DIRECTOR OF
PUBLIC HEALTH
FOR OXFORDSHIRE

ANNUAL REPORT
VI

Reporting on 2011-2013
Recommendations for 2013-2014
Produced: May 2013

Foreword:

This is the 6th Director of Public Health Annual Report for Oxfordshire. It is also the first Annual Report produced since Public Health returned home to Local Government.

<u>What is the purpose of a Director of Public Health's Annual Report?</u>

The purpose of a Director of Public Health is to improve the health and wellbeing of the people of Oxfordshire. This is done by reporting publicly and independently on trends and gaps in the health and wellbeing of the population in Oxfordshire and by making recommendations for improvement to a wide range of organisations.

Producing a report is now a statutory duty of Directors of Public Health and it is the duty of the County Council to publish it.

The Director of Public Health's Annual Report is the main way in which Directors of Public Health make their conclusions known to the public. This helps the Director of Public Health to be an independent advocate for the health of the people of Oxfordshire.

The Annual Report:

> ➢ Is Scientific
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> ➢ Is Factual
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> ➢ Is Objective
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> ➢ Focuses on long term gaps
>
> ➢ Makes clear recommendations

<u>Public Health – everyone's business</u>

Good health and wellbeing are not created in a vacuum. Good health is closely related to a wide range of factors such as employment, quality of neighbourhoods, quality of schools and having a part to play in society. These factors are, in turn, linked to issues of housing, skills and employment and all contribute to the general economic prosperity of the County. **In addition, to make a difference, it is necessary to focus on the same topics for a number of years to make sustained change.**

For these reasons, the recommendations made in this report are long-term and wide-ranging and are not confined to traditional areas such as health services and social care.

<u>What Priorities are Highlighted In this Report?</u>

The six main long-term challenges to long-term health in Oxfordshire are:

- ➢ An ageing population – the "demographic challenge"
- ➢ Breaking the cycle of disadvantage
- ➢ Mental health and wellbeing: avoiding a Cinderella service
- ➢ The rising tide of obesity
- ➢ Excessive alcohol consumption
- ➢ Fighting killer infections

These topics are dealt with one by one. The current issues and recent action are laid out and progress will be monitored in future reports.

Within these topics there is a particular emphasis in this report on 3 issues:

- ➢ Health in rural areas
- ➢ Loneliness as a health issue, and
- ➢ The increase in residents from minority ethnic groups

Your comments are welcome as long-term success will depend on achieving wide consensus across many organisations. Please direct comments to: <u>andrea.taylor@oxfordshire.gov.uk</u> .

<u>Many people have helped to produce this report. It would have been impossible without them. They are acknowledged at the end of the document.</u>

I hope you enjoy the report and act upon it.

Dr Jonathan McWilliam

Director of Public Health for Oxfordshire

May 2013

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Chapter 1 – The Demographic Challenge

The increasing number of older people living in Oxfordshire remains both a blessing and the number one challenge for our health and social services. The 2011 census gives us a clear picture of the continuing increase in the number of older people in the County.

Many older people live healthy lives and need little help from local services, however, when people do need help; we need to ensure that it is available, at the right time and in the right place. Our services are becoming more responsive to the needs of older people, but there is still a way to go. Because there will be an increasing number of people needing care in the future, that care has to be both effective and affordable.

What should we do about this? We should do 3 things as a priority:

1) **We should join up health and social care** to align our priorities and give people a smooth passage through our services. This includes investing in prevention, joining up NHS services and social services, keeping people out of hospital and getting people home as quickly as possible.

2) **We should re-shape services to put people in the driving seat of their own care**. This includes making direct payments to people for care and giving 'expert patients' programmes a boost.

3) **We should help people and communities find their own solutions**. This includes finding new ways to help people help themselves and find new ways to support those who help them, notably family, friends, communities, faith groups and the voluntary sector.

Much work is already underway on the first two of these topics and so this chapter will focus on the third, namely, **helping people find their own solutions**.

But first, let's take a look at the new census data in more detail because it gives us an up to date picture of the situation we face.

What does the new census data show?

The new data tells us important things about three topics: **population growth; rurality and loneliness**. These are all important if we want to help people and communities find their own solutions. The facts are summarized below, beginning with population growth.

The chart overleaf shows the new predictions of the increase of people aged 85+ in the County overall and its five Districts.
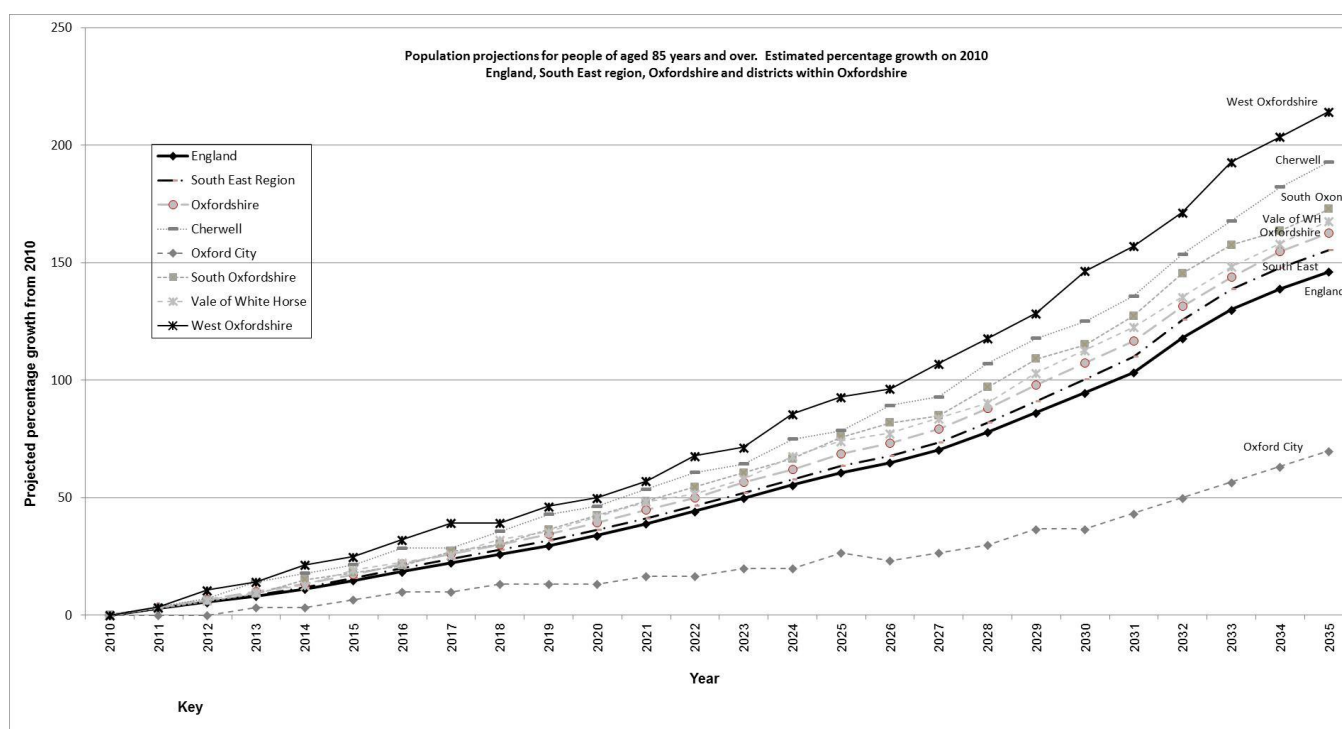
Office for National Statistics (ONS) Subnational Population Projections

This shows that:

➢ Overall, Oxfordshire's population is ageing faster than the national average.

➢ Ageing across the County is far from uniform. West Oxon and Cherwell will 'age' faster than the rest of the County.

➢ The City shows a fundamentally different picture with a much lower increase in numbers of older people.

The stark differences are highlighted in the table below which shows the percentage change in people aged 85+ comparing data for 2001, 2011 and predictions for 2035 for the County and each District.

Area	Number of People over 85 in 2001	Number of People over 85 in 2011	Number of people over 85 in 2035	Increase in people aged over 85 from 2001 – 2011 (%)	Increase in people 85+ from 2011 to 2035 (%)	Increase in people 85+ from 2001 to 2035 (%)
Oxfordshire	**11,277**	**14,683**	**39,400**	30%	168%	249%
Cherwell	**2,140**	**2,819**	**8,200**	32%	191%	283%
Oxford	**2,454**	**2,697**	**5,100**	10%	89%	108%
South Oxfordshire	**2,556**	**3,375**	**9,000**	32%	167%	252%
Vale of White Horse	**2,121**	**3,052**	**8,300**	44%	172%	291%
West Oxfordshire	**2,006**	**2,740**	**8,800**	37%	121%	339%

Office for National Statistics (ONS) Subnational Population Projections

This shows that, comparing 2001 and 2035:

1) There will be more than three times as many people aged over 85 in the County.
2) There will be more than four times more in West Oxfordshire
3) There will be around double the number in the City.

Rurality and the over 85's

The more rural Districts of the County will experience the greatest increase in the over 85s over the coming decades. This is important because:

➢ Access to services is generally poorer in more rural areas
➢ Older people in rural areas are spread out and will be at more risk of isolation
➢ Each rural community is different across the County – if we want to support communities to help themselves, this means we need to find ways that are flexible enough to support 100s of different solutions.

Statistics for population density (i.e. people living per square hectare[1]- which is about 2 ½ acres) give a useful measure of rurality. Overall figures for Oxfordshire are given in the table below and show stark contrasts.
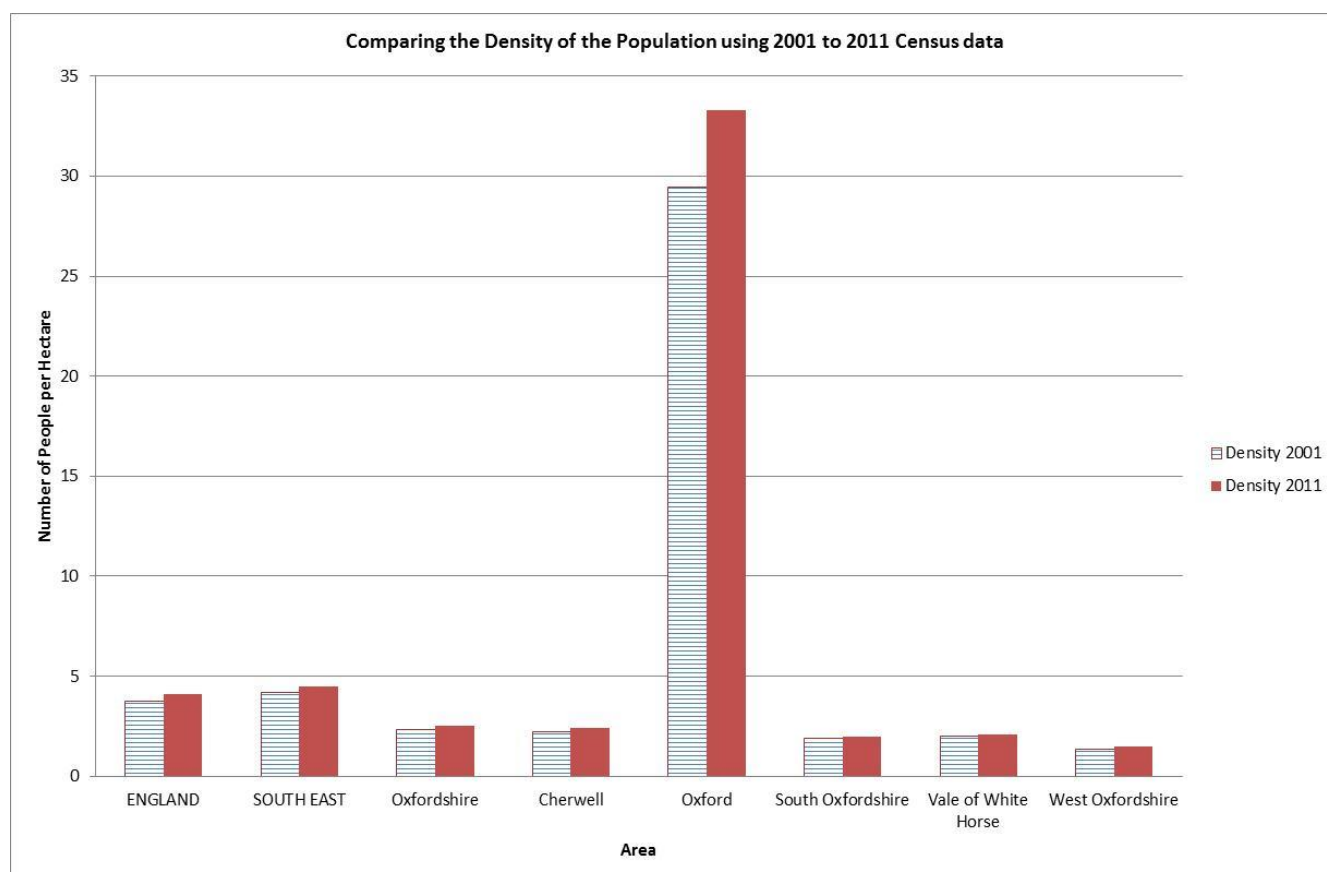
Office for National Statistics (ONS) Census 2011

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[1] The **hectare** is a metric unit of area defined as 10,000 square metres (100 m by 100 m), and primarily used in the measurement of land. A hectare of land is 2.47 acres.

The chart shows that:
- Oxfordshire is much more rural than England and the South East Region with about half the Region's population density.
- Within Oxfordshire there is a massive difference between the City and the other Districts. People in the City are more than 10 times more 'densely packed' (around 33 people per hectare) than in other parts of the County (County average is 2.5 people per hectare).
- Population density for Oxford City (excluding the more rural parts of Wolvercote and Marston) is 39 people per hectare.
- West Oxfordshire is the most rural District with a population density of 1.5 people per hectare. However it is no longer the most rural area in the South East, this honour has been claimed by Chichester.
- Even the presence of Banbury and Bicester in Cherwell District do not raise the population density above 2.4 people per hectare.
- However looking at the wards that make up Banbury and Bicester shows that Banbury has a density of 37.6 and Bicester 40.2 people per hectare which are about the same as Oxford City.

This means that:
- We need to be flexible enough to design services in different ways in different places
- Better still, we need to be flexible enough to allow local people to design their own services in their own way in different places
- Services in the City will need to be very different from the more rural parts of the County because the age structure, population density and needs are markedly different.
- Partnership work between the County Council and Districts and Clinical Commissioning Group localities will need to be flexible. – **There is no 'one size fits all' solution for Oxfordshire.**

Loneliness and older people
Loneliness is becoming a topic of increasing concern. Loneliness can happen anywhere, in both rural and urban communities, but older people living in greater isolation in more rural parts are more at risk. Recent research and a recent conference held in Oxfordshire under the auspices of Age UK pointed out that loneliness is a "hidden killer", increasing the risks of death in elderly people by 10 per cent. Those who are lonely have a higher risk of heart disease and blood clots as they tend to adopt a more sedentary lifestyle, exercise less and drink more alcohol.

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
- Heart disease and stroke
- Increased stress levels
- Decreased memory and learning ability
- Poor decision-making
- Alcoholism and drug abuse
- Faster progression of Alzheimer's disease (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 in 2011As a percentage of all households
Oxfordshire	31,140	29,852	13%	12%
Cherwell	6,118	5,967	12%	11%
Oxford	7,415	6,049	14%	11%
South Oxfordshire	6,728	6,570	13%	12%
Vale of White Horse	5,738	5,947	12%	12%
West Oxfordshire	5,141	5,319	14%	12%

Office for National Statistics (ONS) Census 2011

The data tells us that:
- Living alone in older age is a common finding. There are nearly 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%

Unfortunately we can't tell from census data what the figures for over 85s living alone are.
The implications of this are:
- We CAN use this data to give us a feel for helping to target those most at risk of loneliness.
- Services need to become more geared to recognizing loneliness as a risk factor for disease.
- Individuals and communities need to find ways to use their resources to combat loneliness and statutory services need to help them

As society changes, many of our most rural villages may become populated predominantly by older people with fewer children and young adults. This is the overall trend of the last 10 years. Take a look at the charts below. These show the 'ageing shift' that has taken place in many rural areas over the last 10 years. The blue solid line shows the population in 2001 and the red dashed line shows the population 10 years later in 2011. The more the line 'moves to the right', the more the population is ageing.
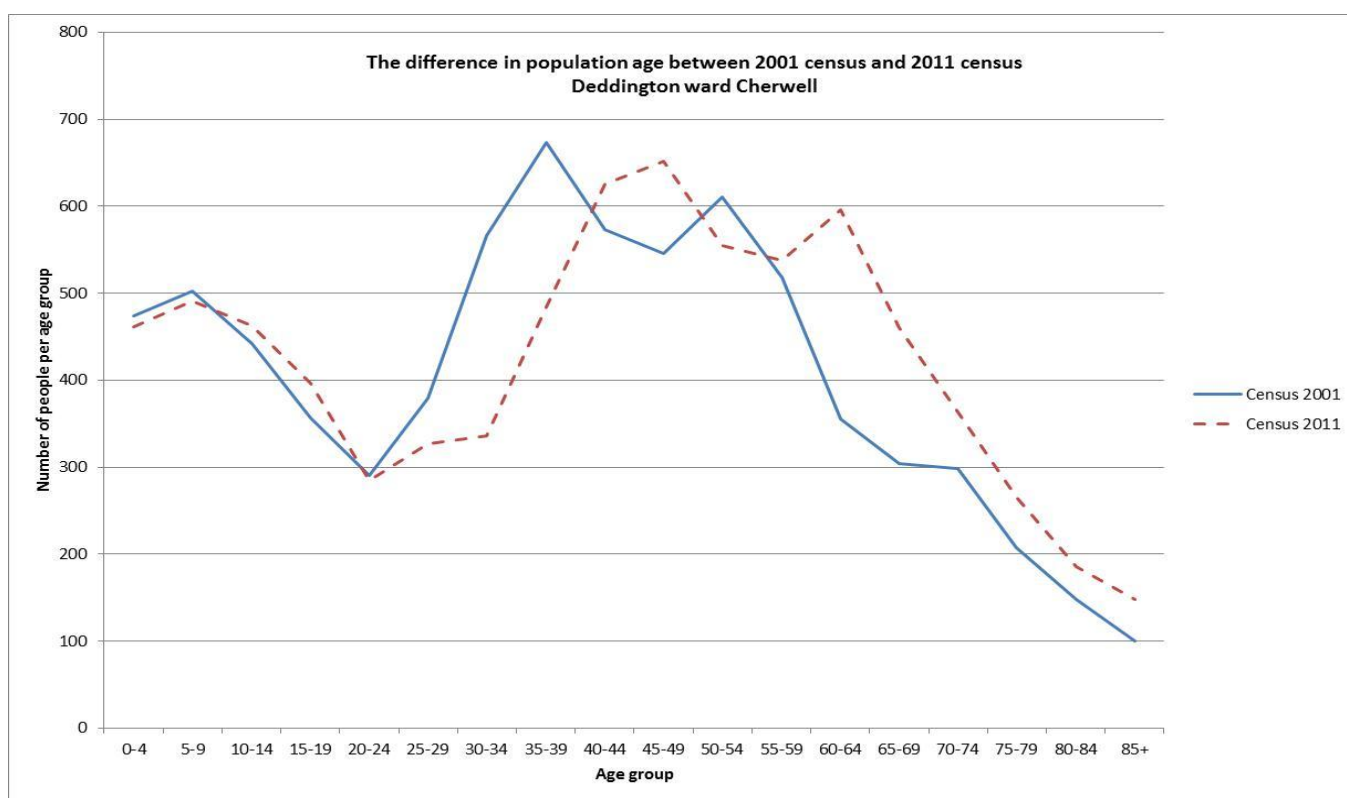
Office for National Statistics (ONS) Census 2001 and 2011

Contrast this with the picture in more urban areas. The two lines for Marston in Oxford City show very little difference – the population here is not ageing in the same way at all. Here the biggest feature is an increase in the number of children aged 0-4.
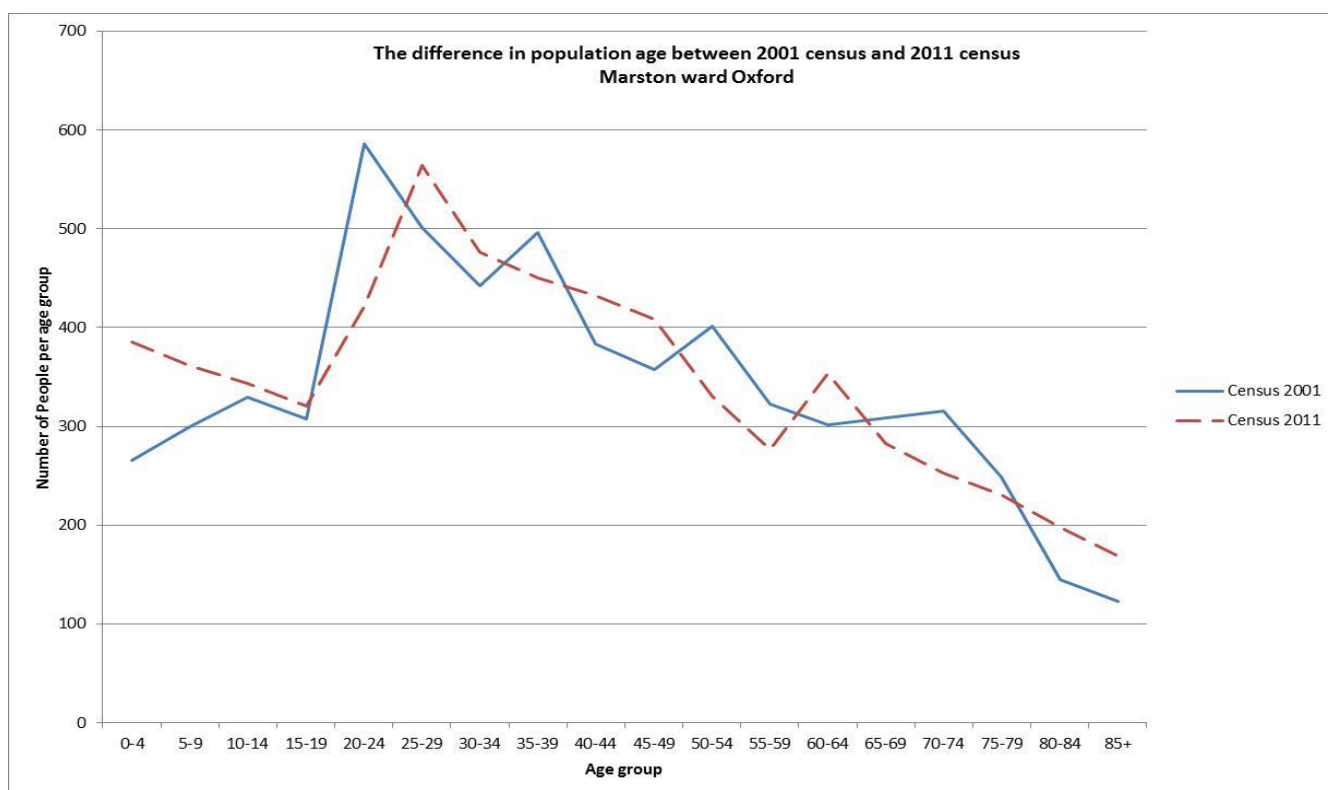
Office for National Statistics (ONS) Census 2001 and 2011

This means that, we need to plan differently in different parts of the County and find both 'rural solutions' and 'urban solutions'.

Once again it should be stressed that each rural community will be individual in its needs and individualistic in the way it finds solutions. The solutions will characteristically depend on the nature of the community and the willingness of its leading members to make a difference. The question is, "How can we best help them to do it?"

Implications
Putting the facts together about population growth, rurality and loneliness alongside a recession, a squeeze on public spending and the government's encouragement for local communities to help themselves to find their own solutions creates a powerful cocktail of factors which affect Oxfordshire deeply.
What does all this mean for policymakers, and what should public sector organisations do? Common sense suggests that we need to find new ways to **empower** the people of Oxfordshire to help themselves.

Empowering Oxfordshire
Local government is well placed to continue its traditional leadership role to empower people and communities to help themselves. The Clinical Commissioning Group, Faith Groups and Voluntary organisations have major roles to play too. What might this look like?
It means finding ways to encourage local people and local organisations to find their own local solutions, particularly in rural communities. This may mean promoting and spreading solutions such as community planning and time-banking, and making it easy for villages to own and run their own village shops. Identifying 'village agents' as a focus for some of this work is also a promising idea. Finding ways to harness the collective power of individuals, local societies, voluntary agencies, faith groups and philanthropists will be crucial if this is to work.

Recommending that we turn our attention towards 'Empowering Oxfordshire' is the main thrust of this chapter. What are the elements of this?

Empowering People
We need to exploit the full possibilities of new rules around making direct payments to people so that people can buy the services they need. We have already noted that this is well underway in Oxfordshire, but we may be able to extend this further and cut more red tape.
Linked ideas in the NHS about helping patients to become the experts driving their own care and owning their own records and care plans may also help. Getting people involved in service planning through our Public Involvement Networks and through the new 'Local Healthwatch' will be important too.

Empowering Prevention
It goes without saying that *'an ounce of prevention is worth a pound of cure'*. We need to make sure that older adults benefit fully from programmes such as bowel screening, which find disease early enough to treat, and flu jabs which directly prevent disease and disability.
We also need to 'mainstream' the prevention of loneliness as a direct means of improving health. This may mean that in the future, every visit to the local lunch club run in the local community becomes as important as a visit to the GP's surgery.

Empowering carers and volunteers.
Without the army of carers and volunteers at work in Oxfordshire, services as we know them would be unable to continue. Recent years have shown a welcome recognition of the work of carers and volunteers. We need to keep our foot pressed fully on the accelerator in terms of identifying and supporting carers and finding easy ways to recruit and encourage volunteering.

What we said last time
The last annual report was produced at a time of unprecedented upheaval in the public sector and was most concerned to keep the demographic challenge high on the agenda of the new Clinical Commissioning Group, the Health and Well-being Board and Public Involvement Network. The Health Overview and Scrutiny Committee were also encouraged to keep a close eye on proceedings.

These things have been achieved and the NHS and social services now work more closely together than ever before - **this is a major achievement.**
It is now time to add a new emphasis which picks up the theme as of an increasingly ageing population, loneliness and isolation particularly in our communities.

Empowering people and empowering communities and the voluntary and faith groups which support them to help themselves has now become the major gap we need to fill.

A final word on dementia.
Previous annual reports have highlighted the need to improve the recognition of dementia and to strengthen treatment services and the care of carers. This remains a priority. There is also a need to ensure that dementia is seen as part and parcel of mainstream health services as it co-exists with other physical illnesses. It should not be seen as solely a 'mental health problem'.

Recommendations

One strategy: One pooled budget: One Plan
By October 2013:
➢ The County Council and the Clinical Commissioning Group should have implemented the agreement to create a genuinely pooled budget bringing together adult social care resources and community health resources
➢ The Health and Wellbeing Board should be re-designed to oversee the management of this resource.
➢ The use of this resource should be guided by a single plan formally agreed between Oxfordshire Clinical Commissioning Group and Oxfordshire County Council (as part of the Oxfordshire Older Peoples' Joint Commissioning Strategy).
➢ This plan should be driven by re-vamped outcome measures and targets agreed as part of the refreshed Joint Health and Wellbeing Strategy.
➢ The Health and Wellbeing Board should receive regular reports on how this money is used.
➢ The Health Overview and Scrutiny Committee should provide strict external scrutiny of these arrangements.

A coordinated approach to tackling Loneliness
By March 2014:
➢ Oxfordshire Clinical Commissioning Group, Oxfordshire's 6 Local Authorities, Age UK, Carers Representatives and other Voluntary and Faith sector partners should bring together practical proposals for tackling the issue of loneliness.
➢ This should build on the start made in The Oxfordshire Older People's Joint Commissioning Strategy.
➢ This work should be overseen by the Health and Social Care Board.
➢ Tackling loneliness should be a goal of the refreshed Joint Health and Wellbeing Strategy.

Chapter 2 – Breaking the Cycle of Disadvantage - New Opportunities: New Challenges

This County is committed to breaking the 'Cycle of Disadvantage', but what does this mean?
It means that we are determined to improve the life chances for our residents living in the areas of the County where disadvantage is passed down from one generation to the next.
The last year has been a year of new opportunities and new challenges.
The 3 main opportunities are:

1. The new 'Thriving Families' initiative
2. The work of the GP Commissioners' locality groups
3. The work of the Health and Wellbeing Board

The 3 major challenges are:

1. The changing ethnic minority structure of the County
2. The possible impact of benefit changes for those on the brink of homelessness
3. The need to guard against complacency and continue to monitor our bread-and -butter indicators of disadvantage

Let's take a look at these one by one:
The 3 Main Opportunities

Opportunity 1) The way in which we have picked up the 'Thriving Families' initiative and run with it.
The Government launched its 'Troubled Families' initiative in December 2011. The County Council adopted this as the more positive 'Thriving Families' programme and invested £1.6 Million into it to make it really fly. Working with partners, the aim is to identify the County's most needy families and give them a hand-up rather than a hand-out.

There are already important lessons to learn from the first 9 months of operation:
Lesson 1: It is only by persistently joining up the long term information held by all organisations like social services, police, NHS and probation that we find the families who need the help most. Individual agencies all have data, but it is knitting it together over the long term that counts. *This has never been done systematically before, and it is bearing fruit.*
Lesson 2: Local sources know best: Talking to the local schools and the local 'bobby on the beat' is a good place to start to piece together a local story
Lesson 3: The families we need to help are spread right across the County. **This approach is helping to identify families in both urban and rural settings. This is a real achievement. We have been searching for a way to find those most in need in rural areas for many years.** These families are too often 'hidden' when we look at data on a bigger scale. It means that we can help people based on their needs not on where they live.

The table below gives an early indication of where the families who need help the most might live.
Take a look at the column on the far right which shows how evenly spread these families are as a percentage of all 'families' in each District.

Area	Number of families tentatively identified so far	Number of families identified as a percentage of all households in the area
County	761	1%
Cherwell	208	1.2%
Oxford	229	2%
South Oxfordshire	122	1%
Vale of White Horse	108	1%
West Oxfordshire	94	1%

Oxfordshire County Council, Thriving Families Team

During the next year work will start to help families in earnest, aiming to make a measurable difference to their lot – watch this space.

Opportunity 2) The way the Clinical Commissioning Group is handling locality planning
The GP Commissioners divide the County into 6 localities. These map roughly onto the District Councils, with separate localities for Banbury and Bicester. Each locality has now started to make plans based on local needs. Some green shoots are beginning to show from this work, for example:
- In Banbury "equalities and access managers" are working with local practices to increase the uptake of cervical screening amongst ethnic minorities.
- Targeting advice on healthy lifestyles and screening programmes to areas of the City with worst health outcomes. This includes a weight loss programme for men called 'Footy Fitness at Oxford United'. Men can be referred by their GP during their NHS Health Check or can just turn up for the weekly weigh-in, advice and football fitness session.
- Encouraging smokers to pledge not to smoke at home or in the car so they can keep the air smoke-free for their children. This work is being targeted in both Banbury and parts of Oxford.
- Providing information and support to people from Asian backgrounds to identify diabetes and make sure they get the right help to manage their condition successfully.
- The 'Benefits in Practice' initiative which places benefit advisors in GP practices - new work in Hardwick and Horsefair surgeries has directed almost 100K to the families who need it most.
- Cooking skills courses in Banbury and in Barton. 17 courses took place in Banbury in 2012 and 247 people have participated from the start of the courses with good results such as reduced consumption of ready meals and takeaway meals and an increase in cooking from scratch and consumption of fruit and veg.
- Working with End of Life Care services to outreach into Black and Minority Ethnic communities and break down barriers to access these services and ensure that services provided are culturally appropriate.
- Working with new migrant communities such as Portuguese speaking communities and East Timorese community, to improve access to health services.

Opportunity 3) The potential for the Health and Wellbeing Board to bring things together.
The Health and Wellbeing Board has identified inequalities as a major theme, and reducing inequalities in life expectancy is one of its targets. It is also working to promote breastfeeding, reduce teenage pregnancy and raise educational attainment, all of which will help to reduce inequalities.

So much for the opportunities, the 3 biggest **new challenges** we face to break the cycle of disadvantage are:

Challenge 1 The changing ethnic minority structure of the County
Early data from the2011 census shows that the County has a substantially increased ethnic mix compared with 10 years ago. Of course, 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.
A real wake-up call was the fact reported in the press that:
"In Oxford nearly half of births (47%) in 2010 were to non UK-born mothers, compared to a national and County average of 26%."
Early indications show that the % of people in ethnic minority groups has risen in between censuses as follows:

Area	% of all ethnic minority groups in the 2001 census	% of all ethnic minority groups in the 2011 census	Number of additional people from ethnic minority groups between 2001 and 2011	% increase over the last 10 years in the proportion of ethnic minority groups in the overall population	% increase over the last 10 years in the ethnic minority population
Oxfordshire	**10%**	**16%**	**46,081**	**7%**	**57%**
Cherwell	7%	14%	9,527	7%	51%
Oxford City	23%	36%	24,006	16%	57%
South Oxfordshire	6%	9%	4,278	3%	65%
Vale of White Horse	7%	10%	4,624	4%	63%
West Oxfordshire	4%	7%	3,586	4%	54%

Office for National Statistics (ONS) Census 2001 and 2011

The headlines are:
> - **An across the board increase in residents from ethnic minority groups of 57% on 2001 figures INVOLVINGEVERY DISTRICT IN THE COUNTY**
> - **An increase of 46,000 residents** from all ethnic minority groups over the last 10 years
> - **Over 1/3 of all City residents are from ethnic minority groups** and over 10% of all Cherwell residents.

The table below looks further ahead at predictions for the growth of Oxfordshire's BME communities up to 2051:

Area	People from All Ethnic Minority Groups in 2001	People from all Ethnic Minority Groups Predicted for 2051	% increase from 2001 to 2051
Cherwell	5431	17164	216%
Oxford	17528	44065	151%
South Oxfordshire	2762	11663	322%
Vale of White Horse	2837	8561	202%
West Oxfordshire	1593	7289	358%
OXFORDSHIRE	30150	88242	193%

Office for National Statistics (ONS) Census 2001 and 2011

Long term trends should always be treated with caution, but the headlines are:
 ➢ There is a predicted long term increase in people from BME communities across the County from 30,000 residents to almost 90,000. **This is a tripling of numbers predicted for the first half of this century.**
 ➢ Around half of these will live in Oxford (44,000)
 ➢ The whole County is involved.

There **WILL** be implications for the policies of all organisations in these figures, some minor and some major but it is too early to indicate yet what they might be. All schools, all public services and all employers will need to continue to adapt. We will need to unpack the more detailed census data as it arrives over the coming months, so this is very much an early indication to 'watch this space'

Challenge 2 To keep a weather eye on the impact of benefit changes for those on the brink of homelessness.
As a result of changes in the way welfare benefits are calculated and paid there may be a temporary or longer term impact on some of the more vulnerable people in our population. These changes have attracted much publicity nationally and the situation needs to be monitored with care. People with mental health problems are thought to be particularly vulnerable. Work is on-going in all Local Authorities to monitor these changes and we need to make sure we are able to respond if need be.

Challenge 3) The Eternal Need to Guard against Complacency
It is vital that we keep a close eye on our routine, well-established indicators of disadvantage. Following increased vigilance over the last 5 years, many of these indicators do show improvement….
However it is all too easy to let the situation slide, and we must not let this happen – the key lies in openly and honestly reviewing the data we have and reviewing it regularly – and *this* is what the remainder of this chapter will do.

We will look at 8 key indicators in the remainder of this chapter.

Indicator 1 - Child Poverty

The County's Child Poverty Strategy shows that the number of children who live in Poverty in Oxfordshire fell slightly from the 2009 figure. In 2008 there were 15,660 children living in poverty. This jumped to 16,940 in 2009 and fell to 16,645 in 2010. These are children living in families who meet the government's definition of child poverty i.e. *'a child living in homes taking in less than 60% of the median UK income'*.

In November 2012, the average annual income was £26,500. The median national income is £565 per week and 60% of it is therefore £339 a week or £17,628 per annum.

There is a lot of debate about whether this is a good measure of poverty, but whatever the rights and wrongs, it does allow us to monitor progress and to compare Oxfordshire's performance with elsewhere. The detail is set out in the chart and table below:
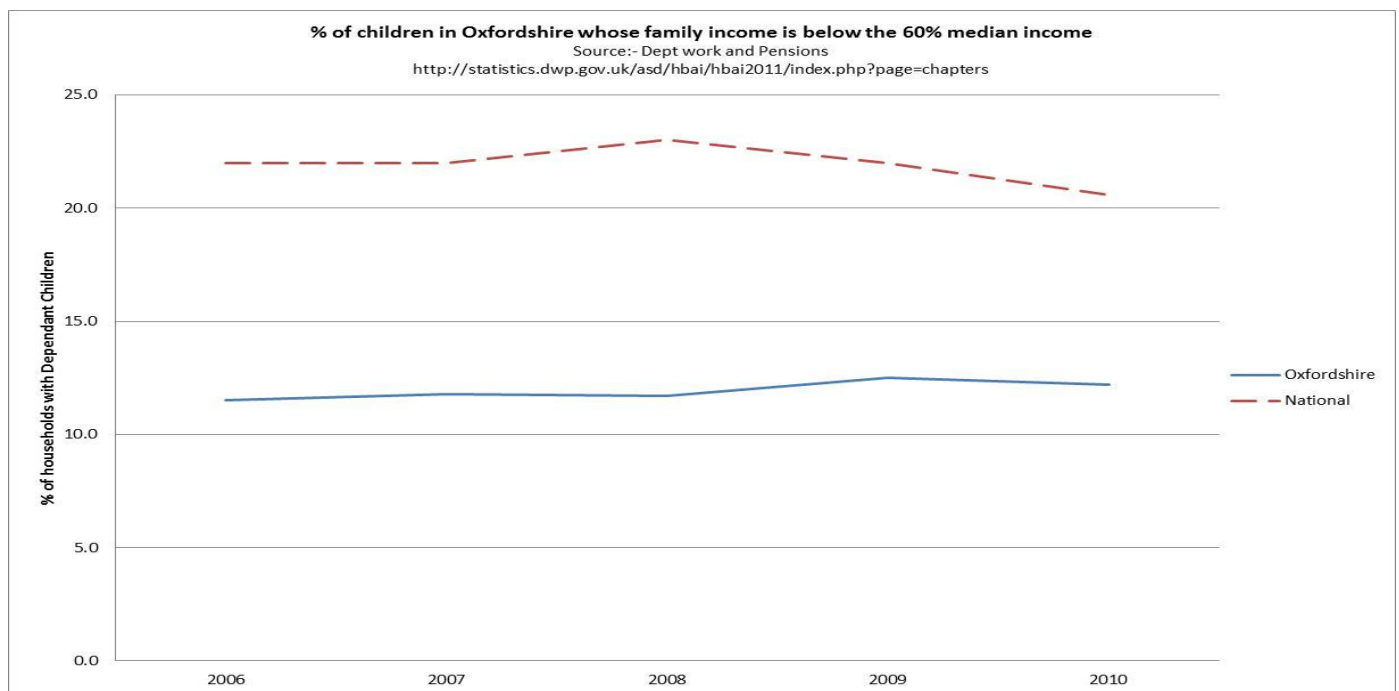
Source: Dept of Works and Pensions, http://statistics.dwp.gov.uk/asd/hbai/hbai2011/index.php?page=chapters

The figures show that:
- Child poverty in Oxfordshire is way below national levels – almost 50% below.
  This is very good news but the County average does mask small areas where levels of poverty are high.
- The Oxfordshire figure is fairly static over time whilst nationally the data shows a reduction; we await more up to date data.

Because the spread is not even across the County we need to look at more detailed data at District level. Data on children living in households claiming out of work benefit gives the following picture from 2011:

Children living in Families who are claiming any Out of Work Benefit

Local Authority	Age 0-15	Age 16-18	Number of Households	% of all households in each District claiming out of work benefit	% of households with Children in each District claiming out of work benefit	Where families claiming out of work benefit live.
Oxfordshire	14,180	1,450	8,100	3.10%	10.7%	
Cherwell	3,350	330	1,950	3.40%	10.9%	24%
Oxford	5,000	520	2,730	4.90%	18.4%	34%
South Oxfordshire	2,150	210	1,260	2.30%	7.8%	16%
Vale of White Horse	2,090	230	1,210	2.40%	8.3%	15%
West Oxfordshire	1,590	160	950	2.20%	7.6%	12%

Snapshot data as at 31 May 2011, DWP using census 2011 household data
http://research.dwp.gov.uk/asd/asd1/ben_hholds/index.php?page=child_ben_hholds

This shows that:
➢ Around a third of all households in the County which claim out of work benefit live in Oxford (2,730 households out of 8,100) and around 1/4 live in Cherwell (1,950 families).
➢ Around 5% of all households in Oxford claim out of work benefit compared with between 2% and 3% in the other Districts
➢ There are 5 wards with over 200 families claiming out of work benefit, these are: Northfield Brook, Blackbird Leys and Barton and Sandhills in Oxford, and Ruscote and Grimsbury and Castle wards in Banbury.

The overall picture means that:
➢ Oxfordshire is very prosperous overall compared with the national average, and
➢ We *can* use data about children living in our worst-off households to target resources within the County

Indicator 2 - Unemployment Benefit Claimants.

Research shows that being unemployed is bad for both the physical and mental health of those affected. Mental health impacts include:
➢ Increased levels of depression
➢ Higher anxiety levels
➢ Feelings of alienation from the local community and therefore lower levels of life satisfaction
➢ Low self-esteem

Physical health impacts include:
  ➢ Increased number of visits to Doctors
  ➢ Increased use of hospital beds
  ➢ Higher number of medications taken compared to working counterparts and poorer self-assessed health with an increased number of diagnoses
  ➢ Poor lifestyle choices which may include poorer diet, lack of physical activity increased use of alcohol and smoking

If we look at the percentage of people in the County who have been unemployed for more than 6 months we can see the following picture:-
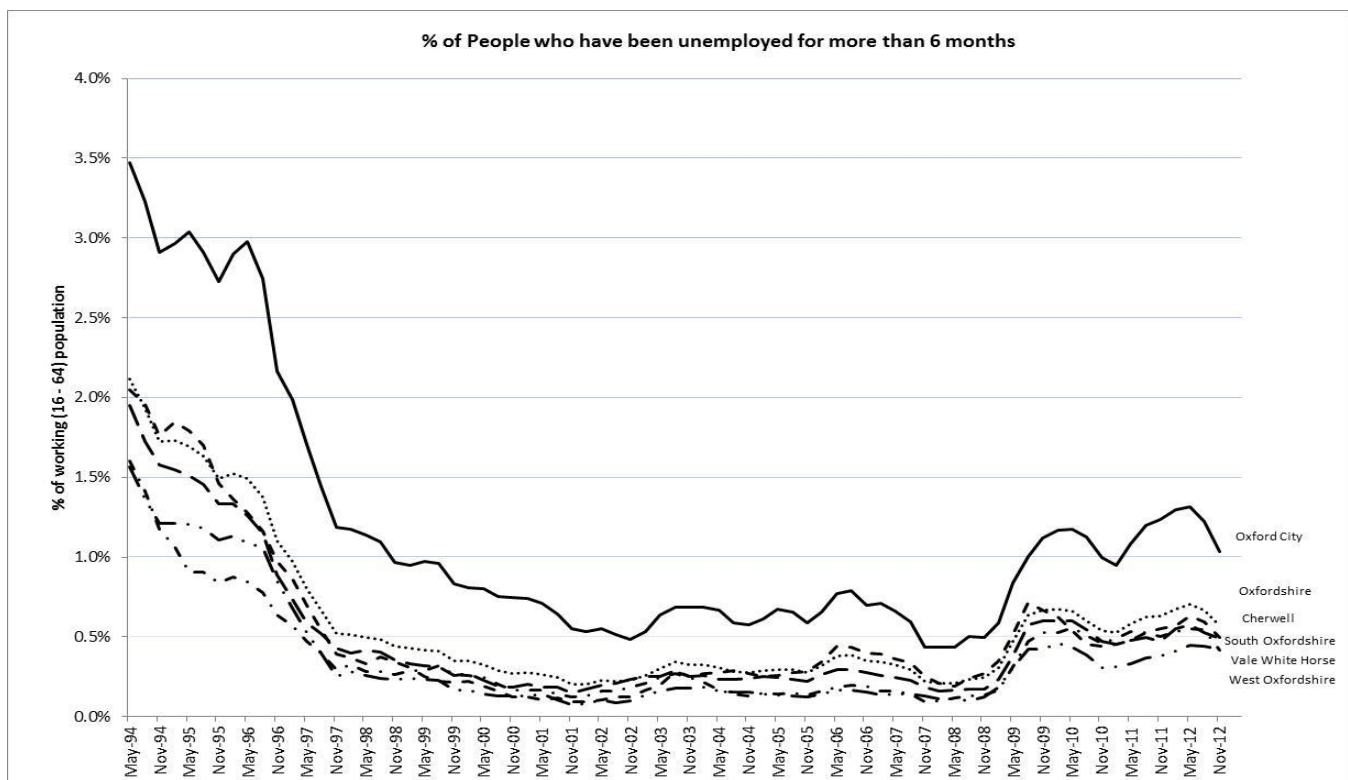
Source: Office National Statistics, Regional Labour Market, March 2012.

This shows that:
  ➢ The percentage of people unemployed fell sharply from a high point in the early '90s
  ➢ The county figures are well below the national percentage of 1%. Oxfordshire's unemployment rate is only half the national rate – which is good news. Oxford City's rate however is equal to the national average and double the County average.
  ➢ The numbers increased as a result of recession in 2009.
  ➢ The most recent figures show another welcome downturn.
  ➢ There is a marked difference across the County with a higher rate of long term unemployed people living in the City (around 1% compared with ½% in the other Districts).

Indicator 3 – Educational Attainment

Educational attainment in Oxfordshire has been a concern over the past few years, however, there is evidence that the hard work which has gone into this area is beginning to pay off. There is good news and not so good news and we must continue to focus on this topic.

The good news is that we are seeing improved figures in younger years, particularly key stage 2 (Children aged 7 – 11years old).
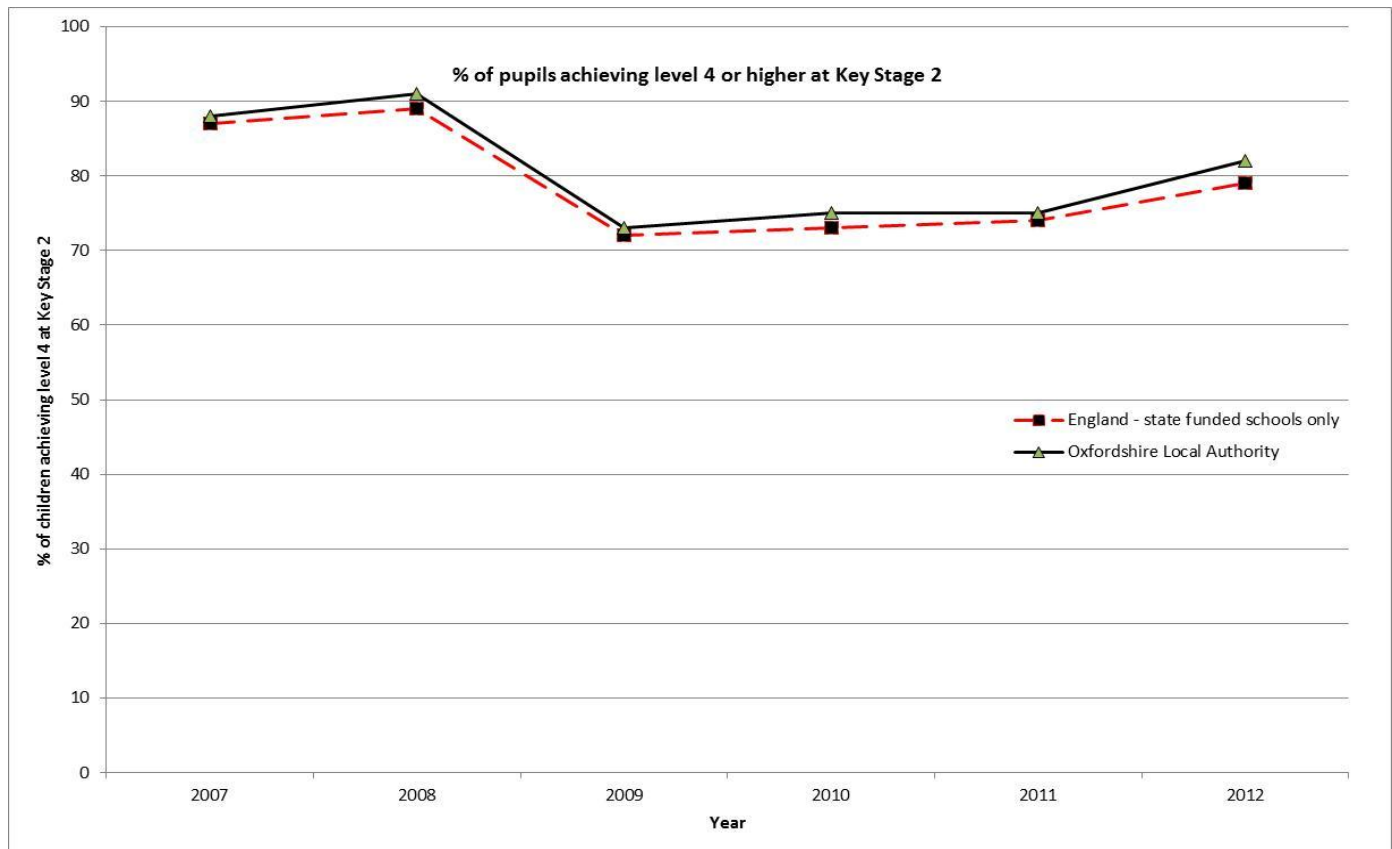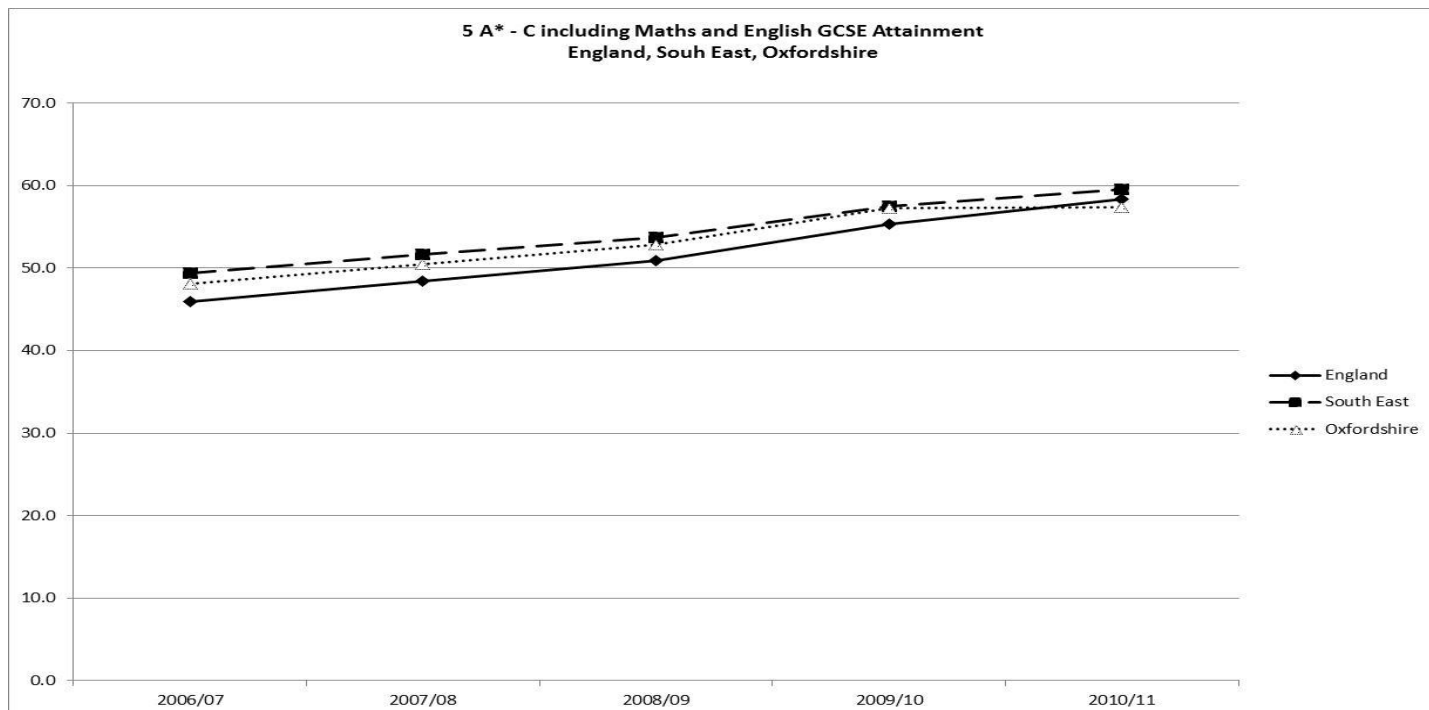

Source: - Department for Education, Statistics: GCSEs (key stage 2).

The chart above shows that Oxfordshire are outperforming England at Key Stage 2 (i.e. children aged 7) and a clear gap is opening up. **This is good news.**

Whilst we are beginning to see the fruits of our labours in these early years, there is continued concern however about GCSEs which has already been widely reported.

A principal concern relates to pupil progress from key stage 2 to key stage 4. Data shows that certain groups of children and young people perform particularly badly, for example those in receipt of free school meals and other vulnerable groups such as children in care. Steps are being taken to address these areas of concern

Looking at pupils achieving 5 A* to C results at age 16 gives the following picture:

Source: - Department for Education, Statistics: GCSEs (key stage 4).

This chart shows that our GCSE results continue to be lower than the national average. This remains a high priority for the County Council and the Health and Wellbeing Board.

There is also continued concern that performance varies widely across our ethnic minority populations. With the increase in numbers of these populations in the County this is a particularly important issue. The chart below gives us the story:
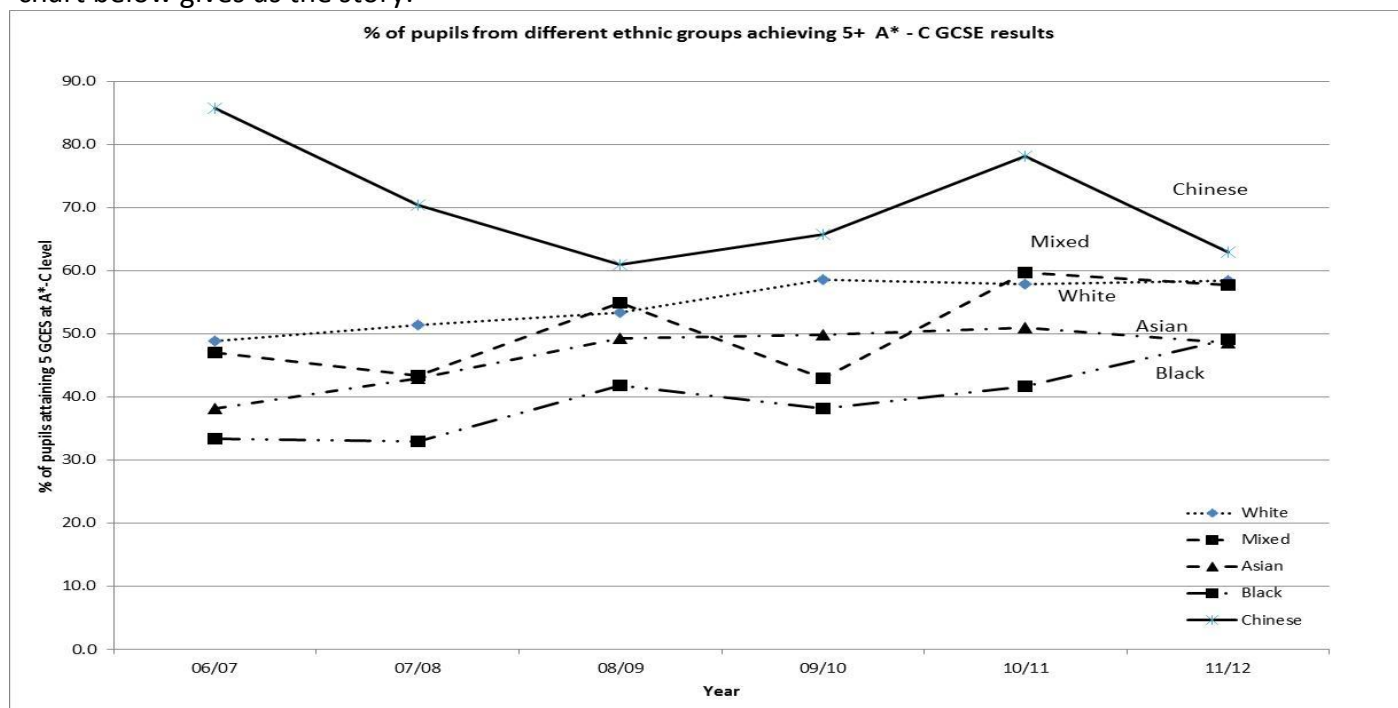
Source: - Department for Education, Statistics: GCSEs (key stage 4).

This shows that children from Asian and Black ethnic minorities perform markedly less well at GCSE than their 'white' counterparts. On the other hand, children from the Chinese community perform well, but we are talking about small numbers of children in this case.

The final facet of inequality in these results we will look at is geographical inequality. The chart below tells the story.
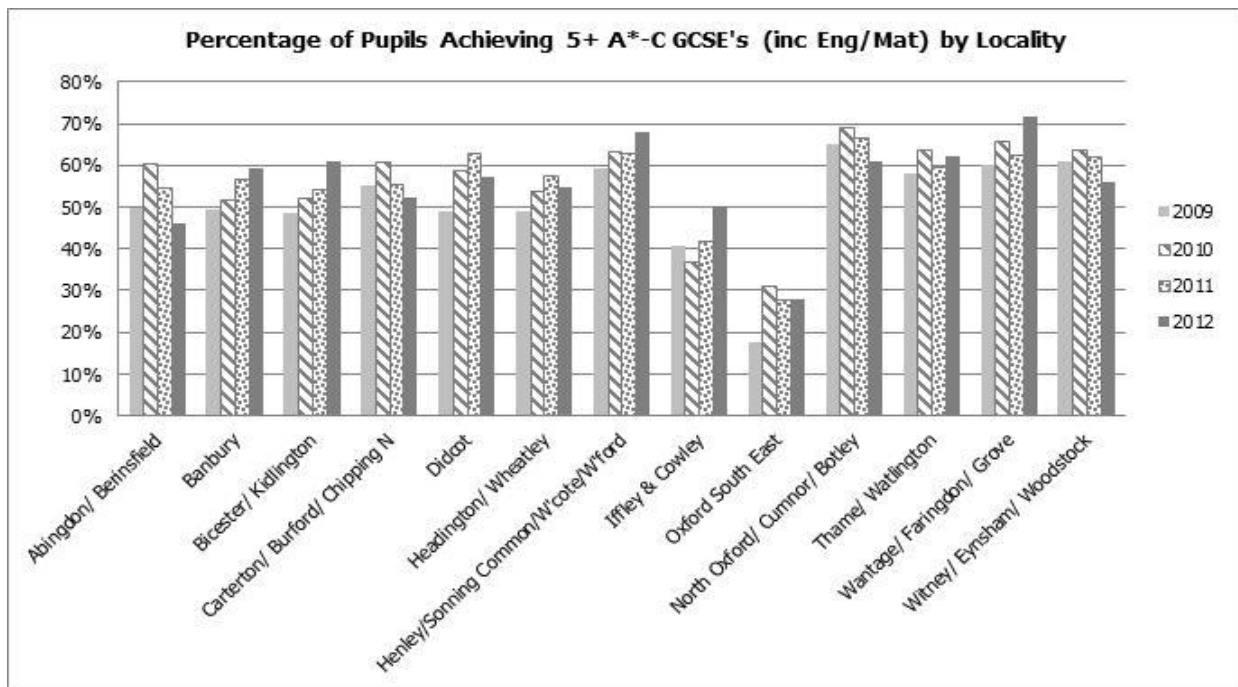
Source: Oxfordshire County Council, Data Observatory

Once again this shows marked variation across the County with children from 'Iffley and Cowley' and 'Oxford South East' performing less well. These are the areas which tend to show poor results across all statistics. This is evidence of the cycle of disadvantage being maintained.

On the other hand, the results for Banbury and Bicester are improving with consistent improvements for the last 4 years. The recent upturn in results in Iffley and Cowley is good news.

Indicator 4 - Teenage Pregnancy

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

The overall picture is shown in the chart below:
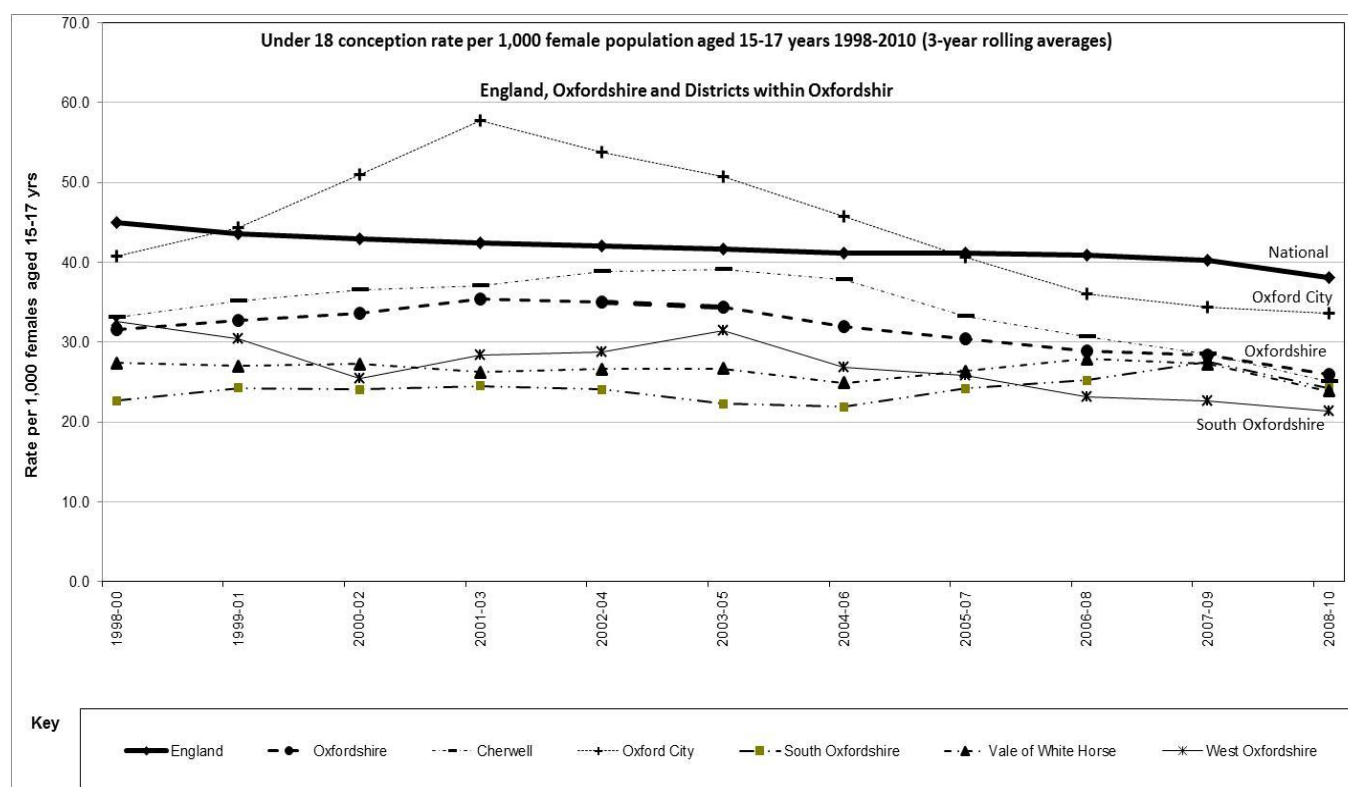
Office for National Statistics (ONS) - combining information from birth registrations and abortion notifications. Conception statistics include pregnancies that result in: one or more live or still births (miscarriages are not included), or a legal abortion under the Abortion Act 1967.

This shows:

- ➢ Oxfordshire's average as well below the national average and the Regional average – this is good news
- ➢ Rates have fallen sharply in the City over the last 10 years. This is good news.

Overall the Oxfordshire under 18 conception rate is decreasing, broadly in line with rates in England. Oxfordshire has the 12th 'best' rates for all Local Authorities in the Country and those Local Authorities with lower rates tend to be smaller authorities in leafy shires with few areas of disadvantage.

The key to success is to identify the 'hotspot' areas and focus services there. If we do this, the hotspots will change over time and reduce in number overall. The most recent analysis shows that **Oxfordshire has 10 hotspot wards with particularly high rates**. Hotspots are defined as those wards that are in the worst 20% of wards in the Country (i.e. currently those with more than 53.1 conceptions per year per 1,000 females aged 15-17 years).

There is no room for complacency, but **this is a considerable improvement to the picture 5 years ago when we had 18 hotspots.** This means we are moving 'up' the national league table and improving faster than elsewhere. The table below is a bit 'busy' but the detail is worth looking at.

It shows the hotspot wards in the County over the last decade.

There are 4 main themes:

➢ The number of hotspots has reduced.

➢ The pregnancy rates have all reduced over time – the worst rate in 2002-4 was 112 pregnancies per 1000 girls and in 2008-10 the worst rate was down to 77 pregnancies per 1000 girls.

➢ There is a group of 8 wards which appear in all 3 'league tables'. These are, from Oxford: Blackbird Leys, Northfield Brook, St Mary's, Rose Hill and Iffley, Barton and Sandhills and Iffley Fields, and from Banbury, Grimsbury & Castle and Ruscote wards.

➢ The latest figures show worryingly high rates emerging in Didcot in two wards: Northbourne and All Saints.

The key to this topic is to keep up our strict surveillance of the issues and then to target our services where they are needed the most.

Wards with high conception rates (in top 20% nationally) 2002 to 2004		Wards with high conception rates (in top 20% nationally) 2004 to 2006		Wards with high conception rates (in top 20% nationally) 2008 to 2010	
Ward Name	Rate 2002/04	Ward Name	Rate 2004/06	Ward Name	Rate 2008/10
Cowley Marsh	112.75	Banbury Grimsbury and Castle	103.91	Blackbird Leys	77.00
Banbury Grimsbury and Castle	103.45	Banbury Neithrop	89.72	Northfield Brook	71.00
Northfield Brook	98.21	Northfield Brook	81.30	St Mary's	65.00
Littlemore	94.34	Littlemore	78.81	Didcot Northbourne	63.00
St Mary's	90.20	Banbury Ruscote	77.52	Rose Hill and Iffley	61.00
Cowley	87.72	Witney Central	70.82	Banbury Grimsbury and Castle	57.00
Blackbird Leys	83.33	Banbury Hardwick	69.44	Banbury Ruscote	57.00
Banbury Ruscote	79.04	Cowley	66.31	Iffley Fields	57.00
Banbury Hardwick	77.88	Blackbird Leys	65.69	Barton and Sandhills	55.00
Iffley Fields	76.70	Lye Valley	63.84	Didcot All Saints	54.00
Barton and Sandhills	73.45	Ducklington	62.60		
Abingdon Caldecott	69.84	Iffley Fields	62.50		
Lye Valley	62.71	Carterton South	59.83		
Rose Hill and Iffley	63.49	Rose Hill and Iffley	58.88		
Jericho and Osney	61.40	Berinsfield	57.35		
Marcham and Shippon	56.91	Abingdon Caldecott	56.74		
Abingdon Abbey and Barton	65.93	Carterton North West	56.13		
Witney Central	64.81	Brize Norton and Shilton	55.87		

In the last 12 years, teenagers in Oxfordshire have had 120 fewer pregnancies than if rates had remained at the 2001/03 levels. The most conservative estimate of the financial impact of a teenage pregnancy is

£19,000- £25,000 over three years, according to the Department of Education and Skills in 2006. This equates to a saving of around £3 Million over 3 years and longer term.

Indicator 5 - Breastfeeding
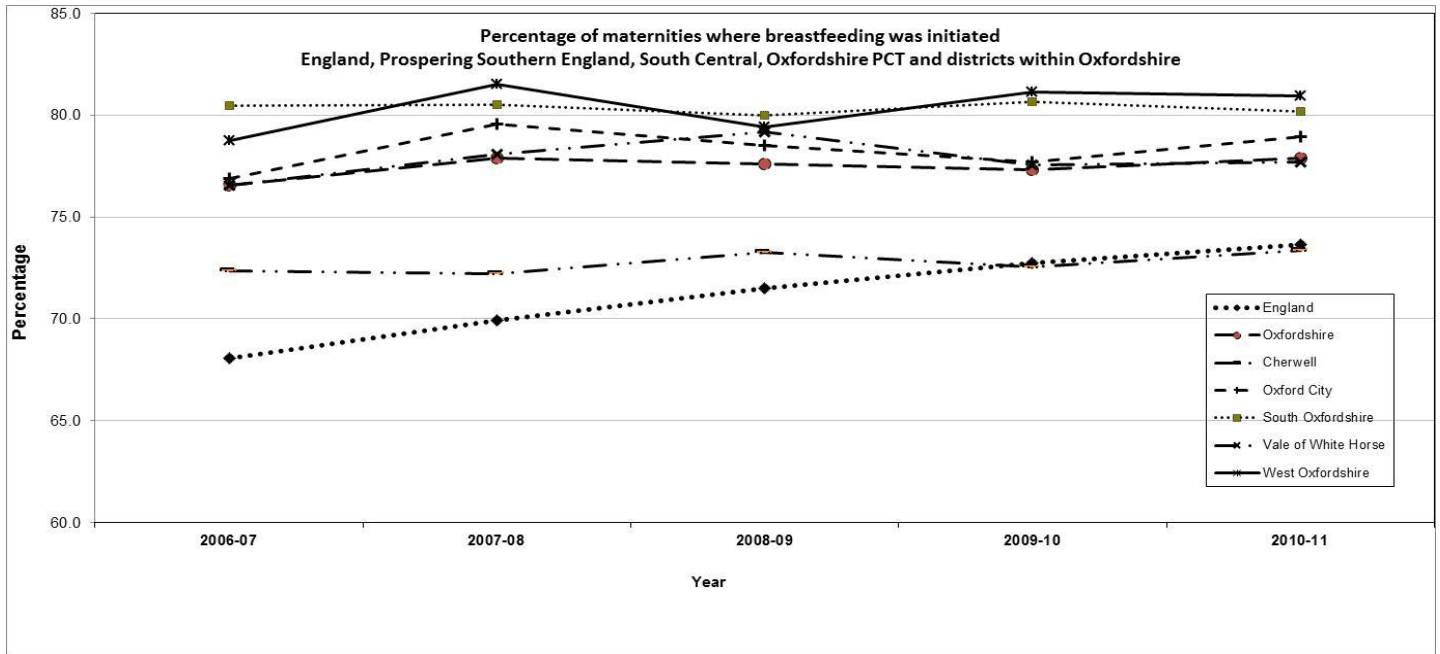
Source: Department of Health, Vital Signs Monitoring Return

Breastfeeding gives children a fantastic start in life. The percentage of mothers breastfeeding across Oxfordshire is high (79%) compared with national levels (74%).This is a good result. However, there are inequalities across Oxfordshire with not all mothers choosing to breastfeed their children.
The data shows high levels of uptake across Oxfordshire but lower levels in Cherwell.
Breastfeeding remains a high priority for the Health and Wellbeing Board and this should be maintained.

## Indicator 6 – Smoking in Pregnancy
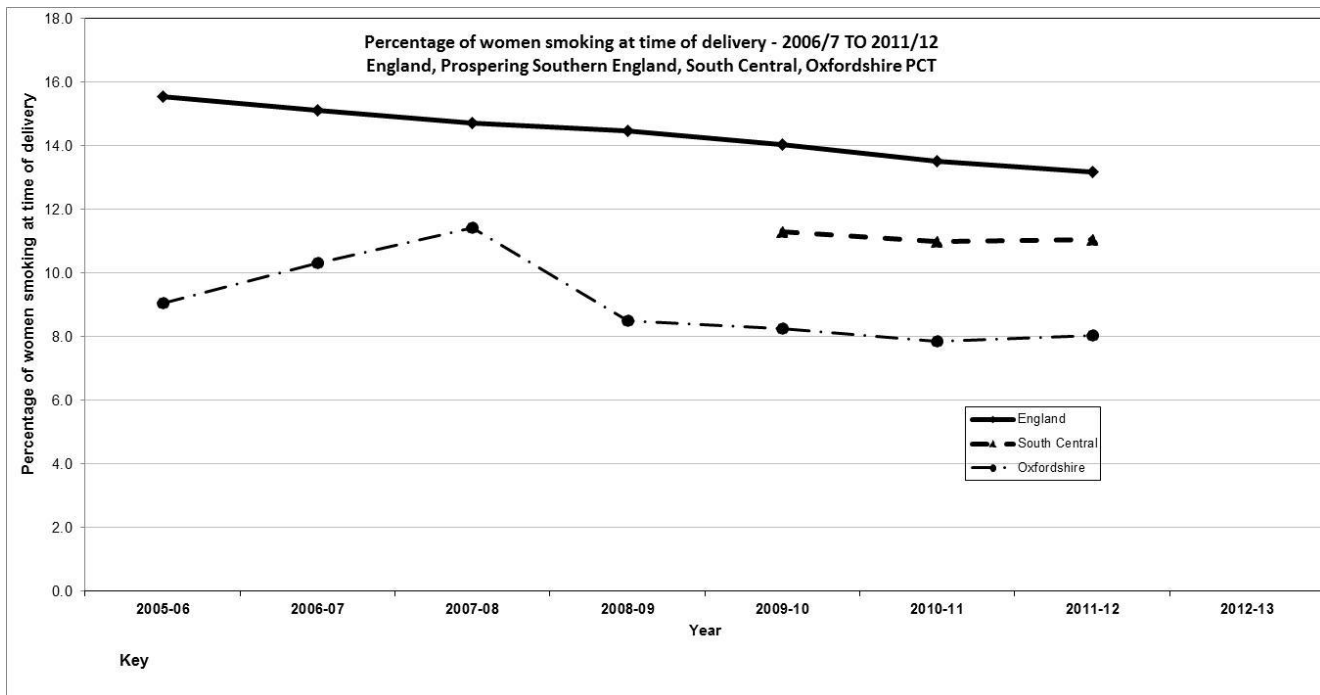
Source: - Prior to 2011/12: Department of Health (national and PCT data); NHS Information Centre Omnibus Survey (local data), 2011/12 onwards: NHS Information Centre (national and PCT data); local hospital trusts (local data)

Smoking in pregnancy is bad for the health of both mother and baby. Oxfordshire's figure stands at 8.1% of pregnant women smoking at the end of their pregnancy which is well below the national level of 13.2% and the regional level of 11.1%. This is a good result but we need to press on and make it even better as this is a really important indicator. Pregnancy is a good time to persuade mothers to give up smoking and if we grasp the opportunity we will produce real long term benefits for both mothers and their families.

This means out of 8,000 or so pregnancies each year, 650 mothers are smokers and only 160 quit using our local services. We perform well compared with elsewhere, but surely Oxfordshire could be doing better. When we look at the number of smoking quitters during pregnancy, we see that rates have not really changed much over the last three years and hover around 40 quitters per quarter.

Indicator 7 - Obesity in Children
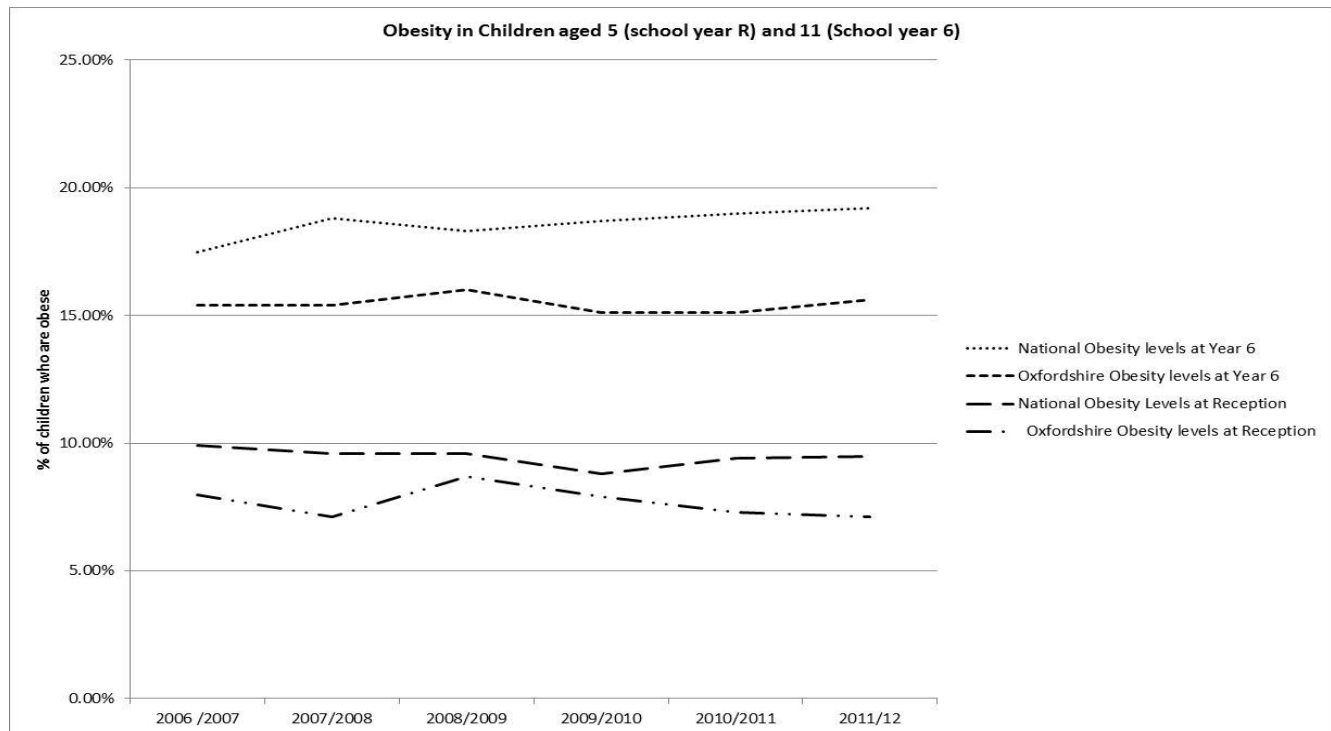
Source: National Child Measurement Programme (NCMP) report, NHS Information Centre, Child Obesity e-atlas, National Obesity Observatory

This section focuses on inequalities in obesity. See chapter 4 for a thorough look at all aspects of obesity.

The data tells us that
 ➢ Oxfordshire has significantly lower levels of childhood obesity than the national average and we are bucking the National trend. **This is very good news.**
 ➢ Levels of obesity more than double (from 7% to 15%) between the ages of 5 (reception year) and 11 (year 6). The rise in obesity levels continues into adulthood. **This is not good news.**
 ➢ National data shows that there is a strong relationship between social disadvantage and childhood obesity. This is borne out when we look at Oxford's data where obesity levels are higher than the County average
 ➢ Analysis for England indicates that there is a higher prevalence of obesity amongst 'Black British' reception year children (15.5% compared with an average of 9%)
 ➢ When we look at exercise data, there are no significant differences between Districts in the County.

Indicator 8 – Deaths in Oxfordshire

Many of the indicators we have looked at have shown that disadvantage has a bad effect on people's health. Disadvantage is also associated with an earlier death.
 If we compare the latest death rates for those living in the 20% best off and 20% worst off small areas of the County we find that there is a 6 year difference in life expectancy, *i.e. :*

'On average the sum total of disadvantage could be said to knock 6 years off your life'.

To put it another way, the odds of you dying in any one year if you come from a well-off area are around 1 in 250. In the most disadvantaged areas the chances of dying each year are 1 in 170.

The chart below shows 2 lines. The top solid line shows the high death rates in the 1/5th most disadvantaged wards in the County. The lower solid line shows the lower death rate in the most well off 1/5th of wards.

Death Rates in Oxfordshire showing the top 1/5th and bottom 1/5th of wards
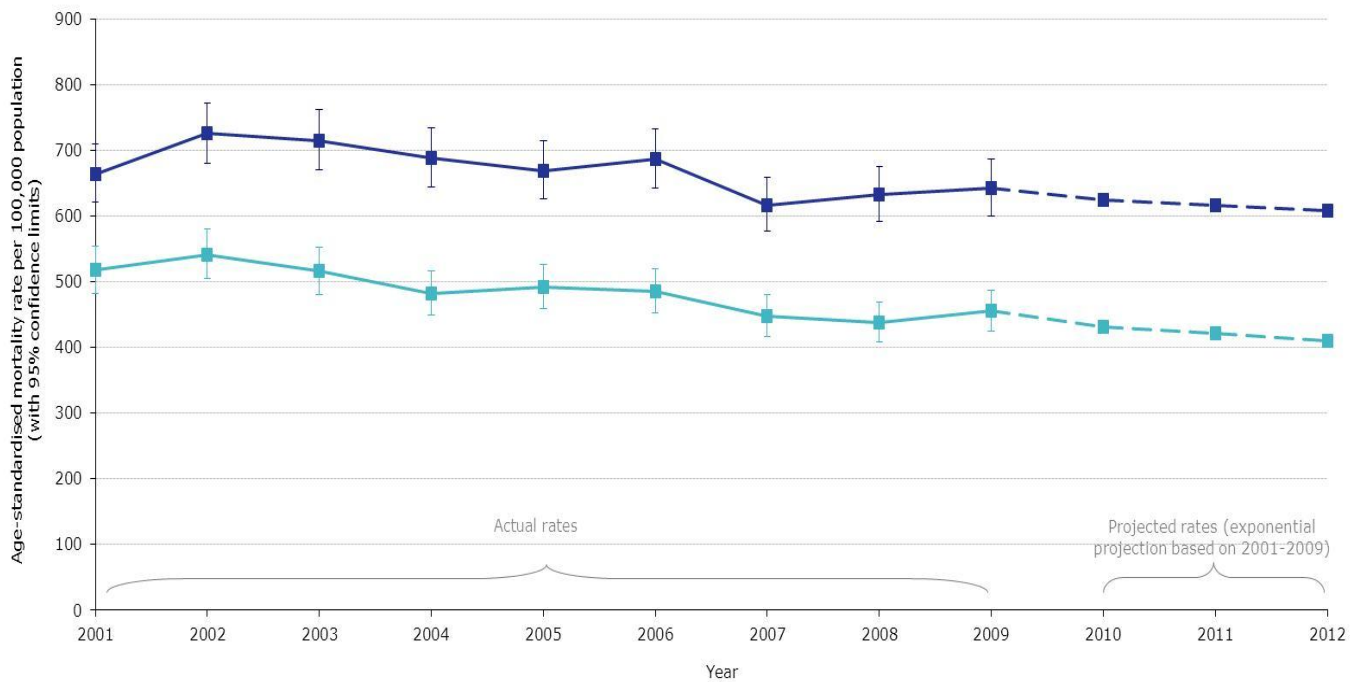
Source: SEPHO Health Inequalities Gap measurement Toolkit. http://www.sepho.org.uk/gap_intro.aspx

The Data shows that:
  ➢ The gap in death rates between the best and worst wards (the distance between the two lines) is fairly static over time.
  ➢ The overall trend in death rates is falling, indicating better health for everyone in general.
Also, we know that Oxfordshire's death rates are considerably lower than the national average - another reflection of our relatively good health overall. This highlights the two biggest common factors for most health data in Oxfordshire:
  ➢ We enjoy better health than the England average
  ➢ There are marked differences in health between the best off and worst off, and these trends are persisting.
The wards in the County with the lowest life expectancy are:
  ➢ Sandford - Oxford (73.1years)
  ➢ Carfax – Oxford (73.6 years)
  ➢ Caversfield- Bicester (74.7 years)
  ➢ Blackbird Leys – Oxford (74.8 years)
  ➢ Banbury Grimsbury and Castle – Banbury (75.5 years)
  ➢ Northfield Brook – Oxford (77.8 years)

The wards in the County with the highest life expectancy are:

➢ Didcot Ladygrove – (90.3 years)
➢ Bicester South (86.4 years)
➢ North Leigh (85.2 years)
➢ Abingdon Dunmore – (84.9 years)
➢ Burford (84.9 years)

Source: Office of National Statistics, Life expectancy at birth for wards in England and Wales, 1999-2003 (experimental), Results for all persons.

Recommendations

Keeping up the pressure to break the cycle of disadvantage.
By October 2013 The Health and Wellbeing Board should ensure that the updated Joint Health and Wellbeing Strategy continues to have reduction of inequalities as a major theme.
This should include improvements in educational attainment, improvements in obesity and in breastfeeding.

By March 2014 Oxfordshire's Thriving Families programme should demonstrate a measurable impact on wellbeing of our most needy families.
The database of families most in need of help should also be maintained.

By March 2014, Oxfordshire Clinical Commissioning Group should be able to demonstrate practical results to reduce disadvantage in each of its localities.

By March 2014 the Health Improvement Board should have monitored any impact on housing and homelessness arising from recent changes to benefit entitlements homelessness. If these changes have an impact on health and wellbeing, the Health Improvement Board should coordinate action to ameliorate this.

Chapter 3 – Mental Health: Avoiding a Cinderella Service

Why does mental health matter?
There are three main reasons.
The first is that mental health problems are common in England, and Oxfordshire is no exception. For example
 ➢ 64,500 people in Oxfordshire suffer from common conditions in this County such as anxiety and depression.
 ➢ 5,000 people in Oxfordshire suffer from severe mental health problems such as schizophrenia
 ➢ 3,200 people in Oxfordshire suffer from dementia and this figure will rise as the population ages.

The second reason mental health matters is that it cannot be separated from physical health. The one can cause the other. For example if you are suffering from chronic lung disease and you are also depressed, your health outcomes will be worse.

The third reason is that mental health problems occur hand in hand with some of the most serious social issues we face as a society, such as homelessness, alcoholism and drug addiction.

These are the 3 reasons why mental health will remain a main priority for this annual report.

The next section reviews progress made over the last year and looks ahead to the challenges we face.

A good, year but storm clouds are gathering
Useful progress has been made during the last year in the following areas:
Strategic alignment of plans - the new GP led Clinical Commissioning Group has adopted the 'Better Mental Health in Oxfordshire Strategy' and the Health and Wellbeing Board has adopted a raft of mental health priorities as part of its Joint Health and Wellbeing Strategy.
Direct payments - good progress has been made in making direct payments to people with mental health problems so that they can have a bigger say about the type of care they receive.
Successful recovery and wellbeing services - the new 'Keeping People Well' service, which aims to ensure those recovering from Mental Health problems are supported, has had a good year with more than 2,000 patient contacts.
Public involvement. The new Public Involvement Network has had success in engaging people who have mental health problems
Integrating services for mental and physical health - new services are planned to support people with physical illness in our local hospitals with mental health services.
The service which supplies 'talking therapies' for people with common mental health problems has been extended - to cover young people and to improve the service for people from black and minority ethnic groups.
The dementia challenge - a huge amount of new work has begun to improve services for people with dementia. This is spearheaded by Oxford University Hospitals Trust and Oxford Health Foundation Trust and brings together all services from the NHS, Local Government and academia.

The storm clouds

We have come a long way in improving mental health and mental health services in this County over the last five years. We now need to prepare to meet a new set of challenges which are growing.

In order to protect the people of Oxfordshire we need to respond to these challenges now. The challenges are:

The danger of integration - Integrating mental health and physical health services is a good idea. However there is a real danger that the focus on mental health issues will be lost within the much bigger topic of physical health services.

Our success in improving mental health services in Oxfordshire arose from focussing specifically on mental health services. We need to make sure this focus is not lost

The need to ensure that severe and enduring mental health problems do not lose out to less severe mental illness.

The focus of recent years has rightly been on improving services for common conditions and dementia and on improving our commissioning. We are now moving on to new services which join up mental health and physical health services.

All of these things are good, but the overall pay packet we are dipping into is not getting any bigger. We are in effect trying to stretch the same old balloon of resources and hoping it does not burst.

Above all we need to take action to ensure that services designed to treat severe and enduring illnesses such as schizophrenia and manic depression do not lose out.

Homelessness: a new threat?

The chapter on breaking the cycle of disadvantage has highlighted the potential issue of an increase in the number of homeless people in society. People with severe mental illness who are on the brink of homelessness face a triple whammy (particularly in Oxford City) of high housing costs, the possible impact of changes in the benefits system and practical difficulties in getting a job. Action is needed to guard against this.

Summary

We have kept up the positive progress on mental health issues in this County over the last year and there are more promising developments on the horizon.

However we also now need to take steps to ensure that the storm clouds gathering on the horizon do not combine to produce a tempest which sweeps our best efforts away.

In this context, the following recommendations are appropriate:

Recommendations

Keeping up the good work
  - ➢ Close monitoring is required to make sure that recent gains are not lost. The Health and Wellbeing Board should continue to treat mental health issues as a priority and this should be included in the refreshed Joint Health and Wellbeing Strategy by October 2013.

Keeping a close eye on serious mental illness.

➢ By March 2014.Oxfordshire's Clinical Commissioning Group should monitor the health of people with severe and enduring mental illnesses to ensure that standards of care do not fall.

Keeping a close eye on homelessness.

➢ By March 2014 the Health Improvement Board should have monitored any impact on housing and homelessness arising from recent changes to benefit entitlements. If these changes have an impact on health and wellbeing, the Health Improvement Board should coordinate action to ameliorate this.

Chapter 4 – The Rising Tide of Obesity[2]

'If you were the standing on the bridge of HMS Oxfordshire you'd be pressing the panic button as the iceberg of obesity loomed dead ahead......'

The Facts
The problem is that every little lifestyle choice you make, or make for your children, decides whether you will put on weight or not. After a decade or so you wake up one day and find that you're in the red zone on the bathroom scales. To a large extent it's your choice, but it's a choice we should all make with our eyes wide open. Why should we care?
Because:

➢ Being obese knocks around 9 years off your lifespan
➢ Once obesity is established in childhood it is very hard to shake off in later life.
➢ Obesity can lead to high blood pressure and long term conditions such as diabetes, heart disease, stroke and cancer which lead to premature death and drive the costs of health and social care which we cannot afford.
➢ The risk of getting diabetes is up to 7 times greater in obese women and up to 5 times greater in obese men.
➢ 1 in 10 of all cancer deaths among non-smokers is linked to obesity.
➢ Obesity decreases mobility making independent living harder which boosts the bill for social care.
➢ The risks of obesity causing diabetes are higher in some groups than others. If you are of South Asian origin your risk of developing type 2 Diabetes is 4 times greater, whilst those from Black African origins have a risk 3 times greater than the white population. Given the changes in Oxfordshire's ethnic minority profile this will become an increasingly important issue.

But it's not all doom and gloom. Next to giving up smoking, losing just a bit of weight is the best favour you can do yourself in terms of your health. The good news is that taking action really does work - a reduction in 10% of body weight gives the following benefits, even if you don't return to a normal weight category. So, if you weigh 12 stone, getting down to just under 11 stone means:

➢ a 20% fall in your chances of dying in any one year
➢ a 30% reduction in your chance of dying from a cause linked to diabetes.
➢ a 40% reduction in your chance of dying from an obesity-related cancer (e.g. bowel cancer).
➢ a 90% decrease in the symptoms of angina.
➢ a significant reduction in blood pressure and cholesterol levels.

Now that's a really good deal!

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[2] [2] Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.
Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).
The WHO definition is:
• a BMI greater than or equal to 25 is overweight
• a BMI greater than or equal to 30 is obesity.

How does Oxfordshire compare with elsewhere?
We have very good data about childhood overweight and obesity thanks to our child measurement programme in schools (this is highlighted in Chapter 2 as indicator 7). This shows that we are still doing better than the national average…… but doing better during what amounts to a national epidemic of obesity is cold comfort.

Data on obesity in adults is less reliable, but again shows that our Region is generally healthier than the national average.

However, the fact remains that around 1 in 4 adults in this County (and rising) are obese

Also, on the exercise front, we are still measured as the sportiest County in the Country for the second year in a row. This is a great achievement and our Sports Partnership is to be congratulated. So, the conclusion is that Oxfordshire is still bucking the national trend – but not by much and not by enough.

Why are we as a society sliding into obesity?
It's really quite simple. There seems to be a delicate balance between eating and exercising as to whether or not we put on weight, and as a nation we tipped over the balance point about 30 years ago. To put it simply, we now eat more and exercise less. We ride in cars when we could walk, we take the lift not the stairs and we eat sweets and biscuits and burgers and drink more beer and wine. We pass on these messages to our children and hey presto! We have obesity.

What can we do about it at local level?
A lot of the causes are complex and are linked to national policies and how we behave as a nation. So what can we do locally?
The key is to take a long term view, stay focused and be persistent. This isn't a quick fix - it's a case of turning The Titanic around. It has taken us a few decades to get into the current situation and it will take decades to get out of it again.
Much work is going on in Oxfordshire and this is a priority for our Health and Wellbeing Board.
We are increasing physical activity initiatives, getting a healthy eating message 'out there' and helping people who are overweight to access treatments. We are joining up agencies to address obesity in a concerted way using the best available evidence. For example:

Initiatives with children
> Oxfordshire has over 50 practitioners who are trained to deliver parenting courses covering Heath, Exercise and Nutrition for the Really Young (HENRY). In 2012, 20 courses were delivered in Children's Centres across Oxfordshire reaching over 160 families
> To celebrate Playday in Oxfordshire a record number of large, community events took place across the County in 2012. Approximately 16,000 people attended the 12 events run in local communities and on Armed Forces bases across Oxfordshire.

Initiatives with adults
> In 2012, the Oxfordshire Sports Partnership launched the popular **Active Women project** which is helping to get more women taking part in Athletics, Badminton, Tennis, Netball, Football and Gymnastics by removing barriers such as lack of childcare, inconvenience, no 'buddy' to play with and expense.

➢ The *Get Oxfordshire Active* **(GO Active)** partnership continues to go from strength to strength and from April 2011- March 2012, 7,296 new participants attended activity sessions such as Just Jog, Zumba and Health Walks throughout the year.

➢ Oxfordshire Weight Loss and Lifestyle Service (OWLS) continue to support obese adults in the efforts to achieve a healthier weight. From Sept 2011 - August 12, 483 patients were referred by their GP and 446 people joined the lifestyle programme. On average, 77% of those who attend the intensive 12 week programme lose weight. Of those who stay on the programme for the full 12 months, approximately half maintain a minimum of 5% weight loss.

➢ Generation Games is a physical activity service for all 50+ in Oxfordshire, delivered by Age UK and commissioned by Oxfordshire Clinical Commissioning group. With a focus on fun and enjoyment, the service offers everything from dance and Tai Chi to seated exercise, bowls and lots more.

What did we say last year?
The aim last year was two-fold:

1. To emphasise the fight against obesity is the most important lifestyle challenge for the County

   And

2. To make sure the Health and Wellbeing Board took obesity seriously, working to a re-vamped County Strategy that would bind all partners together through regular network meetings. Getting this strategic work right gives us the right framework for all our work and helps to make our efforts count for more.

All of these things were achieved.

Recommendations

Keeping obesity high on the health agenda
By October 2014 The Health and Wellbeing board should have refreshed the Joint Health and Wellbeing Strategy to include child obesity as a main priority.

Working hand in hand with partners
By October 2014 the Health Improvement Board should ensure that partnerships to tackle obesity and promote physical exercise are thriving. This should include a full role for District Councils.

Commissioning a wider range of services
By March 2014 the Public Health Directorate should have completed commissioning a full range of services to prevent obesity and to facilitate treatment for it, according to need.

Chapter 5 – Alcohol what's your poison?

'Alcohol is a serious issue. We mustn't sweep it under the carpet.'

During the last year there was no sign that levels of alcohol consumption have decreased and hospital admissions for alcohol related disease continued to rise.

This issue is one of the biggest challenges we face and we are still storing up worse for the future.
In trying to prevent the harm alcohol causes we still have one arm tied behind our backs as cut price booze, relaxed licensing laws and a society that lionizes 'shot drinking' work against us.

So what's all the fuss about?
Let's recap on the issues:
- ➢ Alcohol consumption has risen in the last 40 years and continues to rise.
- ➢ 1 in 5 adults exceed recommended drink levels
- ➢ Drinking in young people has increased, with binge drinking large quantities of spirits seen as the yardstick of a good night out.
- ➢ Alcohol causes disease – this year's 'Health Survey for England' links alcohol as a cause of more than 60 diseases including cancer of the mouth, throat, stomach, liver and breast as well as causing high blood pressure, cirrhosis and depression.
- ➢ The annual cost to the NHS alone has been estimated at £2.7 Billion per year.
- ➢ Alcohol led to 8,747 deaths in the UK in 2011 and leads to 304,200 unnecessary hospital admissions per year and rising.
- ➢ Alcohol is getting cheaper and is easily available - the unit cost of a shot of booze is less than 50% of the cost in the late 80s
- ➢ The health benefits are over-stated. It is an urban myth that some alcohol daily is wholly good for you. It is true that for the over 40s drinking a small amount of alcohol may reduce the risk of heart disease and stroke, but this doesn't apply to the under 40s or to the over 40s who drink more. In addition, any amount of alcohol always increases your risk of cancer.
- ➢ Alcohol damages families and social networks. It is a major factor in domestic violence.
- ➢ Alcohol fuels anti-social behaviour especially at weekends in towns across our County.
- ➢ Alcohol hits the taxpayer hard in terms of emergency services, hospital services and the cost of cleaning up our towns the morning after the 'party'.

Isn't this all a bit 'killjoy' and 'nannying'?
The scientific facts say not. It is simply a factual issue and the problem needs to be plainly stated so we can decide what to do about it.

The **majority** of drinkers are not harmed, but a **worrying minority** are - and they tend to harm society and those around them too.

The chart below shows local hospital admissions due to conditions caused by alcohol. It makes stark reading. These are 'our' people in 'our' local hospitals. They are suffering and the public purse is suffering. It is a practical problem.

Directly age-standardised rate of alcohol-attributable hospital admissions- 2005/06 to 2010/11
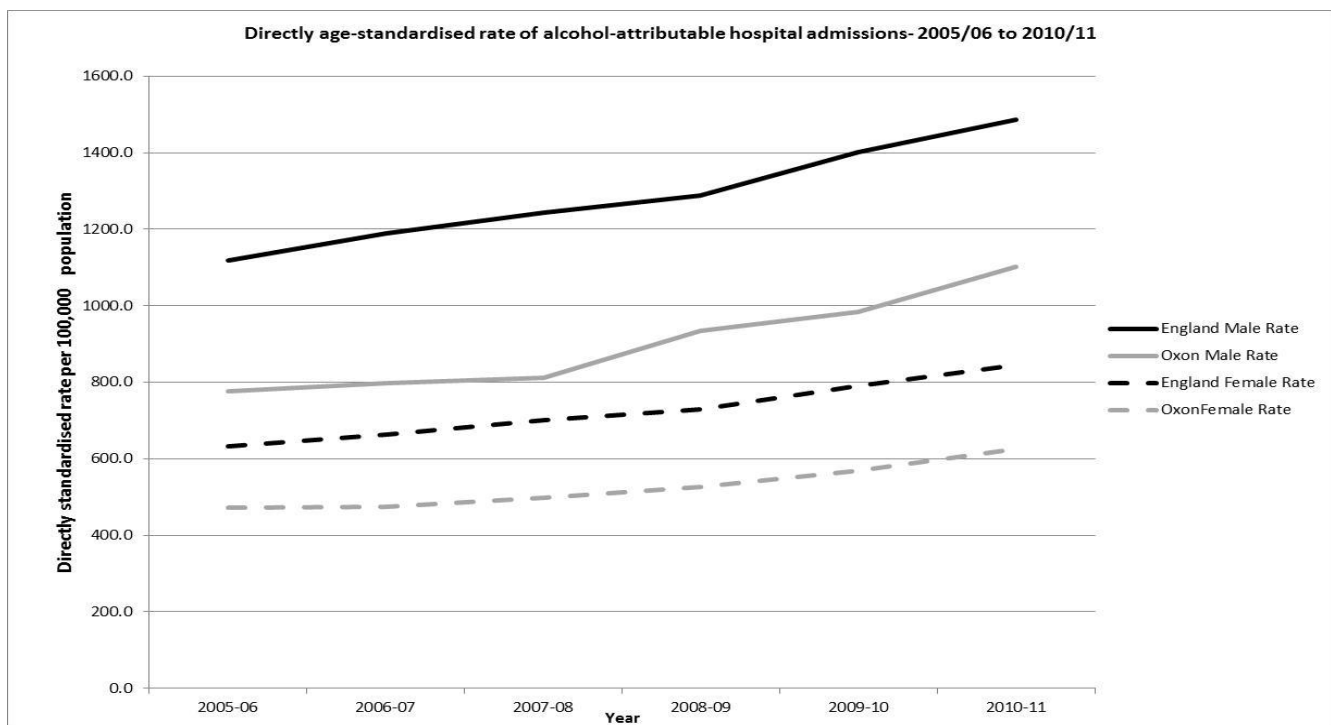
Source: North West Public Health Observatory (NWPHO) from Hospital Episodes Statistics (on-line extract) and Office for National Statistics (ONS) mid-year population estimates.

The chart above shows three main things:
1) Hospital admissions related to alcohol are climbing fast locally and nationally
2) Women are less affected by men – but they are still affected
3) The problem in Oxfordshire is less than the National average – but it is still a big problem.

Sometimes it is thought that this is a problem primarily about young people but the figures say otherwise – the average age of people admitted with these problems is 55 to 64, often the result of a lengthy drinking career.

Is there a happy medium?
It's difficult to say. Most people drink moderately throughout their lives with no real problem….. and yet alcohol is undeniably an addictive poison. The problems come from three main places:
➢ The results of binge drinking in the young and
➢ The slippery slope of alcohol addiction and slowly increasing consumption over the decades which harms people and their families over a whole 'drinking career'.
➢ The impact on society which falls on families, employers and public services

There are three things we can do:

1) Put the brakes on supply at National level
In 2012 the National Alcohol Strategy set out possible measures that can be implemented by Central Government to "Turn the Tide" of alcohol related harm. A formal consultation on some of these ideas was held in early 2013.   A wide range of partners in Oxfordshire collaborated in responding to the consultation. They supported proposals to introduce minimum unit pricing of alcohol and to ensure that health services have a say in licensing decisions where there is an impact on health and wellbeing. They were opposed to proposals to allow other businesses to be licensed to sell alcohol on the premises, such as beauty parlours

and hairdressers. A response from the Government following this consultation is still awaited at the time of writing.

2) Prevention: Keep putting the message 'out there'
We need to keep up the efforts to promote the message of sensible drinking. This needs to be aimed separately at young people and at adults. During the year we have run campaigns to target men, drink drivers and the military. It is a case of endless drip drip drip…….

We will need to work with schools as they change to Academy status to work out how we keep this work going. We also need to make sure our partnerships are strong across the public sector so that we make the most of our combined muscle. Many partner organisations including the police, the NHS, District Councils and County Council have been through a great deal of change in the last couple of years and a period of consolidation is needed to rebuild our strength.

The importance of **'brief advice'** cannot be overstated too. This happens when a professional gives someone specific advice about their drinking in a quick and efficient manner. It has been proved to work and we have a good training scheme in place in Oxfordshire which we need to push further. So far we have trained staff in the health, probation, social care, youth services, prison, housing and mental health services. Next year GPs will be paid a supplement to provide brief advice too which should be a real help.

3) Minimise the harm that is caused.
This is all about the 'blue light' services working closely with licensees, Local Government, A and E departments, street pastors and a host of others. It is about being careful about granting licences and also about putting safeguards in place to keep people and property safe and minimise the damage done.

Street pastors are a good example of what volunteers can do – helping people who are the worse for wear safely into a licensed cab at 3a.m. with the help of a 'taxi marshal' can make all the difference. *But it's still sweeping up the mess after the party and is second best to prevention.*

What did we say last year?
We said we should clarify the roles of the strategic groups involved in this area, including the Safer Communities Partnership and the Health and Wellbeing Board, and this has been done.

We also said that we should strengthen the work on education and brief advice and we have made good progress here too. However we still need to do more to get the prevention message across and make more people and organisations up to the need to take this issue seriously.

Recommendations

Better Strategic Alignment
Oxfordshire's Safer Communities Partnership should continue to consider work on alcohol as a priority.
By March 2014, the work programmes of the Safer Communities Partnership, the Drug and Alcohol Action Team and the Police and Crime Commissioner should be fully aligned.

Brief Interventions
By March 2014 a wide range of professionals should have been trained to offer brief interventions and GPs should be offering this service across the County as part of the NHS Health Checks programme.

Chapter 6 - Fighting Killer Diseases

Killer infectious diseases remain a constant threat to good health. It is a duty of Directors of Public Health in Local Authorities to keep watch over them. Without good monitoring, careful prevention and swift treatment they can easily cause major problems. We should not let the recent decades of the 'age of antibiotics' catch us off guard. Diseases such as these are capable of changing and mutating so it is important we keep our guard up.

Oxfordshire's record shows that this vigilance pays off. New cases of hospital superbugs and HIV are all currently in decline, but without simple measures such as good immunisation and safe sex they would be hitting the headlines again. We will need to be extra vigilant over the coming year as the current responsibilities for communicable disease go into a 4 way split between the new Clinical Commissioning Group, the NHS England in Thames Valley, the County Council and Public Health England. District Councils also continue to have a role in enforcing Environmental Health legislation.

The new responsibilities will look like this:

| Organisation	Roles and Responsibilities
Oxon Clinical Commissioning group	Responsible for commissioning most hospital services and all community hospital and community nursing services such as District Nurses. Covers infectious disease prevention and control, TB services and hospital superbugs.
NHS England	Responsible for buying expensive specialist services such as HIV care, taking a lead role in co-ordinating the NHS response to major outbreaks and pandemics, buying GP services, which includes immunisation and some screening services
Oxfordshire County Council	Has a Watchdog and oversight role and acting as an 'honest broker' between all organisations to ensure that the local population remains safe and that any threats are dealt with effectively. Promoting Public awareness
Public Health England	Keeps a watching brief on communicable diseases and reporting concerns to local Directors of Public Health. Deals with and co-ordinates response to outbreaks of infectious disease.
District Councils	Through Environmental Health, works with Public Health England to manage outbreaks locally.

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

1. Superbugs, known as Health Care Associated Infections (HCAIs) - Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Diff.)

Infections caused by superbugs like *Methicillin Resistant Staphylococcus Aureus* (MRSA) and *Clostridium difficile* (*C.diff*.) remain an important cause of sickness and death, both in hospitals and in the community. However, numbers of infections **can and have been** reduced through considerable focussed effort in this County. Both of these superbugs are now under control or in decline thanks to basic good hygiene like careful hand washing in healthcare settings. **This is an impressive achievement for healthcare in Oxfordshire.**

The two charts below speak for themselves. In 2011/12 there were 15 cases of MRSA across all of Oxfordshire's residents, no matter where they were treated.

We need to keep an eye on MRSA to ensure that the numbers of cases stay low and don't start to creep up again. This is now the responsibility of the new Clinical Commissioning Group.
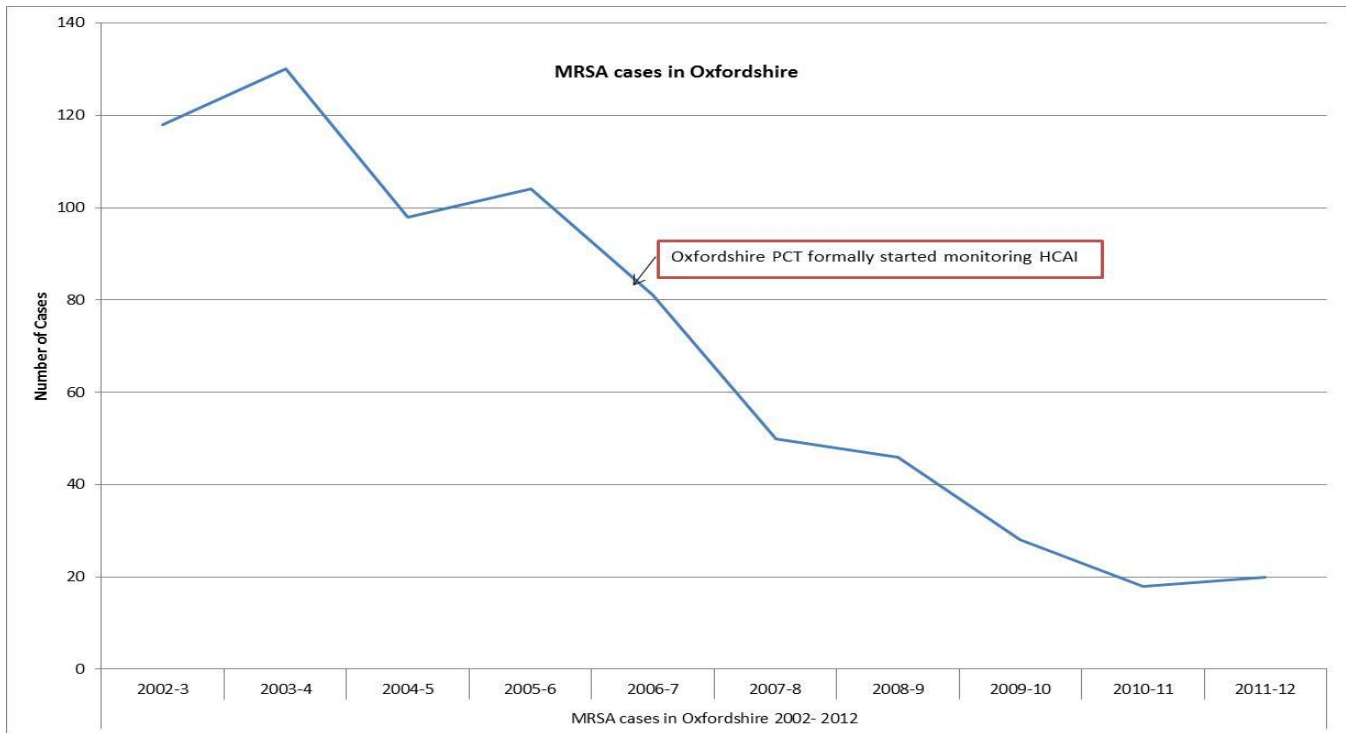
Source: Health Protection Agency (HPA)
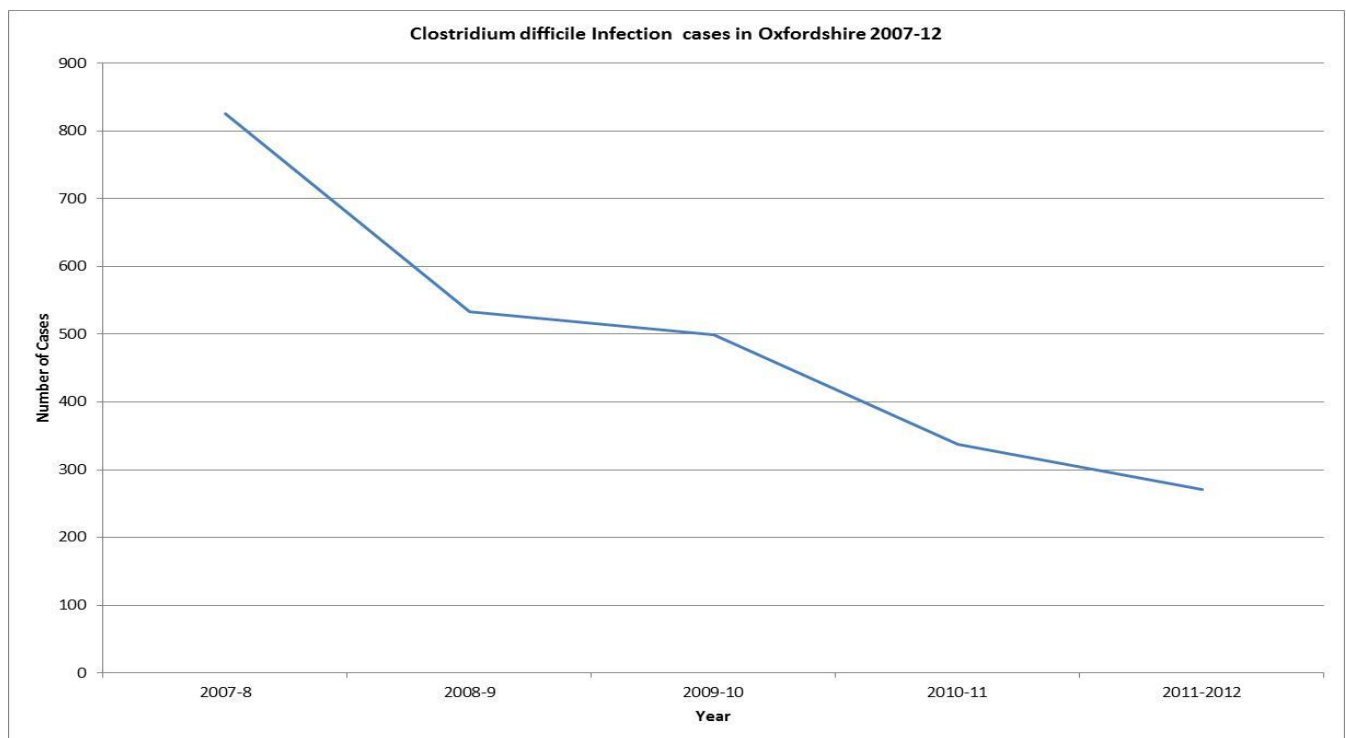
Source: Health Protection Agency (HPA)

Whilst the number of Clostridium Difficile cases has also fallen, the rate in Oxfordshire is still higher than the national average and we need to make a concerted effort to reduce cases further, so that they are in line with the national average.

2. Tuberculosis (TB) in Oxfordshire

TB is caused by a bug that can infect any part of the body, but most commonly affects the lungs. If not treated properly, TB can lay dormant and re-emerge years after the initial infection. When active lung disease is present, TB is infectious. It is important to identify and treat such cases quickly. Treatment is effective but requires long term antibiotics and completing the course properly is crucial to completely cure the infection and for preventing the bugs becoming antibiotic resistant.

Homeless communities, those suffering from alcohol or drug-misuse, people who are immune-suppressed, and people from countries that have a high incidence of TB are more likely to have Tuberculosis.

In Oxfordshire, the county average rate for new cases is consistently lower than the UK rate- we have around 1/3 fewer cases than the UK average. There were 69 cases of TB reported in Oxfordshire in 2011 compared to 59 in 2010. This increase is largely due to us detecting new cases more effectively. Continued vigilance is essential for maintaining our good progress.

This topic has also benefited from the close attention of the Health Overview and Scrutiny Committee (HOSC) who regularly assure themselves that all reasonable steps are being taken.

Tuberculosis incidence rate in Oxfordshire

Year	Number of Cases	Rate per 100,000 population
2006	53	8.4
2007	76	12.0
2008	56	8.8
2009	55	8.6
2010	61	9.5
2011	69	10.7

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

Over the past 5 years the rates of new cases occurring, and the number of cases, has remained highest in Oxford City and Cherwell District Council.

TB incidence rate by Local Authority, Oxfordshire, 2011

Local Authority	Cases	Population	Rate per 100,000 population
Cherwell	16	142,300	11.2
Oxford	43	150,200	28.6
South Oxfordshire	Less than 5	135,000	3.0
Vale of White Horse	6	121,900	4.9
West Oxfordshire	Less than 5	105,400	2.8
Oxfordshire	69	654,800	10.7
UK			14.4

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

The main interventions to control tuberculosis are early diagnosis and completing the long course of treatment. Oxfordshire does very well, with 98% of cases completing treatment. This compares favourably with the Chief Medical Officer's target of 85%.

Given the increased incidence of TB in those who are homeless, mobile x-ray screening was undertaken in this group in Oxford this year. No TB was found on screening a large proportion of Oxford's homeless population. This offers some reassurance that cases among this population are being diagnosed promptly by local healthcare services.

3. **Other Diseases Preventable by Immunisation**

   a) **Childhood immunisations**

   Major life-threatening diseases can be prevented by immunisation in childhood. The World Health Organisation (WHO) sets this threshold for good coverage at 95%.

   Immunisation coverage in Oxfordshire remains high compared to regional and national rates. A lot of effort has gone into tracking down un-immunised children one by one and by checking new children arriving in the County. Maintaining and improving this position requires constant effort.

   b) **Immunisation against Measles Mumps and Rubella (MMR)**

   The rates of measles and mumps infection decreased slightly between 2010 and 2011 in Oxfordshire; there were no cases of rubella. This is the result of relatively high immunisation rates of 93.6% for children who have had 2 doses by the age of 5. This is considerably higher than the national average of 89.1%, however it is still below the WHO recommended 95% uptake rate.

   Nationally, Measles has been in the spotlight, with cases increasing across the country. This is in part due to historical poor uptake of vaccination during the 1990s. When looking at our local figures, cases of measles have not increased.

Year	Number of Confirmed Cases
2010	9
2011	4
2012	6
2013 (January to April)	0

Source: Thames Valley Health Protection Unit

   We cannot be complacent and must be vigilant against outbreaks, which spread quickly within school environments and amongst unimmunised children/young people

   c) **Immunisation against Diphtheria, Tetanus, Pertussis (whooping cough), Polio, and Haemophilus Influenzae B (a type of meningitis); (DTaP/IPV/Hib)**

   2011 immunisation coverage rates remain high in Oxfordshire with 98.0% of babies being vaccinated before the age of 2 with these vaccines, well above the recommended 95% coverage rates but slightly lower than 98.7% achieved in 2010.

   There has been a rise in cases of pertussis (whooping cough) in Oxfordshire in 2011, which mirrors both the national pattern and the usual three year cycle of the disease.

   Oxfordshire's good progress is shown in the chart below.

Childhood Immunisations
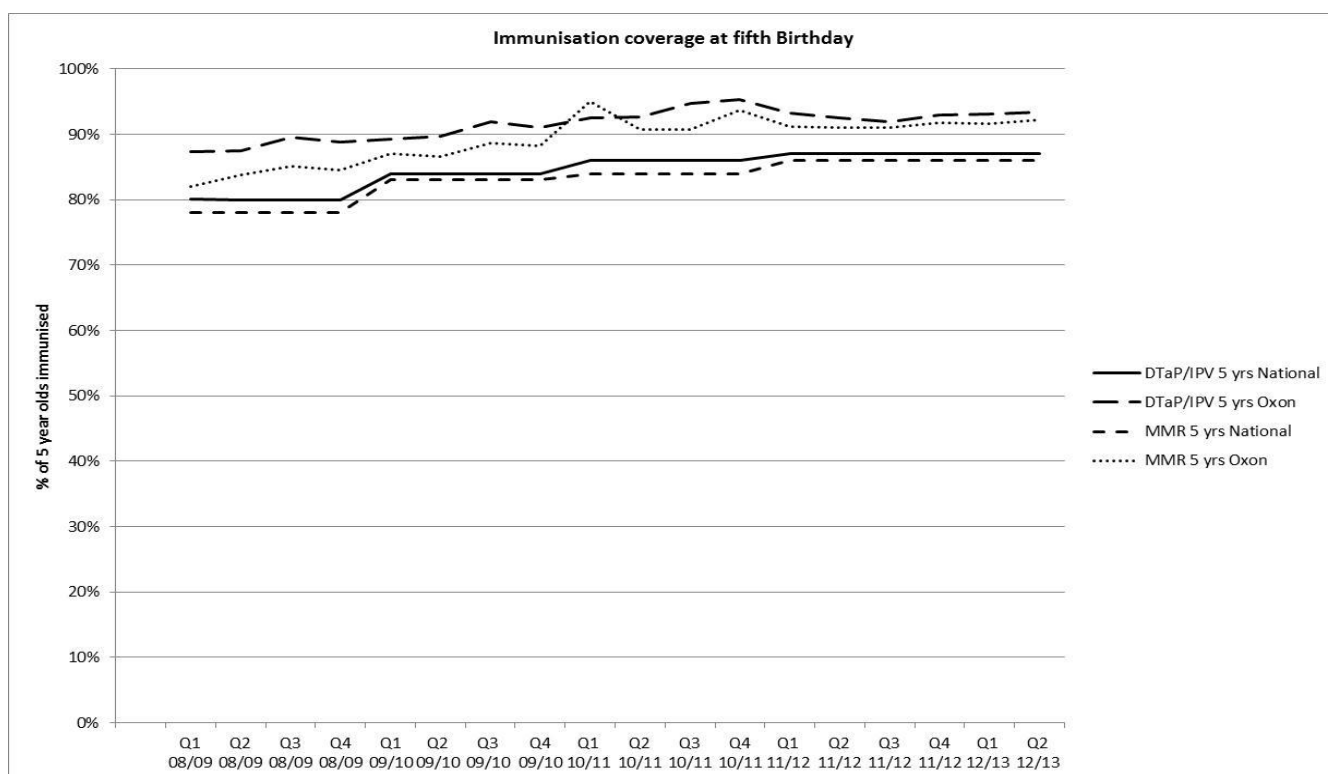
Source: - Health Protection Agency (HPA)

A warning about immunisations.
From the 1st April 2013, immunisation will move from being a County responsibility to a Thames Valley responsibility. The Thames Valley arm of NHS England will be responsible for immunisations. Local Directors of Public Health will work with them and will also act as watchdog to make sure that standards do not decline. The Health and Wellbeing Board and the Health Overview and Scrutiny Committee will help to oversee this. However, keeping immunisation rates high requires constant attention and there is a real risk that standards may fall. This will be monitored carefully and early action taken if required.

4. Sexually transmitted infections

a) HIV & AIDS
HIV remains a significant disease both nationally and locally. During 2011, Oxfordshire saw a drop in the number of new diagnoses.
There are now approximately 500 people living with HIV in Oxfordshire. The national report 'HIV in the United Kingdom: 2010'[3], suggests that ¼ of people with HIV have yet to receive a diagnosis. In Oxfordshire, this equates to another 125 people bringing the total estimated cases for Oxfordshire to 625.

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 two ways:

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[3] 2010, Health Protection Agency, HIV in the United Kingdom: 2010 report.

- 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 introduced 'HIV rapid testing' in three chemists 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 full test is required to confirm diagnosis.

HIV is now considered to be a long term disease and prognosis, once diagnosed, is good, with effective treatments. HIV cannot be cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly decreased.
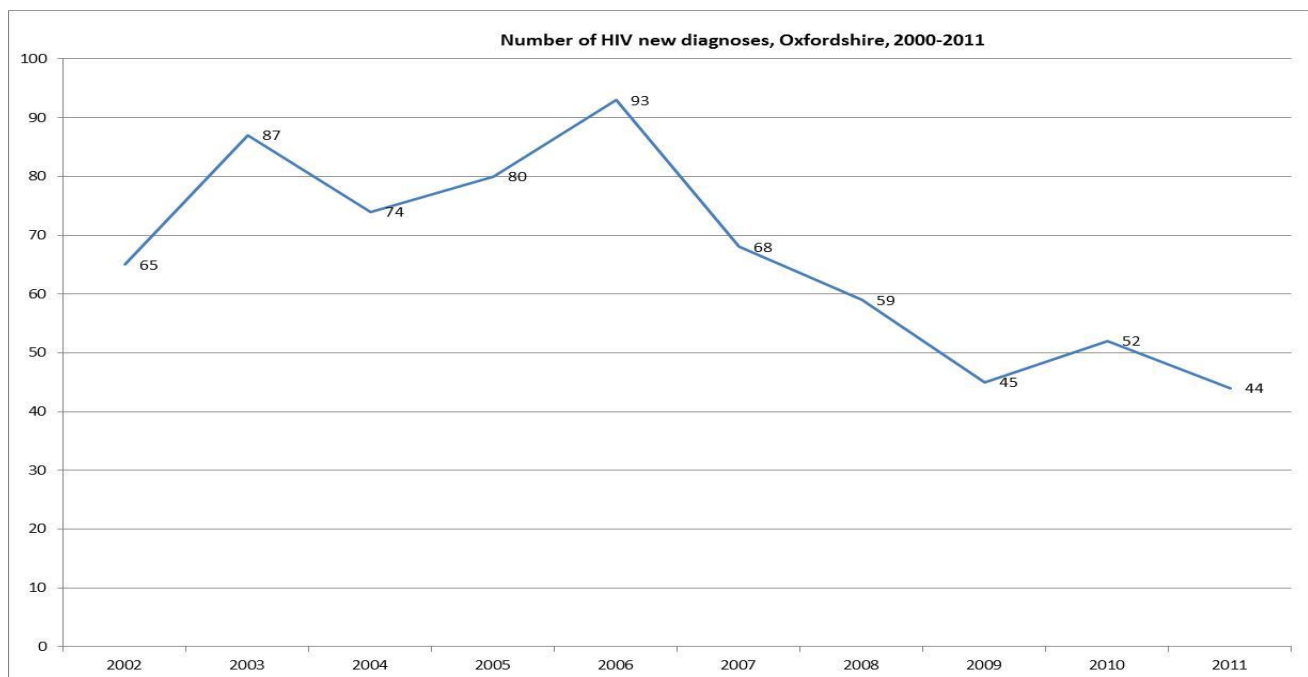
Source: HARs data set, Health Protection Agency (HPA)

b) 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'.

The different types of STI each show a mixed picture which is generally good. Looking at each disease in turn gives the following picture:

- Gonorrhoea – is falling and below national average in all areas of the County
- Syphilis - is falling and below national average in all areas of the County
- Chlamydia –levels are lower than national average – but we have had difficulties in persuading young people to come forward for testing despite, best efforts.
- Genital Warts – rates are slightly higher than national average, Oxford City is significantly higher (reflecting the younger age group) but the trend is stable.
- Genital Herpes – rates are lower than national average except in the City which has higher levels but not significantly so. The total number of cases in the year is small (125). Again this reflects the predominantly younger population in the City.

The following chart shows the overall picture:-
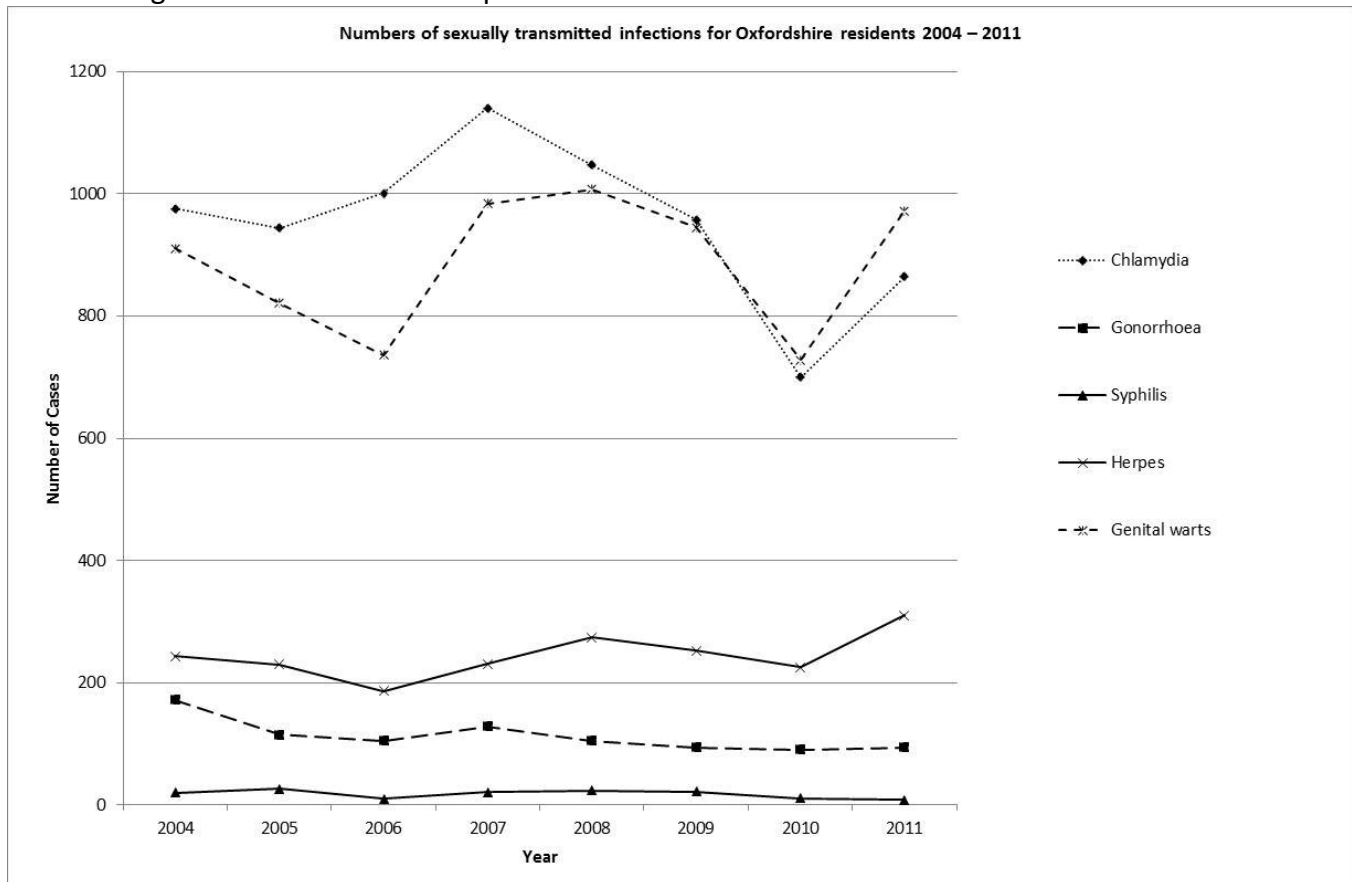
Source: Health Protection Agency - Sexually transmitted infections (STIs) annual data tables

What did we say last year about killer diseases?

Last year the recommendations were all about maintaining vigilance and not letting the situation slip – this has mostly been achieved. We do need to continue to monitor the situation around STIs closely.
 Much credit should also go to our local Health Protection Agency team (now a part of Public health England), who provide an excellent service and are great partners. This recommendation will need to be repeated for next year as responsibility for different killer diseases will go to the GP Commissioners, the NHS at Thames Valley level or to the County Council.

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

Recommendations

Maintain vigilance and priority after reorganisation
The Director of Public Health and the local Health Protection Agency must work closely during the forthcoming year to maintain surveillance of communicable diseases during 2013/14 and take appropriate steps to control these diseases and any new emerging killer diseases.

Active surveillance and monitoring of the NHS will be important as the Clinical Commissioning group and Thames Valley Area Team take up their new responsibilities.

The Health Improvement Board should be charged with overseeing the situation and escalating concerns immediately to the Health and Wellbeing Board and the Health Overview and Scrutiny Committees. This should be in place by September 2013.

The need to refocus on sexual health prevention and promotion
The Director of Public Health should review sexual health services and agree a plan which will include the re-commissioning of services by April 2014

The need to report on these figures in Public
The Director of Public Health should report on killer infections and infectious diseases in subsequent annual reports and should make strong recommendations to all of the organisations responsible to make improvements when this is required.

Acknowledgements

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

Documents and Sources of Information used to produce this Report

Census Data 2001 and 2011
Data from Govt Departments including Office of National Statistics
GP Consortia Information packs – March 2011
Health Protection Agency Infectious Disease data
Joint Strategic Needs Assessment versions 1 - 4
Learned journals
Oxfordshire Children and Young Peoples Plan indicators
Oxfordshire County Council Data Observatory
Oxfordshire PCT Performance data
Oxfordshire Safer Communities Partnership performance framework
Oxfordshire Safer Communities Partnerships Alcohol Strategy Group basket of indicators for Oxfordshire
Public Health Surveillance Dashboard
The Child Poverty Needs Assessment for Oxfordshire