

**DIRECTOR OF  
PUBLIC HEALTH  
FOR OXFORDSHIRE**

**ANNUAL REPORT  
VIII**

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## Foreword

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

This is my 8<sup>th</sup> Annual Report for Oxfordshire.

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

It is for all people and all organisations.

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

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

With best wishes,

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

## **The Thrust of This Report and Its Main Messages**

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

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

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

And

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

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

### **1. Older People and Population change**

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

### **2. Building better health through housing, roads and planning**

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

### **3. Breaking the Cycle of Disadvantage**

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

### **4. Mental Health**

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

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

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

### **6. Fighting Killer Diseases**

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

## **Why Now?**

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

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

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

## **How will we do this?**

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

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

## Chapter 1: The Demographic Challenge

### Main Messages in this Chapter

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

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

### An Ageing Population

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

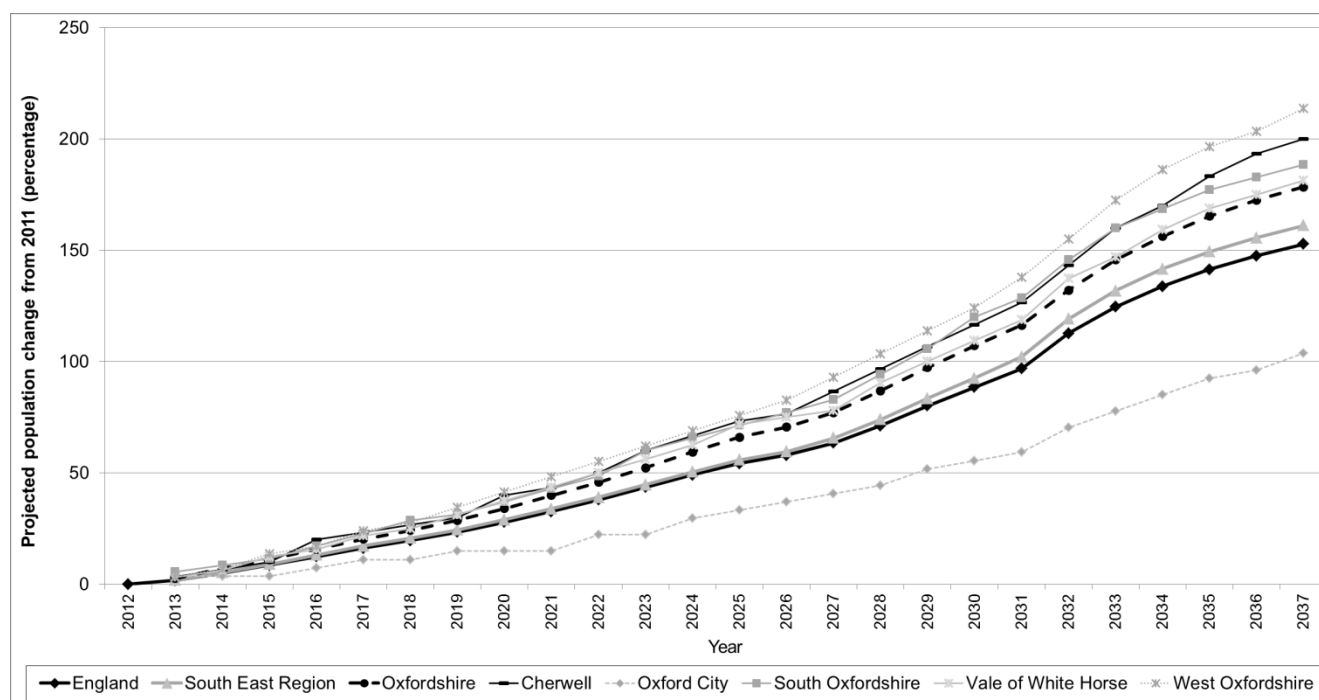
Longer life is of course a blessing, and a healthy, active, productive longer life is an even greater blessing. However, ageing inevitably brings change, and often declining health, some limitations and often loneliness. Learning to adjust to this is a life skill we urgently need to acquire.

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

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

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

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



Source: Office for National Statistics

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

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

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

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

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

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

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

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

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

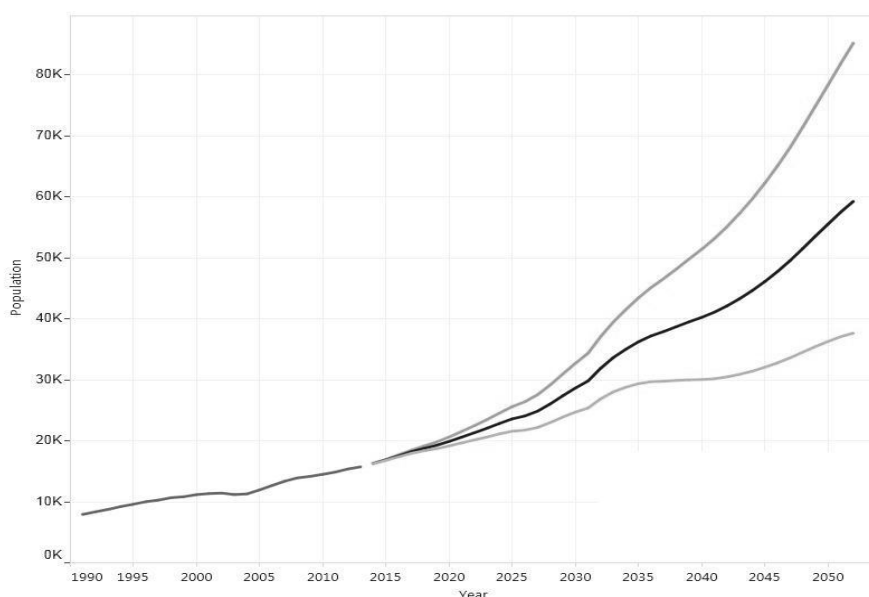
### Just how big will the ageing population be?

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

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

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

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





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

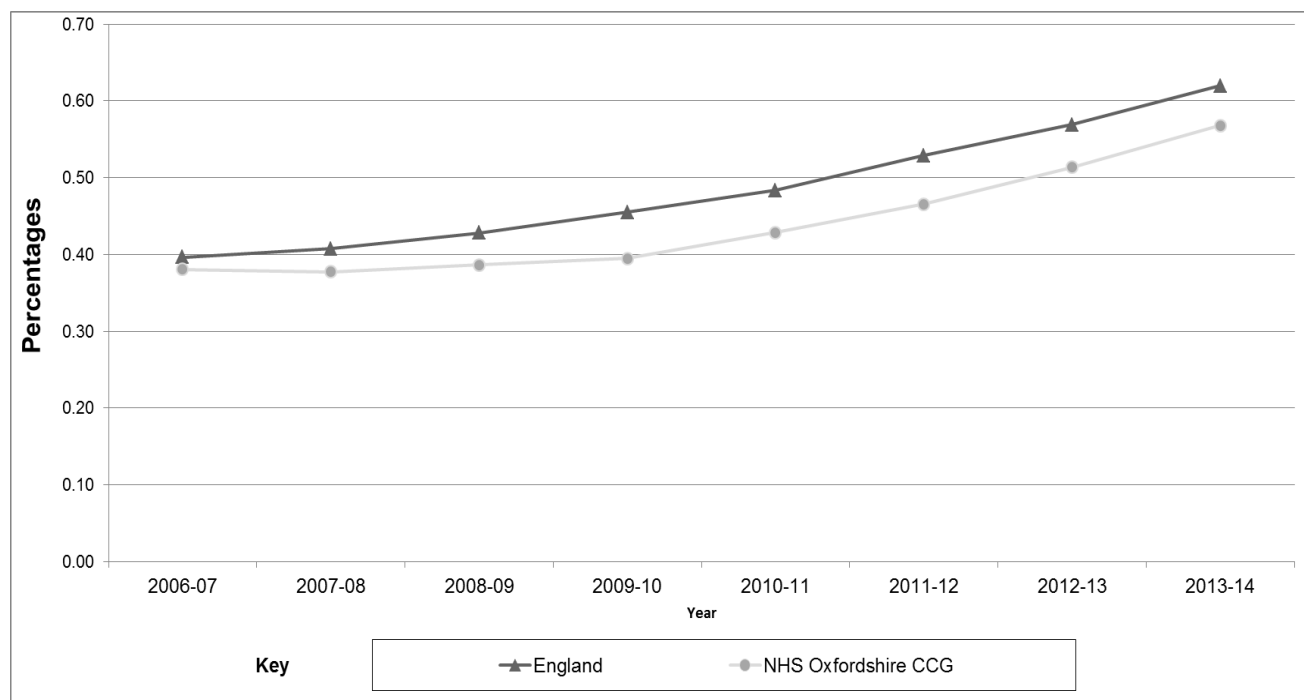
Of course, the projections closest to the present day are the most accurate, and this shows a growth in the ten years from 2013 to 2023 of between 4,900 and 7,700 people (31% increase to a 49% increase). The 'most likely' increase (the middle line) is 6,300 people aged over 85, an increase of 40%.

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

## Dementia

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

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



The chart shows:

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

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

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

## Is Dementia a preventable disease?

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

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

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

## Health and Social Services and Dementia

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

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

## Dementia Friendly communities, organisations and individuals

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

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

## Loneliness and older people

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

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

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

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

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

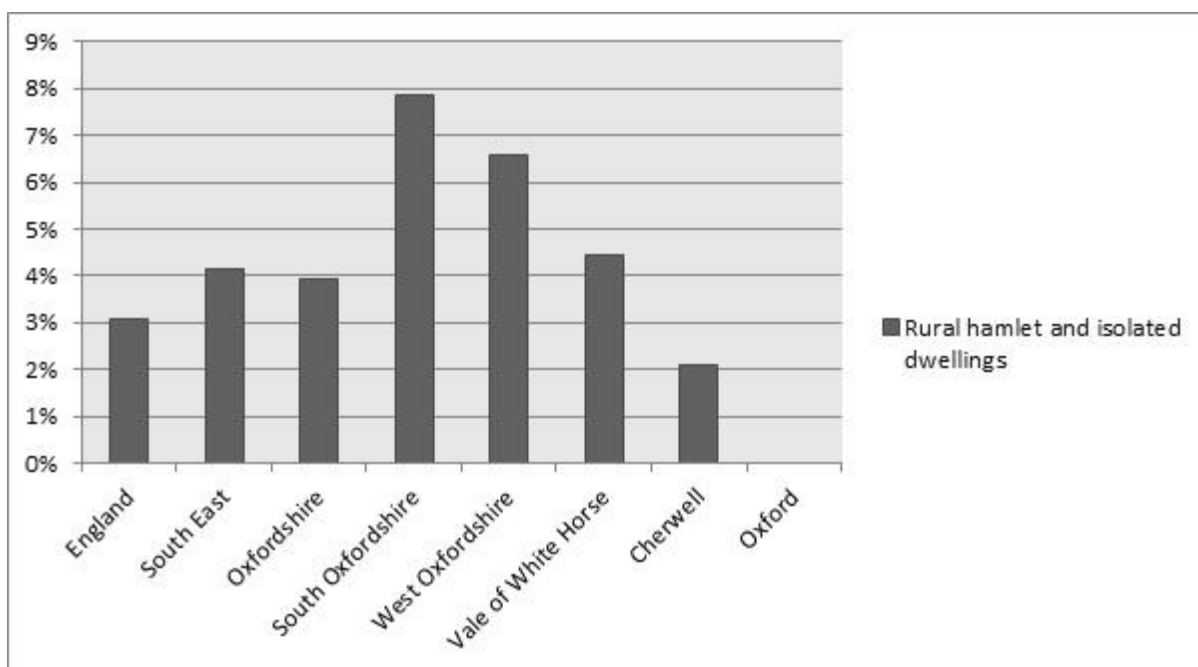
Area	One person households aged 65 and over in 2001	One person households aged 65 and over in 2011	One person households aged 65 and over in 2001 – As a percentage of all households	One person households aged 65 and over 2011- As a percentage of all households
<b>Oxfordshire</b>	31,140	29,852	13%	12%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

The data tells us that:

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

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

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



Source: ONS 2011 Census: Population Density

This shows that:

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

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

## The Impact on Social Care

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

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

Previous annual reports have recommended:

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

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

## Recommendations re Population Change

1. Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Adult Social Care Directorate should continue to plan explicitly for services for an increasing population of frail elderly people. Further integration of health and social care services should include this topic as a priority.
2. The Clinical Commissioning Group and NHS England should work with GP services to consider loneliness as a risk factor for disease and consider how affected individuals could be signposted to use local resources such as befriending services and lunch clubs.
3. The Oxfordshire Clinical Commissioning Group should continue to develop improved services for dementia as a priority.
4. Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospitals Trust and Oxford Health Foundation Trust and NHS England should develop, as a priority, their joint work to collaborate in transforming the local health system. This is in order to provide care new models of care closer to home, care focussed on prevention and early detection of disease, improved care for carers, prevention of hospital admission and speedy hospital discharge through improved community services, the modernisation of primary care and the funding of primary prevention services by the NHS.

5. Oxfordshire Adult Social Care Directorate should continue to analyse carefully the implementation of the Care Act and feed this information into future service planning.
6. The Director of Public Health should continue to commission NHS Health Checks and ensure that the offering and uptake of these services achieved by local GPs is kept at high levels. Poorly performing practices should be helped to improve the way Health Checks are delivered.
7. Oxfordshire Healthwatch should consider paying particular attention to dementia services and care for carers as part of their forward planning.
8. The Oxfordshire Health Overview and Scrutiny Committee should consider scrutinising progress on these matters as part of its forward planning.

## Chapter 2: Health, Houses and Roads

### Main Messages in This Chapter:

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

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

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

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

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

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

### Demography and Housing Numbers

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

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

In summary the SHMA concluded:

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



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

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

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

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

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

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

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

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



## The link to Health and Wellbeing

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

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

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

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

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

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

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

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

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

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

There is also strong evidence to suggest that:

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

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

A realistic list might be:

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

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

## Recent Developments and Progress Made

### Local Transport Plans and Active Transport

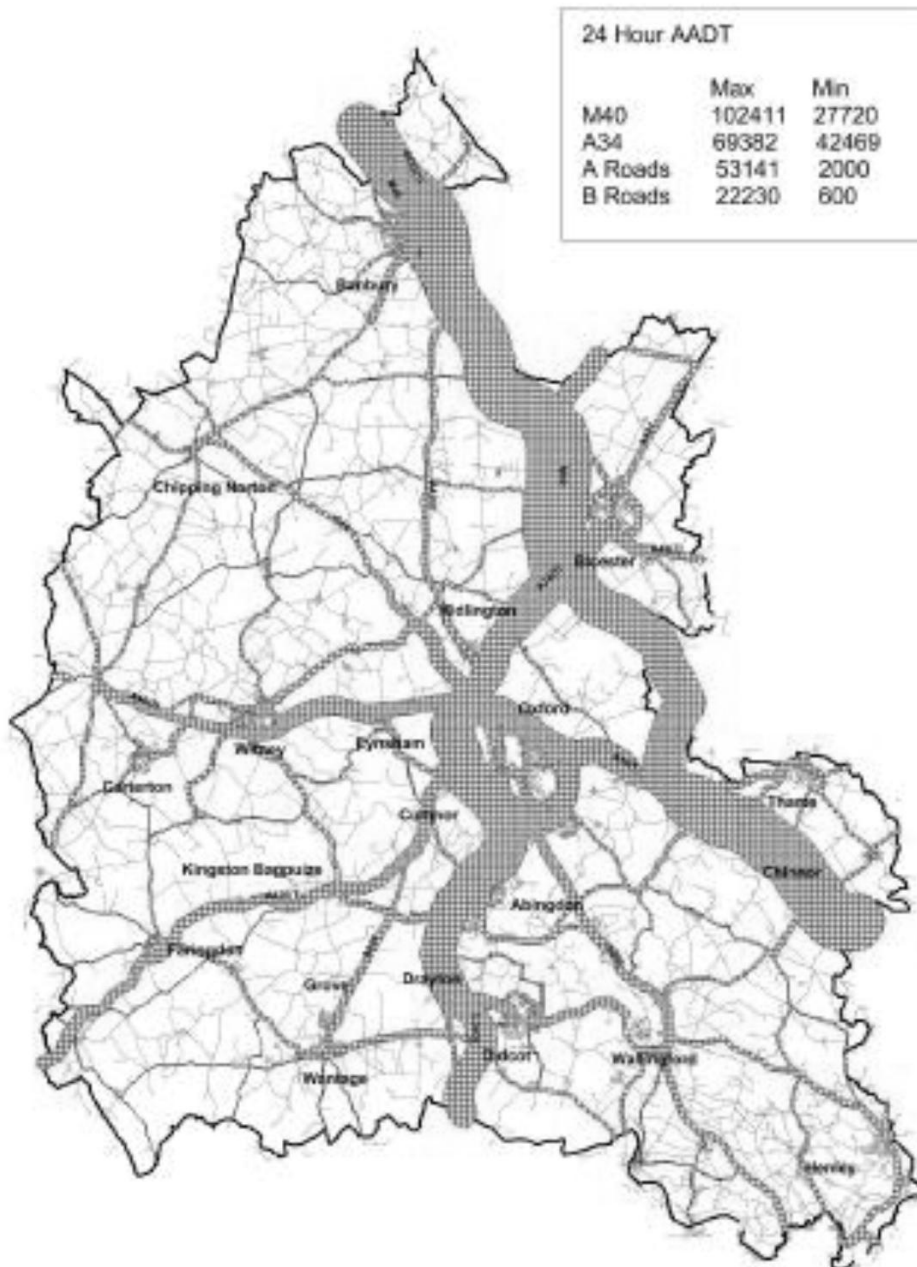
The County is currently completing its fourth Local Transport Plan (LTP4). This plan acts as a blueprint for developments to our road and rail networks, which in turn need to mesh into plans for housing and future workplaces. Its four objectives are:

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

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

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

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



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

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

## **Air Quality**

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

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

## **Broadband as Infrastructure Planning**

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

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

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

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

## A Word about Cycling

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

For example the research shows that:

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

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

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

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

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

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

## Recommendations

1. Oxfordshire County Council's Environment and Economy Directorate should continue to embrace input from the Public Health team and this should develop further.
2. The NHS should become a consultee for local planning decisions and the Clinical Commissioning Group should be offered membership on key planning groups.

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

3. Housing developments and housing developers should more closely reflect population need, with regard to housing options suitable for people as they age, and the needs of key workers should be given increased strategic consideration.
4. Cycling should be seriously encouraged in new road developments which are likely to attract high usage. Alternative cycle-only commuter routes using features such as rivers and canals should be considered.



## Chapter 3: Breaking the Cycle of Disadvantage

### Main Messages in This Chapter

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

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

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

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

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

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

### 1. Disadvantage in gender

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

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

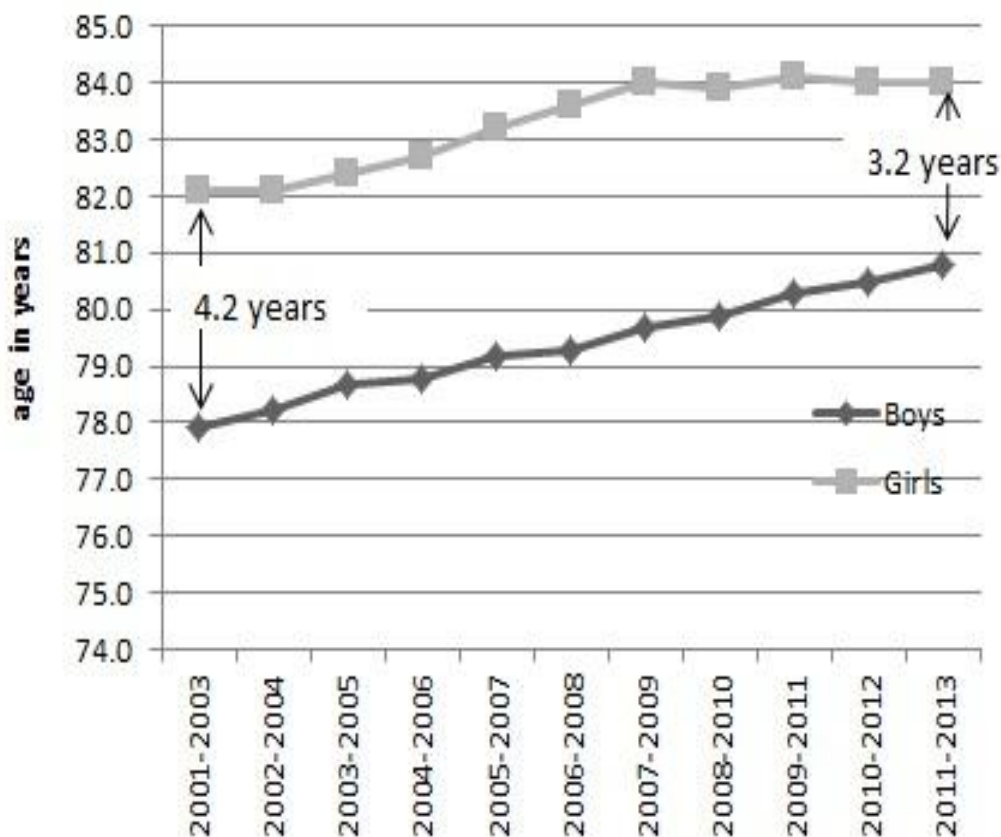
The situation can be summed up as follows:

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

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

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

## Male and female life expectancy at birth in Oxfordshire



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



## 2. Inequalities in Health and Wellbeing and Age

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

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

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

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

## 3. Carers and Disadvantage

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

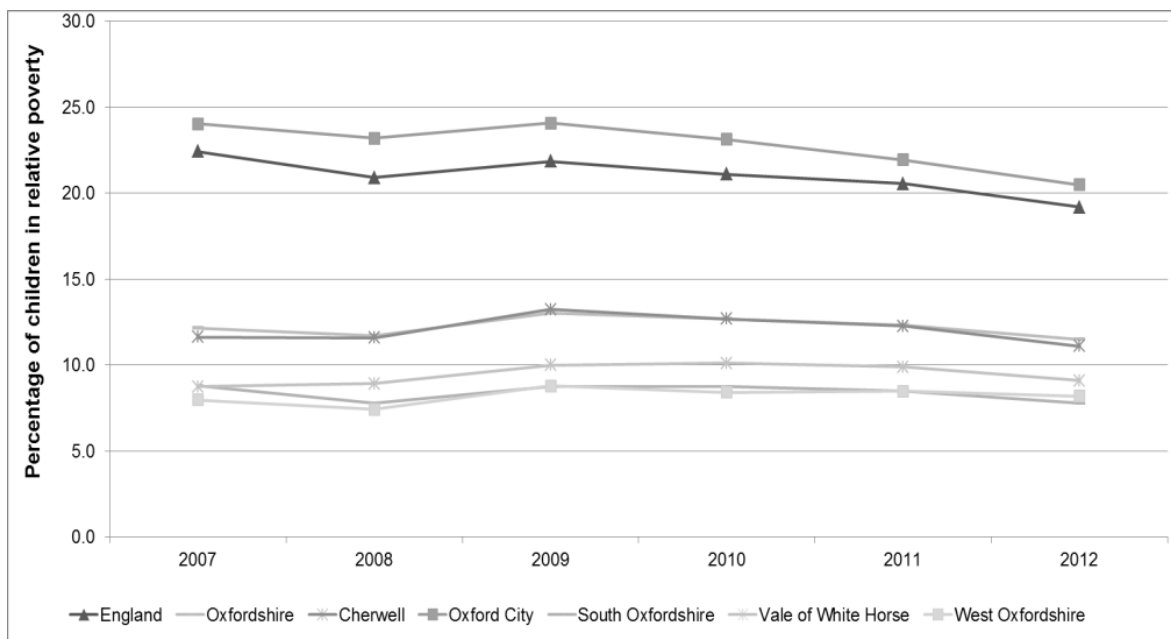
Being a carer can represent a serious disadvantage, and the impact on people's lives needs to be minimised.

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

## 4. Poverty

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

### Child Poverty in Oxfordshire and Districts (2007-2012)



Source: Child Poverty Unit

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

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

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

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

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

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

Top 10 wards in Oxfordshire for child poverty in 2013:

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

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

## 5. Employment

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

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

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

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

Employment rates were similar across different parts of the County.

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

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

## 6. Housing and Homelessness

The Health Improvement Board, which has representation from all District Councils, keeps a close eye on levels of housing need, people on the edge of homelessness and rough sleeping. A great deal of close partnership working takes place to keep the figures as low as possible.

The main measures it looks at and recent trends are summarised in the table below:

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

Households in priority need are defined as follows:

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

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

The data shows that:

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

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

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

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

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

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

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

## 7. Education – School Results

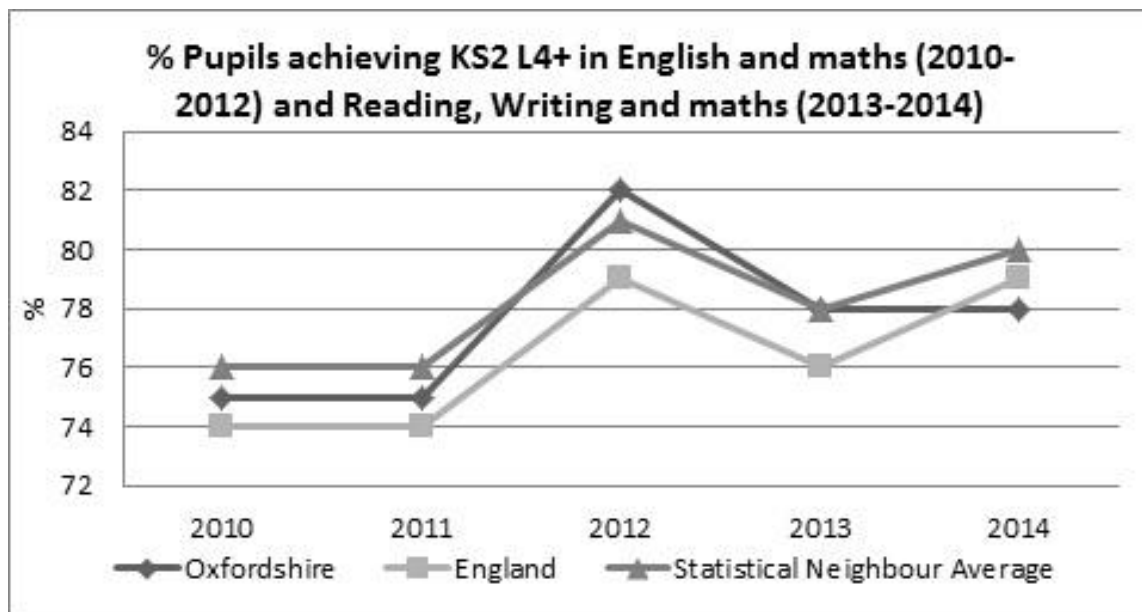
School results give a useful indicator of prospects for children. Poor results can reflect general disadvantage. The accuracy of the data means that these figures can be used to tease out underlying trends.

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

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

### Results at Key Stage 2 (typically aged 11)

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



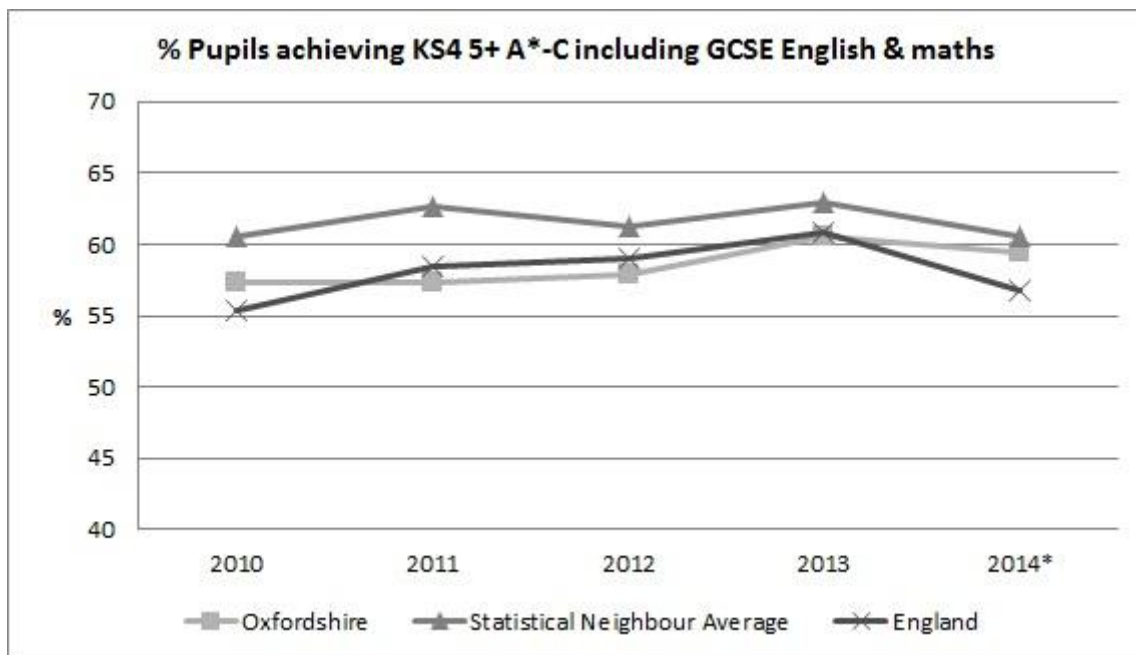
Source: Department for Education

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

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

### Results at Key Stage 4 (typically aged 15)

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



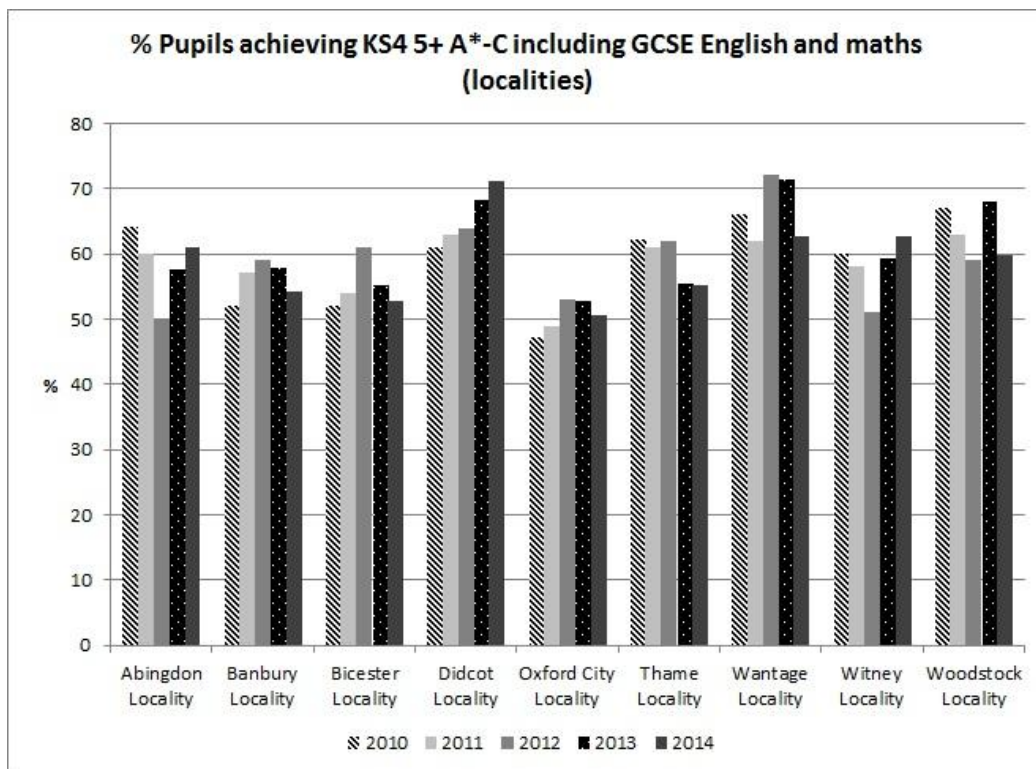
Source: Department for Education

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

## Key Stage 4 results by Locality

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





Source: Department for Education

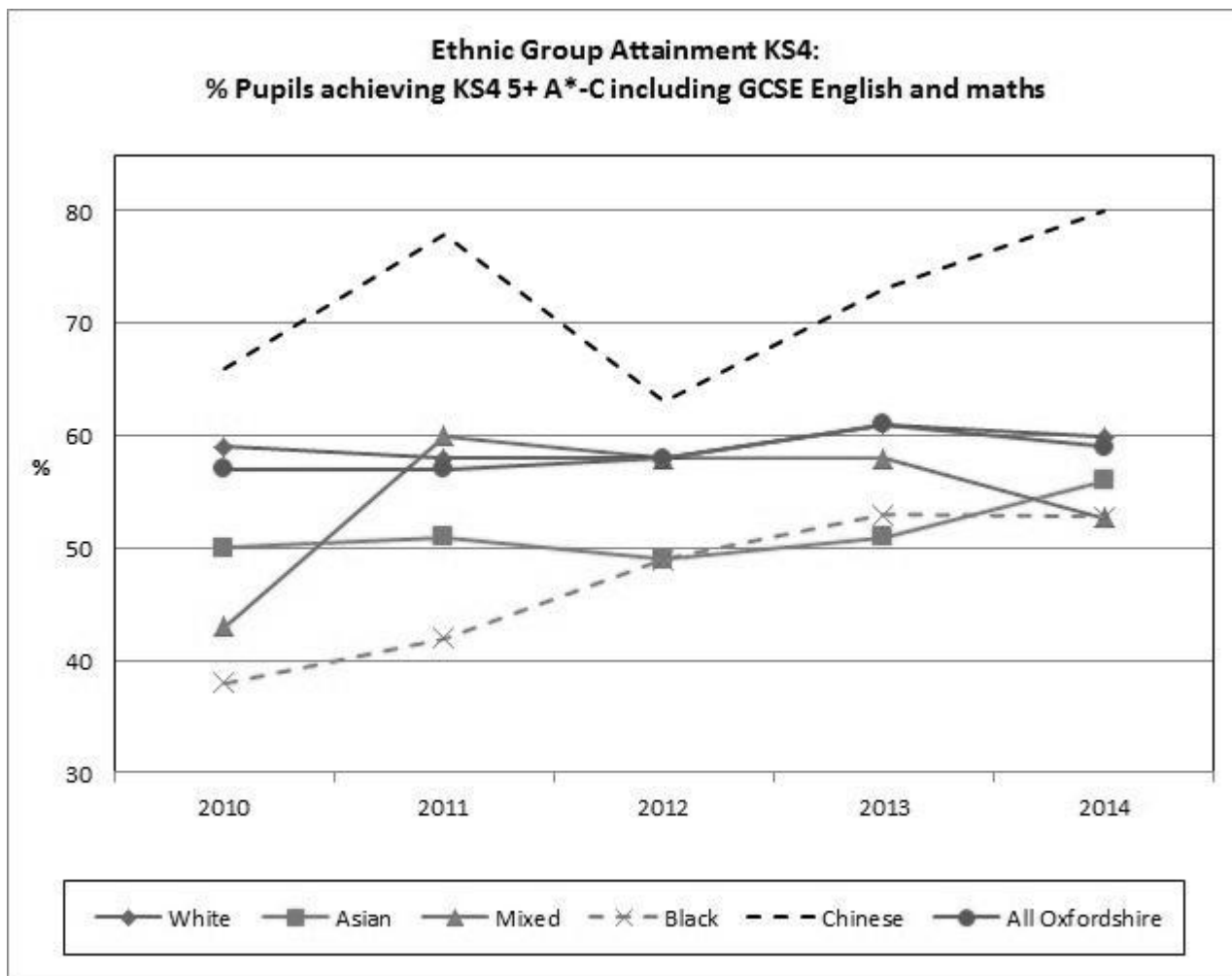
It can be seen that:

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

#### Key Stage 4 results by ethnicity

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





Source: Department for Education

The chart above shows that:

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

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

## 8. Ethnicity related Disadvantage

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

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

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

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

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

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

### **Health related disadvantage**

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

### **Language related disadvantage**

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

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

## **9. Teenage pregnancy**

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

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

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

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

\*\* this ward now includes figures for Holywell ward

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

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

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

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

## **10. Safeguarding and Exploitation**

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

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

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

## **11. Female Genital Mutilation**

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

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

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

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

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

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

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

So far the FGM strategy group has:

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

The next steps in this work are to:

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

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

## 12. Inequalities in mental health and mental health services

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

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

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

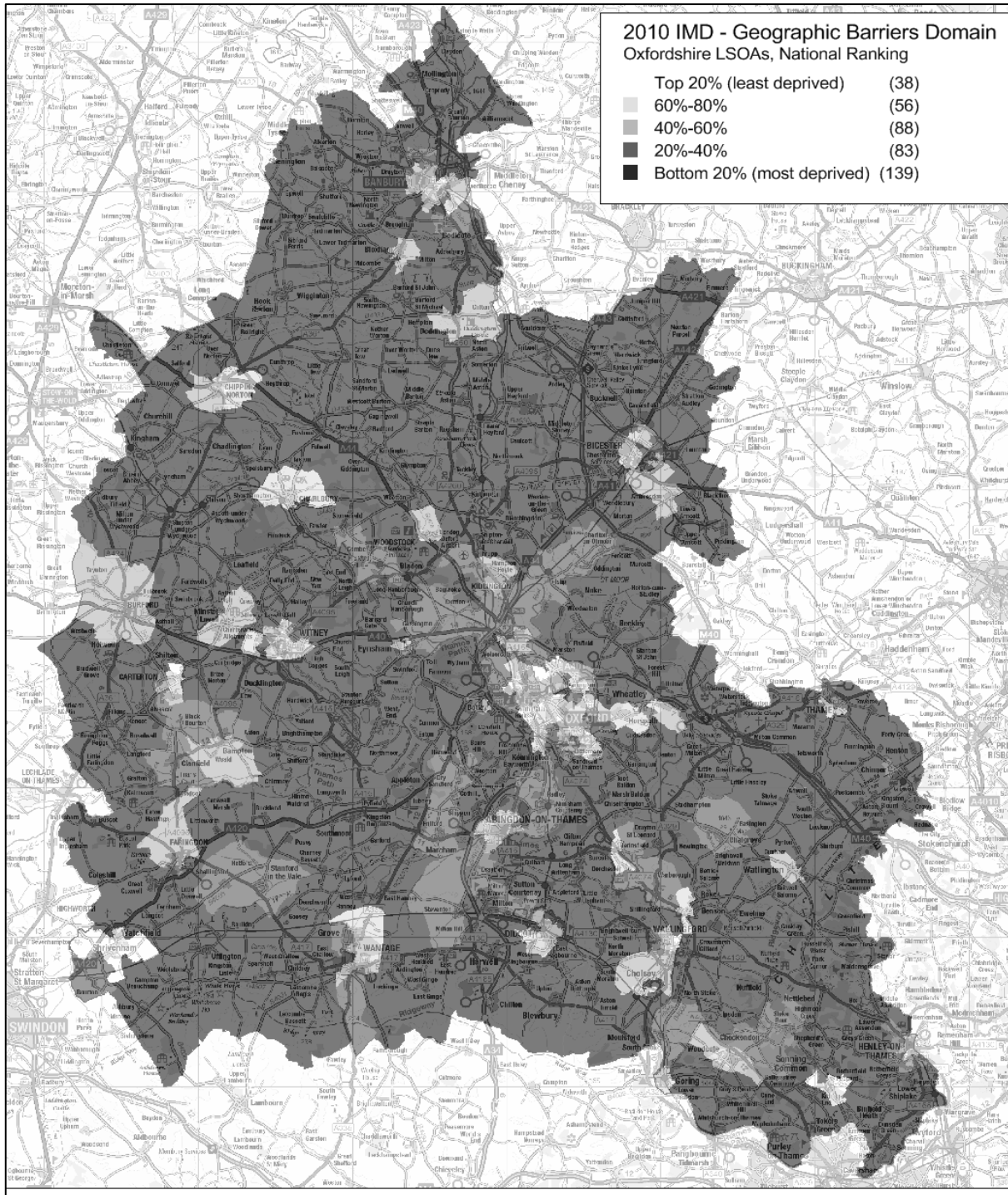
**Conclusion: *There is a way to go, but this inequality is gradually reducing. See the next chapter for more detail.***

### **13. Disadvantage in Access to Services: A Rural County**

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

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





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

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

## 14. Inequalities from place to place

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

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

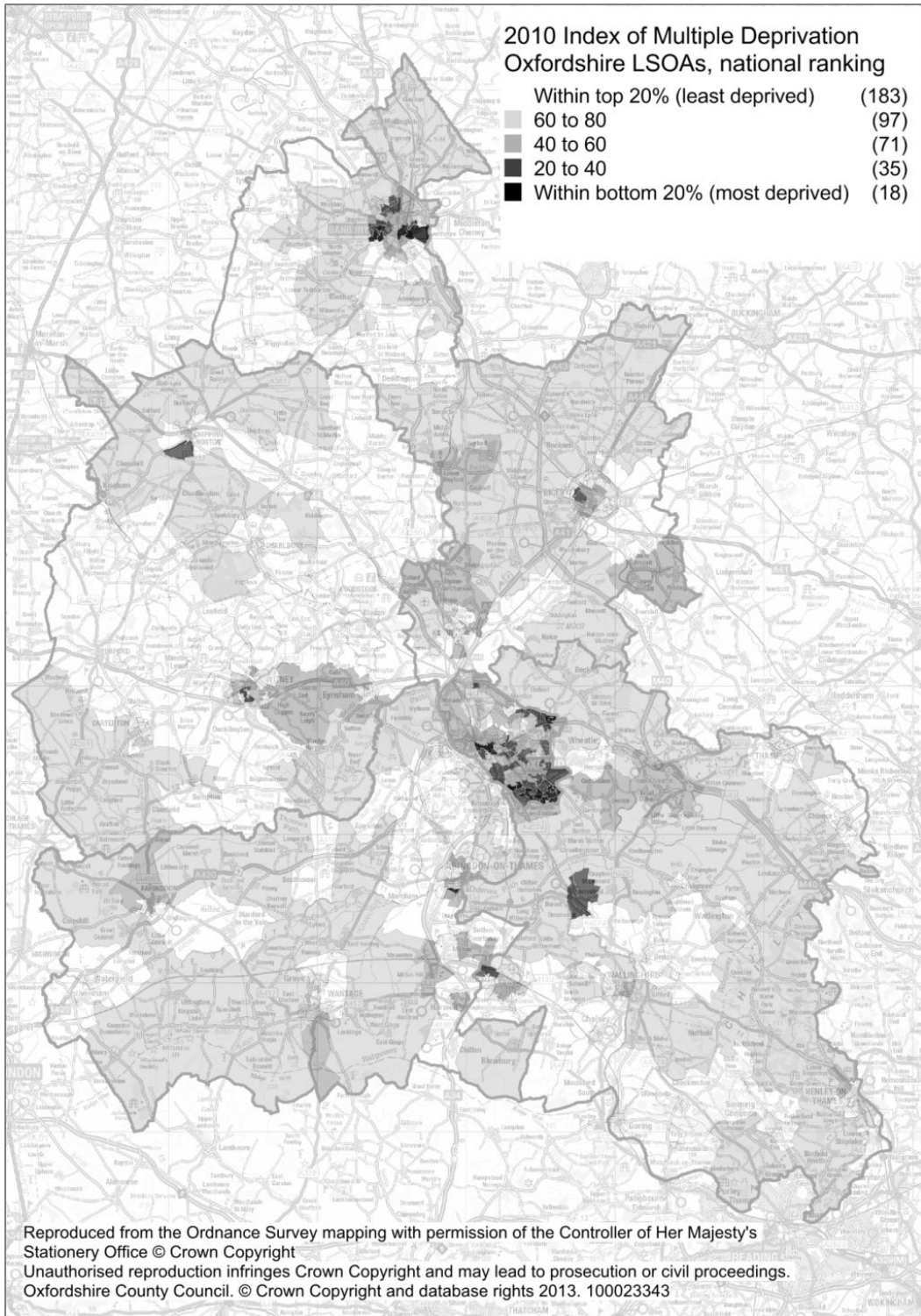
In population terms, around a quarter of the County's population is estimated to live in areas that were ranked among the 10% least deprived areas in England. Over two fifths live in areas ranked among the 20% least deprived.

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

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

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





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



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

### **Phase 1 of the Thriving Families Programme in Oxfordshire**

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

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

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

### **The Results of Phase 1**

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

Of the **810 families** identified:

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

### **The features of phase 2 of the programme**

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

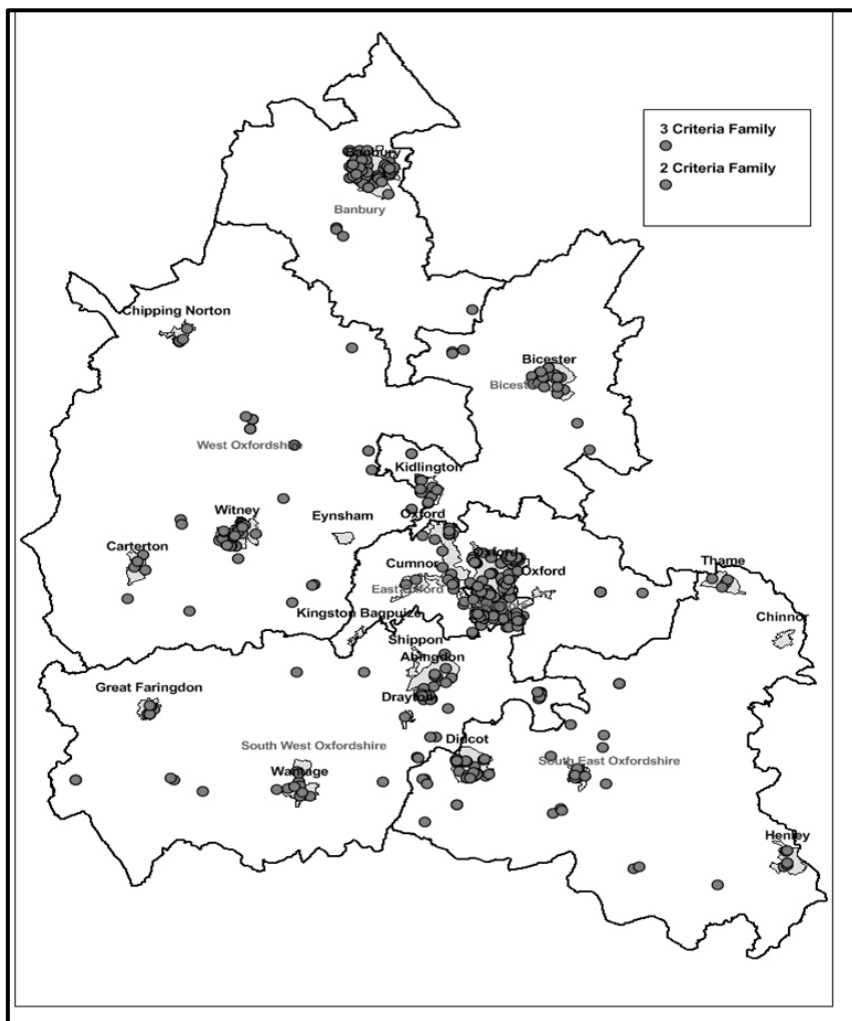
In phase 2 of the programme Oxfordshire have been asked to identify and work with 2,890 families over 5 years from 2015 to 2020 – an ambitious programme.

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

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

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

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



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

***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***

### What have we said previously about Disadvantage in Oxfordshire

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

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

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

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

## Summary of Breaking the Cycle of Disadvantage

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

The table below summarises the information reviewed:

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

## Reducing Disadvantage

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

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

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

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

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

### **Stubborn Causes of Disadvantage**

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

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

### **Increasing Disadvantage**

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

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

### **If targeting is the key who should we target?**

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

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

## How should we target them?

People sometimes shy away from targeting because they think ‘their’ area will lose resources.

This isn’t necessarily the case and making a difference needn’t cost more. Practical targeting is less about big free-standing initiatives and more about ‘tweaking’ the hundreds of initiatives and services we already have to be more sensitive to the groups described above.

## Tackling Disadvantage is in everyone’s interest

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

## Recommendations

### Short term recommendations:

1. The Health and Wellbeing Board should carry out its plans to sponsor a more detailed review of disadvantage, and should use the analysis in this report as a source of information. This analysis should inform the Joint Health and Wellbeing Strategy, Local Authority plans the Clinical Commissioning Group’s 5 year plan and the work of the NHS and County Council Systems Leadership Group and Transformation Board.
2. All agencies should maintain current programmes which are successfully reducing disadvantage. These include:
  - Teenage pregnancy
  - The Thriving Families programme
  - Work with schools to improve school results
  - The promotion of breastfeeding
  - Improved dementia services
  - Improved mental health services
3. All agencies should target the causes of disadvantage which are static or increasing. Specifically:
  - The Health Improvement Board should continue its efforts to prevent homelessness through partnership working
  - GPs and the Public Health team should target NHS Health Checks to improve take up by ethnic groups and manual workers
  - Partnership work to eradicate FGM should continue
4. Contract specifications for services being renewed should carefully consider how to target areas in the bottom 20% IMD and areas of high child poverty so as to give a

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

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

## **Longer term recommendations:**

6. See the recommendations in chapter 2 regarding housing and the design of communities so as to combat isolation, loneliness and to break the cycle of disadvantage in specific areas.
7. The Local Enterprise Partnership, Local Government, Local Employers and Oxford University should continue to work together to secure central government funding to provide the infrastructure to favour continued economic prosperity and high levels of employment.
8. The Health Overview and Scrutiny Committee should consider scrutinising the extent to which reducing disadvantage and inequality are built into the plans of the Clinical Commissioning Group, General Practice and NHS Trusts.
9. Healthwatch should be invited to consider monitoring the inequalities identified in this chapter as part of its on-going work programme.



## Chapter 4: Mental Health

### Main Message of This Chapter:

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

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

### Why is this?

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

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

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

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

This chapter details some of the recent initiatives taken locally.

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

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

- This will include a 2 week wait target for intervening earlier in cases of serious mental illnesses such as schizophrenia and bi-polar disorder (formerly known as manic depression).
- An effective 'psychiatric liaison service' between physical and mental health professionals is being designed and will be in place by 2020. This will ensure that people being treated for physical disorders which have a mental health component (e.g. in hospital) will be treated as a whole person. This is beginning with:
  - A 24/7 liaison service in Accident and Emergency.
  - A psychological medicine service in inpatients in the John Radcliffe Hospital and Horton Hospital– focussing on patients with depression, delirium and dementia.
  - A more active service in outpatient clinics.
  - Assessment of the mental health needs of frequent service users to make more appropriate use of services.
  - Planned improvements for services for eating disorders in children.

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

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

Work is also in progress to improve the Child and Adolescent Mental Health Service to improve the transition from children's to adults' services.

## Recommendations

1. The Clinical Commissioning Group, Oxfordshire Adult Social Services, Oxford University Hospitals Trust and the associated Voluntary Agencies should ensure that outcome-based contracting really does improve outcomes.
2. The Oxfordshire Health Overview and Scrutiny Committee should consider continuing to monitor these proposals as part of its forward plan.
3. Oxfordshire Healthwatch should consider continuing to closely monitor the quality of mental health services from the perspective of the service user.

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

### Main Messages In This Chapter:

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

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

### Obesity, diet and physical activity

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

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

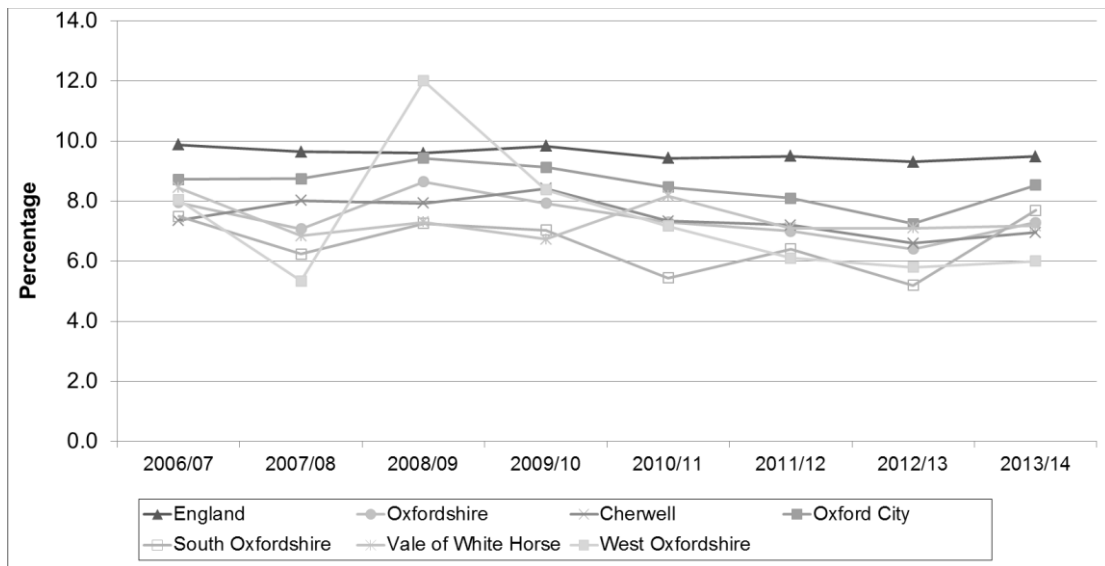
In 2014, Public Health England calculated that NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £50 billion per year.

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

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

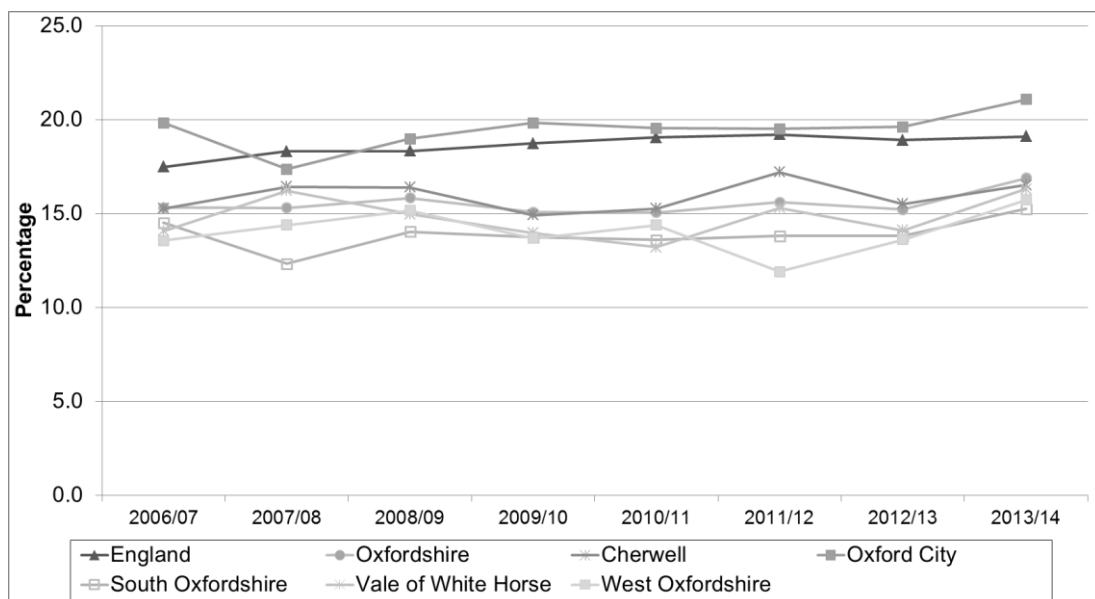
Obesity itself is the tip of the iceberg. **The average adult in this country is now classed as overweight.**

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



Source: National Child Measurement Programme (NCMP)

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



Source: National Child Measurement Programme (NCMP)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **What have we said previously?**

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

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



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

## What do we need to do next?

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

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

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

## Recommendations with regard to Obesity

1. The Health Improvement Board should review its healthy weight strategy and make recommendations for a range of services, including schools, health visitors, school health nurses, hospitals, general practitioners and highway planners. The key role of District Councils should be emphasised with regard to green spaces, leisure centres, play areas and the licensing of premises.
2. The Clinical Commissioning Group should work with the new General Practice Federations and should consider commissioning innovative ways of preventing obesity using NHS funding as this will prevent health care expenditure in the long run.
3. The Health Overview and Scrutiny Committee should consider scrutinising the District Council role in the fight against obesity as part of its forward work-plan.

## Smoking tobacco

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

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

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

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

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

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

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

## **Stop-smoking services**

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

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

## **How Should We Move Forward?**

All organisations should do their bit.

This includes:

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

## Recommendations re Smoking

1. The Health Improvement Board should consider reviewing the actions of all the agencies listed above in order to help more people never to start smoking or to quit.
2. The Clinical Commissioning Group and General Practice should consider how to emphatically promote the brief intervention to 'stop smoking' as a consistent part of all consultations.

## Tooth Decay

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

### The current picture in children

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

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

### The Picture in Adults

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

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

### What are we doing and what should we do next?

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

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

## Oral health promotion interventions aimed at children

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

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

## Oral health promotion interventions aimed at adults

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

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

## **Recommendation for Tooth Decay**

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

## **Drug Abuse**

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

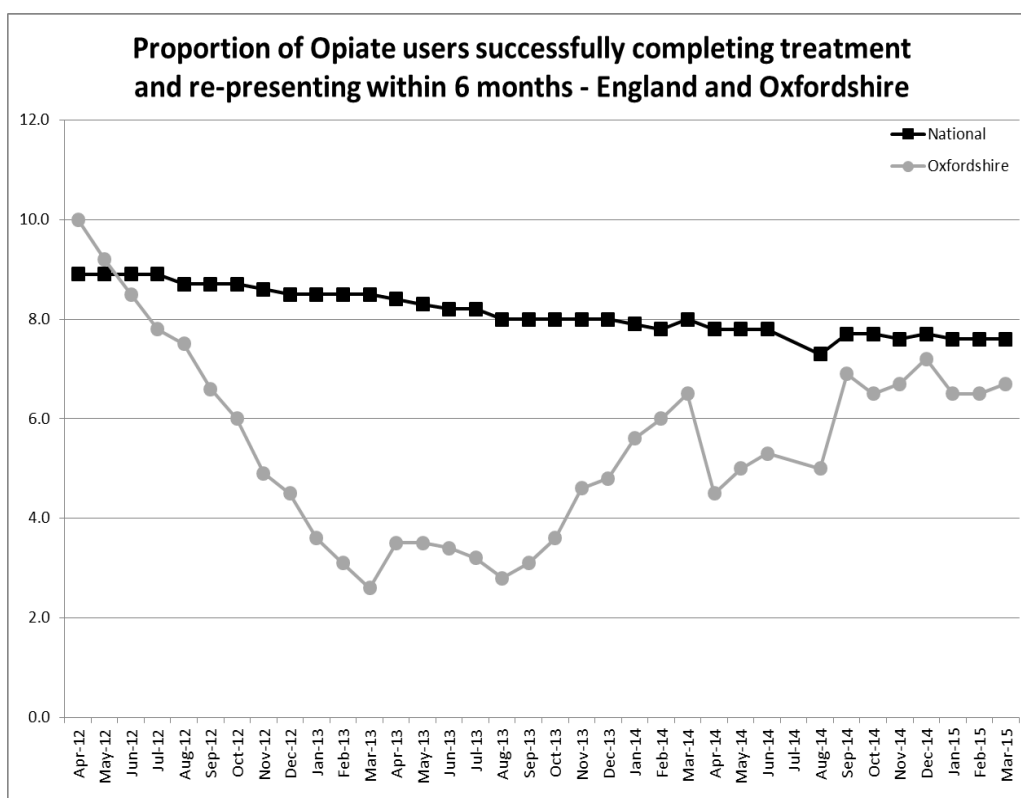
Under the old policy of minimising harm by maintaining narcotics addicts on methadone, Oxfordshire performed well. However, national policy changed a few years ago and is now

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

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

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

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



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

## **Legal Highs (officially called New Psychoactive Substances)**

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

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

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

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

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

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

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

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

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



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

## Recommendations re Drug Abuse and Legal Highs

1. The Directorate of Public Health should continue to lead a partnership of the many agencies involved to continually improve the performance of services for opiate, and non-opiate addiction. Services in primary care should be now be reviewed and updated as a next step.
2. The Directorate of Public Health should continue to lead a partnership to meet the emerging challenge of legal highs as new information becomes available.
3. The Community Safety Partnership, Health Improvement Board and Performance Scrutiny Committee should continue to monitor progress on these topics as a priority.

## Alcohol

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

To summarise, these are:

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

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

## Young People and Alcohol

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

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

## Drinking in adults

Drinking trends are reducing slightly:

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

In summary, the picture seems to be:

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

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

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

Local action taken can be summarised as follows:

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

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

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

## **Recommendation re Alcohol**

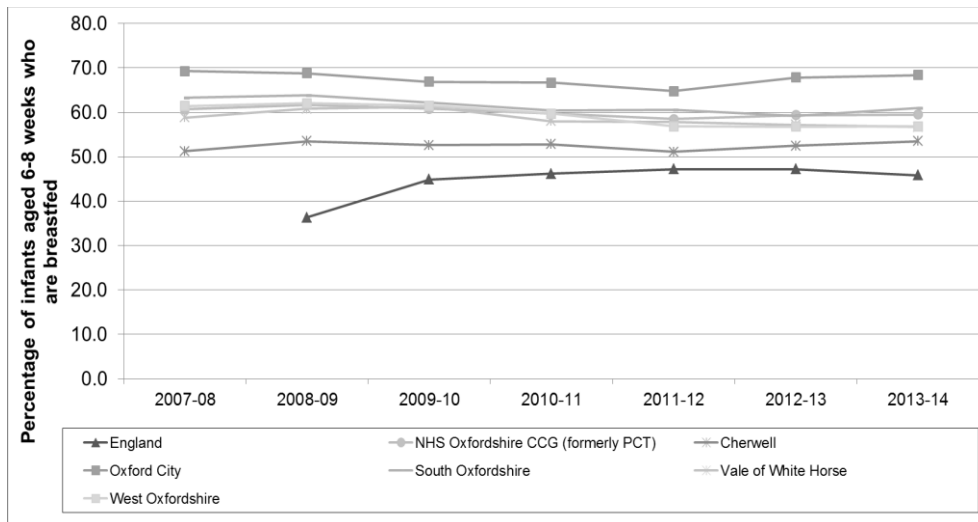
1. Continue to work across agencies to give relevant information and advice to people at risk of alcohol related harm, either through binge drinking on “high days and holidays” or by habitually drinking at harmful levels.

## **Breast Feeding**

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

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

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



The chart shows that:

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

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

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

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

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

## Recommendation re Breast Feeding

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

## NHS Health Checks

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

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

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

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

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

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

## What We Said Before and What We Are Doing About It

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

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

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

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

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

## **Recommendation re Health Checks**

### 1. The Public Health Directorate should:

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

## Chapter 6: Fighting Killer Diseases

### Main Messages For This Chapter:

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

### Part 1. Epidemics: Ebola, Flu Pandemics and HIV

#### No Room For Complacency

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

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

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

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

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

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

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

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



Relationships are good and we compare favourably with other regions.

## How Do We Keep This Work Going?

Success depends on several key elements:

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

## Recommendation re Epidemics, Ebola, Flu Pandemics and HIV

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

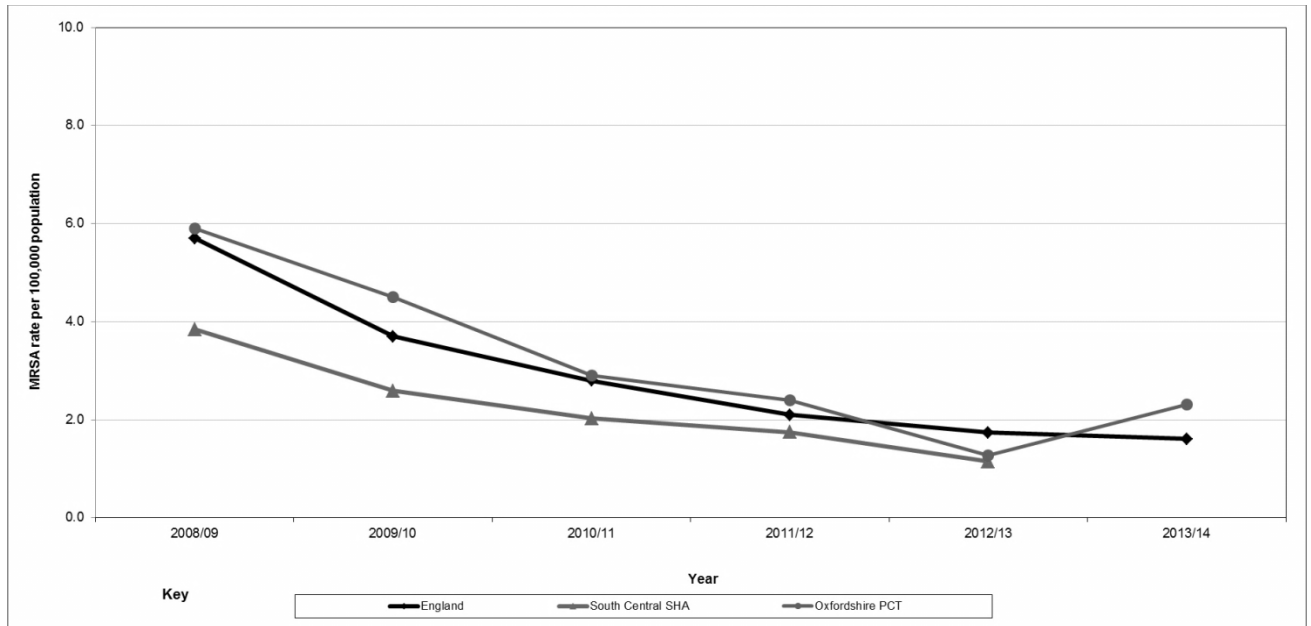
The remainder of this chapter reviews the most serious infectious diseases affecting the population of Oxfordshire and reviews recent progress.

## Part 2. Infectious and Communicable Diseases

### Health Care Associated Infections (HCAIs)

#### Methicillin Resistant Staphylococcus Aureus (MRSA)

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



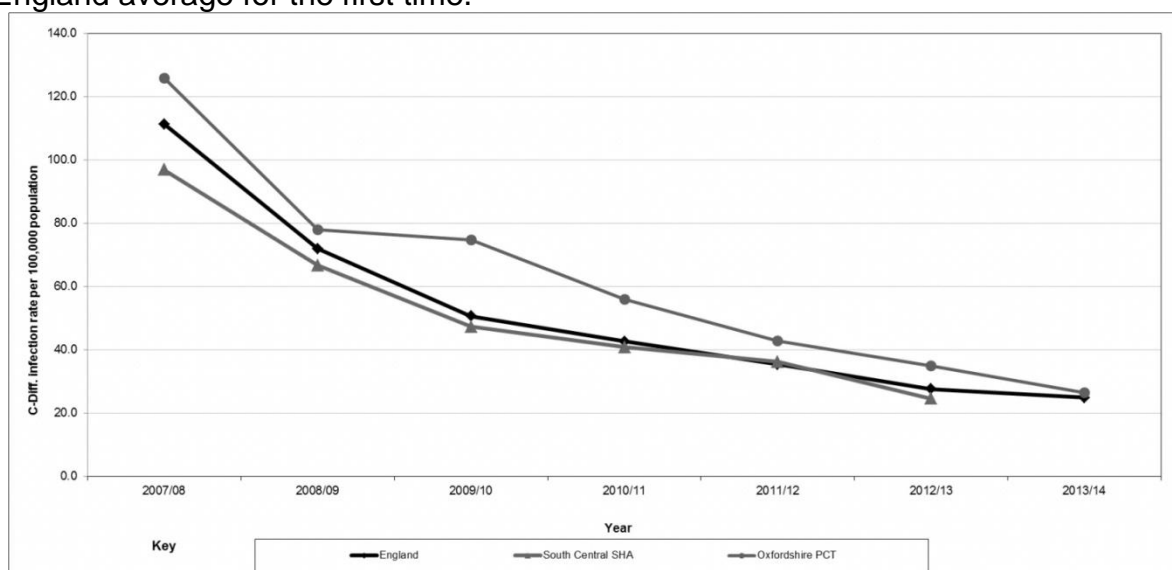
**Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 – 2013/14) England, South Central SHA and Oxfordshire**

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

### Clostridium difficile (C.diff)

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

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

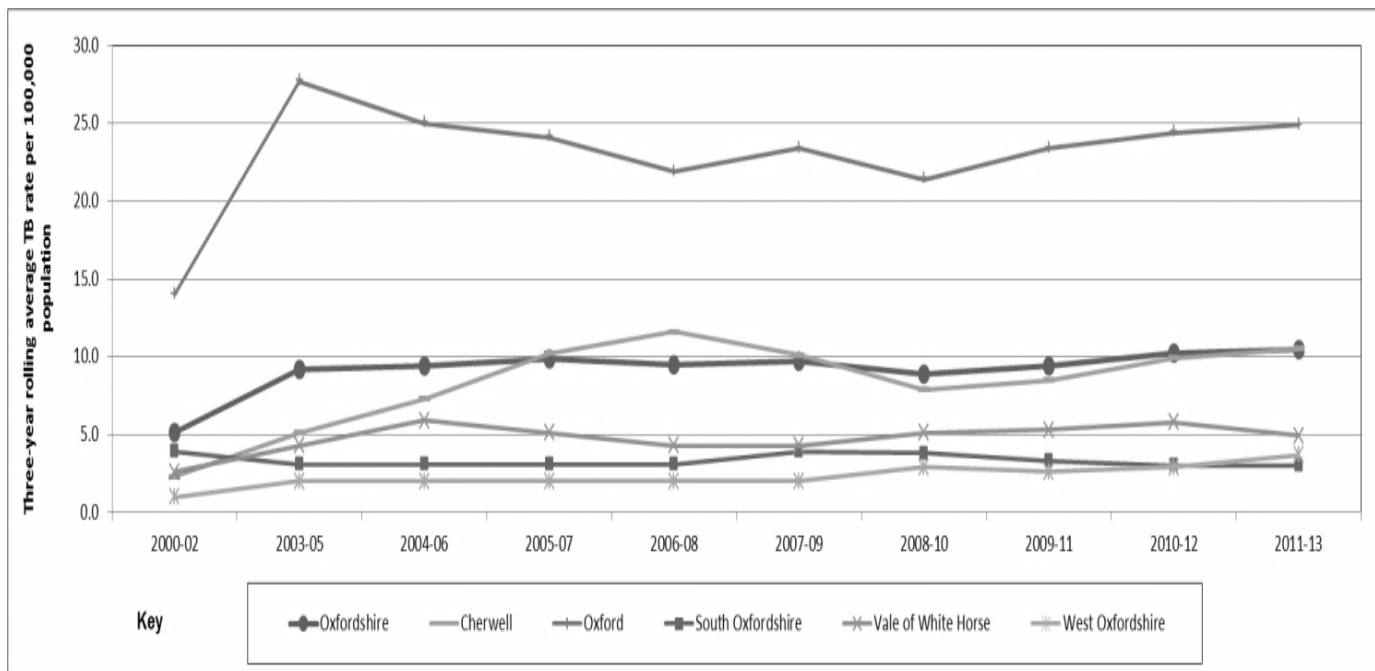


**Clostridium difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2012/13) England, South Central SHA and Oxfordshire PCT**

**Tuberculosis (TB) in Oxfordshire**

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

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



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

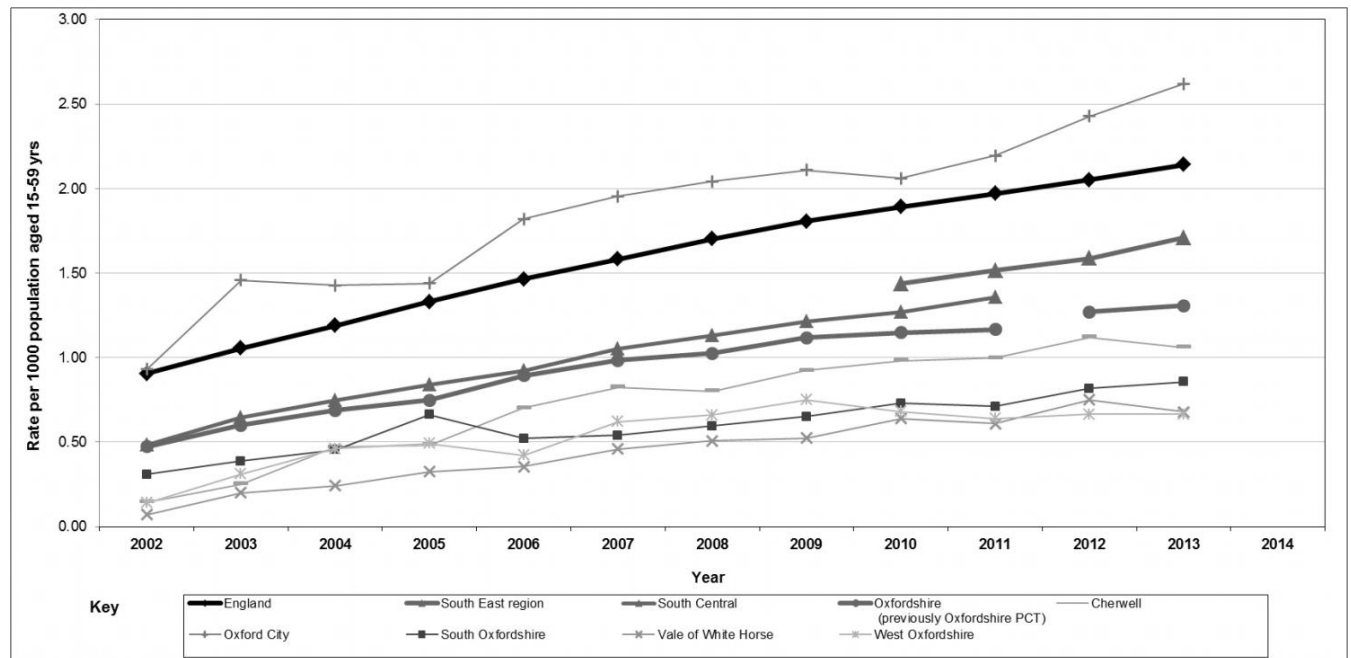
The levels of TB in the UK have been relatively stable over the past seven years. However, despite considerable efforts to improve TB prevention, treatment and control, the incidence of TB in the UK is higher compared to most Western European countries.

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

## Sexually transmitted infections

### HIV & AIDS

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



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

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

- Through Antenatal screening programmes - there are approximately 7,000 deliveries per year in Oxfordshire and 99% of pregnant women are screened for HIV, this identifies an average of 9 women as being HIV positive per year.
- Through community testing - we have 'HIV rapid testing' in a pharmacy in East Oxford as an initial step. This test gives people an indication as to whether they require a full test. The rapid test takes 20 minutes and gives fast results, although a fast tracking to the sexual health service for a full test is required to confirm diagnosis.
- Through offering a test in sexual health clinics when people attend with other diseases.

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

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

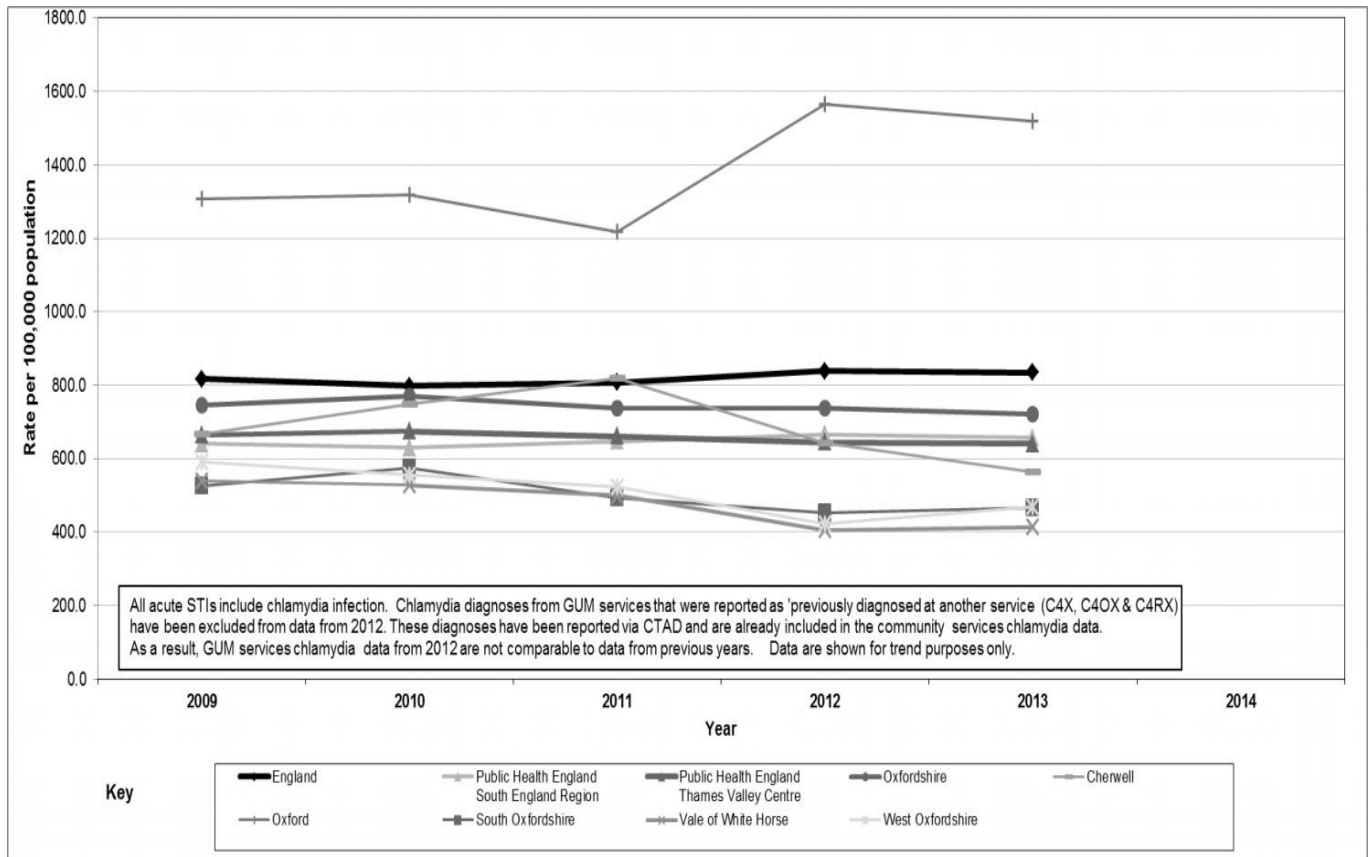
### Sexual Health

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

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

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

The chart below shows the overall position.



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

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

## Recommendations

1. The Director of Public Health, the NHS and Public Health England should remain vigilant, spot the early signs of rising disease levels and continue to take action.
2. The Director of Public Health should report on killer infections and infectious diseases in subsequent annual reports.
3. The new Sexual Health Partnership should steer multiagency action to combat sexually transmitted infection.