DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT V

Reporting on 2010-2011
Recommendations for 2011-2013
Produced: November 2011

Director of Public Health for Oxfordshire
Annual Report V

Purpose of this report

This is an independent report produced by the Director of Public Health for Oxfordshire.

Its purpose is to use the best available science to point the way forward to better health and wellbeing for Oxfordshire.

This report reviews the previous four years of Director of Public Health annual reports, re-assesses priorities and makes recommendations for change.

This report reanalyses the scientific information in the Joint Strategic Needs Assessment (JSNA) and other key data*, and draws conclusions about:

- **Is this topic still a priority for Oxfordshire?**
- **What progress has been made against recommendations in the previous four annual reports?**
- **What further recommendations need to be made to improve health and well-being in this county?**

It is appropriate to review the previous four years of annual reports because we stand at the point of change: The advent of a new government and the prevailing economic situation means that all public sector organisations are undergoing fundamental change.

The planned abolition of PCT's and Strategic Health Authorities and their replacement by GPs in a leading role fundamentally changes the way health services are driven. We are also accommodating radical change and significant cost reductions in local government. In addition, more emphasis is placed than ever before on local people driving local change. At the same time local hospitals and community services are merging to form large NHS Trusts which are more independent and have more freedoms than ever before.

Throughout all this change public health is 'coming home' to local government after a three decades sojourn in the NHS.

We stand at the point of change, and yet at the same time we serve the same population whose problems and issues change only gradually from decade to decade.

Amid so much change, it is highly appropriate to take a fresh view of old problems, review progress and set out clearly and concisely where our efforts need to be placed.

This annual report aims to carry out these tasks.

It is intended that this report is used by planners of services across the County. Its production has been timed explicitly to influence the new Health and Wellbeing board as it sets its priorities. It is therefore deliberately pithy, brief and concise yet wide ranging: it is intended to be used, not to gather dust on shelves.

I hope you enjoy it and more importantly, use it.

Dr. Jonathan McWilliam
Director of Public Health for Oxfordshire
November 2011.

* *(there is a list of the sources used at the end of the report.)*

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Chapter 1 - The Demographic Challenge.

Introduction

The previous four Director of Public Health annual reports have highlighted the challenges posed to services by the growing number and proportion of older people in Oxfordshire. It is a blessing that long lives and good health are increasing steadily in this County, but service planners face the challenge of redesigning services to meet the needs of older people in the face of changing expectations and a harsher fiscal environment.

What does the Joint Strategic Needs Assessment say about the Demographic Challenge?

- The number of older people in Oxfordshire continues to grow as expected.
- The growth in the number of people aged 85+ is roughly in line with the England average, *But: The growth in the number of older people is not uniform across the County. It is markedly higher in our more rural districts than in the City. West Oxon has the highest rates, followed in descending order by Cherwell, South and Vale with the City far below. This is shown in the figure 1.*
- The *proportion* of older people in the population also continues to increase, which means that every pound spent from the public purse has further to go.
- The cost of caring for older people increases markedly with age, rising into the last year and month of life. This is true for both health care and social care. This is shown in figures 2.
- Older people rightly demand and expect a flexible range of services built around their individual needs so that they can maintain independence and stay close to home for as long as possible. A new generation of services is required to meet these needs.
- An increasing number of people are engaged in caring for elderly friends and relatives and many more volunteer their help. Many of these people are elderly themselves. We are dependent upon these friends, relatives and volunteers. Support to enable carers to care and the framework which makes volunteering possible must be husbanded.
- These challenges are faced by the whole of our society. The predicament we are in as a nation and our ability to fund the services as a country have been spelt out clearly in the recent Dilnot report.
- There are wide variations in referrals for older people in all parts of the NHS and social care systems. This lack of standardisation warrants further investigation.
- Access to services for the elderly population living in rural areas is a continuing cause for concern.
- There is a growing number of people with dementia in the County who require access to new emerging treatments.

Key Data.

The following charts tell the whole story. Figure 1 shows the number of people aged 85+ rising into the future. Note the different experiences of the Districts within Oxfordshire, with West having the greatest increase and the City far below the rest. The fact remains that the overall rate of growth is just above the national average.

Figure 1 - Projected population - England, Oxfordshire and districts - estimated percentage growth from 2008 in those aged 85 years and over

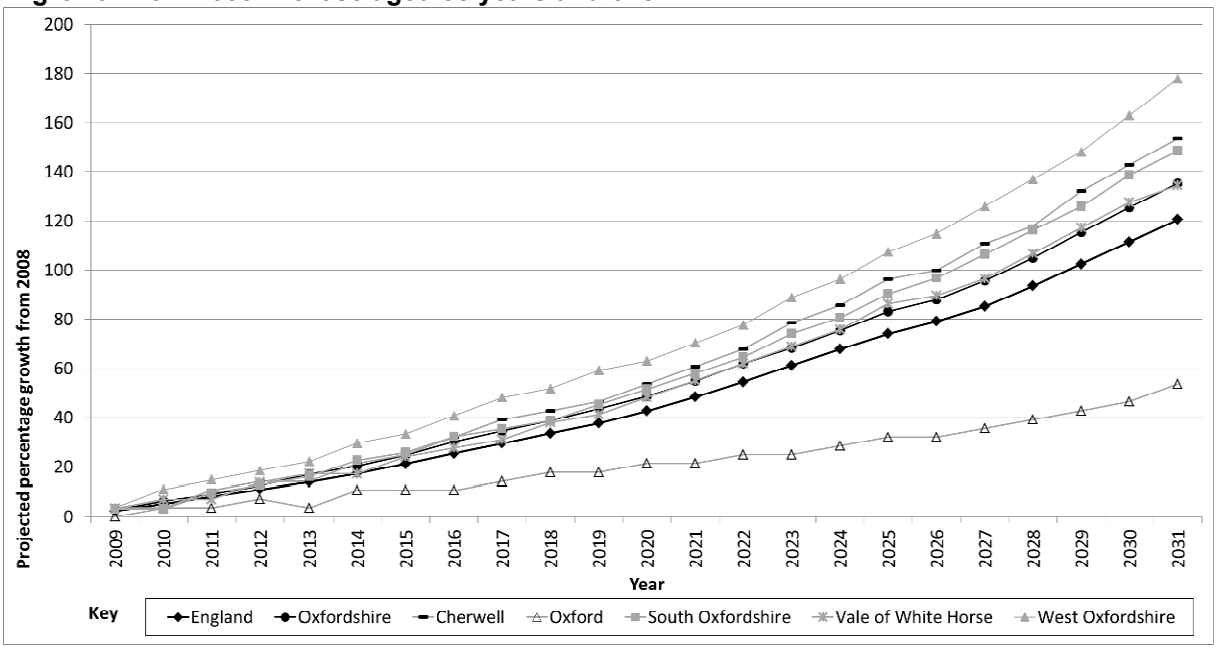
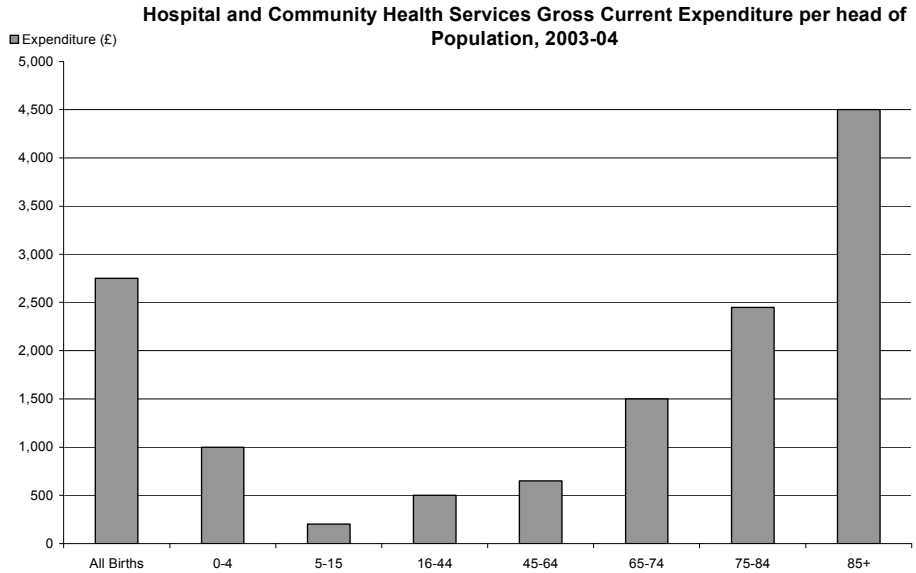


Figure 2 - Department of Health data showing how the cost of health care rises rapidly with increasing age.



The same picture is true of social care and this puts extra pressure on Local Authority budgets. For example, the average age of a person entering a care home in 2011/12 is 86 and the average age of a person starting a care package is 84. Compared with a person aged over 65, a person aged over 85 is 3.5 times more likely to require a new care package and 4 times more likely to require a care home

placement. A person over 90 is 4 times more likely to need a care package and 5 times more likely to need a care home. As the number and proportion of older people in the population grows, the pressure on health and social care to find new ways of doing things will increase. The only solution is to work together as one, particularly with the NHS.

Is 'The Demographic Challenge' Still a Priority for Oxfordshire?

Most certainly, IT IS.

This is the absolute immediate priority and it dwarfs all other priorities in this report. New approaches to the care of older people must be found if the public sector is to remain solvent: we cannot wait.

The recipe for success is becoming clearer all the time. The basic principles bear repeating here. They are:

1. Preventing disease where possible in the middle decades, investing in services backed by scientific evidence.
2. Minimising the impact of disease once it has begun e.g. through early detection programmes and expert patient approaches.
3. Having a single set of service priorities and goals across Oxfordshire's public sector so that public spending in this County is properly aligned (expressed as clear outcome measures and explicit targets).
4. Finding solutions which treat health and social care as though they were a single service.
5. Working hand in glove with the public at all stages.
6. Creating a smooth 'flow' of services from prevention through treatment-and-care and on into rehabilitation.
7. Balancing 'everyday' services for the common conditions faced by the vast majority with 'specialist' services for those with rarer conditions and commissioning these specialist services selectively and with great care.
8. Balancing services which are 'closer to home' while delivering modern, high quality services.
9. Commissioning services using tight specifications based on outcomes, the best evidence and delivery of explicit results.
10. Looking intelligently at wherever REFERRALS are made from one part of the 'system' to another and reducing those which are unnecessary. The decision to refer is the decision to open the public purse, this includes all types of referrals. These include
    - Self referrals by the public to A&E or to GPs.
    - GP referrals to consultants.
    - Referrals from community specialists to consultants.
    - Referrals from one consultant to another (a particular worry in Oxfordshire).
    - Referrals and applications for social care.

    (NB looking at referrals *is* a two-edged sword, as the same careful analysis *can* also result in some increases in referrals where quality is found wanting).
11. Working in partnership with private providers of care.
12. Caring for Oxfordshire's carers and supporting volunteers.

13. Working with older people to put their care into their own hands wherever we can afford to do so.
14. Focussing on high quality end-of-life care.
15. Creating a climate in which communities can draw on their own resources to help themselves.
16. Identifying and using the contribution other organisations can make – not just the NHS and adult social care. Issues like transport, housing, the fire and rescue service and trading standards, are crucial.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

In summary:

- This topic is now well-recognised as being of prime importance.
- Oxfordshire has made good progress in recognising this challenge early on.
- Partnership working is strong and scrutiny committees have made a valuable contribution. We have the opportunity to strengthen this further through the new Health and Wellbeing Boards.
- The importance of good care for our carers has also been recognised and there has been a welcome increase in resources used to fund helpful initiatives such as carers' breaks. This work needs to be further strengthened.
- Preventative services such as screening services (e.g. the new bowel screening programme) and immunisations services (e.g. 'flu jabs') continue to perform well.
- The care of people with dementia is also improving steadily since a specific group was formed to take this forward. This needs to be maintained.

However:

- We have not been immune from structural challenges which are part of the way England's health and social care system is set up. As the 'Dilnot Report' highlighted, it is difficult to marry seamlessly the 'free-at the-point-of-delivery' NHS system with a social care system which is gate-kept by means-testing and thresholds for care. This has shown itself in our struggles to manage the care of people at discharge from hospital into community hospitals or to other provision.
- The ***scope*** of potential joint work for older people is usefully set out in our 'Ageing Successfully' strategy, **but** this is too weak on action planning and ***delivery*** of concrete results to drive work forward. This needs to be rectified.
- We have also yet to identify and agree a set of outcome measures relevant for Oxfordshire for the care of older people for all public sector organisations. Without this we have no compass to steer by and no yardstick to measure progress. This must be a major priority for the new Health and Wellbeing Board.
- We have yet to strike the right balance in this County between 'District General Hospital' services for the majority and 'Specialist and Super-specialist' services for the few. It is a great boon to have internationally renowned hospitals on our doorstep, but it is another two-edged sword. Because we can only spend each pound of public money once, we need to look carefully at referral rates from one consultant to another all of which commit tax payer's money. We need to secure the right balance between high quality care and affordability.

Recommendations

1. Strategic Priorities for the Health and Wellbeing Board

By March 2012 Oxfordshire's Health and Wellbeing Board should establish an effective subgroup specifically designed to take forward practical work that will make an impact on all of these issues. Specifically the subgroup should:

- Be led by adult social care and clinical commissioning Group representatives working together with NHS provider trusts, other service providers the voluntary sector, public representatives and carers.
- Agree clear outcome measures and process targets for 2012, 2013 and 2014 which bind together the efforts of all organizations in a single direction.
- Set clear local trajectories for each outcome measure and performance targets. Performance against these should be monitored and reported publicly through the Health and Wellbeing Board.
- Ensure that plans are produced to correct poor performance.
- The work program should include the commissioning of practical services which will:
    - prevent disease in older people through screening and immunization programs (e.g. screening programmes such as Bowel screening health checks etc and flu jabs).
    - increase the number of carers offered help and support.
    - demonstrate evidence of effective use of the new direct payments for older people.
    - demonstrate that variations in all referral rates will be looked at systematically and action taken.
    - ensure that lengths of hospital stay are minimized while quality is kept high and the figures for delayed transfers of care are reduced.
    - strengthen the careful monitoring and control of specialist-to-specialist referrals for older people so that quality is balanced against cost.
    - show that readmission of patients to hospital or unnecessary admission of patients to nursing homes and long-term care is minimized.
    - ensure good end-of-life care and high quality care for people with dementia.

2. Strategic Priorities for the Oxfordshire Clinical Commissioning Group

By March 2012 Oxfordshire's Clinical Commissioning Group should be fully engaged in joint planning through the Health and Wellbeing Board for improving the care of older people in Oxfordshire, and should plan a general review of the variations in self-referrals, GP referrals and consultant to consultant referrals for Oxfordshire's population.

3. Need for Strong Public Involvement

By June 2012 the Health and Wellbeing Board should ensure that its Public Involvement Board is fully engaged with older people across the County and is in a position to insert their views directly into the planning process.

4. Need to Scrutinise Plans

By September 2012 Oxfordshire's Joint Health Overview and Scrutiny Committee should scrutinize the Health and Wellbeing Board's arrangements for care of older people and should expect to be able to scrutinize a concrete plan based on the items in the recommendations above.

Chapter 2 - Breaking the Cycle of Deprivation

Introduction

Previous annual reports have made the case for concentrating the efforts of all organisations on 'Breaking the Cycle of Deprivation'.
What do we mean by this? We mean that in this County there are a relatively small number of wards where social disadvantage and poorer life chances are handed down from generation to generation. Previous reports have shown that these areas are found primarily in parts of Banbury and Oxford and larger market towns.

This message has been grasped by organisations and mainstream services ***are*** beginning to be re-shaped to focus on these areas. The overall objective has to be to level-up standards across the County where possible.

The question arises, **'is this still an issue, or have we solved it'.**

This chapter attempts to answer this question.

This question is now particularly acute as GP Commissioners arrive on the scene to invest half-a-billion pounds of public money in health services per year.
GP commissioners will build up a county plan from locality plans; it will be a challenge for them to face the need to redistribute resources to break the cycle of deprivation.

What does the Joint Strategic Needs Assessment say about Breaking the cycle of deprivation?

On this topic we can safely let the Joint Strategic Needs Assessment findings do the talking for us. Key indicators from this and companion documents show that:

Indicator 1 - Child Poverty

The County's Child Poverty Strategy shows that in Oxfordshire there are 15,660 children living in poverty, which is almost 12% of all children in the county. (Poverty is defined as living in a household with 60% less than the average household income*). The experience of poverty is not just about lack of money, it's about life chances for young people - a young person participating in a local workshop summed it up as follows "Poverty…. It's what's in your life, not what's in your bank account".

Four out of five children living in poverty live in our towns and the City and one fifth live in rural areas. (12,315 in the City, Banbury and larger market towns and 3,345 in rural areas). This is low compared to the national average, **but** variations between parts of the county tell the critical part of the story.

- **Almost one in four (23%) of children in Oxford City (5800 children) are living in poverty.**
- **Ten wards in Oxford, one in Banbury and one in Abingdon are in the worst 25% in England for levels of child poverty, these are Banbury Ruscote, Barton & Sandhills, Blackbird Leys, Carfax, Churchill, Cowley Marsh, Iffley Fields, Littlemore, Lye Valley, Northfield Brook, Rose Hill & Iffley, Abingdon Caldecott.**

* In this case, the average used is the Median which is the middle of the range of all household incomes

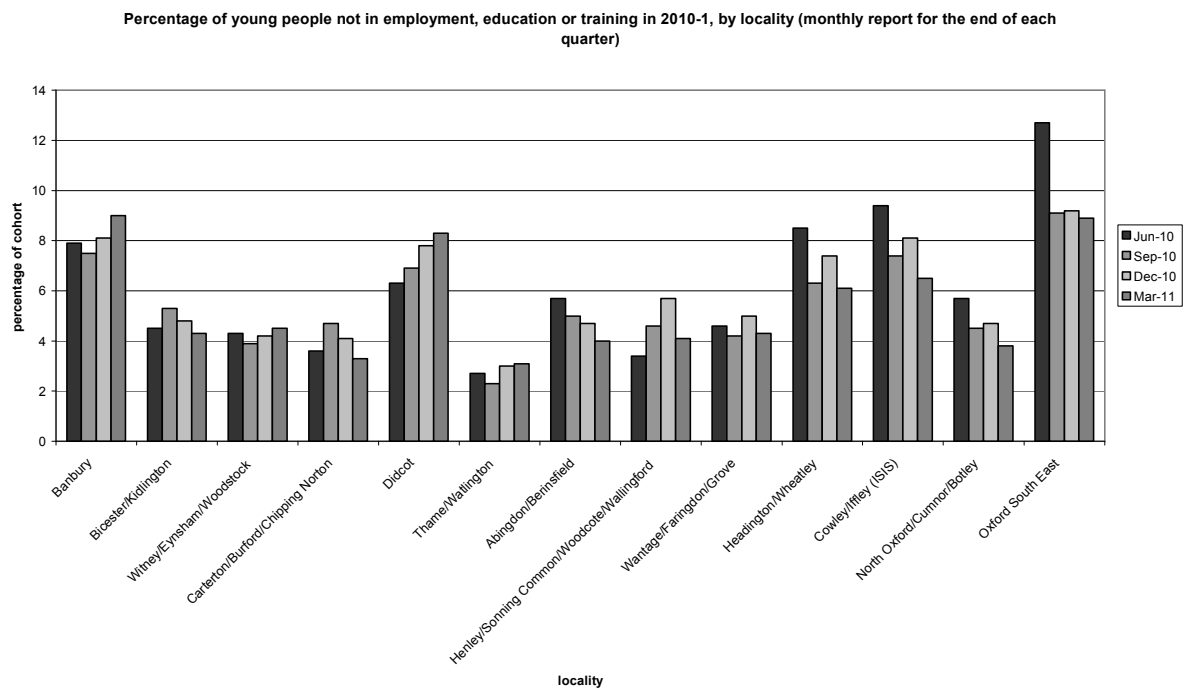
This indicator shows clearly the areas where our attention needs to be focussed to break the cycle of deprivation.

Indicator 2 - Young People Not in Education, Employment or Training

This provides a useful indicator of overall life chances for our young people. Being in education, employment and training helps to provide young people with the skills they need to step out of the cycle of deprivation. The overall picture across the County has improved since 2009 following focussed action, but a closer look within the county shows where the major problems lie. Banbury, socially disadvantaged areas of Oxford and Didcot have a higher percentage of young people who are not in education, employment or training than elsewhere in the County. Rates in Didcot and Banbury are the only places where rates are still increasing.

5.9% young people in Oxfordshire aged 16-18 were classified as NEET in 2010-11. This was higher than the South East average of 5.4% for the same period but lower than the England average, which was reported as 7.3% at the end of 2010.

Figure 3 - Percentage of Young People Not in Employment, Education or Training



Indicator 3 - Unemployment and Benefit Claimants.

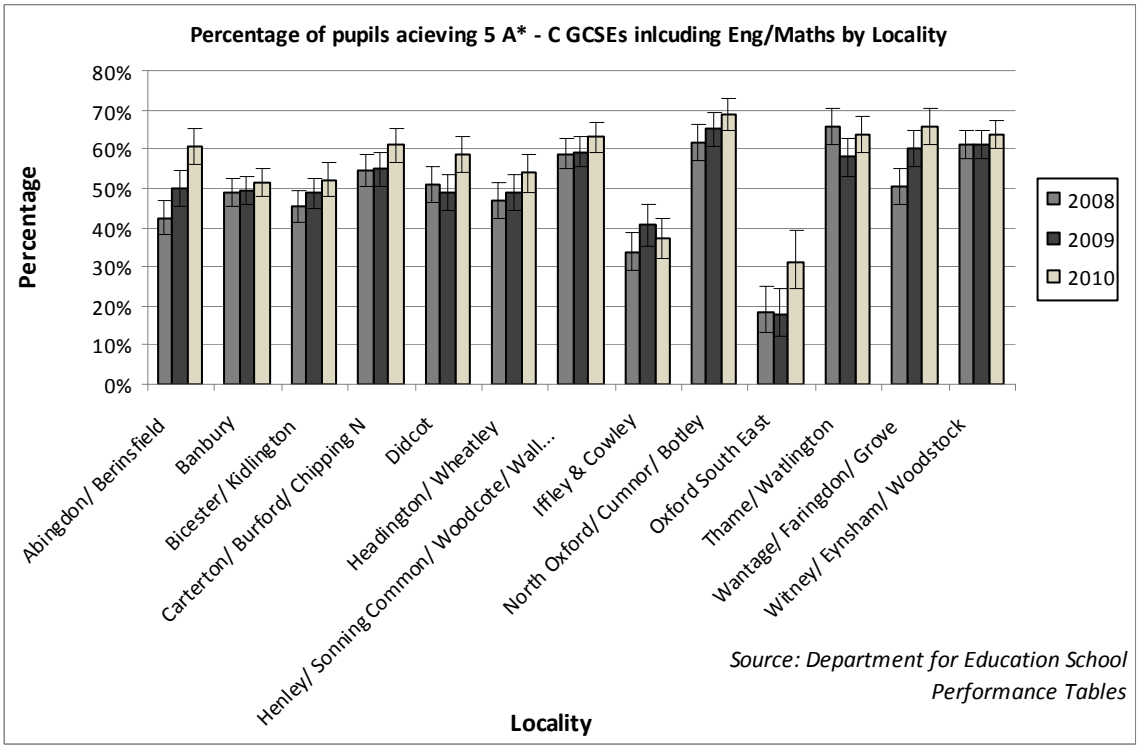
Being in regular work helps individuals and families to improve their life chances and so helps to break the cycle of deprivation. The rate of people claiming Job Seekers Allowance (JSA) in England has been declining slowly since the peak in April 2009, and seems to have levelled off during 2010-11 but is still above pre-recession levels. The number of people claiming unemployment benefits in Oxfordshire has largely mirrored national trends through the recession, and, thankfully, has always remained well below the England average.

However, some parts of the county have percentages of people claiming Jobseekers Allowance (JSA) which are well above England averages, especially in parts of the City and Banbury.

For example, 5.9% of people of working age in Blackbird Leys are claiming Job Seekers Allowance, 4.6% in Northfield Brook and 4.8% in Banbury Ruscote, compared with an Oxfordshire rate of 1.8% and an England rate of 3.7% (figures from Dept for Work and Pensions, April 2011).

Indicator 4 - Educational attainment

Figure 4 - GCSE Attainment

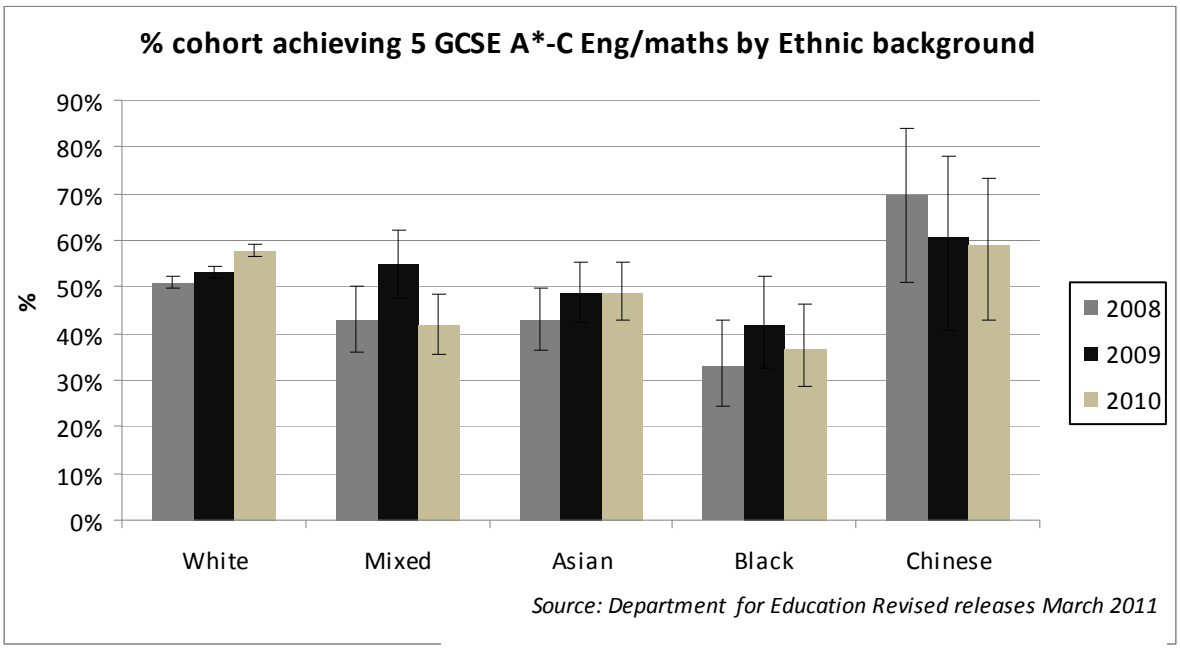


In 2010 the number of young people achieving at least 5 GCSEs with grades of A*-C including English and Maths has risen in almost all areas of the County since 2009. The only exception was the Iffley/Cowley locality in Oxford which will feature in next year's annual report. The 2011 data still awaits full analysis but shows a small fall against national trends.

As the chart shows, there are still stark differences between different areas of the county. Achievement rates in North Oxford/Cumnor/Botley are more than twice as high as those 5 miles away in South East Oxford area which covers the wards of Blackbird Leys, Rose Hill and Iffley, Littlemore and Northfield Brook.

There are also some remaining inequalities in achievement rates by ethnic group. These are shown in figure 5 which shows that results for black, Asian and mixed ethnic children were significantly poorer than their white counterparts.

Figure 5 - GCSE Attainment by Ethnic grouping



Indicator 5 - Teenage Pregnancy

In terms of the 'cycle of deprivation', teenage pregnancy is both a challenge and a success - there are still inequalities across the County, **but targeted action has shown that previously very high rates in the City have fallen steadily over the last 5 years.** This is a major success.

Overall the Oxfordshire under 18 conception rates is decreasing, broadly in line with rates in England. Oxfordshire has the 17th 'best' rates for all Local Authorities in the Country and those Local Authorities with lower rates tend to be smaller authorities in leafy shires with few areas of deprivation.

For Oxfordshire teenage pregnancy remains a useful and relevant measure of social disadvantage and poor life chances for children, young people and families. The most recent analysis shows that **Oxfordshire has 8 hotspot wards with particularly high rates**; hotspots are defined as those wards with more than 60 conceptions per year per 1,000 females aged 15-17 years. This is a cause for concern, but is also an improvement thanks to the attention we have given to this problem: the 8 current hotspots compares with 10 last year and 18 the year before that. The 8 current hotspots include 5 wards in Oxford, 1 in Banbury (the highest) and 1 each in Witney and Didcot. The wards with the highest rates are:

- Grimsbury and Castle (the highest), Banbury
- Northfield Brook, Oxford.
- St. Mary's, Oxford.
- Iffley Fields, Oxford.
- Barton and Sandhills Oxford.
- Blackbird Leys, Oxford.
- Didcot Park, South Oxfordshire.
- Witney Central, West Oxfordshire.

Indicator 6 - Crime

Overall crime rates in all districts of Oxfordshire continued to fall throughout 2010-11. The total number of crimes reported in the County fell by 4% in 2010-11 with violent crimes falling by 20%, Criminal Damage by 9.4% and burglary by 13%.
The picture here is once again uneven across the County. The greatest number of crimes occur in Oxford City, though crime rates there have been falling at proportionately higher rates than that in other parts of the county. Public order offences are more prevalent in the city centre while incidents of domestic burglary and domestic violence are more scattered. A summary of local crime figures highlights crime rates which are higher than the national average is included below.

Figure 6 - Local Crime figures 2010/2011 showing offences per 1,000 resident population. Rates which are higher than the national average are larger and in bold

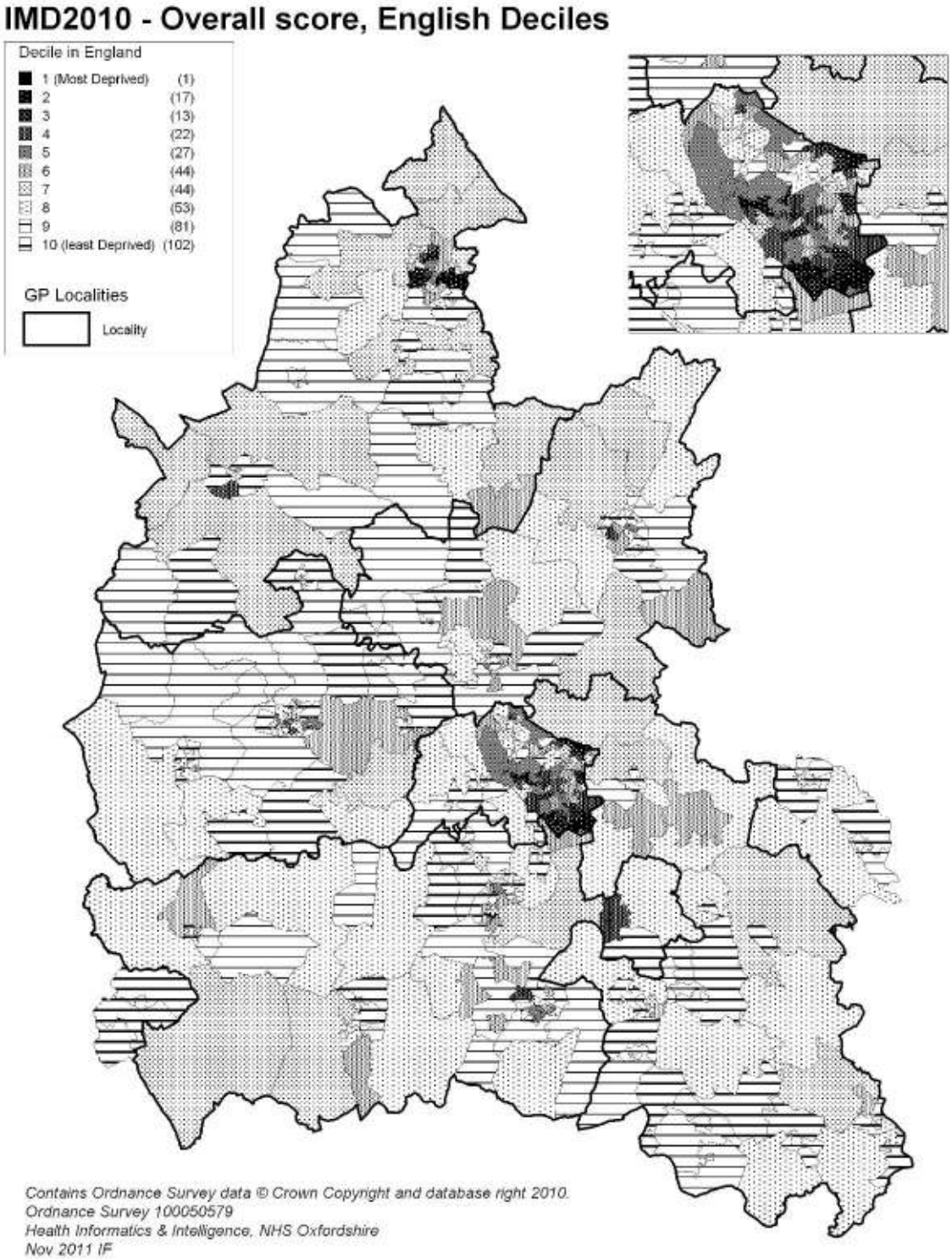
	OXFORD CITY	SODC	WODC	VALE	CHERWELL	England AVERAGE
Burglary	**9.7**	7.6	5.0	4.4	5.4	9.6
Criminal damage	**15.4**	9.7	9.1	7.9	10.7	12.7
Drug offences	**6.6**	2.1	1.2	3.1	3.1	4.2
Fraud and forgery	**5.2**	**4.2**	2.1	2.1	**4.7**	2.7
Offences against vehicles	7.7	5.1	3.4	3.0	4.0	8.2
Other offences	**1.7**	0.6	0.5	0.4	0.9	1.2
Other theft offences	**49.7**	14.1	12.8	11.2	18.2	19.3
Robbery	**1.7**	0.2	0.2	0.1	0.4	1.4
Sexual offences	**1.5**	0.7	0.6	0.7	0.9	1.0
Violence against the person	**23.0**	9.1	9.7	9.2	14.8	14.8

Data supplied by Home Office based on data collected by police forces in England and Wales between 2010 and 2011

Indicator 7 - Index of Multiple Deprivation (IMD)

The Index of Multiple Deprivation 2010 combines a number of indicators (such as the income deprivation affecting children index used above), chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area (called Lower Super Output Areas – LSOA) in England. This allows each area to be ranked relative to one another according to their level of deprivation.

Figure 7 - Map showing Index of Multiple Deprivation 2010 by Small Area (LSOA)



The 2010 IMD scores confirm that in general Oxfordshire is, for most, an affluent place to live. 324 out of 404 small areas are in the top 50% of most affluent places within England. However, on closer examination, the typical picture of disadvantage confined to small areas persists. Northfield Brook is the small area of Oxford which is the most deprived, the next 17 small areas which are most deprived all fall within Oxford City, Banbury and one small area of Abingdon.

Indicator 8 - Early Death and Areas of Social Deprivation

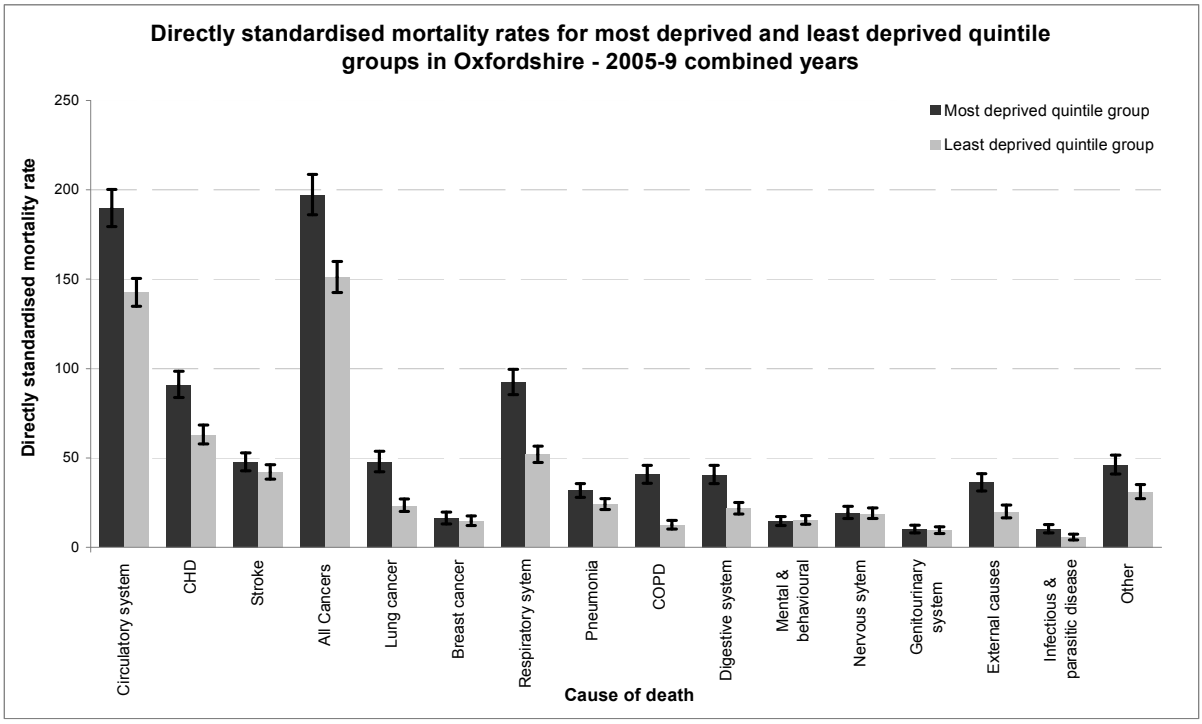
The chart below shows death rates across the county and the causes of death from 2005 to 2009.

For each cause of death the left hand column shows death rates in the 20% most socially deprived wards and the right hand column shows death rates in 20% most affluent wards.

The chart shows clearly that:

- Death rates in socially deprived wards are higher across the board than in affluent areas (i.e. the chances of dying at a younger age are higher).
- This is particularly apparent in the most common causes of death - circulatory diseases (e.g. coronary heart disease (CHD) and stroke and cancer).

Figure 8 - Comparing Mortality Rates in deprived and affluent wards



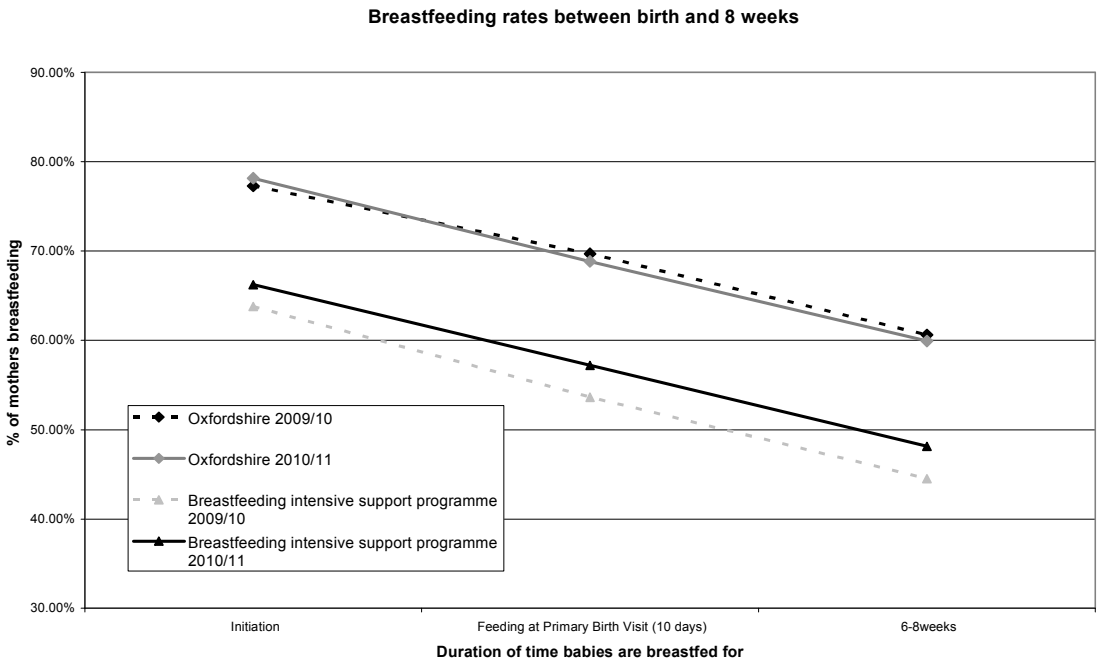
Indicator 9 - Breast Feeding Levels

Breastfeeding gives children a fantastic start in life. The percentage of mothers breastfeeding across Oxfordshire is high (79%) compared with national levels (74%), this is a good result. However, there are inequalities across Oxfordshire with not all mothers choosing to breastfeed their children. In 2009, areas of Oxford and Banbury were identified as having significantly lower breastfeeding rates than the rest of Oxfordshire. An intensive support service was set up, working out of general practices serving the populations with the poorest uptake. The practices were Blackbird Leys Health Centre - Oxford, both Donnington Health Centres - Oxford, Windrush Surgery - Banbury, 12 Horse Fair - Banbury, West Bar Surgery – Banbury

and The Orchard Health Centre - Banbury. The service was designed to support mothers in choosing to breastfeed and then provide practical help to continue feeding during the first weeks of life

Figure 9 shows that as expected, breastfeeding decreases as time goes by. The two top lines show breastfeeding rates for the whole county for the last two years. The bottom two lines show breastfeeding rates for the practices in Oxford and Banbury serving the areas with the lowest rates. This shows that, whilst the county average has been static, the extra support offered in the most deprived areas has improved rates across the board by about 4 percentage points. This is a good result.

Figure 9 - Breastfeeding rates between birth and 8 weeks, for 2009/10 and 2010/11



Indicator 10 - Obesity in Children

Being obese* in childhood puts your health on the back foot throughout life, and any obesity is a cause for concern (see chapter 4, dedicated to this topic). In *this* chapter we look at obesity rates in children in different parts of the County as a marker for where our effort is most needed to break the cycle of deprivation.
In Oxfordshire we measure obesity carefully in schoolchildren at two ages: reception year (around age 4 to 5) and year 6 (around age 10 to 11).
Figures 10 and 11 compare levels of obesity between the Districts within Oxfordshire and with the national average.

* Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.
Body mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).
The WHO definition is:

- a BMI greater than or equal to 25 is overweight - that is a 6 foot man weighing 13 stone 3 has a BMI of 25, whereas a female who is 5 foot 4 weighing 10 stone 6 has a BMI of 25
- a BMI greater than or equal to 30 is obesity - that is a 6 foot man weighing 15 stone 12 has a BMI of 30, whereas a female who is 5 foot 4 weighing 12 stone 7 has a BMI of 30

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults

In reception year, all Districts are below the national average. The City has the highest rates, followed by Cherwell and West Oxfordshire. (The very high figure for 2008/9 in West Oxfordshire is almost certainly inaccurate, due to a data recording error).
By year 6 however the picture changes, with Oxford City significantly higher than the national average with almost 1 in 5 (almost 20%) children obese with the other districts comfortably lower than the national average grouped around the 14-15% obese mark.

Figure 10 - Obesity amongst children in Reception Year 2006 to 2009 (Academic Years). England, Oxfordshire and Districts within Oxfordshire

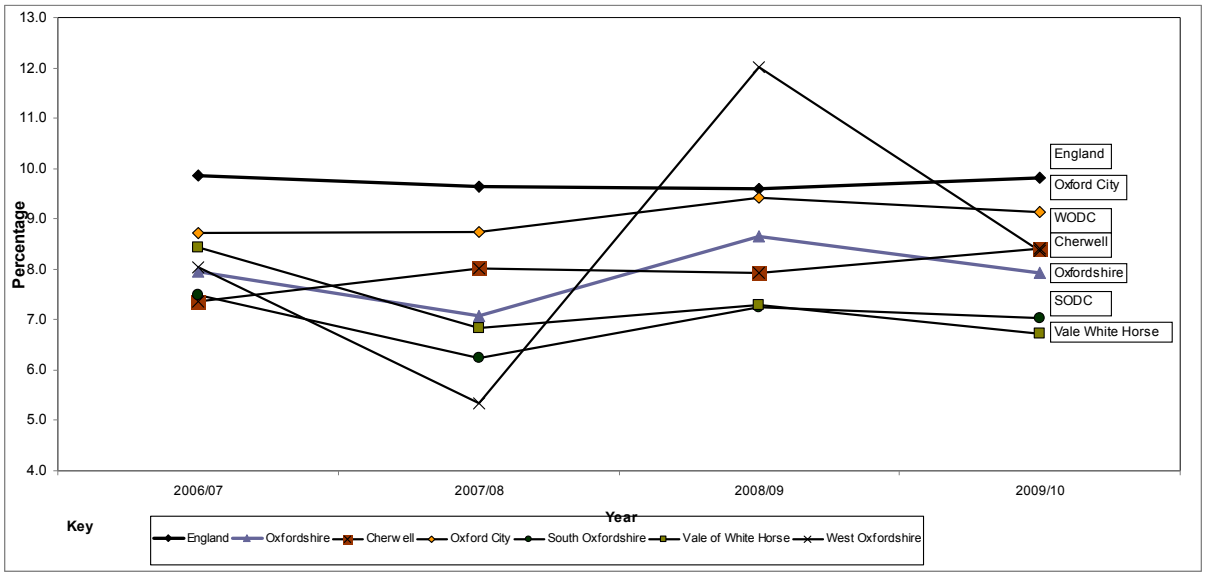
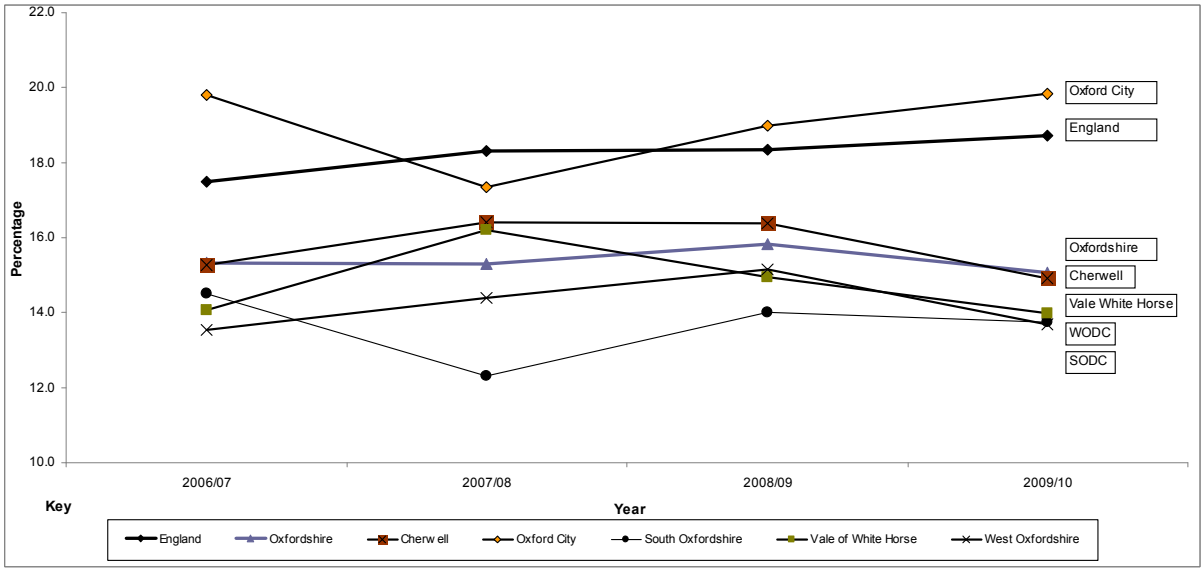


Figure 11 - Obesity amongst Year 6 children 2006 to 2009 (Academic Years). England, Oxfordshire and Districts within Oxfordshire



Is Breaking The Cycle Of Deprivation Still a Priority for Oxfordshire?

Unquestionably yes.

The statistics quoted above paint the picture eloquently:-

Breaking the cycle of deprivation is *the* major long-term social challenge facing Oxfordshire.

As a problem overall, its impact on health is only surpassed by the demographic challenge posed by an ageing population.

We **HAVE** recognised this challenge over the past 4 years and we **HAVE** begun to make a difference and this is a great step forward, but it is clear that efforts will need to be maintained over successive decades if we are to beat this problem.

The issue still overwhelmingly affects the most socially disadvantaged parts of Oxford City and Banbury and consequently, this is where the focus for action must lie. Since we have recognised this issue as a major problem in this County, promising work has begun. It is vital that these green shoots are nurtured with care.

We seem to get the best results when we focus on:

- **making a difference to *specific families in specific areas*** through direct contact and action
- **Re-designing existing *mainstream* services at the margin** to give a slightly enhanced focus on deprived areas as opposed to designing stand-alone, short term initiatives. Stand-alone initiatives are always harder to sustain in times when finances are under pressure, and sustainability has to be the watchword.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Breaking the cycle of deprivation is now recognised as a major plank in Local Authority and NHS policy in Oxfordshire. This is a major achievement and all organisations should take credit for this. The altruistic use of the Local Area Agreement reward grant on this topic bears witness to this and is to be applauded. Important new initiatives and new ways of working have sprung out of this recognition, in particular:

- The family intervention project which has targeted help to the specific families who need it the most
- Work to target schools with poor educational attainment
- Reductions in teenage conceptions in the “hotspot” areas
- Fewer young people as a whole Not in Education, Employment and Training (NEET)
- Job Clubs linking with local employers to offer opportunities
- Apprenticeships, internships and volunteering opportunities for young people.
- Benefits advice available from Citizens Advice Bureau advisors in GP practices in Banbury as well as Oxford
- Further Local Area Agreement reward funding being made available for skills development and improving employability.

However the watchword here is <u>persistence</u>. This means persistence over time despite changes in fiscal policy, and organisational change.

The most pressing challenges in Oxfordshire are to:

- Ensure that the new Oxfordshire Clinical Commissioning Group is fully supportive of Breaking the Cycle of Deprivation as a policy and that their locality structure will enable them to focus on these areas in the County when the need arises.
- Ensure that 'Breaking the Cycle of Deprivation' continues to be a very visible major plank of policy across all organisations in Oxfordshire as partnership structures are reviewed and renewed. This should incorporate the implementation of the Child Poverty Strategy. It will be vital for the Health and Wellbeing Board to adopt this topic as a major priority and it will also be vital for the Community Safety Partnership and the Local Enterprise Partnership to play their parts also.

Recommendations

1. A Strategic Priority for the Health and Wellbeing board

By March 2012 the Health and Well-Being Board should have adopted Breaking the Cycle of Deprivation as a major priority for the public sector in the County.
A Children and Young People's Board should have been set up to continue the work of the Children's Trust on this topic and should report regularly on a basket of outcome measures and key performance targets designed to show progress to the main board. This should include setting specific local trajectories for 2012, 2013 and 2014. The Health and Wellbeing Board should require improvement plans to be in place where progress is not on target.

2. A Strategic Priority for Oxfordshire Clinical Commissioning Group

By March 2012 Oxfordshire's Oxfordshire Clinical Commissioning Group should be a fully signed-up partner to programmes of work designed to break the cycle of deprivation in Oxfordshire under the auspices of the Health and Wellbeing Board.

3. A Strategic Priority for the Community Safety Partnership and Local Enterprise Partnership

By June 2012 the Community Safety Partnership and Local Enterprise Partnership should have identified focussed action that they will oversee to play their part in Breaking the Cycle of Deprivation.

Chapter 3 - Mental Health: Avoiding a Cinderella Service

It is appropriate to conclude that services combating mental illness and promoting mental wellbeing HAVE improved over the last four years in Oxfordshire.

Four years ago mental health was definitely a 'Cinderella issue' - this is no longer the case. The challenge will be to sustain this improvement during a tough fiscal climate, especially as the impact of recession works its way through peoples' personal circumstances.

The analysis below shows why this conclusion is drawn.

What does the Joint Strategic Needs Assessment (JSNA) say about Mental Health?

Measuring and assessing mental health and wellbeing is difficult. Why? Because mental health is such a complex thing - it is so complex and so tied in with peoples social circumstances that it is hard to define. It isn't neat and tidy like diabetes.

Having said that, the JSNA sheds very useful light on the subject -
For example, we know that:

- Mixed anxiety and depression is the most common mental disorder - it is estimated to affect around 35,000 people in Oxfordshire at any one time (9% of adults). It isn't possible to say whether this level is rising or falling, but we DO know that more people than ever before are now receiving treatment for these common conditions.
- Levels of major mental illnesses like schizophrenia recorded by GPs are stable and are not rising.
- Oxfordshire's suicide figures show a decrease to bring County levels in line with national averages after a worrying upward trend.
- Rates of Accident and Emergency attendances for deliberate self-harm such as overdoses have fallen steadily over the last 4 years.
- National data shows early signs that people with mental health problems are becoming less stigmatised. The National 'Attitudes to Mental Illness survey 2011' shows that:
    - the percentage of people agreeing that 'Mental illness is an illness like any other' increased from 71% in 1994 to 77% in 2011.
    - the percentage saying they would be comfortable talking to a friend or family member about their mental health rose from 66% in 2009 to 70% in 2011.
    - the percentage saying they would feel uncomfortable talking to their employer about their mental health fell to 43%, compared to 50% in 2010.

What Evidence is there of service improvement?

The consensus among local professionals is that:

- The need to improve services which help to get people back into work and achieve independent living has been recognised, and these services are now being strengthened.
- Mental health service commissioning is much improved. Services are specified in contracts in much more detail.
- Much better services are in place for common conditions - e.g. more counselling in general practice and improved access to 'talking therapies'.
- The commissioning of dementia services is much improved in line with the national dementia strategy.
- Carers for people with mental health problems are benefitting from a welcome increase in GP-referred carers breaks.
- Joined up early intervention services for children and families will help to spot psychological problems early and will make treatment more accessible.

Is This Still a Priority for Oxfordshire?

Absolutely. The sea may be calmer, but it is by no means all plain sailing from here on. The next raft of challenges includes:

- Maintaining what we have achieved with tightening resources.
- Untangling the way we pay for NHS services within the 'payment by results system'. This tries to fix a standard price for standard treatments and works fine for physical illness…… mental illness however is much more complex as it resists being packaged up and neatly priced. It is hard to see how this will work smoothly.
- The move to join up all mental health services cradle to grave as part of the national 'No Health Without Mental Health' initiative.
- GP Commissioners will be taking the reins of NHS commissioning fully over the next year or so. We will need to keep focus and direction during this change.
- The long term impact of the recession will filter through to increase common psychological conditions - this is an inequalities issue as areas of social disadvantage experience higher levels of unemployment and other stresses.
- The recently created Oxford Health NHS Foundation Trust has now expanded into the physical health arena from its traditional base in providing mental health services. The impact of this is as yet unclear, but it will be important to keep focus here too.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Good Progress has been made:

- Mental health is now firmly on the agenda as a major concern - it is no longer such a Cinderella service.
- There is a much improved focus on older people and on dementia services.
- The creation of a large pooled budget for mental health services will help to 'glue' together the NHS and Local Authorities in commissioning services.
- More emphasis has been given to carers for people with mental health problems.

BUT

- We have struggled to set authoritative outcome measures for mental health - an issue that is currently being wrestled with at national level.

Recommendations

1. Strategic Priority of this Topic
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that a cradle to grave strategy is in place for mental health in Oxfordshire. It should ensure that all of its sub-groups are playing their part to commission integrated services for children, adults and older people.

2. Need to Review Pooled Budgets
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that the pooled budgets for mental health are reviewed and are working effectively to implement mental health commissioning.

3. Need for Outcome measures
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that meaningful outcome measures and trajectories are agreed for mental health services in Oxfordshire.

4. Strengthening the Public Voice
By June 2012 the Health and Wellbeing Board should ensure that its Public Involvement Board is fully engaged with mental health service users and carers and is in a position to put forward their views forcefully into the planning process.

5. Strategic Priority for Oxfordshire Clinical Commissioning Group
By June 2012, Oxfordshire Clinical Commissioning Group should have agreed to make the further improvement of the commissioning of NHS mental health services a priority, and they should be doing this through playing a full role as strategic partners in Oxfordshire's Health and Wellbeing Board.

Chapter 4 - The Rising Tide of Obesity

Previous annual reports highlighted the importance of halting the advance of obesity* in our society. This is important because:

- Obesity is on the increase in epidemic proportions in affluent Western society.
- Once obesity is established in childhood it is very hard to shake off in later life.
- Obesity reduces lifespan by around nine years.
- Obesity can lead to high blood pressure and long term conditions such as diabetes heart disease and stroke and cancer which lead to premature death and drive the costs of health and social care which we cannot afford.
- The risk of getting diabetes is up to 7 times greater in obese women and up to 5 times greater in obese men.
- The risk of developing diabetes is up to 20 times greater for people who are very obese (Body Mass Index over 40*).
- Obesity adds £1 million **every year** to the cost of the NHS in Oxfordshire alone.
- 10% of all cancer deaths among non-smokers are linked to obesity.
- Obesity decreases mobility making independent living harder.

A **reduction in 10% of body weight** gives the following benefits, even if you do not return into a normal weight category:

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

What does the Joint Strategic Needs Assessment say about Obesity?

The key facts from the JSNA are:
For Adults:

- Levels of obesity in over 16s are gradually increasing nationally, but levels in Oxfordshire are not quite so high in comparison (22% for Oxon compared with 24 % nationally).
- National rates for adult obesity continue to creep up around 1-2% per year, but the most recent figures for Oxon show a slight fall - enough to be welcomed cautiously but this could be just a 'blip' in our favour.

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* Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.
Body mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).
The WHO definition is:

- a BMI greater than or equal to 25 is overweight - that is a 6 foot man weighing 13 stone 3 has a BMI of 25, whereas a female who is 5 foot 4 weighing 10 stone 6 has a BMI of 25
- a BMI greater than or equal to 30 is obesity - that is a 6 foot man weighing 15 stone 12 has a BMI of 30, whereas a female who is 5 foot 4 weighing 12 stone 7 has a BMI of 30
- a BMI greater than or equal to 40 is morbidly obesity - that is a 6 foot man weighing 21 stone 1 has a BMI of 40, whereas a female who is 5 foot 4 weighing 16 stone 9 has a BMI of 30

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults

For Children:

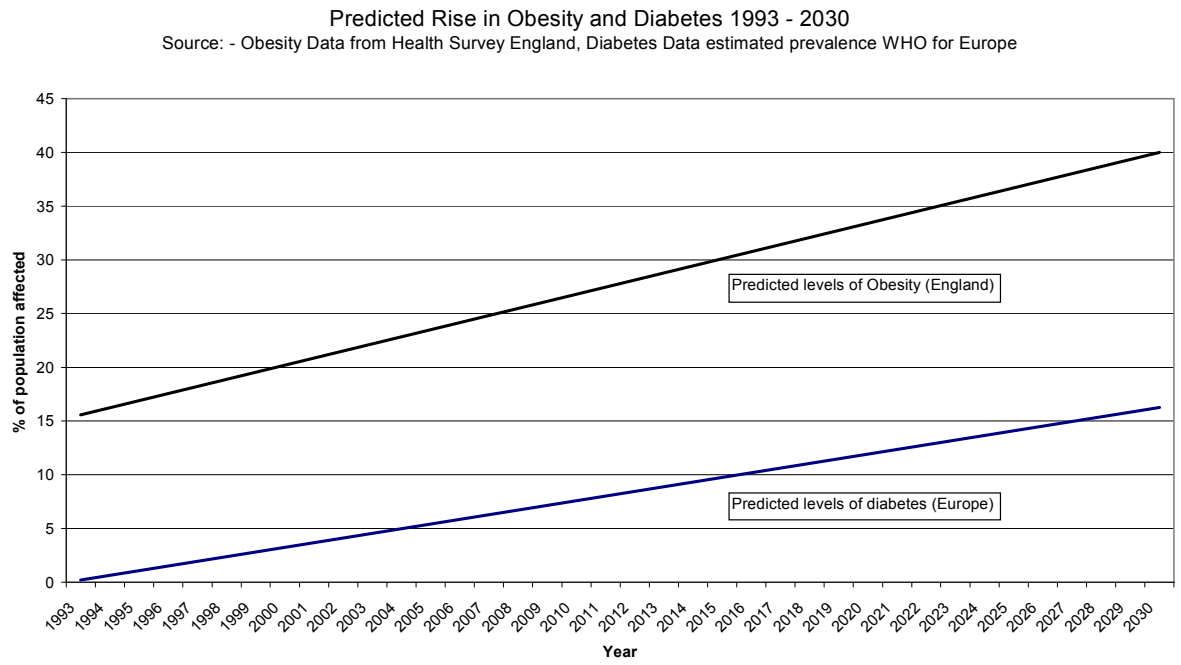
- Among children, levels of obesity are too high at around 8% of reception year children, rising to 15% of year 6 children. This shows that eating too many calories and taking too little exercise gradually increases weight year on year, with year 6 levels being almost double reception levels. This feeds through into ever increasing levels of obesity in young adults.
- The relatively 'good' county average masks the familiar pattern of social deprivation - Chapter 2 has already drawn attention to the fact that obesity levels are significantly higher in the City compared with the rest of the County.

However, that said, it isn't all bad news

- The trend in levels of childhood obesity has been pretty static both nationally and in Oxfordshire in recent years (2006-2010). This is good news as our aim is to halt the rising tide as a first step.
- Also, Oxfordshire's children do have lower levels of obesity than their National counterparts, with Oxon reception year levels around 1% lower than nationally (8% compared with 9%) and year 6 levels around 4% lower (15% compared with 19%).
- Oxon can take further comfort from recent data on exercise levels in adults. It transpires that **Oxfordshire is the sportiest and most active county in England according to the latest Active People survey results released by Sport England** earlier this year. Since 2005 the percentage of people in Oxfordshire participating in regular activity each week has risen year on year to 26%, **the highest in England**, with an increase of 514 people participating regularly compared in the last year. GO Active (Get Oxfordshire Active) is one of the projects in Oxfordshire that has contributed to this increase as a good example of Local Government and the NHS working in partnership. For example, since January 2009 over 13,000 people have taken part in GO Active activities such as Dance, Nordic Walking and Rounders across the county and independent research has shown that 84% of those involved are leading a more active lifestyle as a result.

Trends in chronic disease associated with obesity continue to show an upward trend. Figure 12 shows a worst case scenario for diabetes which we may face based on the "Foresight Report" which looked in detail at obesity levels using data from England and World Health Organisation predictions of worse case scenario diabetes levels across Europe.

Figure 12 - Predicted rises in Obesity and Diabetes



Is This Still a Priority for Oxfordshire?

The fight against obesity is the most important lifestyle challenge for the population of Oxfordshire. We are doing well as a County, but *can* do more to tackle this problem.

The risks of obesity are obvious. The benefits of losing weight are very clear, and yet, on the whole the trend is still going up. Why? Because, on the whole, in Western society as it stands, just by living an 'average' life, it is easier to become obese than it is to maintain a normal weight.

There is some comfort in the data for Oxfordshire, but not enough to justify taking our foot off the accelerator for a second. If we do not continue efforts to turn back the "rising tide" we may not be able to afford to treat the ensuing chronic disease and high levels of physical disability which will result. It is imperative that we continue to tackle obesity as a partnership, with each partner playing a full role.

There is huge scope here for District Councils to link the efforts of GP commissioners, road and transport planners public health staff, health visitors and schools to continue the fight against obesity. It is particularly important to take a cradle-to-grave approach to try to prevent people becoming obese in the first place - an approach which starts before the birth of the child and continues throughout life.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Progress against recommendations has been generally good. The calls for stronger partnership working have been heeded, and obesity was taken seriously as a priority by the Health and Wellbeing Partnership, a body that will be subsumed with the new Health and Wellbeing Board. These actions have helped us to be in a strong place in Oxfordshire going forward.

However:
It has proved difficult to measure reliably levels of adult obesity and physical activity in the general population. It was hoped that reliable information might be available through general practice but this has run into practical and statistical difficulties and is probably beyond our scope currently. We will need to continue to use national estimates and one-off surveys as a proxy to measure progress.

Successful work on obesity depends on good joint working between organisations. **Following the major re-structuring of public sector organisations over the last year, the major task facing us is to maintain, re-vamp or re-create the strong partnership work we traditionally enjoy in Oxfordshire.** It will be particularly important to connect District Councils, GP Commissioners, County Council, schools and the new Public Health Team as it transits to the County Council. The new Health and Wellbeing Board will have a pivotal role to play in driving this work forwards.

Recommendations

1. Strategic Priority for the Health and Wellbeing Board and its Health Improvement Board

By March 2012, Oxfordshire's Health and Wellbeing Board and its subsidiary Health Improvement Board should adopt the fight against obesity as a major priority, should set local targets for Oxfordshire and should regularly monitor progress against these targets. As part of this process, all Local Authorities, GP Commissioners and Healthwatch are recommended to adopt the fight against obesity as an important corporate priority.

2. Requirement for a re-vamped County Strategy

By June 2012, the new Public Health Team should agree and coordinate a cradle-to-grave strategy to prevent and treat obesity, on behalf of all organisations in Oxfordshire. This should include working together with all Local Authorities and GP Commissioners. This should be adopted by the Health and Wellbeing Board

3. Need to Retain Strong Partnership Working of the Sports Partnership Board

By June 2012, the Sports Partnership Board which has instigated and co-ordinated the “Go Active” project (that allowed countywide co-ordination of physical activity initiatives between District Councils and Health Services) should ensure that the scheme is made sustainable going into the future.

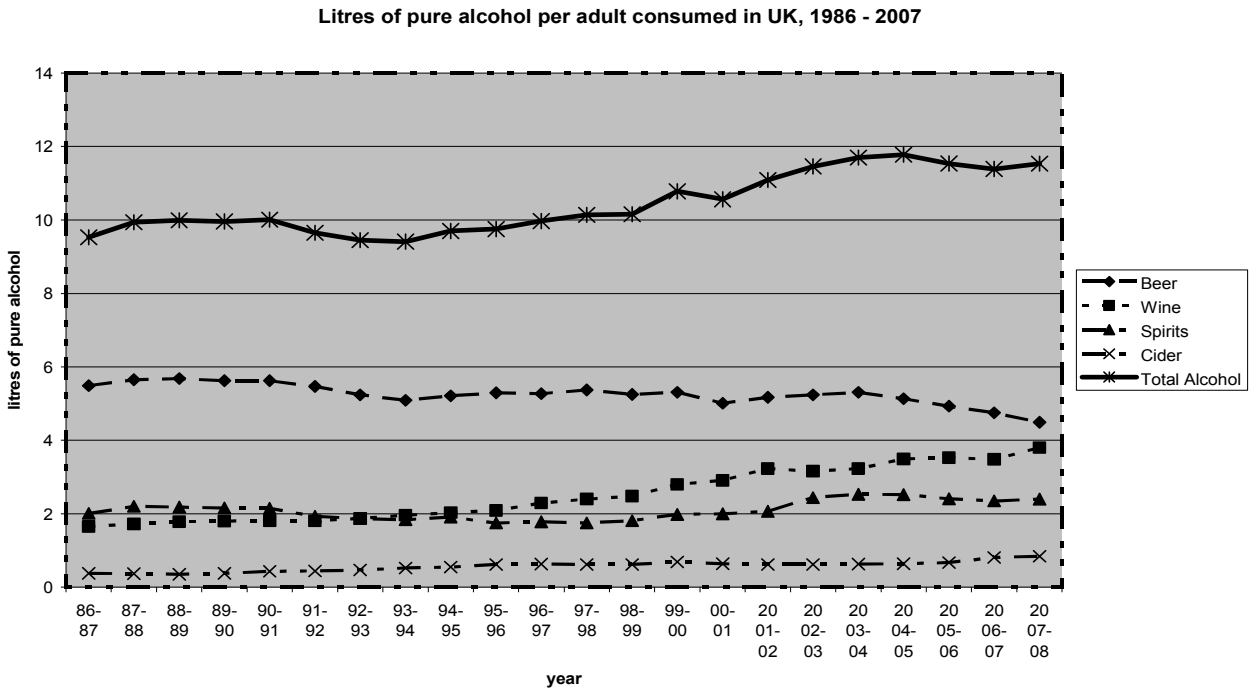
Chapter 5 - Alcohol: What's Your Poison?

Last year's Annual Report established that drinking too much alcohol was a cause of major concern for the future of health in Oxfordshire for the following ten reasons:

1. **Alcohol consumption has risen in the last 40 years**

   In England, average adult alcohol consumption has risen by 40% since 1970. The graph below shows the recent trends in consumption.

Figure 13 - Alcohol Consumption in the UK



Source: Institute of Alcohol Studies Factsheet "Drinking in Great Britain" www.ias.org.uk

2. **Many Adults exceed recommended drinking levels** and one in five drinks at hazardous levels
3. **Alcohol consumption in young people has increased** with heavy drinking and binge drinking a concern in this group. Consumption among young women has been increasing rapidly.
4. **Alcohol, without doubt, causes disease** and early death. It is a poison.
   - In England in 2006, 16,236 people died from alcohol-related causes.
   - The number of deaths from alcohol-related liver disease has almost doubled in the last decade.
   - Alcohol causes cancers of the liver, bowel, breast, throat, mouth, larynx and oesophagus; it causes osteoporosis, reduces fertility and causes accidents of all kinds.
   - Alcohol is responsible for around 950,000 unnecessary admissions to hospital nationally per year, and this is rising (an increase of 70% in the 6 years between 2002/03 and 2008/09).
5. **Alcohol is getting cheaper and more easily available**

   The real cost of alcohol has fallen: a unit of alcohol cost 67% less in 2007 than in 1987.

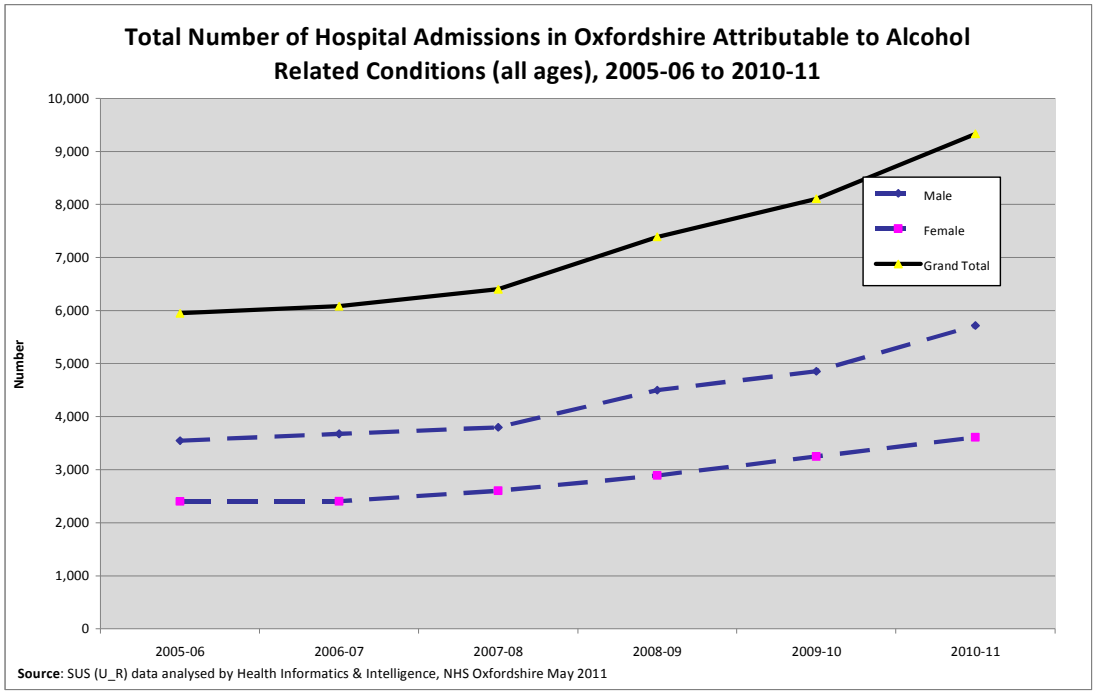
6. **The health benefits of alcohol are overstated**

Despite recent media coverage, attempts to define a 'safe' level of drinking are fraught with difficulty. Although above the age of 40 years, drinking a small amount of alcohol may reduce the risk of heart disease and stroke. For those who drink above this low level, and for those under 40 years who drink any amount, alcohol **increases** the risk of heart disease and stroke. For those of any age, drinking any amount of alcohol increases the risk of cancer, there is no safe limit. Across England, for every hospital admission that alcohol 'prevents', alcohol causes 13 people to be admitted.

7. **Alcohol damages the family and social networks**
8. **Alcohol fuels antisocial behaviour** and changes the character of our towns, especially in the evening at weekends
9. **Alcohol damages front-line services** and the economy and places a huge financial burden on the taxpayer.
10. **Hospital admissions for alcohol related harm in Oxfordshire are rising**

Local statistics show the burden of disease related to alcohol in Oxfordshire. The graph below shows how hospital admissions due to alcohol related conditions are rising steeply and the position is worse than last year.*

Figure 14 - Hospital Admissions attributed to Alcohol



* This calculation takes into account health conditions and other causes of admission to hospital (i.e. accidents) that are either wholly or partially attributable to alcohol. The greatest proportion of alcohol related admissions to Oxfordshire hospitals in 2010-2011 related to the following health conditions;

- Breast cancer, Cataracts, Heart rhythm problems, Unspecified chest pain, Urinary tract infections

What Does the Joint Strategic Needs Assessment say about Alcohol?

Last year's report set out the scene fully:
There are two main points to make.
1) The trends in Oxfordshire mirror the national trends well -
All indications are that levels of drinking are gradually rising and that services are expending more and more effort to respond to the results in terms of ill health, accidents and crime.
2) Although the trend is going up, on the whole, Oxfordshire's levels are better than the England average.
In short, we do have a big problem to deal with even though other's have it worse.

Is This Still a Priority for Oxfordshire?

This topic *SHOULD* be a priority for Oxfordshire and the real solution is through prevention - that means persuading people of all ages to drink sensibly.

However, it is often said that “there is a tide in the affairs of men”, and all the indications are that society as a whole is not yet ready to hear this message. It is highly unlikely that in the current climate the public sector can push back against the wave of cheap booze, relaxed licensing laws and a culture which subtly condones drinking.
As with the early years of public awareness campaigns regarding smoking and seat-belt legislation, the public are not yet prepared to hear the 'prevention' message when it comes to alcohol. It is even more of a tricky issue because, unlike smoking, alcohol in modest doses causes minimal harm, and it is also deeply embedded in social activity…. But then, 20 years ago so was smoking…….

This leaves us with a two-edged strategy:
1) Do what we can to chip away at public attitudes which support drinking to excess through education of all age groups.
2) In the meantime continue to apply sticking plaster to the symptoms through 'harm minimisation' approaches.

We are good at harm minimisation in Oxfordshire and we should be proud of what our blue-light services have achieved working with Local Authorities, the NHS and other partners. Some of the good work done is showcased in the next section.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Last year's recommendation was a clarion call to strengthen our harm minimisation strategy for Oxfordshire. This has been achieved well. A new strategy is in place and it is being actioned by a well-organised strategy group working across many organisations.

Here are 3 priority areas giving examples of good progress:

1. Community safety
   - Violent crime rates have continued to fall and our cities and town centres are safer. Latest figures for July – Sept 2011 show a decrease of 23% in the number of violent crimes compared with the same three months last year. This is a total of 169 fewer crimes just in those 3 months. The City had the biggest reduction, with 104 fewer violent crimes than in this period last year. This continues a long term trend for falling crime rates across the County. In addition, offering targeted advice to the most vulnerable people in A&E who are injured because of their drinking people has shown a 70% reduction in repeat attendances. The advice is offered to those who have already attended A&E several times and everyone aged under 18 with alcohol related conditions.
2. Health
   - Comprehensive guidelines have been produced for GPs and other practitioners to help with offering advice or referral for help to reduce alcohol related harm. The first step is to use a simple set of questions to get an idea of alcohol intake and then the practitioner can offer help and support accordingly.
3. Children and Young People
   - Lesson plans and follow-up activities for the school curriculum are available for teachers so that the issue of alcohol can be raised for discussion with young people. Work is also underway to help young carers whose parents may be misusing alcohol.

Recommendations

1. Strategic Priority of this topic

By March 2012 the Oxfordshire Community Safety Partnership and The Oxfordshire Drug and Alcohol Action Team should confirm the Alcohol prevention and harm minimisation remain priorities. Within this framework, the multi-agency approach of the Alcohol Strategy Group must be maintained and continually developed.

2. Strategic Alignment and clarity of who-does what

By March 2012, the Oxfordshire Community Safety Partnership and the Oxfordshire Health and Wellbeing Board should have reached agreement that the Oxfordshire Community Safety Partnership will take a lead role on setting outcome measures for alcohol and achieving progress. This progress should be reported to the Oxfordshire Health and Wellbeing Board via its Health Improvement Board.

3. Prevention and Education

By June 2012 an authoritative 'set' of public messages should be widely used throughout Oxfordshire tailored to different audiences, to help people to understand the personal implications of drinking alcohol. This is intended to help people make their own informed choices. These messages should be planned and promulgated through the Oxfordshire Community Safety Partnership working with Oxfordshire's Public Health Team.

4. Harm Minimisation

By June 2012 work the Oxfordshire Community Safety Partnership should conclude work with the Oxfordshire Clinical Commissioning Group to find the best means to develop the offer of brief advice through primary care and other settings, not just targeting those who are drinking at harmful levels but also using the AUDIT screening tool to help everyone understand their current level of drinking and whether there is reason to be concerned.

5. Moving gradually 'upstream' from harm minimisation towards prevention

By June 2012, the Oxfordshire Community Safety Partnership should ensure that essential reactive services are maintained to minimise alcohol related harm, (for example, through Nightsafe initiatives), **And** continue to move towards prevention in all this work. Specific plans should be drawn up to enhance the preventive element of all harm minimisation programmes. Examples of these approaches are:

- Promoting the work of Street Pastors who provide an important preventive element in keeping the night time economy safe.
- Finding new ways of reducing under-age sales.
- Enforcing licensing conditions.

Chapter 6 - Fighting Killer Diseases

Communicable diseases can have a major impact on the health of a population. A communicable disease is one which spreads from person to person through the air, water, food or person to person contact.

Over the last four years, most of the major killer infectious diseases have been in decline across Oxfordshire. However, these diseases remain a threat but their impact can be reduced further by good surveillance and information, early identification and swift action basic cleanliness, hand washing and good food hygiene.

This chapter reports on the most important diseases one by one.

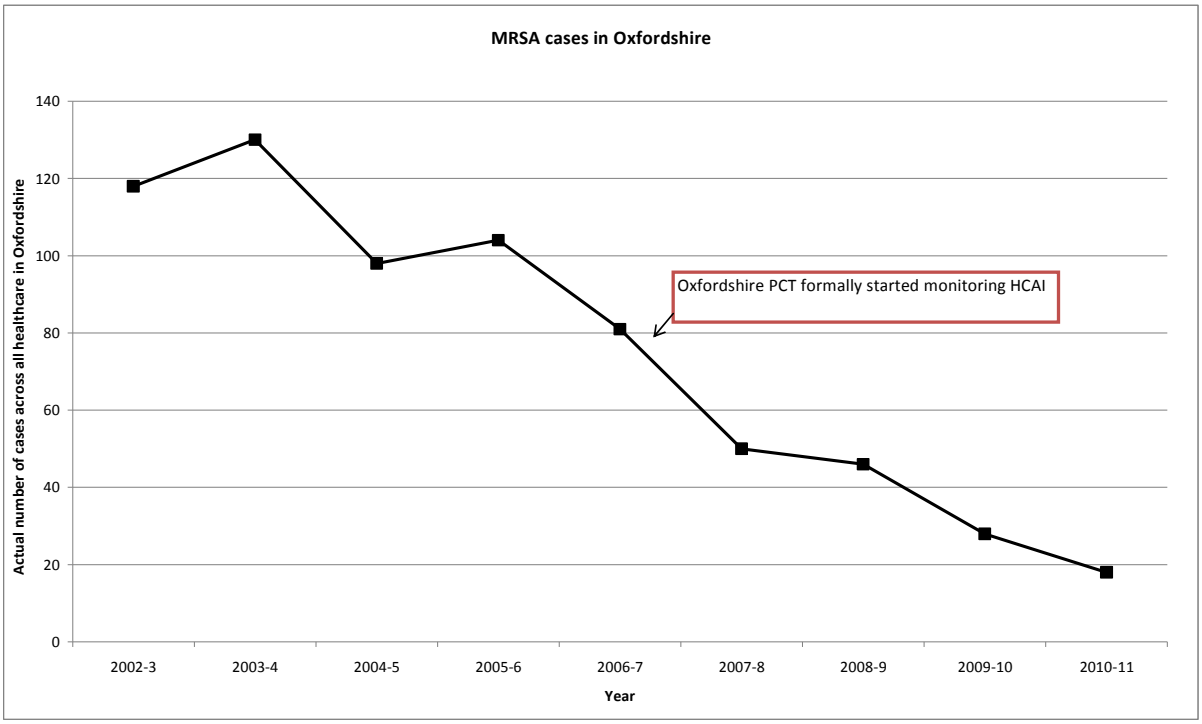
1. Health Care Associated Infections (HCAIs)

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. However numbers of infections **can and have been** reduced through considerable focussed effort in this County.

a) 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 (bacteraemias). 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. The reduction in MRSA bacteraemia continued its downward trend seen since 2002-3. **This is an impressive achievement for healthcare in Oxfordshire**. Success has been due to improved detection, improved cleanliness, improved clinical procedures, focussed management action and strict surveillance.

Figure 15 - MRSA cases in Oxfordshire

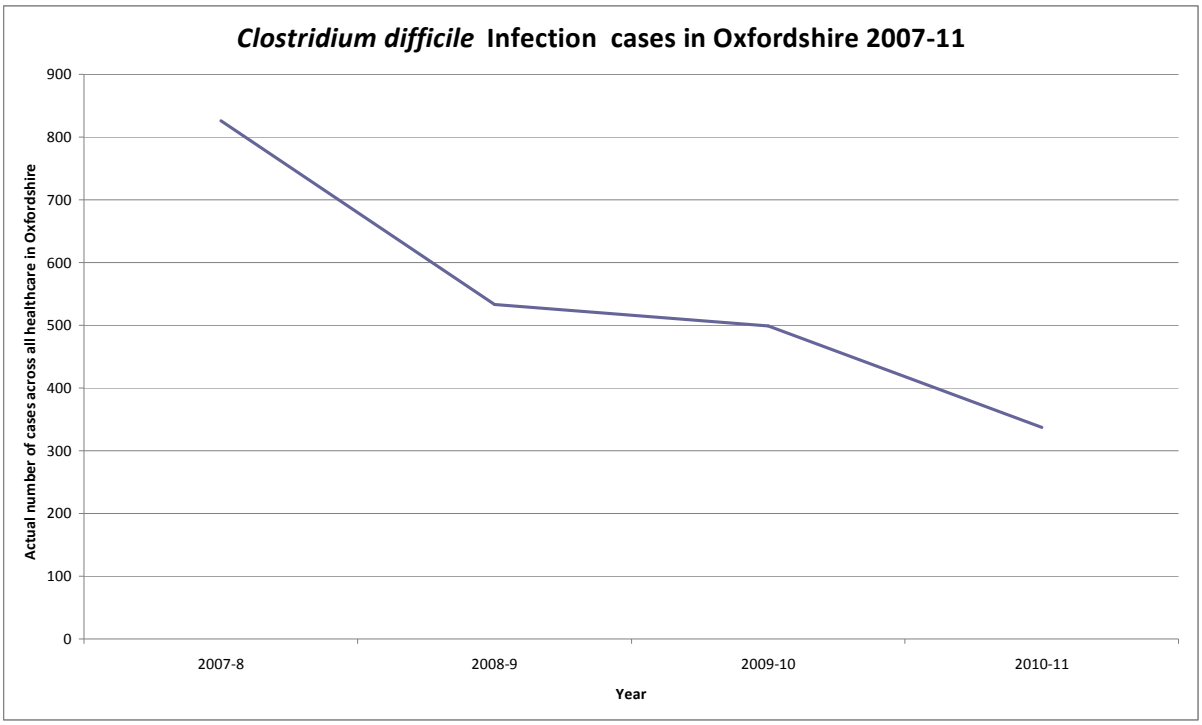


b) *Clostridium difficile* (*C.diff*)

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.

Figure 16 - Clostridium Difficile Infections in Oxfordshire



Work continues in the Oxfordshire health economy to reduce inappropriate antibiotic use, and in healthcare settings improve the speed of isolation of suspected cases and cleanliness of the environment.

2. Tuberculosis (TB) in Oxfordshire

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

In Oxfordshire, the number of cases of TB in 2010 was 61 (28 with lung disease and 33 with other TB). The small increase in numbers in 2010 is related to our success in identifying TB in non-UK born population rather than as a threat to the Public Health.

Figure 17 - Tuberculosis incidence rate in Oxfordshire

Year	Number of Cases	Rate per 100,000 population
2006	53	8.4
2007	76	12
2008	56	8.8
2009	55	8.6
2010	61	9.5

Over the past 4 years the rates of new cases occurring, and the number of cases, has remained highest in Oxford City and Cherwell District Council. The county average rate for new cases is consistently lower than the UK rate. **This is a good achievement.**

Figure 18 - TB incidence rate by Local Authority, Oxfordshire, 2010

Local Authority	Cases	Population	Rate per 100,000 population
Cherwell	14	139,200	10.1
Oxford	32	149,300	21.4
South Oxfordshire	4	130,600	3.1
Vale of White Horse	6	118,700	5.1
West Oxfordshire	5	102,500	4.9
UK			13.9

Source: Enhanced TB Surveillance System
Prepared by: Thames Valley Health Protection Unit

The Chief Medical Officer has set local services a target of recording all TB cases and completing successful treatment in 85% of cases. Oxfordshire's successful treatment rates have risen to 94.5% in 2009 (above the Thames Valley average) compared with 84.2% in 2007 and 89.3% in 2008. High completion rates are an important indicator of good control. This year has seen the TB service introduce an even greater degree of accessibility helping improve the response times to TB.

3. Other Diseases Preventable by Immunisation

a) Childhood immunisations

Immunisation is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire continue to improve, with uptake now amongst the highest levels in the country. The work which has been on-going around data collection and record keeping, involving general practice, community and PCT staff, is resulting in more children being fully immunised.

The new Child Health Information System which went 'live' in mid February 2010 is an absolutely essential tool for keeping information accurate and quality high. The small number of children who are not immunised can now be followed up individually and offered immunisation.

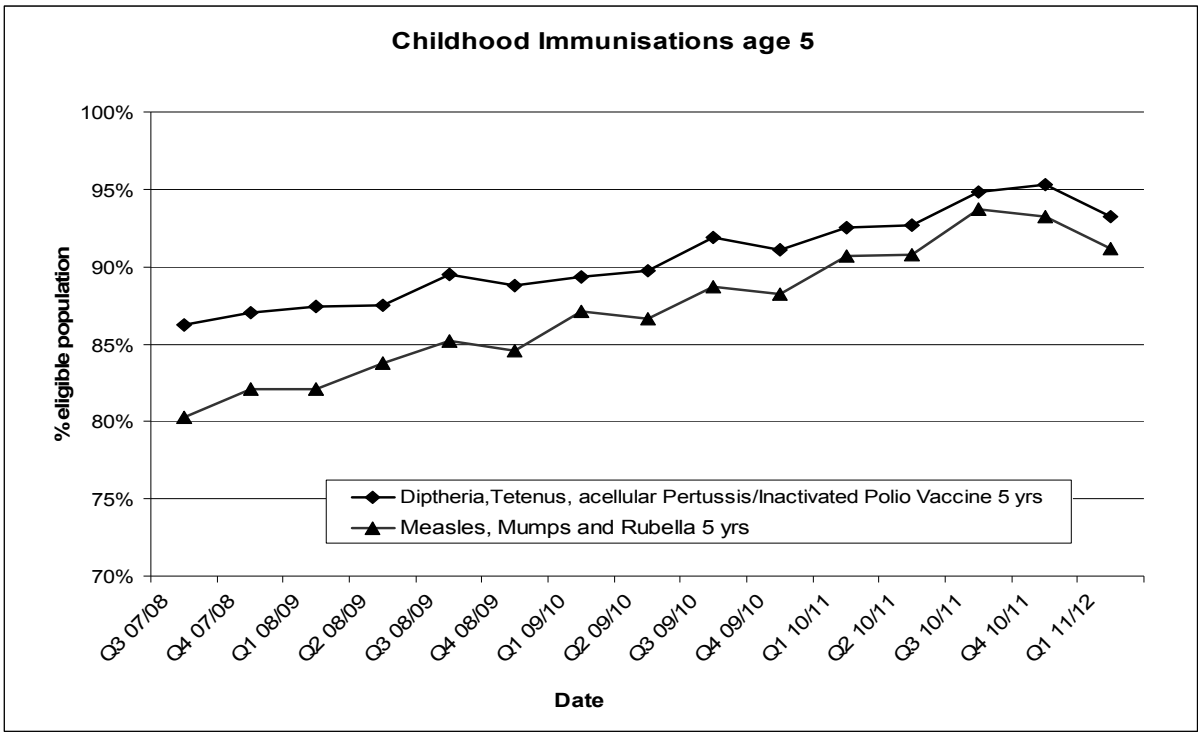
b) Measles Mumps and Rubella vaccine (MMR)

Uptake of this immunisation has risen by 6% over the last year and Oxfordshire's levels are the best in the Region. The importance of this is underlined by considering measles as an example:

In the absence of vaccination there would be approximately 8,000 cases of measles per year on average in Oxfordshire. Of these, approximately 40 people would suffer convulsions as a complication, 8 encephalitis and an average of 1 person per year would die.

The chart below shows the good success we have had in Oxfordshire overall in immunising our children against measles, mumps, rubella, diphtheria tetanus and polio. We will need to ensure that the downturn in the last quarter's data is reversed.

Figure 19 - Childhood Immunisations



c) Human Papilloma Virus vaccine (HPV): preventing cervical cancer

The problem with human papilloma virus (HPV) is that it may go on to cause cervical cancers. It is so common that at least 50% of sexually active men and women get it at some point in their lives although only a handful of the women affected go on to develop cervical cancer.

There is no treatment for the virus itself but a highly effective vaccine is available that protects against HPV types 16 and 18, the types most which between them cause over 70% of all cervical cancers. **HPV vaccination will save the lives of an estimated 400 women each year in the UK with 4 lives saved per year in Oxfordshire.**

We are currently immunising the 3rd cohort of girls with HPV vaccination – these were students in school year 8 during 2010/11 – the uptake for the whole course of 3 injections is expected to be at least 90% in this age group. The catch up programme, offering HPV to all girls up to the age of 18 years, took place during the academic year 2009/10.

This new vaccine is a significant step forward in the prevention of cancer.

4. Sexually transmitted infections

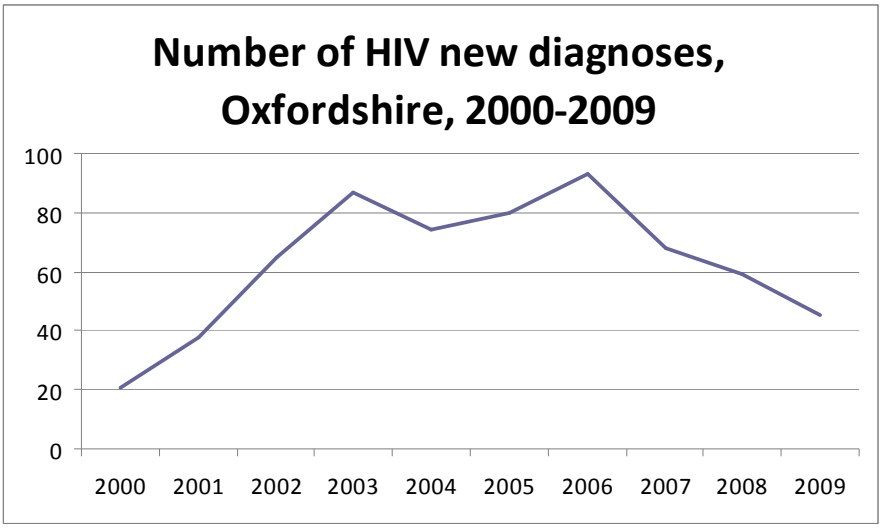
a) HIV & AIDS

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, and significant mortality.

It affects men and women, straight and gay, can be acquired in the UK or abroad and the best form of protection is still through 'safer sex' techniques.

In 2009, there were 214 new diagnoses of HIV in Thames Valley which is a 19% reduction from 2008. This is a good result. Of these new diagnoses 45 were new HIV diagnoses in Oxfordshire. The Oxfordshire figures continue to fall. We continue to work in partnership to get the prevention message across.

Figure 20 - Number of new HIV diagnosis reported in Oxfordshire, 2000-2009

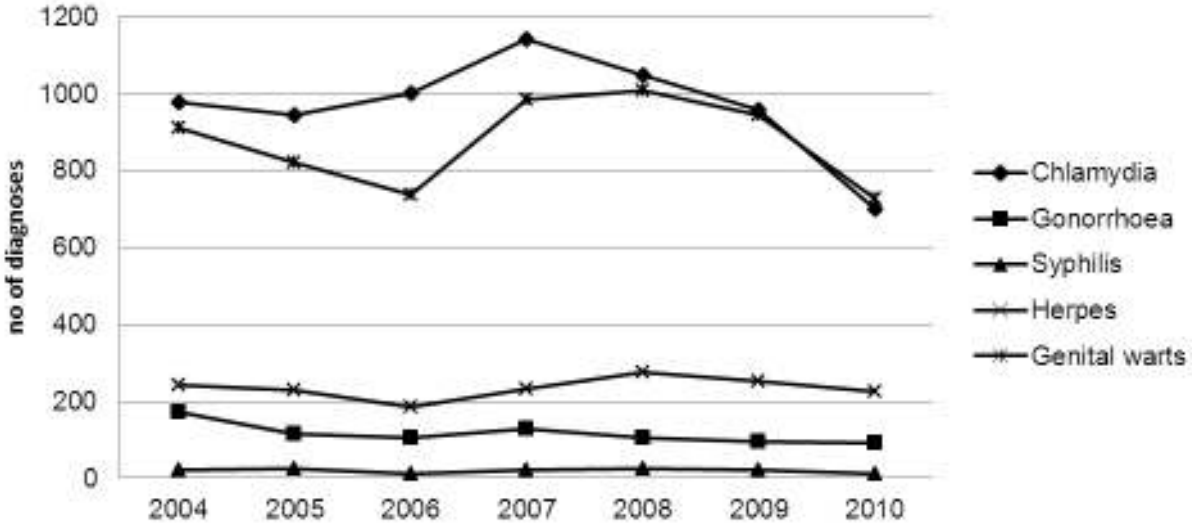


b) Sexual Health

It is important to monitor sexually transmitted diseases carefully to watch for increases in disease, the vast majority of which are preventable through taking basic 'safe sex' precautions. This is an important area to address because if Sexually Transmitted diseases are left undetected and untreated they may result in serious complications such as infertility in later life.

It is heartening to see that all the major sexually transmitted diseases fell during the last year. Chlamydia and genital warts remain the most common although there have been decreases in Chlamydia cases over both 2008 and 2009 from a highpoint in 2007.

Figure 21 - Diagnosed sexually transmitted infections for Oxfordshire residents 2004-2010



Is Fighting Killer Diseases Still a Priority for Oxfordshire?

Improved surveillance and good teamwork with the Health Protection Agency mean that all the major killer infectious diseases are in decline……for now.

However, this is a trend that can quickly be reversed and it is imperative that we remain vigilant to the threats posed by new diseases emerging, old diseases developing resistance to treatment and peoples behaviour becoming more risky.

Killer communicable diseases are well managed in Oxfordshire but remain an ever-present threat. Constant vigilance is required and careful management will give us the best chance to keep these infections at bay.

This topic must always remain a top priority in order to protect the public health of Oxfordshire.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

All the recommendations from the previous DPH annual reports have been met. Services, surveillance and management of diseases have been steadily improving over the last 4 years.

Recommendations

1. Maintain vigilance and priority during reorganisation
The Director of Public Health and the local Health Protection Agency must work closely during the forthcoming national reorganisation of public health services to maintain surveillance of communicable diseases during 2011/12/13 and take appropriate steps to control these diseases and any new emerging killer diseases.

2. The need to Report on these figures in Public
The Director of Public Health should report on killer infections and infectious diseases in subsequent annual reports.

Documents and Sources of Information used to produce this Report

Joint Strategic Needs Assessment versions 1 - 4
Public Health Surveillance dashboard
Health Protection Agency Infectious Disease data
Oxfordshire Safer Communities Partnerships Alcohol Strategy Group basket of indicators for Oxfordshire
The Child Poverty Needs Assessment for Oxfordshire
Oxfordshire Children and Young Peoples plan indicators
Oxfordshire PCT Performance data
GP Consortia Information packs – March 2011
Learned journals
Data from Govt Departments
Oxfordshire safer communities safer communities partnership performance framework

Acknowledgements

This document relies on the time and talent of colleagues whose contribution is acknowledged with grateful thanks.

Angela Baker
Mark Booty
Alison Burton
Sarah Breton
Paul Cann
Julie Dandridge
Clare Dodwell
David Etheridge
Arash Fatemian
Shakiba Habibula
Anna Hinton
Becky Hitch
Donna Husband
John Jackson
Paula Jackson
Huw Jones
Mary Keenan
Kate King
Amanda Le Conte
Jim Leivers
Sue Lygo
Noel McCarthy
Val Messenger
Sonia Mills
Keith Mitchell
Catherine Mountford
Ronan O'Connor
Jan Paine
Stephen Richards
Sian Rodway
Sue Scane
Joanna Simons
Paul Smith
Val Smith
Meera Spillett
Gail Stockford
Guy Swindle
Martin Tugwell
Matthew Tait
Patrick Taylor
Fenella Trevillion
Peter Von Eichstorff
Alan Webb
Jackie Wilderspin