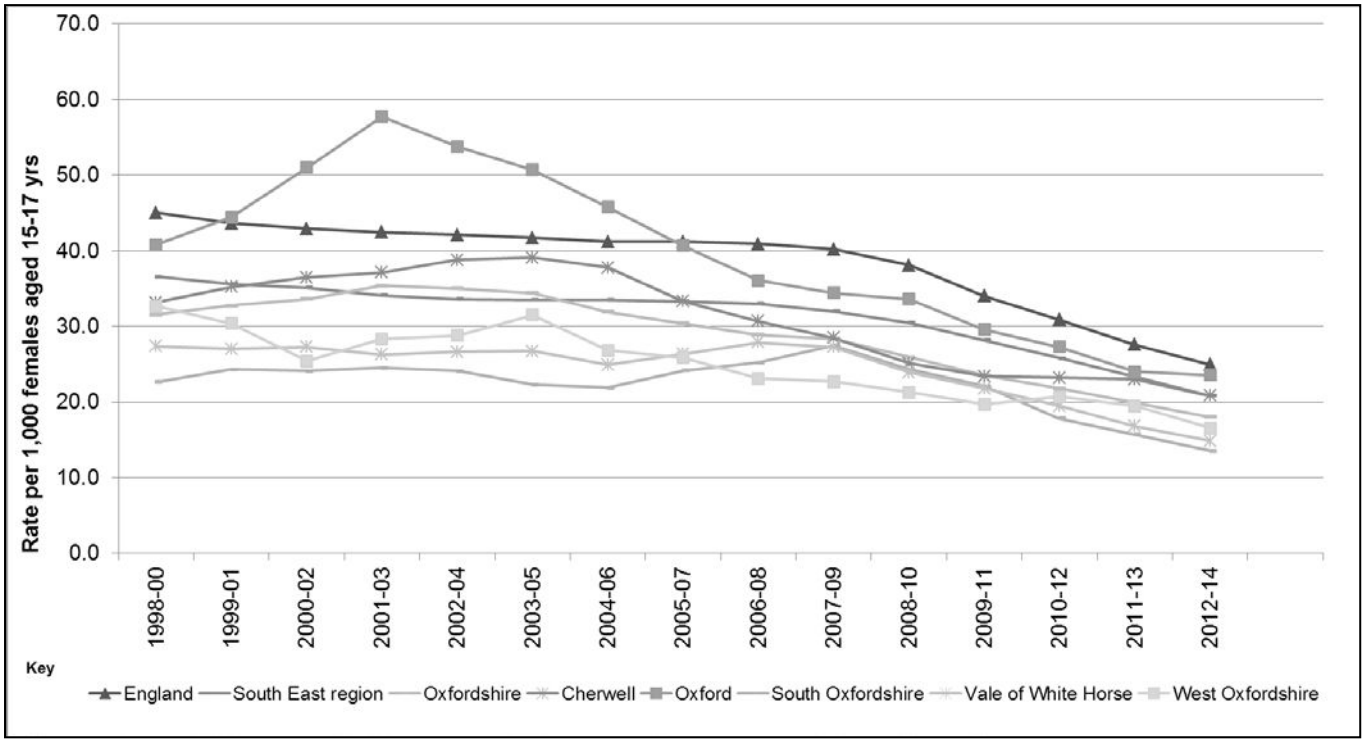
Indicator 2. Teenage Pregnancy

This measure includes all conceptions no matter whether the pregnancy ends in birth or in a termination.

Features of the baseline data:

- The overall trend is downwards in line with national trends.
- All Districts are below the national average.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998/2000 - 2012/14 (3-years combined)



Source: Office for National Statistics (ONS)

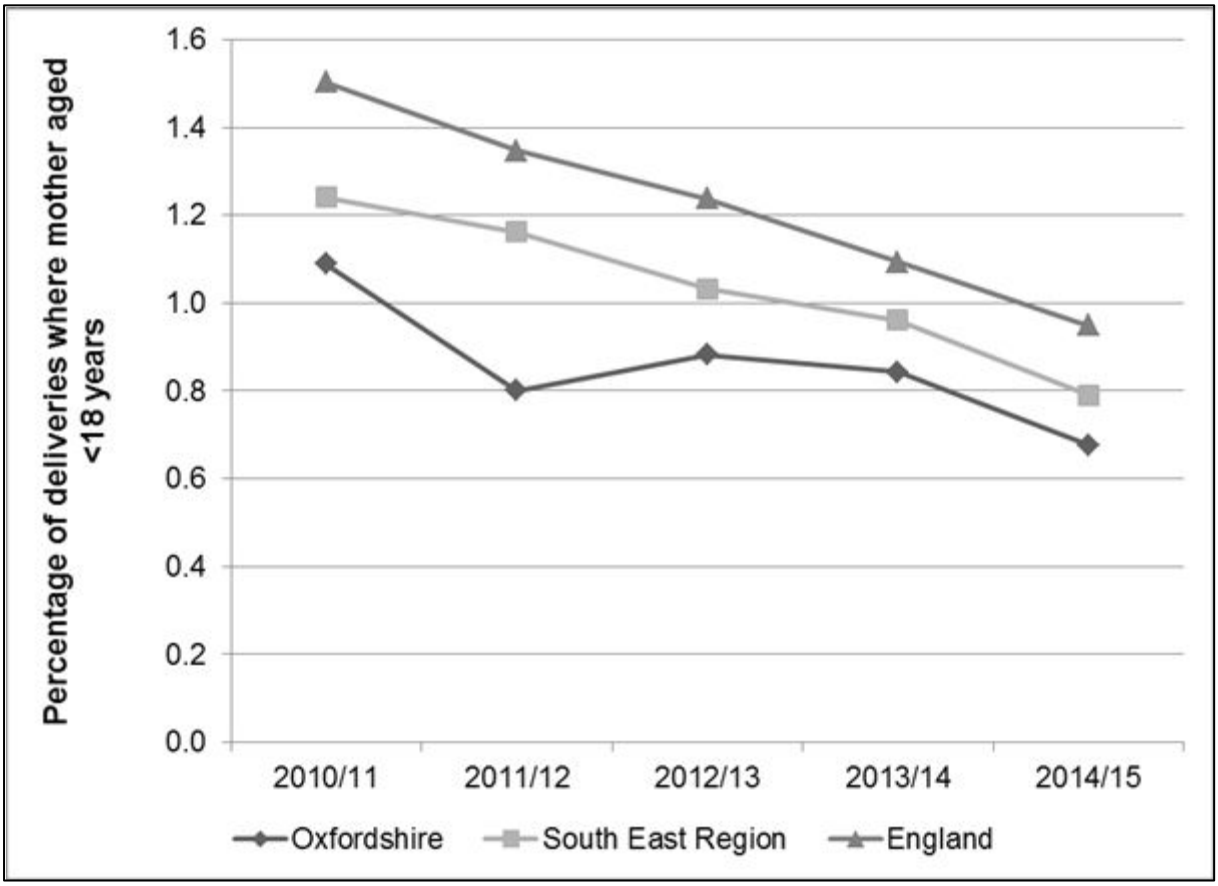
Indicator 3. Percentage of Teenage Mothers

This indicator measures the percentage of babies delivered where the mother was under 18.

It differs from teenage conceptions in that some teenage conceptions result in terminations. Because it is a percentage of all deliveries, it doesn't tell us as much as teenage conceptions per se. It also assumes that the number of deliveries to mothers aged over 18 stays fairly constant.

Features of the baseline data:

- The percentage of births to under 18s is very small – around 1 in 100 births nationally and around 0.7 per 100 births (7 per 1000) in Oxfordshire.
- The percentage is gradually reducing.
- Oxfordshire does better then then both regional and national figures.



Source: Children & Young People Benchmarking Tool (PHE)

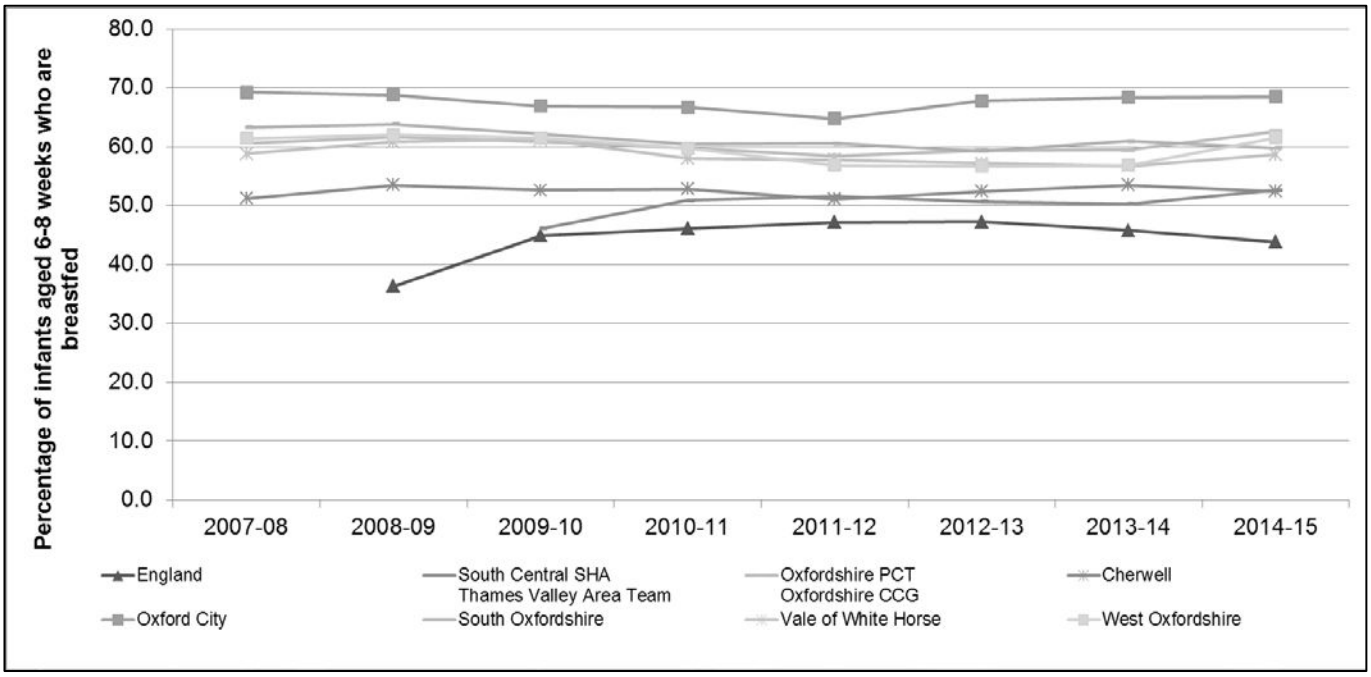
Indicator 4. Breastfeeding at 6 to 8 weeks

This is a good general measure of quality of care during pregnancy and it has a protective effect on the child. We should remember however that despite best efforts, some mothers cannot breastfeed.

Features of the baseline data:

- The County average of just over 60% is much higher than the national average of around 43%
- The City performs exceptionally well at almost 70%, however this is due to very high rates in North Oxford of around 80% which mask much lower rates in the more disadvantaged parts of Oxford.
- Cherwell has always lagged behind the rest of the County at just over 50% despite best efforts. The reasons for this are unclear.

Percentage of Infants aged 6-8 weeks who are being breastfed (totally or partially) - 2007/08 to 2014/15



Source: NHS England

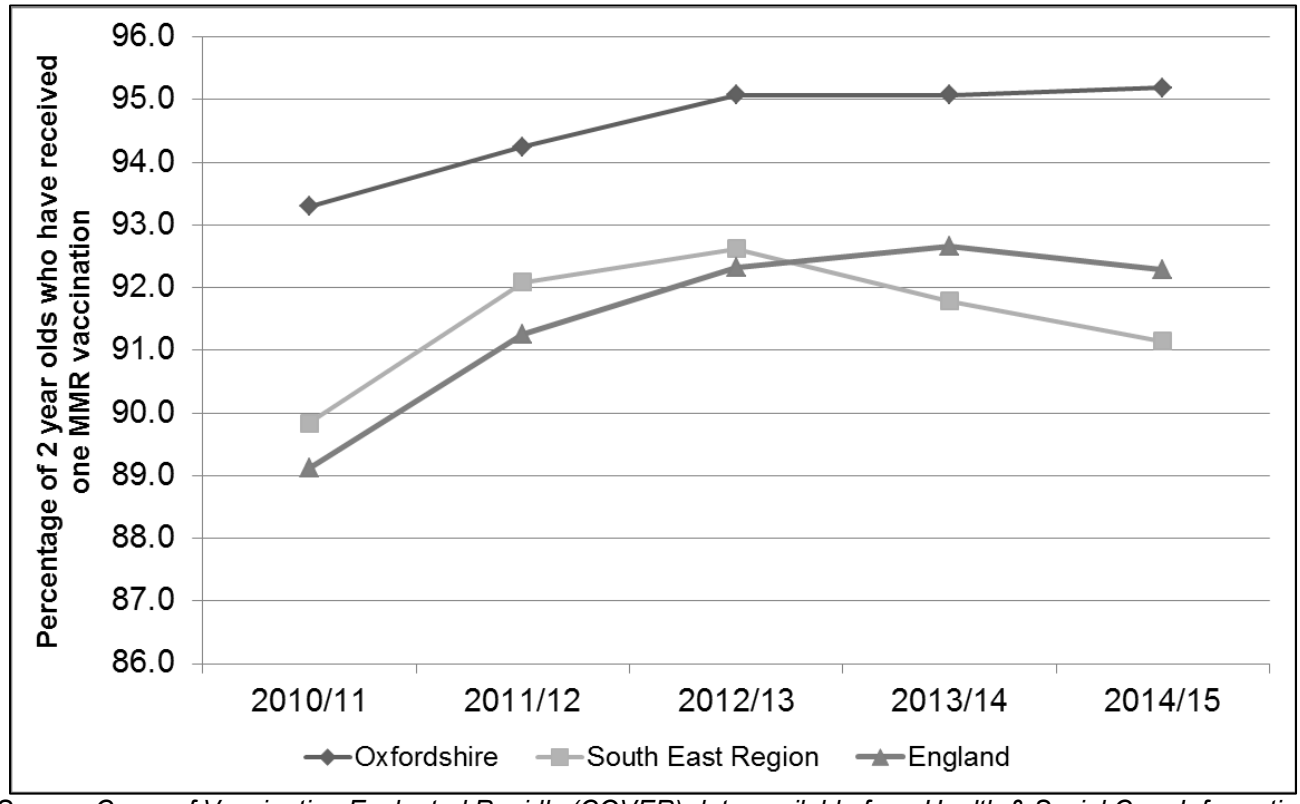
Indicator 5. Childhood Immunisation

This is a good general measure of the quality of general practice and the extent to which families cooperate to protect their children. There are many immunisation statistics – I have chosen immunisation for Measles Mumps and Rubella (called MMR) as it has a controversial past, and we have struggled to get the County average above the recommended 95%. This service is delivered by NHS England.

Features of the baseline data:

- The level of uptake is higher in Oxfordshire at around 95% than national and regional averages of 91% to 92%.
- The trend in Oxfordshire is rising slightly while it is falling slightly regionally and nationally.

Percentage of 2 year olds who have received one MMR vaccination



Source: Cover of Vaccination Evaluated Rapidly (COVER) data available from Health & Social Care Information Centre (HSCIC)

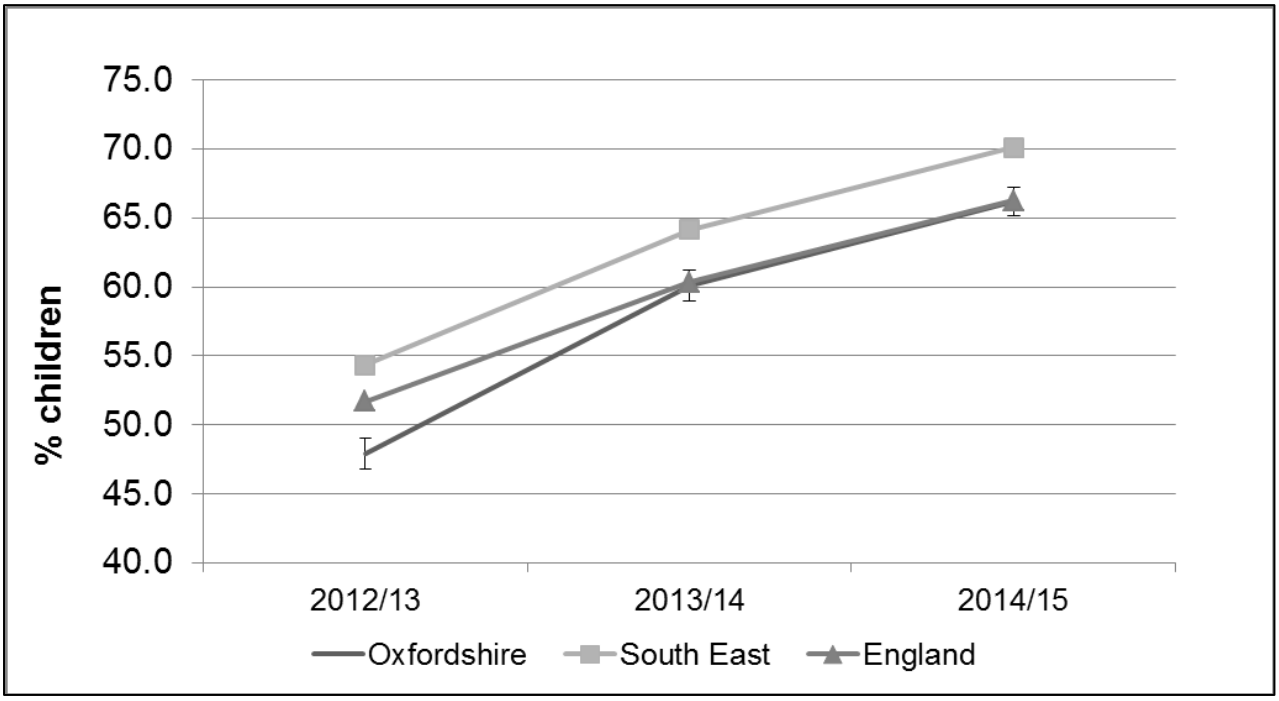
Indicator 6. School Readiness

This indicator measures school readiness at the end of reception year. It is a useful measure of future life chances of local children. The definition of school readiness is based on children reaching a sound level of development covering personal relationships, social relationships, emotional development, physical development and communication skills as well achieving learning goals in maths and literacy.

Features of the baseline data:

- Oxfordshire's figure is the same as the national average at around 66%.
- It is below the regional average and there is room for improvement.
- All national and local trends have been upward in the last few years.

School Readiness: the percentage of children achieving a good level of development at the end of reception



Indicator 7: GCSE results

This is an excellent indicator of school achievement overall in state schools. It points forward to children's overall 'success' in life. The chart for this is included earlier in this chapter.

Features of the baseline data:

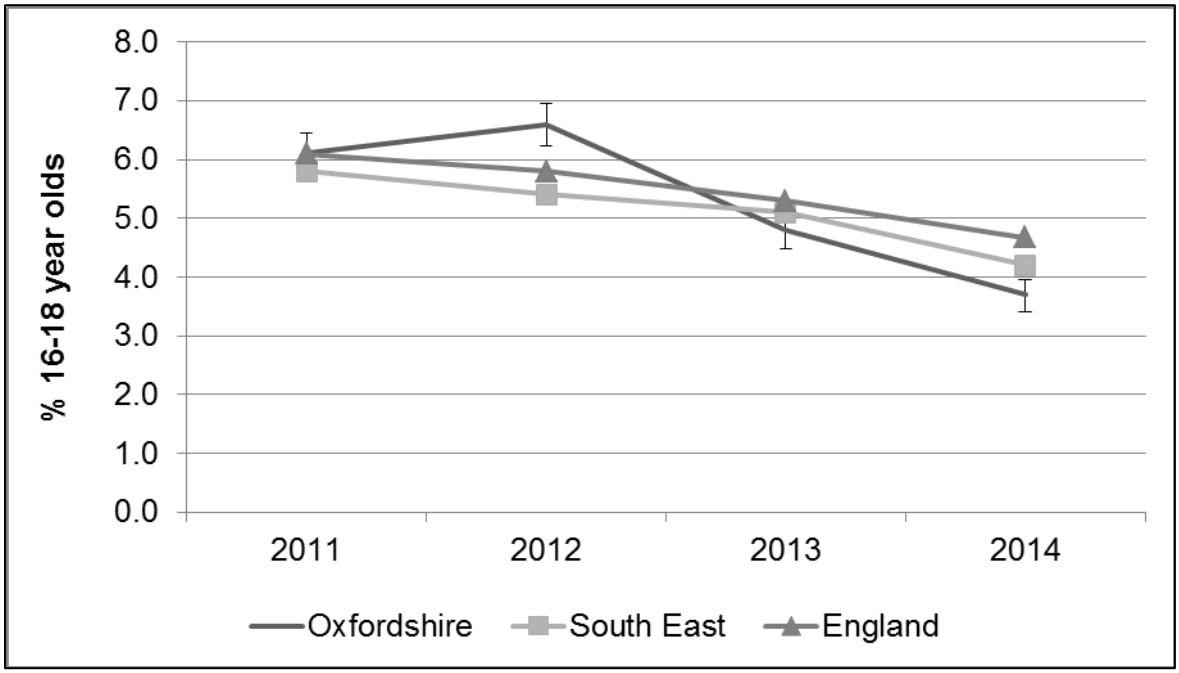
- Around 60% of Oxfordshire's state educated children achieve at least 5 GCSEs at grades A* to C including English and maths.
- This has been a success story in recent years. Oxfordshire used to lag below the national average and now we are around 3 percentage points above.
- This is a good result, but there is still room for improvement as we are 2 percentage points behind similar Local Authorities (our statistical neighbours).

Indicator 8. 16-18 year olds not in education employment or training

This is a direct measure of success in young peoples' achievement in higher education and training, which foreshadows their economic success and that of the County.

Features of the baseline data:

- Progressively fewer young people are not in higher education or training.
- Oxfordshire's figure is better than both the national and regional figures at just under 4%.
- This is a good result



Indicator 9. Obesity in children in reception year.

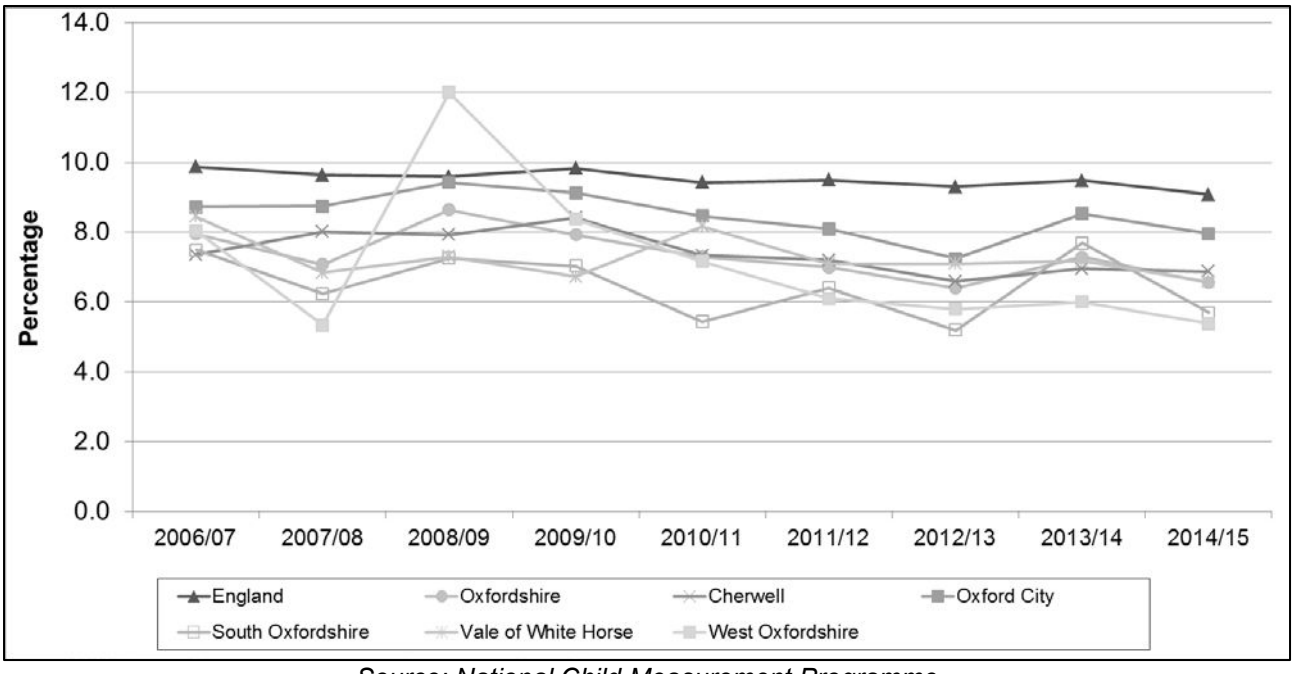
This is a useful indicator of children's life chances in terms of health. Obesity and overweight gradually increase with age which foreshadows the future likelihood of diseases such as diabetes, heart disease, some cancers and ultimately an early death. It is linked to levels of physical activity. Keeping this figure as low as possible is crucial for the health of the next generation.

There is more detailed information on obesity in the next chapter.

Features of the baseline data:

- Overall Oxfordshire does better than national figures by about 2 percentage points.
- Oxfordshire's current level of obesity in reception year is between 6% and 7%.
- However there are clear inequalities in this data, with Oxford City showing consistently higher levels than other Districts. The City's figure is around 8% - still better than the national average.
- The remaining District's figures fluctuate around the 6% mark.

Percentage of children in Reception Year (4/5 years) who are obese - 2006/07 to 2014/15 (Academic Years)



Source: National Child Measurement Programme

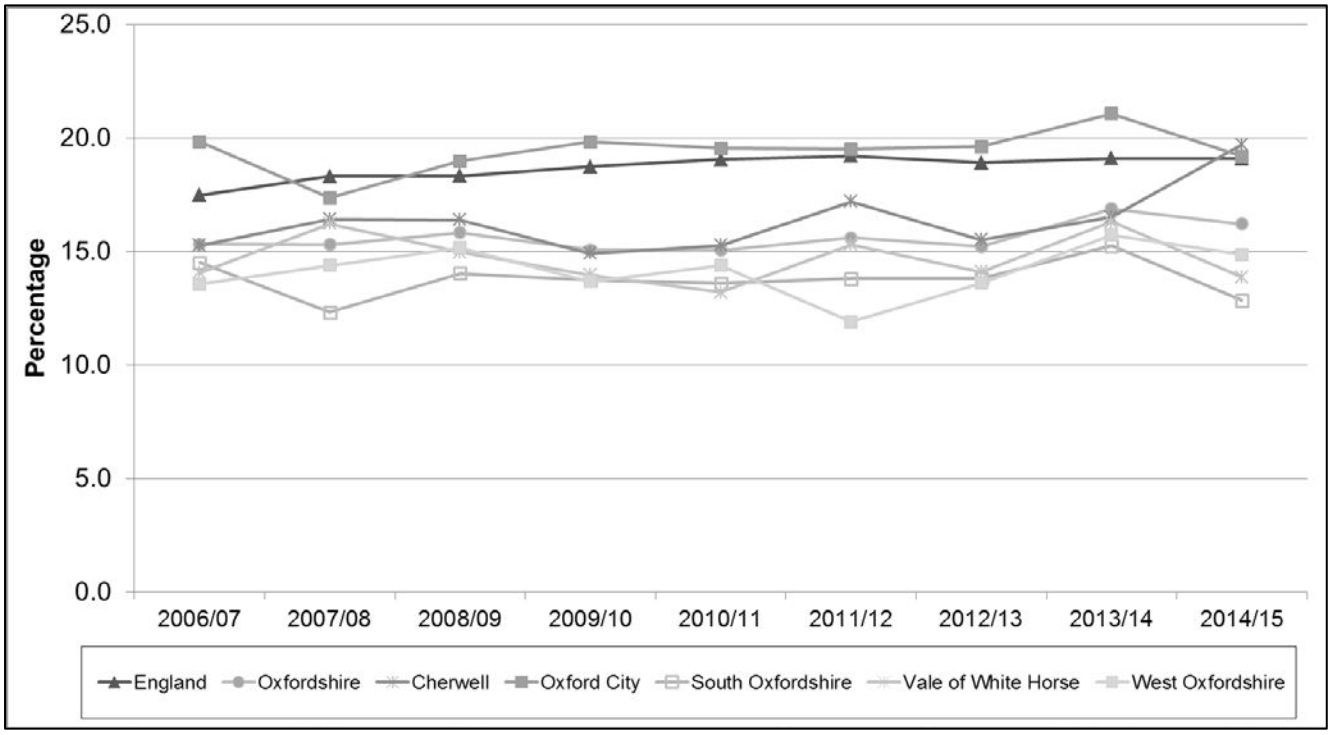
Indicator 10. Obesity in 10 to 11 year olds – (school year 6)

Seen alongside the data on obesity in reception year above, this figure tells the story of obesity and overweight in children as they grow older – gradually more slip from a healthy weight into overweight and obesity. This trend will tend to continue into adulthood and is the root cause of much later chronic disease. Obesity also magnifies the impact of all disabling conditions such as joint and mobility problems and so it also affects the need for social care.

Features of the baseline data:

- The County figure stands at around 16% having increased from 7% in reception year.
- The County figure is better than the England average by 2 percentage points.
- Until last year, the City's figure was the worst – just above the national average.
- Last year showed a sharp rise in the figure in Cherwell. It is too early to say if this is a 'real' change or a 'blip' in the statistics, but it is important and we need to keep a close watching brief.

Percentage of Year 6 children (10-11 years) who are obese: 2006/07 to 2013/14 (Academic Year)



Source: National Child Measurement Programme

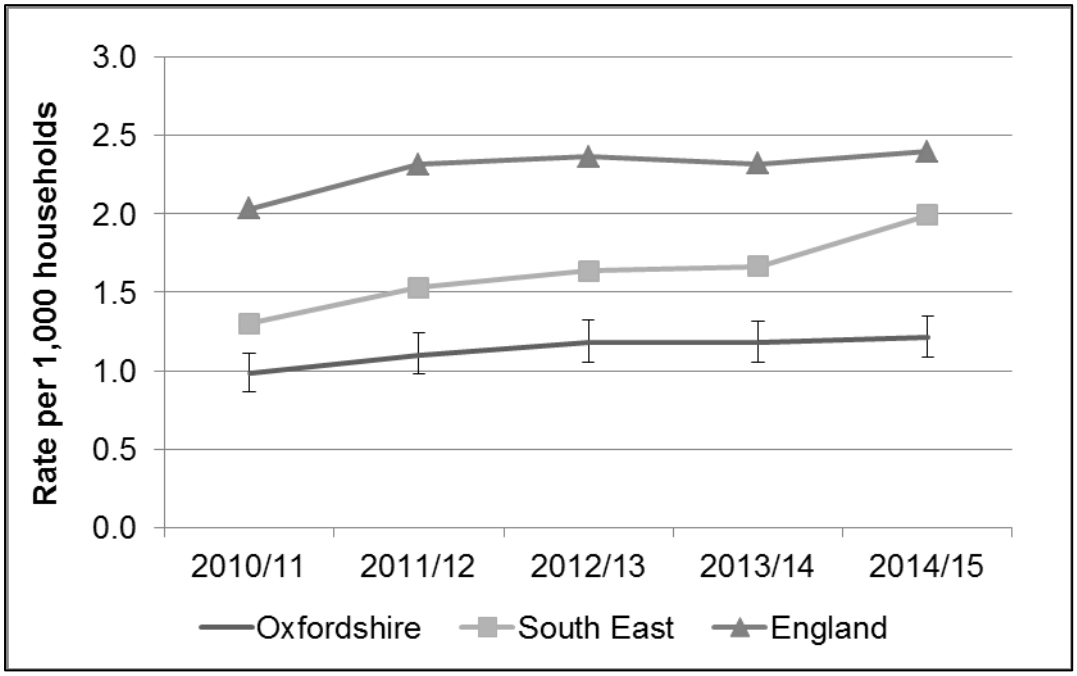
Indicator 11. Homeless Households

Being part of a homeless household has a serious impact on children and families. Young people who are homeless have markedly poorer life chances. This indicator gives us a general 'feel' for the trends in homelessness in the County.

Features of the baseline data:

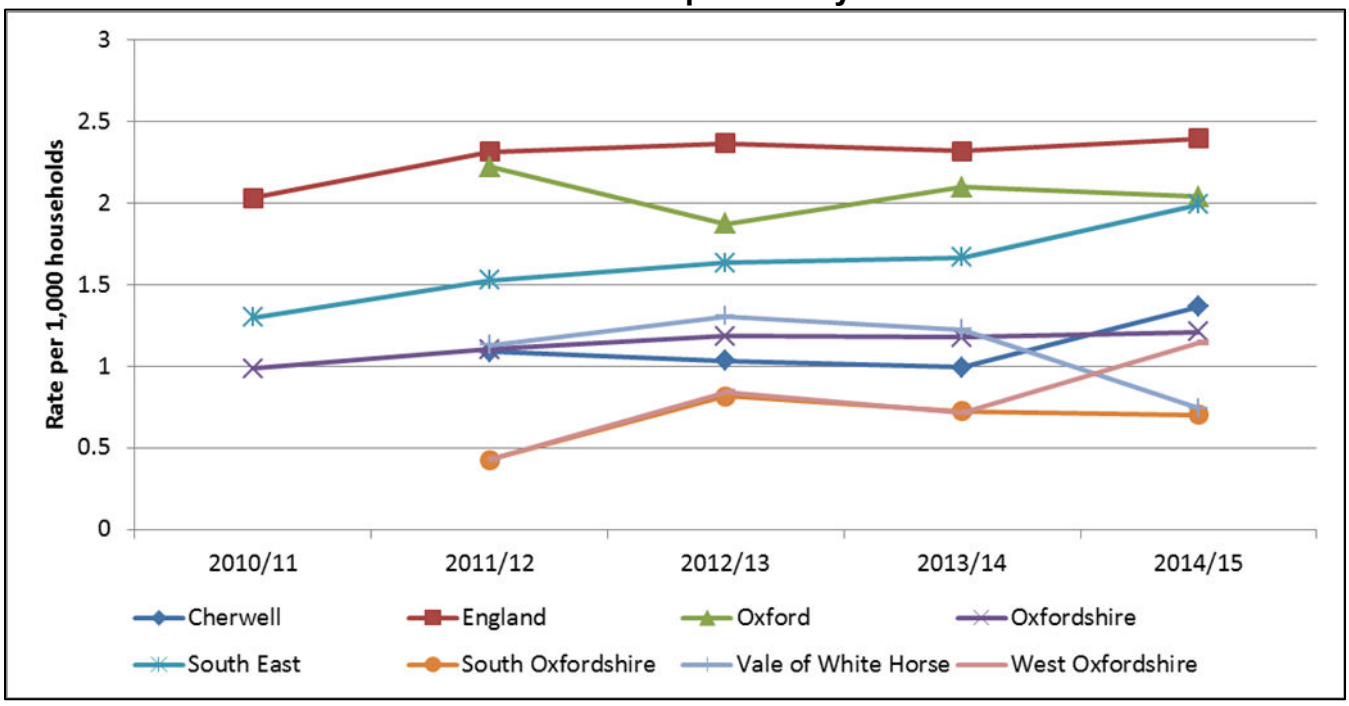
- The figure for Oxfordshire as a whole is low - just over 1 in a thousand households.
- Oxfordshire's figure outperforms national data which stands at just under 2.5 per thousand households.
- Oxfordshire performs better than similar local authorities.
- The general trend is rising slightly.

Homelessness acceptances per 1,000 households



The position on this indicator is not uniform across the county. For the sake of completeness, results for each district are shown below.

Homelessness acceptances by district



The chart shows that:

- The rate in all districts is lower than the England average.
- The City has had the highest rates for some years at around 2 homeless households per 1000 while the other districts cluster at one homeless household per 1000.

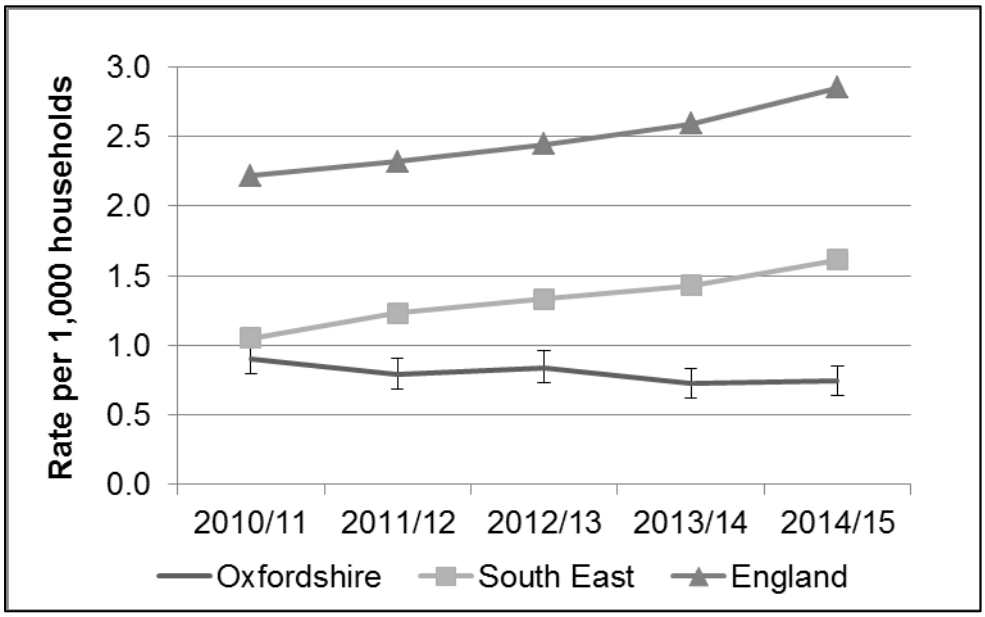
Indicator 12. Households in temporary accommodation

Homelessness is prevented in part by placing families in temporary accommodation. This is not a good option in terms of life-chances, but it much better than facing homelessness.

Trends in the baseline data:

- Oxfordshire's compares well with national figures and compares well with similar Local Authorities.
- Oxfordshire's figure stands at less than 1 per thousand households being placed in temporary accommodation and the rate is falling.
- This is in sharp contrast to the national figure which stands at almost 3 per thousand and is rising.

Households in temporary accommodation per 1,000 households



Breaking The Cycle Of Disadvantage: Summary and Recommendations

Summary

- Overall it has been a good year for reducing disadvantage.
- Progress has been made on last year's recommendations.
- School results are up.
- Employment is up.
- Child poverty and teenage pregnancy are down.
- In equalities in school results and employment have reduced.

However there are some early warning signs for women's health and childhood obesity levels are still too high despite comparing favourably with national figures.

It is vital that we maintain this momentum, particularly during times of change for children's services.

Establishing a basket of indicators for children is an important step forward – we now have a firm baseline against which to compare future developments.

We await the results of the Independent Commission on Health Inequalities so that we can add the Commissioners' insights to the overall picture.

The key to success remains:

Identify the Disadvantage
Put in place long term interventions to counteract it
Persist in this over decades
Monitor progress assiduously

We are making steady progress in Oxfordshire and it is vital that this is maintained in these times of change.

Recommendations

1. The report of the Commission for Health Inequalities should be studied carefully when it is published and all organisations should use it to challenge current practice and make appropriate changes to services.

2. Trends in disadvantage should continue to be monitored closely in Director of Public Health Annual Reports

3. The Children's Trust is requested to consider the basket of children's indicators proposed in this report and to drill down into indicators to uncover further inequalities at more local level using data from services.

4. The NHS's Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The NHS 'offer' should not be 'one size fits all'.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

Main Messages in this chapter

- **Obesity remains the biggest lifestyle challenge in Oxfordshire and preventing it is a key requirement for reducing disease levels and early deaths.**
- **NHS Health Checks continue to perform well.**
- **Solid progress has been made in tackling alcohol problems and in combatting poor oral health.**
- **There has been a sea-change in the way people quit smoking tobacco through the use of e-cigarettes.**

Obesity, Diet and Physical Activity

Why is obesity an issue?

Obesity is widespread, a quarter of children aged 2-10, and one third of 11-15 year olds and two thirds of adults are overweight or obese. This remains our greatest lifestyle challenge.

Overweight and obesity in adults is predicted to reach 70% by 2034.

This is a crucial issue because being overweight increases the risk of cardiovascular disease, diabetes and some cancers. It is also associated with poor mental health in adults, and stigma and bullying in childhood.

Obesity can cause:

- Heart disease, stroke and late-onset diabetes.
- Depression and anxiety, asthma, cancer, liver disease, reproductive complications, osteoarthritis and back pain.

There are also inequalities in levels of child obesity which was mentioned in chapter 3, with prevalence among children in the most deprived areas being higher than among children in the least deprived areas. If an individual is less well-off, he or she is more likely to be affected by obesity and its health and wellbeing consequences. The impact is uneven across ethnic groups – obesity is more prevalent among males in black ethnic minorities.

The consequences of obesity are costly to health and social care and have wider economic and societal impacts. The annual **cost** of obesity is estimated to be:

- £27bn to the economy through reduced productivity and increased sickness absence
- £6.1bn cost to NHS
- £352m cost to Social Care by way of additional disease, disability and mobility problems.

Obese people are over three times more likely to need social care than those who are a healthy weight.

Obesity reduces life expectancy by an average of 3 years whilst severe obesity reduces life expectancy by 8-10 years.

Where are we now?

Chapter 3 showed the local picture in children. The Oxfordshire picture is better than the national average and levels fell slightly last year. This is a good result but there is no cause for complacency.

We now have enough data about local children to show what happened between their being measured in reception year and again in year 6.

Children measured in Year 6 in 2014/15 are the same cohort as those who were measured in Reception Year in 2008/09. **The level of obesity for this cohort when in Reception Year in 2008/09 was 8.6% and is now 16.2% which clearly shows that obesity has doubled in this cohort of local children over a six year period as they have grown up.**

This indicates that we need to act to prevent obesity during pregnancy and in the very early years. Breast feeding is protective against obesity and makes an excellent start for children whose mothers are able to breastfeed.

The Adult obesity, Health Survey for England (HSE) 2014 showed that:

- 58% of women and 65% of men were overweight or obese. This is now the social norm.
- The prevalence of morbid obesity (the most severe category of obesity) has more than tripled since 1993, and reached 2% of men and 4% of women in 2014.
- Over three quarters of females aged 45+ were overweight or obese.
- Black women were considered to be most at risk of diabetes, with 60% having high risk, and a further 27% having increased risk.
- Amongst men, White groups had the highest mean BMI (27.4) and Asian groups the lowest (26.0).
- Amongst women, Black groups had the highest mean BMI (29.5) and Asian groups the lowest (26.2).
- For women, the prevalence of obesity increased with disadvantage, from 22% in the least disadvantaged areas, to 33% in the most disadvantaged areas. This relationship was not evident for men.

Obesity is everyone's business

Obesity is everyone's business and every organisation needs to play a role in tackling it. To help an individual stay slim requires multiple actions both locally and nationally with changes needed to food labelling, food marketing, and the design of local communities which encourage physical activity.

We have talked about the role of planning healthy communities in chapter 2. It is now time to look more closely at physical activity.

The Role of Physical Inactivity

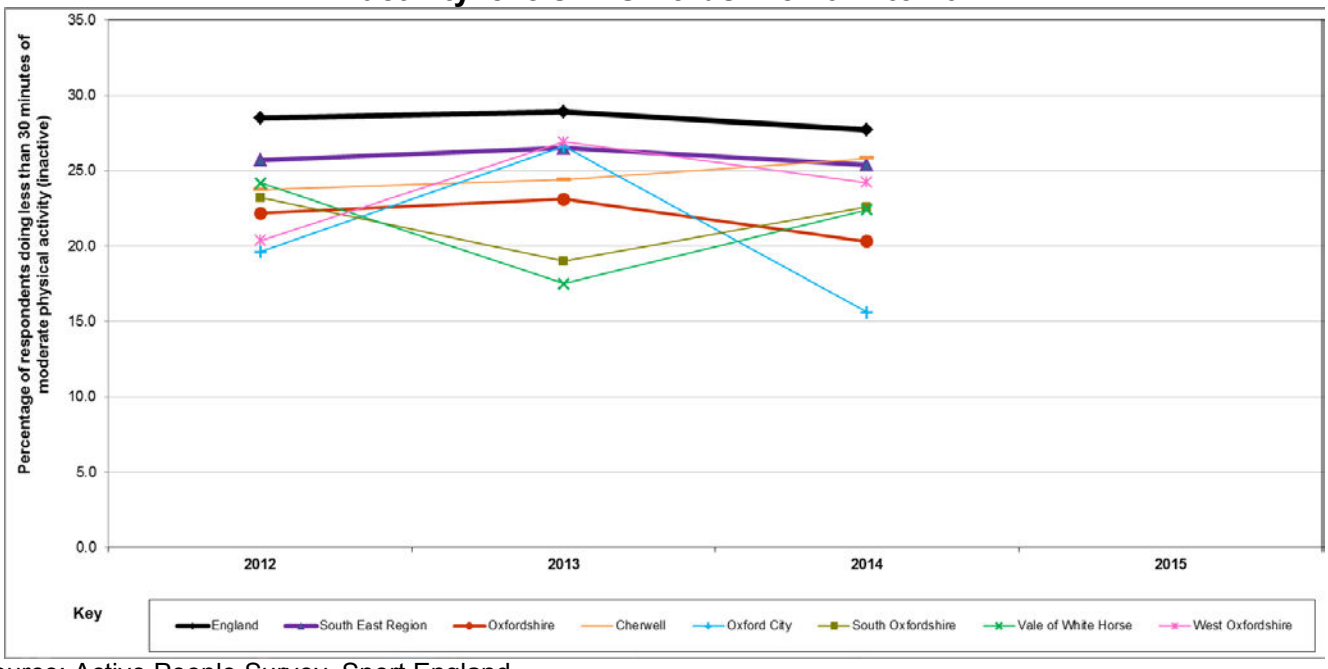
Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle.

The health benefits of a **physically active lifestyle** are well documented and there is a large amount of evidence to suggest that regular activity is related to reduced incidence of many chronic conditions such as diabetes, osteoporosis, colon cancer, breast cancer. Physical activity also improves mental health.

Physical activity contributes to a wide range of health benefits and regular physical activity can improve health outcomes irrespective of whether individuals achieve weight loss.

The chart below shows levels of inactivity across the County.

Inactivity levels in Oxfordshire 2012 to 2014



Source: Active People Survey, Sport England

It shows that in 2014, rates of inactivity in adults were better than for England, but still too high at around 20%. The England level is around 28% inactive.

Levels of physical activity levels amongst 5-15 year olds are falling. The proportion of boys who met the weekly physical activity guidelines fell from 28% in 2008, to just 21% in 2012. The proportion of girls who met the weekly physical activity guidelines fell from 19% in 2008 to 16% in 2012.

What did we say last year and what are we doing about it?

The Health Improvement Board is taking recommended action to review its physical activity strategy which brings together the action of District and County Councils, the NHS and other major partners. District Councils have a key role to play in their stewardship of green spaces and recreation facilities.

The Health Overview and Scrutiny Committee carried out a scrutiny of District council functions as recommended.

Less progress has been made by the NHS in improving the referral and treatment of physical disability. If we are to tackle obesity we need to see a real 'shift to prevention' and find new ways for clinicians, nurses and therapists to help people who are overweight more actively.

What should we do next?

The main challenge is to make work on prevention a mainstream activity in health services. There is an understandable tendency to concentrate on disease once it has happened rather than focus on preventive work from cradle to grave. It is hoped that the NHS's Sustainability and Transformation Plan will focus on preventative work over the next 5 years.

Recommendations regarding obesity, diet and physical activity

1. The prevention of obesity and its treatment should become a priority for the NHS and over the next 5 years actions should be put in place to train all health professionals to help in the fight against obesity. This should become part of the NHS's Sustainability and Transformation Plan.

2. The Health Improvement Board should continue to monitor partnership work on the prevention of obesity across the county.

NHS Health Checks

The NHS Health Check is a national cardiovascular risk assessment and prevention programme required by statute. It is delivered by local GPs and has been commissioned by the County Council since 2013**.**

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.

Eligible individuals aged 40-74 years old are invited for a Check every five years (191,000 people), which means that 20% of this age group are invited per year so that every eligible person is invited at least once every five years. The age range is set nationally because it is the most cost-effective group in which to detect preventable cardiovascular disease.

In Oxfordshire, the Joint Health and Wellbeing Strategy set an aspirational target for 66% of those invited for NHS Health Checks to turn up for their Check. Nationally this same target has

now been set by Public Health England. We have not yet reached this target but we aspire to do so.

Last year in 2015/16 in Oxfordshire, GPs invited 38,293 people for a NHS Health Check and 19,212 people took up this invite and received a Check. The continued good performance of the NHS Health Check programme helped the Public Health Directorate achieve a quality premium payment from Public Health England.

Since the County Council took the responsibility for NHS Health Checks in 2013, 119,792 people have been offered a Check and 59,613 people have had a Check done. These Checks have helped the local health of the population by:

- **identifying 1,063 people who had high blood pressure and required an anti-hypertensive drug**
- **discovering 2,957 people who were at high risk of cardiovascular disease and required a statin**
- **detecting 251 undiagnosed cases of diabetes and 27 cases of chronic kidney disease, allowing people to manage their condition sooner and prevent complications**
- **referring 479 people to local weight management programmes, with 8,100 obese patients receiving brief advice**
- **offering 20,249 people brief advice to take up more physical activity, with 4,640 signposted to local physical activity services**
- **generating 434 referrals to smoking cessation services, with 5,777 receiving brief advice**
- **providing 2,125 people with brief advice to reduce their alcohol intake**
- **helping to 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 continue to work with GPs to improve the uptake of the offer of a free NHS Health Check. The Public Health team continue to work with GPs to improve the quality of delivery of the programme; this work was recognised by Public Health England with a nomination for a national award.

This work has helped embed the NHS Health Check programme as a reliable method of promoting the health of the local population and engaging with people in the community to think about their own health.

The Oxfordshire Clinical Commissioning Group recognise the value of the NHS Health Check programme and are looking to incorporate the programme in their bid to be part of the second

wave of the National Diabetes Prevention programme in 2017. They have also chosen the NHS Health Check programme as an indicator for their quality premium submission with NHS England. **This is all good progress.**

We also said we would continue to market the NHS Health Check programme and raise awareness in the local community. This has been met with some success - in a recent survey the NHS Health Check programme was the most recognised programme of services advertised by the County Council.

In the last year we launched a NHS Health Check results booklet for every person who received a Check. This gave people who received a Check a record of their results with information about services and lifestyles to refer to at their leisure.

Recommendations for NHS Health Checks

The NHS Health Check programme continues to perform well and is well received by the public. However we cannot be complacent and must continue the efforts to improve this programme. This includes:

1. Continue to market the NHS Health Check programme in new and innovative ways to further raise awareness in the local community.
2. Continue to work with GPs to improve the uptake of the offer of a free NHS Health Check, including improving the invitation process.
3. Better identify and engage with high risk groups to take up the offer of a free NHS Health Check.
4. Continue to work with partners to further improve the quality of the programme locally and add to the knowledge base supporting the programme nationally.

Smoking Tobacco

Smoking tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, vascular disease to respiratory diseases and events such as heart attacks and strokes, dementia, rheumatoid arthritis and macular degeneration - the leading cause of sight loss in people aged over 50.

In Oxfordshire the prevalence of adult smokers has seen a continued decline in the past few years. The prevalence of adults who smoke in Oxfordshire is currently estimated to be 14% which is better than the national prevalence (18%). **This is a good result.**

However we still cannot be complacent about smoking rates in the County. There still continues to be an inequality in who smokes, with much higher levels of smoking found in more disadvantaged communities. Indeed in routine and manual workers the level of smoking is as high as 29% - double the County average. To meet this challenge, we need to target services at the groups who need help the most.

Regular smoking in young people in Oxfordshire has also seen a decline over the past years, which is positive. Current estimates are that 5.7% of 15 year olds are regular smokers; similar to the national average of 5.5%.

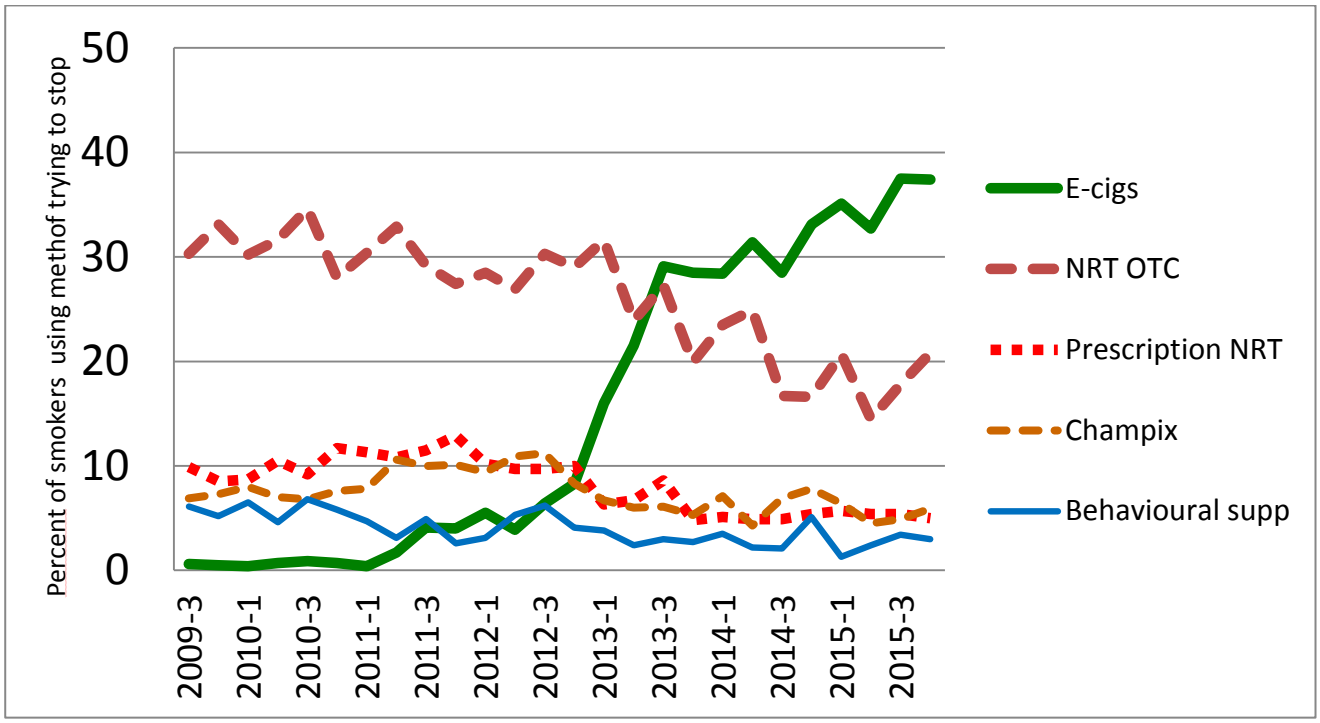
Stop Smoking Services
The decline in people accessing traditional stop smoking services seen in recent years continued last year both nationally and locally. The suggestion that the "easier quits" have already been made still holds true and that the challenge is to address the higher levels of smoking in more deprived and hard to reach groups.

The impact of the dramatic increase in use of e-cigarettes in the UK cannot be ignored as a significant contributor to the reduction in people accessing stop smoking services. E-cigarettes are now estimated to be the most common form of quitting aid in the country being used by nearly 40% of people attempting to quit using tobacco.

The use of e-cigarettes as a quit aid and the increasing usage has opened a debate in the public health community on a national and international scale. This has seen an increase in the perception in the wider population that e-cigarettes are as harmful to health as normal cigarettes which is not the case.

The chart below shows the dramatic rise in those using e-cigarettes as a means of quitting tobacco smoking as opposed to those helped by various nicotine replacement gums and patches.

Quit attempts by method of quitting



Different product types used by smokers in most recent quit attempt. In 11,000 adults who smoke and tried to stop or who stopped in the past year; method is coded as any (not exclusive) use.
Source: www.smokinginengland.Info/latest-statistics

With the increasing amount of conflicting information for and against e-cigarettes becoming available in the public arena there has naturally been confusion for the public and health professionals alike. In response, **Public Health England published an evidence update which concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking. The report also concluded there is no**

evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers. This is further supported by a report from the Royal College of Physicians publish in April 2016 which states that e-cigarettes are an effective method for people wanting to quit tobacco and the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.

How we should move forward?

- More staff in health care should become 'level 1 quit- advisors' to encourage smokers they encounter to quit smoking no matter what illness they come for help with.
- The Public Health team should continue to work with GPs to engage with their patients to quit smoking.
- All health professionals should target hard to reach groups to explain the dangers of smoking and how to get support to quit.
- We need to maintain a watching brief on the effects of e-cigarettes in line with national guidance from Public Health England.

Recommendations regarding smoking

1. The Health Improvement Board should continue to monitor activities of local smoking services and wider agencies to help people quit smoking and also not start in the first place.

2. The Clinical Commissioning Groups and GP practices should develop services to target hard to reach and priority groups and continue to deliver brief interventions to quit as part of routine consultations.

Alcohol

Alcohol remains a risk to health in our society. The impact can be summarised as follows:

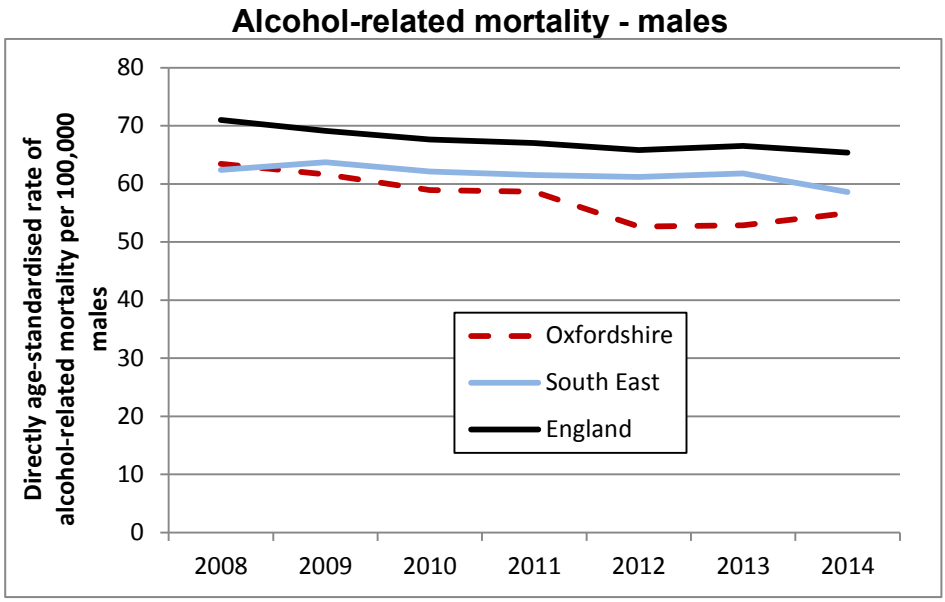
- In the UK there are around 1 million hospital admissions each year related to alcohol consumption.
- There are around 8,000 alcohol-related deaths in the UK each year.
- Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression.
- Males accounted for approximately 65% of all alcohol-related deaths in the UK.
- 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.

- 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%.
- There is no absolutely safe drinking level – the Chief Medical Officer has warned that any alcohol consumption increases the risk of cancer.

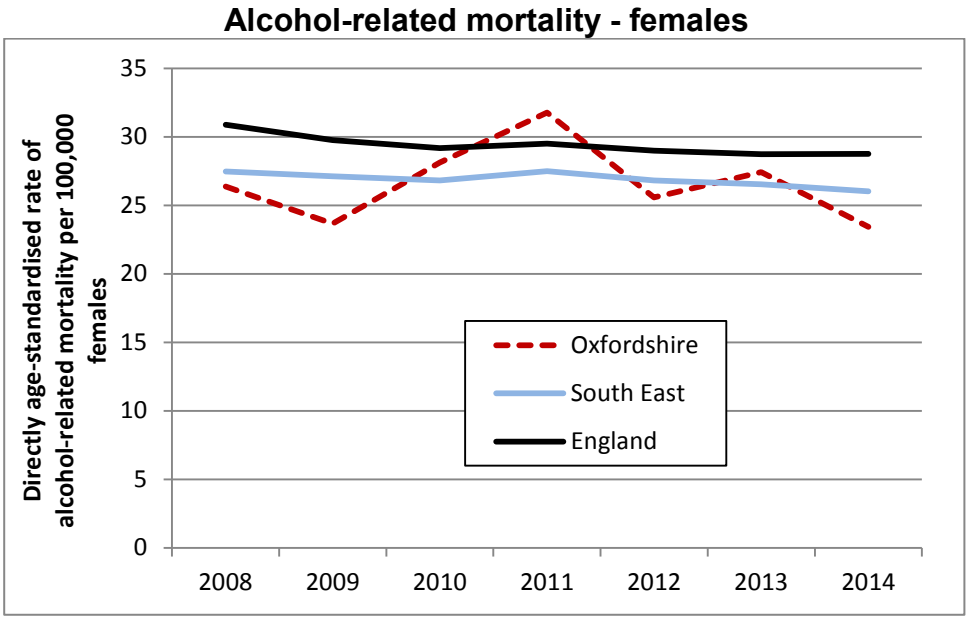
What has happened in the last year?

A review of the data presented in the Alcohol and Drugs Strategy has been carried out and the following conclusions have been drawn:

1. In 2014 there were an estimated 7,900 **deaths related to alcohol use** in England. The trends for both men and women are shown in the 2 charts below



Alcohol-related mortality (males and females) - Deaths from alcohol-related conditions, all ages, directly age-standardised rate per 100,000 population (standardised to the European standard population).

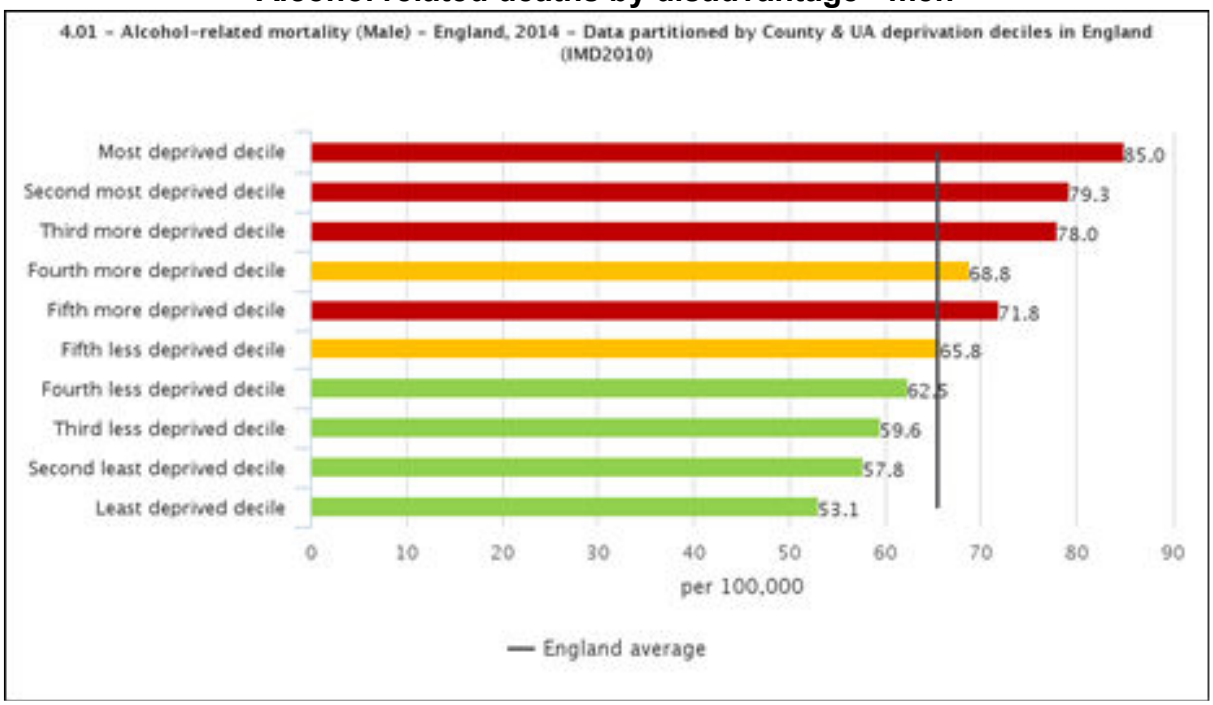


The charts show that:

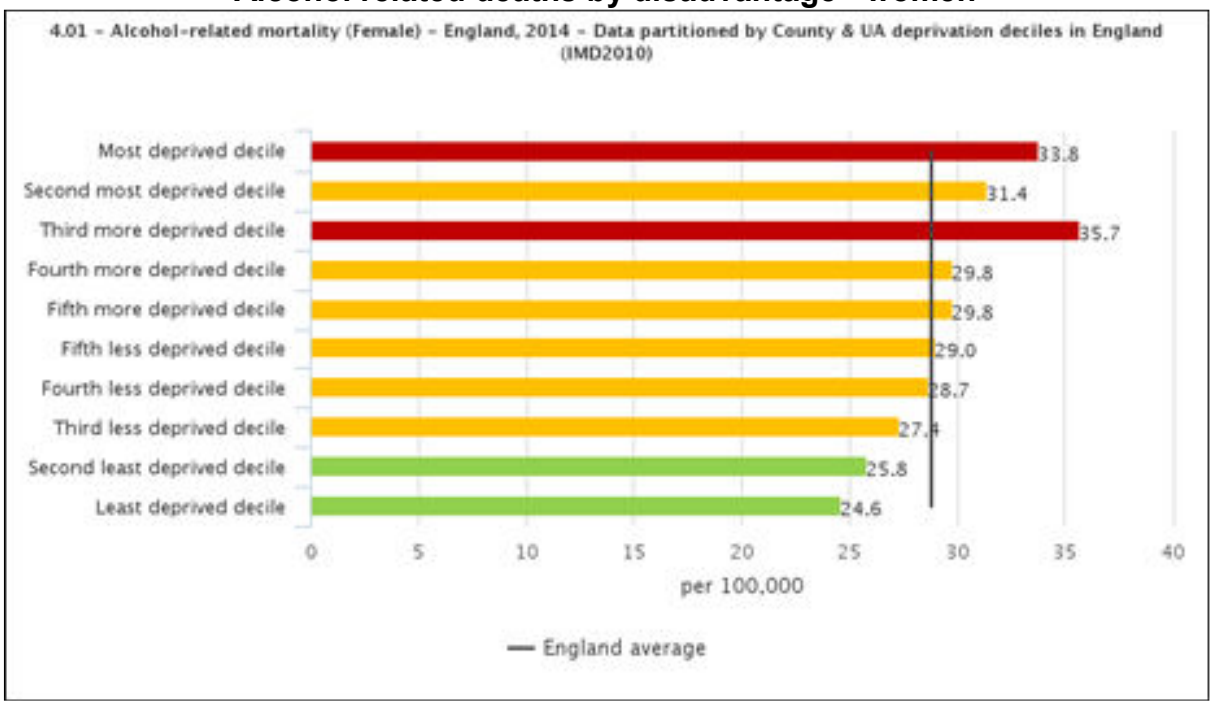
- Deaths related to alcohol are gradually falling across the board overall.
- Deaths in Oxfordshire are lower than national levels.
- Deaths in females are around half those of men.
- Male deaths in Oxfordshire rose slightly according to the latest figures and female deaths fell.

2. **Alcohol-related mortality by socio-economic class** is not analysed at a local level, but new figures have been published at national level. The charts below show the alcohol related deaths split for England by most/least disadvantaged groups. The chart for men shows a greater difference between the best and worst off than for women. The most disadvantaged tenth of the population are shown at the tops of the chart and the least disadvantaged at the bottom.

Alcohol related deaths by disadvantage - men



Alcohol related deaths by disadvantage - women

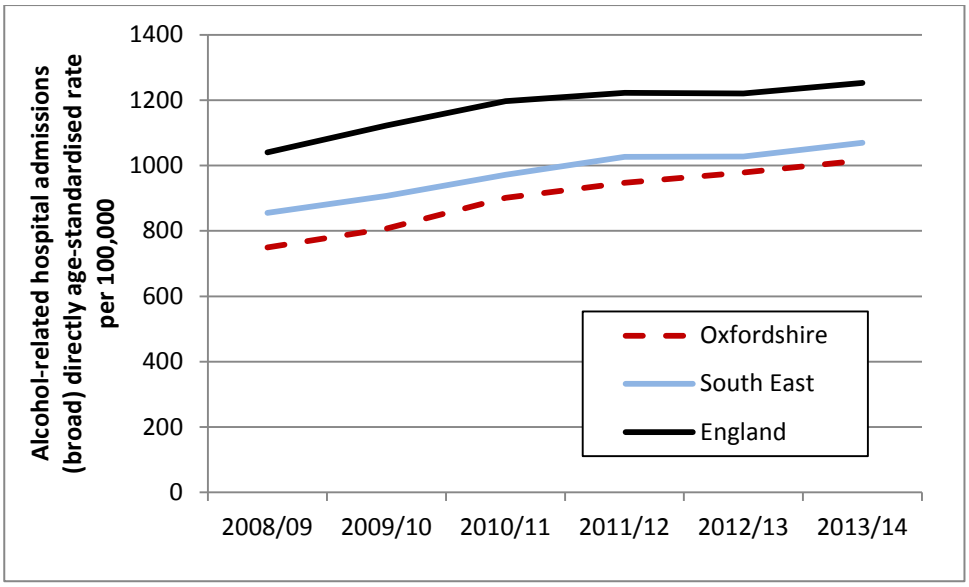


The charts show that:

- There is a strong inequality in deaths related to alcohol.
- In men death rates in the most disadvantaged 1/10 of the population reach 85 per 100,000 and in the least disadvantaged 53 per 100,000.
- In women, death rates in the most disadvantaged 1/10 of the population reach 34 per 100,000 and in the least disadvantaged 25 per 100,000.
- The pattern is stronger and the inequality greater in males than in females

3. Death rates may be gradually falling, but, In 2013/14 there was a continuing upward trend for **alcohol-related hospital admissions** in England. (almost a 4 % increase on the previous year) The annual increase was greater for women (+5%) than men (+3%) **and it remains the case that rate of admissions in the most disadvantaged is 77% higher than rate in least disadvantaged areas.**

Alcohol related hospital admissions



What Did We Say Last Year and What Have We Done About It?

The recommendation focussed on giving people information so that they could make their own decisions about their drinking (particularly about binge drinking) rather than nannying them.

A summary of the work of the Alcohol and Drugs Partnership summarises the actions taken:

- Provision of Identification and Brief Advice (IBA) training for front-line staff and professionals across Oxfordshire.
- The promotion of the Dry January campaign targeting middle aged women.
- A major Alcohol Conference for professionals with presentations from a wide range of specialists.
- Exploring test purchasing initiatives with Thames Valley Police to target excessive intoxication in the night time economy.
- Work with the local hospitals to improve referral pathways for young people into support services.

Achievements in 2015-16

a) Identification of people drinking at high levels and giving them 'Brief Advice'

Training in how to identify opportunities to talk to people about their drinking and offer relevant brief advice is an effective evidence-based intervention. This can be delivered by a range of professionals in the health service and other settings. Six training sessions were commissioned by the County Council's Public Health team in the last year. The training was offered in locations across the County and has been well attended by a range of professionals.

In addition a 'Train the Trainers' session was provided to Oxfordshire Fire and Rescue Service. This was a bespoke session combining 'giving brief advice' for alcohol and helping people to quit smoking. The session was also very well received.

b) An Alcohol Conference was held to get the facts more widely known

The County Council held a highly successful Alcohol conference in December 2015, with over 140 delegates attending. The day included a number of guest speakers, including a keynote address from Professor Kevin Fenton, the National Director for Health and Wellbeing at Public Health England.

Participants came from a wide range of Council departments, partner organisations and local services including Community and Residential Treatment Services, Housing services and services for the homeless, Oxford University Hospitals Trust, Oxford Health NHS Foundation Trust, Medical Centres and GP Surgeries, Pharmacies, Thames Valley Police, Oxford Brookes University, Community Dental Services, Public Health England, Mental Health services and charities, Oxfordshire Domestic Abuse Service, Oxford Jobcentre Plus and criminal justice services.

The conference was very well received with 90% of those who filled in the evaluation questionnaire stating that they found the event to be relevant to their learning needs, and 93% felt it increased their knowledge and understanding of alcohol use and the associated risks.

c) Alcohol workers in a hospital setting

Public Health commissioners are working in partnership with Oxfordshire Clinical Commissioning Group (OCCG) to boost hospital-based early intervention and advice.

d) Campaigns

The focus of the 'Dry January' campaign this year was on women, particularly those aged 35 and over and who may be drinking regularly at home. The campaign was conducted on social media, Healthy Oxon Facebook and Twitter channels and through radio. The campaign promoted the health benefits of taking part in Dry January and then continuing to have 2 alcohol free days a week. The campaign also promoted use of the DrinkAware App to record drinking, and sign up for Dry January to go 'booze free for 31 days'.

Recommendations

1. The NHS should use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This is a real opportunity to nip alcohol related diseases in the bud.

2. This should be backed up by staff training and support.

Oral Health

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. This is a welcome continued trend.

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

The picture in children

The latest available data from the 2015 oral health survey of five year old children shows that 77% of 5 year old children in Oxfordshire are now free from any dental decay which is higher than the national average of 75% and improved locally from 67% since the 2012 survey. Whilst this is encouraging there is room for improvement - the number of children who are decay free is significantly lower in Oxford than the other districts at 67%.

The major sources of the sugar which causes decay in children are found in soft drinks and cereals. The announcement of a levy on sugary drinks is a positive step in reducing sugar intake. However, locally we will need to continue to work to educate children and parents about the impact of diet choices on their teeth and wider health.

The picture in adults

Tooth decay has fallen in adults in England from 46% having active decay 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 changing need, particularly as the number of people needing more complex dental work rises steadily with age.

What did we say last year and what has been done?

Last year's recommendations focussed on the need to monitor closely a new oral health promotion service commissioned by the County Council which completed its first year of operation on 31st March 2016. This service has in collaboration with wider dental services aimed to prevent oral health problems in children and adults.

The new service has achieved the following:

- Setting up an accreditation scheme for pre-school settings for 26 locations to help young children with oral hygiene
- Training 40 school health nurses in oral health promotion 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 evidence-based, age-appropriate, oral health information for parents, carers and children, including details on how to access local dental services.
- Delivering 106 oral health promotion sessions and events in the community.
- Training 38 people who work with young children in oral health to better understand the causes of decay, how to look after your teeth and signposting to local dental services
- Training 117 people who work in the community with adults to promote oral health including understanding the causes of poor oral health in adults, how to maintain good oral health and how to access local dental services.
- Delivering oral health promotion in local workplaces including BMW, Siemens, The John Radcliffe Hospital and in Oxfordshire County Council
- Carrying out promotional events during National Smile Month and National Mouth Cancer Awareness Month.
- Establishing a lending service of health promotion resources for use by local services.

Recommendations for oral health

1. The NHS should ensure that improvements in access to NHS dentistry are maintained including complex care for older people.
2. Providers of care home facilities should be aware of maintaining good oral health in their clients which can significantly affect their quality of life. They should also ensure that their clients have access to dental services to help maintain a pain free mouth.
3. Work should continue with school health nurse and health visitor services to embed oral health promotion into children's health from 0-19, to give a healthier start to life.

Chapter 5: Mental Health

Main messages in this chapter:

- **The demand for young peoples' mental health services is rising.**
- **New services have been put in place and these need to be monitored carefully.**
- **Levels of self-harm in young people appear to be rising and require careful monitoring.**
- **Mental health conditions should not be seen as distinct from physical conditions.**

This year I want to report on two aspect of mental health I have not reported on before that are a cause for concern. These are:

Mental Health in Young People and Self Harm.

I will discuss each in turn.

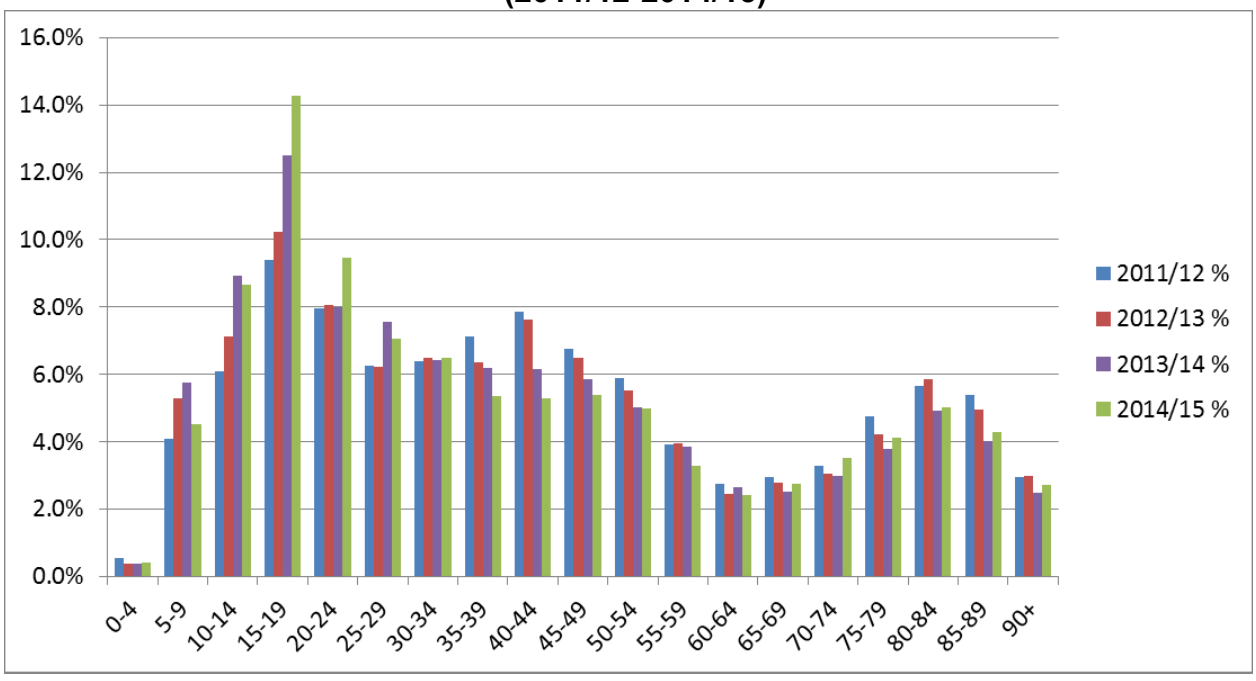
Children and Young People's Mental Health

The chart below records the number of mental health referrals by age group to our local services, and two facts leap out:

1) The highest number of referrals is in teenagers

2) The number is steadily growing, particularly for young people aged 15 to 19.

Oxford Health mental health referrals for Oxfordshire residents, % in each age band (2011/12-2014/15)



Why should this be?

The first question to answer is:

What are emotional disorders in children and young people and why are referrals for treatment going up?

This is not an easy subject. Emotional disorders in adults are difficult enough to define and count. In children the situation is more difficult because:

- Childhood and adolescence covers a wide range of different stages that can't be grouped easily.
- Disorders and treatments vary greatly with age. The whole topic is tangled up with the overall development of the individual.
- Mental health problems don't always express themselves in the same way as in mature adults. Underlying problems can show themselves through changes in behaviour, changes in mood or changes in activity level – or mixtures of them all.
- To some extent, society creates and modifies the categories of what is deemed be a disease and these vary over time.
- What may have been dismissed as poor or unusual behaviour in the past is now recognised as an emotional disorder.

To some extent the rise in referrals is a positive development – we want to encourage young people to come forward to talk about problems at an early stage as this gives better outcomes in the long term.

In her 2013 Annual Report the Chief Medical Officer concluded that there was in fact an increase in emotional problems in young people. The possible reasons are unclear, and may or may not be connected to the new pressures young people face as they are the products of a digital world. New stresses may be present in social media, such as cyber-bullying. Also the digital world is 24/7 – there is no respite unless it is self-imposed.

What is the local picture?

Teenagers' mental wellbeing

The recent 'What About YOUth' survey found that a majority of children aged 15 in England reported having high or very high life satisfaction. On average, boys reported higher life satisfaction than girls. Young people from Black and Minority Ethnic (BME) backgrounds reported lower levels of life satisfaction than those from a White background. Poorer life satisfaction was also seen among young people who were living in more disadvantaged areas, who were in worse health, or who had experienced bullying.

The same study showed that mental wellbeing among children aged 15 in England was better among those who were:

- living in less deprived areas
- had a more positive perception of their body-image
- had high life satisfaction
- were in better health
- consumed more fruit and vegetables
- exercised more

What builds psychological resilience in Children and Young People?

The Chief Medical officer quotes the following list of factors which build resilience in young people and so helps them withstand the stresses and strains of modern life. These are:

- Positive relationships with caring adults
- Effective caregiving and parenting
- Intelligence and problem-solving skills
- Self-regulation skills
- Perceived efficacy and control
- Achievement / motivation
- Positive friends or romantic partners
- Faith, hope, spirituality
- Beliefs that life has meaning
- Effective teachers and schools

In contrast, when these factors are deficient, the individual's resilience is likely to be lowered.

Mental health problems in Children and Young People

1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder; that is around three in every class at school or 8,000 children across Oxfordshire. According to national prevalence rates 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 16-24 age groups.

Most serious and enduring mental health problems emerge during this time, and if detected and treated early, outcomes are improved. There is evidence that dealing with anxiety and depression effectively the first time it occurs in young people, helps to prevent recurrence and the likelihood of them suffering mental health problems in later life.

The most disadvantaged communities have the poorest mental and physical health and wellbeing. **Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%.** Parental unemployment is also associated with a two- to three-fold greater risk of emotional or conduct disorder in childhood.

Looked After Children (LAC) experience significantly worse mental health than their peers, and a high proportion experience poor health, educational and social outcomes after leaving care. It is estimated that between 45 and 60% of Looked After Children aged 5 to 17 have mental health difficulties: over four times higher than the average.

Approximately 40% of young people who have a learning disability may also have a mental health disorder. 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.

Children and young people with poor mental health are more likely to have poor educational attainment and employment prospects, social relationship difficulties, physical ill health and substance misuse problems, and to become involved in offending.

What is the local picture and what are we doing about it?

Children and young people's mental health services have been under pressure for some time. Local services work with around 3,500 young people at any one time, with more than 5000 referrals every year, the majority of whom are aged 10-15 years old.

Analysis of the data is hampered by the lack of standardised reporting systems, and so performance cannot be readily compare from place to place.

The CQC rated local services as good, but they were nonetheless creaking as evidenced by increases in waiting times – and so a review was undertaken in 2015 which made a range of recommendations, the thrust of which was:

- To involve young people in service design.
- To reduce waiting times.
- To use online and self-help tools.
- To catch disease earlier in a school setting, teaming mental health support workers with our school health nurses.
- To train frontline services to identify symptoms and provide direct help or make more accurate referrals.
- To improve the service offer to Looked After Children and 'children on the edge of care'.

What progress has it made and is it working?

The new service has now been launched. It is too early to judge whether it has improved matters. This is more difficult to judge than normal, because we aren't trying to reduce referrals per se, we are trying to help more young people in more effective ways using new technology and through strengthened partnerships between professionals. The key changes that aim to make a difference include:

- A dedicated specialist Eating Disorder Service.
- A new therapeutic team specifically working with young victims of child abuse and Child Sexual Exploitation.
- Dedicated workers in every secondary school working with School Health Nurses to provide support, training and direct interventions.
- A new team to work with children who are Looked After and those young people who are on 'the edge of the care'.

Recommendation for Children and Young People's Mental Health

This is an important issue. Progress made by the new service should be reported on in the next Director of Public Annual Report.

Self-harm

Self-harm is defined as *'intentional self-poisoning or self-injury, irrespective of type of motivation or intent'*. Self-harming behaviour in England has increased in recent years with an increased number of young people needing hospital admissions as a result of injury or poisoning. Relationship issues are often cited as a main contributing factor in self-harming behaviour.

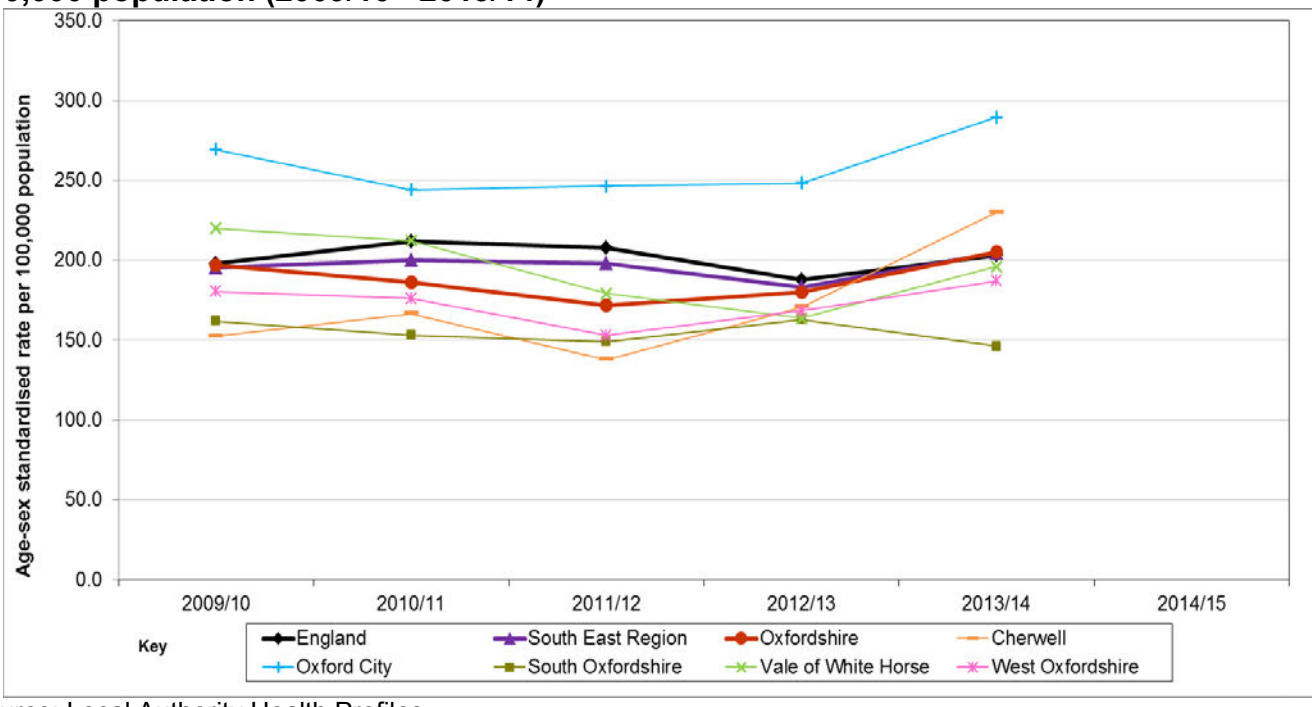
The rates for self-harm in all ages in Oxfordshire give us an idea of the local trends. During 2013/14 the number of emergency hospital admissions for intentional self-harm in Oxfordshire was 1,421. The rate of hospital admissions for intentional self-harm is rising in Oxfordshire, similarly to the regional and national picture.

However, looking at longer term trends in self-harm shows that overall rates in those aged 15 and over have fallen overall since 2000 but have risen in recent years.

The peak ages for self-harm are 15 to 24 in females and 20 to 29 in males.

The data in the chart below looks at hospital admissions for self-harm and covers all age groups. It will not include patients who attended Accident and Emergency (A&E) or Minor Injury Unit (MIU) or who were not admitted to hospital; it is likely to be an underestimate of the true rate of self-harm in our population.

Age/ sex-standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population (2009/10 - 2013/14)



Source: Local Authority Health Profiles

The chart shows that:

- Oxfordshire's rate is broadly in line with the national rate and rose with it during 2013/14.
- The overall trend is however fairly static from 2009/10 to 2013/14.

- Admission rates are higher in Oxford City than elsewhere in the County, other Districts are on average just below the national levels.

Young people who self-harm are more likely to be vulnerable such as being a Looked After child or in the youth justice system. Those who self-harm have an increased risk of death by subsequent suicide, and over half of people who die by suicide have self-harmed previously. A survey of young people and professionals found that self-harm was a topic that was least likely to be addressed due to fear of stigmatisation and not having adequate confidence in how to access support services. Furthermore, these young people felt that the issue of self-harm should be addressed within school and an open dialogue should be sought.

Report of a local County Council initiative

An initiative was launched by the County Council in 2015 to try to help the situation based on our knowledge that:

- efforts to raise awareness of self-harm and how to access support in adolescents may contribute to improved overall wellbeing and reduce the risk of suicide
- Approaches using theatre as a form of raising awareness and reducing stigma of mental health issues have been successful previously.
- Within Oxfordshire, rates of admissions to hospital for unintentional and deliberate injuries in 0-14 year olds and 15-24 year olds, is higher than the national average.
- Local surveillance using data from Oxford University Hospital Trust identified that during 2014 there were monthly increases in the numbers of admissions to hospital for self-harm in both female and male young people from homes across the county.

What did we do?

The County Council's Public Health team commissioned a local Oxfordshire theatre company, Pegasus, to perform a play on self-harm in secondary schools across the county. This involved interviewing young people who had self-harmed as well as working in partnership with Schools, School Health Nurses, Educational Psychologists and Child and Adolescent Mental Health Services.

The play was called 'Under My Skin'. Its aims were to:

- Give young people vital information about coping with feelings around self-harm, stress and the relevant services that can support them.
- Reduce the stigma of discussing self-harm and accessing support
- Highlight the School Health Nursing service as a first port of call in schools for young people and professionals who have concerns over self-harm.
- Give professionals information and subsequent confidence about how to support a young person, and who to refer onto.

The evaluation of the play showed that:

- It went to 28 secondary schools and was very well received.
- Approximately 5000 young people in years 8/9 (ages 12-14) watched the play.
- 50% reported the play increased their knowledge of self-harm a lot.
- 71% of young people knew how to access support after seeing the play.

As a result, we will commission the play again for the academic year 2016/2017.

Recommendations for self-harm

1. Self-harm is a serious issue. Self-harm levels in Oxfordshire should be closely monitored.
2. The new Child and Adolescent Mental Health Service should work with partners to improve the detection of self-harm and offer coordinated support to young people.

What we said last year and what has happened since?

Last year's report described a range of improvements planned for mental health services as a whole, called for close monitoring of a newly-let contract for adult services and recommended that the Health Overview and Scrutiny Committee and Healthwatch keep a close eye on the quality of services.

This has been achieved, and the Clinical Commissioning Group is about to bring forward new plans to improve mental health services further and to join up services for physical and mental health more closely.

These are welcome developments which again call for continued surveillance.

Recommendation

Future Director of Public Health Annual reports should continue to focus on mental health issues and mental health services in the county.

Chapter 6: Fighting Killer Diseases

Main messages for this chapter:

- **We need to make sure our specialist services for fighting major outbreaks of disease such as Ebola stays strong and resilient.**
- **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 and cooperation across organisations is essential.**
- **The threat of antibiotic resistance is real and everyone has a role to play**

Part 1. Epidemics: Ebola, Flu Pandemics and Antibiotic Stewardship

Never had it so good?

We are fortunate to live in times where major illness and large numbers of deaths due to communicable diseases are seen as a problem in poor and developing countries far away or something suffered by our ancestors.

This has been a fortunate consequence of improvements in the quality of our living conditions and the advances in modern medicine. However we cannot be complacent about the risks of this changing and the risk of a pandemic and drug resistant bacteria becoming a very real issue.

Most of us live our daily lives unaware of the continued surveillance and planning of many national and local organisations that protect us. The recent Ebola outbreak in Africa was a reminder to everyone how new dangers can arise at any time and present a very real risk to the planet as a whole. Many lessons were learnt from this event nationally and internationally to help us prepare for the next outbreak, wherever it may arise.

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

As I stated last year 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. This is still the case and we still need to remain vigilant.

We have been fortunate in the past few years that the **influenza** seasons have been relatively mild. However it is important that we do not forget the potential that flu has to cause serious illness and death in young children, old people and those with poor health. Since the flu pandemic in 2009 we have seen a year on year decline in the numbers of people getting a flu vaccine. To protect these groups from flu it is still important that people understand that the risk of flu has not gone away and that it is important for people at risk to get a flu vaccination every year.

Another cause for concern is the rising threat of **antibiotic resistance** and the rise of "superbugs". Antibiotics are important drugs for both humans and animals in fighting bacterial infections which were once life threatening. Bacteria are highly adaptable in responding to antibiotics. Widespread misuse of antibiotics and inappropriate prescribing has led to increasing numbers of bacteria which are resistant to antibiotics which used to be effective.

The risk of bacteria which cannot be treated by antibiotics of any kind is a very real and pending threat not only in the UK but throughout the world. This has been brought into sharp focus by the recent development of a resistant strain of Gonorrhoea which is spreading in small clusters in England. Whilst this strain has not been reported yet in Oxfordshire it is could do so in the future.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections.

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.
- Educating and advising the public of their role as individuals in limiting antibiotic resistance.

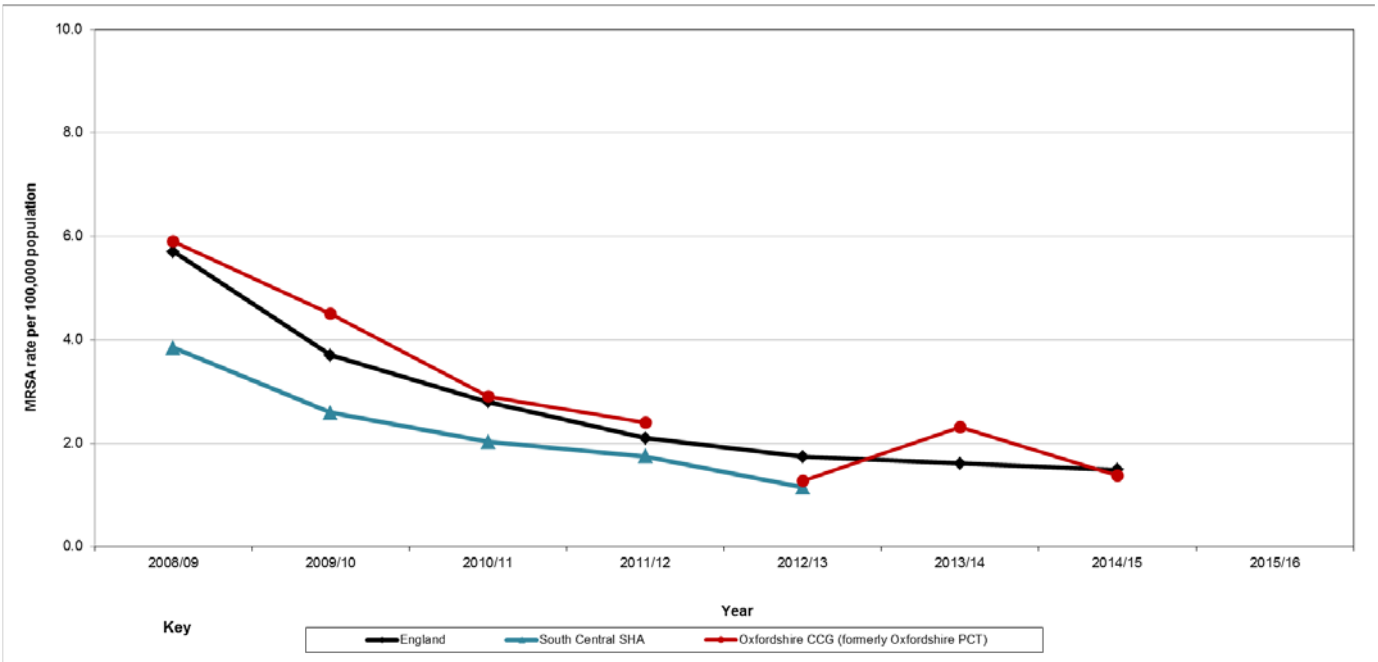
The key is to keep the specialist workforce we have now and to nurture this work carefully.

Part 2. Infectious and Communicable Diseases

Health Care Associated Infections (HCAIs)
Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.diff.) remain an important cause of sickness and death, both in hospitals and in the community. While these infections do not grab headlines as much as they used to it is vital that everyone remains vigilant to limit the increase of these infections.

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 in response to the direct measures taken by hospital and community services to combat it. The local situation is shown below.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 – 2014/15) England, South Central SHA and Oxfordshire



This shows that infectious diseases can be tackled, often by traditional hygiene measures. Nationally there is a zero tolerance policy and rate of MRSA is still higher than we would like. There have been improvements in the rate of MRSA in Oxfordshire over the past few years. While the levels in Oxfordshire had increased slightly in 2013/14 to be higher than the average for Thames Valley and England they have reduced to be similar to National levels in 2014/15. The recent slight increase reaffirms that continued vigilance is required by all hospital and community services to address this increase.

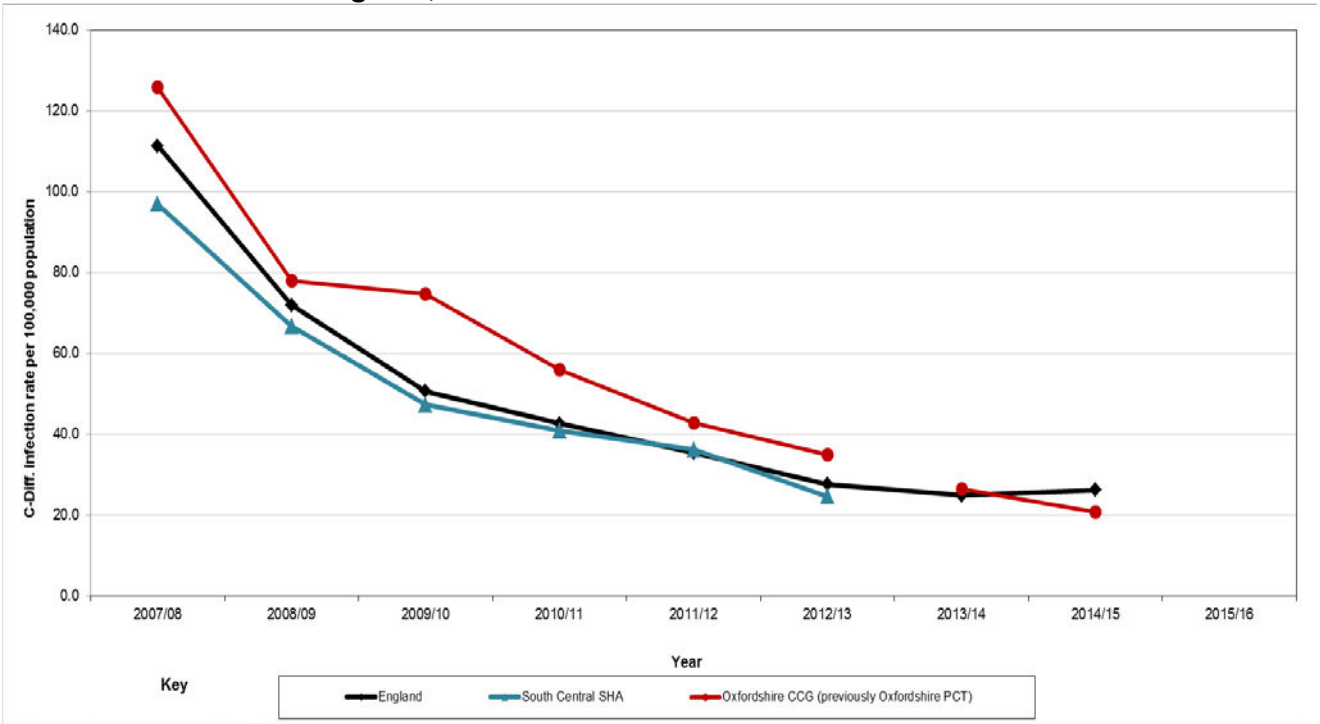
Clostridium difficile (C.diff)

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.

A focussed approach on the prevention of this infection is resulting in a steady reduction in cases since 2007/08 as shown in the chart below. This is in line with regional and national trends. There has been a continued improvement in the rates of C.diff in Oxfordshire.

The reduction in C.diff involves the coordinated efforts of healthcare organisations to identify and treat individuals infected and also careful use of the prescribing of certain antibiotics in the wider community. There are still on-going concerted efforts locally to continue to improve the rate of C.diff infections.

Clostridium Difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2014/15) England, South Central SHA and Oxfordshire PCT

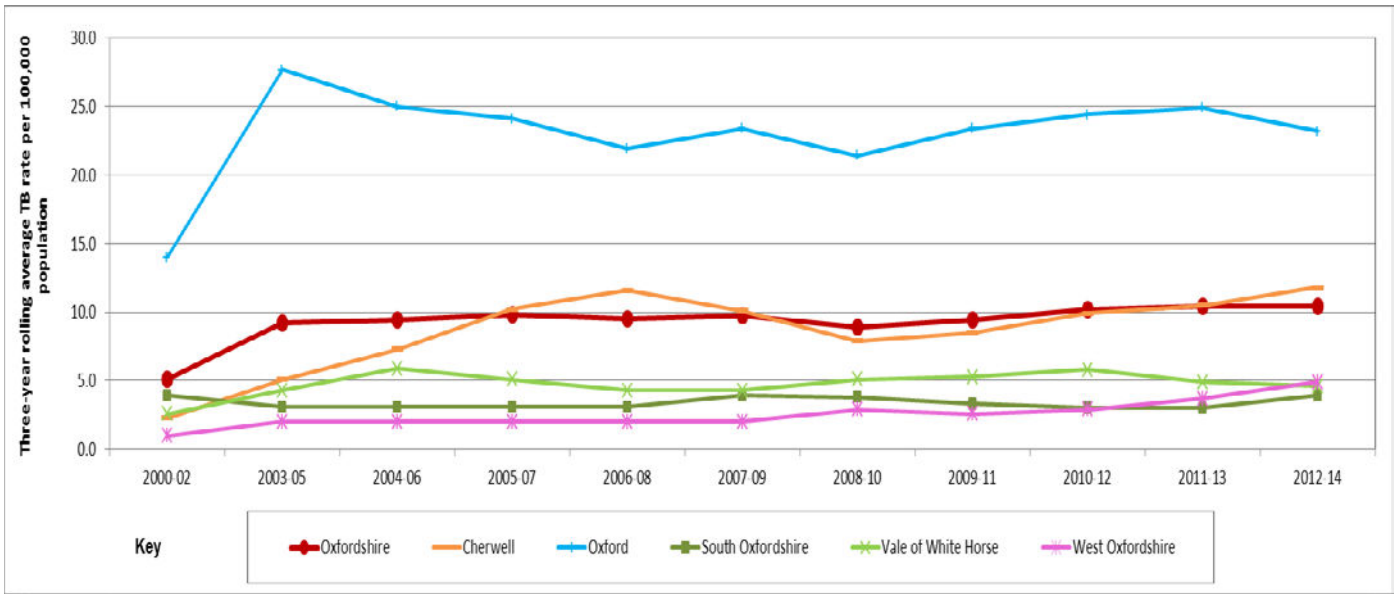


Tuberculosis (TB) in Oxfordshire

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.

In Oxfordshire, the numbers of cases of TB at local authority level per year are very low. The local figures are shown below.

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 years. Much effort has gone into improving TB prevention, treatment and control.

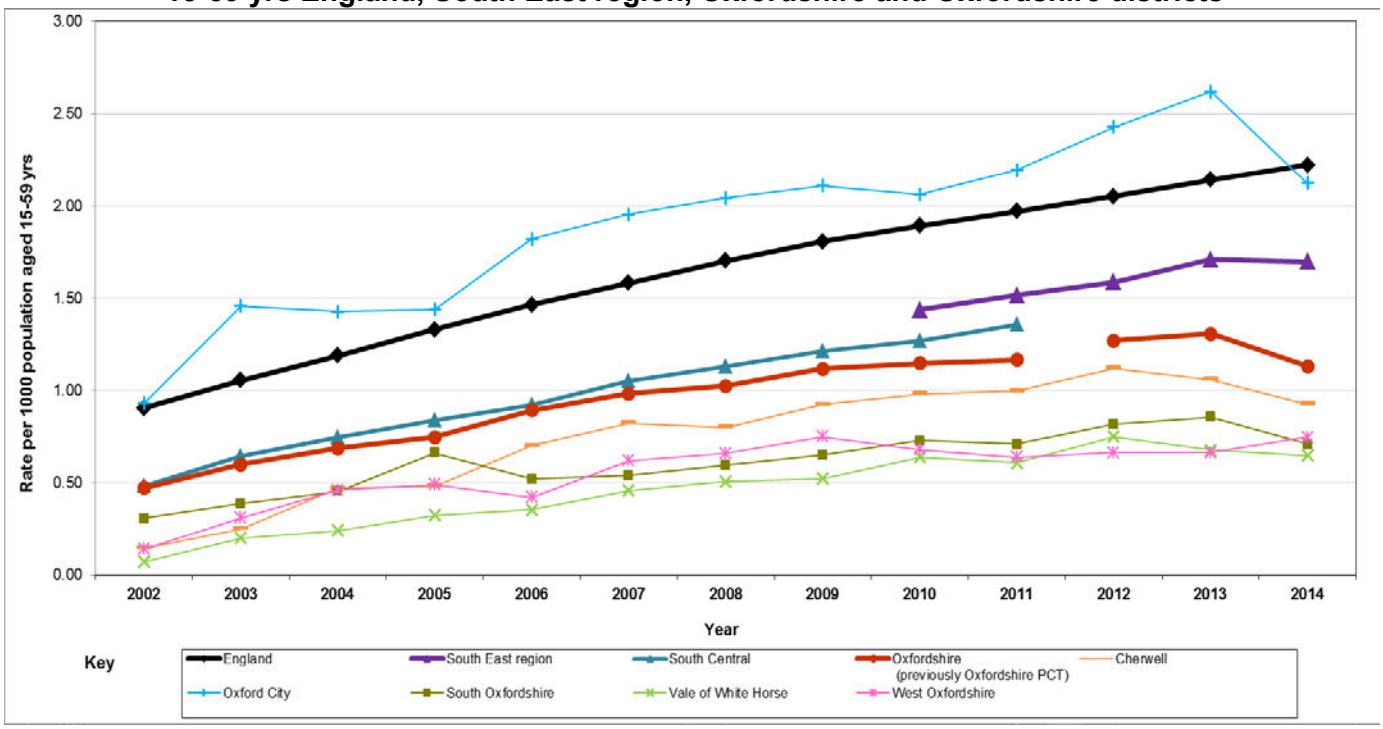
The rate of TB in Oxfordshire is lower than the National average and levels in Oxfordshire, Buckinghamshire and Berkshire combined. In the UK the majority of cases occur in urban areas amongst young adults, those coming in from countries with high TB levels and those with a social risk of TB. This is reflected in the higher rate of TB in Oxford compared to other Districts in the county.

Public Health England has developed a TB strategy to address TB nationally. TB control boards have been established to look at regional levels of TB and services to provide treatment. In Oxford the Clinical Commissioning Group are implementing a latent TB screening programme as part of a national initiative to identify and treat new entrants from high TB prevalence countries.

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. 2014 data shows that there are 457 people diagnosed with the infection living in Oxfordshire, 231 out of 457 live in Oxford City. This trend is shown in the chart below and shows a decrease over the last year across the County.

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 three ways:

- Providing accessible testing for the local population. In 2014/15 the sexual health service delivered 4,251 HIV tests across the service.

- Through community testing, we have 'HIV rapid testing' in a pharmacy 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.

- Prevention and awareness. Educating the local population about safe sexual practices and regular testing in high risk groups.

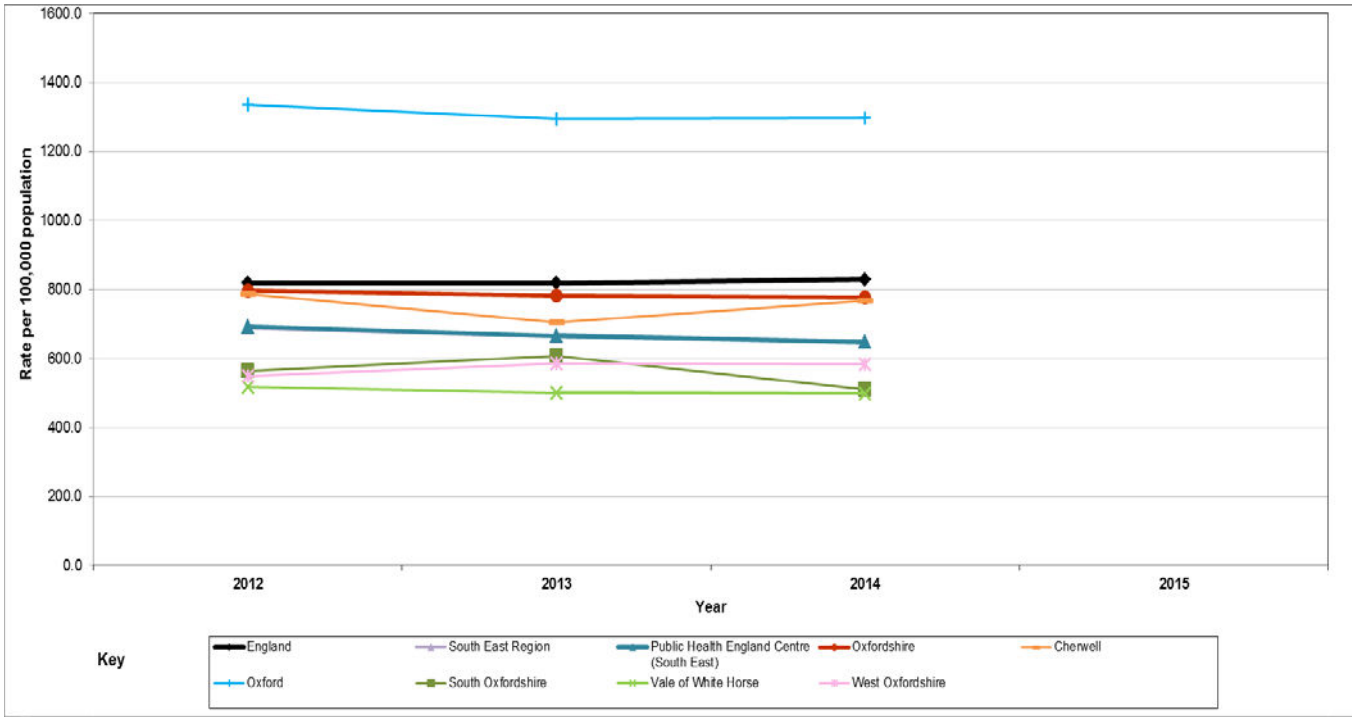
Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments. HIV cannot be cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly decreased.

Sexual Health
Sexually Transmitted Infections (STIs) are still high 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 remained at a similar rate since 2013. The local picture is shown in the chart below.

The different types of STI each show a mixed picture which is generally good. Looking at each disease in turn gives the following picture:

- Gonorrhoea – is below national average for Oxfordshire as a whole and all districts except in Oxford City. An investigation of recent increases revealed that an apparent increase was a consequence of oversensitive tests resulting in false positive diagnoses. New methods of validation should reduce the number of false positive cases.
- Syphilis - is continuing to fall and is below national average in all areas of the County.
- Chlamydia –levels are lower than national average in all Districts – 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. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.
- 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.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2014England, South East Region, PHE South East Centre, Oxfordshire and districts within Oxfordshire



The integrated sexual health service which began in 2014 has seen increasing activity levels and this is to be welcomed. This service has improved access to contraceptive and sexual health services at the same time.

In the first year of operation, the sexual health service delivered

- 28,283 Genito-Urinary Medicine consultations
- Provided 19,059 tests for STIs and HIV
- Positively identified 2,215 STI and HIV infections
- Provided 15,888 consultations for family planning
- Fitted 9,809 contraceptive devices
- Prescribed 897 Emergency Hormone Contraceptives

The service has successfully established itself in the community as a range of accessible locations across the county where the local population can access all their sexual health services in the one location.

In line with best practice a partnership of local stakeholders was established in February of 2015. This group still continues to work together to identify and address priorities locally to further improve on the decline in STIs in Oxfordshire.

Recommendation

The Director of Public Health should report progress on killer diseases in the next annual report and should comment and any developments.

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Health Improvement Partnership Board
Forward Plan 2016-17

Date	Item
23 Feb 2017 2-4pm The Kings Centre	• Healthy Weight Action Plan • Housing Related Support • Health and Care Transformation • Domestic Abuse Review
20 Apr 2017 2-4pm Oxford Town Hall	• Health Improvement Board Priorities 2017-18 • Annual Basket of Housing Indicators • Housing Related Support
27 Jun 2017 2-4pm Oxford Town Hall	
Oct 2017 tbc	• Health Protection Forum Annual Report • Air Quality Management Report
8 Feb 2017 2-4pm Oxford Town Hall	
Standing items:	
• Minutes of the last meeting and any matters arising • Report from HIB Healthwatch Ambassadors • 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 Sport and Physical Activity	

12 October 2016

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