DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT IV

Reporting on 2009-2010
Recommendations for 2010-2011
Produced: May 2010

SUMMARY

This is the fourth Annual Report by a Director of Public Health for Oxfordshire (jointly appointed by the NHS and the County Council). The recommendations are made for all organisations in Oxfordshire and for the public.

The aims are simple:
1. To report on progress made in the last year and set out challenges for the next year
2. To galvanise action on five main threats to the future health, wellbeing and prosperity of Oxfordshire
3. To add an emphasis on two strongly emerging threats, namely those posed by dementia and alcohol abuse.

The five main long-term threats are:
- Breaking the cycle of deprivation
- An ageing population – the "demographic time bomb"
- Mental health and wellbeing: avoiding a Cinderella service
- The rising tide of obesity
- Fighting killer infections

The threat posed by dementia is described in the chapter on an ageing population.

The threat posed by alcohol abuse takes its place as the sixth long-term threat to health.

Progress will be monitored in future reports. Your comments are welcome as long-term success will depend on achieving wide consensus across many organisations.

Please direct comments to: ruth.fenning@oxfordshirepct.nhs.uk

I hope you enjoy the report and act upon it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire
May 2010

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INTRODUCTION

What is the purpose of a Director of Public Health's Annual Report?

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

The role of the Director of Public Health is to be an independent advocate for the health of the people of Oxfordshire.

The Director of Public Health's Annual Report is the main way by which Directors of Public Health make their conclusions known to the public.

This is the fourth Annual Report by a Director of Public Health appointed jointly by local government and the NHS. This report attempts to build on the momentum generated by the first three which were generously received by a wide range of audiences.

What is the thrust of this particular Annual Report?

This report aims to keep the spotlight firmly on the five main long term threats to public health by reporting on progress made in the last year and by making recommendations for next year. The main threats are:

- Breaking the cycle of deprivation
- An ageing population – the "demographic time bomb"
- Mental health and wellbeing: avoiding a Cinderella service
- The rising tide of obesity
- Fighting killer infections

Sound progress is now being made across the county on these five areas.

It is now timely to emphasise two new threats which are emerging, namely those posed by dementia and alcohol abuse.

The threat posed by dementia is described within the chapter on an ageing population.

The threat posed by alcohol abuse is set out in a new chapter 'Alcohol: What's Your Poison' making it the sixth current major threat to the public's health.

Public Health – everyone's business

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

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

The Contents of this Report

The first chapter takes an overview of general progress made during the last year.

The following six chapters concentrate on progress made on the six major threats. Recommendations for improvement are made at the end of each chapter.

Progress against recommendations will be reported each year and, in this way, this document has been designed as a tool to be used and built upon the year on year. I hope you enjoy it and act on it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire
May 2010.

CHAPTER 1: Progress Report 2009/10: A Year In The Life Of The Public's Health

2009/10 was a momentous year for the public health of Oxfordshire. Among many other highlights, we tackled the flu pandemic, took active steps to tackle deprivation, completed work to give our immunisation systems a much-needed overhaul and made steady progress on all of the major threats to the public's health and wellbeing.

This chapter summarises gains made and areas of concern in improving public health and the areas of concern in Oxfordshire during the year 2009/10. It starts with the gains and then describes the concerns.

Evidence of Gains in the Public's Health

The Battleships are lining up!

Previous reports have stressed the fact that all of the major threats to the public's health require joined-up action by statutory agencies because **no one organisation can do it alone**. This has been likened to lining up battleships so that all move in a single direction as a single fleet against a common enemy.

Reviewing evidence of progress made over the last 3 years shows clearly that this is happening. In particular, gains have been made over the past year on work to help older people and the mentally ill as well as tackling long term problems such as deprivation and dementia. This is encouraging. It will take more years of determined perseverance to make a lasting difference, but gains can clearly be seen and are noted throughout this report. The challenge now is to keep this focus, develop clear action plans and define clear milestones so that we can measure our progress en route to long term success.

The Swine Flu Pandemic

It may seem strange to see the flu pandemic as a gain, given the suffering caused. There were, however, undeniable gains made in our ability to get organised to fight major public health threats. For example, we now know our emergency plans work; we now know how to run national call centres in health emergencies and we now know how to run mass vaccination programmes. All these things are significant gains. The flu pandemic forced the grasping of many nettles at national level with good success. This is to all our benefit. More detail is given in chapter 6.

Immunisation of children continues to improve

During the year the proportion of children vaccinated against serious infections continued to rise, with Oxfordshire's rates some of the best in the country. For example, for children aged two, most vaccination rates in the county were among the top 20 in England (out of 152 Primary Care Trusts), with over 9 in 10 children immunised. The increase in rates has been helped by significant improvements in the way data are collected so that individual children who miss their injections can be followed up more easily. For most vaccinations it is important to reach as many people as possible to reduce the risk of the infection spreading in the community.

Bowel Screening

Bowel Screening began in Oxfordshire. A service for residents living around the Horton General Hospital became operational in January 2010, followed by the rest of the County in April 2010.

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths. In Oxfordshire around 93 new cases are diagnosed each year in 60-69 year olds. Regular

bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

The programme offers screening every two years to all men and women aged 60 to 69 with 40,918 people in Oxfordshire due for screening between 22/01/2010 and 21/01/2012.

Screening consists in the first instance of a postal test kit for blood in the stool. Around 98 in 100 people will receive a normal result and will need no further investigation. Around 2 in 100 people will receive an abnormal result. They will be referred for further investigation and usually be offered a detailed examination of the large bowel using a flexible hi-tech camera (colonoscopy).

Superbugs in decline

Methicillin Resistant Staphylococcus Aureus **(**MRSA) infections of the bloodstream continued to fall. Over the last 3 years the number of cases fell from 50 cases, to 43 cases, to 32 cases. During the year, people going to hospital for surgery have had their skin tested for MRSA before admission. If MRSA was found, people were given an antibacterial wash to get rid of the bugs. This has helped bring the number of cases down. Tightening up on the use of catheters has also helped.

Infections caused by *Clostridium difficile* (*C.diff*) have also reduced dramatically with 325 fewer cases occurring in 2009/10 compared to 2007/08. (2007/08 826 cases; 2008/09 533 cases; 09/10 500 cases) This has been brought about by improving antibiotic prescribing, improving the speed of isolation of suspected cases and improved cleanliness in hospitals.

More pregnant women say 'I quit'

Giving up smoking is the single best thing you can do for your health. The Oxfordshire Smoking Advice Service has strengthened its service to pregnant women to good effect. A specialist now provides intensive one-to-one support for pregnant smokers and their partners. Support continues throughout the pregnancy and up to six months after the baby is born. Alternatively pregnant smokers can access NHS stop smoking services in GP practices, Children's Centres and some pharmacies. In addition a weekly stop smoking clinic is held at the Horton Hospital in Banbury. Details are given in chapter 3.

Praise from the (former) Home Secretary for work to reduce alcohol related harm.

The use of information from the Emergency Department in the John Radcliffe to help police and others to reduce City Centre violence won plaudits from the former Home Secretary in a visit to Oxford in February 2010. Alan Johnson praised the strength of partnership work and commended Oxfordshire as a national leader. Information on where and when people get injured in fights or accidents is now collected alongside Ambulance pick-up data and crime statistics to help action planning. Direct results have included closure of some pubs and clubs or changes to licensing conditions requiring drinks to be served in plastic glasses. Taxi queues are now marshalled at particular times to prevent flare-ups. There was also extra praise for work done in following up people who had been injured when drunk – an effective way of helping them to change their behaviour and prevent repeat incidents

'6 Chiefs' fight deprivation in Banbury and Oxford

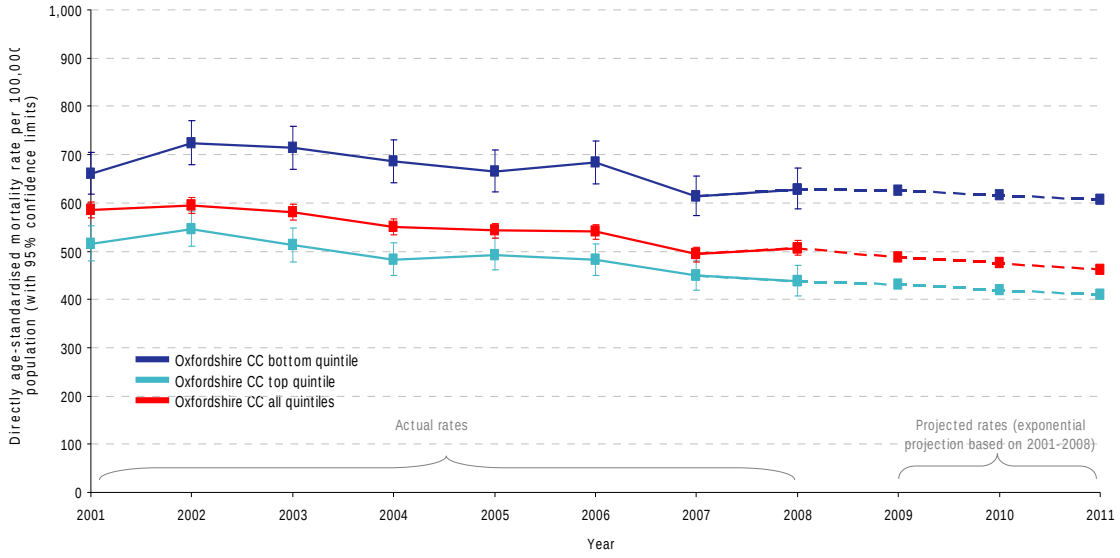
The Chief Executives of Oxfordshire County Council, Oxford City Council, Cherwell District Council , Oxfordshire PCT, Thames Valley Police (Oxfordshire) and Oxford and Cherwell Valley Colleges joined together to find a lasting way to tackle deprivation in small areas of Banbury and Oxford (see Chapter 3). The work will include a focus on helping families with young children to get a better start in life. The initiative was awarded £1 million of grant money to kick start the work…….. but there is a long way to go and final success will take years rather than months.

Areas of Concern in the Public's Health

The Inequality Gap widens slightly

Each year we measure what we call the inequality gap in Oxfordshire. The graph below compares death rates in the populations who live in the most deprived 20% of localities in Oxfordshire with those who live in the least deprived 20% (i.e. roughly the best and worst off).

Figure 1.1: Trend in all-age, all-cause mortality rates for Oxfordshire CC most and least deprived quintiles of Lower Super Output Areas, 2001-8 (actual) and 2009-11 (projected)



The solid top line on the chart shows the trend in death rates for the worst off up to the end of 2008. The dotted line predicts what might happen in the future. Overall death rates for this group are falling, though in the last year there was a slight upturn.

The bottom line on the chart shows the trend in death rates for the best off 20% of areas. Here too you can see a general reduction in death rates, and these continued to fall in 2008.

The middle line on the graph shows the average for the whole County.

The gap between the top and bottom lines is the 'inequality gap' and we can see that this latest data shows that, **the inequality gap in Oxfordshire widened**. This data is limited as it only reflects the position 18 months ago It may be a 'blip' and the measures put in place during the last year may improve the situation, but we need to continue to monitor these trends vigilantly.

Rates of cervical screening in younger women are too low

Cervical screening is an effective way of detecting and treating cancers of the womb neck at an early stage, significantly reducing the chance of illness and death among women taking part in the programme. Although the overall uptake rate for women eligible for cervical screening – around 4 in 5 women (80%) – is satisfactory, the rate in women aged 25-49 is around 10 per cent lower. We are working hard to raise awareness of the benefits of screening in this age group, to reduce women's risk of developing cervical cancer in the county.

Childhood Obesity is on the increase

Data collected on Oxfordshire's schoolchildren showed that the 2009 cohort of children is more overweight and obese than 2008's cohort. The data shows a significant rise in reception age children being overweight and obese compared to 2008 Oxfordshire data. This is also the first time that our local data has been worse than the national figures. The detail is given in chapter 3 and the proposed action is in the chapter 5 which is dedicated to the topic of obesity.

CHAPTER 2: Older People and the Demographic Time Bomb

What is the Issue and Why Does It Matter?

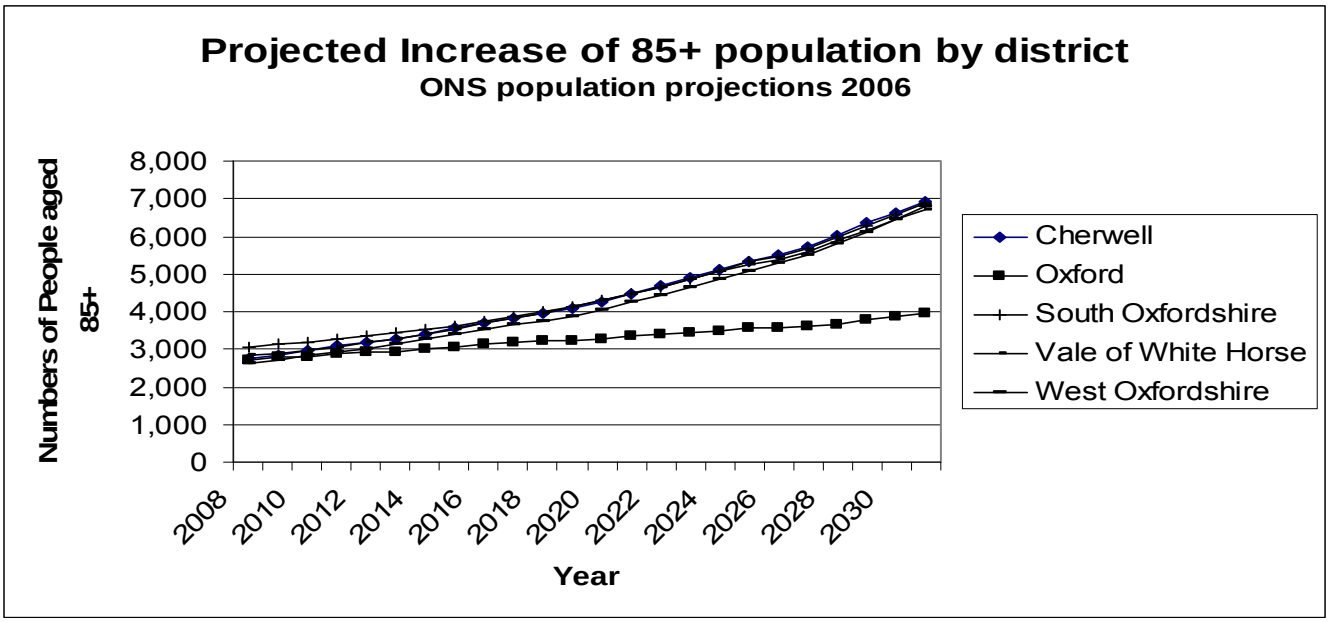
The growth in the number of older people in Oxfordshire is now universally accepted as one of the major challenges to the wellbeing of this county.

The reasons for this are well worth repeating. They are:

- The number of older people is increasing, particularly over 85s.
- The proportion of older people in the population is increasing. The working population will be increasingly stretched to fund public services for the retired.
- The increase will be uneven across the county. By 2029 people aged 85+ will increase in number by around 150% in Cherwell, Vale and West Oxfordshire, by around 125% in South Oxfordshire and by around 70% in Oxford City. This is an example of an inequality that hits rural areas hardest.
- The impact on services will be severe. The current range of services we provide will simply not be affordable.
- Because the proportion of younger people in Britain is falling compared with older people, demand for informal care for older people is predicted to exceed supply within the next ten years – by 2017.
- **There is increasing concern at both national and local levels about the challenges posed by the growing number of people with dementia in an ageing population. The issues are set out in a separate section within this chapter.**

The effect of the 'timebomb' is illustrated in the graph below. It shows the rise in the numbers of people aged 85 and over in the 5 Districts of Oxfordshire. The number of people in this age group more than doubles over the 22 years from 2008 to 2030, by around 4,000 people in four out of five Districts in Oxfordshire. It is noteworthy that the effect is much less pronounced in the city because of its younger overall age profile. The increase here is around 1,000 people.

Figure 2.1:



What recommendations were made last year?

The thrust of last year's report was to recommend that:

- A clear map of services should be produced setting out a clear direction forward for older people. **This has been achieved.**

- Preventative work for older people should be grouped together. **This is being achieved**.

- Clear outcome measures should be identified. **This has not yet been achieved but has begun**.

- A senior, dedicated, joint commissioner for older people and healthy ageing should be appointed. **This has been achieved.**

- Carers should be actively supported, particularly by the NHS**. A good start has been made**.

Older People: Progress
This section will cover overall progress followed by a report on support for carers and then a new section on dementia.

A. Overall progress made

OPINION: Good progress has been made in grouping and organising work for older people across the County, given the huge size of the task. We have done well to include younger age groups in an all-embracing healthy ageing strategy. The strategy needs to be tightened, process and outcome measures identified and clear action plans implemented which will make a difference for older people on the ground.

The good progress made over the last year is tempered by the growing realisation of the sheer size and complexity of older peoples' issues in the County. During the year the decision was made to tackle the whole topic of "ageing successfully". In effect this means it has been decided to include preventative work for people in their 40s and 50s and 60s. This is the right decision to make so that problems are prevented in later years, but it does increase the scope and scale of what has been taken on. Preventative work in this context means helping people with chronic disease to stay well as well as more traditional preventative work around exercise, diet and smoking.

A single long-term strategy called "Ageing Successfully" has been produced and is undergoing consultation having been agreed by the Health and Well-Being Partnership Board. The strategy is broad and ambitious in scale, ranging from prevention through to end-of-life care and also includes vitally important issues for well-being such as housing and transport. **This is the first time this has been achieved in Oxfordshire**.

Overall progress is good but more now remains to be done. We need in particular to have a clear sense of where we are going. This can be achieved through defining clear results to be achieved in the future (outcome measures) and also by defining clear milestones along the way so that we know we are going in the right direction (process measures). This work has begun, and needs to be completed during the next year.

Better organisation of existing work across agencies brings some of the 'first fruits' of partnership working to early ripeness. There are numerous examples of this across the County, two of which are given below.

- **Falls** are common in older people, particularly those who are taking a mixture of medications and who have eyesight problems. Oxfordshire is acknowledged as having one of the leading Falls Prevention services in England. Improvements have recently been made to improve services for people who have fractures from falls in the John Radcliffe Hospital.

- We now have an improved "pathway of care" for **people who have had a stroke.** The pathway joins up all aspects of care, including prevention, care by people themselves, home care, GP services, community services, specialist hospital services and community hospital services. There has also been investment in rehabilitation in the community. As a result more people are being treated in services dedicated to those who have had strokes.

B. Caring for our carers

Most people prefer to be cared for by their family or other informal carers as this is often the highest quality of individual care that can be given. This type of care is continuing to shore up health and social care services. We will rely increasingly on informal care as the population ages.

In last year's report the need for Oxfordshire PCT to take a more strategic approach to supporting informal carers was recognised. There were three main areas for action:

- Strengthening the GP's role in identifying carers and championing their needs. **This was partly achieved.**
- Identifying current money spent and investment over time in support of carers in the NHS. **This was partly achieved.**
- Strengthening the NHS contribution to the Joint Carer's Strategy. **This has been achieved**.

Progress in detail:

OPINION: Since the need to care for our carers was identified as a major issue last year a good start has been made. There is much still to do but we are now on the right track. We need to build on this.

The thrust of last year's recommendations was to improve the NHS contribution to work on carers to bring this up to the level of the work of Local Authorities. This is now being achieved. In particular:

(i) Oxfordshire PCT increased the budget available for support to Carers by £250,000 from 2009-10. This money has been invested in:
    - Local implementation of the National Carers Strategy,
    - Piloting the prescription of carers' breaks by GPs
    - Commissioning training programmes to make the task of caring easier and to help carers find the support they need more readily.

In addition:

(ii) A document called "The Carers' Protocol for Primary Care" has been revised and distributed to general practices. This sets out expectations for best practice and enables primary care teams to make this part of what they do.

(iii) 6,800 people are now known to their GPs as Carers and can therefore be offered services such as an annual health check. However, there are an estimated 60,000 carers in the county so there is still a long way to go.

(iv) A contract is in place with an organisation called "Rethink" for running support services for carers of people with mental health problems.

(v) The PCT now has a high quality Carers Action Plan 2009-2012 which was agreed by the PCT Board in April 2009. This dovetails with the Oxfordshire Carers Strategy which sets out the partnership approach across the county.

C. The Growing Threat of Dementia

What is dementia?

Dementia is not a single illness. It is a group of symptoms caused by specific brain disorders. The most common cause is Alzheimer's disease, but dementia can also be the result of a stroke or mini-strokes.

Dementia is progressive – the symptoms will get worse over time. Although there is no cure, treatments can slow the progression of the disease, and there are ways of helping to keep it manageable.

What is the issue?

Dementia presents a huge challenge to society, both now and increasingly in the future. There are currently 700,000 people living with dementia in the UK. Dementia costs the UK economy £17 billion a year and in the next 30 years the number of people with dementia in the UK will double to 1.4 million, with the costs predicted to treble to over £50 billion a year.

Dementia is therefore a demographic timebomb within a demographic timebomb

In addition, recent national reports and research have highlighted the shortcomings in the current provision of dementia services in the UK.

While the numbers and the costs are daunting, the impact on individuals with the illness and on their families is profound. Dementia results in a progressive decline in multiple areas of function, including memory, reasoning, communication skills and the skills needed to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which complicate care and can occur at any stage of the illness. Carers of people with dementia are often old and frail themselves, with high levels of depression and physical illness and a diminished quality of life. Dementia is a terminal condition but people can live with it for many years after diagnosis.

What is the position in Oxfordshire?

The estimated number of people with dementia in Oxfordshire is almost 7,000. The Oxfordshire Older People's Health Needs Assessment (2007) showed a total of 2,400 people with a definitive diagnosis of dementia recorded by Oxfordshire GPs in 2007. This is in line with the national estimate of between only 20% and 40% of people affected by dementia receiving a diagnosis.

The estimated number of people with dementia by Local Authority in Oxfordshire is set out in the table below alongside the percentage increase expected by 2016. Overall, an increase of around 20% is expected over ten years.

Again, this is an issue which will have the greatest impact on more rural parts of the county.

Table 2:1: Predicted prevalence of dementia in Oxfordshire, 2007 and 2016
(Source: POPPI & PANSI data systems)

Local Authority	People aged Over 65 estimated to have dementia in 2007, showing current numbers and predicted % increase by 2016
Oxfordshire	6,828 to increase by 19.3%
Oxford City	1,249 to increase by 4.1%
Cherwell	1,376 to increase by 24.1%
South Oxfordshire	1,496 to increase by 20.8%
Vale of White Horse	1,391 to increase by 23.1%
West Oxfordshire	1,316 to increase by 23%

Dementia is also the second largest contributor in the county to lengthening a hospital stay. Recently discharged patients with dementia also manage more poorly in the community and are more commonly readmitted than patients discharged with any other condition.

Progress in detail

OPINION: Dementia is an important topic. A good start has been made. The Dementia Strategy and individual projects now need to become part of mainstream work on older people.

Nationally
The National Dementia Strategy was published on the 3rd February 2009. It aims to provide a framework which can be adapted locally. In effect it improves awareness and services for dementia by grouping all the issues together in one place and recommending good practice.

The national strategy identifies 17 objectives to improve dementia services, which have been grouped into three broad themes:

- Raising awareness
- Early diagnosis
- Living well with dementia

Locally
In Oxfordshire, the 17 objectives of the National Strategy have been grouped into 5 work streams with a number of programmes and projects being delivered within each. The work streams include:

1. Improved quality of life for people with dementia and their carers
2. Early diagnosis and complex care
3. Early onset dementia – Including learning disability and alcohol related dementia
4. Provision of information
5. Making change happen

Local progress in detail:

- A draft Dementia commissioning strategy has been written and a Dementia Development and Implementation Board has been set up to make the strategy a reality.

- From May 2010 a programme of support and training for carers of people with dementia will be put in place. Carers will have a choice of 3 training courses or a one-off payment to support their needs.

- Specific services designed to help people with memory problems are well established in Oxfordshire but two different models co-exist. Work is underway to develop a single system.

- Oxfordshire is one of the Demonstrator Sites for a Dementia Advisory service. To date, four Dementia Advisors have been recruited by the County Council and are linked to specific GP surgeries to provide an 'information prescription' to patients who are newly diagnosed. Dementia advisors will also signpost people to support services. Following this Dementia Advisors from the voluntary sector will be recruited.

- A national campaign will be implemented, aimed at improving public and professional awareness and understanding of dementia. This will begin in March 2010.

- The 'Careforce Oxfordshire' project has been established to ensure that all staff working with people with dementia receive specific training, both as part of basic training and as ongoing professional development.

Recommendations

Recommendation 1
By December 2010 the Ageing Successfully strategy should be completed with agreed overall direction and clear outcome measures, process measures and action plans, through the PCT Director of Service Redesign and County Council Director for Social and Community Services.

These outcome measures and process measures should be monitored vigorously by the Health and Wellbeing Partnership Board.

The Oxfordshire Health Overview and Scrutiny Committee should also consider scrutinising progress made as part of its annual plan.

Recommendation 2
By December 2010 Oxfordshire PCT, through its Director of Public Health, should have identified 20% more carers in primary care.

Recommendation 3
Work on Dementia in Oxfordshire should be formalised in a joint strategy, led by Oxfordshire PCT and Oxfordshire County Council through their Directors of Service Redesign and Director of Social and Community Services. It should include on the identification of people with dementia and support of carers for people with dementia. It should contain clear outcome measures, process measures and a clear timescale for implementation. This strategy should be completed by March 2011 and should be monitored vigorously by the Health and Wellbeing Partnership Board.

The Oxfordshire Health Overview and Scrutiny Committee should also consider scrutinising progress made as part of its annual plan.

CHAPTER 3: Breaking the Cycle of Deprivation

What is the Issue and Why Does It Matter?

We are now tackling areas of stubborn inequality in this county, where poor life prospects and poor health have been handed down from one generation to the next. This has been recognised as an important priority for Oxfordshire's public services, and work to tackle this problem has begun in earnest and is showing promise, although the final results will take time to show through in the data we collect.

The statistics show that there are specific areas of the County which experience poor school attainment, excessive ill health, higher crime rates, higher levels of teenage pregnancy, higher unemployment and, ultimately, an early death. There is also early evidence from across the country that the impact of the recession is falling most heavily in these areas, particularly through unemployment rates. This is how the cycle of deprivation perpetuates itself and underlines the fact that long term resolve will be needed break the cycle.

Paying for these problems through additional public services adds to the drain on the public purse for the whole county: **This is an issue of concern for everyone**.

Tackling the Issues: The Oxfordshire Approach

We have agreed to tackle this problem on two fronts

1. **A countywide approach to breaking the cycle of deprivation in children, young people and families** led by the Children's Trust, focusing on Banbury, Oxford City, Abingdon/Berinsfield and smaller rural areas.

2. **A specific focus on the most deprived wards of Oxford and Banbury covering all age groups,** involving all organisations and led by the Oxfordshire Partnership (the partnership-of-partnerships where community leaders meet to create an overall strategic plan for Oxfordshire).

This chapter reports on progress and makes recommendations for each of these two topics in turn.

1. Breaking the Cycle of Deprivation in Children, Young People and Families

The issue

Over the last 3 years the need to break the cycle of deprivation in this County has been well recognised.

What recommendations were made last year?

- That the existing work on 'deprivation and narrowing the gap' should be drawn into a single comprehensive workstream. **This has been achieved.**
- That commissioning of children's services should be drawn together more tightly within Children's Trust arrangements. **Good progress has been made.**
- That work to encourage breastfeeding should improve and that the inequality gap between wards with the highest and lowest rates should be reduced**. Improved services are in place and modest progress has been made to narrow the inequality gap.**

Progress made in detail

OPINION: Breaking the cycle of deprivation in children, young people and families is now firmly mainstream business for organisations in Oxfordshire. New determination is evident and the new joint plans are the best yet. Outcome measures have not yet improved as this will take a number of years to achieve. We should focus on developing 'process measures' to make sure we are achieving steady progress towards the ultimate goal.

This work has now entered a transitional phase; the statistics below show that we have not yet broken the cycle of deprivation, but on the other hand current work shows that we are en route. This is evidenced by a palpable new determination to tackle these issues at root, evidenced as follows:

- The production of a new Children and Young Peoples' Plan containing a major section on tackling inequalities called 'Minding the Gap', demonstrating the commitment of the Children and Young People's Trust to tackle these issues.
- The personal commitment of the Leader of Oxfordshire County Council to improve educational attainment results and to reduce the number of people who are not in employment, education or training (NEETS) as stated at the Oxfordshire Partnership and Council meetings.
- The personal commitment of the Deputy Leader of the County council to improve educational attainment results as stated at the Public Services Board
- A number of targeted initiatives cited in this report which focus selectively on areas of longstanding social deprivation in this county.
- The '6 Chiefs' initiative in Banbury and Oxford described later in this chapter- this work contains a strong commitment to help those families who are worse off.
- The appointment of a new Director for Children, Young People and Families in the County Council committed to resolve these issues through partnership working led by the Children's Trust.

Examples of good progress made in more detail are:

1. A revised Oxfordshire Children and Young People's Plan 2010 – 2013 was published in January 2010 and it is heartening to see that Narrowing the Gap for our most disadvantaged and vulnerable groups is one of only 3 strategic priorities for Oxfordshire Children's Trust.

2. The Children's Trust commissioning subgroup has focused on improving services for some of the county's most vulnerable children and young people including children with disabilities and young people who abuse drugs and/or alcohol.

3. Three Area Trust Boards have been established and are being developed to drive forward actions to deliver the priorities in the Children and Young People's Plan based on local information and needs.

4. Breaking the Cycle of deprivation is a strategic priority in the PCT Operational Plan and a detailed programme of work is in place for 2010-2011.

5. A new community-based infant feeding support service has begun which will deliver intensive support in the first 2 weeks of life to women living in areas with the lowest breast feeding initiation and duration rates.

The facts about children in Oxfordshire

Measure 1: Child Poverty.

National data has not been updated on this measure since 2007 and it is therefore inappropriate to report on it. Further data will come from the 2011 census. The findings were that overall the county ranks highly for child well being, BUT there was wide variation across the county with Oxford City in the bottom third of all districts. 10 wards were among the 10% most deprived wards in the country, 9 of which were in Oxford and one in Banbury.

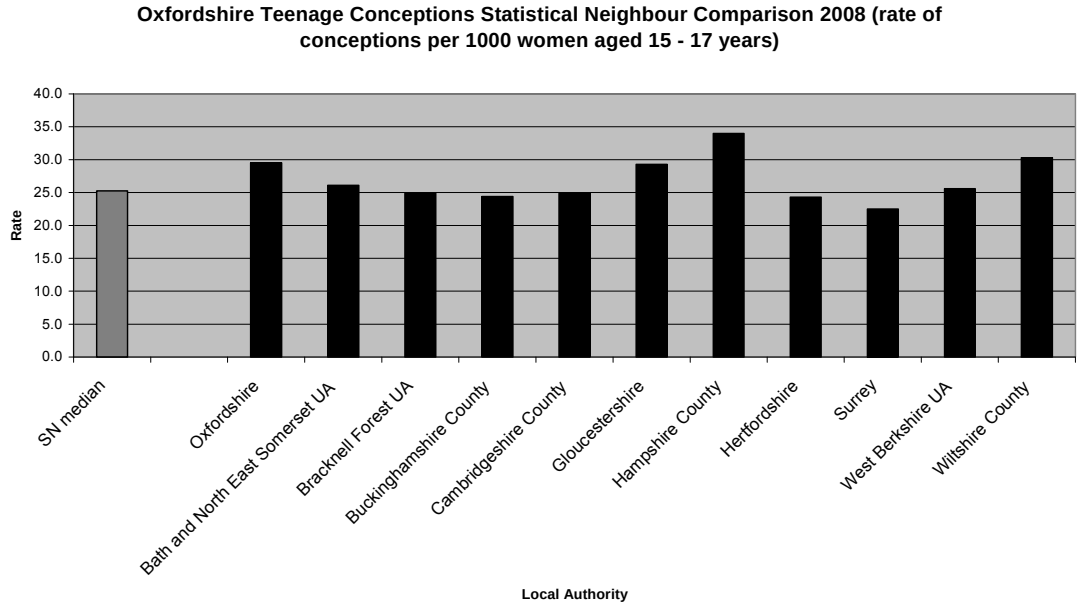
Measure 2 Teenage pregnancy and sexual health

It is appropriate to take a different approach to teenage pregnancy targets this year. The national way of measuring teenage pregnancy is not very satisfactory as it only measures how fast the number of pregnancies falls. This also tends to hide the real problem as follows:

As a largely affluent county, Oxfordshire's teenage pregnancy rates are among the lowest in the country and so on the whole we do well (currently we are 19th best in the country). However there is considerable variation across the county with some small areas having persistently high rates. We have 18 wards in the county which have teenage pregnancy rates in the highest 20% in England. Of these, 13 wards are in Banbury and Oxford and the solution has to lie in targeting those small areas with the highest rates - and this is what we are doing. There is evidence that **focused work in deprived parts of Oxford over the last 5 years is now working well, and the overall teenage pregnancy rate in Oxford (though still higher than other Districts) is falling year on year.**

A comparison with Local Authorities which are similar in terms of size and demographics shows that there is still room for improvement. All of these Local Authorities are near the top of the class nationally. (These are called in the jargon our 'Statistical Neighbours'). The following chart shows that Oxfordshire does better than Hampshire and Wiltshire but can still do more to catch the likes of Buckinghamshire and Surrey, although there are some question marks about whether the comparison is totally fair given lower levels of deprivation in Buckinghamshire.

Figure 3.1:



During October 2009 Oxfordshire Children and Young People's Trust reviewed and revamped its plans for teenage pregnancy. Much good practice was found and new services were put in place to target some of our most vulnerable young people at highest risk of becoming pregnant. For example:

- Since 2008 we have made significant investment in health visitors and school health nurse services. We have increased the number of school health nurses working in teenage pregnancy hotspots in Oxford and Banbury. As a result, a school health nurse is available 52 weeks a year in person or on the phone.

- A special service was commissioned to provide advice and support to under-18s following the birth of their baby or after a termination of pregnancy. The service also works closely the Youth Offending Service and Social Services to offer 1 to 1 support for young people at high risk of becoming pregnant

- In January 2010, a home visiting programme began targeting first time mothers aged under 20. This service will be offered to 100 families living in Oxford and Banbury. Specially trained nurses visit young families starting during pregnancy and continuing until the child is aged 2 years.

Measure 3: Breastfeeding

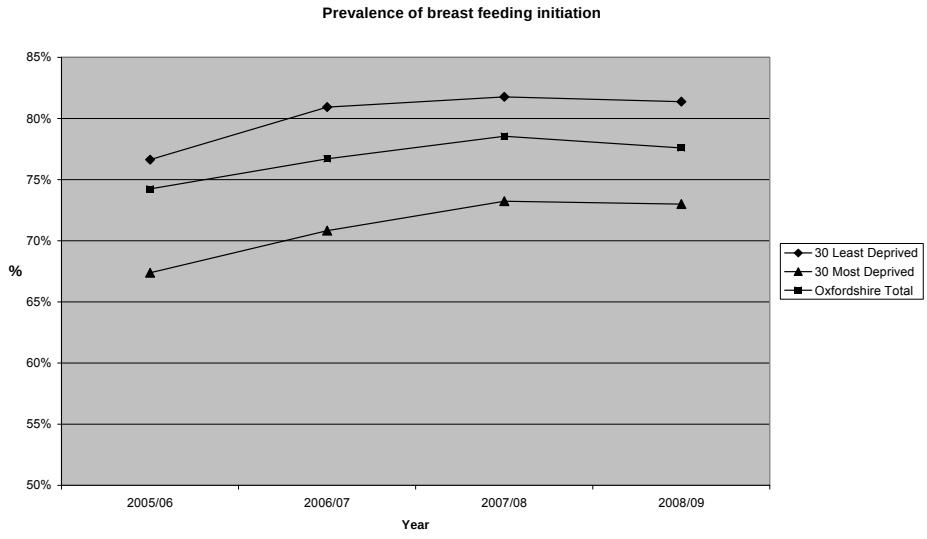
Breastfeeding is one of the best ways of getting a healthy start in life. It provides the perfect food for babies and protects against disease and obesity in later life.

The data shows that we have had some modest success in narrowing the gap in initiating breastfeeding between our most deprived and our least deprived wards since 2006/07- but we need to do more. This was a requirement of last year's report. The 'gap' can be seen as the distance between the top and bottom lines of the graph below. **The really good news is that all of the rates are steadily climbing which is a gain for the public's health long term.**

Despite this we know that in some wards, particularly in Banbury, less than half of mothers choose to breast feed their baby.

Overall in Oxfordshire around 80% mothers choose to breast feed their baby. By the age of 6-8 weeks less than half of all babies are fully breastfed. To address this gap a new community Infant feeding service was commissioned, with the aim of providing intensive support to women during the vital first 2 weeks when long term breastfeeding is established. The service will be delivered in Oxford and Banbury in communities where we know breast feeding rates are particularly low.

Figure 3.2:

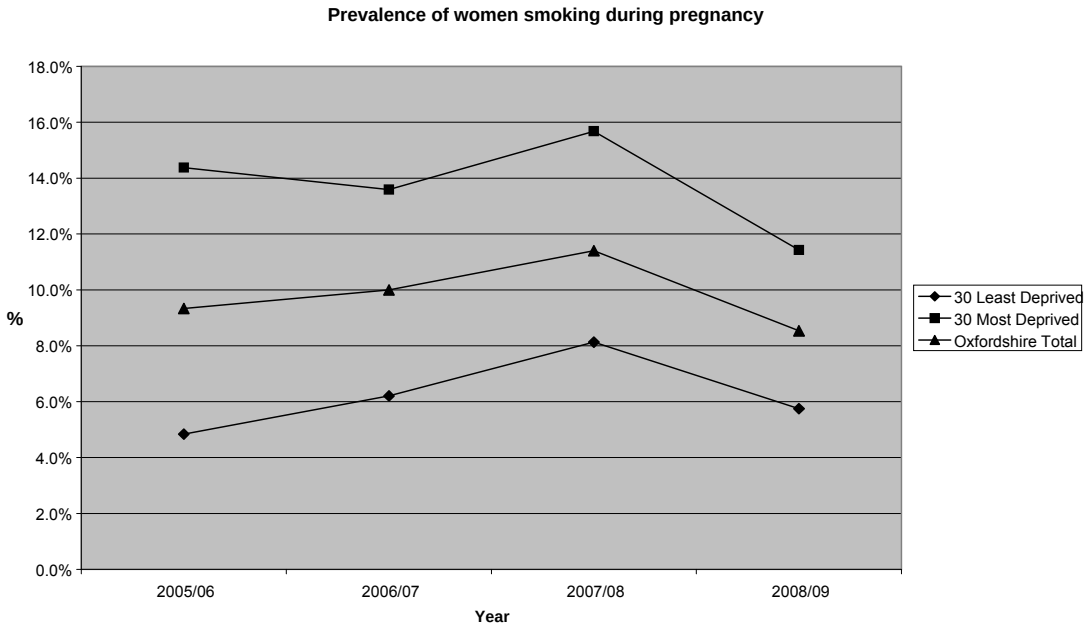


Measure 4: Smoking in pregnancy

Following a concerted effort from our smoking cessation service the percentage of pregnant women who smoke has fallen during the year, reversing the trend of the previous two years. **This is a good achievement.**

Because of careful targeting, the gap between those best and worst off in the county has narrowed, making 2009/10 a doubly successful year. The proportion of women living in deprived wards who smoke throughout their pregnancy is still roughly double those in better off areas (around 6% vs. around 12%). The graph below shows trends over the last 4 years in Oxfordshire.

Figure 3.3:

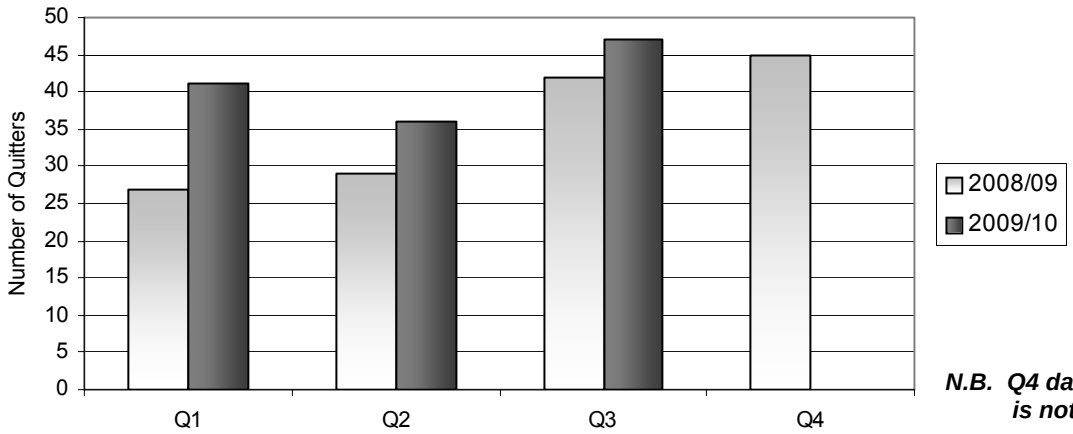


In England as a whole, the number of women smoking in pregnancy was 14.4% in 2008/09.

Additional stop-smoking services for pregnant women were described in chapter 1.

The Chart below compares the last two years, quarter by quarter and shows the increased number of smoking quitters achieved last year. Around 25 additional pregnant women were helped to stop smoking in the first 9 months of the year, compared with the previous year.

Figure 3.4: Pregnant Four Week Smoking Quitters



N.B. Q4 data for 2009/10 is not yet available

Measure 5: Obesity

We are continuing to improve our local data on childhood obesity through the National Child Measurement Programme. This year we weighed and measured 11,256 children in Oxfordshire.

The stark fact is that the 2009 cohort of Oxfordshire children are more overweight and obese than 2008's cohort. Data collected in 2009 shows a significant rise in reception age children being overweight and obese compared to 2008 data. This is also the first time that our local data is worse than the national figures.

This is a clear signal that we need to get 'back to basics' in terms of preventing obesity. This theme is elaborated in chapter 5.

Figure 3.5

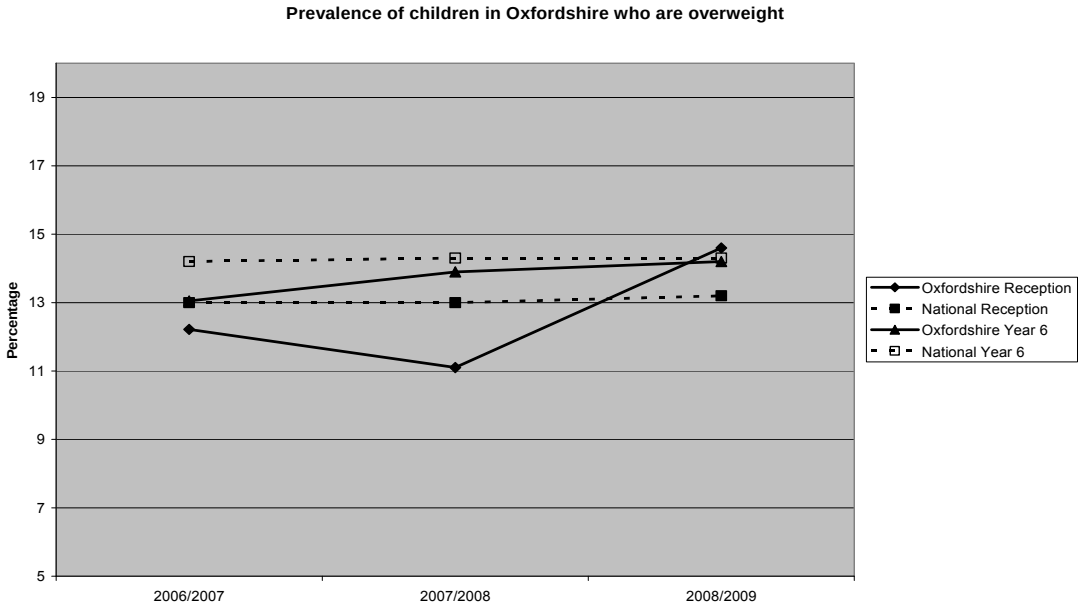
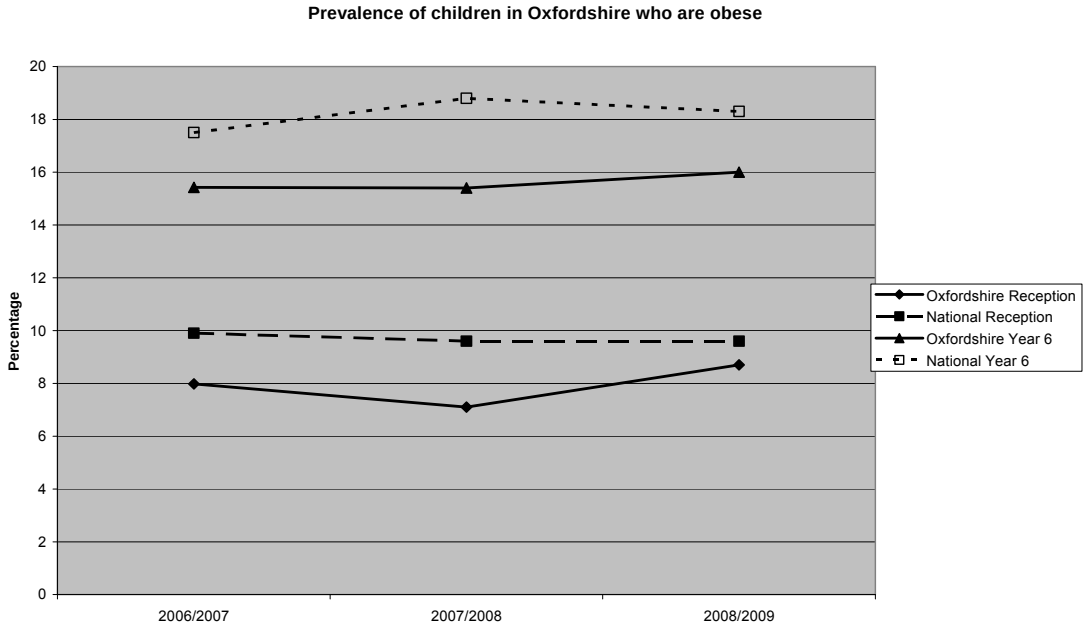


Figure 3.6



Measure 6: GCSE Attainment

It is important that educational attainment is carefully monitored each year.

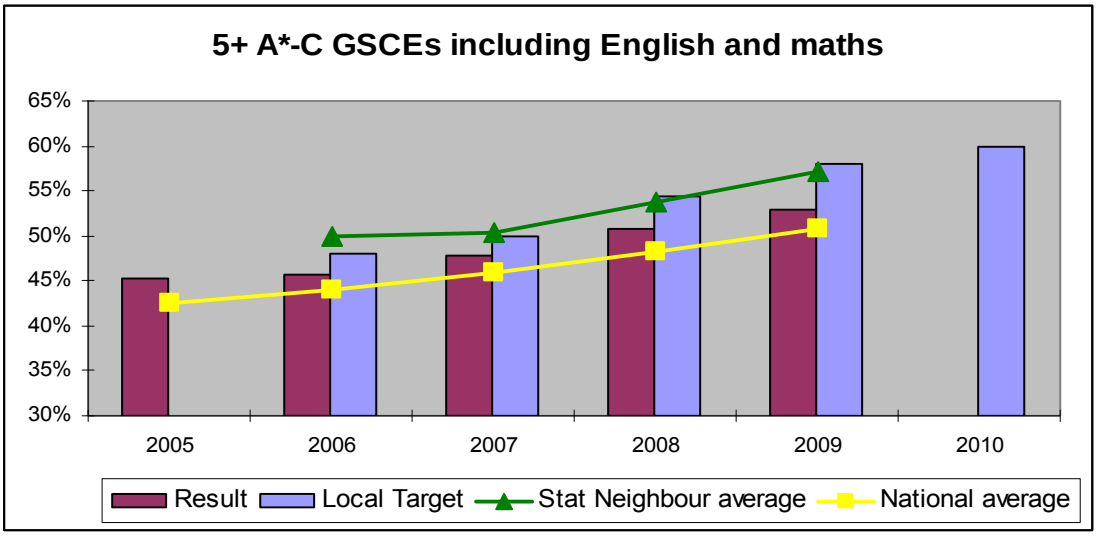
Educational attainment is a useful summary indicator of underlying problems in a society. All organisations have some responsibility for remedying this situation as educational attainment is a product of many family and social factors as well as the quality of our schools.

In this section the key performance measure used is a National Indicator called NI 75 which measures the percentage of Year 11 pupils achieving 5 A-star to C grades including English and Maths at GCSE (5 GCSEs A*-C inc English and Maths).

a. Overall attainment compared with national results

The percentage of children in year 11 achieving 5A*-Cs including English and Maths in Oxfordshire has improved consistently since 2005 to 52.9% in 2009. In 2009 Oxfordshire's results were 2.2% above the national average for maintained schools, a slight decrease on 2008. However, performance still remains below the local target of 58% and is lower than similar Local Authorities shown by the top line on the graph below. Despite the improved results therefore, this indicator remains a cause for concern and is a priority for the County Council and partners. A comprehensive set of actions is in place to remedy the situation.

Figure 3.7



	2005	2006	2007	2008	2009	2010
Oxfordshire	45.3%	45.6%	47.9%	50.7%	52.9%	
Local Target		48.0%	50.0%	54.3%	58.0%	60.0%
Statistical Neighbour average		50.0%	50.4%	53.7%	57.1%	
National average	42.6%	44.1%	45.9%	48.3%	50.7%	

Source: DCSF statistical first releases Dec 2009

b. Comparison with statistical neighbours

This information allows us to benchmark the attainment of our young people against similar local authorities. The data shows that Oxfordshire performs below its statistical neighbours. The percentage of Oxfordshire children gaining 5A*-Cs including English and Maths was 4.4% lower than the average score of statistical neighbours in 2006. The

Oxfordshire average improved to be only 2.5% lower than statistical neighbours in 2007 but the gap has widened again to 4.2% in 2009 and remains a cause for concern.

c. Inequalities in attainment between schools.
In 2009, all 32 maintained secondary schools in Oxfordshire reached the government's 'floor target', which requires at least 30% of a school's Key Stage 4 pupils to attain 5 A*-C GCSEs including English and Maths.

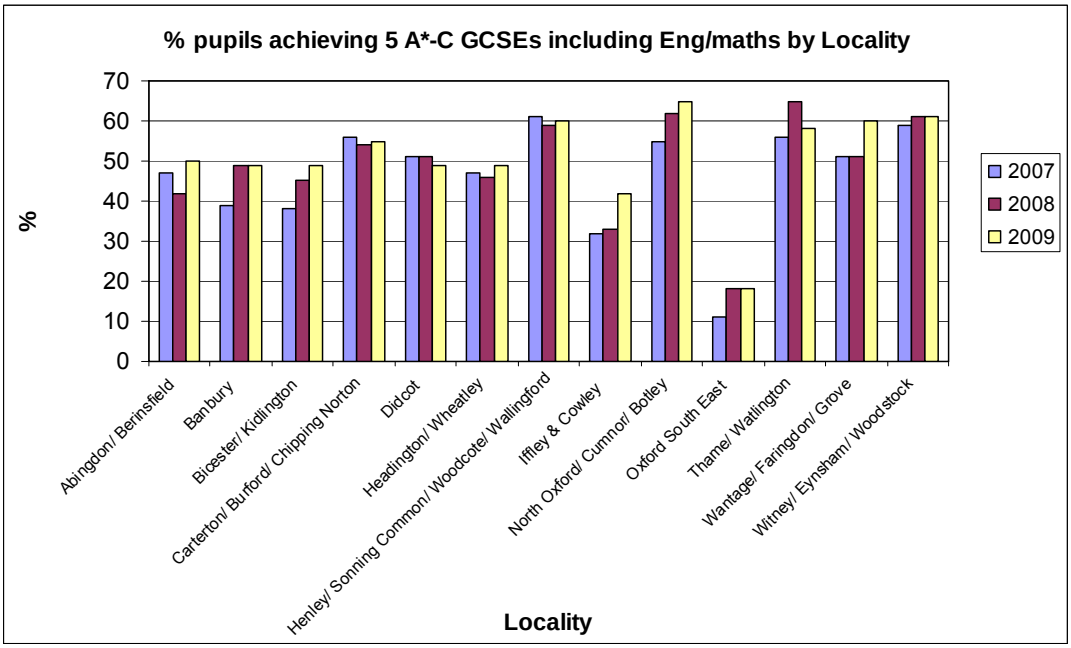
The range of pupils achieving 5 or more GCSEs A*-C including English and Maths in 2009 varied widely across the county, from Matthew Arnold School (70%), Bartholomew School (66%) and Gillotts School (65%), to Oxford School (35%), North Oxfordshire Academy (25%) and Oxford Academy (18%).

In 2009, 11 schools (32%) had 50% or fewer pupils achieved 5+ GCSEs A*-C including English and Maths, an improvement from 13 schools in 2008. These results need to be used to target services and resources by all organisations.

d. Inequalities in attainment by locality
The overall shape of GCSE results achieved by pupils attending schools situated in the 13 agreed localities for children's services has changed little overall during the year. There have been welcome increases in Iffley/ Cowley (9% increase), Wantage/Faringdon/Grove (9% increase) and Abingdon/Berinsfield (8% increase). Banbury and Oxford South East localities which both showed welcome increases in 2008 have maintained these results.

The percentage of pupils achieving 5+ A*-C inc English and Maths obtained by pupils attending schools in Oxford South East (including Blackbird Leys and Rose Hill – the area served by the Oxford Academy) and Iffley & Cowley remains markedly lower than the rest of Oxfordshire.

Figure 3.8

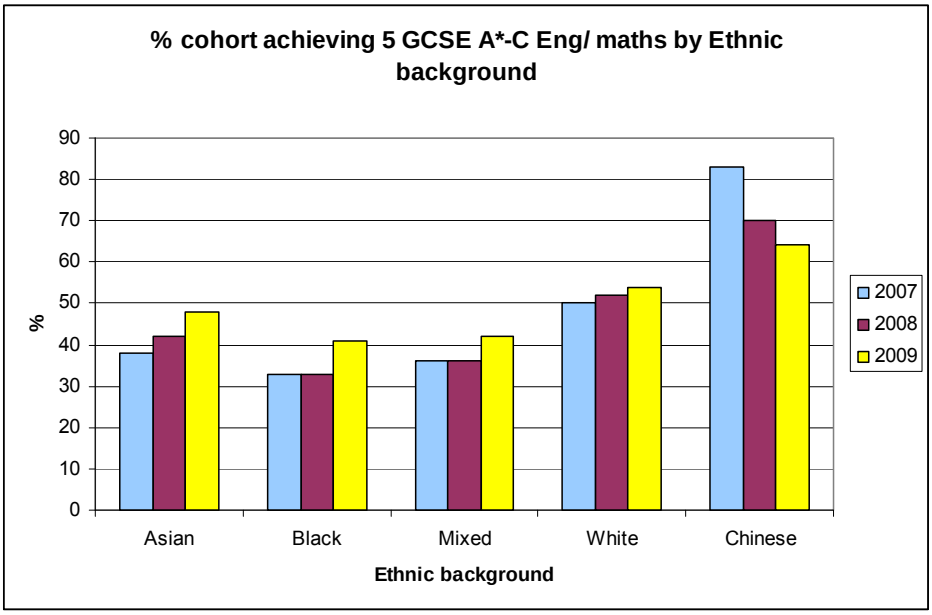


Source: DCSF statistical first releases Dec 2009

e. Attainment in black and minority ethnic groups
The chart below shows that over the previous 3 years the proportion of pupils from Asian, Black and Mixed backgrounds achieving 5A*-Cs including English and Maths has been consistently below the Oxfordshire average**. However in 2009 the proportion of pupils**

reaching 5A*-Cs from all 3 of these groups increased noticeably (pupils from Black backgrounds improved by 8%, Asian and Mixed backgrounds improved by 6%). The results also show that the proportion of children from Chinese backgrounds achieving 5 A*-C including English and Maths has fallen in recent years. The performance of Black and Minority Ethnic (BME) groups has improved overall which is to be welcomed, but there is room for improvement and this remains a cause for concern.

Figure 3.9

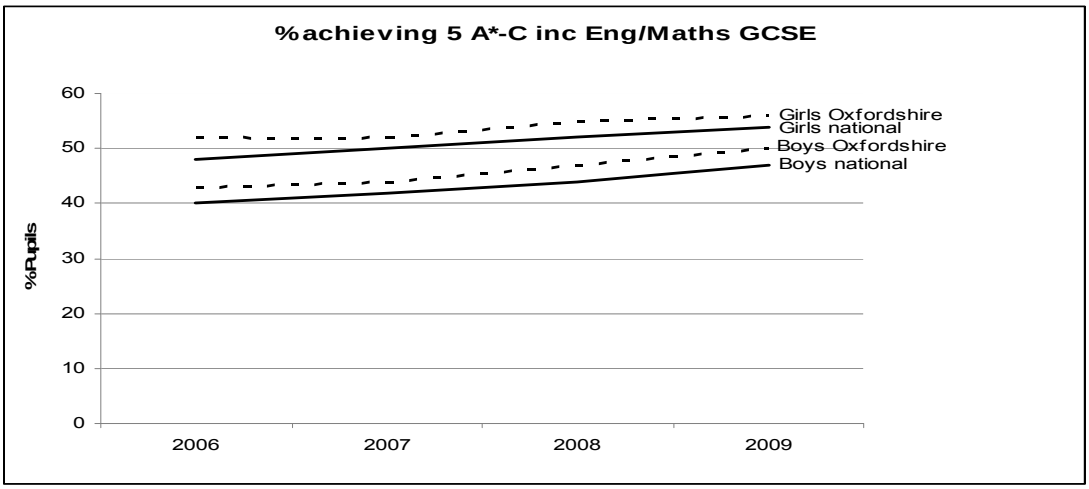


Source: DCSF statistical first releases Dec 2009

f. Differences in attainment between boys and girls

The data below shows that girls consistently out perform boys by around 6-8 percentage points in GCSE performance. This mirrors the national picture and represents a further inequality to be investigated by the Children's Trust. The picture is more complex when looking at individual subjects, however. For example, girls consistently outperform boys in Science and in English, whereas in Maths performance is more evenly balanced.

Figure 3.10



Percentage of pupils achieving:		Results							
		National				Oxfordshire			
		2006	2007	2008	2009	2006	2007	2008	2009
5+ A*-C inc GCSE En & Ma	Boys	40	42	44	47	43	44	47	50
	Girls	48	50	52	54	52	52	55	56

Measure 7: Oral health

Oral health in children is an important marker of general health, inequality and deprivation.

Dental decay significantly compromises health and well being throughout life as well as causing pain and discomfort. Oral health problems in children are largely preventable. Oral health has improved over the last 30 years but there is still a long way to go

The last national survey of 5 year olds (2007/2008) indicated that although the County as a whole was better than the England average, children living in Oxford and Cherwell had higher than the National average levels of tooth decay (measured in decayed, missing or filled teeth - DMFT), 1.32 and 1.2 teeth decayed, missing or filled per child respectively, compared to children in other areas of the county. This underlines the familiar pattern of inequality seen in Oxfordshire.

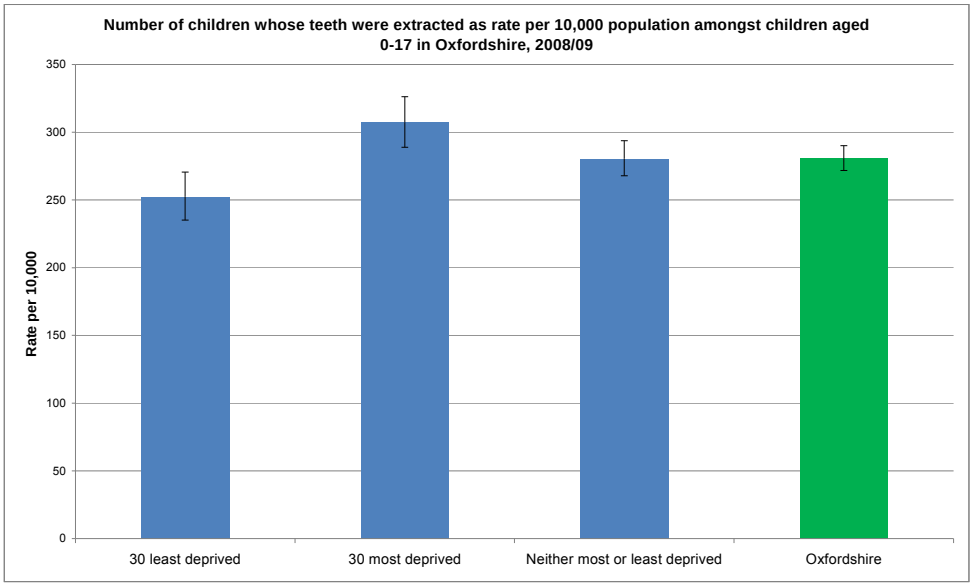
Table 3.1

Local Authority/PCT	**Average number of decayed missing or filled teeth.**
Cherwell	1.20
Oxford	1.32
South Oxfordshire	0.47
Vale of White Horse	0.59
West Oxfordshire	0.63
PCT Average	0.86
England	Average = 1.11. Range for all PCTs = 0.48 to 2.50

Another indication of inequalities in our children's oral health is the number of children who had teeth extracted under general anaesthetic in primary care dental services in the community. This is demonstrated by the graphs below. There is a statistically significant difference in the rates of extraction between the 30 most and the 30 least deprived wards.

In 08/09, 486 children aged 0-17 had dental extractions. Again, many of these would have been preventable given good oral hygiene.

Figure 3.11



To try to improve this situation, in the last year NHS Dentistry provision in Blackbird Leys and Banbury has been increased. Following the opening of the new practice in Blackbird Leys the percentage of the local population seen by an NHS dentist has increased from 47% to 62%. Over 3000 patients have been seen by the new practice since August 2009.

An oral health education programme has also been commissioned to address the health needs of vulnerable children in Oxfordshire. This includes training professionals to be oral health educators. A pilot project in two schools in Oxford City and Banbury will aim to measure the effectiveness of health education, screening and the application of fluoride varnish in a community setting to help improve the oral health of children.

Recommendations

Recommendation 1
Oxfordshire County Council, Oxfordshire PCT and Local Authorities should continue to drive forward plans to further integrate children's services planning and commissioning across the county under the Children and Young People's Trust through the Directors for Children, Young People and Families and the PCT Director of Service Redesign so that clear process and outcome measures for commissioning plans are agreed by March 2011.

Recommendation 2
The Oxfordshire Children and Young People's Trust should ensure that all community services and community resources for children living in localities with high levels of social deprivation (including schools) are better coordinated so as to target those who need the services the most, with the aim of bringing the areas with the lowest outcome measures up to the county average. This work should show demonstrable progress by March 2011.

Recommendation 3
The Children and Young People's Trust should review initiatives aimed at preventing and treating obesity in children across Oxfordshire and should consider re-directing resources towards primary prevention of obesity by March 2011.

Recommendation 4
The Oxfordshire Children's Trust Board should receive regular progress reports from the '6 Chiefs' work (described below), which overlaps with the Children's Trust programme of work called 'Minding the Gap', with a view to integrating this work into Children and Young People's Trust planning by March 2011.

2. Breaking the Cycle of Deprivation in the Most Deprived Wards of Banbury and Oxford

What recommendations were made last year?
The thrust of last year's recommendations was that:

- Organisations should join forces to break the cycle of deprivation **because no one organisation can do it alone. This has been achieved.**
- Priorities identified for change should be identified and action plans should be produced. **This has been partly achieved.**
- The chief officers of Oxfordshire County Council, Oxford City Council and Cherwell District Council should join forces with the chief officers of Oxfordshire PCT and the Police Force in Oxfordshire to steer and direct this work, which is consequently now known as the "five chief's project". **This has been achieved.**
- The Oxfordshire Partnership should actively oversee this work and ensure that concrete action happens. **This has been achieved and is ongoing.**

Progress in Detail

OPINION: Good progress has been made. A clear strategy with clear outcome measures and action plans now need to be finalized so that we can drive on to make lasting change.

This initiative has had a successful year. All of last year's recommendations have been achieved or partly achieved. Since this issue was first brought to prominence two years ago it has now become a mainstream priority across Oxfordshire. Positive developments are described below.

The 5 Chiefs met in May 2009 and agreed how they wanted to run this project, focusing on 4 major priorities. These are:

1. Giving children a good start in life by supporting vulnerable families
2. Improving employability by focusing on improved skills and increasing job opportunities
3. Improving the physical environment including housing and housing policy
4. Reducing health inequalities e.g. by identifying those at risk of heart disease

It was agreed to develop an "Oxfordshire Model" through careful evaluation of this first stage of work. This is important: If we can prove we can make lasting change then we can use this model elsewhere in the County.

Work began in Oxford as part of a broader piece of work to regenerate parts of the city. Priorities for Blackbird Leys, Greater Leys, Rose Hill and Littlemore and Barton wards have been set.

Following thorough analysis of the local situation, work in Banbury is focusing on parts of Neithrop, Ruscote and Grimsbury wards.

A bid to the Public Service Board for £1 million of one-off 'reward grant' money was successful. This money will be used to start work off in the target localities.

Because of the importance of developing peoples' skills, a sixth chief officer has been added to the steering group from Oxford and Cherwell Valley Colleges making it the "six chiefs' project". This move is designed to reduce the number of people not in education, employment or training (and so reduce the level of NEETS mentioned earlier in this chapter).

Ways of working in the next year which will help us to break the mould for the long-term are:

- Building solutions by **joining up existing services** which are already part of core funding rather than relying on temporary add-ons from the reward grant and other short-term funding - ***we want to eat the whole cake, not just the icing.***
- **Keeping it simple** so that we can really measure the impact of a few key changes.
- **Making sure we can measure not only the end results, but also the milestones along the way.**
- Taking a scientific approach and **evaluating the degree of success** in a small area or for a small group of families so that we can definitely say whether this approach works or not.

Recommendations for 2010/11

Recommendation 1
By March 2011, the six chiefs should ensure that this project has work plans in place which concentrate on:

- joining up existing core services
- identifying simple and definable service improvements that can be measured, focused primarily on getting a better start in life
- beginning to evaluate this work.

Recommendation 2
By October 2010, the 6 Chiefs should have agreed a clear 'basket' of measures which will tell them accurately whether or not this work is on track to break the cycle of deprivation in the long term.

Recommendation 3
By December 2010 The Oxfordshire Partnership should have received a specific progress report on this work and should seek evidence of progress in line with the three points in recommendation 1 above.

Recommendation 4
By December 2010 Oxfordshire Partnership and/or Public Services Board should have considered whether this work could be part of a **"Total Place"** initiative (or a similar approach under the new Government) focusing on increasing the number of people in education, training or employment **(and thus reducing NEETS**). This work should seek to coordinate the effort and spending of public sector organisations to achieve more while being more efficient. The focus could be either on specific wards or on specific families who have particularly high needs.

CHAPTER 4: Mental health in adults: avoiding a Cinderella service

What is the Issue and Why Does It Matter?

Last year's report explained why mental health matters. To recap:

- Mental health problems are common: **one in six of the adult population** has a mental illness at any one time. This could happen to any one of us.
- Mental health accounts for a quarter of all disease suffered at any one time.
- Mental health problems strike at economic productivity - nationally mental health problems cost £77 billion a year
- We need to work in partnership to tackle these problems. Factors such as the quality of the physical environment, poverty, inequality, social cohesion and economic prosperity all combine to cause or exacerbate mental health problems.
- There is a high social cost to the individual, their relationships, their families, the wider society and thus the economy: mental health problems affect us all.

What recommendations were made last year and what progress has been made?

OPINION: Real progress has been made during the last year to improve commissioning of mental health services. Effort must now focus on agreeing clear outcome and process measures to drive this work forward.

Last year's recommendations focused on four points:

- That commissioning should be strengthened by the appointment of a senior joint commissioner. **This has happened.**
- That a clear strategy should be produced with clear outcomes. **This is well on the way.**
- That commissioning of services for older peoples' mental health should not be forgotten and should be well developed. **This has not yet happened and remains a high priority**. The section on dementia in chapter 3 sets out part of the problem.
- That issues affecting carers remained a priority for mental health as well as for older people. **Good progress has been made.**

This body of work is now well on track to make a real difference. The issue has been accepted as a major priority, a single strategy is in place and clear priorities have been set. More specific plans are now being drawn up so that progress can be monitored. A mental wellbeing component is also now well embedded in this work which is breaking new ground in Oxfordshire.

A practical example of progress made

A long standing gap in Oxfordshire - access to psychological therapies (counselling, behaviour therapy and the like) - was filled by a new service which began in May 2009. The number of patients seen from across Oxfordshire is shown in the table below and has increased from 2,300 per year to 4,300 per year, planned to rise to 9,000 per year by 2011/12. The service has not been without teething troubles – demand has far exceeded supply for example – but nonetheless, this is an excellent step forward.

Table 4.1: Oxfordshire Residents seen by the new psychological therapies service plus service plans 2008-2012

Year	Actual or planned	Number of patients
Pre 2008	Actual	2,300
2008	Actual	2,700
2009/10	Actual	4,300
2010/11	Planned	7,000
2011/12	Planned	9,000

What happens next?
The success of joint work so far on mental health will inevitably bring into view a new set of challenges to be overcome if this work is to deepen. This is typical of any large programme of work in partnership and is in effect a measure of maturity and success. The next set of challenges to be faced will include:

- Making 'pooled budgets' work efficiently, especially when public sector funds are squeezed. (Pooled budgets contain money that is formally combined by the PCT and County Council for a specific purpose).
- Moving from health and social services planning to more complex issues around housing and independent living for people with Mental Health problems – this will involve closer working with District Councils.
- Collecting accurate information about patients' experiences and using this to shape service planning.

Recommendations

Recommendation 1
The PCT Director of Service Redesign should continue to drive progress forward until improvements to outcomes are achieved. Further demonstrable progress should be in evidence by March 2011.

Recommendation 2
The Director of Service Redesign and the Director for Social and Community Services should ensure that a commissioning strategy for older people's mental health is produced by March 2011 and this should form a part of the Ageing Successfully strategy. This should include a section on the care of people with dementia.

CHAPTER 5: The Rising Tide of Obesity

The importance of preventing adult obesity

Britain is in the grip of an epidemic. **Almost two-thirds of adults and a third of children are either overweight or obese** and it is estimated that, without clear action, these figures will rise to **almost nine in ten adults and two-thirds of children by 2050.**

Because there is a need to revamp our strategic approach to obesity in this County, the case for working on obesity as a priority is set out in more detail than in previous years.

It has been well documented that being overweight or obese increases the risk of a number of diseases. The risks rise the heavier you are and so are greater for people who are obese. For example:

- 10% of all cancer deaths among non-smokers are related to obesity
- the risk of Coronary Artery Disease increases 3.6 times for each unit increase in BMI
- 85% of high blood pressure is associated with being overweight
- the risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25

A Note on Jargon and Definitions of Obesity and Overweight

Obesity is defined as a body mass index (BMI) of 30 or more. Body Mass Index is measured by weight in kilogrammes divided by height squared. Overweight is defined as BMI of 25 to 29.9.

For example, a man aged 30 who weighs 13 stone 6lb (85kg) and is 6 feet tall (183cm) will have a BMI of 25.4, just in the overweight category; if he weighed 16 stone(101kg), he would enter the obese category with a BMI of 30.2.
For those of you who like maths:
Height squared = 1.83 X 1.83 = 3.34
Therefore BMI at 85Kg = 85/3.34 = 25.4
Therefore BMI at 101Kg = 101/3.34 = 30.2

A women aged 50 who weighs 10 stone 8lb (67kg) and is 5 foot 4 inches tall (163cm) will have a BMI of 25.3,again in the overweight category; if she weighed 12 stone 10 lb(80kg), she becomes obese with a BMI of 30.2
For those of you who like maths:
Height squared = 1.63 X 1.63 = 2.65
Therefore BMI at 67 Kg = 67/2.65 = 25.3
Therefore BMI at 80 Kg = 80/2.65 = 30.2

In the worst case scenario, current levels of child obesity mean that today's parents could outlive their children.

It has been calculated that approximately 116,600 adults in Oxfordshire (almost ¼ of all adults) are obese. Adult obesity is an issue across the whole county; however it is likely to be more prevalent in areas with high levels of deprivation.

The case for action

The price of obesity

Obese and overweight individuals place a significant burden on the NHS. Direct costs are estimated to be £4.2 billion nationally and these will more than double by 2050. The costs to Oxfordshire PCT of treating diseases related to overweight and obesity are set to increase by approximately £1 million each year. If current trends continue the estimated annual costs to Oxfordshire NHS of diseases related to overweight and obesity are set to rise from £143 million in 1997 to £159 million in 2015.

A reduction of 10% in body weight has been demonstrated to result in:

- A 20% fall in the total death rate,
- A 91% reduction in the symptoms of angina
- A reduction in blood pressure (of 10mmHg) sufficient to prevent a significant number of heart attacks and strokes.

- Substantial reductions in cholesterol and fats carried in the blood which lead to heart disease and stroke
- A 40% reduction in obesity-related cancer deaths

By 2020 obesity could lead to an additional 6,900 cases of diabetes in Oxfordshire alone, costing an additional £9.8 million each year and/or an additional 1,776 cases of Myocardial Infarction (heart attack) costing an additional £8.5 million each year.

The benefits of healthy eating

Diet-related ill health is responsible for about 10 per cent of deaths in the UK, and is estimated to cost the NHS some £6 billion every year. This is more than double the cost to the NHS of tobacco use. If diets matched the nutritional guidelines on consumption of fruit and vegetables, saturated fat and added sugar and salt intake, around 70,000 fewer people (10% of current annual mortality) would die prematurely each year in the UK. The benefits of meeting the national nutritional guidelines have been estimated to be as high as £20 billion savings each year.

Improving a person's diet by increasing consumption of fruit and vegetables can significantly reduce the risk of many chronic diseases. It has been estimated that eating at least 5 portions of a variety of fruit and vegetables a day could reduce the risk of deaths from chronic diseases such as heart disease, stroke, and cancer by up to 20%.

It has been estimated that diet might contribute to the development of one-third of all cancers, and that **eating healthily is the second most important cancer prevention strategy, after reducing smoking.**

Research suggests that there are other health benefits too, including delaying the development of cataracts, reducing the symptoms of asthma, improving bowel function, and helping to manage diabetes.

Good nutrition is vital to good health. While many people in England eat well, a large number do not, particularly among the more disadvantaged and vulnerable in society. There are many inequalities in nutrition and health that need to be addressed. For example, consumption of fruit and vegetables varies markedly between socio-economic groups. 27% of men and 33% of women in the managerial and professional groups consume the recommended five portions per day compared to 16% of men and 17% of women in routine and semi-routine occupations.

Poor nutrition and inequalities in nutrition are a major cause of ill health and premature death in this county.

The benefits of being active

Getting more people more active is one of public health's best buys. Primary and secondary care costs attributable to physical inactivity have been estimated to cost Oxfordshire PCT £8 million each year.

Almost ¾ (73%) of Oxfordshire's population still do not participate in enough activity to benefit their health.

Inactive lifestyles in England are twice as prevalent as smoking. Evidence shows that **the health impact of inactivity, in terms of heart disease, is comparable to that of smoking and almost**

Recommended physical activity levels

Adults: 30 minutes of moderate intensity physical activity at least 5 days a week. (Should make you slightly breathless and sweaty!)

Children: 60 minutes of moderate intensity physical activity each day

Targets can be achieved with 10-minute bursts of activity spread throughout the day.

as great as having a high cholesterol level. On average, an inactive person compared with an inactive person spends 38% more days in hospital, has 5.5% more GP visits, needs 13% more specialist services and has 12% more nurse visits.

There is a clear causal relationship between low levels of physical activity and early death. People who are physically active reduce their risk of developing heart disease, stroke, cancer and diabetes by up to 50%, and the risk of premature death by about 20–30%. Inactivity also has far-reaching implications for the wider public sector. Increased activity promotes independent living in older adults, and thereby reduces the cost of social care.

Oxfordshire has already made good progress in getting more people more active. Since 2006 an extra 20,000 more adults are now more active as a result of increased physical activity opportunities across the county. However a great deal still needs to be done to promote activity further.

Conclusion: Making modest improvements to your diet and physical activity really can really benefit your health as an individual, <u>but</u> these changes have to be made by the majority to prevent the growing spend on obesity-related diseases. The main focus of work must be on making it easier for the majority to adopt healthier lifestyles.

<u>What was recommended last year?</u>

In last year's Annual Report, 3 recommendations were made as follows:

- Progress against the County Obesity Strategy should be formally reviewed and reassessed. **This has been done (see below).**
- All public sector organisations should identify an obesity champion. **This has not been achieved and the immediate need for it is superseded by the results of the review of the strategy**.
- True levels of obesity can be measured in Oxfordshire's population. **To report BMI for the population of a single county has proved to be a more complex task than envisaged and remains a priority for the new strategy. To do this meaningfully will take time as the science is complex.**

Progress in Detail

OPINION: A good start has been made over the last 3 years and the coordination of work across the County is the envy of our neighbours BUT we need to take a step back during the next year and re-focus our effort on 'an ounce of prevention' for the majority of people by revamping our strategy and focusing on what really works. All organisations will need to play a part.

An appraisal of the existing strategy confirms that we have made a good start on grouping together work and coordinating current efforts. We have improved levels of physical activity, but childhood overweight and obesity are on the increase. **(See chapter 4 which shows that our children are now more overweight than the national average and that we are less far ahead of the national average than last year for childhood obesity).**

The review of our existing work shows both the good work done and the scope for further achievement. The main points of the review are summarised below.

Ownership of strategy

There is a perception that this is largely a PCT strategy not one "owned" by key partners. Consequently responsibility for tackling obesity rests with the PCT. Action plans should be drawn up collaboratively and signed off by all key partner agencies (especially by the PCT and Local Authorities).

Accountability

We need to make sure that "children's" initiatives join up with "adult" initiatives as one is reported to the Children's Trust and the other to the Health and Wellbeing Partnership Board.

Physical activity initiatives

In general there is a co-ordinated approach to these interventions countywide, although the focus is on sport rather than everyday physical activity such as walking and using stairs instead of lifts.

Healthy Eating initiatives

A more strategic approach to healthy eating is required. There is lots of good practice countywide but it is patchy and not joined up.

Health and Social Care settings

The primary focus of the strategy to date has been to develop a high quality care pathway for people who are overweight and obese. We now have a clear pathway from early intervention to surgical treatments. More focus also needs to be given to weight management for people with long term conditions. Interventions in social care settings are not clearly mapped and work needs to be undertaken to strengthen these services.

Primary prevention (i.e. preventing obesity in the first place)

The revamped strategy needs to place greater emphasis on primary prevention and early identification. GPs and Local Authorities will have a major role to play in this.

Getting thinking on diet and exercise into planning decisions at all levels

There are more questions than answers here …. For example, we need to attempt to influence planning decisions and influence supermarket chains to make healthy food more attractive and available. Who is going to buy apples when you can get 5 Mars bars cheaper? (5 Mars bars cost £1.68; a bag of gala apples (approx 6-8) costs £1.75) Which young person is going to eat salad when they can get chips from the shop next to the school/college etc? What can we do to influence food policy at a national level and how can we ensure sports facilities do not get cut in spending reviews as these will impact on what we can achieve? There is some comfort in the fact that the latest long term plan for roads in Oxfordshire (called, in the jargon, Long Term Plan 3 or LTP3) contains things like provision of footpaths and cycle paths within its structure. Health promotion staff from the Public Health team are also part of the planning group.

Recommendation

The County strategy for prevention of obesity should be reviewed and refreshed by March 2011 through the Director of Public Health. The new strategy should be a true partnership effort and should have an emphasis on the prevention of obesity rather than its treatment. It should include a focus on the important role of GPs. Work with children and adults should be seamless. Those at increased risk should be targeted.

CHAPTER 6: Fighting killer diseases

The issue

Killer diseases remain a threat to the population of Oxfordshire. However their impact can be reduced by good surveillance and information, early identification and swift action, basic cleanliness, hand washing and good food hygiene.

By far the biggest event in 2009-2010 was the worldwide flu pandemic, which saw the emergence of swine flu caused by a new type of influenza A virus – H1N1.

This chapter reports on the recommendations from the 2008/09 DPH Annual Report and highlights the work around the flu pandemic. It also sets out the current state of play around important diseases and makes recommendations for action.

Progress report on 2008/09's recommendations

All the recommendations from the last DPH annual report have been addressed met as follows:

- Hepatitis C infection has been reviewed and a strategy and action plan drafted (see below);
- The PCT has invested in infection control and health protection;
- Investment has continued in Tuberculosis (TB) with new funding being directed to improving access to vaccination against TB for children at increased risk.

Progress in detail:
This section sets out the current position on the killer diseases which most threaten the health of the people of Oxfordshire.

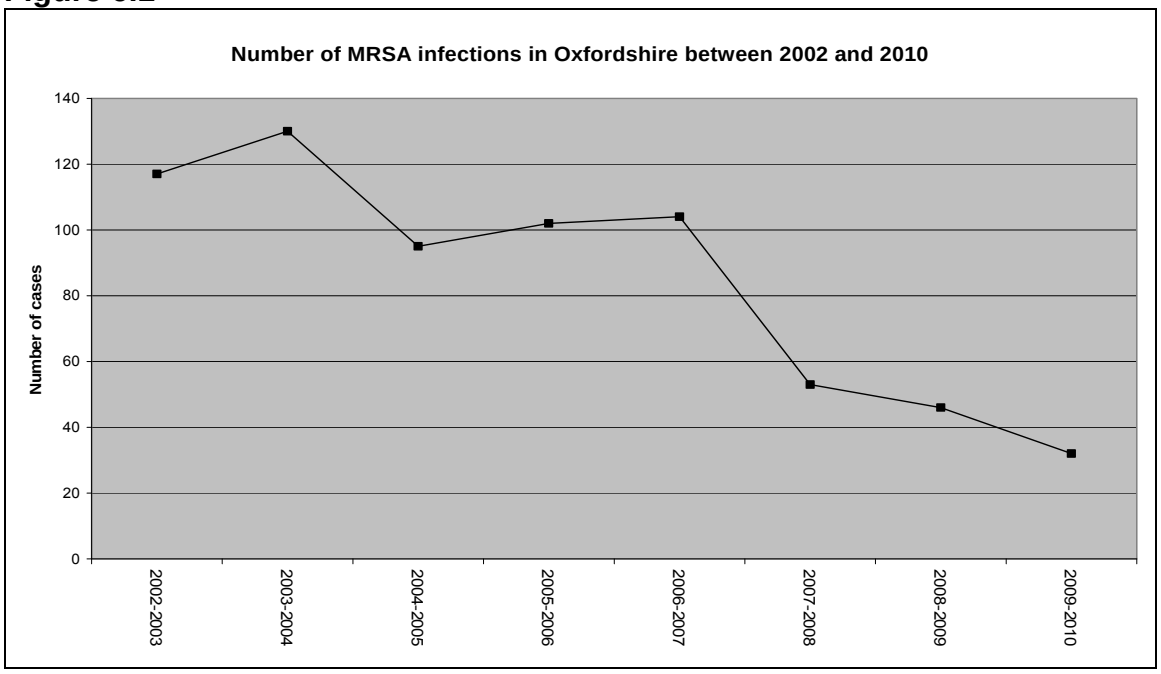
OPINION: Killer diseases are well managed in Oxfordshire but remain an ever-present threat. Constant vigilance is required.

1) Health Care Associated Infections

Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and *Clostridium difficile* (*C.diff*.) remain an important cause of sickness and death, both in hospitals and in the community. However numbers of infections **can** be reduced and considerable effort has been put into tightening all our systems to reduce the numbers of cases. As a result, we are seeing a reduction in the numbers of infections associated with hospital settings and now need to work to get a decrease in the community.

a) Methicillin Resistant Staphylococcus Aureus (MRSA)
MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. during surgery or other invasive procedures) it can cause blood poisoning (bacteraemias). It can be difficult to treat as it is resistant to commonly used antibiotics. MRSA bacteraemias continue to fall during 2009/10. The graph below shows the impressive achievement of the last 7 years.

Figure 6.1



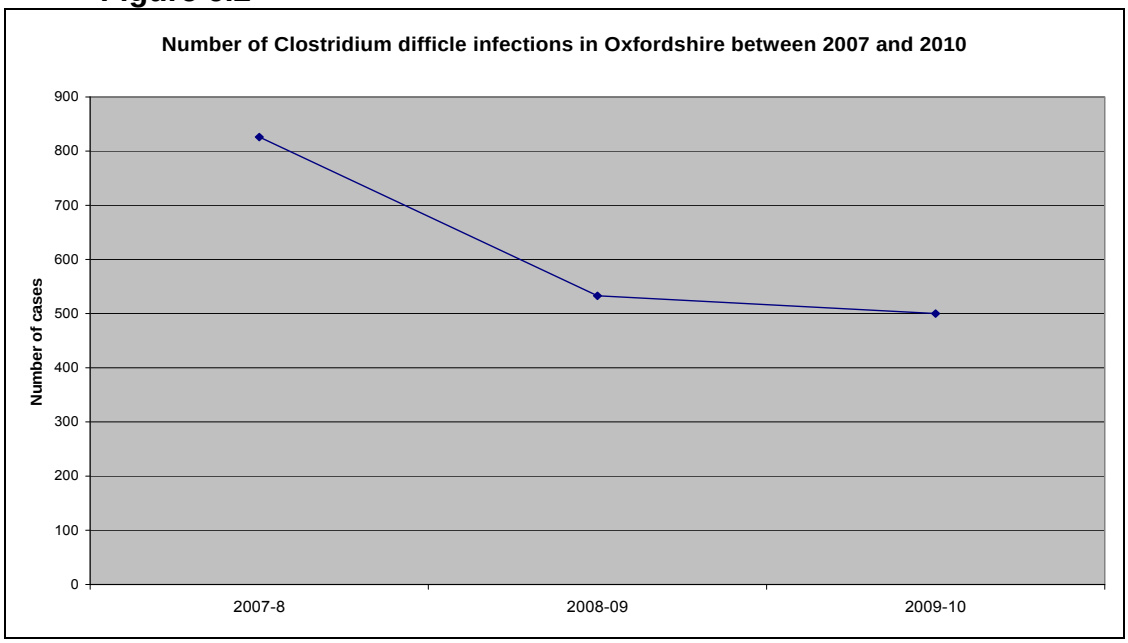
Approximately a third of MRSA bacteraemias are diagnosed within 48 hours of admission. These cases are reviewed by the PCT and a significant number are due to long term indwelling urinary catheters. As a result a countywide project is ongoing to reduce this cause. All planned admissions to our specialist hospitals are now screened for MRSA and if necessary patients are treated to remove the bacterium from their skin.

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

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

Cases of *C.diff* are thought to have started outside hospital if they are diagnosed within 72 hours of hospital admission. These account for about half of all cases. No one can say for sure how these cases arise, but general practices with high numbers of cases have been reviewed by the infection control team and a pharmacist to check prescribing of antibiotics and the quality of infection control. The data below shows the reduction in cases since 2007/08. Work continues on reducing inappropriate antibiotic use, improving the speed of isolation of suspected cases and improving cleanliness in hospitals.

Figure 6.2



2) Tuberculosis (TB) in Oxfordshire

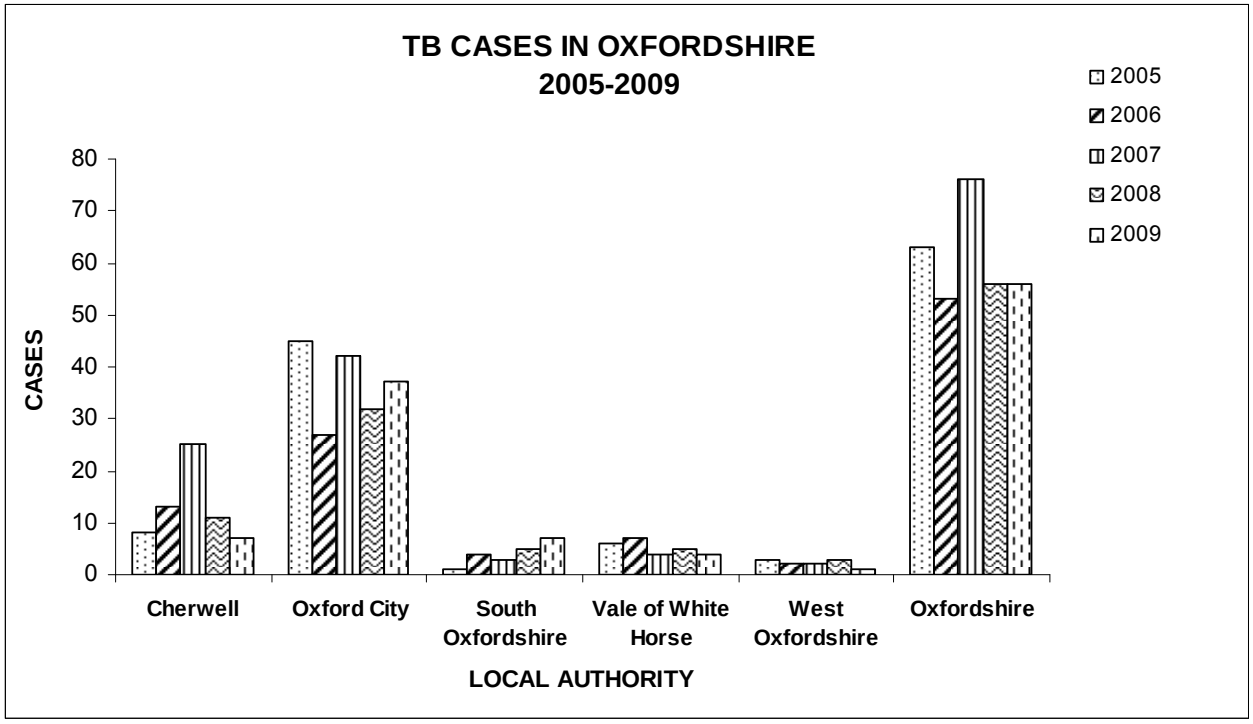
The latest data shows that TB rates in Oxfordshire fell compared with rates in 2007. Rates have remained highest in Oxford City and Cherwell District Council over the last five years (Fig 1). The substantial drop from 2007 to 2008 in the Cherwell District Council population follows the detection and successful treatment of a cluster of linked cases in this area during 2007.

Table 6.1: Tuberculosis incidence rate in Oxfordshire

Year	Number of cases	Rate per 100,00 population
2005	63	10.3
2006	53	8.4
2007	76	12
2008	56	8.8
2009	55	8.8

The Oxfordshire incidence rate of TB is consistently lower than the UK rate which provisional data suggests is 14.9/100,000 for 2009 across the UK. **This is a good achievement.**

Figure 6.3: Tuberculosis cases by local authority in Oxfordshire, 2005-2009



In Oxfordshire 55 TB cases were reported in 2009.

The Chief Medical Officer set local services a target of recording all TB cases and completing successful treatment in 85% of cases. Oxfordshire successful treatment rates have risen to 89.3% in 2008 (above the Thames Valley average) compared with 83.3% in 2006 and 84.2% in 2007.

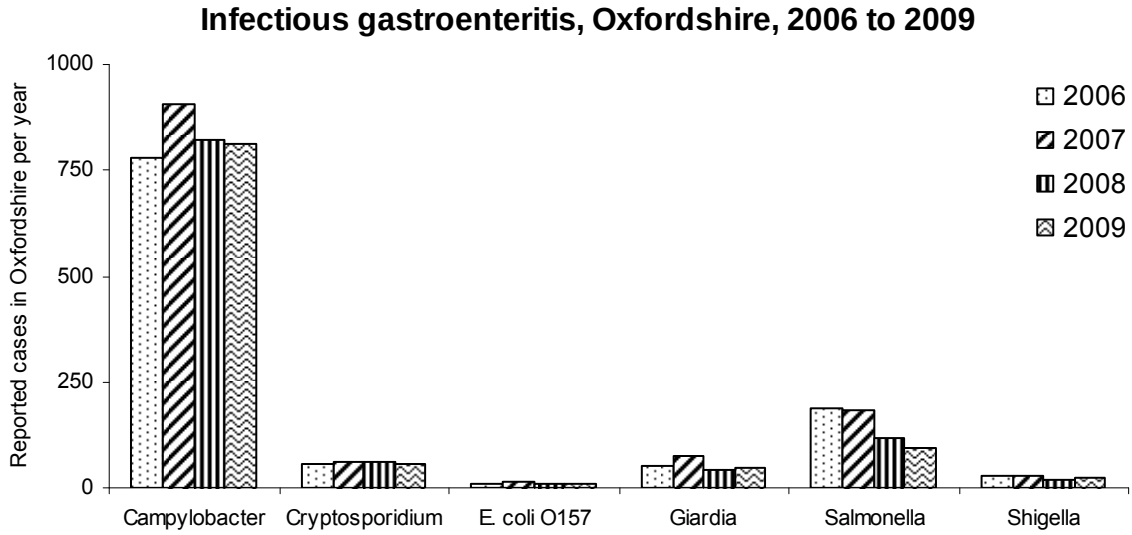
3) Gastrointestinal Disease

Food poisoning and other forms of infectious gastroenteritis continue to be a substantial burden of disease on the population of Oxfordshire. National regulations and standards are implemented locally by the environmental health staff of district councils. This year the five district councils in Oxfordshire collaborated to launch the excellent "Scores on the Doors" project where restaurant hygiene ratings are displayed prominently in restaurants and on the internet at http://www.scoresonthedoors.org.uk/fac.php?area=SE&county=OX . This is part of the ongoing work to ensure that safe food is served to the Oxfordshire population and visitors to the county. The need for continued public health work to assure safe food is shown by substantial numbers of cases of food borne disease in the County.

Surveillance data

There were over 1,000 reported cases of infectious gastroenteritis in 2009. This was an improvement on the previous year and shows satisfactory progress, apart from campylobacter infection which remains a cause for concern (see below).

Figure 6.4



More information on infection control is available from the health protection unit tvhpu@hpa.org.uk.

All of these infections can spread from person to person but this is usually easily prevented by hand washing and avoidance of preparing food for others while infected. For *Cryptosporidium,* infected children swimming in pools appear to be an important ongoing risk and all reported cases now receive advice to help with this.

The large number of cases of *Campylobacter* gastroenteritis is near to record highs, and with an estimated 8 cases occurring for each of the 811 that were confirmed by laboratory testing, we estimate that over 6,500 people suffered from this infection in the county in 2009, with young children being particularly affected. The main protection that is available to reduce this risk locally is to ensure that chicken is always well cooked and that raw chicken is not allowed to come into contact with other foods.

4) Vaccine Preventable Diseases

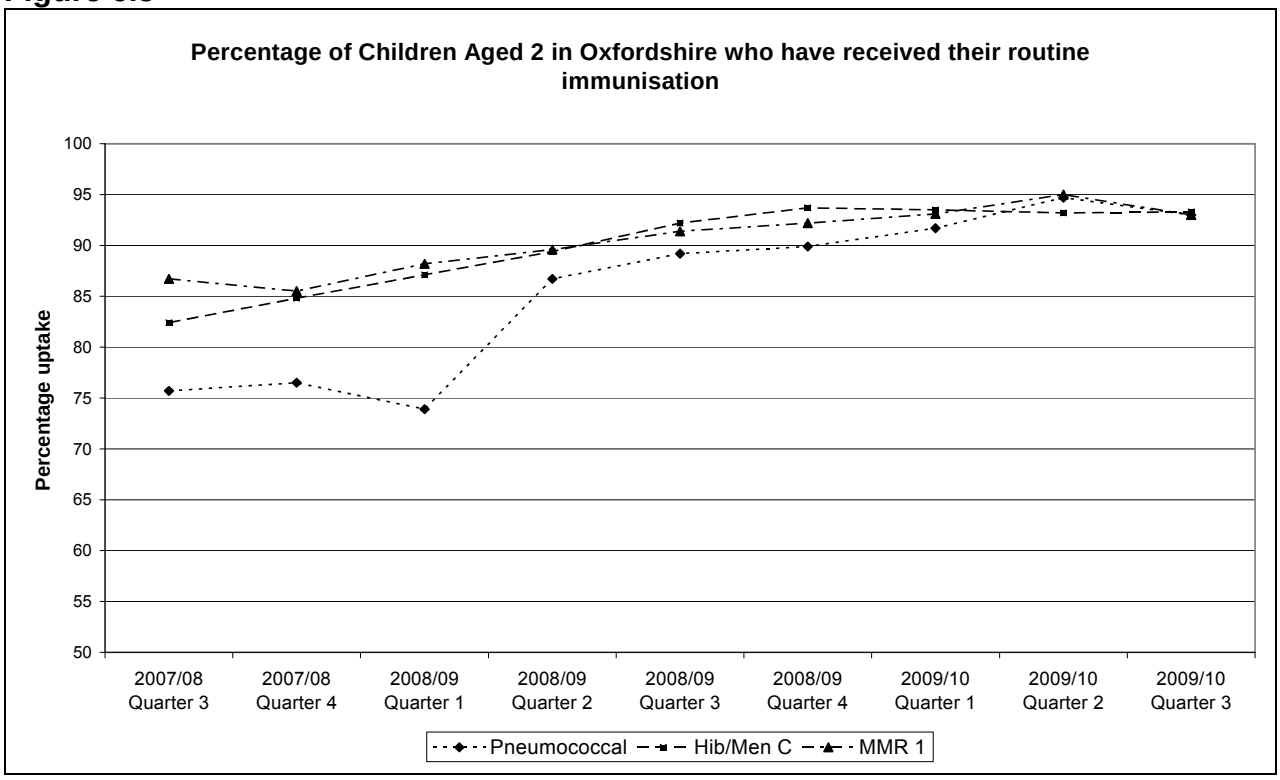
a) Childhood immunisations

Vaccination is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire have improved steadily over the years. A huge amount of work has been done to improve the way data is collected and recorded resulting in much more accurate information held by GP practices and the PCT. Practice staff, community staff and the PCT have been working together to achieve this – and this work was recognised nationally when the team were 'highly commended' at the Health Service Journal awards in November 2009.

A new Child Health Information System went 'live' in mid February 2010; this is an absolutely essential tool for keeping information accurate and quality high. This small number of children who are unimmunised can now be followed up individually and offered immunisation.

From the data up to February 2010 we anticipate that Oxfordshire will achieve the national targets set for immunisation. The graph below shows progress made.

Figure 6.5

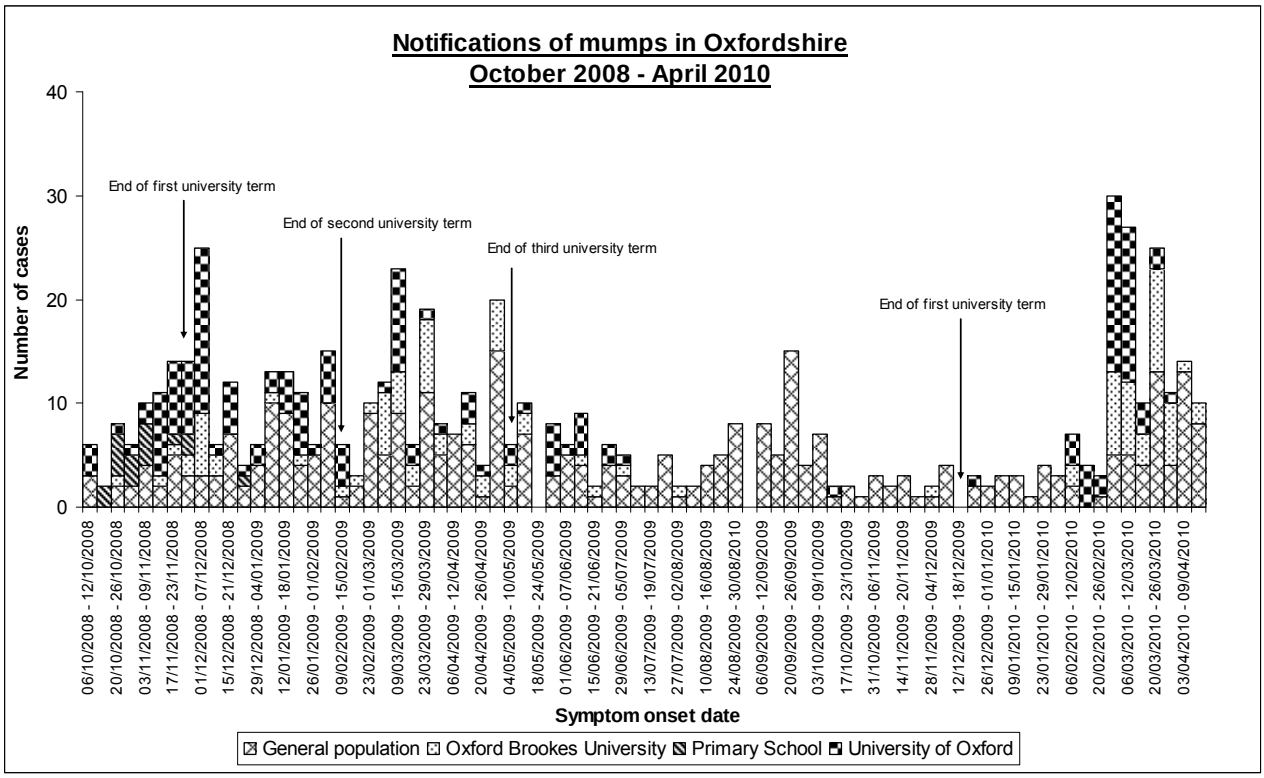


b) Measles Mumps and Rubella vaccine (MMR)

Two doses of Measles Mumps and Rubella vaccine (MMR) provides 99% of people with long term protection against measles (and 100% protection to the whole population if coverage is sustained at in excess of 95%). In the absence of vaccination there would be approximately 8,000 cases of measles per year on average in Oxfordshire. Of these, approximately 40 people would suffer convulsions as a complication, 8 encephalitis and an average of 1 person per year would die. However, the very success of vaccination programmes can lead to complacency, a fall in vaccination levels, and the recurrence of diseases. This has happened nationally with the resurgence of measles leading to over 1,100 cases nationally between January and September 2009, including 40 in the Thames Valley. Because we have prioritised vaccination in Oxfordshire, there were only 2 cases between January and October 2009 and 1 in 2008. Nonetheless, because the stakes are so high, the PCT has begun a major programme to improve performance further.

The relatively low rate of measles in Oxfordshire over the past year contrasts with an increased number of cases of mumps due to spread among university students in Oxford arriving from out-of-county (Figure 4). This involved students in an age group who had received only one dose of MMR and one of MR (measles and rubella but lacking mumps) in the 1994 MR campaign.

Figure 6.6



Provision of vaccination by general practitioners and information e-mailed to university students during the 2008/2009 academic year partly closed this gap in protection. Information highlighting this problem was provided to new students for the 2009/2010 academic year before coming up to university in an "MMR vaccination: it's not just for children" information sheet allowing them to ensure with their usual general practice that they were protected before leaving home.

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

Genital human papilloma virus (HPV) is the most common sexually transmitted infection. It is so common that at least 50% of sexually active men and women get it at some point in their lives. There is no treatment for the virus itself but a highly effective vaccine is available that protects against HPV types 16 and 18, the types most commonly associated with cancer between them cause over 70% of all cervical cancers. **HPV vaccination will save the lives of an estimated 400 women each year in the UK with 4 lives saved per year in Oxfordshire.**

The first cohort to be immunised were girls in school year 8 in 2008/09, who were offered a three-dose course of HPV vaccination in school, over six months. A very impressive 90% of the girls took up the offer to have the three doses of HPV showing a highly successful start to a new vaccination programme. A catch up programme, the next phase of the HPV programme, started in September 2009 offering HPV to all girls up to the age of 18 years at 31 August 2009.

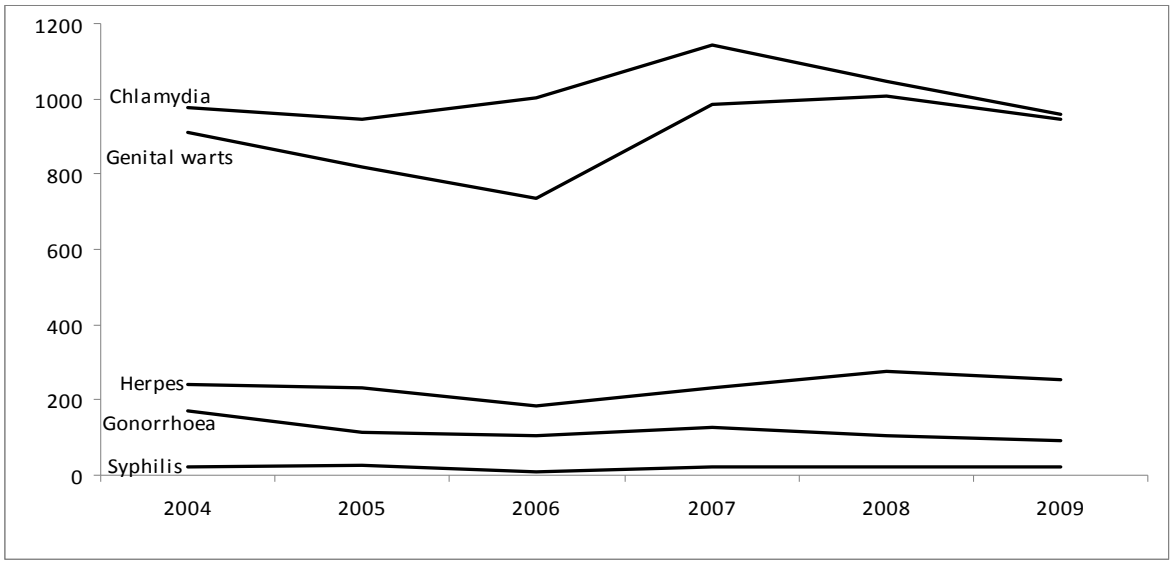
This new vaccine is a significant step forward in the prevention of cancer.

5) Sexually transmitted infections

It is important to monitor sexually transmitted diseases carefully to watch for increases in disease, the vast majority of which are preventable through taking basic 'safe sex' precautions.

Overall sexually transmitted infections diagnosed at genitourinary medicine clinics in Oxfordshire show a largely stable picture over the long term although there is some year to year variation. It is heartening to see that all the major sexually transmitted diseases fell during the last year. Chlamydia and genital warts remain the most common although there have been decreases in Chlamydia cases over both 2008 and 2009 from a high in 2007.

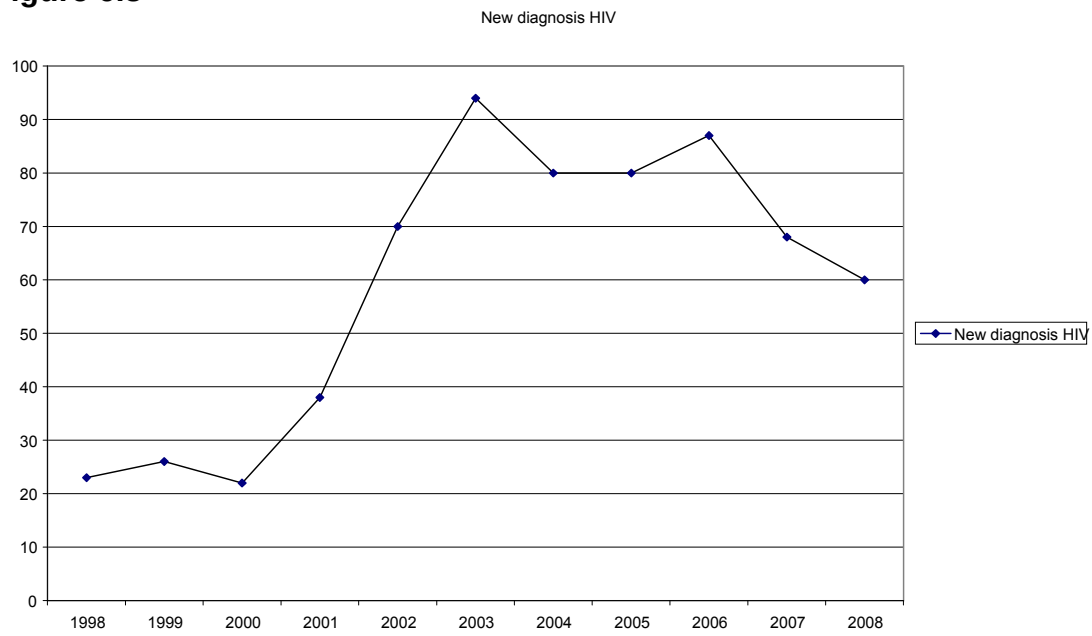
Figure 6.7: Sexually transmitted infections diagnosed at genitourinary medicine clinics in Oxfordshire, 2004-2009



HIV & AIDS

In 2008, there were 60 new HIV diagnoses across Oxfordshire and 267 across the Thames Valley, continuing the welcome downward trend begun the previous year. Work continues with vulnerable groups, delivered through partnerships with Terence Higgins Trust and Oxfordshire County Council.

Figure 6.8



6) Hepatitis C virus infection (HCV)

HCV is a blood borne virus that causes liver disease. A small proportion of cases go on to develop cirrhosis of the liver and a small proportion of these will contract liver cancer and die of the disease. HCV is contracted if a small amount of blood from an infected person gets into someone else's bloodstream. Most cases are injecting drug users, people who received blood transfusions in the UK before screening began in 1991 and people who have had transfusions in parts of the world where quality controls are poor. Many people will remain symptom-free and so will be unaware they have it.

The number of people estimated to be infected with HCV in Oxfordshire is around 2,000. 52 people were offered treatment in 2009/10.

Last year's DPH annual report called for the situation to be improved.

Oxfordshire PCT has worked productively with partners throughout 2009 to understand the current picture, identify the gaps, and draft a strategy to prevent this disease and improve treatment. This work is ongoing.

7) Influenza A (H1N1) – The Swine Flu Pandemic

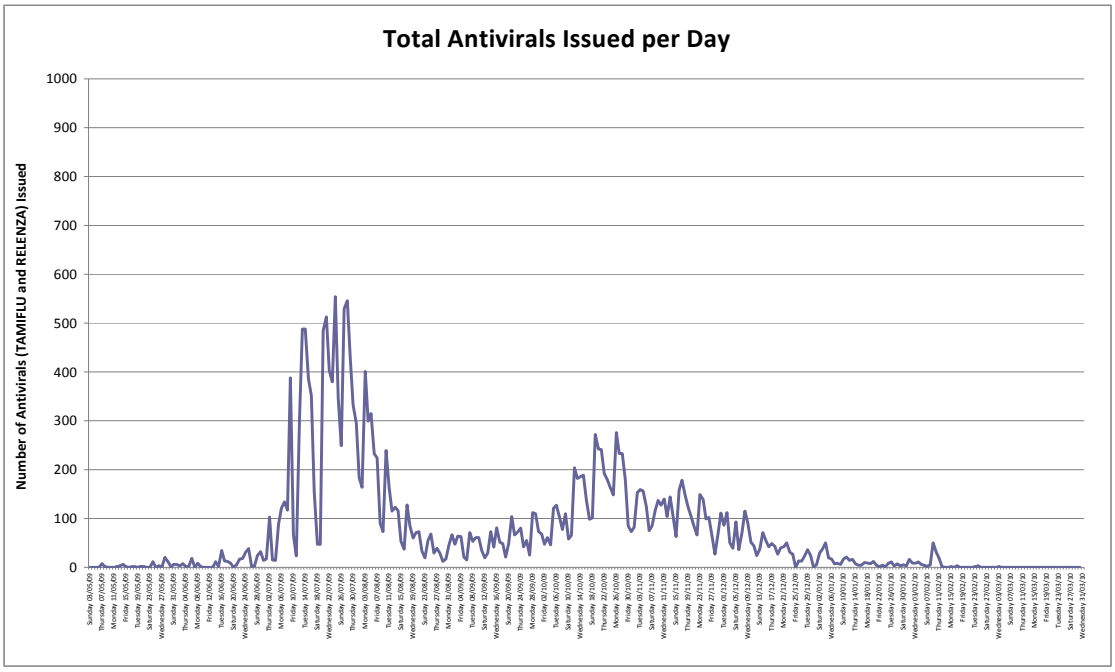
Influenza A (H1N1) was first identified in Mexico in April 2009. In June 2009 the World Health Organisation declared that it had become a pandemic, which meant that the virus had spread around the globe. It spread quickly because it was a new type of flu virus to which few people have full resistance. In most cases the virus has proved to be mercifully mild, however around the world hundreds of people have died. The confused picture in the early days in Mexico led the world to expect a virulent pandemic and so a full emergency response was triggered.

Oxfordshire has spent the last 4 to 5 years carefully preparing for a pandemic and this meant that the NHS and Local Authorities were able to respond very quickly. The multi-organisational response was excellent and all organisations played their part. Support from and teamwork with the Health Protection Agency, the Police, and a wide range of organisations were crucial to success.

In addition, Oxfordshire successfully took an overall lead for health services across the Thames Valley. In the first stages the PCT was able to support the Health Protection Unit and primary care in swabbing and treating individuals with confirmed disease and providing prophylactic antiviral drugs to slow down the spread of the infection in people who had contact with those with suspected swine flu.

As the numbers of individuals with suspected swine flu increased, the PCT opened antiviral collection points around the county to enable individuals to get their antiviral drugs. Numbers peaked at around 500 doses given per day. As numbers reduced access to antiviral drugs came from community pharmacies. The graph below shows the number of courses of antiviral drugs that were issued during the pandemic.

Figure 6.9



In June 2009 guidance was received from the Department of Health (DH) regarding the vaccination against swine flu and Oxfordshire PCT implemented a vaccination programme. This included making vaccination available to frontline health and social care workers and to priority groups including those that were pregnant, immunosuppressed or at higher clinical risk and to those between 6 months and 5 years. Data shows that Oxfordshire PCT achieved a high rate of uptake in health care workers thus protecting themselves and those patients with whom they have contact.

Table 6.2: The total number of frontline health care workers that have been vaccinated by each PCT in the Thames Valley as at 28 February 2010

Organisation	Eligible	Vaccine administered	%
Milton Keynes PCT	1,164	480	41.2
NHS Oxfordshire	3,343	1,350	40.4
Buckinghamshire PCT	3,017	921	30.5
Berkshire East PCT	2150	721	33.5
Berkshire West PCT	2,373	641	27.0

No Oxfordshire resident died of swine flu throughout the pandemic.

The question arises, was it all a storm in a tea cup? The answer is an emphatic no! Because of this pandemic we have learned much and improved services in new ways as follows:

- We know our joint plan works and it can now be improved
- We know that organisations in Oxfordshire and Thames Valley can cooperate well in a long drawn out emergency.
- We now know that we can slow down the spread of a pandemic through cough etiquette and handwashing
- We now know how to set up mass local and national phone-in services
- We now know how to give mass treatments to hundreds of people day after day
- We now know how to immunise thousands of people at short notice

- We know more about patterns and speed of spread around the globe and how these can be slowed down
- We now have a much better-linked network of intensive care services across Thames Valley.
- Improved planning also has wider benefits. Lessons learned during the flu pandemic helped the County deal better with the heavy snowfalls last winter.

OPINION: We are performing well in the fight against killer diseases in this County. There is no room for complacency and we need to refocus our efforts year on year to stay abreast of these diseases.

Recommendations

Recommendation 1
The Director of Public Health and the local Health Protection Agency must work closely to maintain surveillance of communicable diseases during 2010/11 and take appropriate steps to control these diseases and any new emerging killer diseases.

Recommendation 2
Oxfordshire PCT should continue to be ready and prepared to make investment in infection control services and health protection, through 2010/11.

Recommendation 3
The Director of Public Health should report on killer infections and infectious diseases in the DPH annual report in April 2011.

CHAPTER 7: Alcohol: What's your poison?

Why is it time to take Alcohol seriously as a major Public Health issue?

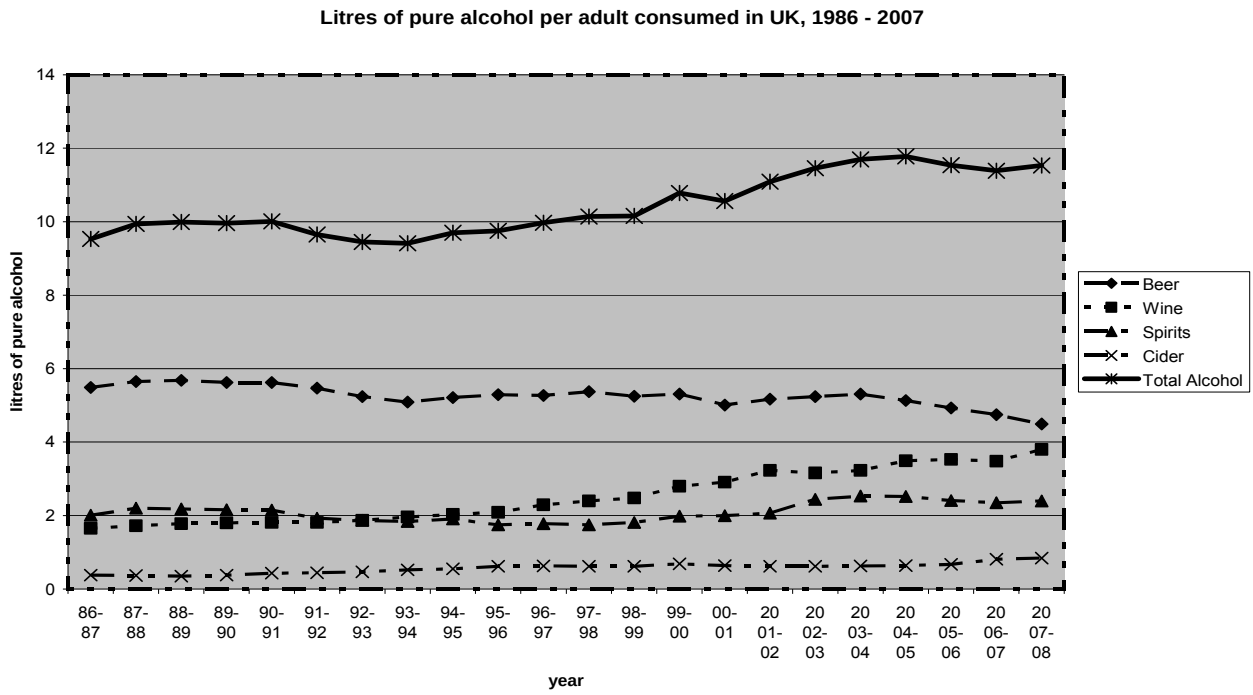
Alcohol is perhaps the last major gap in Oxfordshire's Public Health defences.

Despite good, innovative work in the county over recent years, this issue is not yet sufficiently in the mainstream of Oxfordshire's policy making, and it needs to be. Why? Alcohol is a deeply ingrained part of British culture. It is widely used in the home as a relaxant and its effect in lowering inhibitions is valued in social gatherings. Indeed, to many, the presence of alcohol is a social signal that says 'party'. Indeed, the majority of adults in our society do control their drinking and 9% abstain altogether. So, what is the problem? The list is as follows:

Alcohol consumption has risen in the last 40 years

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

Figure 7.1



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

A comprehensive summary of definitions relating to alcohol use and abuse are provided at the end of this chapter.

Many Adults exceed recommended drinking levels and one in five drinks at hazardous levels

- In 2006, almost half (48%) of British men and 4 out of every 10 British women exceeded recommended daily guidelines on at least one day in the previous week.
- Similarly, British men and women aged 25 to 44 were more likely than other age groups to have drunk heavily on at least one day during the previous week, followed closely by those in the 16 to 24 age group.
- Individuals in managerial and professional occupations are more likely to have drunk alcohol in the previous week, and to drink more frequently than those in routine and manual occupations

- In 2008 one in every five of over 16's consumed alcohol at hazardous levels.
- Only 9 per cent of the White British population are non-drinkers, but the proportion is higher among some ethnic minority groups, rising to 90 per cent or more among those of Pakistani and Bangladeshi origin.

Alcohol consumption in young people has increased with heavy drinking and binge drinking a concern in this group and consumption among girls has been increasing rapidly.

Between 1990 and 2006, drinking in UK's 11-15 year olds roughly doubled from an average of around 5 units per week to around 11 units per week.

In addition to this there are proven links with risk taking behaviour which may result in:

- Teenage conceptions
- Sexually transmitted infections
- Mental health problems
- Alcohol related accident and injury
- Poorer school attendance and lower attainment
- Involvement in anti-social behaviour and crime

Alcohol without doubt causes disease and early death. It is a poison.

- In England in 2006, 16,236 people died from alcohol-related causes.
- The number of deaths from alcohol-related liver disease has almost doubled in the last decade.
- Alcohol causes cancers of the liver, bowel, breast, throat, mouth, larynx and oesophagus; it causes osteoporosis, reduces fertility and causes accidents of all kinds.
- Alcohol is responsible for around 950,000 unnecessary admissions to hospital nationally per year, and this is rising (an increase of 70% in the 6 years between 2002/03 and 2008/09).

Alcohol is getting cheaper and more easily available

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

The health benefits of alcohol are overstated

- The potential health benefits of alcohol tend to be greatly overstated.
- Above the age of 40 years, drinking a small amount of alcohol may reduce the risk of heart disease and stroke.
- For those who drink above this low level, and for those under 40 years who drink any amount, alcohol **increases** the risk of heart disease and stroke.
- For those of any age, drinking any amount of alcohol increases the risk of cancer – there is no safe limit.
- Across England, alcohol results in over 13 people being admitted to hospital for every one that it prevents.

Alcohol damages the family and social networks

- Living with somebody who misuses alcohol can be a horrendous ordeal. Alcohol can make a partner's behaviour unpredictable, aggressive and erratic.
- Marriages in which one or both partners have an alcohol problem are twice as likely to end in divorce.
- British Crime Survey figures for 2007/08 suggest that 125,000 alcohol-related instances of domestic violence occurred over this one-year period.

Alcohol fuels antisocial behaviour and changes the character of our towns, especially in the evening at weekends

- Local Councillors have frequently stated their unease about the drinking culture apparent in towns across Oxfordshire, particularly among young people in the evening at weekends.
- Nationally, aggressive behaviour resulting from alcohol misuse, in particular binge drinking, is a major cause of street violence. The British Crime Survey found that almost half of the 2 million victims of violence thought that their attacker was under the influence of alcohol, with 39,000 reports of serious sexual assault also being associated with alcohol consumption.
- The effects of crime extend beyond those who are directly attacked, creating an environment of fear.

Alcohol damages front-line services and the economy and places a huge financial burden on the taxpayer.

- Half of all assaults on staff in hospital emergency departments are committed by those under the influence of alcohol.
- There are over 8,000 alcohol-related assaults on police officers every year in the UK.
- This makes it difficult to deliver community services in areas where staff feel threatened, demoralising front line healthcare staff and other professionals.
- One in every four accident and emergency attendances is related to alcohol
- The total cost to the NHS is estimated to be £2.7 billion per year and rising - almost double the cost in 2001 when the cost was £1.47 billion.
- At least 14-17 million working days are lost per year in the UK because of alcohol, costing up to £6.4 billion per year.
- The National Social Marketing Centre estimated that the total annual societal cost of alcohol misuse to the nation to be £55.1billion.

In 2008 the Chief Medical Officer summed up the problem well:

"*Drinking alcohol is a deeply ingrained part of our society; each year the average intake per adult is equivalent to 120 bottles of wine. Since 1970, alcohol consumption has fallen in many European countries but has increased by 40% in England.*

The consequences of drinking go far beyond the individual drinker's health and well-being. They include harm to the unborn fœtus, acts of drunken violence, vandalism, sexual assault and child abuse, and a huge health burden carried by both the NHS and friends and family who care for those damaged by alcohol. "

<u>The position in Oxfordshire:</u>

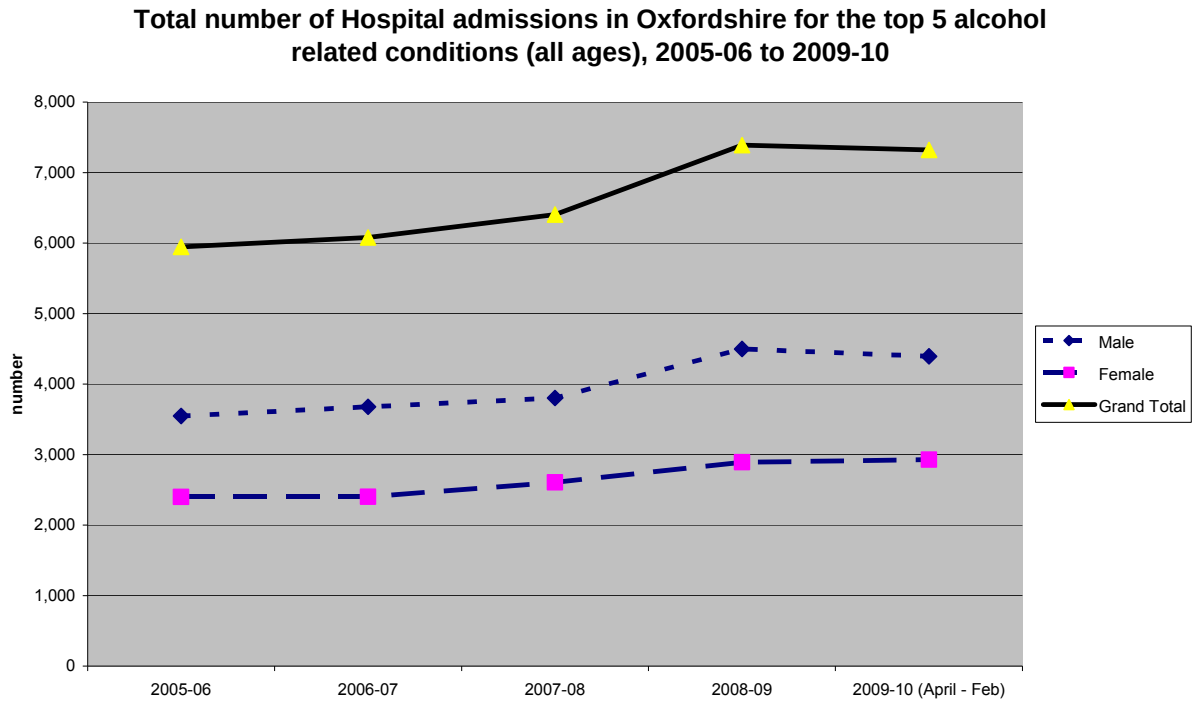
Hospital admissions for alcohol related harm in Oxfordshire

Local statistics show the burden of disease related to alcohol in Oxfordshire.

The graph below shows how hospital admissions due to alcohol related conditions have been rising steadily from 2005 to 2010. This calculation takes 5 common conditions and records the proportion of each one that is caused by alcohol.

The top five alcohol related illnesses are breast cancer or other related illness, heart rhythm problems, rectal cancer, heart disease related to artery deposits and other unspecified chest pain.

Figure 7.2



Source: SUS (U-R) data analysed by Decision Support, NHS Oxfordshire April 2010

Self reported under-age drinking in Oxfordshire

The Big Voice survey was carried out in Oxfordshire between March 2008 and June 2009. An online survey was completed at school by almost 5000 young people aged 4 – 19 with additional on-street interviews for 16-19 year olds. This gave the following results which many may find shocking.

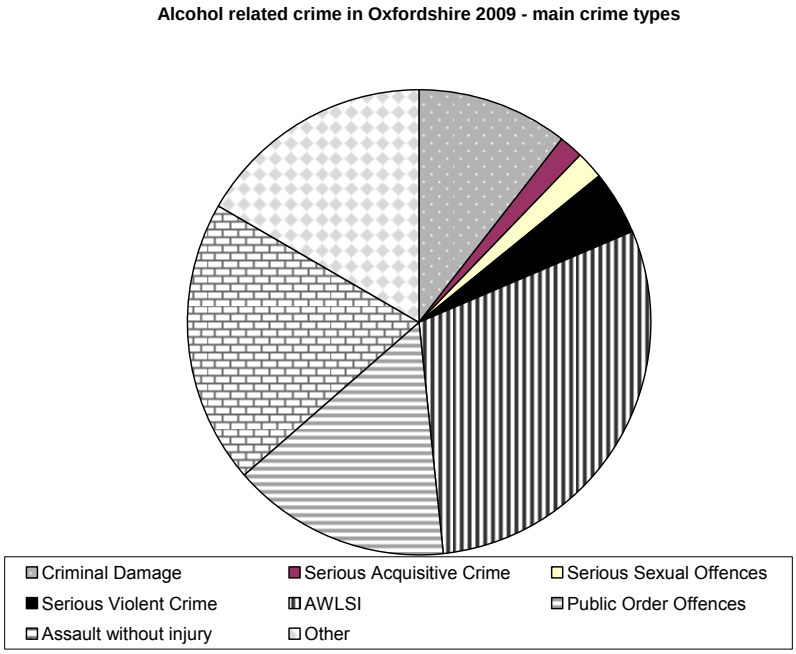
- 72% of young people aged over 11 have drunk alcohol,
- 9% regularly drink,
- 51% have been drunk
- 9% are regularly drunk.
- 5% agree that there is a lot of pressure to drink alcohol.

Under age sales of Alcohol in Oxfordshire

Police Licensing Teams and Trading Standards officers carry out checks of sales of alcohol to under age young people. Results of the police led operations in 2009-10 showed:

- 50 out of 207 premises tested sold alcohol to underage customers (24%)
- Over a third of these failed again when re-tested
- Seven premises were prosecuted for repeated failures

Figure 7.3: Alcohol related crime in Oxfordshire



Source: Thames Valley Police, March 2010 (Note – AWSLI stands for Assault with Less Serious Injury)

- **Over 11% of all crime in Oxfordshire last year was related to alcohol consumption**
- **This absorbs a substantial proportion of taxpayers' money spent on police services**
- Assaults make up the largest proportion of crimes which are committed under the influence of alcohol,
- Public order offences make up a high proportion of these crimes including being drunk and disorderly and using threatening words or behaviour. This behaviour often leads to other criminal behaviour including assault or the causing of criminal damage.

The cost of alcohol related crime can be estimated. For example, the crime figures from Oxfordshire last year indicate that:

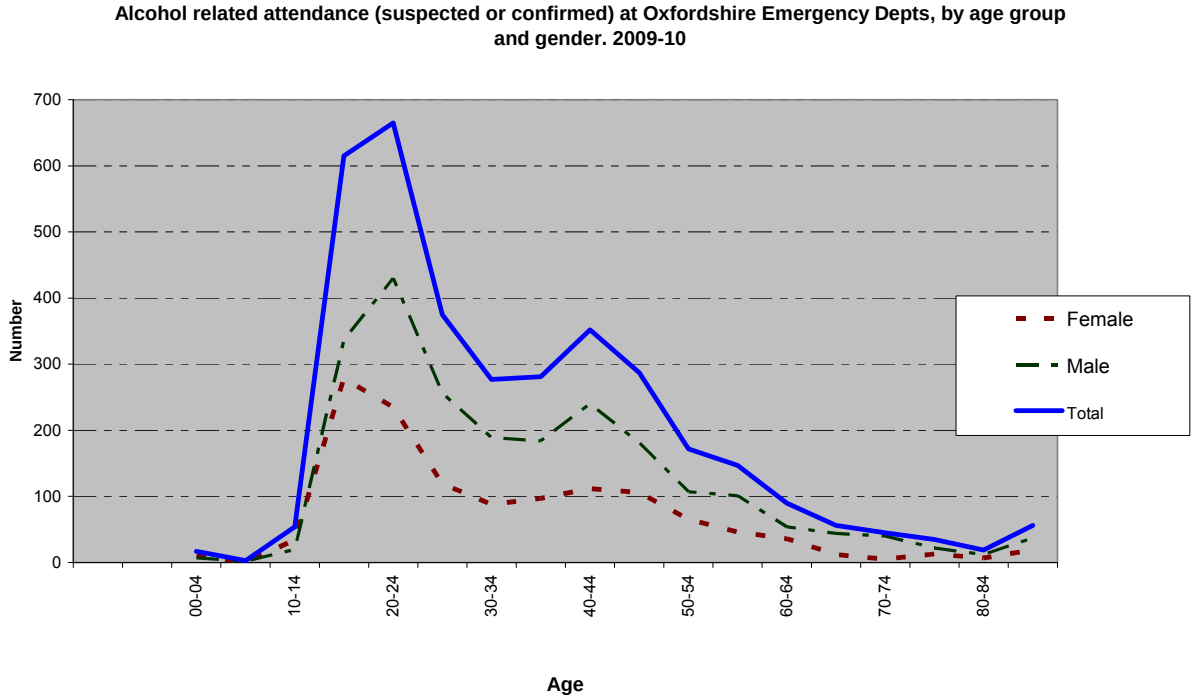
- Alcohol related criminal damage cost approximately £4.5m (over 5,000 incidents at an indicative cost of £890 per incident)
- Violent assaults fuelled by alcohol in Oxfordshire cost approximately £1.5m (149 offences at an indicative cost of £10,409 each)
- Serious sexual offences linked to alcohol use cost approximately £3.1m (99 offences at an estimated cost of £31,438 each)

Accident and Emergency (A & E) attendances caused by alcohol in Oxfordshire

3,500 A and E attendances were related to alcohol in 2009/10. This is expensive to the taxpayer and inefficient for our services, especially when our emergency departments struggle to see patients within the national 4 hour standard. These 3,500 attendees mean longer waits for everyone. The predominance of young people and young adults, especially young men, is simply a reflection of the drinking culture society permits, aided by liberal licensing laws around opening times. In Oxford at the weekend it is easy to carry on drinking until 3 o'clock in the morning.

National statistics indicate that 70% of emergency admissions on a Friday and Saturday night are due to alcohol consumption.

Figure 7.4



Source: Data from Oxford Radcliffe Hospitals Trust, analysed by Decision Support, NHS Oxfordshire.

Ambulance call-outs related to crime and disorder incidents in Oxfordshire

The further cost of alcohol to society is reflected and is shown in ambulance call outs to crime and disorder incidents. One quarter's data shows the pattern of activity, often focusing on built up areas in Oxford and Cherwell, resulting in 4,000 to 5,000 call outs a year.

The Oxford Nightsafe Partnership maps this data by location of the pick-up on a regular basis. They particularly look at the ambulance attendance where there is a record of assault / sexual assault, overdose / poisoning or stabbing or gunshot wounds. A high proportion of these pick-ups are made at licensed premises.

Table 7.1: Records of ambulance call outs to crime and disorder incidents in Oxfordshire July – Sept 2009

	Month (2009)			
LA district	**Jul**	**Aug**	**Sep**	**Total**
Cherwell	83	92	87	**262 (21%)**
Oxford	165	184	147	**496 (41%)**
South Oxfordshire	39	52	28	**119 (10%)**
Vale of White Horse	78	57	45	**180 (15%)**
West Oxfordshire	52	48	42	**142 (12%)**
Total	**417**	**433**	**349**	**1199 (100%)**

Source: South Central Ambulance NHS Trust (Oxfordshire)

Summary

The British Medical Association summed up the position well in 2008, and also criticised the effectiveness of our current national policies to control alcohol.

"*Alcoholic beverages consumed in moderation are enjoyed by many. Although socially accepted, alcohol can be an addictive drug. Alcohol misuse can be harmful foremost to the individual but also places a substantial burden on families and society. The levels of alcohol-related disorder, crime, morbidity and premature mortality in the UK are*

unacceptably high. Despite this, the strategy to reduce alcohol-related harm in the UK has seen an over-reliance on popular but ineffective policies, as well as liberalisation of the major drivers of alcohol consumption: availability and price. This represents a significant shortcoming in the political drive to improve public health and order."

What are we doing about it?

Our current strategy is a good start and provides a solid foundation.
The Oxfordshire Alcohol Strategy 2008-11 has made a very good start. Put together by an impressively wide range of organisations, its key priorities are to:

- Reduce alcohol related disorder
- Increase the consistency and quality of alcohol awareness for all ages
- Develop key health initiatives and commission alcohol treatment
- Develop a balanced sustainable leisure economy for the benefit of all ages
- Reduce young people's demand and supply of alcohol and its associated harms

This strategy is now due for renewal, and that gives us an opportunity to move forward faster.

Evidence of green shoots and good practice
New actions which have been carried out as part of this strategy include:

- A campaign to raise awareness of the safe drinking levels
- A wide range of organisations coming together including the police and ambulance services to keep our City and town centres safer at night time (the Nightsafe partnerships)
- Joining up work between the public health department and the John Radcliffe A and E Dept to follow up people with alcohol related injuries with the aim of reducing alcohol intake.
- Checks on shops selling alcohol to underage drinkers leading to successful prosecutions and greater awareness.
- A special theatre production for schools aimed at raising awareness of alcohol problems and limits called Last Orders.
- Brief Advice training for schools and Health Trainers (people working in the community to offer help on health issues to those who are the hardest to reach) so they are confident to raise the issue of drinking.
- A new alcohol treatment service procured by DAAT as mentioned above.
- Revising the Children and Young Peoples' Plan to include better action plans which will bring more joined up action from a range of organisations
- Carrying out the Oxfordshire Voice Survey of alcohol consumption and attitudes showing that levels of awareness are quite high.

What should we do next?
The direction of travel on tackling alcohol issues is good and we need to build on this success. The focus of this work, our understanding of the issues and the delivery of initiatives have increased enormously in the last few years. From a position where tackling alcohol related harm was not "owned" by anyone we now have a shared vision and a plan which is being implemented by several partners. The Alcohol Strategy has brought people together and given leadership to this issue.

OPINION: A good start has been made to tackle alcohol issues in this county. Given the size of the threat posed, this topic should be given a higher priority in the County. The preparation of a revised County alcohol strategy is an opportunity to do this which should be seized.

How do we get there?

We have to be realistic. Some of the actions needed to change attitudes and behaviour in connection with alcohol have to be carried out at a national level. Campaigns, information and regulation are important. The debate will continue on whether the Government should set a minimum price for a unit of alcohol and many would say that tax is already high, but it is undeniable that price does have an influence on consumption.

We have to shift the emphasis to prevention and give people the right information to help them take responsibility for their health. It is only changes in individual behaviour that will lead to reductions in overall consumption and this disease.

We have to use 'brief advice'. Many professionals could take the opportunity to raise the issue of alcohol consumption and give brief advice if required**.** There is good evidence that this works. Early detection and increased awareness are the best tools in the prevention agenda. The role of GPs and primary care are crucial in this. This work should be stepped up and made consistent across the county.

Recommendation

The revision of the Alcohol Strategy in the next year will give a great opportunity for a further step-change. We need a strong strategy which should include the following key elements by March 2011.

1. Powerful and far reaching information about the potentially toxic effects of alcohol to health, community safety and family life that make it a personal issue for all of us.
2. Further reductions in alcohol related crime and disorder in our towns and City with targeted approaches and a firm resolve to enforce action against premises and people causing problems. This is a lead area for Nightsafe partnerships around the county who should continue to develop their role.
3. Joined up and effective advice and treatment services are needed, including in primary care. The NHS and Drug and Alcohol Action Team should work together to commission prevention and treatment services proportionate to the size of the issue.
4. Involvement of young people is essential in devising and rolling out campaigns and activities to tackle the youth drinking culture. This will need to be part of the planning carried out by the Children's Trust.
5. Enforcement of the law to prevent sales of alcohol to under 18s (or people buying it for them). Trading Standards and the Police Licensing Officers can work together to ensure consistent coverage on this issue across the county.
6. A comprehensive set of process and outcome measures should be set monitored and reported regularly so that the impact of this step change can be seen. This responsibility should fall to the Alcohol Strategy Group who should make sure their results are reported to the Health and Wellbeing Partnership and the Children's Trust as well as to the Community Safety Partnership
7. The Health Overview and Scrutiny Committee should consider scrutinising progress made as part of their work plan for 2011/12.

Alcohol: a note on terms used

Looking closely at the subject of Alcohol requires some special jargon. The key terms are defined in this box.

Unit
In the UK, alcoholic drinks are measured in units (10 millilitres (ml) of alcohol.) One unit of alcohol is about half a pint of ordinary strength beer, lager, or cider (3-4% alcohol by volume), or a small pub measure (25ml) of spirits (40% alcohol by volume). There are 1½ units of alcohol in a small glass (125ml) of ordinary strength wine (12% alcohol by volume). There is substantial variation in the measures used in bars and restaurants and measures poured in the home tend to be larger.

Recommended drinking guidelines
In the UK, it is recommended that men should not regularly drink more than three to four units per day, and women should not regularly drink more than two to three units per day. In terms of weekly limits, men are advised to drink no more than 21 units per week and women no more than 14 units per week i.e.:

- **for men**, an **average** per day of 1½ pints of beer, 3 shorts of spirits or 2 **small** glasses of wine
- **for women** an **average** per day of 1⅓ **small** glasses of wine, 2 shorts of spirits or 1 pint of beer

Harmful drinking: drinking that causes harm
Harmful drinking is a pattern of alcohol use that causes damage to physical and/or mental health. Harmful use commonly has adverse social consequences.

Hazardous drinking: drinking that puts the individual at risk of future harm
Hazardous drinking is a pattern of alcohol use that increases the risk of harmful consequences for the individual. In contrast to harmful drinking, hazardous drinking is of public health significance despite the absence of any current disorder in the individual use as it is likely to lead to future problems.

Heavy drinking: drinking in excess of what is considered moderate
A pattern of drinking that exceeds some standard of moderate drinking. In the UK, heavy drinking is defined as consuming eight or more units for men and six or more units for women on at least one day in the week.

Binge Drinking: heavy drinking in one session
Binge drinking is defined as drinking at twice the recommended levels or more in one session. This would be 8 or more units for men and 6 or more units for women in one go.

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