DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT X

Reporting on 2016/17
Produced: August 2017

Contents

Foreword

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

This is my 10th 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 you find it 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.
August 2017

Chapter 1: The Demographic Challenge

Let's keep this simple.

There are two major challenges facing Oxfordshire:

➢ How do we cope with the increasing stresses and strains a growing population brings?

➢ How do we keep children and adults of all ages healthy so that disease is minimised as the population grows?

Of course there are many other problems and issues, but these two are the overwhelming ones, and this report looks at these two issues from many different angles.

This chapter focusses on the first of these two – the demographic challenge.

The demographic challenge is a challenge because of 5 interlocking factors:

1. The population is growing

2. The population is ageing

3. The proportion of older people is increasing

4. Public expectations are high

5. Money is tight

A further problem is rapidly approaching which will further complicate matters – being overweight is the new norm in adults and increasingly prevalent in younger people, and this will inevitably lead to higher levels of disease – but that's for chapter 4.

Disadvantage also acts as a brake to stop people achieving their full potential and this is another confounding factor – you will find that topic in chapter 3.

Population growth means we have to plan our communities better and poor air quality - generated by more people and more activity – is an important issue - covered in chapter 2.

All of these changes put stresses and strains on the mental wellbeing of young people – see chapter 5.

…… and of course, let's never forget the shadow cast by infectious disease – sleeping, but not defeated - chapter 6.

So let's look first at population growth and population ageing.

Population Growth

Between 2000 and 2015, the total population of Oxfordshire increased by 70,700 people (+12%) compared with 11% across England.
Plans for a significant expansion in new housing, following the Oxfordshire Strategic Housing Market Assessment, imply a growth in the population of Oxfordshire over the next 15 years of more than double that of the previous 15-year period.

Oxfordshire County Council population forecasts, based on expected housing growth, predict an increase in the number of Oxfordshire residents of 183,900 people (+27%) between 2015 and 2030.

This is a massive increase by any standards and will put a huge strain on our already stretched infrastructure such as roads and schools- a factor I will pick up in chapter 2.

Will Government funding of statutory services keep pace? No one knows the answer, but we do know that health and social services are already stretched to breaking point.
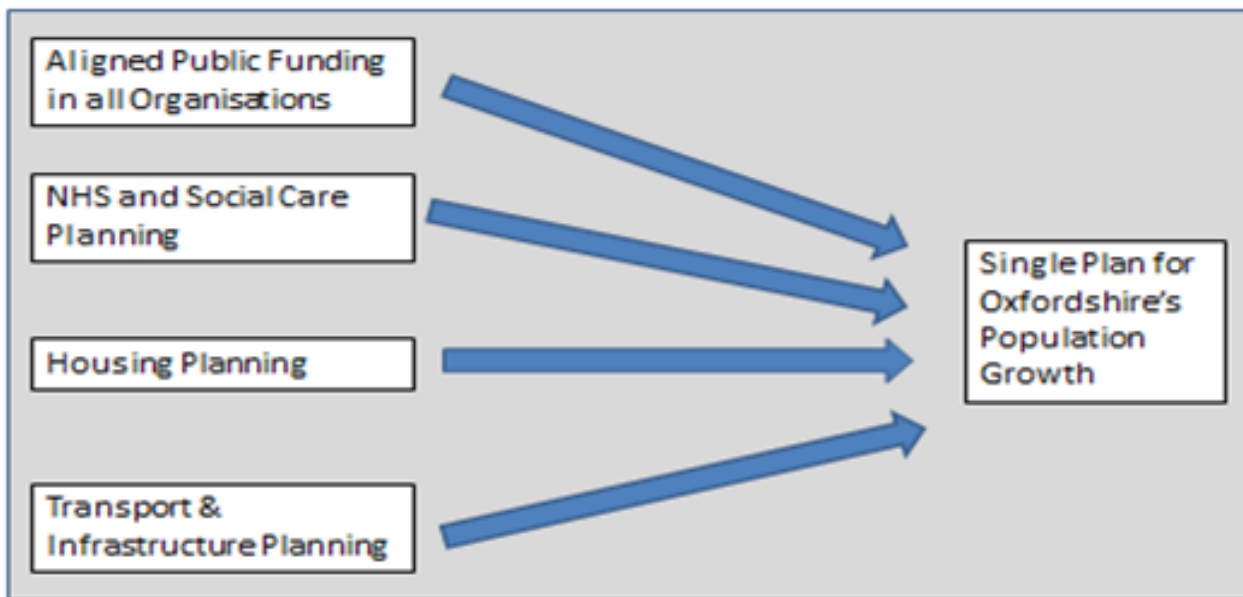
What we also know is that the old ways of doing things aren't likely to cope with such an increase as they stand. Our planning systems need to work far more slickly and intelligently if we are to have the transport systems people will demand. The daily commute will become increasingly tortuous and movement more difficult. Perhaps home working and IT solutions point the way forward.

Of course, people tend not to like change – it's hard-wired into us. During the last year local NHS organisations put forward proposals about radically changing the way hospitals and community services might be changed to cope with this pressure. The response was - to put it mildly - mixed. It's like one of those problems in which you push the problem down in one place but that makes it pop up in another – for example, the NHS proposed increasing the care carried out by people coming to hospitals for the day (ambulatory care), but it is outside the NHS's remit to plan for the increase in journeys and traffic and parking that implies, and so another problem is created.

All of this means that the problem of population growth is too big for any one organisation to cope with alone – we need to harness plans for housing, transport, the NHS and social care to the same yoke so that we can plough a single furrow.

We haven't solved this yet but the problem is staring senior executives and senior Councillors in the face. Necessity will, as always, drive the solution, and the solution we need is to craft a unified planning system.

In simple terms it will need to look something like this:

There are signs that we are closer to this than ever before, and these have occurred during the last 18 months. These are:

➢ Council Leaders and the NHS, Local Enterprise Partnership and the Universities debating new forms of local Government and Devolution

➢ The NHS trying to join up the currently fractured system through a single plan

➢ The Hospital Trusts and Universities reaching out to Local Authority planners to seek a `joined up' approach.

This is good. These are green shoots. They cause much controversy, but they are clear signs that all the big organisations are saying 'we can't go on as we are' and that is always the first step. No one knows where it will lead, but we seem to have begun the journey, and this is to be welcomed, for the problem of population growth is very real and the solution is likely to be radical.

Expected growth in housing

The plans for housing growth recommended for Oxfordshire shed a factual side-light on the scale of future population growth. In April 2014 the Oxfordshire Local Authorities, published the Strategic Housing Market Assessment (SHMA) for Oxfordshire.

The Assessment suggested that the demographic trends and growth of the County economy and the level of affordable housing required would necessitate **100,060** additional new homes in Oxfordshire between 2011 and 2031. More houses mean more people. There are currently over 600,000 people living in Oxfordshire. 100,060 more houses will swell this number considerably.

Up to the end of March 2016, just under 11,700 homes had been built in Oxfordshire and, since 2011, the year with the highest rate of housing completions was 2015/16 with 3,350 homes built. This leaves a remaining requirement of 88,400 new homes to be built by 2031, or just under

6,000 homes per year for each of the next 15 years. This is a contentious topic and is much debated. Where will the houses go? When exactly will they be built? Will they be grouped to make best use of the 'developer contributions' which can fund the sensible road and transport links we need? The risk is that a piecemeal planning system which doesn't take a view of the whole is less likely to help. This is another reason why organisations need to pull together if we are to cope.

The Strategic Housing Market Assessment represents a view of how Oxfordshire 'should' grow in the national context. Of course it's not just about houses. Houses mean people and people mean more roads, more schools and more workplaces….and more diseases. More people also implies a much higher volume of attendances at GP surgeries and hospitals and more need for social care. All of this requires careful planning and, as highlighted in previous annual reports, there is a widely shared view that our current planning processes are fragmented and won't cope well as they stand. Hence the need to move towards a single planning process.

During the year, a useful start has been made on this and the infrastructure requirements of all organisations across the County have been drawn together in one place in a document called Oxfordshire Infrastructure Strategy. This is a start and is to be applauded. The question is, can this be used to make the disparate cogs of the planning process turn as one smooth machine to serve local people? Only time will tell.

Where will the nurses, home care workers and ancillary staff come from?

The very real and tangible effects of population growth, the relative prosperity of Oxfordshire, low unemployment and sluggish housing growth of affordable housing all combine to create a very big problem for services.

It is becoming increasingly difficult to recruit the staff we need to fill nursing, caring and ancillary posts. In the last few weeks, I attended meetings where the hospital and social care services were spelling this out very clearly. Some hospital wards are for example reported to be running with 25% vacancies. This is unlikely to be sustainable. Looking at local house prices sheds light on this and underlines the problems of high house prices in Oxfordshire. The statistics are as follows:

Housing affordability

- In 2016, house prices in Britain were 10 times the annual salary of residents.
- **Oxford was the least affordable city, with house prices being 16.7 times higher than annual earnings** - on a par with London.
- Burnley was the most affordable city, with house prices being 4.1 times the average annual earnings – 4 times more affordable than Oxfordshire.
- All the top 10 least affordable cities were located in the South of England. The majority of the most affordable locations were in the North West and Yorkshire regions.
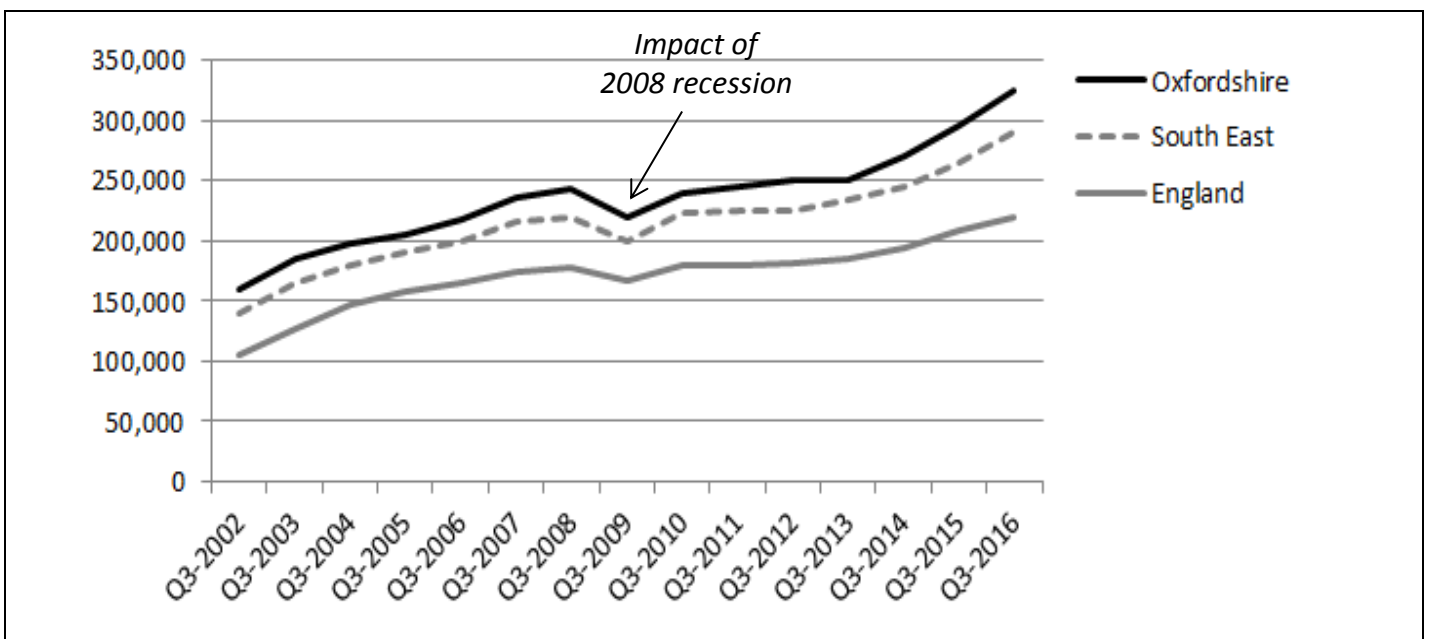
Here is the relevant table.

Housing affordability ratio

Rank	City	Affordability ratio	Average house price, 2016 (£)	Yearly wages, 2016 (£)
10 cities with the highest affordability ratio				
1	Oxford	16.7	491,900	29,400
2	London	16.7	561,400	33,700
3	Cambridge	15.8	475,800	30,100
4	Brighton	13.7	367,900	26,800
5	Bournemouth	12.5	309,300	24,700
6	Aldershot	11.6	360,400	31,200
7	Reading	11.3	375,200	33,300
8	Worthing	10.7	279,100	26,100
9	Exeter	10.5	253,500	24,100
10	Bristol	10.4	275,900	26,600

Trends in house prices

Over the past 10 years the increase in the median (mid-point) house price in Oxfordshire has been above the South East region and England. Between 2006 and 2016, the median price of housing in Oxfordshire increased from £218,000 to £325,000, an increase of 49% compared with 46% in the South East and 33% in England. The districts seeing the highest increase were Cherwell (60%) and Oxford (60%). In other words, the local affordability gap is getting worse compared with England.

Median house price 2002 to 2016

Source: ONS released March 2017; *These data are part of the House Price Statistics for Small Areas (HPSSAs) release, produced by ONS. These statistics report the count and median price of all dwellings sold and registered in a given year. They are calculated using open data from the Land Registry, a source of comprehensive record level administrative data on property transactions.*

Median house price 2006 to 2016

	Q3-2006	Q3-2016	Q3-2006 to Q3 2016	
Cherwell	£183,000	£292,250	£109,250	+60%
Oxford	£235,000	£375,000	£140,000	+60%
South Oxfordshire	£241,100	£355,000	£113,900	+47%
Vale of White Horse	£225,000	£325,000	£100,000	+44%
West Oxfordshire	£212,000	£300,000	£88,000	+42%
Oxfordshire	**£218,000**	**£325,000**	**£107,000**	**+49%**
South East	£198,950	£290,000	£91,050	+46%
England	£165,000	£220,000	£55,000	+33%

Source: ONS, released March 2017

All services are trying to find new ways to address this problem, and we are likely to need to look beyond the county boundary to developments around, say, High Wycombe to find the solution. Other options such as building hostels for workers are also being considered.

I have dwelt on housing prices because they illustrate with crystal clarity why the demographic challenge is real, it is here now, and it our most pressing challenge.

The ageing population

It is a blessing and a great achievement that people are living longer, often into a productive and active old age……… But it brings with it a new raft of issues for society to deal with…….

Growth of the population aged 65+

Between 2015 and 2030, Oxfordshire County Council predicts that the growth of people in the age group 65+ to be, 62,700 or **an increase of 53%.** This takes into account the plans available for new housing.
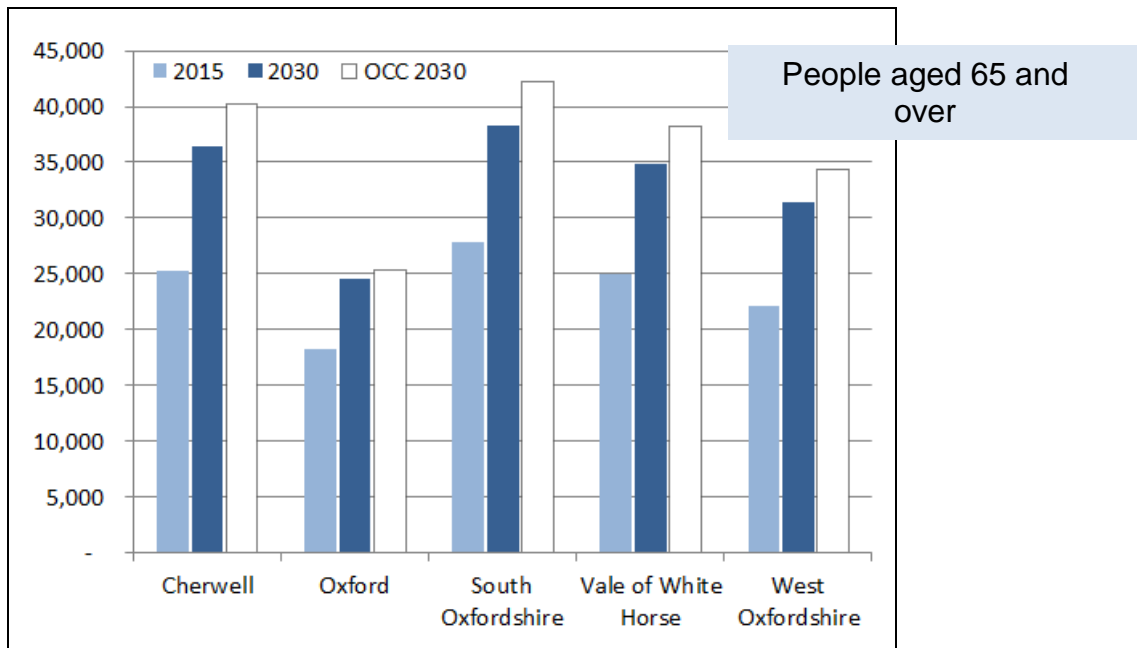
Growth of the population aged 85+

Between 2015 and 2030, Oxfordshire County Council predicts that the increase in people aged 85 and over in Oxfordshire to increase by +15,600 or **an increase of 96%** - a huge percentage increase.

Why does this matter? It is to be welcomed that life expectancy is increasing and in terms of opportunities it has been said that "70 is the new 50". But in planning terms it presents a serious dilemma. It matters because as well as being simply more people, it means more people in the age group who experience most long term disease and disability, and, with advances in treatment and care that means more expense per head than in previous decades….. and not only that…….

………….It matters also because at the same time the proportion of older to younger adults is increasing and this puts a pressure on the tax-base. Every penny going into the exchequer has to be made to go further while the demand on every pound increases.

Looking at this in more detail, different parts of the county are affected differently. The chart below tells the story. It shows the 65 plus population in 2015 and then shows two growth scenarios for 2030. The middle bar in each group shows the growth without house building and the bar on the right of each group takes account of what we know of planned housing growth.

Forecast growth in the number of people aged 65 and over between 2015 and 2030– ONS vs Oxfordshire County Council projections
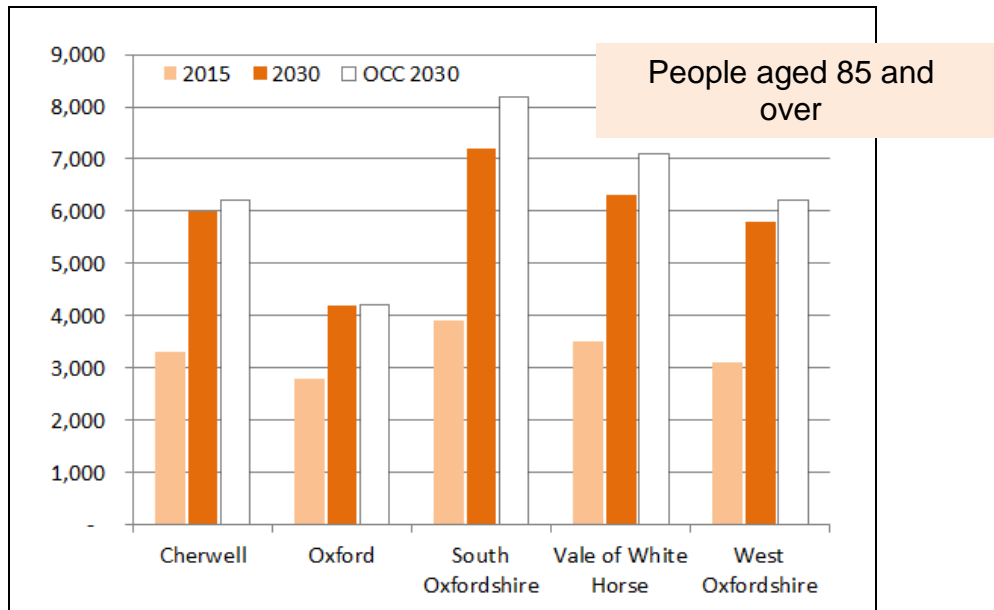

Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

➢ The rate of growth is pretty evenly spread across all Districts

➢ Housing increase swells the numbers considerably, apart from in Oxford where housing growth is constrained

Looking at the same data for over 85's using the same format gives the picture below:

**Forecast growth in the number of people aged 85 and over between 2015 and 2030
ONS and Oxfordshire County Council projections**

Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

➤ There is uneven growth. The city is the outlier as it has a 'younger' population.

➤ Housing growth adds to the predicted rise more in South Oxfordshire and Vale of the White Horse than elsewhere.

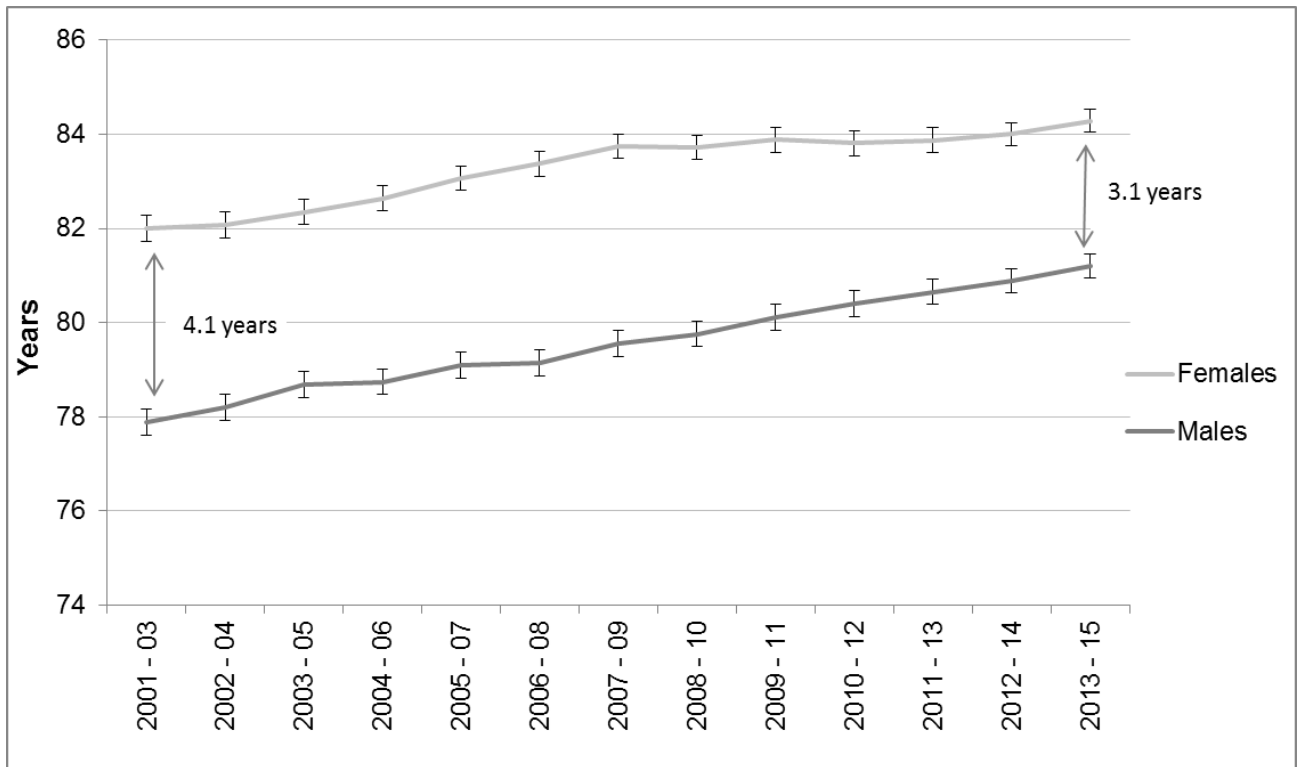OK, one might ask, so *the population is ageing, but is it getting healthier?*

…………………An interesting question with no easy overall answer.

We can shed light on it by comparing two statistics.

The first is called 'life expectancy at birth' which estimates the average number of years a person born in an area could expect to live if they were to experience that area's mortality rates in the future. It's a best estimate, as no one really knows the exact answer.

It predicts that both males and females will continue to live longer. The gap between male and female life expectancy in Oxfordshire is narrowing. The gap in 2013-15 is the same as it was in 2012-14. A similar narrowing can be seen for England and in the South East region, so this is a national trend.

**Male and female life expectancy at birth in Oxfordshire,
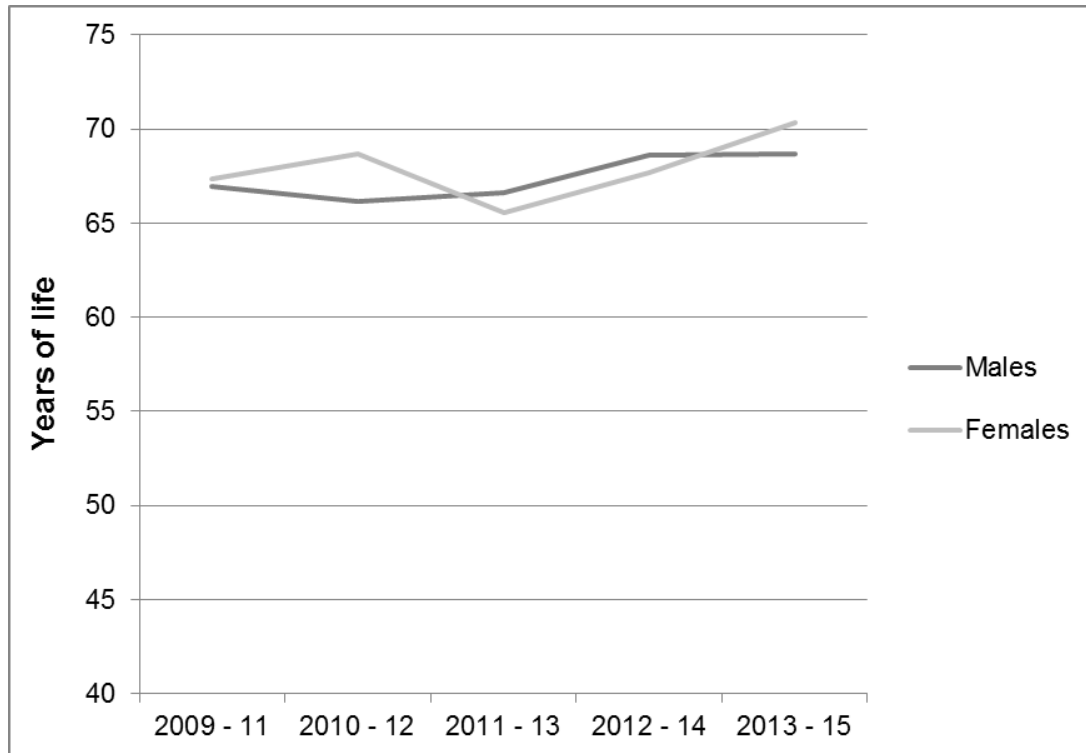3-year rolling data for 2001-03 to 2013-15**

Source: Office for National Statistics (ONS). Vertical axis starts at 74 years, not zero

So far so good – longer life is the engine which drives the demographic challenge with regard to ageing, but the big question is *are we ageing well or will more older people add to the demand for health and social care?*

A second statistic called 'Healthy Life Expectancy' points towards an answer. This statistic estimates how long we can expect to live in a reasonable state of health.

The picture is shown over the page:

Healthy Life expectancy at birth in Oxfordshire (2009-11 to 2013-15)

It shows that, on average, healthy life expectancy lasts into one's late sixties and the trend is moving slowly upwards – which is a good thing, BUT it isn't increasing as fast as average overall life expectancy………

So we can conclude that ***an ageing population will indeed create a further increase in demand for services because 'good health' isn't increasing as fast as 'long life'.*** This in turn means that services really do need to adapt quickly to demographic change, or, other things being equal, they will simply not cope.

What should we do about it?

Keeping it very simple again, and assuming the exchequer doesn't find a crock of gold any time soon, the answer would seem to contain the following elements:

1. Stay in good health for longer through preventing ill health

2. Coordinate all health and social care services so that they pull together, using new technologies to find new solutions

3. Create a single planning system for Oxfordshire encompassing health, social care, housing, and infrastructure planning

4. Be open to new ways of doing things because……………

The demographic challenge means the change is inevitable.

What did we say last year and what progress has been made?

Last year's recommendations have essentially been met. They talked about the need to have a full debate about the NHS's consultation and to scrutinise it thoroughly. The recommendations also proposed that health and social care should be better integrated and more should be done to prevent disease before it starts. So what has been achieved? Looking at the big picture:

 ➢ The NHS has put forward significant proposals for change to meet these challenges in a lengthy consultation. Its reception was mixed to say the least. Overall, I think the need for change was broadly accepted, but the specific changes put forward proved controversial. A decision has now been made and is currently being challenged – we await the results.

 ➢ Local Government leaders have debated publicly the need to pull together via the many different proposals for reshaping Local Government and through devolution proposals. This has also proved to be very contentious.

 ➢ Integration of health and social care has moved forward through the Government's new 'Improved Better Care Fund' and we have a new Director of Adult Social Services in post who is reviewing current arrangements thoroughly so that we can move forward.

 ➢ The basics of prevention are in good order (immunisation, screening, maternal health etc.), but organisations have not been able to release funding to make a further step change as tight budgets are swallowed by the immediate service needs of today.

What should we do next?

Again, keeping it very simple, essentially we need to resolve these issues and move on – which is what we are all trying to do. It sounds easy but in practice it is difficult because the precise solutions are not obvious and so debate continues. However, being locked in debate and achieving little is unlikely to suffice for long. Perhaps we need to find a 'good enough' solution that everyone can agree to live with so that we can move on. I understand that this is a re-statement of the obvious, but I am hoping it might help to do just that. The key is that these are interlocking issues that need to solved as a single whole.

Recommendations

1. The NHS, County Council, District Councils, Universities and the Local Enterprise Partnership should pull together to resolve the current debates about 4 topics:

 ➢ What is the best shape for NHS services for Oxfordshire?

 ➢ What is the best way of achieving a sensible integration of health and social care - including local democracy in health care planning?

 ➢ How can all organisations pull together a 'masterplan' to tackle issues such as the future use of NHS sites in Headington and Banbury, including travel and transport issues, so that services are improved and the 'knowledge economy' boosted?
 ➢ How should housing growth be best coordinated so that developments and their supporting infrastructure are planned as one?

2. Local Government organisations should work together to create a single planning framework including 'health and social care planning', housing planning and infrastructure planning as a single whole.

3. All organisations should agree how to fund a step change in preventative services.

Chapter 2: Building Healthy Communities

For the last two years I have concentrated on public health aspects of the built environment. This year I want to combine that topic with a focus on air quality because two are closely connected in terms of solutions. I will look at air quality first.
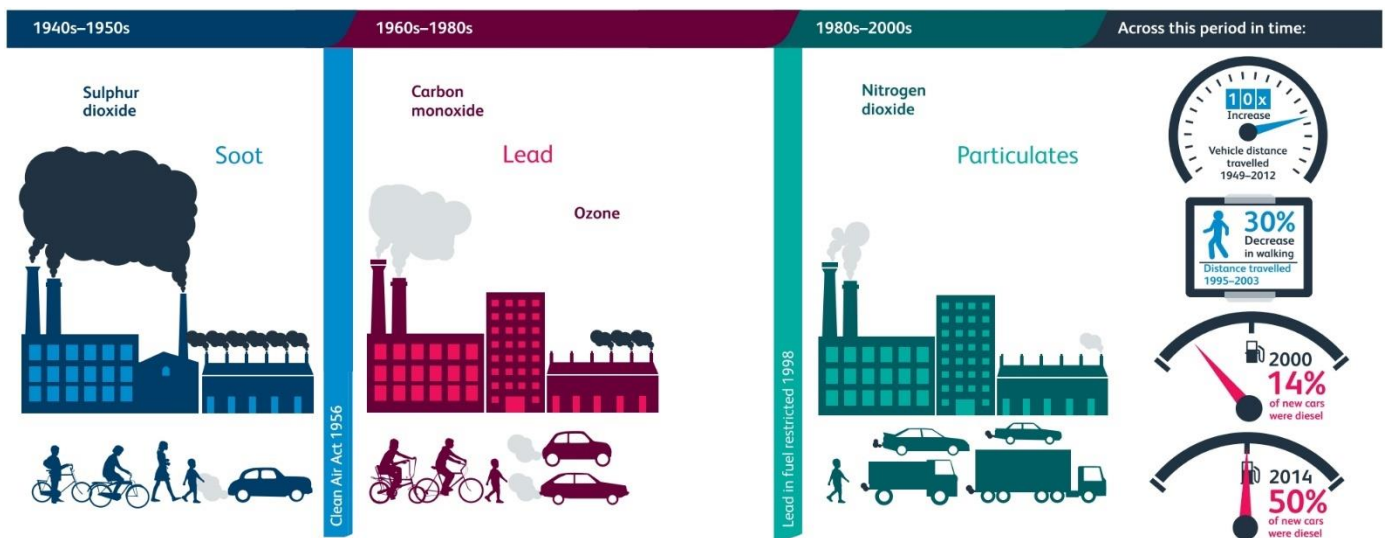
Air quality

Air quality is a complex topic and I want to approach it from a Public Health point of view. The history of the long term improvement of the air we breathe is a jewel in Public Health's crown.

It's also an interesting topic because it underlines a historical truth of all public health activity – you solve one problem and another rises up to take its place.

Just as beating off many infectious diseases leads to the challenges of long life, and just as improving prosperity and diet leads to the challenges of obesity, so it is with air quality.

In this case it's an issue of scientific advances revealing underlying problems we didn't know were there before – in this case the problems of 'particulates' in the air and their health consequences.

The history of Public health and air quality is summarised in the following schematic:

This shows that in the 19th and 20th centuries the big problem was soot from coal fires and industry – which we solved. In the mid to late 20th century the big problem was lead, mainly from petrol – which we solved.

The new problem is oxides of nitrogen - nitrogen dioxide and its family of gasses – shorthanded as NOx. This has grabbed the headlines recently and is now being grappled with by Government because it is the only atmospheric pollutant where the UK fails to meet EU standards and the Government have been obliged to tackle this by the High Court.

Road transport makes up 38% of all NOx pollution, and it is highly concentrated in towns & cities where people live. Road traffic continues to grow: between 2000 – 2015 the number of licensed

cars increased from 24.4m to 30.3m. Diesel cars, the worst offenders when it comes to nitrogen oxide, have increased their share of the car market from 12.9% to 37.8%. The widely reported controversy over the accuracy of testing vehicles for particulate emissions has helped to push this issue to the top of the agenda.

Historically the problems of air pollution have generally been solved through national and European standards and legislation. There is a huge debate raging as I write about the Government's proposals to tackle NOx. This includes extending initiatives such as clean air zones and whether responsibility should sit at national or local level. Whatever the outcome of that debate, money remains tight and we need to seek out low cost options we can start to do today.

In this report I want to concentrate on what we can do NOW in Oxfordshire and under our own steam as individuals and within current organisational budgets irrespective of Government's deliberations

Let's look in more detail at particulates in the air

In the 1990s it was felt that air pollution was no longer a major health issue in the United Kingdom. Legislation had made the great smogs of the 1950s a thing of the past. But evidence started to emerge that small particles emitted to the air from various sources, such as road transport, industry, agriculture and domestic fires, were still having an effect on health. This type of air pollution is so small that it can't be seen by the naked eye, but can get into our respiratory systems. For example, nitrogen dioxide and sulphur dioxide are produced by burning fuel, whilst ozone is formed by chemical reactions in the air.

The scientific understanding of the health effects of everyday air pollution has changed dramatically in recent years. Population effects of air pollution that were largely unknown in the 1990s and uncertain until recently are now quantifiable.

Studies have shown that long-term exposure **(over several years)** reduces average life-expectancy, mainly due to triggering death from cardiovascular and respiratory causes and from lung cancer. Air pollution is now associated with much greater public health risk than was understood even a decade ago.

In the UK, the Committee on the Medical Effects of Air Pollutants (COMEAP) estimated the burden of particulate air pollution in the UK in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 life years lost.

It is important to understand that long-term exposure to air pollution is not thought to be the sole cause of deaths. Rather, it is considered to be a contributory factor – this is an important point.

Impact on deaths

An Air Quality Toolkit for Directors of Public Health was published by Defra in March 2017 and looks at the health impact of air pollution and particulates in particular. According to the toolkit:

> *'Short-term exposure to particulates over a period of a few hours to weeks can cause respiratory effects such as wheezing, coughing and exacerbations of asthma and chronic*

bronchitis. It can trigger CVD-related mortality and non-fatal events including myocardial ischemia and myocardial infarctions (MI), acute decompensated MI, arrhythmias and strokes.'

In plain English, this means that if you are exposed to particulates for a period of time, it may cause breathing problems and in some cases it can trigger underlying heart problems and strokes. These may in turn contribute to one's death. This is, it seems, the mechanism through which particulates impact on health.

Because of the indirect nature of the effect, it is difficult to measure, estimate or be certain about.

The toolkit sets out a method for calculating the rate of mortality 'attributable' to Particulate Matter. We always need to be careful with 'attributable' statistics. It means that a group of experts have looked at the science and have made a best estimate. In Oxfordshire this rate is 12.6 deaths per 100,000 population per year. What does this actually mean? Well, there is a sort of 'league table' of 'attributable' causes of death (all are best estimates) which looks like this for under 75s:

	Mortality rate, per 100,000	
Measure	**Oxfordshire**	**England**
Overall preventable mortality	142.6	184.5
Preventable cancer	64.5	81.1
Preventable heart disease and stroke	34.7	48.1
Mortality attributable to Particulate Matter	12.6	39.0
Preventable Liver disease	11.3	15.9
Communicable diseases	9.4	10.5

It is very clear that the number of deaths relating to air quality, preventable cancer, heart disease stroke, preventable liver disease and communicable diseases in Oxfordshire are well below the national averages and this is a good result. However, this does not mean that we should be complacent. We need to act to consolidate this position and strengthen it further.

The figures mean that preventable deaths associated with particulates are estimated to be associated around 1/5th of the number of preventable deaths due to cancer and around 1/3 of the number of preventable deaths associated with preventable heart disease and stroke.

It is important to grasp when particulates contribute to a death they generally act as a trigger. This isn't like smoking or alcohol related deaths where the main cause is the tobacco or the alcohol directly.

Clearly this isn't an exact science. It is easy to build castles on sand using these statistics, but it does give us a guide – enough to say that the experts think that particulates are a real health issue and should be tackled.

The Government's recent consultation on the topic summed it up as follows,

*Poor air quality is the largest **environmental** risk to public health in the UK. It is known to have more severe effects on vulnerable groups, for example the elderly, children and people already suffering from **pre-existing** health conditions such as respiratory and cardiovascular conditions. Studies have suggested that the most deprived areas of Britain bear a disproportionate share of poor air quality.*

I would stress that this isn't the biggest threat to the public's health, but it is judged the most pressing environmental risk.

Much of the action has to come nationally from Government, but there is evidence that people are voting with their feet and sales of diesel cars are reported to have fallen recently.

Where does air pollution come from?

The following schematic paints the picture and shows that the sources of pollution are many and varied from the fire in your hearth, to traffic, to pollen, to aircraft, to industry, to agriculture. There's no escape, but this diversity of sources *does* mean that we can all do something about it. for example, 39% of these tiny particles of dust that lodge in the lungs are caused by coal and wood burning.

Exposure to air pollution in everyday life can come from ordinary activities like being near traffic, sitting in traffic jams, traditional home fires and bonfires.

The effects are localised, so, although they are more concentrated in towns, they also occur at hot spots in rural areas like busy crossroads.

Also, air pollution levels tend to be higher in less well-off areas, this is yet another cause of disadvantage which being less well-off brings. These are analysed in chapter 3.

What can we do about it?

While we wait for Government to decide what to do, there are actions we can take – and the good news is that many of these are already in hand. For example, we can:

➢ Make it easier for people to cycle and walk more through better planning
➢ Plan cycle routes through quiet areas
➢ Build pedestrian areas and green spaces into the design of communities and regeneration schemes
➢ Shift transport fleets to electric or electric hybrid vehicles
➢ Choose new cars with more care.
➢ Encourage fewer car journeys through 'park and ride' and similar schemes
➢ If you suffer from diseases that high levels of pollution might trigger, you can keep an eye on DEFRA's pollution warnings and adapt your lifestyle to avoid areas with high levels of emissions.
➢ Consider 'no-idling zones' outside schools and similar areas
➢ Consider where possible installing gas central heating, or modern wood stoves rather than open fires, smokeless coal rather than house coal or burning dry high quality wood rather than green wood.

Whatever the outcomes of the debate on air pollution, the local actions will all boil down to better local planning, which builds health into community design, and residents making choices which are heathy ones.

All of which leads us nicely into an update on the main featured item from last year's report, namely getting health into local planning and the 2 healthy new towns we have as pilot sites in Oxfordshire in Bicester and in Barton.

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

Last year we talked about the benefits of building green spaces, community areas, cycle paths and the like into the design of communities. I want to report on progress in two ways – a report of a workshop we held and an update on the Healthy New Towns.

 'Planning For Health' Workshop

In November 2016, the County Council hosted a County-wide Health and Planning learning event for Officers working in areas such as planning, transport planning, health commissioning and health improvement. Officers from County, District and City Councils and the local NHS attended. The idea of the event was to enable us to learn together about best practice for creating healthy environments. We were grateful for the support from our regional colleagues at Public Health England (South East) who helped with guiding the learning themes and sourcing the key note speakers.

We aimed for participants to be able to:

➢ understand the link between health and the built environment
➢ understand how the planning system works and how it can contribute to health improvement
➢ keep abreast of national, regional and local work to improve health through the built environment

➢ learn about current good practice through case studies
➢ meet other health and planning colleagues from across Oxfordshire to network and learn more about each other's roles.

A wide range of speakers gave the national, regional and local perspective. Some of our speakers included Public Health England, the Town and Country Planning Association, other Local Authorities and both Healthy New Towns in Oxfordshire.

The event was really 'buzzing' and enthusiastic. The main lessons learned included:

➢ **Early involvement in the Planning Process** - including the need for early health involvement in planning and for a Health Impact Assessment (HIA) to be completed early on for new developments.

➢ Working in constructive partnerships is essential.

➢ Understanding the **roles of stakeholders/organisations** and how they could contribute to health through planning.

➢ Understanding the specialist 'tools' that help to make sound plans.

➢ Learning from **examples of good practice** elsewhere.

➢ **Evidence and statistics** being useful to be able to demonstrate the impact of planning innovation on health

➢ **Understanding the health Issues** within communities, and that loneliness and isolation are big issues that need to be addressed. There was recognition of the impact of disadvantage on health and the potential of small initiatives to make a big difference.

➢ **Understanding the economic benefits** of greener and healthier forms of transport and how these can be encouraged - including the long term benefits of investment in walking. Considering and encouraging active travel (i.e. going by bike or walking) at the earliest possible stage in planning new communities.

The event was a real boost to this area of work, and we need to keep this momentum going. We all have a part to play in this. We need to remember though, it's not just about infrastructure. It's about creating a place where people can actually meet and get together, and where it is easy to stroll, cycle and play in safety.

Healthy New Towns – what has happened in the year since my last report?

Last year I highlighted the NHS Healthy New Town Programme and the opportunities that this could bring to Oxfordshire. With two Healthy New Towns, Barton and Bicester, both within our County there is a real chance to make a difference to the health of not only those living in (or who will be living in) those areas to benefit, but momentum to share this benefit and learning wider – and this is perhaps the real added value.

We can see that the builders are on site now, but what else is happening in the actual community, and what does it mean for the people who live in those areas now or who might live there in the future?

I can report that it's been a productive year. Both areas have been:

➢ Fine-tuning priorities and keeping the dialogue between organisations flowing.

➢ Engaging the community to pave the way for new residents coming to the area. Various engagement workshops/meetings have taken place. Everyone tells me that getting residents involved early on is the key.

Bicester is taking a whole town approach and similarly Barton a whole area approach as 'One Barton'

We can look at some of the key achievements and successes of each of the Healthy New Towns in more detail.

Barton

➢ Funding was secured through WREN (a not-for-profit business that awards grants for to communities) for physical improvements to Fettiplace Road linking the 'linear park' to Barton Park via what is now called 'Barton's Park'. This will mean that people can access green space, play areas and socialise and it will join the new community to the existing community.

➢ Carrying out a **'**Health Impact Assessment' (a device for systematically recording the impact on residents' health when new initiatives are planned) was commissioned which suggested improvements.

➢ Supporting Bury Knowle's social prescribing pilot (a jargon term for 'prescribing' healthy activities to people instead of pills and powders). This might include joining a group or a club to reduce loneliness and isolation or attending a local exercise class or health walk to become more active.

➢ Commissioning research to gain a deeper understanding of existing and potential residents' health needs. This can be used by health and other service providers including the voluntary and community sector providers, GPs, leisure and physical activity services, green spaces etc, to help inform the planning of services for the area.

➢ Providing training for people working in Barton to:

• understand the link between food, poverty, poor diet and health, and how all that links to the price and availability of fresh fruit and veg and how to avoid the really fatty and salty foods.

• give people brief advice about stopping smoking, cut down on drinking and tips for staying mentally healthy.

➢ Supporting the Oxford Brookes University's Healthy Urban Mobility study to look into how access to cycling in Barton can be improved for older people.

➢ Eight community-led health and wellbeing pilot projects receiving grant-funding to generate learning from practice. The grant scheme was open for applications up to £5,000. Projects included a full independent review of Food Banks to shape the future management of the food bank within the Barton Neighbourhood Centre, ensuring that people needing to access the food bank are best supported. This work then led to the creation of a Barton Community Cupboard - a market-style provision which includes a fridge, recipe cards and a cook book inspired by recipes from local residents' attending a cooking session for all ages. The project has aimed to reduce the stigma attached with using a food bank.

➢ Another real success story has been the work in Barton to increase the uptake of Healthy Start Vouchers. Healthy Start is a national service through which free vouchers are given to selected families every week to spend on milk, fresh and frozen fruit and vegetables, and infant formula milk. You can also get free vitamins. You qualify for Healthy Start if you're at least 10 weeks pregnant or have a child under four years old and you or your family receive:

- Income Support, or
- Income-based Jobseeker's Allowance, or
- Income-related Employment and Support Allowance, or
- Child Tax Credit *(with a family income of £16,190 or less per year)*
- Universal Credit *(with a family take home pay of £408 or less per month)*
- You also qualify if you are under 18 and pregnant, even if you don't get any of the above benefits.

This was done by an outfit called Good Food Oxford. They did it by producing:

- A paper and electronic map of retailers which accept Healthy Start Vouchers
- Promotion by local retailers their participation in the scheme
- Use of posters and community newspaper
- A guidance leaflet for frontline service providers to help individuals to complete the form

Bicester Healthy New Town

Initiatives during the year included:

➢ Launch of the community activation programme with small grants available up to £1000. Some of the activities funded have included:

- A Scout Group purchasing equipment to provide adventurous outdoor activities for children aged 6+.

- A pilot street-play activity delivered by Oxfordshire Play Association.

- Setting up a Bicester meeting for local learning disabled adults through the voluntary organisation My Life My Choice. The programme has encouraged the group to be active and take responsibility for their health as well as offering the usual support of the organisation which promotes volunteering and social activity.

- Bicester and Kidlington Ramblers were funded for the printing of a book of local walks of 5 miles and under. The book aims to encourage people to get out and enjoy their local area more and to become more active.

➢ Looking at how to improve the care of people with diabetes between primary, secondary and community care. Some of this will involve collaborative working with other Healthy New Town sites to work out the impact of population growth on demand for GP services.

➢ A Healthy Weight Strategy produced to address childhood obesity in Bicester. The plan outlines life stages, services, key messages and initiatives. The plan aims to provide a co-ordinated approach, with consistent messages which will link to national and local initiatives.

➢ Engaging all Bicester schools to participate in Walk to School week for May 2017. A springboard to promote a year round walking to school programme.

What else have we done in the past year?

There are many signs that the penny has dropped and that 'getting health into planning' is now a necessity. The Public Health team's work with planners at County and District level has increased remarkably and there is a demand for more – which is a really positive development.
BUT

It doesn't just happen by accident and it needs a sustained and coordinated approach which we are now moving towards – on a shoe-string….

The key is to

➢ know your topic so you have something positive and easy to offer

➢ Know the people and get involved in the networks

➢ concentrate on the economic benefits and the need to cut diseases such as diabetes, heart disease and some cancers off at the source – as well as slowing the progress of dementia….. and avoid preaching and nannying!

➢ keep selling the message:

'planning is health and health is planning'

Recommendations

1. All Local Authorities should improve air quality at local level under our own steam through keeping up the work to integrate 'public health and planning'.

2. All Local Authorities should continue to monitor and actively engage with the Healthy New Towns programme and use the lessons learnt to improve all local planning across the County

Chapter 3: Breaking the Cycle of Disadvantage

This year I want to achieve 4 things:

1. To keep the issue of disadvantage high on organisations' agendas

2. To describe overall disadvantage in Oxfordshire in a straightforward way

3. To report in detail on the basket of indicators agreed last year to monitor progress

4. To report on the work of the excellent Health Inequalities Commission

Why is this topic important?

Because disadvantage is one of the factors strongly associated with poor health and poor life chances. Reducing disadvantage will directly improve health and will help people to live lives which are productive and less burdened by disease.

Overall disadvantage in Oxfordshire in two pictures

If I were asked to give a 'helicopter view' of disadvantage in Oxfordshire, I would do it through two pictures, one highlighting rural disadvantage and one urban disadvantage.

Rural Disadvantage

A major cause of disadvantage in the County stems from its rural nature. This means that some areas have more difficulty in accessing services as well as having a high proportion of older people. This is shown in the map below in a measure called 'geographical barriers'. It takes into account the many challenges posed by rurality in terms of accessing services. It was updated in 2015. This index is based on road distances to post offices, primary schools, GP surgeries, and general stores or supermarkets.
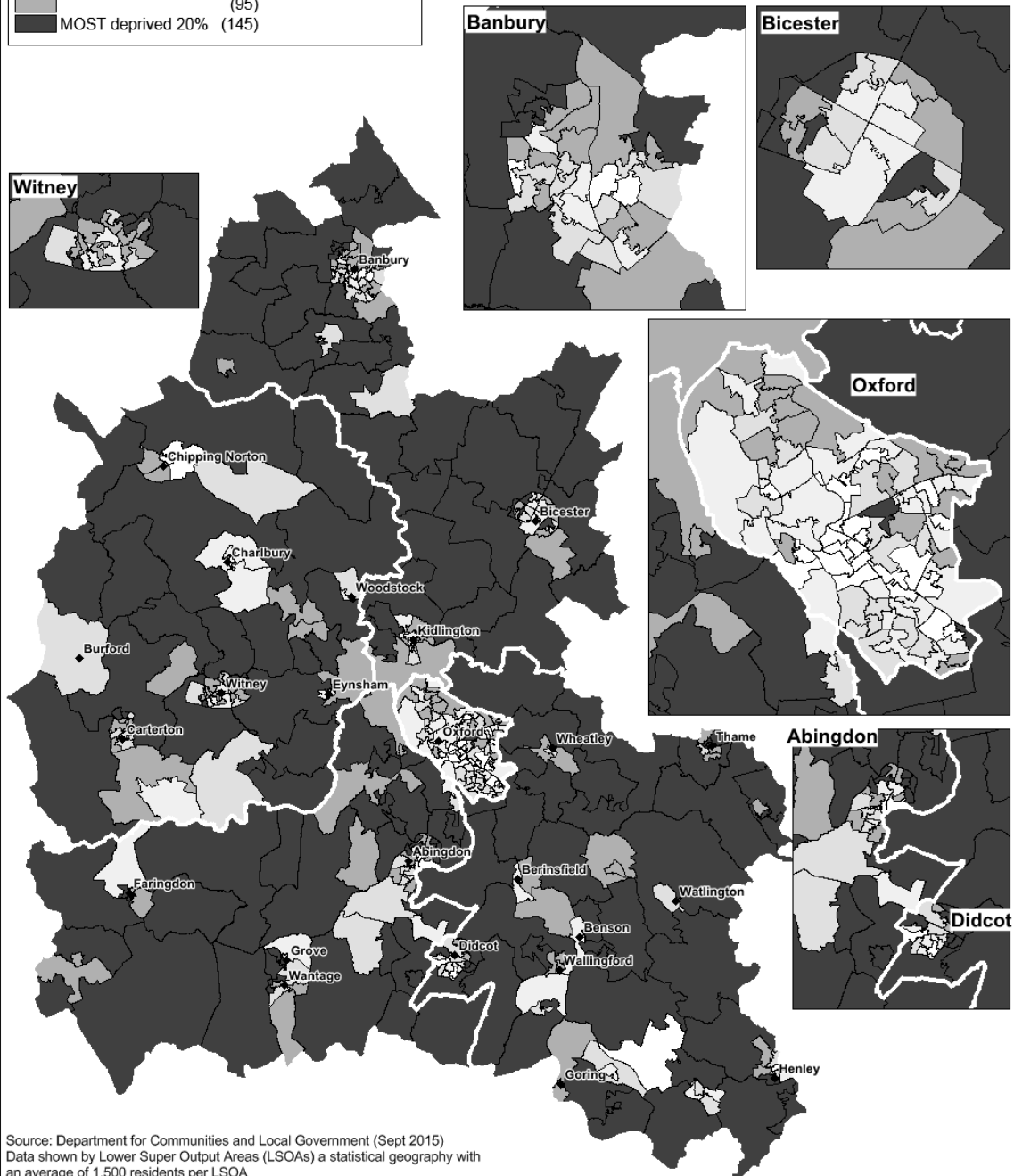
Indices of Deprivation 2015, Geographical Barriers to Services
by Lower Layer Super Ouput Areas showing District boundaries

IMD 2015 Geographical Barriers to Services
England deciles

LEAST deprived 20%	(33)
	(65)
	(69)
	(95)
MOST deprived 20%	(145)

Banbury

Bicester

Witney

Oxford

Abingdon

Didcot

Chipping Norton

Charlbury

Woodstock

Kidlington

Burford

Witney

Eynsham

Carterton

Oxford

Wheatley

Thame

Faringdon

Abingdon

Berinsfield

Watlington

Benson

Grove

Didcot

Wallingford

Wantage

Goring

Henley

Banbury

Bicester

Source: Department for Communities and Local Government (Sept 2015)
Data shown by Lower Super Output Areas (LSOAs) a statistical geography with
an average of 1,500 residents per LSOA

The IMD 2015 Geographical Barriers sub-domain includes:
- Road distance to a post office: A measure of the mean distance to the closest post office for people living in the Lower-layer Super Output Area
- Road distance to a primary school: A measure of the mean distance to the closest primary school for people living in the Lower-layer Super Output Area
- Road distance to a general store or supermarket: A measure of the mean distance to the closest supermarket or general store for people living in the Lower-layer Super Output Area
- Road distance to a GP surgery: A measure of the mean distance to the closest GP surgery for people living in the Lower-layer Super Output Area

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

The implications of this mostly fall on older people and we see the results particularly in terms of isolation and loneliness and in terms of difficulty in getting about. This is where the demographic challenge will be felt the most and services will need to be designed to meet the needs of these communities.

This is difficult because:

➢ modern hi-tech services tend to need centralised kit and centralised specialists

➢ it gets harder for anyone to do home visits because of the increasing busyness of the roads

The way to square the circle seems to be to use hi-tech aids (like the alarm systems some people wear on their wrists or round their necks) and on-line communication, and to plan the routes of home carers really carefully. The other solution was discussed in the previous chapter – i.e. planning new communities around communal spaces and local facilities. Nonetheless, there are inevitable challenges to come as GP surgeries coalesce, becoming more specialist and less local.
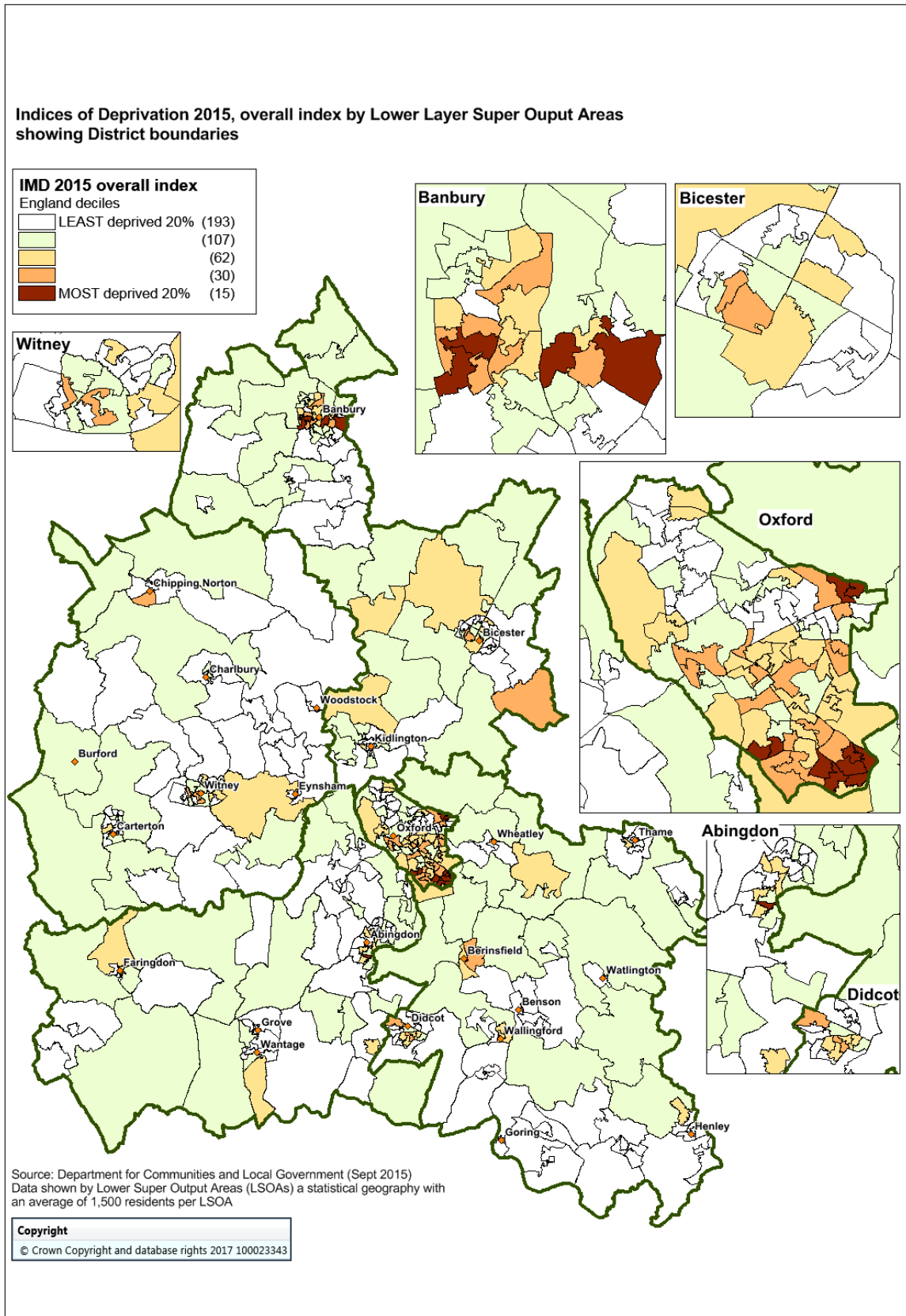
In conclusion, this picture of rural disadvantage presents one side of the coin of disadvantage in Oxfordshire.

Urban Disadvantage – the 'Index of Multiple Deprivation' (IMD)

This is the flip side of the coin and tends to pick out disadvantage in areas of greater population density - which I am loosely calling 'urban'.

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

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

Indices of Deprivation 2015, overall index by Lower Layer Super Ouput Areas showing District boundaries

IMD 2015 overall index
England deciles

LEAST deprived 20%	(193)
	(107)
	(62)
	(30)
MOST deprived 20%	(15)

Source: Department for Communities and Local Government (Sept 2015)
Data shown by Lower Super Output Areas (LSOAs) a statistical geography with an average of 1,500 residents per LSOA

Copyright
© Crown Copyright and database rights 2017 100023343

The map shows that:

➢ Most of Oxfordshire's 407 small areas are less disadvantaged than the national average.

➢ 110 are among the least deprived 10% nationally.

➢ Overall, nearly half (46%) of the county's population lives in areas that are among the least disadvantaged 20% in England.

➢ More than four in five residents (82%) live in areas that are less disadvantaged than the national average.

➢ Of course this does not mean that there is no disadvantage in those areas –Berinsfield is a good example of an area where disadvantage is 'masked' by being included in larger more affluent areas, and many rural communities can tell the same story.

➢ 13 areas are among the 10-20% most disadvantaged (down from 17 in 2010).

➢ Two areas are among the 10% most disadvantaged in England. These are in Oxford City, in parts of Rose Hill and Iffley ward and Northfield Brook ward. In 2010 only Northfield Brook was among the 10% most disadvantaged areas in the country

The most disadvantaged areas are concentrated in parts of Oxford City and Banbury with one in Abingdon.

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

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

In summary, these two 'faces of Oxfordshire' usefully sum up the overall picture when it comes to disadvantage.

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

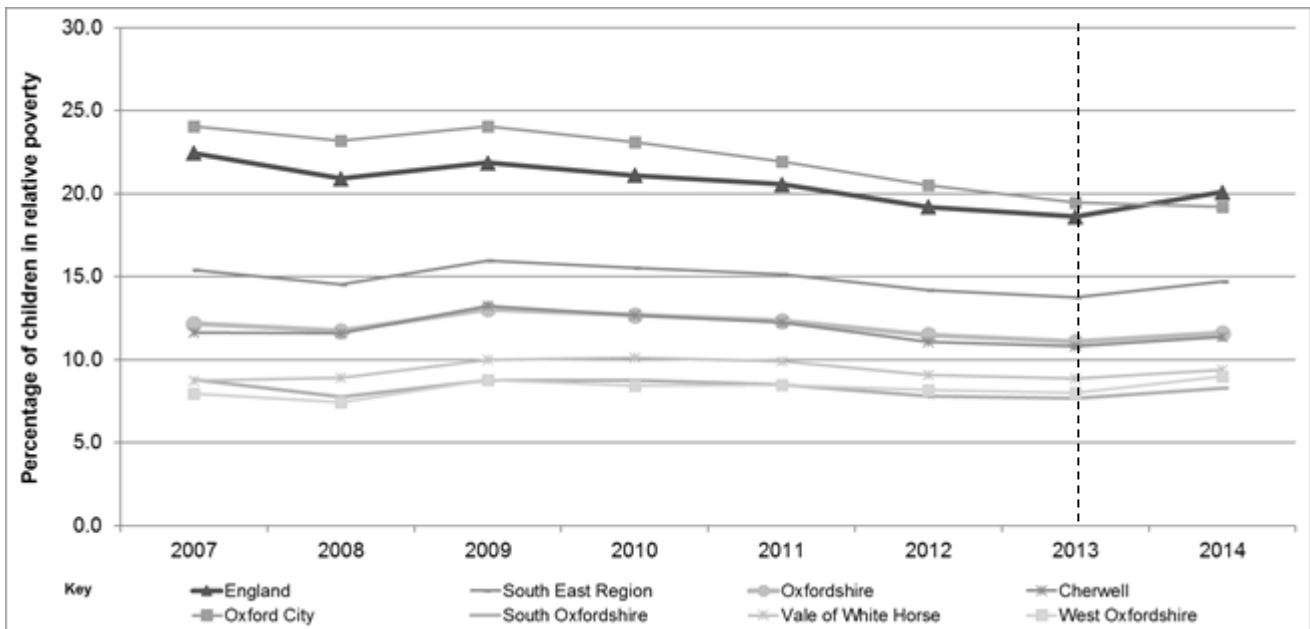**Report on the Basket of Indicators**

In last year's report I identified a basket of high quality indicators which would help us to measure progress in the fight against disadvantage. I set a baseline figure for comparison and will report on progress against these one by one.

Indicator 1. Child poverty

Percentage of children (under 16 years) in Low-Income Families (2007 to 2014 calendar years)

The proportion of families classed as having 'children in poverty' had fallen for the last few years but has increased slightly across the board according to the latest data from 2014. This is a national trend. The reasons for this are unclear, and a single year's figures need to be treated with caution but it is important that we closely monitor this figure going forward. The correct name for this is indicator is 'relative poverty'. An individual is considered to be living in relative poverty if their household income is less than 60% of median national income. Nationally two-thirds of children in poverty are living in households where at least one adult is in work.

Percentage of children (under 16 years) in Low-Income Families Local Measure (2007 to 2014 calendar years)

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

The chart shows that:

➢ The proportion of children in poverty has increased slightly since we set the baseline (2013 data) across all geographic areas.

➢ Oxfordshire has a significantly lower percentage of children in low-income families than England. This is good news.

➢ Oxford City has higher levels than the rest of the County and is closer to the national average.

Note: this is a national statistic and takes time to collate and so we are still seeing historic data from 2014.
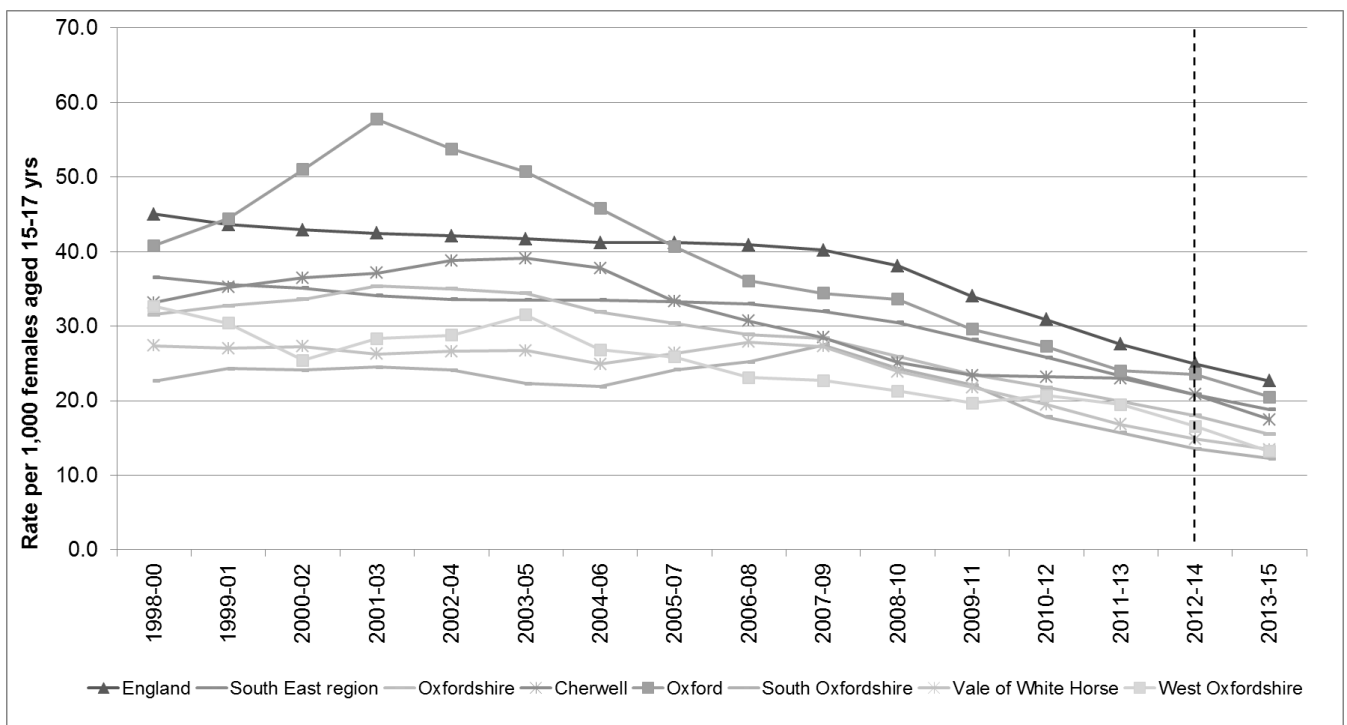
The profound influence and impact of poverty on health needs to be widely recognized and systematically addressed.

Also, as ever, if we drill down into the figures the gaps widen. Whilst Oxfordshire is overall a very 'healthy and wealthy' county, there are significant differences in poverty. For example: children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in less wealthy families.

Indicator 2. Teenage pregnancy

This indicator measures all conceptions in females under 18 years of age, no matter whether the pregnancy ends in birth or in a termination.

**Under 18 conception rate per 1,000 female population aged 15-17 years
1998-2000 to 2013-15 (3-years combined)**

Source: Office for National Statistics (ONS) - combining information from birth registrations and abortion notifications

The chart shows that:

➢ The teenage conception rate in Oxfordshire is lower than the national average and is decreasing broadly in line with national and regional trends.

➢ There has been a welcome sharp decline in Oxford City since 2001-03

➢ Most recent data (2013-15) continues on a downward trend across all geographies.
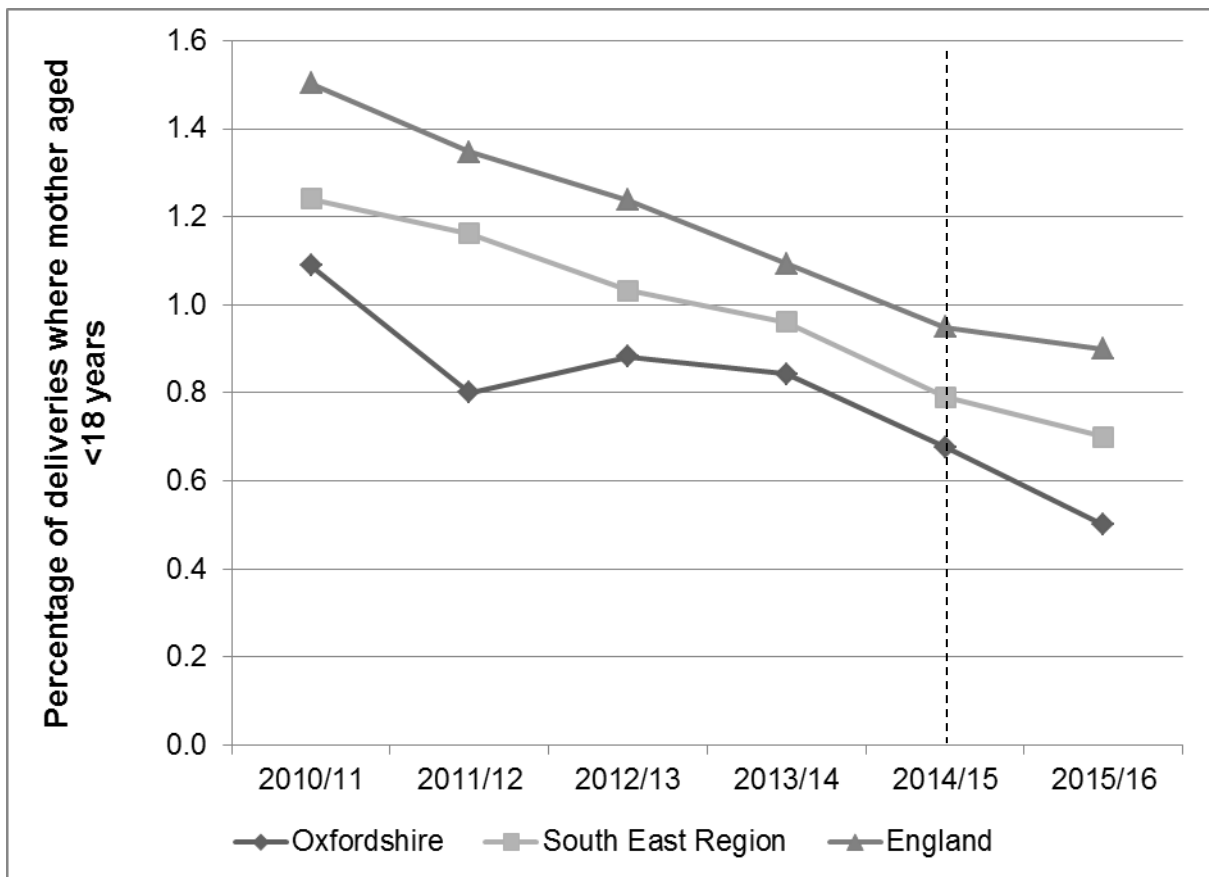
➢ This is a good result.

Indicator 3. Percentage of Teenage Mothers

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

Almost half of teenage conceptions result in termination. This indicator measures the percentage of births to mothers aged under 18.

**Under 18 conception rate per 1,000 female population aged 15-17 years
1998-2000 to 2013-15 (3-years combined)**

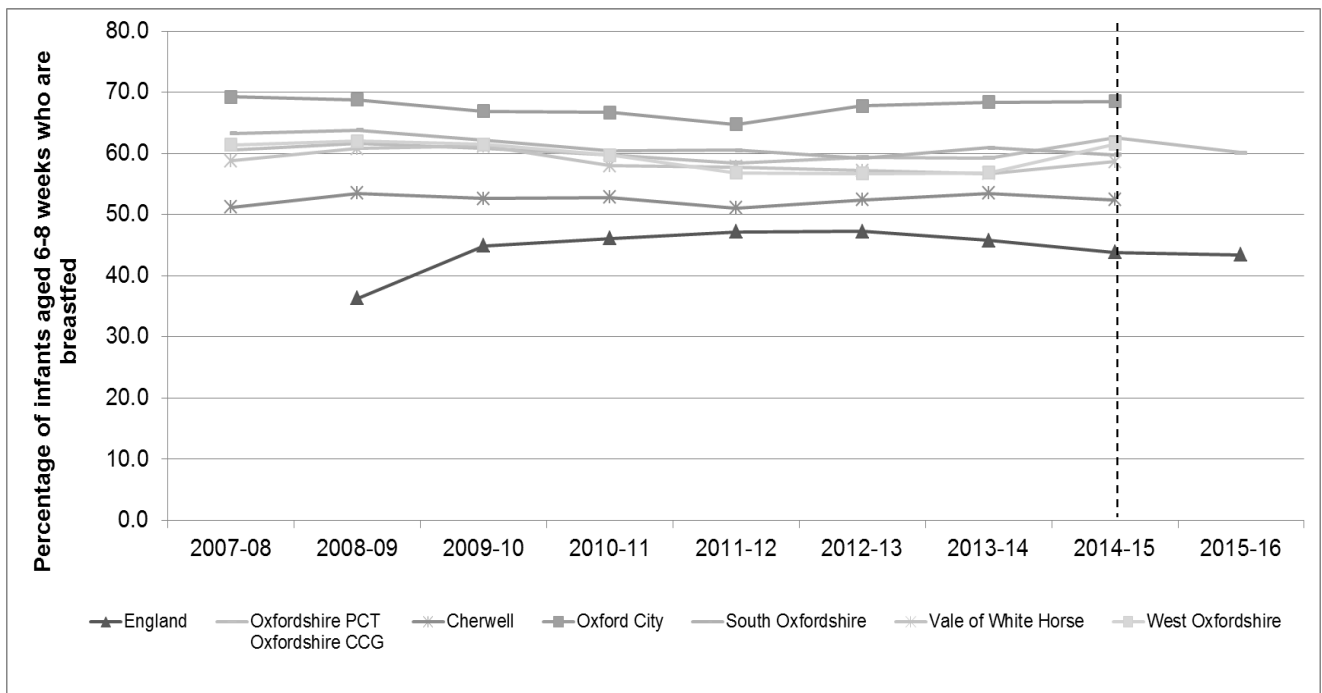*Source: Public Health England: Child Health Profiles: Pregnancy & Birth*

The chart shows that:

➢ The proportion of births to mothers under 18 years has reduced.

➢ This is a national trend.

➢ The proportion in Oxfordshire continues to be lower than the national or regional figures.

➢ This is another good result, and particularly good in Oxfordshire.

Indicator 4. Breastfeeding at 6-8 weeks

Breastfeeding is important and underpins a healthy life. Its positive effects on health are long-lasting. The breastfeeding rate remains high in Oxfordshire compared to England. The challenge is to get the rates higher in the lowest areas which are historically: Banbury, Bicester, Kidlington, Didcot, Wantage and South East Oxford.

Percentage of infants aged 6-8 weeks who are being breastfed (partially or wholly) – 2007/08 to 2015/16
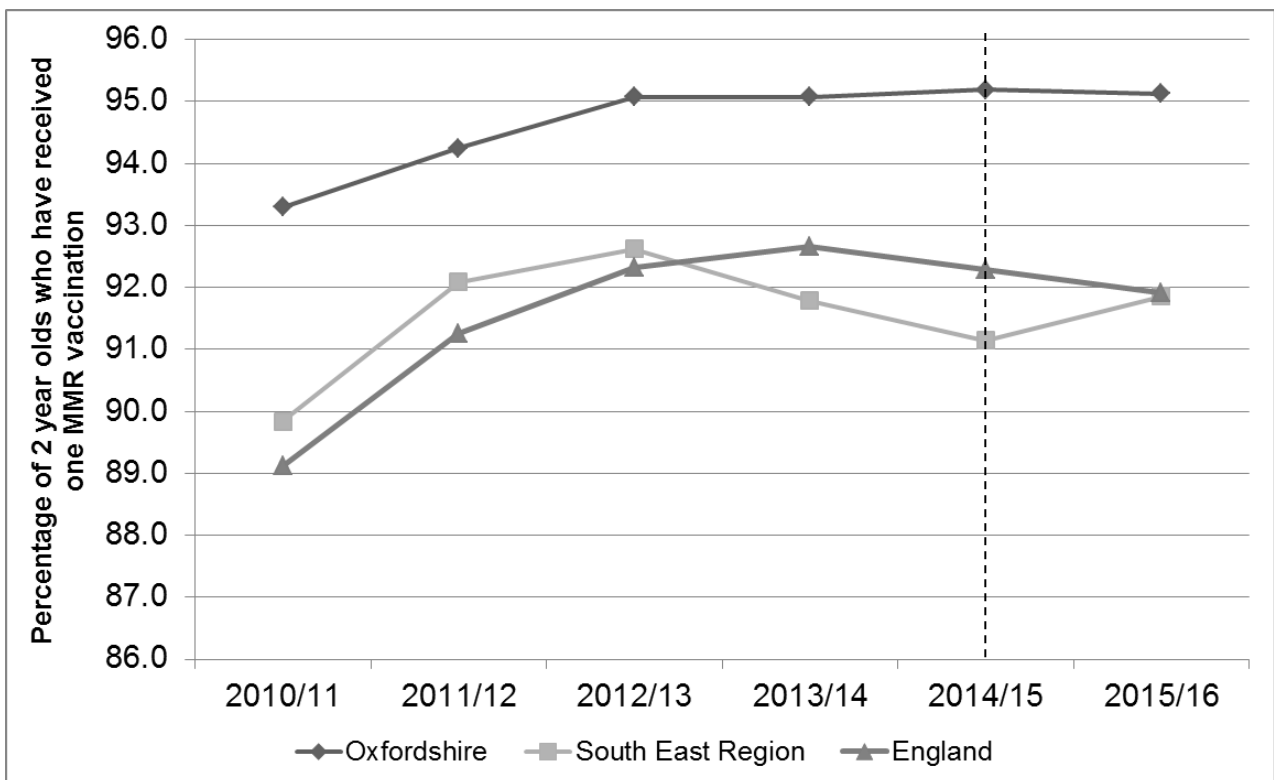

Source: NHS England

The chart shows that:

➢ Nationally the prevalence of breastfeeding at 6-8 weeks increased over this time period and now appears to be levelling off at around 43%

➢ Oxfordshire has a significantly higher rate of breastfeeding at 6-8 weeks than England average at just over 60% This is a good result.

➢ Locally breast feeding rates remain fairly stable for the county as a whole.

➢ Data at district level are currently not available for 2015/16

Indicator 5. Childhood Immunisation

Children should receive two Measles, Mumps and Rubella (MMR) vaccinations, one by the time they are 2 years old and the second by 5 years old. We use this as an indicator for the uptake of all immunisations as this is one of many immunisations for children. We monitor all the rates thoroughly through the Public Health Protection Board and through the Health Improvement Board. Oxfordshire's results are very good and NHS England and Public Health England are to be congratulated. An initiative has begun to push the rates higher by tracking down the families who slip through the net individually and offering their children the vaccine.

Percentage of 2 year olds who have received one MMR vaccination

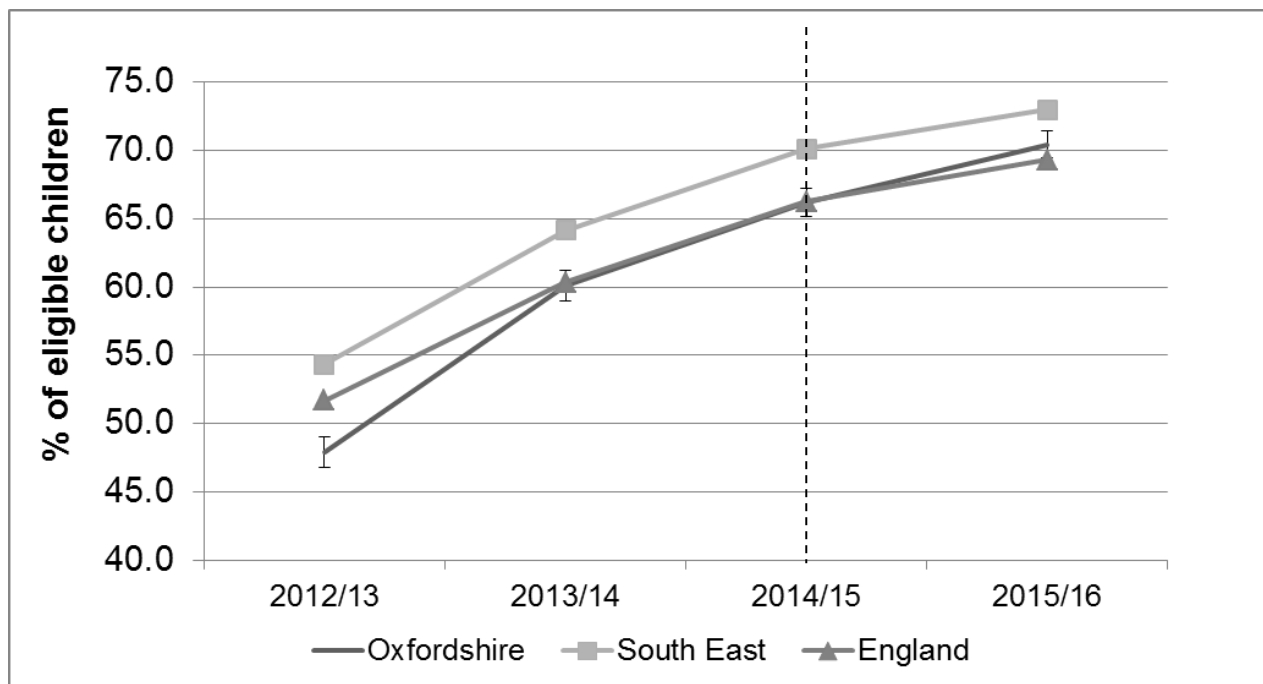*Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England*

The chart shows that:

➢ Oxfordshire remains significantly higher than national and regional average. This is an excellent result – our vigilance is paying off.

➢ Nationally this vaccination coverage is falling and we are bucking this trend.

Indicator 6. School readiness

This indicator measures children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children. Children are defined as having reached a good level of development if they achieve at least the expected level in their 'early learning goals' in the following areas: personal, social and emotional development; physical development and, communication and languages, as well as early tests of mathematics and literacy. This is a useful measure of health in its broadest sense of 'life potential' and a useful marker for disadvantage between different groups of children.

Percentage of children achieving a good level of development at the end of reception year

The data shows that:

- Oxfordshire has a slightly higher percentage of children with a 'good development' compared with the England average but remains below the regional average.

- The proportion of children achieving a good level of development at the end of reception year has increased across all three geographies.

- There is a clear gap between males (63%) and females (78%) in Oxfordshire, similar to national and regional figures.

- The percentages in children with free school meal status is much lower at 51% (43% in males and 59% in females).

- This is reasonable progress but shows the need to focus on disadvantaged groups if performance is to improve.
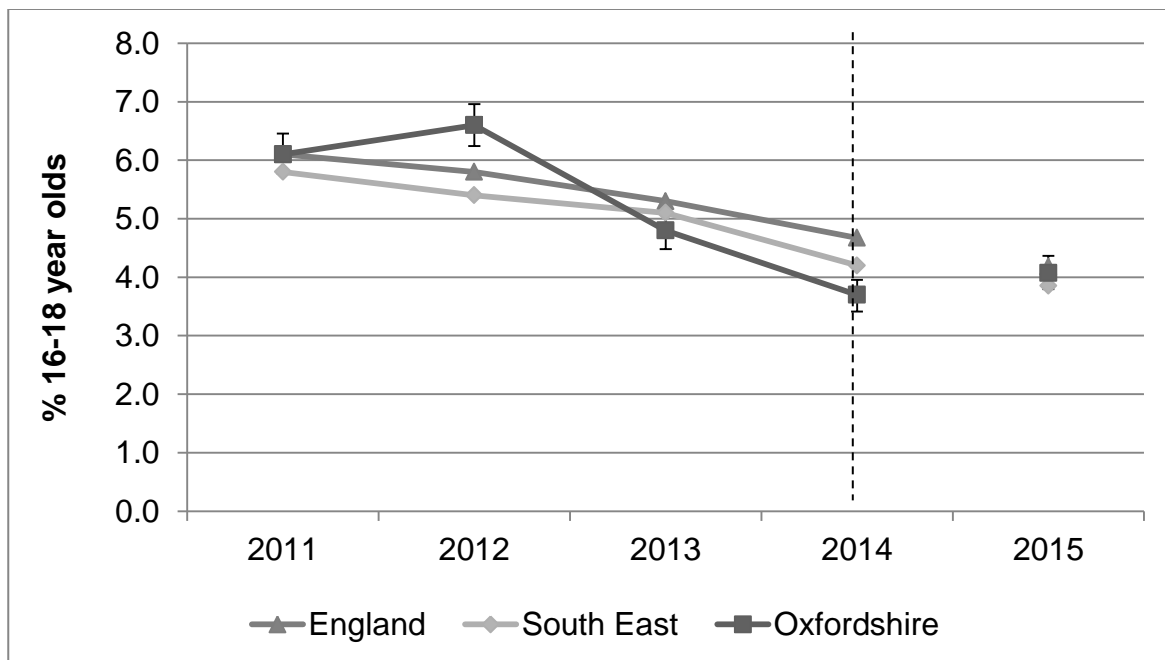
Indicator 7. GCSE results

Unfortunately, the previous indicator which allowed us to measure GCSE performance between different areas and different groups of children in the County has been discontinued by Government. It is unclear whether the new 'performance 8' statistic will be as useful – and there is as yet little data for comparison. Rather than report on this figure prematurely this year, I will need to see how well it is received before I use it to draw conclusions.

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

This is a useful general indicator of future life chances and prosperity for young people.
The way the data has been counted has also changed since last year to try to make it more accurate, so we can't compare it accurately with previous years. The problem comes because for some young people it is not known what their status is. To try to account for this, the new method takes figures for where it is not known if young people are not in education, employment or training and assumes a proportion of them are not and adds this to the old figure. For that reason, there is a break in the line in the chart below and then new figures are shown as a new 'blob' for 2015.

Percentage of 16-18 year olds not in education, employment or training
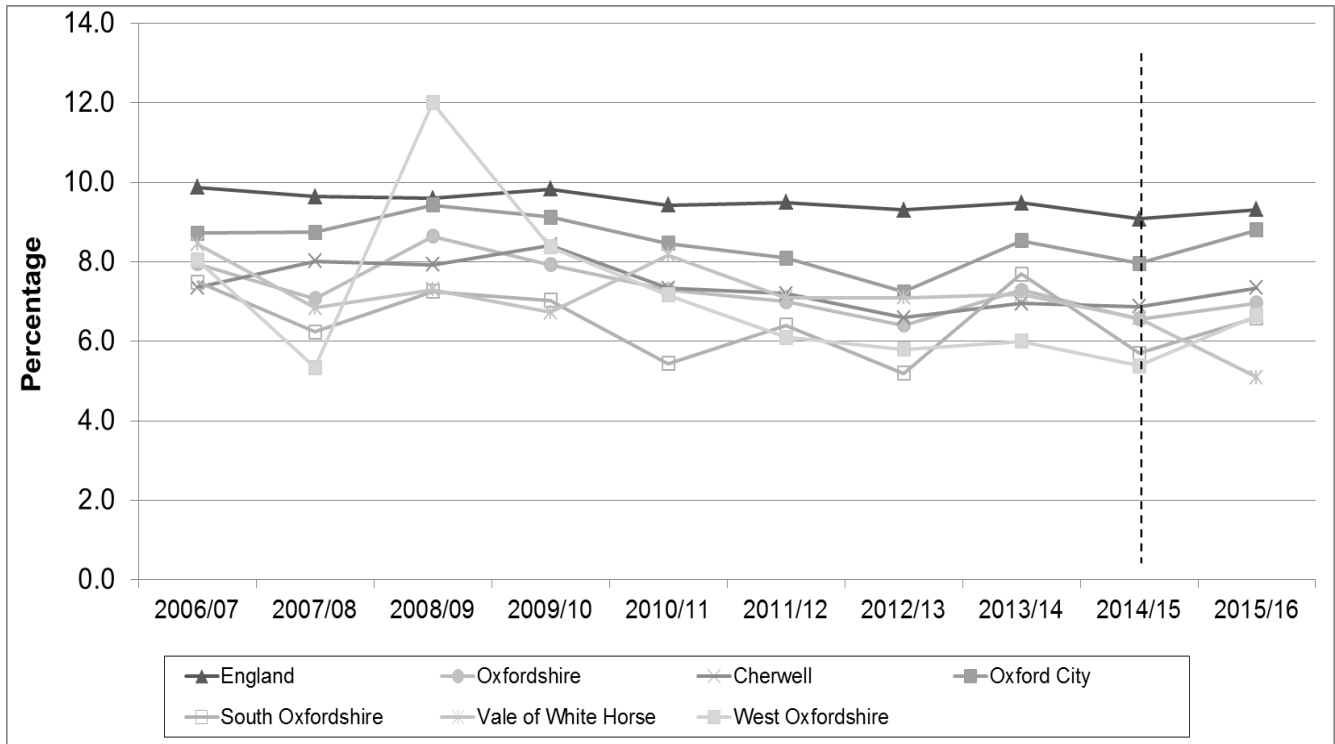

Source: Public Health Outcomes Framework

The data shows that:

➢ The Oxfordshire figure is comparable to regional and national levels.

➢ We will monitor this new data in future reports.

Indicator 9. Obesity in children in reception year

**Percentage of children in Reception Year (4/5 year olds) who are obese
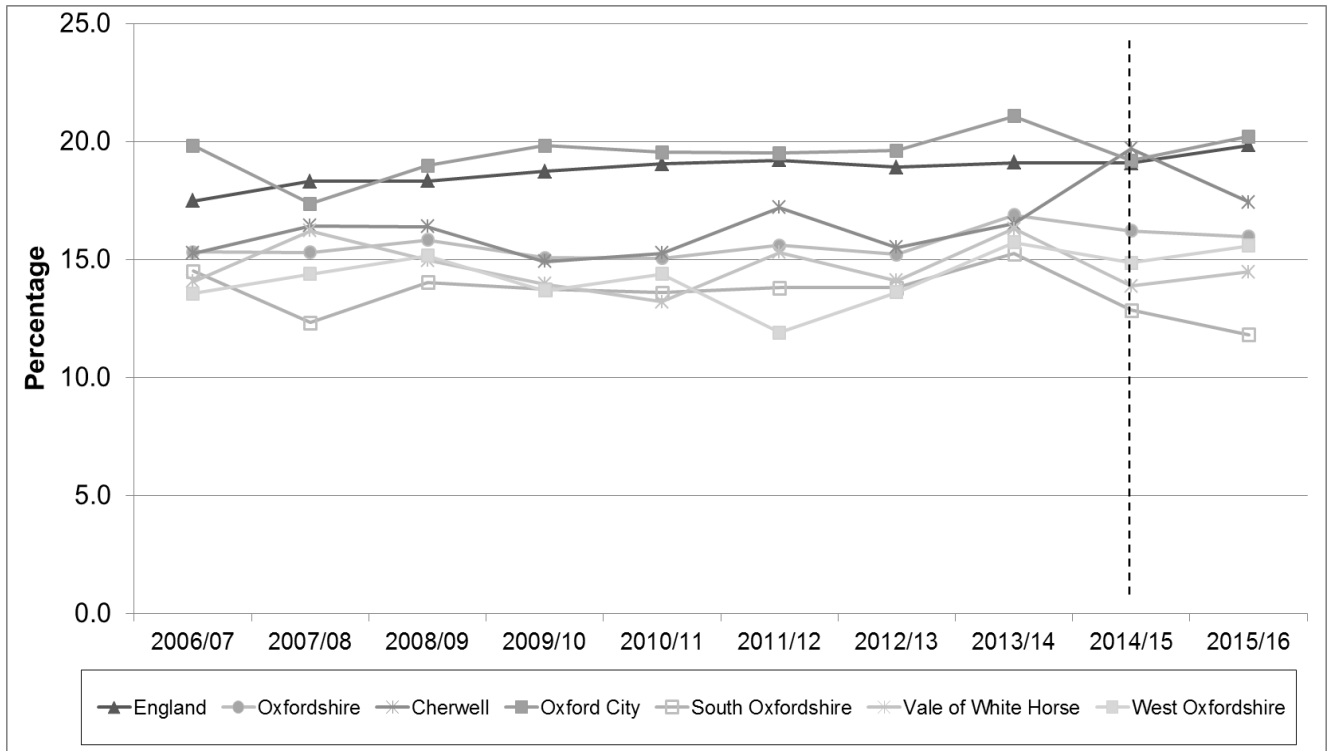2006/07 to 2015/16 (Academic years)**

Source: National Child Measurement Programme

➤ Prevalence of childhood obesity among this age group has remained fairly level at around 7% with some fluctuation at a district level.

➤ We continue to buck the national trend which is just over 9% and this is a good result.

➤ Levels of obesity in this age group remain higher in Oxford City, probably reflecting the association between social disadvantage and higher levels of obesity.

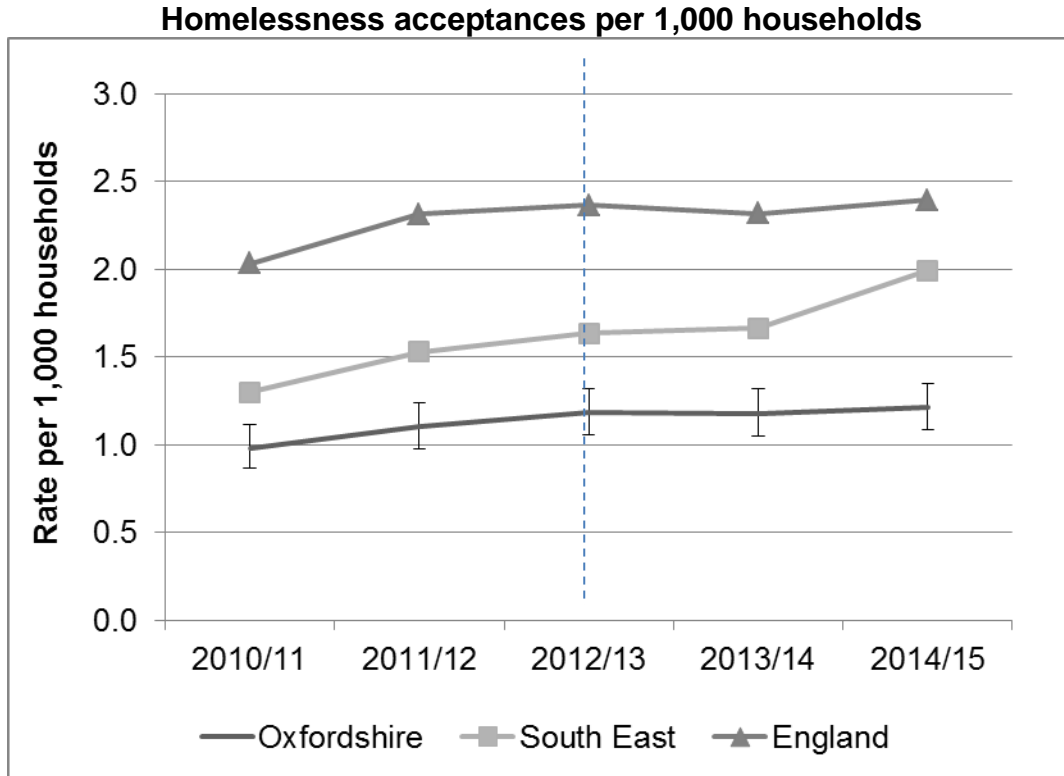**Indicator 10. Obesity in Year 6 (10/11 years)**

**Percentage of year 6 children (10-11 years old) who are obese
2006/07 to 2015/16 (Academic years)**

- The county figure has continued to fall and is around 16% - better than the England average by almost 4 percentage points (19.8%). This is a significant achievement.

- Oxford City has a higher rate at 20%, again, probably reflecting higher average rates of social disadvantage.

- After an increase in 2014/15 the rate in Cherwell has decreased to 17% for 2015/16 which is good news.

Indicator 11. Homeless Households

Homelessness is a direct reflection of disadvantage to families and is therefore a useful overall indicator.

Homelessness acceptances per 1,000 households

The chart shows that:

➢ Oxfordshire's results are well below the national average and have remained fairly stable.

➢ National figures are slightly up and regional figures show a sharp upward trend.

➢ It is a good result that Oxfordshire's figure is both lower and more stable than our regional neighbours.

Homelessness acceptances per 1000 households by districts in Oxfordshire

We know that homelessness varies widely across the different Districts. As this is an important indicator, it is worth drilling down more into the data to look at the trends at District level.
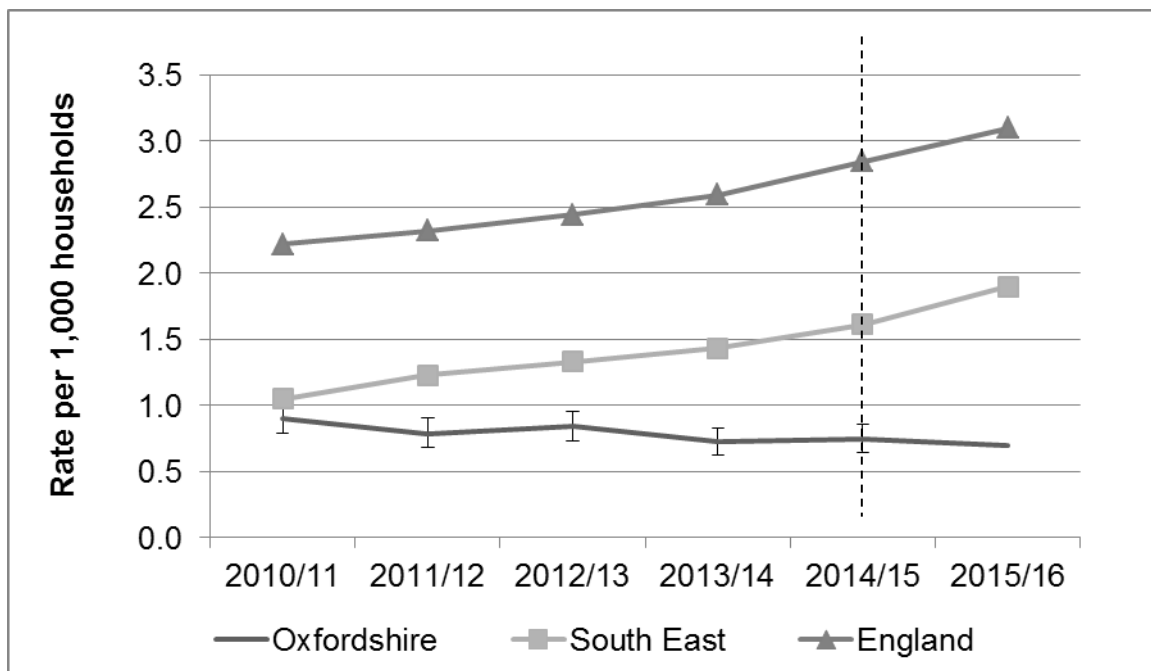

The chart shows that:

> ➤ Oxford City has increased to 2.5 homeless acceptances per 1,000 households (higher than the rate for England), putting the level higher than it has been in recent years. This is concerning and the trend needs to be monitored closely. It is possible for quite wide random fluctuations to occur in this data as the numbers involved are quite small and so a watching brief is appropriate, but the figure is a cause for concern.

> ➤ The rates in the other districts have also fluctuated – up slightly in Cherwell and down in South Oxfordshire and West Oxfordshire. Vale of the White Horse continues to show a marked downward trend.

Indicator 12. Households in temporary accommodation

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

Households in temporary accommodation per 1,000 households

The chart shows that:

➢ The rate in Oxfordshire shows a gradual continued reduction while rates nationally and regionally have increased.

➢ This is a good result and indicates overall success in tackling disadvantage.

Summary from the basket of indicators.

Statistics around teenage pregnancy, teenage mothers, obesity, young people in employment and training, households in temporary accommodation, homelessness overall and breastfeeding show good or reasonable results indicating that progress is being made.

Statistics around child poverty, school readiness and homeless acceptances in the city require a close watching brief.

What we said last year and what we have done about it

Last year's recommendations are set out below with a commentary on progress made:

1. The report of the Commission for Health Inequalities should be studied carefully when it is published and all organisations should use it to challenge current practice and make appropriate changes to services.
   Progress report: Good progress has been made and this is set out immediately below.

2. Trends in disadvantage should continue to be monitored closely in Director of Public Health Annual Reports
   Progress: This has been done through the Joint Strategic Needs Assessment and through this report.

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

4. The NHS's Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The NHS 'offer' should not be 'one size fits all'.
   Progress: In the event, the consultation was divided into two parts. Disadvantage featured in the local phase 1 consultation document published by the CCG earlier in the year. However, it is the mooted phase 2 consultation on community services which will probably reflect whether variations between localities have been adequately taken into account to ameliorate health inequalities, so it is too early to form a judgement.

The Work of Oxfordshire's Health Inequalities Commission

I want to report here on the most significant event in tackling health inequalities and disadvantage which happened during the year – a report on the work of Oxfordshire's Health Inequalities Commission.

What is the Health Inequalities Commission?

The independent Health Inequalities Commission for Oxfordshire was commissioned by the Health and Wellbeing Board and carried out its work throughout 2016. It was the brainchild of the Chair of Oxfordshire's Clinical Commissioning Group and took two years of persistent effort to bring about. The Clinical Commissioning Group, the County Council's Public Health team, along with many other partners, including Oxfordshire Healthwatch played a midwife role. The report of the Commission was presented by the independent Chair, Professor Sian Griffiths, to the Health and Wellbeing Board in November 2016 and at a launch event on 1st December, chaired by the Leader of the County Council, attended by the media and a wide range of partners.
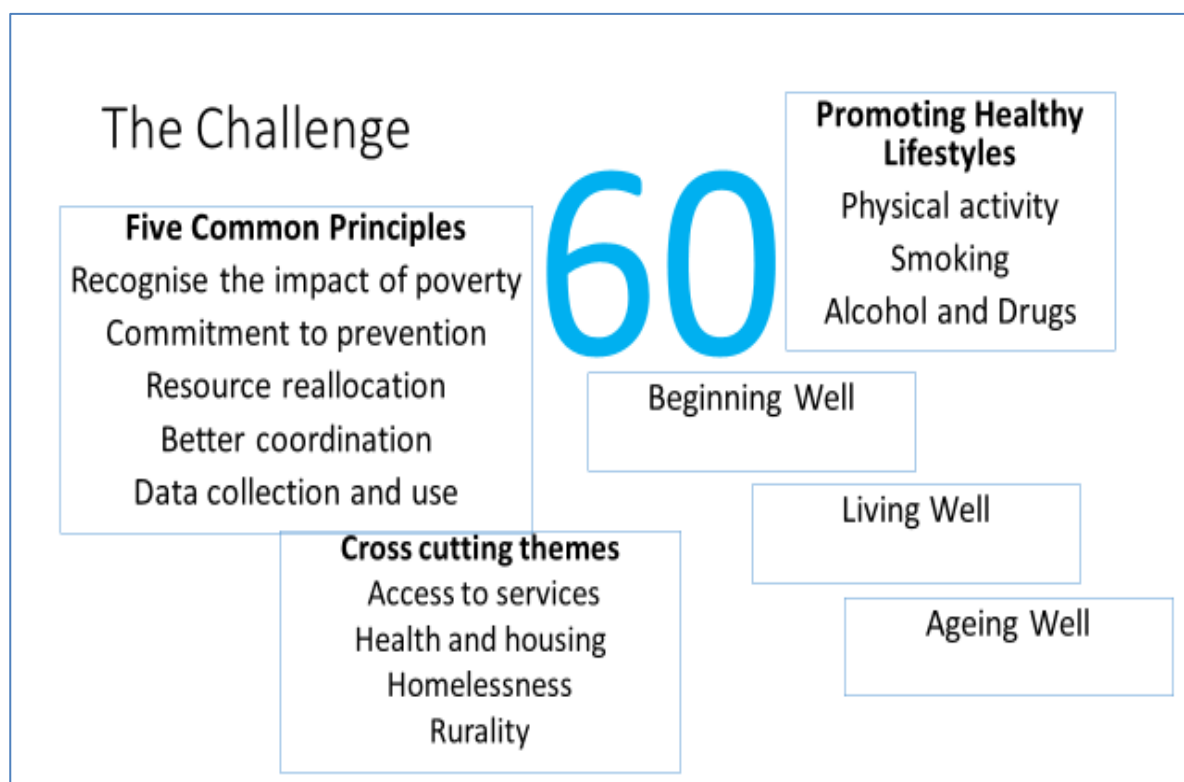
The Health Inequalities Commissioners were independent members selected from statutory and voluntary sector organisations and academia. They received written submissions and verbal presentations from a wide range of people and organisations at four public meetings held around Oxfordshire in the winter and spring of 2016. Local data and information on health inequalities were also presented to the Commissioners supported by access to a wide range of local and national documents, including the Director of Public Health Annual Reports, the Joint Strategic Needs Assessment and data from Public Health England.

What did it say and who signed up to its recommendations?

The Introduction to the report of the commission summarised their remit as follows:

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. But as Sir Michael Marmot has highlighted, health inequalities are not just poor health for poorer people but affect us all – "it is not about them, the poor, and us the non-poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone".

There are 60 recommendations in the report which are arranged in a set of themes as follows:

The Challenge

Five Common Principles
Recognise the impact of poverty
Commitment to prevention
Resource reallocation
Better coordination
Data collection and use

60

Promoting Healthy Lifestyles
Physical activity
Smoking
Alcohol and Drugs

Beginning Well

Living Well

Ageing Well

Cross cutting themes
Access to services
Health and housing
Homelessness
Rurality

How are we taking it forward and who is involved?

The Health and Wellbeing Board agreed to oversee the implementation of the recommendations and receive regular updates.

The report was discussed by a wide range of organisations who signed up to deliver the recommendations, including:

➢ Oxfordshire Health and Wellbeing Board and its subgroups - The Children's Trust, The Health Improvement Board and the Joint Management Group for Older People.

➢ Oxfordshire Clinical Commissioning Group Executive, Board and Localities.

➢ Oxford University Hospitals Foundation Trust Management Executive and Public Health Steering Group

- ➤ Oxford Health Foundation Trust Board

- ➤ The Stronger Communities partnership in Oxford and the linked Local health partnerships in Wood Farm and Rose Hill

- ➤ Cherwell Local Strategic Partnership and 'Brighter Futures' in Banbury

- ➤ Oxford City Council Scrutiny Committee, in their oversight capacity.

In addition, an Implementation Workshop was held in May 2017 attended by a wide range of public and voluntary sector organisations. They began the process of identifying current work and discussing how this can be developed.

It may be impossible to keep a complete overview of the activity that develops as a result of the report, as many groups and organisations have renewed their efforts and energy in addressing health inequalities – that was one of the goals of the Commission, to mainstream the debate about health inequalities. This is good news. In addition, a multi-agency Implementation Steering Group has now been set up and will work together in taking forward the recommendations in a more formal way. Their first tasks include:

- ➤ Making sure there is a comprehensive overview of all the recommendations and what is being done in response

- ➤ Setting up a workshop to explore social prescribing (prescribing healthy activities) as a means of improving health inequalities and beefing up existing prevention initiatives

- ➤ Setting up a (modest) Innovation Fund and determining the criteria by which money pledged by all local authorities and the Clinical Commissioning Group can be used effectively.

How do we keep this initiative going?

It is important to maintain the interest and focus on tackling inequalities and disadvantage that have been stoked by the Health Inequalities Commission. This can be done in several ways:

- ➤ Demonstrating the impact of current work and new developments on tackling inequalities will keep the momentum going. Keeping watch over a range of indicators that show the variation in health outcomes will be important and a basket of indicators is being drawn up to help with that.

- ➤ Changing systems so that they address inequalities. For example, commissioning new services should consider the needs of people in the population who have worse outcomes or poor access to services. The Joint Strategic Needs Assessment and other sources of information will help with this needs assessment.

- ➤ Adopting the "Health in All Policies" approach to developing public policies which looks at the health implications of decisions, tries to join things up and prevents harmful health impacts.

➢ Making sure major plans, such as the Sustainability and Transformation Plan and Joint Health and Well Being Strategy, include action to address inequalities and deliver results.

➢ Using the Innovation Fund well and attracting more funding to sustain and develop good practice and make a difference.

This annual report is part of that process, and also aims to help carry the torch lit by this work.

What concrete things have happened as a result?

Individual organisations will of course be taking their own actions, not all of which we will know about, and this is to be welcomed. The report aims to galvanise us all – not just the big organisations. The process of bringing about change in the statutory services will be a long haul and we are still putting the foundations in place - but there are already some encouraging signs that things are happening:

The response to the call to improve prevention initiatives includes:

➢ Oxfordshire Sport and Physical Activity have begun to prepare plans for improving levels of physical activity in disadvantaged groups. Although an initial bid to Sport England to take the work forward was unsuccessful, other opportunities are being worked through.

➢ A database of food banks and other free or affordable food suppliers has been drawn up by Good Food Oxford.   They are also providing 'food poverty awareness' training for front line services and have developed guidelines on "healthy cooking" for those who are training people in cooking skills.

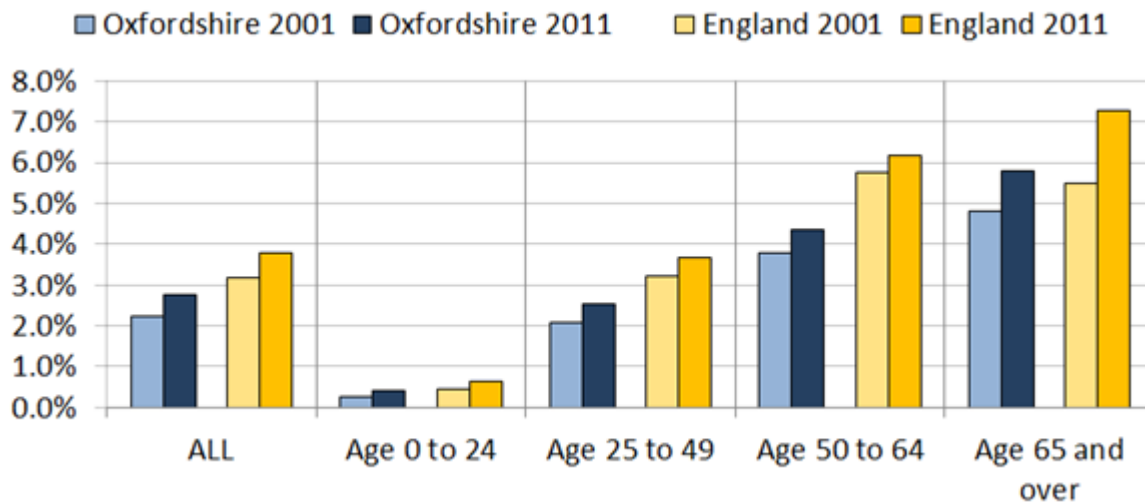Challenges to improve inequalities faced by vulnerable groups are being responded to, for example:

➢ Planning to make Barton a dementia friendly community as part of the Barton Healthy New Town initiative.

➢ A Trailblazer grant to reduce homelessness on discharge from hospital or prison. This involves a wide range of partners, led by the City Council.

➢ Programmes that promote personal resilience and positive lifestyle choices are being run for specific vulnerable groups. This includes a programme for people recovering from drugs or alcohol misuse which is called "Get Connected", run by Aspire and Turning Point. A similar programme, "Active Body, Healthy Mind", is run for mental health service users along with access to regular physical health checks.

➢ A pilot project has been set up to provide counselling to children who are asylum seekers or refugees. This is already in place in Oxford Spires Academy and needs more funding to be expanded. This is led by Refugee Resource.

Caring for others as a cause of disadvantage

Previous reports have highlighted caring for others as a factor which can cause disadvantage. Before I close this chapter I am keen to report on the current situation.

Looking at the last two censuses shows the following picture for Oxfordshire compared with national data:

% of people providing 20 or more hours of unpaid care per week by age 2001 to 2011, Oxfordshire and England

The chart shows:

➢ An increase in the proportion of people providing unpaid care (of 20 or more hours per week) across all age group in Oxfordshire.

➢ The proportion of carers in each of the broad age groups in Oxfordshire remains below the England average.

➢ Between 2001 and 2011, the increase in the proportion of carers in the age group 50 to 64 in Oxfordshire was above the increase in that age group nationally.

As highlighted in previous reports, carers do a marvellous job, and organisations should continue to make sure they are well supported and taken into account when planning new services.

Recommendations

1. The Health and Wellbeing Board should ensure that the work of the Health Inequalities Commission continues to be taken forward.

2. The Basket of indicators of inequalities in childhood should be reported in the DPH annual report next year. The Health Improvement board should monitor homeless acceptances closely during the year.

3. The next phase of the Oxfordshire Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The service 'offer' should not be 'one size fits all' and the needs of different parts of the county should be recognised.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

We are what we eat, breathe, drink and do: whichever way we look at it, how we live our lives has a huge impact on our health. True, our genetics at birth deal us a basic hand of cards to play, but how well we feel, and how long we live has a lot to do with how we play our hand. What's your game-plan?

This chapter looks at some of the things people in Oxfordshire do that affect their health and looks at some of the actions we are taking to inform them of their choices and give them a helping hand.

This isn't about nannying, it's about giving the people the inside info to help them make the best choices they can.

The Health Survey for England gives us a good place to start – and the picture here will apply pretty well to Oxfordshire. In 2015 a total of 8,034 adults (aged 16 and over) and 5,714 children (aged 0 to 15) were interviewed. 5,378 adults and 1,297 children had a nurse visit as part of the survey.

The headlines (which we will unpack in this chapter) were:

➢ Smoking in adults fell from 28% in 1998 to 18% in 2015 – this is excellent. However, we know that around 25-30% of manual workers still smoke – this is a serious health inequality

➢ Alcohol consumption in adults is falling slowly (bringing with it a decline in alcohol related disease) – good news

➢ Obesity and overweight increased – it is now the new 'norm', with around half of adults overweight or obese – this is bad news for our future health.

➢ Children reporting smoking and drinking both fell steeply – more good news –though of course new threats like 'new psychoactive substances' (formerly called "legal highs") may be filling some of this gap.

➢ I would also add that teenage pregnancy continues to fall both locally and nationally – which is also good news.

So, what does this quick overview tell us?

It tells us that the lifestyle challenge that is still on the rise is all about obesity. Let's look at that first.
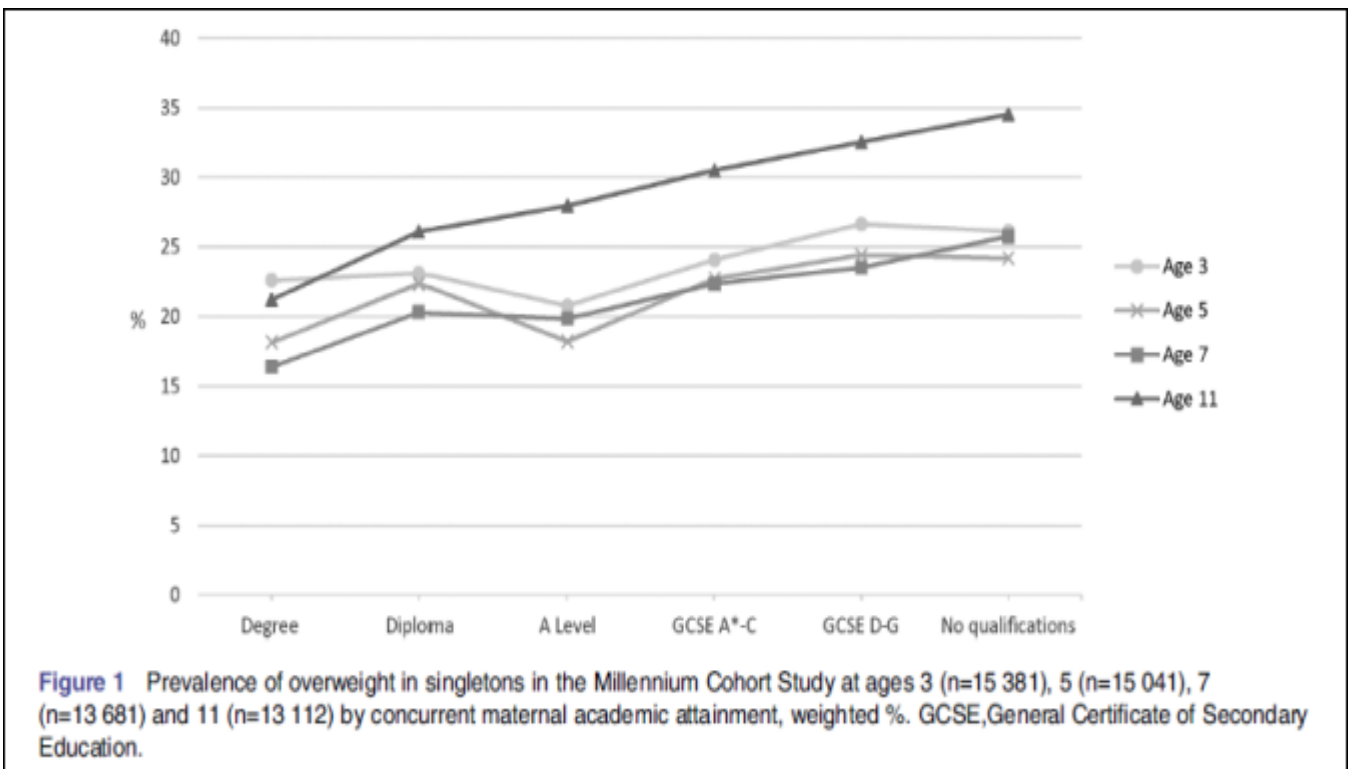
Obesity, Diet and Exercise

I'm not for a moment minimising other challenges and issues, but the unavoidable fact is that as a society the problem we are storing up for ourselves is all about our weight. Why? Because it leads to heart disease, cancer, mobility and disability problems and costs the economy an estimated £27bn, the NHS £6bn and social care £350m each year.

We also know that it is an inequalities issue and affects women more than men, unskilled workers more than skilled and Black and Asian ethnic groups more than white.

The UK Millennium Cohort Study, published an update in 2017 which illustrates this point beautifully. The following chart from the report shows very clearly that prevalence of children overweight increased by age and by lower maternal academic attainment. Mothers without qualifications (and so with less income and fewer choices) had on average children who were around 75% more likely to be overweight than mothers with degrees. The chart also underlines the steady increase in overweight children with age.

Figure 1 Prevalence of overweight in singletons in the Millennium Cohort Study at ages 3 (n=15 381), 5 (n=15 041), 7 (n=13 681) and 11 (n=13 112) by concurrent maternal academic attainment, weighted %. GCSE,General Certificate of Secondary Education.

We saw again in the previous chapter that obesity begins early – doubling between reception year and year 10, and continues to increase into adulthood.

A recent report from Public Health England sets out the situation with regard to physical inactivity well;

"Put simply, we are not burning off enough of the calories that we consume. People in the UK are around 20% less active now than in the 1960s. If current trends continue, we will be 35% less active by 2030. We are the first generation to need to make a conscious decision to build physical activity into our daily lives. Fewer of us have manual jobs. Technology dominates at home and at work, the 2 places where we spend most of our time. Societal changes have designed physical activity out of our lives."

This won't be news to anyone who has read these reports before as it has featured as an issue in ten out of ten reports. Why? Because it is still a problem and, as a collective, we still haven't cracked it…… although there may be some 'green shoots' of hope emerging.

If it matters so much, and we all know about it, why is it so hard?

I suspect this is for a number of reasons which I have teased out below. This isn't about victim blaming – absolutely not – this is really hard stuff – if it wasn't, it wouldn't be such a problem. In brief, the issues seem to be:

1. What we want regarding our lifestyles short-term works against us long- term when it comes to weight gain. We want comfortable lives, we want to travel by car or public transport, we want to watch TV, we want fast and easy food - and all these things lead to weight gain over time.

2. Our genetic programming may work against us. The evolutionists tell us we are programmed to gobble goodies when we see them to hedge against times of famine from our hunter-gatherer days (e.g. a glut of ripe fruit on a tree) by building up a fat store. That makes sense, but we are fortunate that the famine doesn't come any more, and so the fat builds up.

3. Because weight gain is insidious and we are hard-wired for short term responses. We seem to be programmed to respond to immediate dangers and tend to be blind to longer term issues.

4. Because the problem becomes invisible when the majority have it – I suspect that if you could bring a coach full of time-travellers from the 1950's they would be truly surprised to see us now.

5. Because the answer is multi-facetted. The answer isn't simple and implies change by individuals, families, organisations employers and government. We need a 'team UK' effort – and this is always difficult.

6. Because it isn't fair –Our metabolic rates and our genetic make-up are like hands of cards dealt to us at birth. It means that we put on the pounds in different patterns to one another. Where one loses another gains – it isn't fair. It also means that the answer isn't a one shot deal. The answer will vary from individual to individual and this makes setting a consistent policy harder.

7. Because it changes with age. I think many of us know that if we were to eat now what we ate as twenty-somethings we would put on weight very quickly. We are probably on average also less active than in our younger days. This implies that our eating and exercise patterns need to change with age. It is another challenge of an ageing society – how do we adapt to each decade, because the answers at 25 do not apply to 55.

8. Because it's so easy to put on weight and so hard to get it off. It's a bit like a lobster pot: easy to get into and hard to get out again. Many of us have tried slimming, and I think we all know how difficult it is to keep the pounds off once they have been lost. It does take a lifestyle change- and that can be hard graft.

9. Because we don't like preaching – especially if it makes us feel a bit uncomfortable. The messages are I think clear to us all. But they can get a bit 'preachy' and that tends to make us close our ears.

So what do we do?

The answer has to come through teamwork between the individual, family, government, employers, planners and organisations. It's about 1000 adjustments to 1000 tillers to turn the flotilla we all sail in…………….. and there *are* green shoots - for example, in the last year or two:

➢ The health messages continue to seep home into the public's mind – the '5 a day' message is well embedded and shoppers are demanding healthier prepared foods – and the supermarkets are responding.

➢ At national level, Government has taken steps to improve food labelling and to reduce the sugar content of drinks.

➢ The climate in schools is changing – take for example the adoption of the 'daily mile' in schools across the country.

➢ Health and exercise options are being main-streamed by planners into new developments.

➢ The inequalities issues are clearer - and our Health Inequalities Commission report helps.

➢ Front-line health professionals are more willing to consider giving lifestyle advice during routine consultations.

And more locally……

➢ We have made very good progress in building exercise options into planning through the Healthy New Towns.

➢ The Health Improvement Board has made useful efforts to begin bringing recreation and leisure services together with the Sports Partnership to update its healthy weight strategy.

➢ The NHS has taken the topic of 'making every contact count' more seriously so as to get health advice into more face to face consultations.

➢ More schools are looking at options such as the 'daily mile'.

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

We said that this topic should become a priority for the NHS's Sustainability and Transformation Plan – this has happened on paper, but there is no spare cash to fund the scale of change needed.

We said that the Health Improvement Board should play its part in partnership activity and this has been more than achieved.

What should we do next?

To keep it brief, this is a long haul, so essentially it is more of the same – more awareness, more coordination and more money are required.

Recommendations regarding obesity, diet and physical activity.

1. The NHS should continue to seek a serious investment fund to take this work forwards.

2. The Health Improvement Board should continue to coordinate the activities of all Local Authorities and the NHS

3. Planners should continue to plan communities that support active lifestyles until this is the norm.

Alcohol

There seems to have been a helpful shift in drinking patterns that will reap benefits in the decades to come.

Previous reports have set out the real health risks of alcohol as a causative factor for a wide range of diseases and its corrosive effects on society when consumed to excess.

I am not saying the problems have gone away altogether because:

➢ There were over 1 million alcohol related hospital admissions in England in 2015 and over 23,000 deaths related to alcohol.

➢ Alcohol is a causal factor in many medical conditions including mouth, throat, colon, liver and breast cancers; strokes and heart failure; liver disease and pancreatitis as well as road traffic accidents and injuries due to falls.

➢ Alcohol affects us all – for example, the highest earners (those earning £40,000 and above annually) are more likely to be frequent drinkers and "binge" on their heaviest drinking day when compared with the lowest earners.

But on the other hand:

➢ Overall alcohol consumption in the UK has decreased between 2000 and 2014, reducing from over 10 litres of pure alcohol per person aged 15+ to around 9.5 litres per head

➢ The proportion of the adult population of Great Britain (aged 16 and over) who drink alcohol has fallen from 64% in 2005 to only 60% in 2016).

➢ Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group.

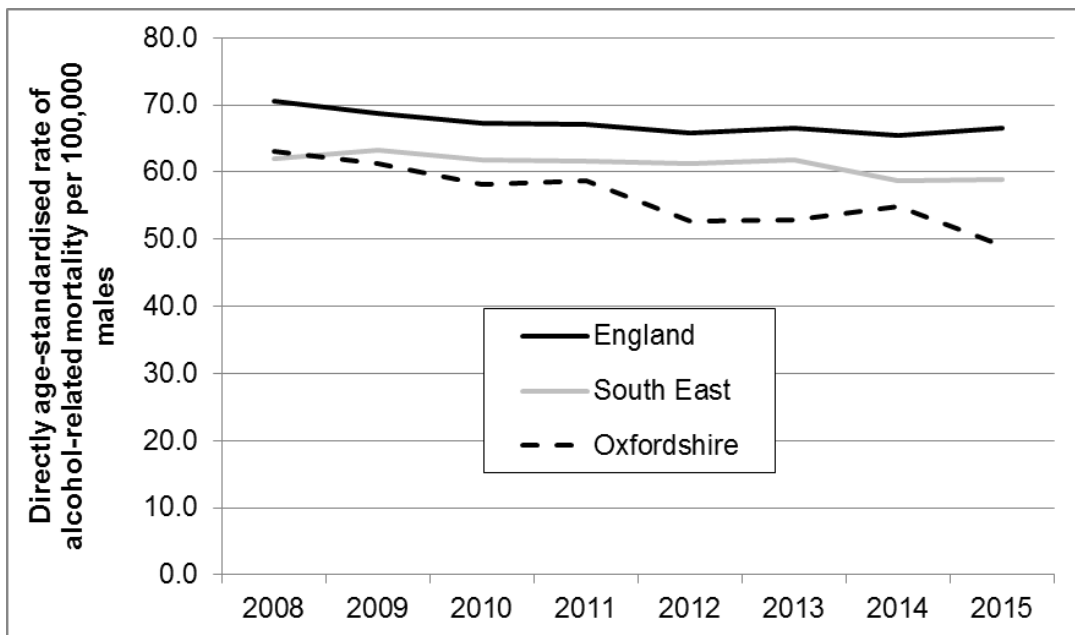➢ Alcohol consumption in young people in general is falling

Why should this be?

I'm not sure anyone really knows. It may be that the health messages have hit home, or it may just be one of those complex societal 'fashions'. My money would be on the latter. Looked at over centuries, the average trend in alcohol consumption per capita has always fluctuated. We may have entered a down-turn and, whatever the reason, that is very good long term news.
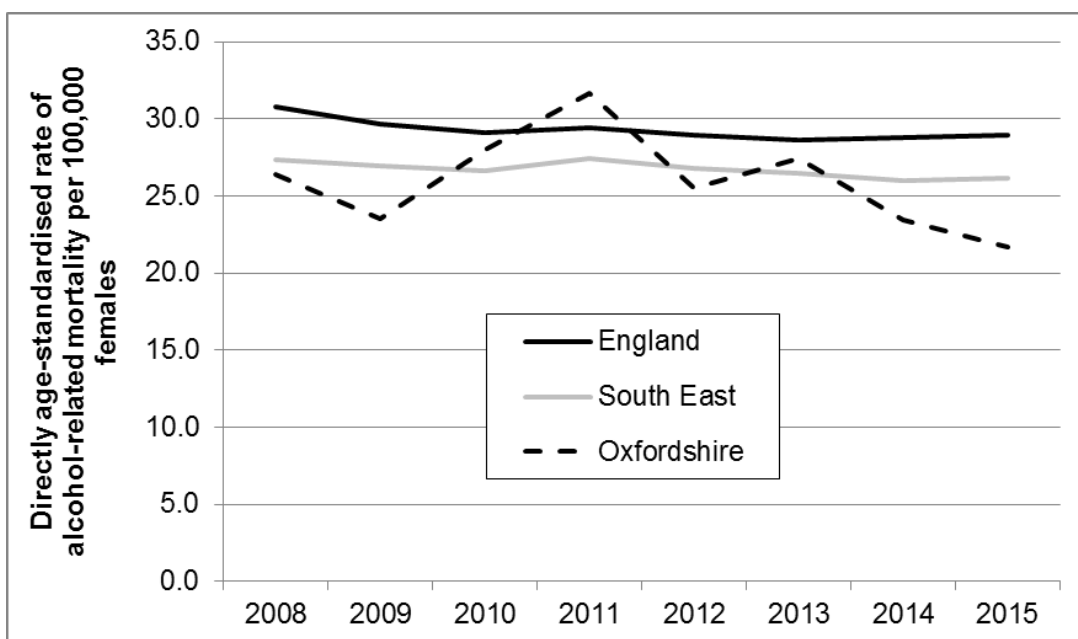
The statistics paint the picture well:

➢ Alcohol related deaths in males and females have been declining over the last 6 of 7 years and the figures are better for Oxfordshire than nationally. Also, deaths in females are around half of those in men

Alcohol-related mortality – males

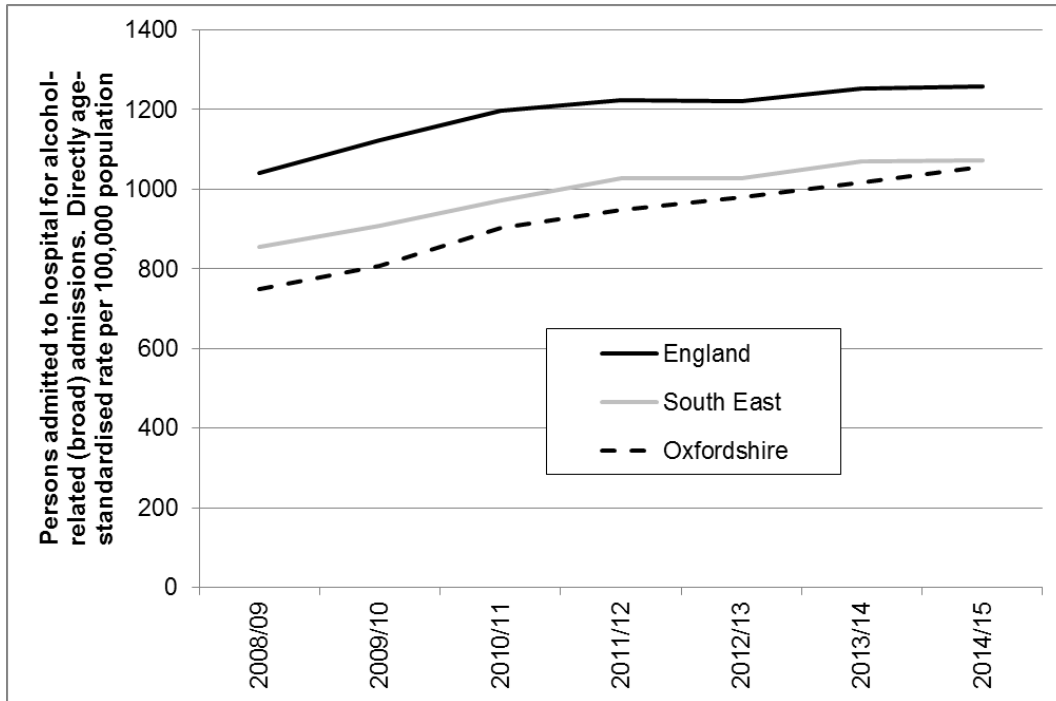### Alcohol-related mortality – females

However, we aren't out of the woods yet as the figures for alcohol-related hospital admissions continue to show an upward trend. You can see this in the charts below which show people

admitted to hospital each year per 100,000 population. Because alcohol-related disease is long term, this might be the long term legacy of the drinking habits of previous decades – time will tell.

Whatever the reason, it is good news that the levels in Oxfordshire are well below national levels.

Persons admitted to hospital for alcohol-related conditions) - all ages

What Did We Say Last Year and What Have We Done About It?
Achievements in 2016-17

The Alcohol and Drugs Partnership reports the following progress in partnership work:

1. Identification and Brief Advice (IBA)

   The goal is to equip professionals with the confidence to give brief advice to people who are drinking too much. The partnership's role is to train the professional. This year the training was expanded to include smoking cessation and all sessions have been well attended by a range of professionals including those working in adult social care, early Intervention services, mental health organisations, charities, housing providers, primary care, pharmacies and Oxford University Hospitals Trust.

2. Targeted alcohol campaigns

   This year the Dry January campaign was again supported by the Fire and Rescue Service, and included 'mocktail' sessions run by Alcohol Concern. Advertising for the campaign included social media, the County Council's Yammer pages as well as an article in the Oxford Mail.

3. Improvement in Pathways to treatment.

Oxfordshire treatment services have been working hard to improve pathways between local hospitals and their services. Referral routes from both A&E and ward admissions back into the community have been reviewed as well as barriers to communication and continuation of prescribing. Staff from Turning Point (a drug and alcohol treatment organisation) continue to develop joint-working with the NHS, and a community alcohol detoxification nurse attends the John Radcliffe Hospital weekly to discuss patients and provide on-going community support for patients leaving hospital.

4. Street Pastors

Street Pastor schemes continue to flourish in the City and several market towns across Oxfordshire. Street Pastor schemes work in partnership with organisations such as the Police, Local Authorities, local door staff and licenced premises. They patrol the streets with a remit to 'care, listen and help'. Between April and September 2016 over 577 people were assisted by the street pastors.

What we said last year and progress made

Recommendations for 2016-17 were set out as follows:

1. The NHS should use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This is a real opportunity to nip alcohol related diseases in the bud.

2. This should be backed up by staff training and support.

Progress report: This work is ongoing and, due to delays in publishing the Transformation Plan for Oxfordshire, it is not yet clear that last year's recommendations have been fully implemented.

Recommendations for 2017-18

1. The NHS should continue use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This should be backed up by staff training and support.

2. Campaigns should focus on the impact of alcohol on health so that there is increased awareness of the harmful effects of alcohol on cancer and cardiovascular disease in particular.

NHS Health Checks

The NHS Health Check is a national cardiovascular risk assessment and prevention programme which is commissioned by the County Council. It is delivered by local GPs and has been commissioned by the County Council's Public Health team since 2013

NHS Health Checks specifically target the top seven causes of preventable death: high blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

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

In Oxfordshire, the Health Improvement Board has set a target of 55% of those invited for a NHS Health Check take up the offer and receive the Check.

In 2016/17 in Oxfordshire 34,667 people were offered NHS Health Checks (18.2% of eligible population) and 17,847 checks were completed (9.3% of the total eligible population and 51.5% of those offered a check). This is an improvement on 2015/16 in terms of uptake (51.2% in 2015/16), but a decrease in percentage offered (20% in 2015/16) and percentage completed.

During 2016/17 of the 17,847 people who had a Health Check:

➢ **896 people were found at high risk of CVD, with 417 people now taking a statin**

➢ **275 people diagnosed as having high blood pressure, with 252 now on an antihypertensive drug**

➢ **63 people were diagnosed with diabetes**

➢ **1537 people were given brief advice regarding smoking, with 148 people referred/signposted to the local stop smoking service**

➢ **6310 people were given brief advice regarding physical activity, with 1706 people referred/signposted to the local physical activity services**

➢ **5821 people were given brief advice regarding weight management, with 283 people referred/signposted to the local weight management services**

➢ **1574 people completed a screening tool for their alcohol consumption. In addition1658 people were given brief advice regarding alcohol, with 8 people referred to the local alcohol services.**

This is a good result.

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

Last year we said we would continue to bring the NHS Health Check programme to the public's attention in new and innovative ways to further raise awareness in the local community. This peaked with a month long campaign in January using local radio and advertising on transport links- which is thought to have contributed to the increased uptake in quarter 4.

We also said we would continue to work with GPs to improve the uptake of the offer, including the invitation process. Commissioners are working with GPs to investigate a combined approach of electronic communications from GPs and simultaneous targeted marketing online to improve uptake of the offer.

The commissioning team continue to closely support practices and have visited every practice as part of quality auditing the programme. They provide feedback to GP practices on how to improve on the quality of the programme. The approach to quality auditing taken by the public health team is still considered a national exemplar.

Recommendations for NHS Health Checks

The NHS Health Check programme continues to perform well, is now well embedded in the health system and is well received by the public. However, the concerted efforts to raise the profile of this programme with the public and improve on it must be maintained. In order to achieve this we need to:
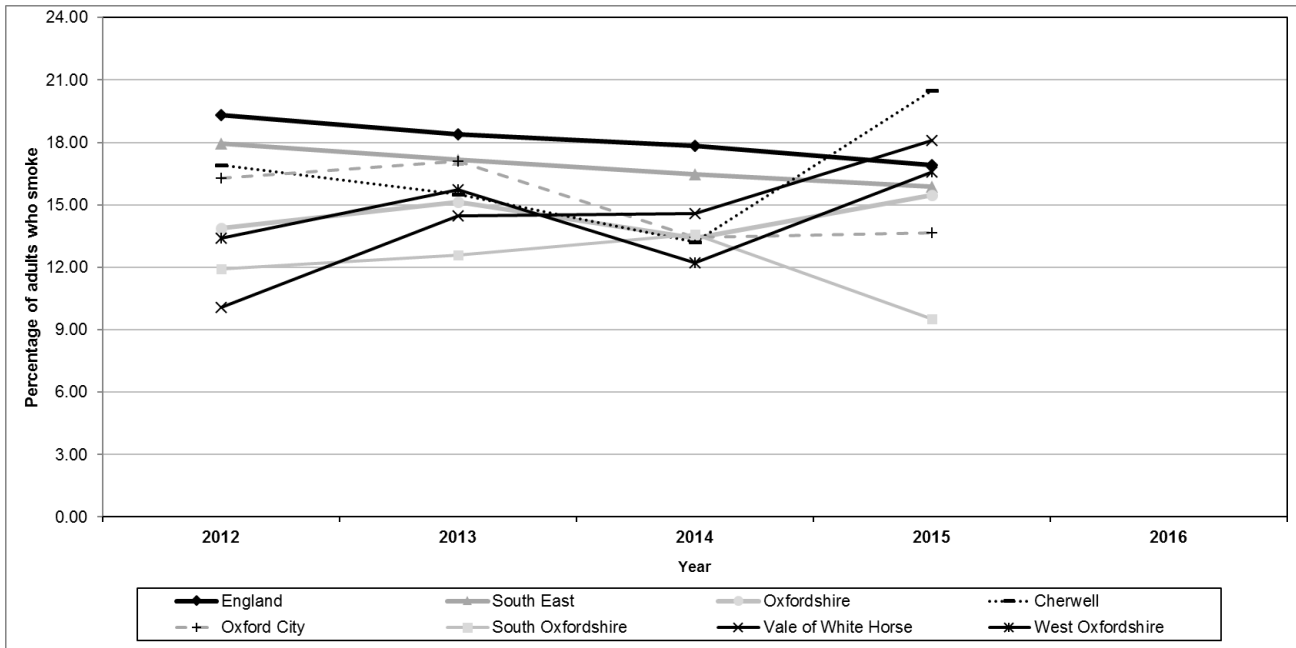
1. Continue to market the NHS Health Check programme in new and innovative ways which take advantage of emerging technologies to raise awareness and understanding of the benefits of the programme with the public.

2. Continue to work with GPs to improve on the uptake of the offer of a free NHS Health checks and investigate new ways to best collaborate on improving the invite process.

3. Better identify and engage with high risk groups to take up the offer of a free NHS Health Check.

Smoking Tobacco

Smoking Tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, vascular diseases and events such as heart attacks and strokes, and dementia. In Oxfordshire the prevalence of adult smokers has seen a very welcome continued decline in the past few years. This decline is shown in the figure below. The prevalence of adults who smoke in Oxfordshire is currently estimated to be 15.5% (an estimate of 91,892 people) which is better than the national prevalence (16.9%). This is a good result.

The chart below shows the results. Because this is based on a survey of a limited number of people, the national line will be accurate, the County line fairly accurate and the District lines far less accurate and subject to wide fluctuations.

Smoking prevalence in individuals aged 18+ by District in Oxfordshire

(Source PHE)

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

Smoking is highly addictive and the best thing for health is not to start. Although the trend for smoking in young people is falling the prevalence of young people aged 15 years who report in the survey that they are current smokers is 10.4%. This is significantly worse than the national average of 8.2%. While this is of concern some caution has to be exercised as the data is estimated based on responses provided to surveys of young people and can be subject to statistical errors (i.e. in plain speak it may be a 'blip'.). We should monitor this trend to see if this is a consistent finding.

Stop Smoking Services

The decline in people accessing traditional stop smoking services seen in recent years was halted in Oxfordshire with 1923 quits recorded for 2015/16 – three less than in the previous year total of 1926. This was against the national decrease of 10% in the recorded number of quits recorded nationally. This is to be applauded but preventing a further decline in recorded quits is becoming increasingly difficult. Why? Because there are fewer smokers 'out there' and there has been a sea-change in the way people choose to quit tobacco – increasingly opting for self-help solutions rather than statutory services.

The impact of the dramatic increase in the use of e-cigarettes in the UK is the most significant contributor to the reduction in people accessing stop smoking services. Latest data estimates:

➢ An estimated 2.9 million adults in Great Britain currently use e-cigarettes up from 700,000 in 2012

➢ For the first time there are more ex-smokers (1.5 million) who use e-cigarettes than current smokers (1.3 million).

➢ Over half (52%) of e-cigarette users are now ex-smokers and 45% continue to smoke as well.

➢ The main reason given by ex-smokers who are currently vaping is to help them stop while for current smokers the main reason is to reduce the amount they smoke.

➢ The use of e-cigarettes as a quit aid and their increasing usage has opened a debate in the public health community on a national and international scale. Currently in 2017, public perceptions of harm from e-cigarettes still remains inaccurate with only 13% accurately understanding that e-cigarettes are a lot less harmful than smoking. Among those who smoke, perceptions of e-cigarettes are also getting more negative, with only 20% accurately believing in that e-cigarettes are a lot less harmful than smoking compared with 31% in 2015.

With the increasing amount of conflicting information for and against e-cigarettes becoming available in the public arena there has naturally been confusion for the public and health professionals alike.

Public Health England have helped to clarify the position and published an evidence update which concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking.

The report also concluded there is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers. This is further supported by a report from the Royal College of Physicians published in April 2016 which states that e-cigarettes are an effective method for people wanting to quit tobacco and the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.

How should we move forward?
Our current services are now outdated. We need to move to a service which helps the general public but which also actively seeks out smokers in the most at-risk groups.

The public health team, in line with The National Institute for Health and Care Excellence (NICE) recommendations, are considering the following main areas for future services:

➢ Mass media and other education campaigns
➢ General education campaigns aimed at everyone;
➢ Media campaigns aimed at under 18s.
➢ Planning evidence based stop smoking services;
➢ Preventing children and young people from taking up smoking;
➢ Illegal sales
➢ Coordinated approach in schools
➢ Developing services which encourage better uptake in disadvantaged and minority communities who have higher rates of smoking.

Recommendations regarding smoking

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

2. Commissioners should re-commission services to deliver a blend of services to meet the changing attitudes and use of stop smoking services.

Oral Health

The marked improvement in oral health and the number of adults keeping their teeth as a result of better brushing with fluoride toothpaste and more awareness of oral health is welcome. However nationally in England the biggest cause of child hospital admission for general anaesthetic procedure is to provide dental extractions due to severe tooth decay. Tooth decay is one of the most easily preventable diseases and the high level of extractions under general anaesthetic is avoidable.

The picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions at lower than County level. 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 inequality in the County. Latest available data from the 2015 oral health survey of five-year-old children shows that 77% of 5-year-old children are now free from any dental decay which is higher than the national average of 75% and improved locally from 67% since the 2012 survey. Whilst this is a good result there is room for improvement, the number of children who are decay free is significantly lower in Oxford than the other districts at 67%, probably reflecting social disadvantage.

During the 2016/17 dental teams have been conducting the latest national five-year-old children's survey and we expect to refresh the local data in the next twelve months.

The major sources of sugar which causes decay in children are found in soft drinks and cereals. Locally we will continue the work to educate children and parents about the impact of dietary choices on teeth and also wider health.

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 changing need - 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 has been split three ways. The NHS has a responsibility for dentists and more specialised oral surgery, Public Health England

provides dental public health advice while Local Government has an emphasis on prevention and commissioning oral surveys in line with the national programme.

The oral health promotion and dental epidemiology service commissioned by the County Council has been in operation since 1st April 2015. This service aims to work in collaboration with wider dental services to prevent oral health problems in children and adults. The range of activities provided by the service include:

➢ Accreditation scheme for pre-school settings

➢ Piloting tooth brushing programme in primary schools. Four primary schools took part in the pilot programme in which children brushed their teeth under supervision of staff. The programme developed better understanding of oral health and improved brushing skills in children, making tooth brushing a routine part of the day which improved attitudes to brushing in the young children involved.

➢ Training of school health nurses in oral health promotion to promote a 'whole school' approach to oral health in education such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting evidence-based, age-appropriate, oral health information for parents, carers and children, including details on how to access local dental services.

➢ Piloting an accreditation scheme for care homes for elderly residents. The pilot successfully accredited three care homes as oral health promoting environments. The service trained staff to better understand the oral health needs of residents, the causes of oral disease, good oral hygiene for their residents and how to access dental services. The participating care homes also developed policies to better promote oral health for residents.

➢ Delivering oral health promotion sessions and events throughout the county

➢ Training health visitors in oral health to better understand the causes of tooth decay, oral development in young children, looking after teeth in young children and accessing dental services.

➢ Training staff who work in the community with children and adults to promote oral health with their client and user groups including causes of tooth decay, oral hygiene and access to dental services.

➢ Delivery of oral health promotion in local workplaces including Siemens and Thames Valley Police.

➢ Promotional events during National Smile Month and Mouth Cancer Awareness Month

➢ Provision of a lending service of health promotion resources for local stakeholders.

In the next year the oral health promotion service will

➢ Continue the supervised tooth brushing scheme in primary schools. Two of the schools in the pilot are planning to continue the programme and the service is looking to recruit new schools for the 2017/18 academic year.

➢ Find ways to reach a wider number of care homes.

➢ Continue to train staff in healthcare and community settings to become oral health promoters within their workplace with their service users and make every contact count.

➢ Continue support of oral health promotion development within both school health nurse and health visitor services.

➢ Continue to participate in oral health promotion events and sessions in the community to directly work with the public on raising the awareness of the importance of good oral health and accessing dental services.

Recommendations for Oral Health

1. The NHS should ensure that improvements in access to NHS dentistry are maintained including complex care and domiciliary care for older people and work continue to work to reduce child admissions for dental extractions under general anaesthetic.

2. Providers of care home facilities should be aware of maintaining good oral health in their clients which can significantly affect their quality of life. Commissioners of the oral health promotion should work with colleagues to develop this programme to increase the number of care homes who sign up to this programme.

3. Continue to work with school health nurse and health visitor services to embed oral health prevention and promotion into children's health from 0-19, allowing for a healthier oral health start to life.

4. Continue to develop the supervised brushing scheme in primary schools, developing on the encouraging work of the pilot programme.

Chapter 5: Mental Health

Mental Health - Children and Young People

I reported last year on mental health in children and young people and I want to keep that focus this year.

Last year I reported on two topics – trends in mental wellbeing in this age group in general and self-harm.

Looking at each of these in turn, we noted that:

➢ mental wellbeing and mental distress are difficult to define and measure in this age group and that what is classed as a mental health problem changes over time

➢ however, the indications are that living in the modern world and a digital age puts new stresses and strains on young people

➢ young people are coming forward to seek help – and we can see this in the work of our school health nurses and through rising referrals to NHS services

➢ this increase is no bad thing as it also shows young people's awareness of the issues they face and also young people's general self-help attitude.

To recap, the picture of emotional resilience and mental wellbeing can be summed up as being built up in the following ways:

➢ Positive relationships with caring adults
➢ Effective caregiving and parenting
➢ Intelligence and problem-solving skills
➢ Self-regulation skills
➢ Perceived efficacy and control
➢ Achievement / motivation
➢ Positive friends or romantic partners
➢ Faith, hope, spirituality
➢ Beliefs that life has meaning
➢ Effective teachers and schools

In contrast, when these factors are deficient, the individual's resilience is likely to be lowered and there is a greater vulnerability to stresses and strains.

Regarding more severe mental health problems in Children and Young People, the main facts are:

➢ 1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder; that is around three in every class at school or 8,000 children across Oxfordshire. According to national prevalence rates about half of these (5.8%) have a 'conduct disorder', whilst others have an emotional disorder (anxiety, depression) and Attention
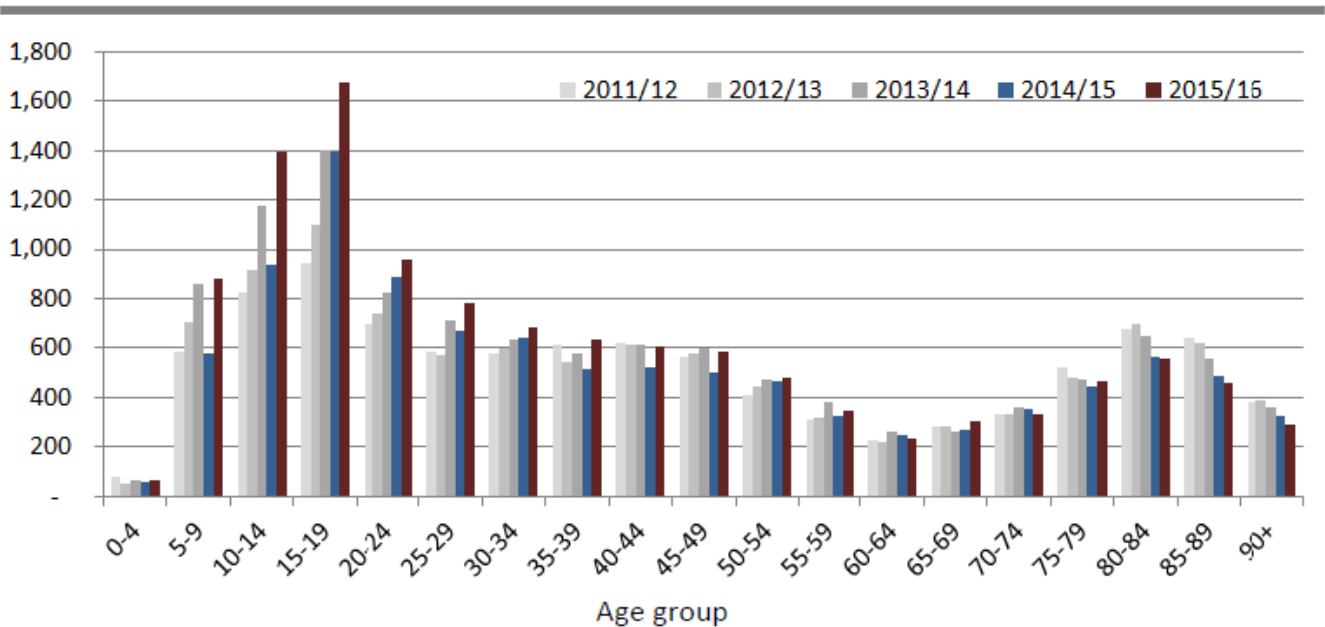
Deficit Hyperactivity Disorder (ADHD). The prevalence increases with age and rises to 20% for the 16-24 age groups.

➢ The most disadvantaged communities and the most disadvantaged groups have the poorest mental and physical health and wellbeing. **Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%.** Parental unemployment is also associated with a two-to three-fold greater risk of emotional or conduct disorder in childhood. This doesn't mean that one causes the other, it simply points out that the two factors are found together in the same families.

➢ Children and young people with poor mental health are more likely to have poor educational attainment and employment prospects, social relationship difficulties, physical ill health, substance misuse problems and to become involved in offending.

➢ These issues are therefore significant and important.

In very general terms I suspect that what we are seeing overall is a generation who are subject to more moderate stresses (cyber-bullying for example), and that they have an increasing awareness of this, and, most importantly that they are seeking help. The chart below shows this through the rise in referrals of young people to mental health services.

Number of Oxfordshire residents referred to Oxford Health mental health services (2011-12 to 2015-16)

Source: Oxford Health NHS Foundation Trust

➢ The 15-19 age group continues to make up the largest proportion and number of patients referred to Oxford Health mental health services in 2015-16 and has seen the biggest increase since 2011-12.

➢ Between 2011-12 and 2015-16, the number of patient referrals aged 15-19 increased by 77%

I reported last year that children and young peoples' mental health service had just been overhauled. This is timely. The results of this were that a new contract for a new service model was awarded. The new service focusses on early prevention and intervention in partnership with voluntary agencies, public health services, education and children's social care to ensure children, young people and their families can get information, advice and support (including self-care) when there are emerging mental health problems. This is aimed at preventing more chronic and complex mental health problems, which can affect long term outcomes into adulthood.

We should also note the very valuable contribution our School Health Nurses make to the treatment of mental distress day in day out in our secondary schools.

The new service features:

➢ A single point of access for all referrals including self-referrals and clear publicised pathways for the most common conditions

➢ Active support for families and individuals to help them access other community services where this is more appropriate

➢ Partnership with voluntary organisations to support families better and improve movement between services for the young people with the most complex problems

➢ Reducing waiting times to improve access to support and treatment using evidence- based interventions to improve long term outcomes into adulthood

➢ Consultation, information and advice to families, young people and the wider children's workforce and the promotion of self-care and use of technology.

➢ Prevention and early intervention by working in schools and colleges to provide consultation, training and treatment in partnership with school health nurses and children's social care services

The service will include newly established specialist services such as:

➢ A dedicated Eating Disorder Service

➢ A new therapeutic team specifically working with young victims of child abuse and child sexual exploitation

➢ A new team to work with children who are 'Looked After' and those young people who are on 'the edge of care'

➢ An Autism Diagnostic Service with support for families after a diagnosis has been made

➢ A forensic psychiatry post working in the young people's housing pathway providing mental health expertise to some of our most complex young people and building capacity in the housing provider market

The focus for the first year is to deliver the 'single point of access' which will improve access to consultation, information and advice and treatment and, in addition, to start transforming the service into providing prevention and early intervention through working with primary and secondary schools across Oxfordshire. This includes School Health Nurses and improving integration and joint working with Children's Social Care. Voluntary organisations will play a key role as partners in delivering Child & Adolescent Mental Health Services (CAMHS).

This is clearly a substantial change and seems to respond well to the needs of young people. Implementation will take time – working with every Oxfordshire school is a huge task and a long process.

I think these are useful steps in the right direction.

Careful monitoring of this service and of new trends in the overall wellbeing of this age group will be essential.

Self Harm

I also reported last year on self-harm and reviewed the recent upward trend.

The last year has seen a mixed picture.
Measuring self-harm using hospital admissions shows that:

➢ rates in 10-14 year olds are down slightly

➢ rates in 15-19 year olds are up slightly

➢ rates in 20-24 year olds are down slightly

All of these figures are similar to the national picture. The trends we are seeing in Oxfordshire around self-harm are part of a national picture rather than a local one.

The new service mentioned above is intended to help to relieve the stresses that result in self-harm. It will be important to monitor the situation to see if there is a lasting impact.

In addition, last year I reported on an initiative that the Public Health team had undertaken locally. To recap, we commissioned a local Oxfordshire theatre company, Pegasus, to perform a play on self-harm in secondary schools across the county. The play was called 'Under My Skin'. Its aims were to:

➢ Give young people vital information about coping with feelings around self-harm, stress and the relevant services that can support them.

➢ Reduce the stigma of discussing self-harm and accessing support.

➢ Highlight the School Health Nursing service as a first port of call in schools for young people and professionals who have concerns over self-harm.

➢ Give professionals information and subsequent confidence about how to support a young person, and who to refer to.

The evaluation of the play showed that:

➢ It went to 28 secondary schools and was very well received.
➢ Approximately 5000 young people in years 8/9 (ages 12-14) watched the play.
➢ 50% reported the play increased their knowledge of self-harm a lot.
➢ 71% of young people knew how to access support after seeing the play.

As a result, we have re-commissioned the play again for the academic year 2016/2017.

It is important that professional help to young people is made part of the mainstream of many services rather than as a stand-alone service.

Examples of this in action are shown by the following 'snapshots' of work in hand in mainstream services across Oxfordshire:

➢ School Health Nurses have been trained in child & young person mental health through a programme called PPEPcare. The training includes:

- Supporting young people with low mood
- Supporting young people with anxiety
- Supporting young people who self-harm

➢ In addition, our nurses have run awareness campaigns to ensure that young people are aware of techniques they can use to improve their well-being and where they can access support should they need it.

➢ School Nurses also support young people with exam stress – and example comes from the Matthew Arnold School where the School Nurse ran sessions with sixth formers approaching exams. This will lead to 'Chill Out Tuesday' and 'Wind Down Wednesday' next year for all young people approaching exams.

➢ By the end of March 2017, the Oxfordshire Young Carers Service had identified and supported a total of 2,684 children and young adults (aged 0 -25 years) who provide unpaid care to a family member. Caring is also well known as an additional cause of stress for young people. This included 456 new young carers identified in the year 2016-17.

➢ The Health Visiting service also has a role to play - the County Council have commissioned Oxford Health NHS Foundation Trust to create a specialist post which will set up new postnatal mental health groups and train those who run them. This recognises that addressing mental health needs of mothers is paramount in promoting mental wellbeing and preventing mental health problems in their children.

In summary, self-harm is an important issue. There is evidence that services are responding well, but this situation needs to be actively monitored.

Recommendation

Children and Young Peoples' mental health and wellbeing and its related services should be monitored in future Director of Public Health annual reports.

Chapter 6 – Fighting Killer diseases

Main messages for this chapter:

Part 1. Epidemics and Antimicrobial Stewardship

The improvement in the quality of our living conditions and the advances in modern medicine have meant that the threat of major illness and large numbers of deaths due to communicable disease are seen as a problem of times past.

The continuing vigilance of Public Health services and sound planning of local and national organisations to respond to the spread of communicable diseases means that most of us can go about our daily lives without being aware of the efforts to protect the wider community from disease. The Ebola and Zika outbreaks of recent times are stark reminders of the continuing threat that can arise at any time and present a very real risk to us all, irrespective of borders. The Ebola cases in the Democratic Republic of Congo and elsewhere act as a stark reminder of the need for continual vigilance across the world.

We need to continue to prioritise the work that is done in the background every day of the year to prepare for the worst and the unimaginable. Directors of Public Health work closely with Public Health England and the NHS across Thames Valley to ensure that the response to any threat will be matched by a coordinated response to any outbreak, wherever it may arise. It is important that this partnership and cooperation is continued.

The right response still remains systemic and calm planning and organising ourselves NOW so we can respond when the need arises without fear or panic. The need to remain vigilant still holds true.

A continuing cause for concern is the threat of **antibiotic resistance** and the rise of "superbugs". Antibiotics are important drugs for animals and humans in fighting bacterial infections which were once life-threatening. Bacteria are highly adaptable and the widespread misuse of antibiotics and inappropriate prescribing of antibiotics continues to lead to bacteria which have developed resistance to the antibiotics which were once effective.

The risk of bacteria which cannot be treated by any existing antibiotics is a real threat here in the UK and throughout the world. We continue to see outbreaks of resistant strains of bacteria, if we do not act we will see the number of resistant strains increase.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections, returning us to the situation before the discovery of penicillin.

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.

➢ Continuing to build and maintain long standing relationships with colleagues in Public Health England and the NHS.

➢ Mainstreaming our plans by working with the Police, Military and many of the other organisations under the auspices of the Thames Valley Local Resilience Forum (LRF).

➢ Educating and advising professionals and the public of their role as individuals in limiting antibiotic resistance.

It is vital to keep the specialist workforce we have now to continue with this important work.
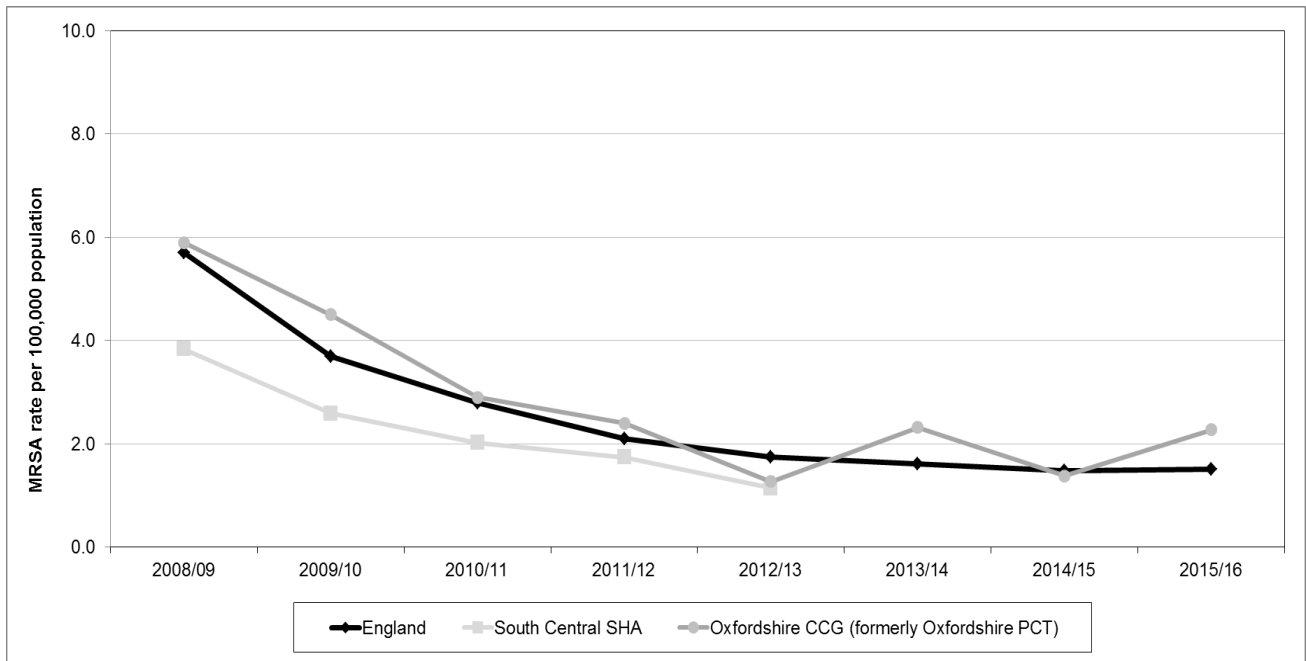
Part 2. Infectious and Communicable Diseases

Health Care Associated Infections (HCAIs)

Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff.) continue to be an important cause of avoidable sickness and death, both in hospitals and in the community. These infections do not grab headlines as they have in the past but they still need everyone to remain vigilant to limit an increase in the incidence of infection.

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 an invasive procedure or a chronic wound) it can cause blood poisoning (bacteraemia). It can be difficult to treat people who are already very unwell so it is important to continue to look for causes of the infection and identify measures to further reduce our numbers of new cases of infection. MRSA has fallen gradually in Oxfordshire in response to the direct measures taken by hospital and community services to combat it. The local situation is shown below.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 - 2015/16)

Public Health England (PHE), Health Protection Agency (HPA)
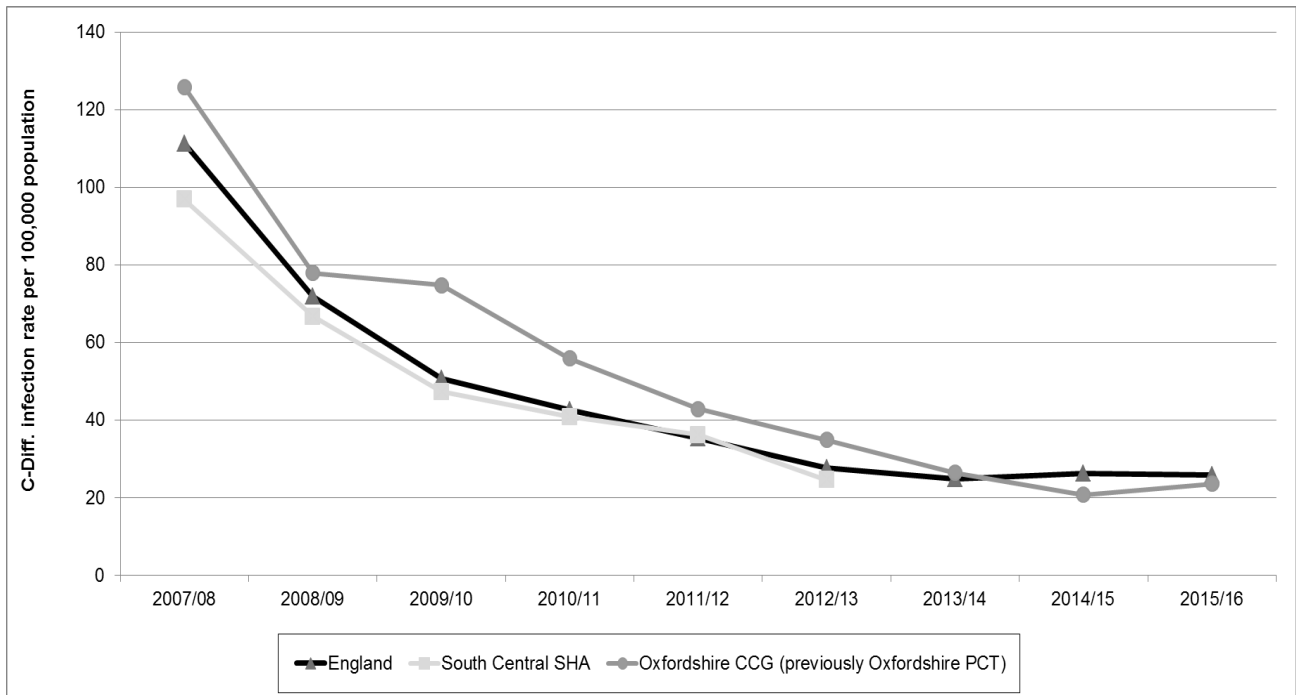
This shows that infections can be tackled, often by traditional hygiene methods. Nationally there is a zero tolerance policy and the rate of MRSA is still higher than we would like. There have been improvements in Oxfordshire over the past few years. However, the levels in Oxfordshire have increased slightly again in 2015/16 to be higher than the national average. This slight increase, which may be a statistical 'blip' due to the small number of cases each year reaffirms why continued vigilance is required by all hospital and community services to combat MRSA infections.

Clostridium difficile (C.diff)

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

A focussed approach on the prevention of this infection has resulted in a steady reduction in cases in Oxfordshire since 2007/08 as shown in the chart below which is in line with the National trend. The reduction in C.diff involves the coordinated efforts of healthcare organisations to identify and treat individuals infected and also careful use of the prescribing of certain antibiotics in the wider community. There are still on-going concerted efforts locally to continue to improve on the rate of C.diff infections.

**Clostridium Difficile Infection (CDI) - crude rate per 100,000 population
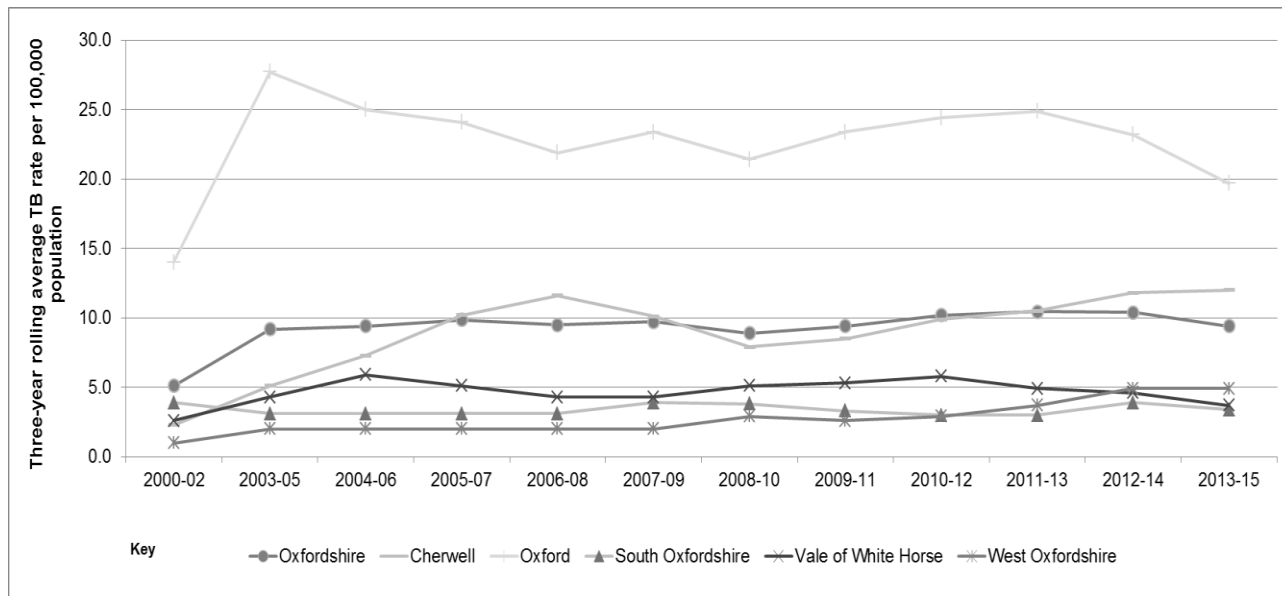(2007/08 to 2015/16)**

Public Health England (Health Protection Agency)

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 TB is not treated, active TB can be fatal.

In Oxfordshire, the numbers of cases of TB at local authority level per year are very low. The local figures are shown below.

Tuberculosis (TB) – Incidence rate per 100,000 population (2000-2 to 2013-15)

Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

The levels of TB in the UK are beginning to show a reduction due to coordinated efforts by TB control boards across England to improve TB prevention, treatment and control.

The rate of TB in Oxfordshire is lower than the National average and similar to average levels in Thames Valley. In the UK the majority of cases occur in urban areas amongst young adults, those moving into the area from countries with high TB levels and those with a social risk of TB (e.g. homeless people). This is reflected in the higher rate of TB in Oxford compared to other Districts in the County.

Public Health England has developed a TB strategy to address TB nationally. The TB control boards look at regional levels of TB and services to provide treatment. The Oxfordshire Clinical Commissioning Group is developing a model for a latent TB screening programme as part of a national initiative to identify and treat new entrants from high TB prevalence countries.
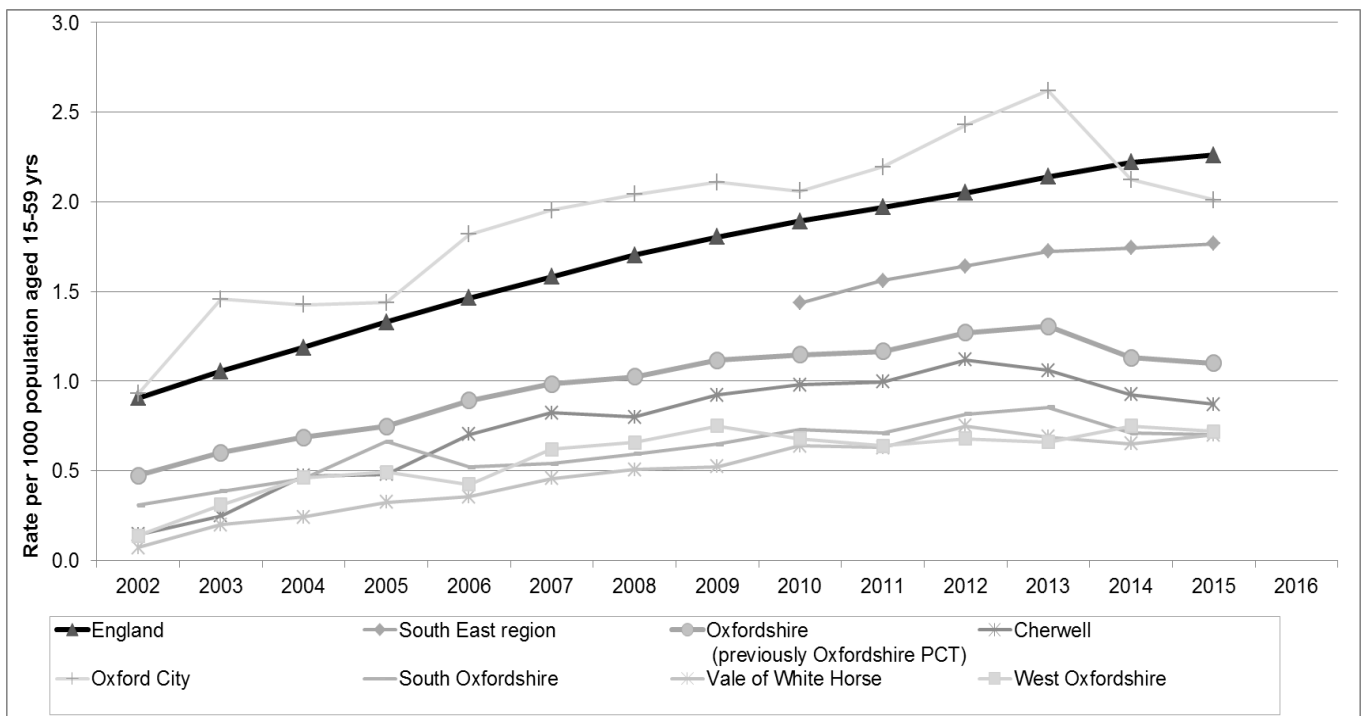
Sexually transmitted infections

HIV & AIDS

HIV does not raise public alarm like it did in the 1980s, but is still remains a significant disease both nationally and locally. Due to the advances in treatment, HIV is now considered a long term condition and those who have HIV infection can now expect to have a longer lifespan than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2015 data shows that there were 448 people diagnosed with HIV living in Oxfordshire, 221 out of these 448 live in Oxford City. This trend is shown in the chart below and shows another decrease this year across the County.

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

Public Health England Sexual and Reproductive Health Profiles

Finding people with HIV infection is important because HIV often has few symptoms and a person can be infected for years, passing on the virus before they are aware of the illness. Also the sooner an infected individual begins their treatment the more effective treatment is with a better prognosis for the individual concerned. Trying to identify people with undiagnosed HIV is vital. We do this in three ways:

➢ Providing accessible testing for the local population. Since it started providing services in 2014, the sexual health service has provided 48,885 HIV tests across the service.

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

➢ Prevention and awareness. Educating the local population about safe sexual practices and the benefit of regular testing in high risk groups. In addition, the eligibility for accessing the condom scheme has been extended to men who have sex with men (MSM) and commercial sex workers, both groups being at higher risk of contracting HIV.

Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments available. HIV still cannot be fully cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly can be decreased. Beyond Oxfordshire there are interesting developments nationally in preventing the spread of HIV in high risk groups using drugs to halt transmission (PrEP). NHS England will be trialling PrEP over the next three years.
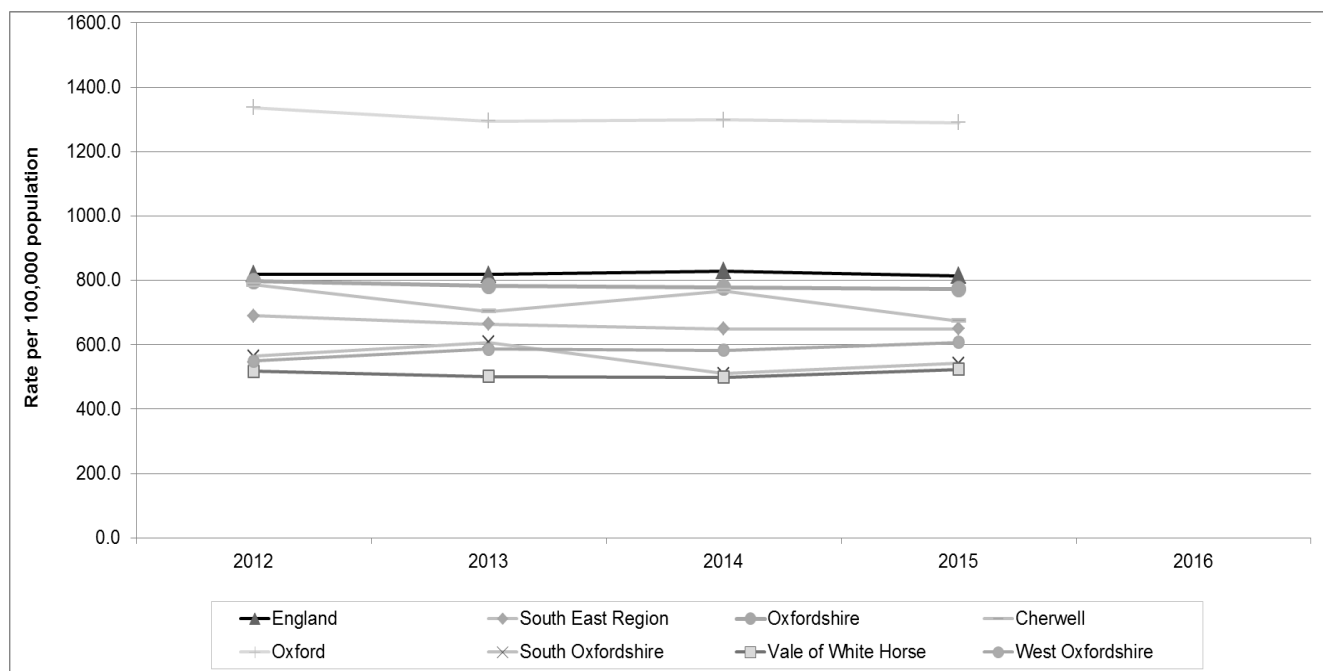
Sexual Health

Sexually Transmitted Infections (STIs) are still high in England with the greatest number of cases in young heterosexual adults, and men who have sex with men (MSM). STIs are preventable through practicing 'safe sex'. Total rates of STIs in Oxfordshire are still below the national average except in the City which has remained at a similar rate since 2013. The local picture is shown in the chart below.

Looking at each disease in turn gives the following picture which is generally good:

➢ Gonorrhoea- is below national average for Oxfordshire as a whole and all districts except in Oxford City. This is likely to be due to its younger age profile. There is a new system of testing to reduce the number of false positive diagnoses and it is expected that a reduction in diagnoses should be seen when the latest data are released.

➢ Syphilis- still continues to fall and is below average in all areas of the County.

➢ Chlamydia- levels are lower than the national average in all Districts. Following evaluation and consultation the local service has been reshaped to be more focussed on accessing testing through online services. It is hoped that this will be more acceptable and accessible for young people to have a Chlamydia test.

➢ Genital Warts – rates are still below national average and have seen a decline in line with the National trend. Oxford City still has significantly higher number of cases (reflecting the significantly younger age group) but the trend is stable. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.

➢ Genital Herpes – rates are lower than national average except in the City which has higher levels. However the total number of cases in the year is small. Again this reflects the predominantly younger population of the City.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2015

Public Health England / Health Protection Agency - Sexual and Reproductive Health Profiles

The local sexual health service, which began in 2014, has seen good levels of activity and this is to be welcomed. The service has improved access to contraceptive and sexual health services conveniently in the same location which has improved the service for local users.

Since the service began in the first three years of operation, the service has delivered

➢ **91,763 STI treatment and testing consultations**

➢ **Provided 171,213 tests for STIs and 48,885 HIV tests**

➢ **Positively identified 32,629 STIs, HIV infections and other sexual health diagnoses**

➢ **Provided 51,156 consultations for family planning**

➢ **Fitted 5995 contraceptive devices (Long Acting Reversible Contraception)**

➢ **Prescribed 27,402 other forms of contraception**

➢ **Prescribed 3004 Emergency Hormone Contraception Treatments**

The service has continued to deliver on its established reputation in the community as a provider across a range of locations across the county where the local population can access all their sexual health services in one location.

In addition to this in the same period GP providers have delivered 15,760 coils and contraceptive implants and pharmacies have provided 4,103 doses of emergency hormonal contraception.

In line with best practice a partnership of local stakeholders continues to work together to identify and address priorities locally to further meet the sexual health needs of Oxfordshire and further improve on the decline of STI's in Oxfordshire.

Recommendation

The Director of Public Health should report on progress on killer diseases in the next annual report and should comment on any developments.