

**DIRECTOR OF
PUBLIC HEALTH
FOR OXFORDSHIRE**

**ANNUAL REPORT
IX**

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Contents

| | |
|---|-----------|
| Foreword..... | 3 |
| Chapter 1: The Demographic Challenge..... | 4 |
| Chapter 2: Building Healthy Communities | 17 |
| Chapter 3: Breaking the Cycle of Disadvantage | 22 |
| Chapter 4: Lifestyles and Preventing Disease Before It Starts..... | 59 |
| Chapter 5: Mental Health | 74 |
| Chapter 6: Fighting Killer Diseases | 81 |

Foreword

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

This is my 9th Annual Report for Oxfordshire.

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

It is for all people and all organisations.

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

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

With best wishes,

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
July 2016

Chapter 1: The Demographic Challenge

Main messages in this chapter:

- **The demographic challenge is about all ages, not just older people.**
- **However the growth in the number and proportion of older people in the population remains the biggest challenge to health and to services.**
- **Services will need to change to respond to the challenge – doing nothing is not an option.**
- **The change is not even across the County – service change will need to be tailored to different localities – there is no ‘one size fits all’ solution.**
- **The demographic challenge affects all of us now. Its effects can be felt on our busy roads and through plans for housebuilding in the County.**
- **Because of its relatively ‘old’ population profile, Oxfordshire will be affected more and sooner than elsewhere.**
- **The nature of the population will change too- for example the population will become increasingly diverse.**
- **New patterns of disease and new forms of inequality will follow and we need to be ready to tackle these.**
- **Shifting from a focus on treatment to a focus on prevention will be key.**

In this chapter I want to focus on health and change in our population and what this means for services and what it may mean for each one of us as individuals.

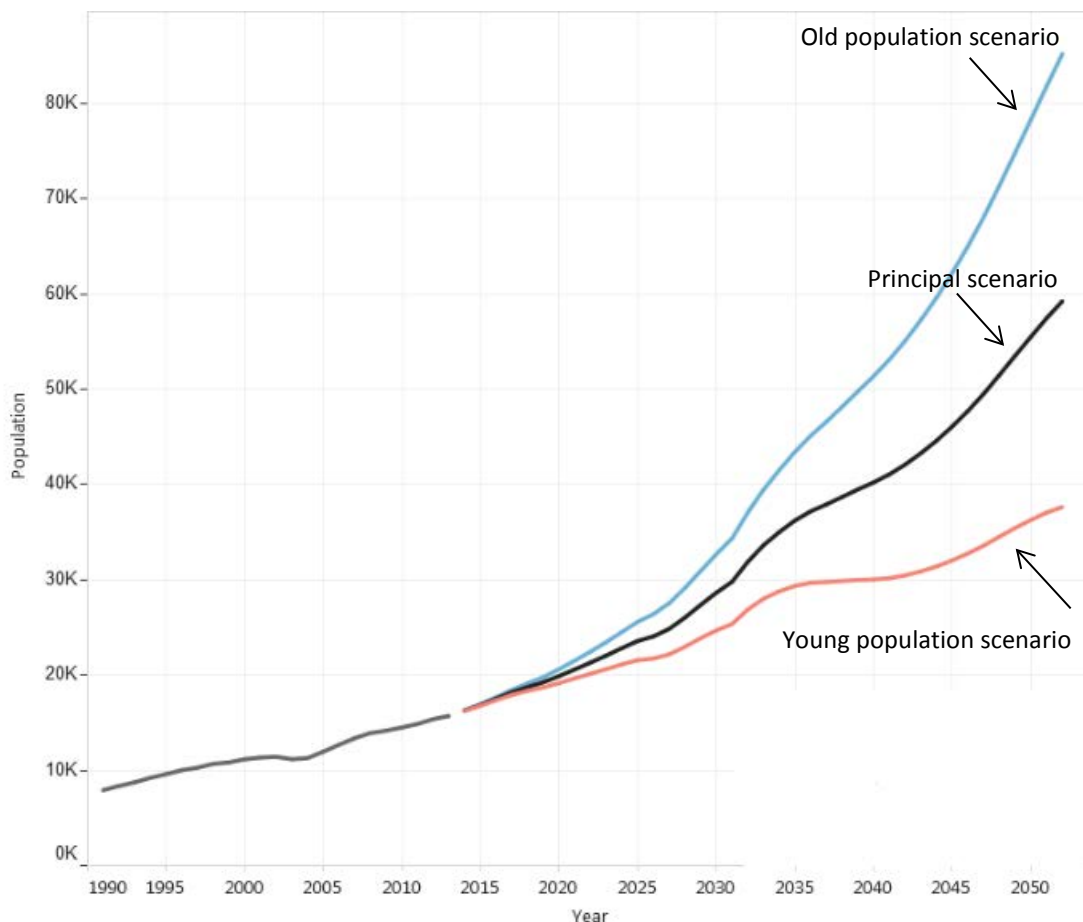
The demographic challenge isn't just about older people – there are issues for all age groups and for the changing composition of the population itself, particularly linked to changes in ethnic group composition. In this chapter I will look at each of these factors in turn.

The overall conclusion is that the demographic challenge is a real game-changer for services and that there is no ‘do nothing’ option: change is inevitable.

The ageing population

Everyone knows that the population is ageing, and this remains by far and away the biggest challenge to all current services and is the biggest health issue in the County. The chart below shows the picture well for those aged 85 and over in Oxfordshire, looking forward as far as 2050.

Change in Oxfordshire’s older population (age 85+)



Source: ONS population estimates/ Oxfordshire County Council Research & Intelligence long-range projections (autumn 2014)

It shows that:

- The 85 plus population is set to increase by around 7,800 people between 2014 to 2026.
- That is an increase of 48% - a huge increase.
- There is uncertainty about the absolute numbers, as no one is sure how long people will live for in the future. The top line shows the maximum growth scenario, the bottom line the minimum and the middle line the most likely. The most dramatic projection to 2050 shows that there may be 75,000 people aged 85+ living in Oxfordshire compared with around 16,000 at present.
- If this even comes close to being an accurate projection it will completely change the nature of society, and services, as we know them.

The **proportion** of older people differs from place to place across the County and this will be significant in terms of the shape of future services.

The balance between those contributing relatively more to the tax-base (i.e. those of working age) compared with those who are over 75 affects affordability of services going forward. I know that older people make a significant contribution to the economy through taxation, but not at the same rate as those in pre-retirement years. A higher proportion of older people means that services funded from taxation will become progressively more stretched.

This isn't a static situation. **An 'ageing population' means that both the number and proportion of older people in the population are changing.** This is a crucial point. If all ages were increasing at the same rate it would mean that we would all have less space to live in but factors such as the tax-base for funding services would stay the same, i.e. services can be 'more of the same but more of them'. It is a more affordable scenario. **However, if the proportion of older people also changes it affects the balance of diseases that need to be treated, the availability of carers and the range and shape of services that need to be offered.**

This means that staying as we are simply isn't an option and things must change – it is a simple and inevitable fact.

The table below shows the proportion of the population aged 65+ in the County as a whole and in Districts using 2014 data.

Number of people aged 65 and over in Oxfordshire and its districts

| Area | Number of people aged 65+ | % of area's population |
|--------------------------|---------------------------|------------------------|
| Cherwell | 24,500 | 17% |
| Oxford | 17,800 | 11.3% |
| South Oxfordshire | 27,300 | 19.9% |
| Vale of White Horse | 24,400 | 19.5% |
| West Oxfordshire | 21,600 | 19.9% |
| <i>Oxfordshire Total</i> | <i>115,600</i> | <i>17.2%</i> |

Source: ONS mid-year population estimates, 2014

The table shows that:

- Overall, around 17% of the population are aged over 65.
- In South Oxon, Vale and West Oxon the figure is higher than 19%
- In the City the figure is markedly lower at around 11%.

Looking even more closely at the proportion of over 65s shows that some wards top the 25% mark for people aged over 65, and Burford hits over 32%. The table below sets out the Oxfordshire wards topping 25% of residents aged 65+.

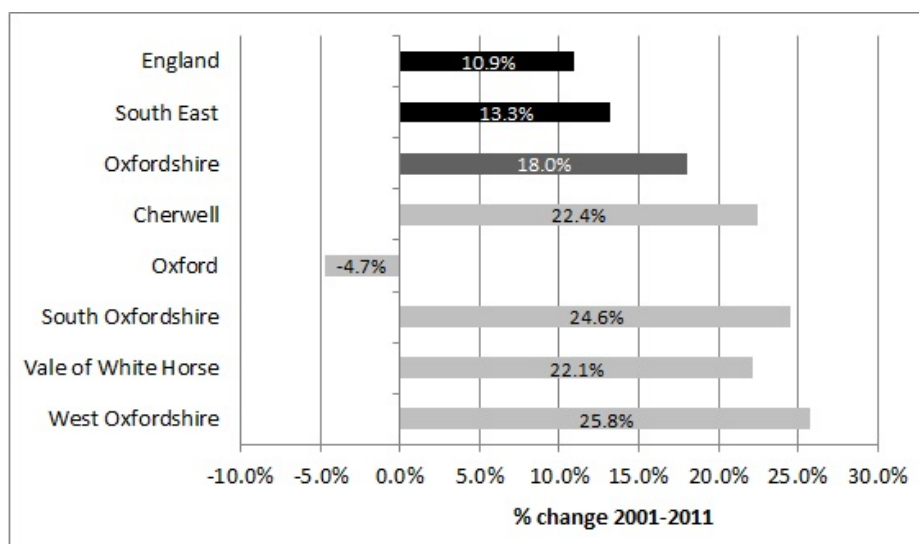
Oxfordshire wards where older people make up more than a quarter of the population

| Ward and District | Number aged 65+ | % of ward's population |
|---|-----------------|------------------------|
| Burford, West Oxfordshire | 630 | 32.5% |
| Goring, South Oxfordshire | 1654 | 28.7% |
| Henley North, South Oxfordshire | 1560 | 27.8% |
| Greendown, Vale of White Horse | 654 | 27.3% |
| Sonning Common, South Oxfordshire | 1478 | 27.1% |
| Ascott and Shipton, West Oxfordshire | 544 | 26.9% |
| Cropredy, Cherwell | 715 | 26.1% |
| Deddington, Cherwell | 692 | 25.9% |
| Woodstock and Bladon, West Oxfordshire | 1080 | 25.7% |
| Blewbury and Upton, Vale of White Horse | 542 | 25.7% |
| Adderbury, Cherwell | 745 | 25.2% |
| Milton-under-Wychwood, West Oxfordshire | 525 | 25.2% |
| Kennington and South Hinksey, Vale of White Horse | 1141 | 25.0% |

Source: ONS mid-year population estimates, 2014

Not only is the proportion of older people different in different places, the proportion is also changing at different speeds. The table below shows how the number of people aged 65+ has already increased dramatically in the County and four out of five Districts between 2001 and 2011.

% change in the number of older people in Oxfordshire and its districts (2001- 2011)



Source: ONS, 2001 and 2011 Censuses

It shows that this affects Oxfordshire more than the national and regional pictures – the national and regional increases are around 11% and 13% respectively compared with a huge 18% for Oxfordshire as a whole and topping 22% in Cherwell, South Oxfordshire, Vale and West Oxfordshire.

The City is very different – more younger residents means that the number of 65+ residents fell by almost 5% in the same period.

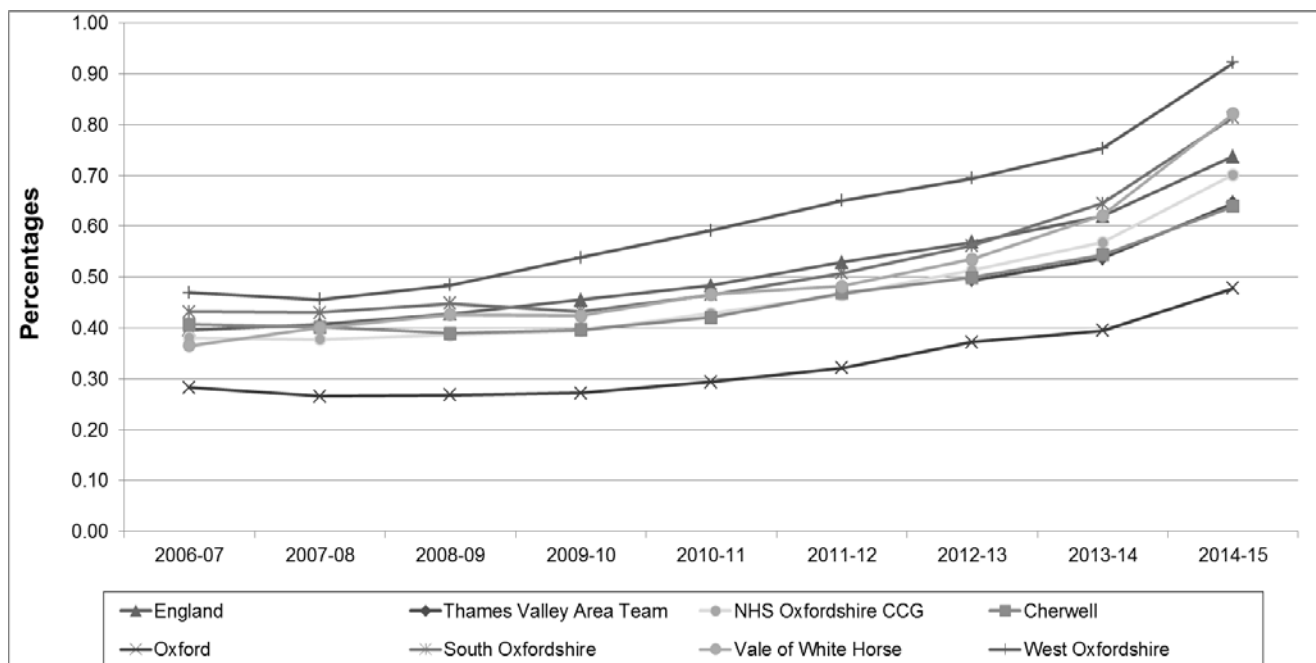
This means that the need for change to services will hit Oxfordshire harder and faster than elsewhere in the country. This puts more pressure on the ‘Oxfordshire £’ and means that our services will be hit harder and sooner than elsewhere, making the case for change even more compelling.

The differences between different Districts also show that **the right range of services for the future will not be ‘one-size fits all’**. Taking into account journey times and distances from health facilities and hospitals means that each locality will need a tailor-made service.

An ageing population means that patterns of disease are changing.

This applies to many chronic diseases such as diabetes, but most topically to dementia. Previous reports have looked at the good developments in detecting and treating dementia in the County and the potential for preventing dementia from a healthy diet, keeping the mind active and exercising more. Upward trends in the detection of dementia are shown in the chart below.

Percentage of patients with a recorded diagnosis of dementia in the GP registered population - 2006/07 to 2014/15



It should be noted that this measures the percentage of dementia in a population – the figure for the City is low because the percentage of older people is lower than elsewhere – it is the rising trend in detection that is important and this should be welcomed.

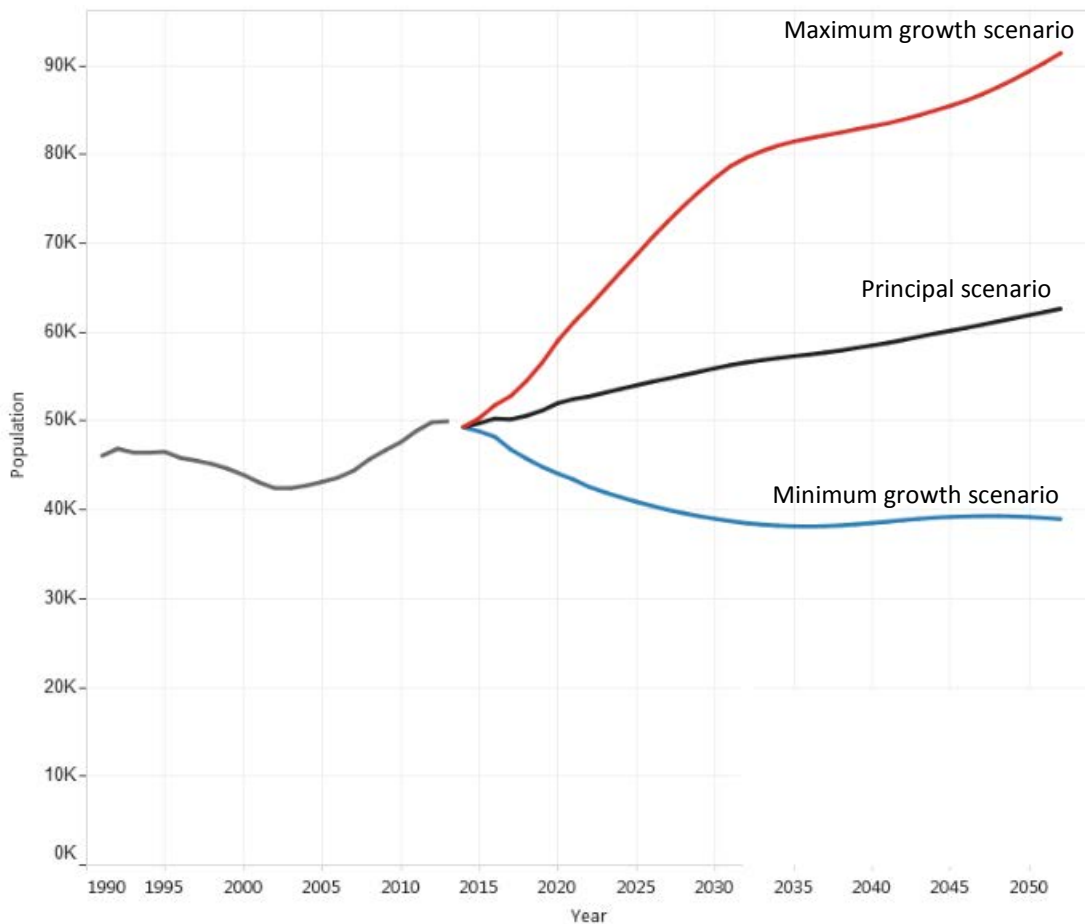
The Demographic Challenge and younger age groups

Population growth due to new housing will tend to swell the number of younger families in the county. The **long range population projections** take into account ambitions for **93,560-106,560**

new homes between 2011 and 2031, as set out in Oxfordshire’s Strategic Housing Market assessment

According to the County Council’s principle population projection (the most likely scenario), the number of 0-5s in the population is set to increase from 49,600 in 2014 to 54,400 in 2026 (a rise of around 10%). However, there is considerable uncertainty around these figures, as is clear from the chart below. The actual number will depend on a range of factors, including future birth rate, migration patterns, and housing developments on the ground.

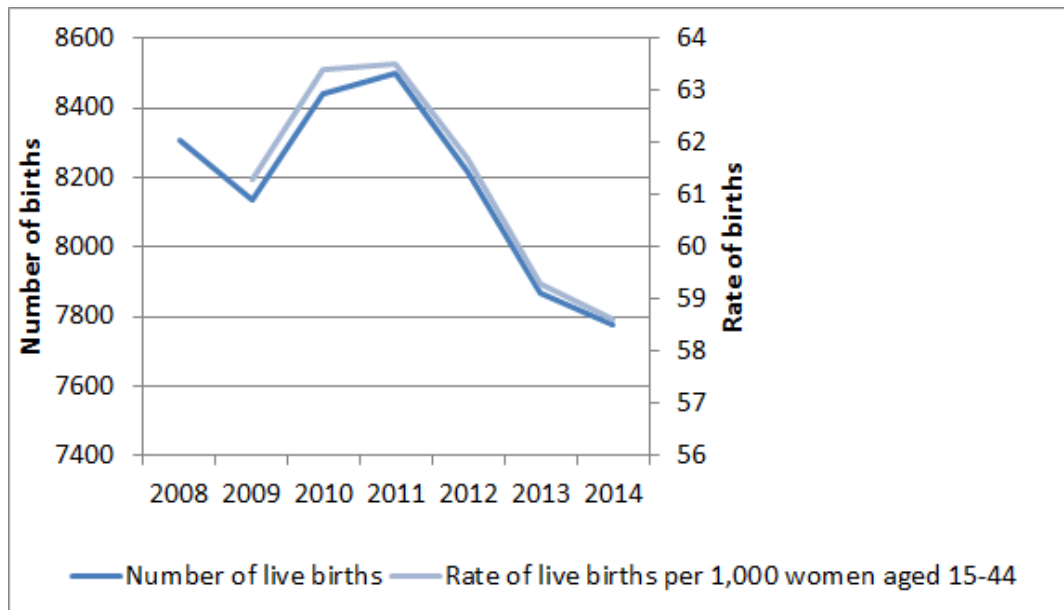
Change in Oxfordshire’s population aged 0-5 (inclusive)



Source: ONS population estimates/ Oxfordshire County Council Research & Intelligence long-range projections (autumn 2014)

The impact of growth due to future housing developments is demonstrated by comparing this growth with the underlying local birth rate which has been falling steadily for the last few years as shown in the chart below. In 2014 there were 7,775 live births to Oxfordshire mothers, representing a rate of 59 babies being born per 1,000 women aged 15-44 each year.

Number and rate of live births in Oxfordshire (2008-2014)



Source: Office for National Statistics Birth Statistics

The expected growth in young families in the County will have obvious implications for provision of health care, midwifery services, health visiting services and school provision and a much wider range of services. All of this will need to be funded from a shrinking tax base.

This is a further reason why change is inevitable.

We will simply have to find new ways to provide services.

If we didn't have growth from housing and more people moving into the County, would the population grow or shrink?

A statistic called the total fertility rate (TFR) or completed family size (CFS) gives the answer. It adds up the number of children women will have in their reproductive lifetime on average. A figure over 2.1 children per woman means the population size is steady – i.e. people replace themselves through childbirth.

A figure lower than 2.1 means the population will fall and over 2.1 means the population will grow, all else being equal. Of course this is an average. Women having 3 or 4 children make up for those having none or one.

The current figures are:

- Oxfordshire: 1.75
- England: 1.83

This means that if nothing else happened, the Oxon population would naturally fall, and it would fall faster than the England rate.

This shows that population growth stems from housing and net migration into the County.

More People in the Same Space Means Inevitable Change

As we have seen, the net population of Oxfordshire is set to increase and to carry on increasing.

Simply having more people in Oxfordshire will impact on services, travel, housing stock house prices and the nature of the local workforce.

The implications of having more people living in Oxfordshire are:

- **There will be more pressure on existing services and increased demand for new services and new ways of delivering services.**
- **It will be more difficult to travel around the County** if things remain as they are. Travelling to Oxford hospitals for tests or outpatients (and finding a parking space) can already be challenging and may become more so. New options will have to be found which are more local or use online technology.
- **Mobile services like home care and district nursing will need to be organised** to cope with traffic congestion and the areas professionals can practically cover in a day will shrink.
- **The housing stock will need to change to meet the needs of an ageing population** as well as for young families. This means that we will need to develop more options like extra care housing. Older people may demand a different model of housing, and may well wish to group together for mutual support and to reduce the costs of care. It is possible that more people will want to trade in their existing home as they age for a place in purpose-built communities which provide company, care and medical support as seen in other countries.
- The debate about prevention may well change considerably. In the future **preventative services may become a matter of economic necessity**. People may well take prevention of disease and the imperative to adopt a healthier lifestyle more seriously as a means of self-defence and an economic tool. Once the link is firmly made in people's minds between piling on the pounds and a less-rewarding and less wealthy old age, we may see a sea-change in the way in which diet and exercise are viewed by people in their 40s 50s and 60s. **In the future, prevention of disease and investing in a healthy lifestyle may well be taken as seriously as pension planning is now.**

'We' are not the same 'We' as we were.....

In looking to the future it is important to note that the population structure is changing in other ways too. In a very real sense, collectively, 'we' are not the same type of population as 'we' were twenty years in the past or will be twenty years from now. Our habits, beliefs, and use of technology will all change patterns of health, sickness and expectations.

Add in change due to changing ethnic mix and we are looking at completely new scenarios. These issues are picked up in detail elsewhere in the report. In summary the main impacts are as follows:

Re changing lifestyles:

The major changes may well be about diet and activity. Both increasing obesity and decreasing activity as independent factors result directly in more chronic disease, diabetes and cancers. Alcohol consumption leads to a wide range of diseases and cancers and fuels obesity. The trend for alcohol consumption to creep up as we get older is a cause for concern. Any alcohol intake increases the risk of cancer as the Chief Medical Officer has recently pointed out, but the greatest effect in terms of numbers might be seen through the high calorie content of alcohol as a factor in middle-age weight gain.

Re the changing face of health and care technology:

A summary of recent trends shows the following:

- more can be done locally and remotely to diagnose, monitor and treat disease and care needs
- drugs to combat heart disease and cholesterol have helped to reduce deaths from heart and circulatory disease. New drugs now in the pipeline may help.
- new treatments are developed all the time fuelling both expectation and cost of services. The cost of new health technology and drugs outstrips baseline inflation rates. Recouping the research and development costs that go into new treatments makes them very expensive initially.

Re the changing ethnic mix of the population:

- The figures are given in full in chapter 3. I want to focus here on the impact of changing ethnicity on ageing. The ageing population will increasingly be ethnically diverse. This means that the pattern of disease will change. For example, people from parts of Asia and the Indian sub-continent are more prone to develop diabetes and its complications at lower levels of obesity. We haven't yet seen the impact of this, but it will become a more significant factor.
- In 2011, the ethnic mix of over 65s for the whole County was: 94% White British, 4% White Non-British and 2% Black and other Minority Ethnic Groups.
- This contrasts with the picture seen in the City which has a more diverse population. Around 7% of City residents aged 65+ are Asian, Black and other Minority Ethnic Groups – 5 percentage points more than the County average. This trend will continue and will be seen in all parts of the County.

The Demographic Challenge: Putting It All Together

We have seen that many factors in the population are changing – it is not just about change in older people.

We have looked at the implication of simply having more people. Other factors will change as well, for example:

New patterns of Inequalities may emerge

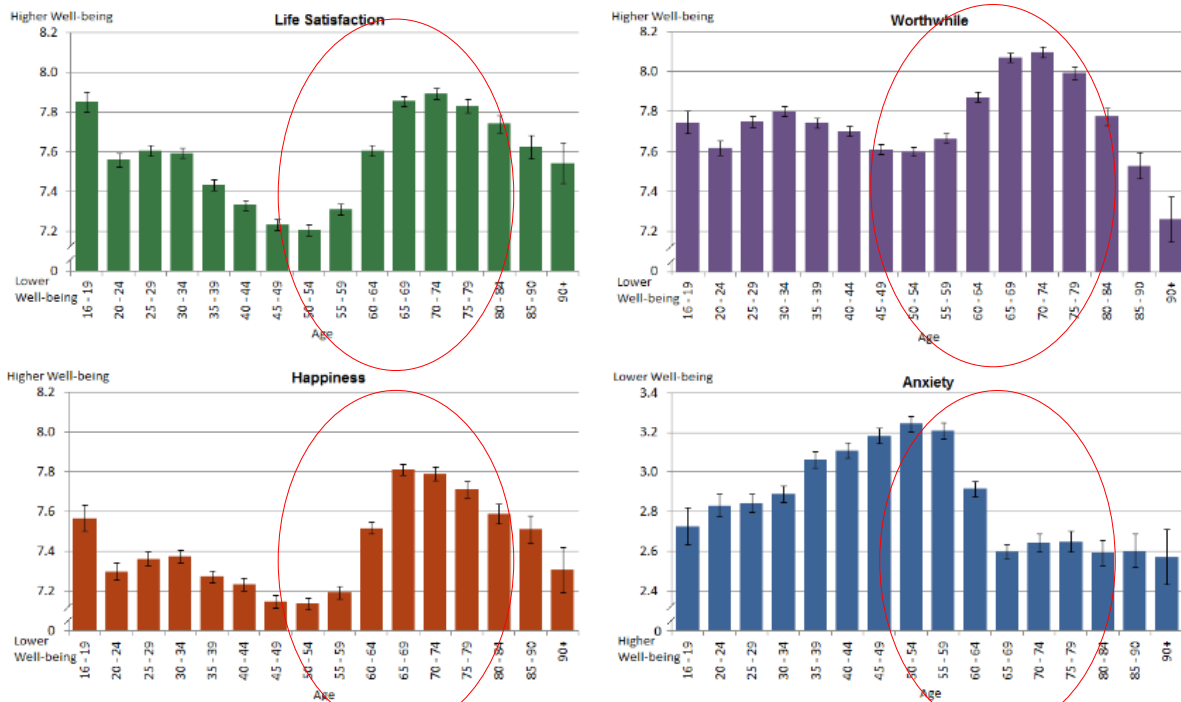
It is likely that new forms of inequality will emerge. For example we may start to see:

- ***Inequalities of support and companionship*** – having supportive networks and a peer group to lean on is like cash in the bank. We know that isolation and loneliness lead to all manner of worse health outcomes. The people who have supportive networks will simply do better and those who do not will be more at risk.
- ***Inequalities of take-up of lifestyles which prevent disease*** may be another key inequality to emerge. Those who make a series of small changes to their daily lives – simple things about more exercise, better diet and drinking less – will tend to have better health en masse than those who do not. Again, it is like cash in the bank – an inequality may emerge between those who create their own personal plan for improving their lifestyle and those who do not– it's like backing yourself in life's race to improve your odds of a healthier life.
- ***Inequalities in health knowledge***. If you don't know something might be bad for you, you can't make the choice to do something about it. Simple messages like '5 a day' do hit home and do change people's behaviour in the long term. We can see this for sure when supermarkets start to market '5 a day' products because there is a demand for them. This isn't about preaching and nannying – it's about informing local people about health issues so that they can make their own decisions within their means. Everyone can make small positive changes – taking the stairs more often or eating the odd apple instead of a chocolate bar – but not if they don't know it might be a good idea.

But it isn't by any means all bad news – the up-side of older age

UK data asking people about their levels of satisfaction with life, happiness and anxiety shows some surprising and hopeful results for older people. The results are shown below in 5 year age bands from age 16 onwards below.

Average personal wellbeing ratings in the UK, by age (pooled data for 2012-2015)



Source: Office for National Statistics

The results show:

- All measures of happiness and wellbeing dip in the 30s, 40s and 50s and then leap up around retirement age.
- Anxiety levels do the opposite – they are high in adults of working age and then fall dramatically.
- As older age increases, life satisfaction and happiness do fall, but anxiety does not increase.

Factors stated by people in the survey as reasons for poorer mental wellbeing in the over 50s are (in order): financial difficulties; having long term illness or disability; being unemployed or retired; being divorced or separated; having a mortgage and living in an urban area.

I don't pretend to be able to interpret these statistics, but they do seem to give something of a clue about the recipe for increasing the odds of a contented old age which seem to be something like: enough money to get by, positive relationships, being in generally good health, a lack of day to day worries and having a sense of purpose.

When will the demographic challenge kick in? The future is already upon us.

The effects of these changes have already begun – we all know it – you just have to look around you to see:

- At some times of day it is hard to make journeys on our major roads
- Hospital parking is more difficult
- GP services have changed radically – for most people there is no such thing as ‘my own Doctor’
- The health and social care sectors are short of cash
- The retirement age is getting later
- Pensions are under pressure
- Half of adults are now overweight
- Health scares have changed – once it was all about heart disease and ulcers, now it’s dementia and diabetes
- Some parts of the County are now multi-ethnic communities
- So many things are done on-line with new technology
- Radical service changes are being formulated as we speak.

So, all in all, the inescapable conclusion is that it isn’t about whether services and our approach to disease changes; it’s about how we must change.

What Can We Do to Meet the Demographic Challenge Head-on?

Mixing common sense and clinical evidence suggests that we should do the following 8 things:

- 1. Do more to prevent disease from starting in the first place**
- 2. Re-shape health and social care**
- 3. Use housing growth to build communities which encourage good health**
- 4. Level up inequalities**
- 5. See mental and physical health as a continuum, not as two separate things**
- 6. Help carers, community groups, voluntary groups, volunteers and faith groups to bridge the gap between statutory services and what people can do for themselves**
- 7. Join up services better to give a better start in life**
- 8. Protect people from ‘unseen threats’ such as infectious disease, emergencies and disasters**

The chapters in this annual report deal with many of these points.

Chapter 2 reports on building health communities through the Healthy Towns Initiative

Chapter 3 takes a close look at disadvantage and inequalities, focussing on children

Chapter 4 looks at how we can prevent more disease from starting

Chapter 5 focusses on current mental health issues

Chapter 6 reports on infectious diseases and emergencies

With regard to re-shaping services, the NHS is about to embark on a major service consultation about the future shape of health services in the County. It will be vital to engage the public in this, as every one of us has a part to play in the changes that are inherent in the demographic challenge.

What did we say last year and what has happened?

Last year the recommendations focussed on the need for the NHS to plan for the increasing number of older people in the population, the rise in dementia and to take account of loneliness as a risk factor for older people's health. The need to integrate health and social care was also highlighted, as was the need to further improve NHS Health Checks.

This to a large extent has happened – the NHS is currently preparing a major public consultation on service change which will take these factors into account. This is scheduled for the Autumn.

Progress on NHS Health Checks is covered in chapter 4.

Recommendations

1. The major NHS service consultation about 'care closer to home' should be debated thoroughly and the views of the public and partners taken into account. The extent to which the proposals meet the need to re-shape services to meet the demographic challenge should be a major consideration.
2. The Health Overview and Scrutiny Committee and Healthwatch should consider the consultation carefully and take the issues covered in this chapter into account in their responses.
3. The County Council and the Clinical Commissioning Group should consider the factors in this chapter in shaping plans to integrate health and social care and should do more to prevent disease from starting.

Chapter 2: Building Healthy Communities

Main messages in this chapter

- **If we are to meet the demographic challenge we need to get health issues into local planning of housing, communities and transport schemes.**
- **The Healthy New Towns initiative gives this work an excellent boost in Oxfordshire.**
- **The challenge will be to apply the lessons learned to local planning across the board.**

What can we do to plan, design and build healthier places.

Last year I looked in detail at the intertwined relationship between health, housing, transport, environmental factors and community planning.

In particular I focussed on the complexities of getting health issues into the local planning system with network of Councils, developers, developer contributions, appeals etc.

This year I want to be a little more positive and look at some local work that may help to point the way forward - the Healthy Towns initiative.

This is an important step towards meeting the demographic challenge head on.

In general, the penny seems to have dropped that if we are to combat the demographic challenge we have to think differently about community planning and be more sophisticated about building in healthy features such as cycle paths and community spaces as well as making provision for homes that adapt as one ages, and homes that can be afforded by the lower paid hospital and care workers we depend on.

This is more easily achieved in new developments where we start with a blank sheet of paper – trying to add things like cycle routes to existing medieval road layouts is another matter altogether.....

The Healthy Towns initiative

This idea is being showcased in a Government initiative called the NHS Healthy New Towns initiative via a number of pilot sites. It is about putting 'health' at the forefront of the design of new communities.

We are the only County in the country to have two sites chosen to become part of this, which is a real achievement. The 'Healthy Towns' initiative is led by the NHS in close collaboration with Local Government. District, City and County Councils have all been involved, as has the local NHS and the Public Health team. There is also the bonus of expert help from Government Departments and a grant from the NHS.

In a nutshell the Healthy New Town Programme aims to make it easier for people to make healthier choices for themselves and their families.

Being part of the NHS Healthy New Towns Programme puts Oxfordshire on the map as one of the leaders in getting health into planning.

We have two NHS Healthy New Town sites in Oxfordshire, one in Bicester and one in Barton Park. The sites were selected from an original 114 applications and were announced in March 2016. Bicester has 26,000 new homes that will be available across the whole town, of which 13,000 will be new homes including the exemplar Elmsbrook at NW Bicester Eco development. Barton Park has 885 residential units planned. The two sites are very different but there is much we can learn from these differences as well as sharing the learning from the similarities.

The Barton Park programme is developer and City Council led, with housing to be built alongside the existing Barton area which is an area of significant social disadvantage. Integration of both parts of Barton will be essential to spread the benefit of this new approach.

The idea is to design communities where:

- walking to school or cycling to work become the default option
- public spaces are dementia-friendly from the outset
- health services are joined up with other local services, using digital technology to promote health
- houses can be adapted to meet the needs of people as they age.

It is worth dwelling on some of the details in the **Barton Park** initiative which include the building of a new school which is expected to link with the existing school in Barton. The school will also have community space which will provide an area for social activities, clubs, groups and activity sessions to keep people active and to reduce isolation and encourage mental wellbeing. It is hoped that these will link to the existing community facilities such as the Barton Neighborhood Centre. Being a part of the school also means that a community 'hub' is created where there is an opportunity for more contact between a wide range of people.

There will also be a civic area which will include shops and further opportunities for social contact with others.

The football pitch provision is planned to be upgraded. It is expected that some of the pitches will be artificial turf and so available to play on for longer during the year. The pitches will mean that pupils at the school will be able to keep active and play sports, but they will also provide a community facility for local clubs to use.

There are also plans for upgrades to the allotments which will serve the whole community, both existing and new. Working on allotments will help people to be active, enjoying the fresh air and socialising with others, as well providing the means for healthy food to be grown.

Green routes are planned where people can walk through attractive areas for pleasure or to reach facilities and services in other areas of the development. Some sections will also link to footpaths leading out to the open countryside, which will make it easier for people to be active and enjoy the outdoors without having to travel in the car to get there.

It is planned that there will be play areas where children can be active outside in open spaces. A 'trim trail' will be created which will link to the existing green area in Barton. It is also expected that there will be upgrades to the GP practice in the existing Barton area which will serve both the existing and new communities.

The development will be designed to 'fit in' with the area, with the use of design materials local to Oxford where possible. It is planned that the streets will be designed so that choosing to cycle or walk is easier than choosing to drive. Cycling and walking instead of using the car boosts physical health and mental wellbeing and makes socializing easier which reduces isolation.

The programme at **Bicester** is focusing on the whole town and how the new housing can improve the health and wellbeing of all residents. This is based on a broad partnership of around 21 organisations and, along with the developer, includes Local Authorities, health service commissioners, universities, businesses and many more. The plans include:

- options for people to choose healthier ways to travel through cycling, walking or using these in combination with public transport
- more opportunities for social interaction with others
- green space such as parks and walkways and cycle networks which will give people safe and attractive areas to walk or cycle through and will make these methods of transport more appealing.
- Homes designed so that people can live independently for as long as possible. The houses will have features such as good insulation to prevent them from becoming damp, to keep people warm and well and to reduce the amount of money that they will need to spend on heating bills.
- It will be easier for people to eat healthily by ensuring that there are adequate cooking facilities in people's homes, with easy access to shops and plans to provide opportunities to grow food locally.
- Some of the community facilities and services will be located in shared buildings or in the same area so that resources can be shared and they are easier for people to get to them and use them.
- Well-designed community spaces that are attractive and easy to access will give people more opportunities to have contact with others to help reduce isolation and improve mental wellbeing.

Technology will be key in NHS Healthy New Towns. The Elmsbrook Eco development in Bicester will consist of 393 houses which will be installed with digital tablets known as 'Shimmy's'. The tablets will enable households to have access to a range of information. This could include community information such as opening times of services, dates of local events, contact details of services and can carry reliable health information and messages. The Shimmy could also have a feature to let people know 'live' travel options e.g. when the next bus will be, how long it would take to walk to their destination and the routes they could take to make it easier for people to choose travel options that don't automatically mean getting in the car.

There will also be an element of home energy efficiency on the Shimmy where people could monitor temperatures and the amount of energy that they are using in their homes. There are also plans to improve access to health care through the Shimmy such as appointment booking, remote consultations and electronic monitoring of people's vital signs.

That's all well and good, but will it happen and is it generalizable?

This is the big question and the proof of the pudding is in the eating. We will have to wait and see which of these features can be achieved and which make a real difference.

Fancy developments with some Government funding are fine, but what about the 1000's of other developments being proposed across the County? No-one knows the answer, but the Healthy Towns initiative could mark a turning point. Health is now on the map in terms of local planning, and there are many ideas coming from the Healthy Towns development that could be built in to other areas.

Of course the market will have an influence – if these developments prove to be popular, there could be a commercial incentive for developers to build them in elsewhere.

The key is to realise that that we need this type of development if we are to cope with the demographic challenge.

Also the ideas may only be really viable in medium and large size developments. If we continue with 'pepper-pot' developments of a few houses here and there it may be difficult to spread the benefits.

The NHS is alive to the issue of getting health into planning. Proposals for changes to health services are likely to look towards more efficient use of public buildings – the same goes for changes to library services, schools and other public amenities.

The NHS's Sustainability and Transformation Plan is talking about finding ways to work with Local Government in Oxfordshire, Buckinghamshire and Berkshire on local planning as a matter of course.

Various options for Unitary Local Government are currently being debated in the County. It is clear that a Unitary approach would make this sort of planning easier as planning, road building, housing, environmental health, social care and public health functions would all be run by one organisation.

There is far to go and this journey has just begun, which is just as well as we will need to pull together in this way if we are to tackle the demographic challenge while managing a tightening public purse.

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

Last year's report introduced the topic of 'getting health into planning' and looked at the health issues such as the effect of pollution and the importance of cycling in some detail. The recommendations were all about taking this work further and the Healthy New Towns initiative means that good progress has been made.

Recommendations

1. The Healthy New Towns initiative should be monitored closely and lessons learned should be generalised within the current and future planning system.
2. The NHS through its Sustainability and Transformation Plan should carry out more detailed work with Local Authorities to get health issues into local planning as a routine activity.

Chapter 3: Breaking the Cycle of Disadvantage

Main messages in this chapter

- **Disadvantage and Inequalities remain a major issue for the Public Health of Oxfordshire.**
- **There has been a further modest reduction in disadvantage overall and this is to be welcomed.**
- **We await the findings of the independent Commission on Health Inequalities for Oxfordshire– it will be published later in the year.**
- **There has been steady progress against last year’s recommendations.**
- **Because children’s services are changing we need to establish a firm baseline of indicators now so that we can measure any future changes. A basket of indicators is set out here.**
- **It is vital that this topic is kept under close review**

We are in between two important developments:

1. Last year this report reviewed thoroughly all aspects of disadvantage in the County and drew the conclusion that, overall, useful progress had been made but there was more to be done,
2. By next year the Health and Wellbeing Board’s Independent Commission on Health Inequalities will have reported, having sifted the evidence with a fresh pair of eyes which should help to point the way forward.

This year therefore I want to do 3 things:

1. Review progress on last year’s recommendations in detail
2. Report on new data which has emerged during the year
3. Concentrate on children and young people by proposing a set of indicators to monitor changes to children’s services in the future

Detailed review of last year’s recommendations

Because this topic is so important to improving health, I am going to repeat the detail of last year’s recommendations and formally review progress on each one:

The recommendations came in two parts – short term and long term:

Review of Short term recommendations made last year:

Each recommendation from last year is set out in full and is followed by a progress report:

Recommendation 1 said:

The Health and Wellbeing Board should carry out its plans to sponsor a more detailed review of disadvantage, and should use the analysis in this report as a source of information. This analysis should inform the Joint Health and Wellbeing Strategy, Local Authority plans, the Clinical Commissioning Group's 5 year plan and the work of the NHS and County Council Systems Leadership Group and Transformation Board.

Progress report:

Good progress has been made. The Health and Wellbeing Board has sponsored an independent Commission on Health Inequalities and the work is due to report in the Autumn. It has taken evidence from a wide range of sources and has had access to local data.

The NHS's 5 year plan is being implemented through a 'Sustainability and Transformation Plan' (STP), which is including prevention and health inequalities as a major concern to be addressed. The NHS has determined that this plan should cover Oxfordshire, Buckinghamshire and the West half of Berkshire.

Making plans is all well and good – it will be important to make sure this is followed by real action.

Recommendation 2 said:

All agencies should maintain current programmes which are successfully reducing disadvantage. These include:

- Teenage pregnancy
- The Thriving Families programme
- Work with schools to improve school results
- The promotion of breastfeeding
- Improved dementia services
- Improved mental health services.

Progress Report

Satisfactory progress has been made on all of these programmes – many will form part of the NHS's Sustainability and Transformation Plans (STP) mentioned above.

Further information on school results, teenage pregnancy and the Thriving Families programme are included later in this chapter.

Recommendation 3 said:

All agencies should target the causes of disadvantage which are static or increasing.

Specifically:

- The Health Improvement Board should continue its efforts to prevent homelessness through partnership working
- GPs and the Public Health team should target NHS Health Checks to improve take up by ethnic groups and manual workers
- Partnership work to eradicate Female Genital Mutilation should continue.

Progress report:

The Health Improvement Board is currently grappling with the issue of homelessness through a multi-agency sub-group. We await the results, but the problem is being pursued in detail.

NHS Health Checks were reviewed to make sure that there are no inequalities in the invitations sent out to people. Next year will see plans come forward to increase uptake in priority groups where disease levels are higher such as manual workers and ethnic minority groups.

Work to prevent Female Genital Mutilation (FGM) has continued successfully as planned. A study has been set up to work with communities with high levels of FGM to find out more about why the practice might be sustained in a UK context. There is currently a dearth of factual information about this because of the sensitivity of the topic. The more we know, the more we can prevent FGM at source. Community researchers have been trained to work with their own communities to tackle the factors that motivate people to consider FGM.

The project will be completed in late 2016 and the findings reported to the FGM partnership group and the Children's Safeguarding Board.

Recommendation 4 said:

Contract specifications for services being renewed should carefully consider how to target areas in the bottom 20% 'Index of Multiple Deprivation' and areas of high child poverty so as to give a good service across the county and a specific service to meet the needs of these areas.

Progress Report:

The issue of placing 'smarter' NHS contracts for services so that areas of high social disadvantage can be targeted has been proposed as part of the 'prevention' plan as part

of the NHS's Sustainability and Transformation Plans (STP). We wait to see developments. This is important and we need to keep a watching brief on progress.

Recommendation 5 said:

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

Progress Report:

This is another strand of what is proposed in the NHS's Sustainability and Transformation Plans (STP). Again, the proof of the pudding will be in the eating and we need to keep monitoring progress.

Longer term recommendations from 2014/15:

Recommendation 1 said:

Recommendations regarding housing and the design of communities so as to combat isolation, loneliness and to break the cycle of disadvantage in specific areas should be progressed.

Progress Report:

The Healthy Towns initiative described in Chapter 2 has given a real boost to this strand of work.

Making real progress on the mixture of housing stock available, designing communities which encourage social contact and building new developments that can be adapted easily as residents age, will probably require a resolution to the current 'unitary debate' going on in the County at present.

The real change is that these topics are now 'on the agenda' as mainstream issues whereas they were given scant regard in previous decades.

Recommendation 2 said:

The Local Enterprise Partnership, Local Government, Local Employers and Oxford University should continue to work together to secure central government funding to provide the infrastructure to favour continued economic prosperity and high levels of employment.

Progress Report:

We work well together as partners in Oxfordshire on these topics and our County remains one of those which contributes positively to the national economy. Making real progress on this topic will also require resolution of the 'unitary debate'. The intense debate in the County about devolution and unitarisation has had the beneficial effect of bringing

forward ambitious thinking about how to attract national funding to drive the economy forward.

Recommendation 3 said:

The Health Overview and Scrutiny Committee should consider scrutinising the extent to which reducing disadvantage and inequality are built into the plans of the Clinical Commissioning Group, General Practice and NHS Trusts.

Progress report:

The Health Overview and Scrutiny group has considered issues of inequity in specific services – the committee has had its plate full in considering major health service plans, CQC and Healthwatch reports, changes to community hospitals and other urgent issues. The time for the Health Overview and Scrutiny Committee to consider inequalities in the round will be when the NHS puts forward its Sustainability and Transformation Plans (STPs) in the Autumn and the Commission on Health Inequalities publishes its findings later in 2016.

Recommendation 4 said:

Healthwatch should be invited to consider monitoring the inequalities identified in this chapter as part of its on-going work programme.

Progress Report:

Healthwatch have continued to champion topics related to inequalities during the year and have helped give voice to those who might otherwise go unheard, including through the Health and Wellbeing Board and the Health Scrutiny Committee. Healthwatch have also been able to contribute constructively to the Commission for Health Inequalities while preserving their neutrality. Their commentary on the published report will be valuable.

Breaking the Cycle of Disadvantage part 2: Update on data produced during the last year

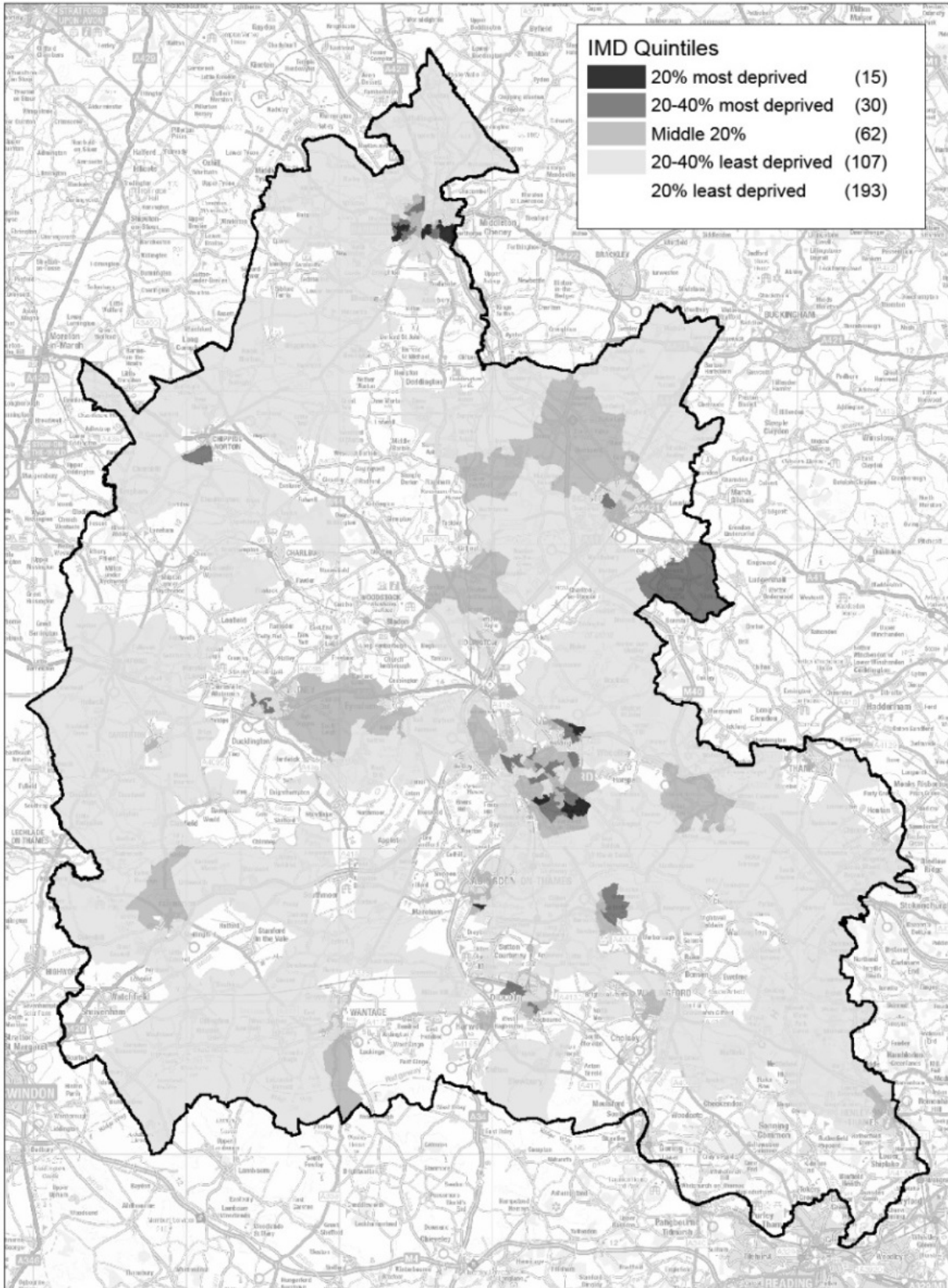
Measuring overall geographical disadvantage – the ‘Index of Multiple Deprivation’ (IMD)

The best overall measure of disadvantage in the County – the ‘Index of multiple deprivation’ (IMD) has been updated.

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

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

Overall map of multiple disadvantage in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

The map shows that:

- Most of Oxfordshire's 407 small areas are less disadvantaged than the national average.
- 110 are among the least deprived 10% nationally.
- Overall, nearly half (46%) of the county's population lives in areas that are among the least disadvantaged 20% in England.
- More than four in five residents (82%) live in areas that are less disadvantaged than the national average.
- Of course this does not mean that there is no disadvantage in those areas – individual communities such as Berinsfield for example are 'masked' by being included in larger more affluent areas, and many rural communities can tell the same story.
- 13 areas are among the 10-20% most disadvantaged (down from 17 in 2010).
- Two areas are among the 10% most disadvantaged in England. These are in Oxford City, in parts of Rose Hill and Iffley ward, and Northfield Brook ward. In 2010 only Northfield Brook was among the 10% most disadvantaged areas.

The most disadvantaged areas are concentrated in parts of Oxford City and Banbury with one in Abingdon. They are set out in detail in the following table, along with their national 'ranking' – a sort of league table of all 34,844 small areas in England, where the lower the number, the greater the disadvantage.

Small areas in Oxfordshire among the 20% most disadvantaged nationally

| Small Area | Ward | District | Deprivation Decile | Rank position in England (where 1 is the most deprived and 32,844 is the least disadvantaged) |
|--------------------------|------------------------------|---------------|----------------------|---|
| Oxford 016E | Rose Hill and Iffley | Oxford | 10% most deprived | 2,578 |
| Oxford 018B | Northfield Brook | Oxford | 10% most deprived | 3,078 |
| Cherwell 004A | Banbury Grimsbury and Castle | Cherwell | 10-20% most deprived | 4,701 |
| Cherwell 004G | Banbury Grimsbury and Castle | Cherwell | 10-20% most deprived | 6,520 |
| Cherwell 005B | Banbury Ruscote | Cherwell | 10-20% most deprived | 6,173 |
| Cherwell 005F | Banbury Ruscote | Cherwell | 10-20% most deprived | 6,299 |
| Oxford 005A | Barton and Sandhills | Oxford | 10-20% most deprived | 4,722 |
| Oxford 005B | Barton and Sandhills | Oxford | 10-20% most deprived | 5,319 |
| Oxford 016F | Rose Hill and Iffley | Oxford | 10-20% most deprived | 6,182 |
| Oxford 017A | Blackbird Leys | Oxford | 10-20% most deprived | 5,225 |
| Oxford 017B | Blackbird Leys | Oxford | 10-20% most deprived | 3,785 |
| Oxford 017D | Northfield Brook | Oxford | 10-20% most deprived | 6,523 |
| Oxford 018A | Blackbird Leys | Oxford | 10-20% most deprived | 4,293 |
| Oxford 018C | Northfield Brook | Oxford | 10-20% most deprived | 3,553 |
| Vale of White Horse 008C | Abingdon Caldecott | V White Horse | 10-20% most deprived | 5,936 |

Source: DCLG English Indices of Deprivation 2015

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

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

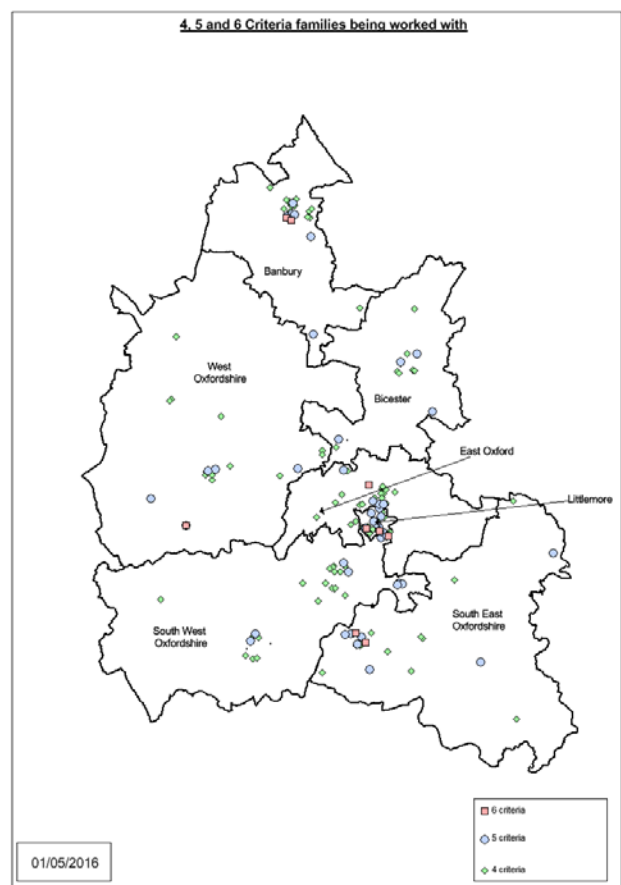
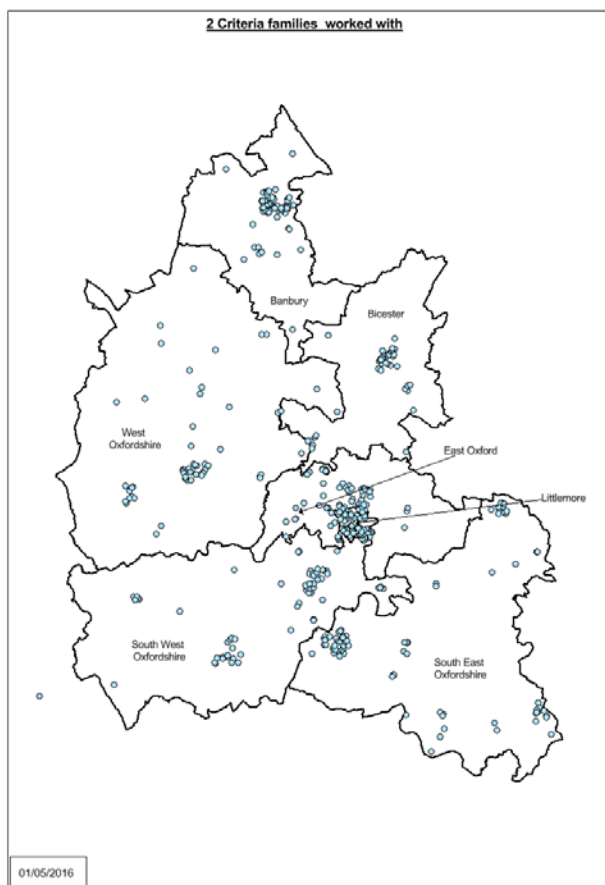
Conclusion: Breaking the cycle of disadvantage in Oxfordshire is all about targeting services to level the experience of all up to the best. Disadvantage in small areas of the County remains the biggest challenge, and services need to be designed to focus on them.

We can get more insight into the spread of individual high-need families by looking at the ‘Thriving Families’ data below.

Thriving Families Data (The national Troubled Families programme)

This national programme measures 6 indicators of high need in whole families and then focusses services to help them, aiming to break the cycle of disadvantage, get children back into school, adults into work and save the state money.

The families identified can be mapped depending on how many of these 6 criteria they meet. The maps are revealing. I have included 2 of the maps below, one for families with any 2 factors and one map for families with higher needs with 4, 5 or 6 factors:



Comparing the 2 maps shows:

- Families with any 2 of the 6 criteria are spread across the County in rural and urban areas, with clusters in more populated areas.
- Families with 4, 5 or 6 criteria, and therefore greater need, show less 'scatter' and are more concentrated in urban areas, especially Oxford and Banbury.

These maps illustrate well the practical difficulty of planning services on the ground in Oxfordshire – yes, there are needs across the whole County, **but** they are focussed on the main population areas and do cluster in the bigger towns.

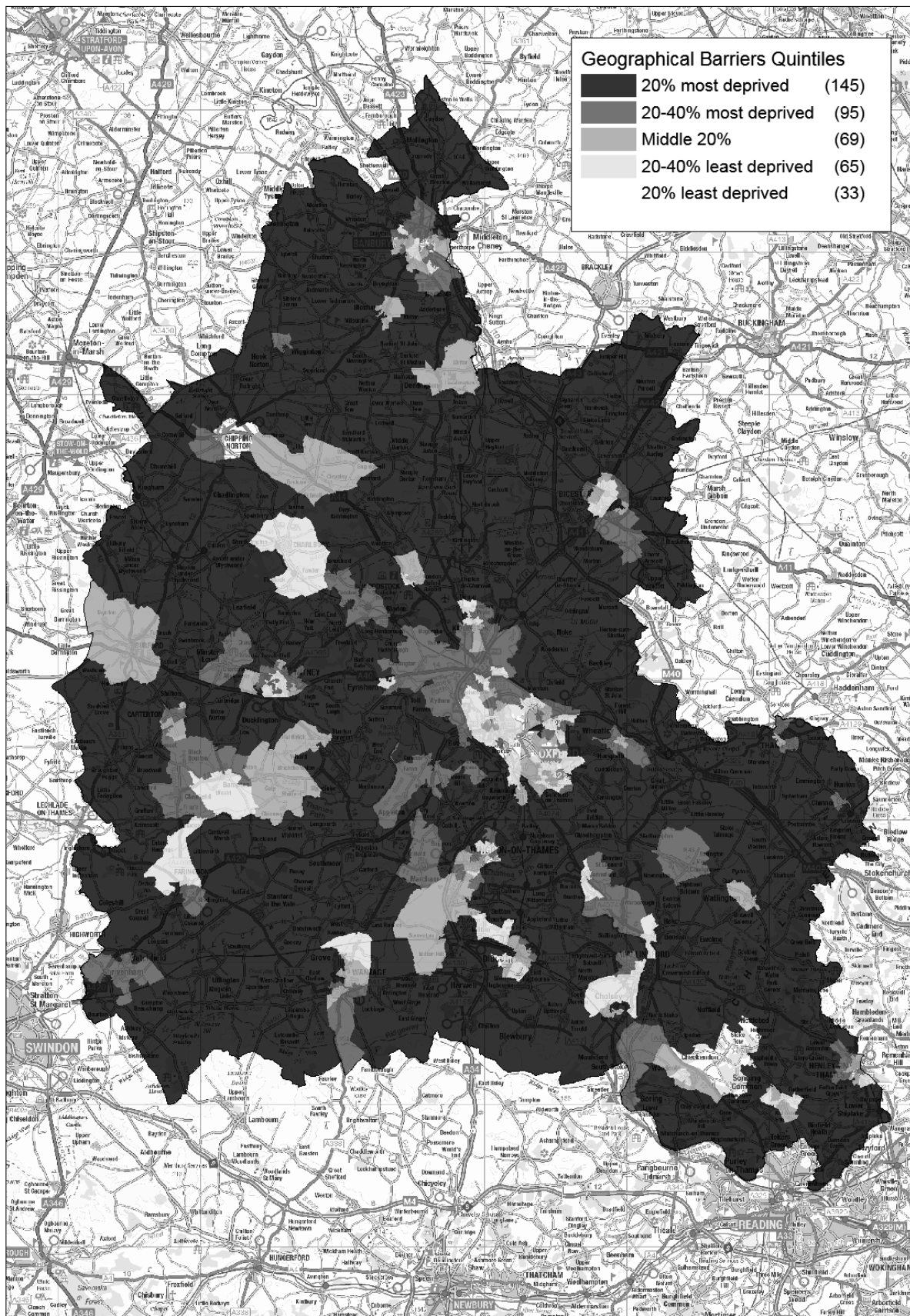
Conclusion: Because the 'Thriving Families' programme is reaching out to all parts of the County, urban and rural, and because it achieves demonstrable results, it is likely that this represents a decrease in disadvantage.

However, the true cycle of disadvantage is passed down from one generation to the next. This will be more likely to happen in communities where many disadvantaged people live together. So, to break the cycle we do need to focus efforts on such communities.

Rural Disadvantage

The other major cause of disadvantage in the County stems from its rural nature. This means that some areas have more difficulty in accessing services as well as having a high proportion of older people. This is shown in the map below in a measure called 'geographical barriers. It takes into account the many challenges posed by rurality in terms of accessing services. It was updated in 2015.

This index is based on road distances to post offices, primary schools, GP surgeries, and general stores or supermarkets.



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

The implications of this were discussed in chapter 1. This is where the demographic challenge will be felt the most and services will need to be re-designed to meet the needs of these communities.

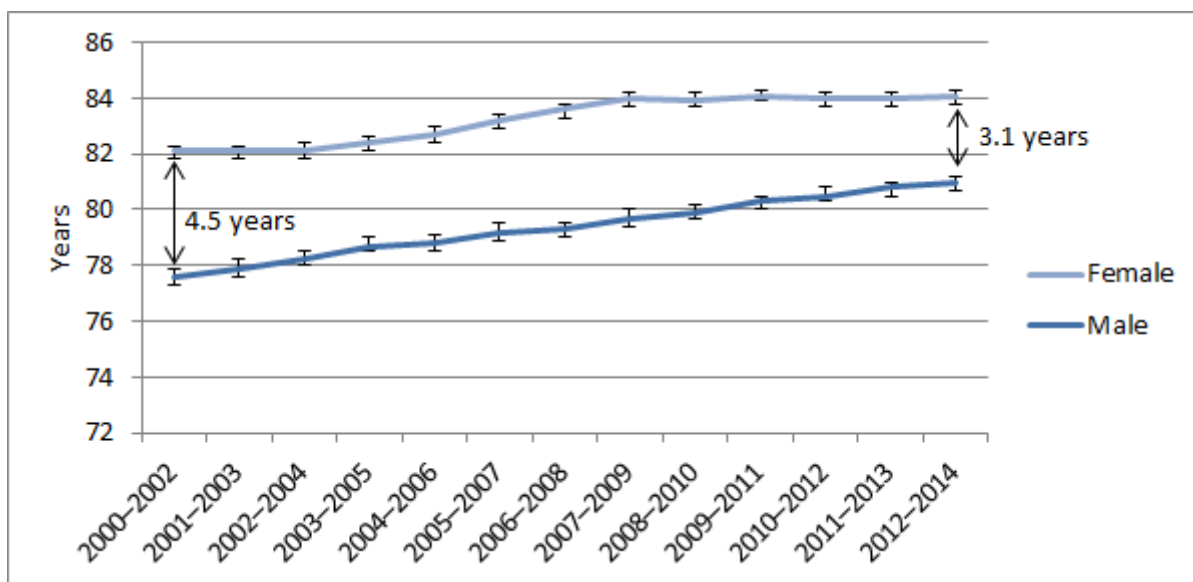
Conclusion: The rural nature of Oxfordshire presents a real challenge to providing services fairly across the County and this form of disadvantage needs to be monitored closely.

Reduction in the ‘life-expectancy gap’ between males and females.

Life expectancy at birth predicts the average number of years a person born could expect to live if they were to experience their local area’s death rates in the future. It is an estimate, but a useful general indicator of life chances in general.

Male life expectancy continues to edge upwards to 81 years, closing the gap on females. Males lag behind by 3.1 years – it was 3.2 years last year. Female life expectancy however seems to have plateaued at 84 years on average. It is still too early to suggest why this might be.

Male and female life expectancy at birth in Oxfordshire, 3-year rolling data for 2000-02 to 2012-14



Source: Office for National Statistics. NB the vertical axis starts at 72 years, not 0 years.

For the 2012-14 period, life expectancy for both sexes was higher in Oxfordshire than the national average. *Male* life expectancy was also higher than the regional average (whereas *female* life expectancy was similar to the regional average).

Conclusion: we need to keep this indicator under review, especially as it may indicate a levelling off female life expectancy.

Healthy life expectancy

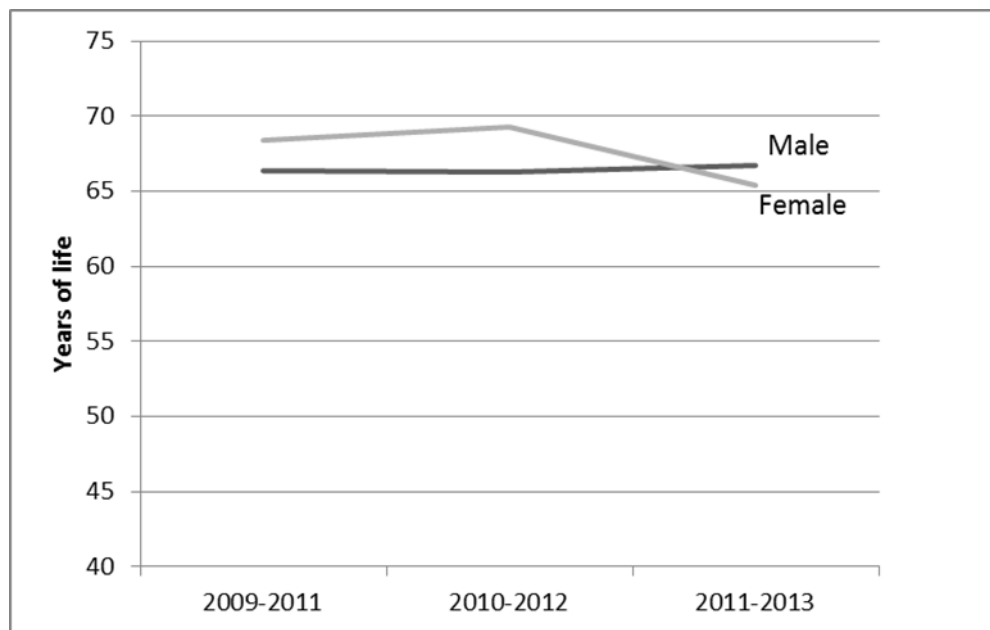
The question then arises, ‘so how long can I expect to live in good health’. To answer this we have **healthy life expectancy** figures. Nationally, overall life expectancy has been increasing faster than healthy life expectancy in recent years; ***this means people may have more years living in ill-health in the future.***

Males do better than females this time – males can expect nearly 67 years of good health on average and the figures are steady year on year, whereas the figure for females is just over 65 and has fallen slightly and is now lower than for men.

Again, no one is sure quite why this is, but it is important to keep a watching brief.

Healthy life expectancy in Oxfordshire is above the national average for both sexes and close to the Regional average.

Healthy life expectancy at birth in Oxfordshire (2009-11 to 2011-13)



Source: Office for National Statistics subnational health expectancies. NB vertical axis starts at 40 to aid legibility.

Conclusion: This data sounds another note of concern for women’s health as a whole and we need to monitor the situation closely

Changes in the ethnic minority population

It is worth reviewing the changes in the ethnic minority population again, as this shows a need to provide a wider range of services in the future if disease is to be prevented and detected early. Comparing the last two censuses, Oxfordshire's Black and Minority Ethnic (BME) communities numbered 59,800 in 2011, - just over 9% of the population. This was nearly double the 2001 proportion of just under 5%, and resulted from growth across all of the county's BME communities.

People from Asian backgrounds constituted the largest BME group, numbering 31,700, or almost 5% of the county's population (up from 2.4% in 2001). Most came from Indian backgrounds (1.3% of the population) or Pakistani backgrounds (1.2%).

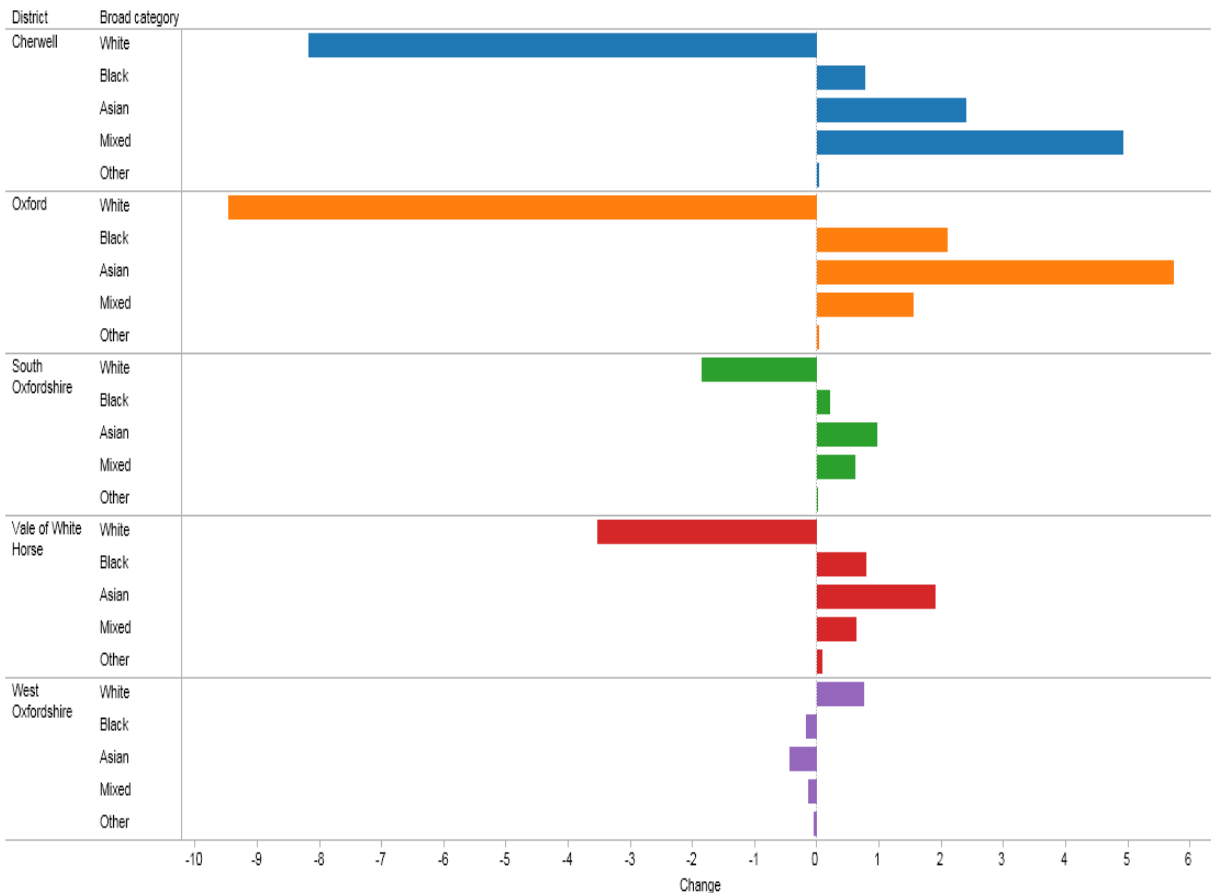
There were 13,200 people from mixed ethnic backgrounds, accounting for 2% of the population (up from 1.2% in 2001).

The number of people from all Black ethnic minority groups was 11,400, or 1.8% of the county's population (up from 0.8% in 2001).

The chart below shows the percentage increase or decrease in the main BME groups between the censuses. The chart shows that:

- Oxford and Cherwell saw the largest increases in the proportion of the population made up by BME communities between 2001 and 2011.
- There was a 6% increase in the proportion of people from Asian backgrounds in Oxford, the largest increase of any of the broad categories.
- Cherwell saw a 5% increase in the proportion of people of mixed ethnic backgrounds.
- Vale and South Districts showed modest rises.
- The proportion of the population made up by ethnic minorities fell slightly in West Oxfordshire.

Change in the proportion of the population made up by ethnic groups



Source: Oxfordshire Insight, data taken from 2001 and 2011 ONS Census surveys

Conclusion:

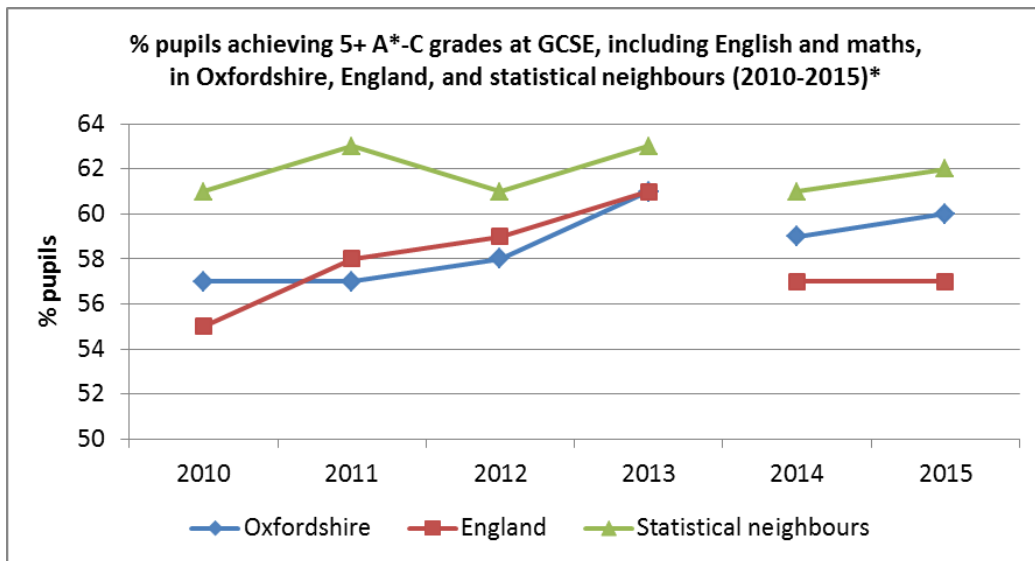
The increasing diversity of Oxfordshire’s population remains a key factor in tackling disadvantage through targeting services.

School results at GCSE (typically children aged 15)

These are important measures of the life-chances of children and I report on them each year.

2015 was a good year overall, with **60% of pupils achieving five or more A*-C grades at GCSE, including English and maths. This was above the England average of (57%).**

This is very good news because the chart shows an increase in good results above the national figures. There is further to go as the results were below the average across Oxfordshire’s statistical neighbours (similar Counties) by 2 percentage points.



Source: Department for Education

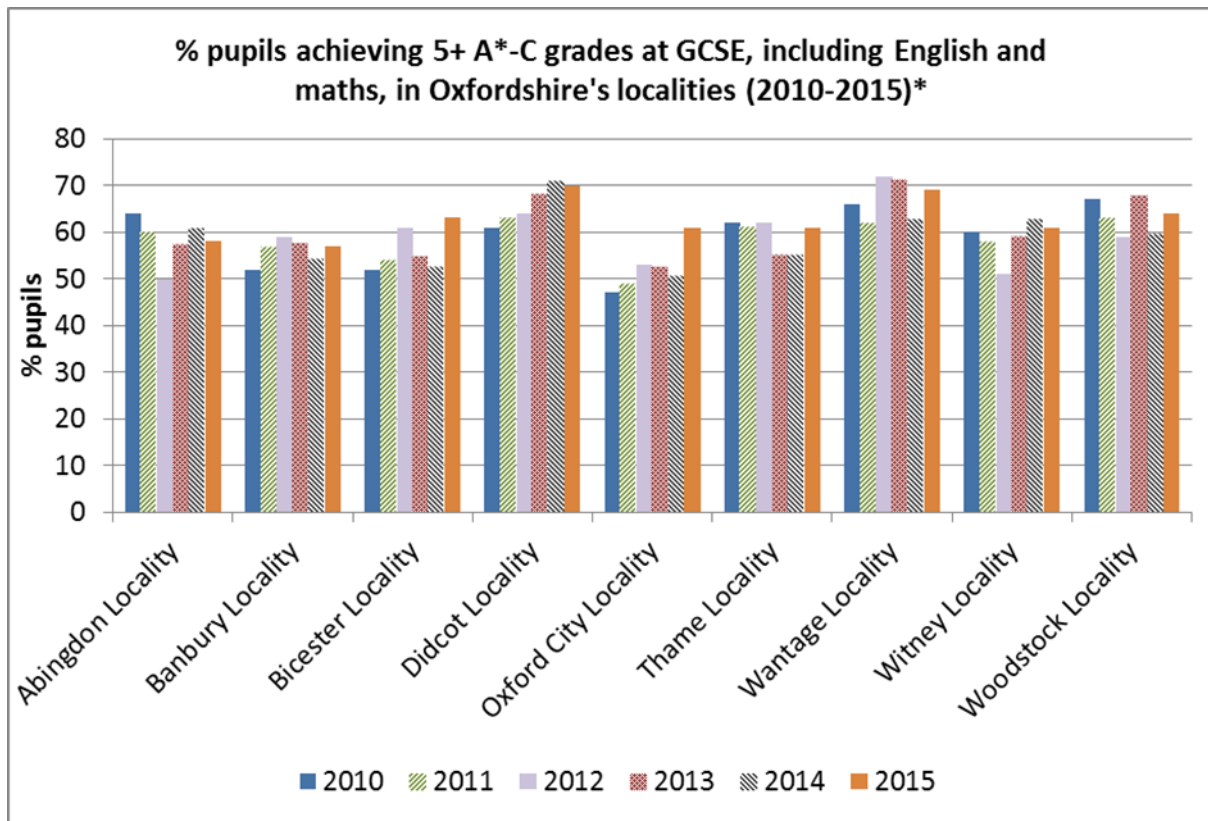
*Before 2014 the measure was based on best entry; from 2014 it is based on first entry

**NB vertical axis starts at 50 to aid legibility.

However, this good news must be tempered when we look at results for **children eligible for free school meals** which we can use as a rough measure of poverty - 31% of pupils known to be eligible for free school meals achieved five or more A*-C grades at GCSE, including English and maths, compared with 62% of other pupils (a gap of 31 percentage points). This was slightly worse than the England average by 2 percentage points, but it was higher than our statistical neighbours by 1%.

School results at GCSE by locality

There is some good news here too. The chart below tells the story with results at GCSE shown by locality for the last 6 years. **Compared with last year, results were more even across the board and there was a very welcome improvement from schools in Oxford City which have been worryingly low for some time.** Oxford's performance in achieving 5 GCSE's at grades A* to C just passed that in schools in Banbury and Abingdon. Scores ranged from 57% in the Banbury and 58% in Abingdon, to 69% in Wantage, and 70% in Didcot.



Source: Department for Education

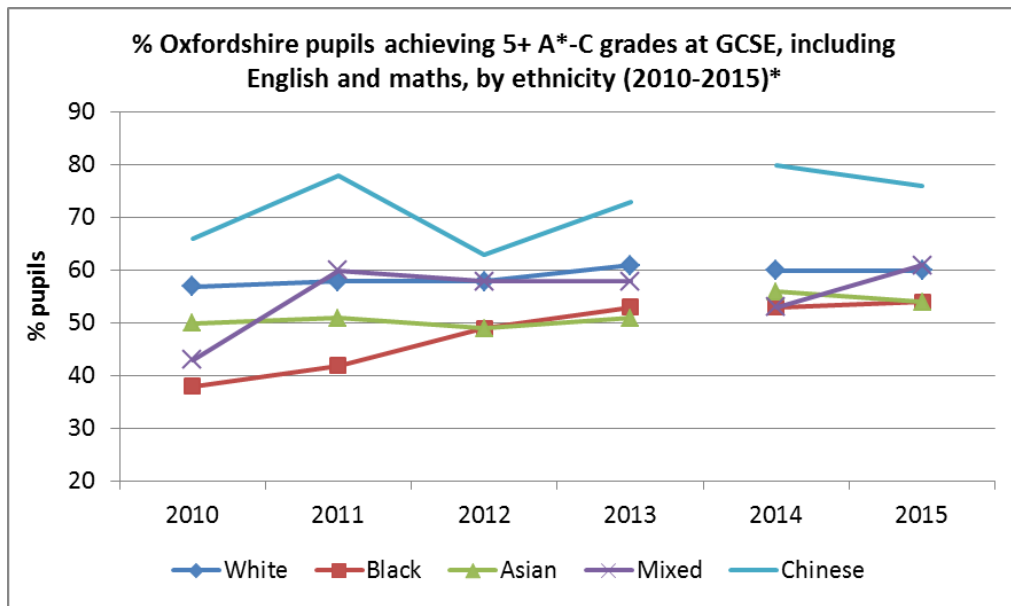
*Before 2014 the measure was based on best entry; from 2014 it is based on first entry.

GCSE results by ethnic minority

The chart below compares performance between the different ethnic groups in Oxfordshire. The results show:

- Chinese pupils continued to outperform those from other ethnicities.
- On average, GCSE attainment among pupils from White and Mixed ethnicities was similar to the Oxfordshire average.
- Attainment among pupils from other Asian and Black ethnicities was below the Oxfordshire average, but children from Black ethnic minority groups show gradual improvement.

We should interpret these figures with some caution due to the relatively small numbers of non-White pupils: this is likely to account for some of the fluctuation from year to year.



*

Source: Department for Education

*Before 2014 the measure was based on best entry; from 2014 it is based on first entry

**NB vertical axis starts at 50 to aid legibility.

Conclusions:

The overall standard of attainment in Oxfordshire’s state schools is improving and inequalities are reducing.

The inequality gap between pupils from different ethnic groups is closing overall and this is to be welcomed.

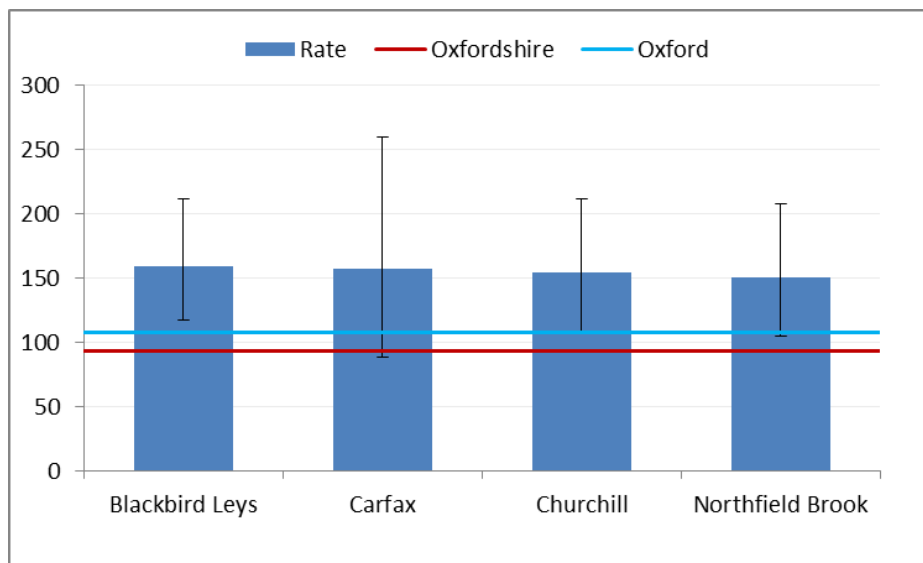
The performance of children receiving free school meals remains a matter of concern.

Deaths from Cancer by District and wards.

Looking at death rates gives us another insight into how disadvantage plays out in the County.

The chart below shows characteristic findings for Oxfordshire:

Oxfordshire wards with the highest cancer mortality (indirectly age-standardised ratios)



Source: Public Health England

The chart shows that:

- Disadvantage has very tangible results – in this case higher death rates from cancer in Oxford City than in the rest of the county.
- The bars on the chart show the death rates for the highest areas in the County. Death rates in the most disadvantaged wards are 50% higher than the County average.
- This pattern of the results of disadvantage is mirrored in many statistics about death and disease and underlines the reasons for tackling disadvantage head on.

Health and disadvantage among carers

The population’s health and our services depend on carers. Being a carer can have its rewards, but it is also a significant disadvantage in terms of everyday freedoms and life choices as set out in previous annual reports.

From the 2011 census we already knew that:

- 61,000 people in Oxfordshire said they provided some level of **informal care** to a relative or friend.
- This is just over 9% of the County’s population – slightly lower than the national average.
- The proportion of carers by District mirrors the age structure of each District – a higher proportion of older people means a higher proportion of carers.
- Figures for Districts are: Oxford City 8%, Cherwell 9% and 10% in West, South and Vale.
- 72% provided between 1 and 19 hours of care per week, and 18% provided more than 50 hours.
- Most carers are aged 50-64. In this age group 1 in 5 are carers.
- Females provide 58% of care and males 42%.
- 1,300 children aged 0-15 were carers.

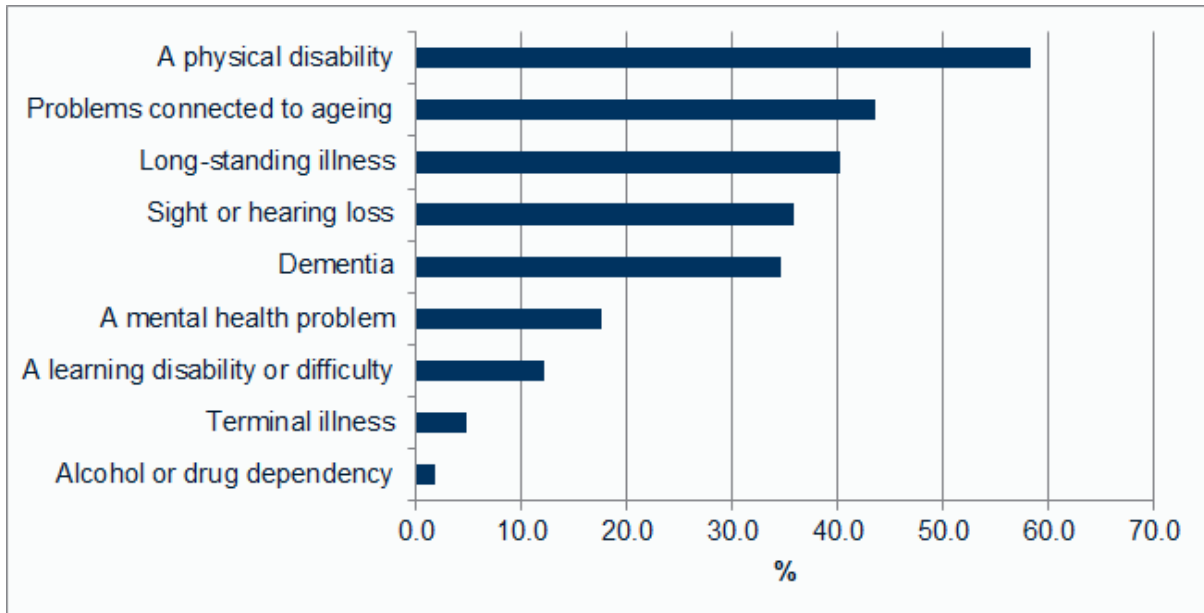
17,200 carers have had their needs assessed by Oxfordshire County Council's social care team during the year, some of whom will also have received a service from the council.

New data was produced as part of a national survey of carers giving a more accurate and up to date picture up to September 2015. The Personal Social Services Survey of Adult Carers in England is carried out every two years covering 18s and over, and it took place for the second time in 2014-15 and 715 carers in Oxfordshire responded. The results show that:

- About three quarters were living with the person they cared for.
- More than one in three had been caring for more than ten years.
- Slightly under half of respondents (44%) reported providing 100 or more hours of care per week.
- Nearly two thirds of the carers who responded (65%) were retired.
- 16% of respondents said they were not in employment *because of* their caring responsibilities.
- Only one in five respondents to the survey in Oxfordshire said they were able to spend their time as they wanted, doing things they value or enjoy.
- 14% said they didn't do anything they value or enjoy.
- Seven in ten respondents said they did not have as much control over their daily life as they want.
- 15% said they had little social contact and felt isolated.
- Most respondents said they had found it easy to find information and advice about support, services and benefits. Nearly 90% had found the information and advice they had received helpful.
- More than three quarters of carers who had received support or services from Social Services said they were satisfied with what they had received. A little under half said they were very or extremely satisfied. These satisfaction levels were broadly similar to regional and national averages.
- These findings overall are broadly in line with the national picture.

For over half of the carers in Oxfordshire who responded to the survey, the person they cared for had a physical disability. The full results are shown in the table below:

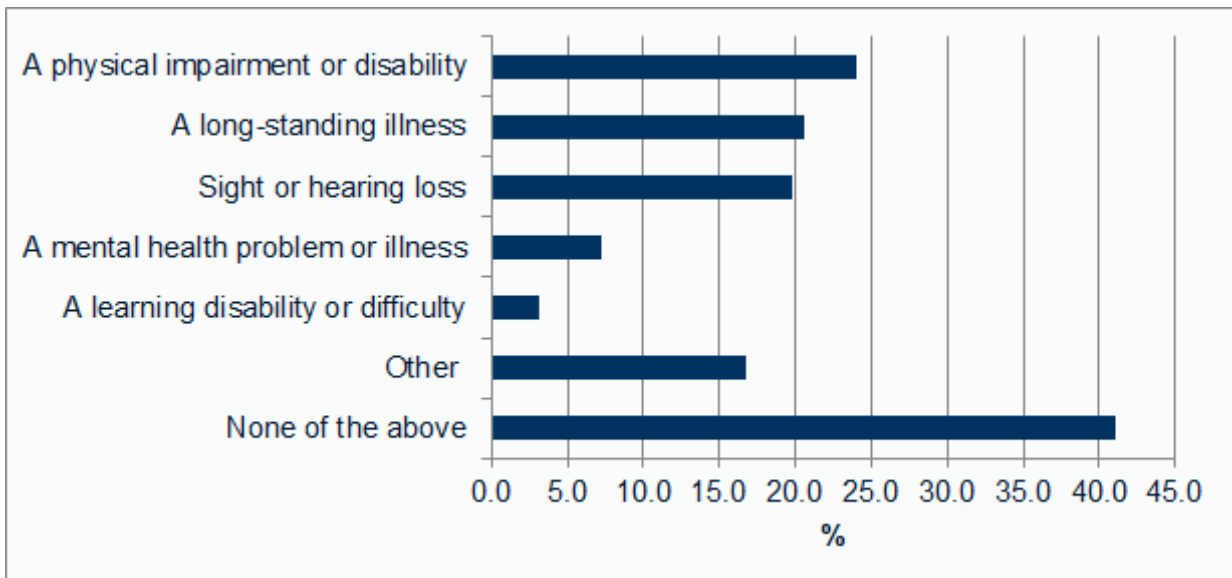
Carers in Oxfordshire, by health condition of the person they care for (2014/15)



Source: Health and Social Care Information Centre

Over half of the carers surveyed reported having a health problem themselves, commonly a physical impairment or disability, a long standing illness, and/ or loss of sight or hearing. The full details are given below:

Health conditions of carers in Oxfordshire (2014/15)



Source: Health and Social Care Information Centre

Conclusion:

This new information highlights the crucial role played by carers.

It also shows the down-side of caring and the limitations it imposes on life choices.

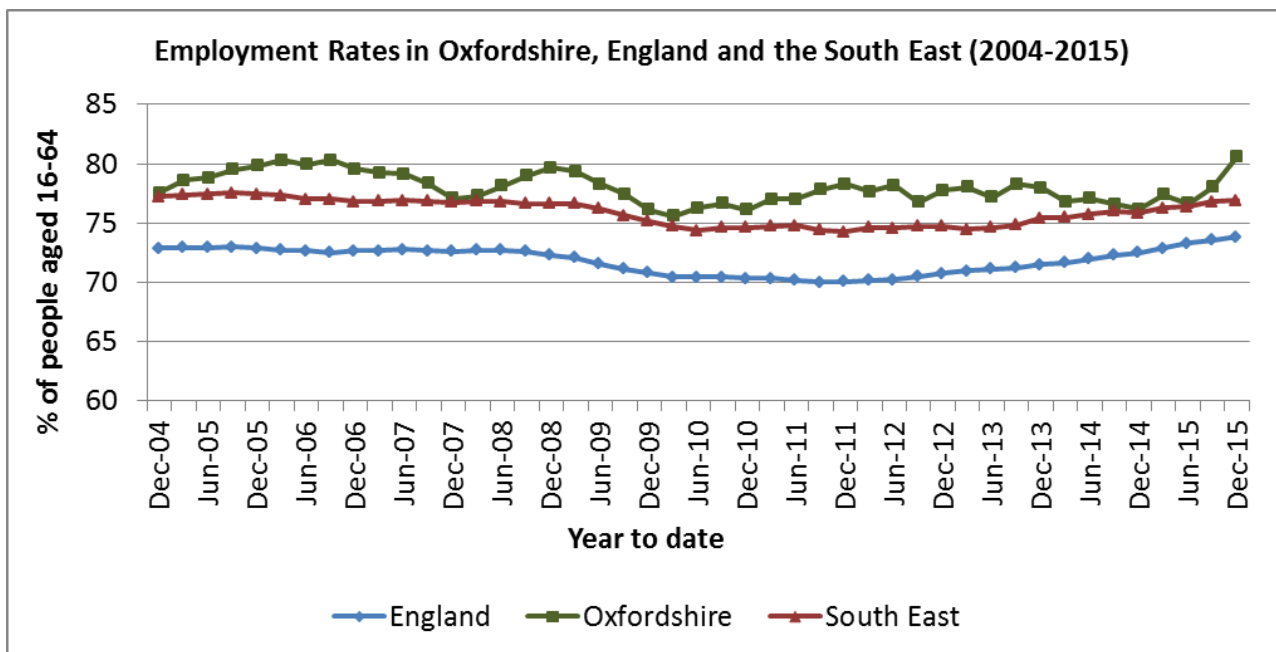
Our services perform well in terms of looking after carers and this is taken as a serious responsibility. We need to ensure that this position does not slip and that it is improved if possible – our carers and our services depend upon it.

A Good Year for Employment

Being in work is good for both physical and mental wellbeing and is crucial for the economy. During last year employment rates rose so that data for the 2015 calendar year show that in Oxfordshire:

81% of people aged 16-64 were in employment, numbering 342,000. Again, this was significantly higher than both the England average (74%) and the South East average (77%). The proportion of men aged 16-64 in employment (86%) was significantly higher than the proportion of women (75%). 70% of people aged 16-64 in Oxfordshire were working for an employer, whilst the remaining 10% were self-employed.

The chart below shows the picture.

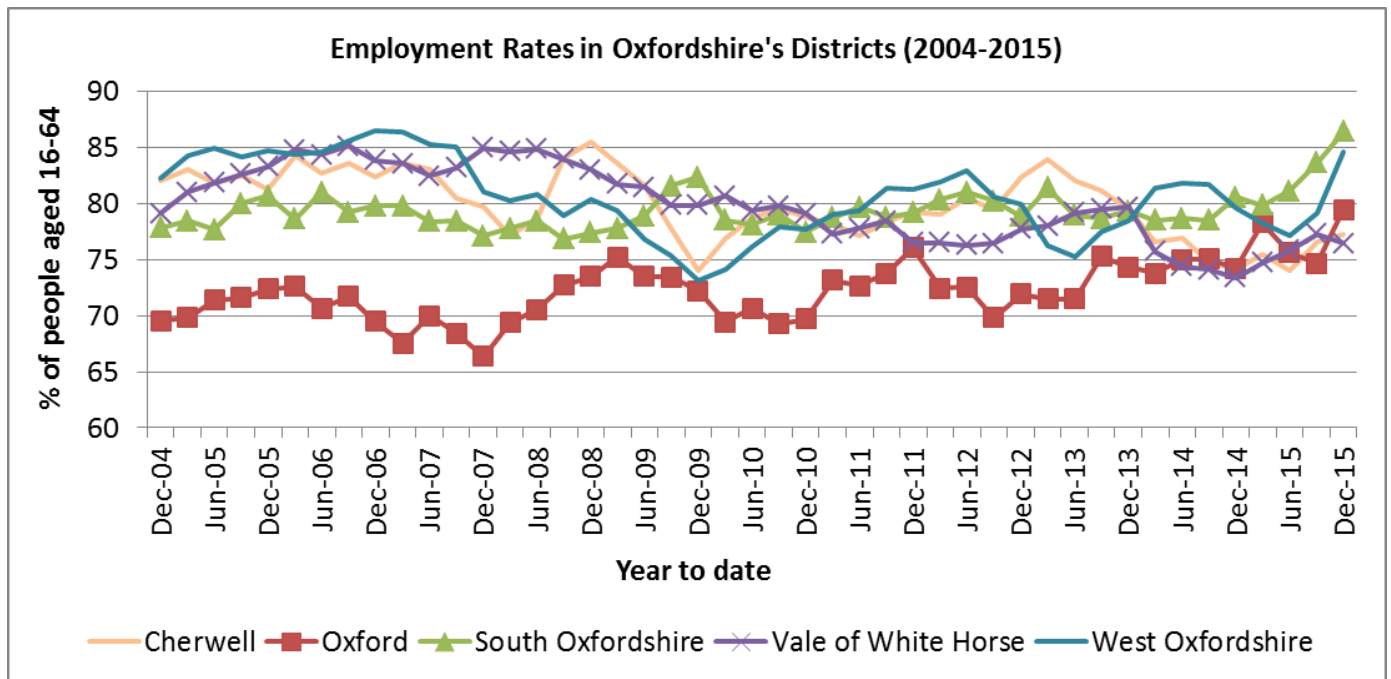


Source: Annual Population Survey. *NB Vertical axis starts at 60 to aid legibility.

Employment varies by District

- Employment rates in Districts have varied over the last 10 years with rates in the City gradually rising from 70% to 80%.
- In 2015 employment rates rose in all Districts, but rose more sharply in South Oxfordshire, West Oxfordshire and the City.
- **Overall, disadvantage due to lack of employment is reducing, and inequalities between Districts have reduced over the last 10 years.**
- **This is a good result.**

The chart below tells the story.



Source: Annual Population Survey. *NB Vertical axis starts at 60 to aid legibility

Unemployment rates fell slightly during 2015

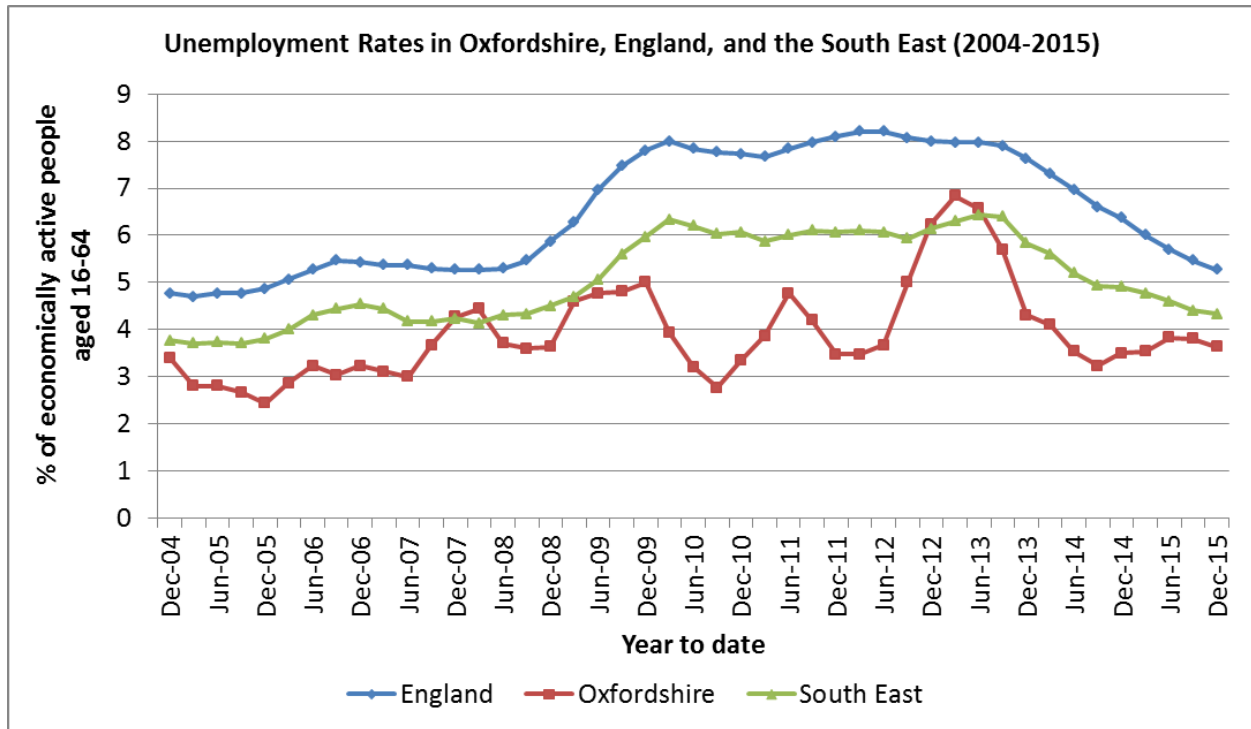
3.6% of economically active people aged 16-64 were unemployed, numbering 12,700 – a modest reduction over the year. This unemployment rate was significantly lower than the England average of around 5%.

As of March 2016, less than 1% of people aged 16-64 were claiming benefits due to unemployment. Claimants are more likely to be men than women.

These are good results.

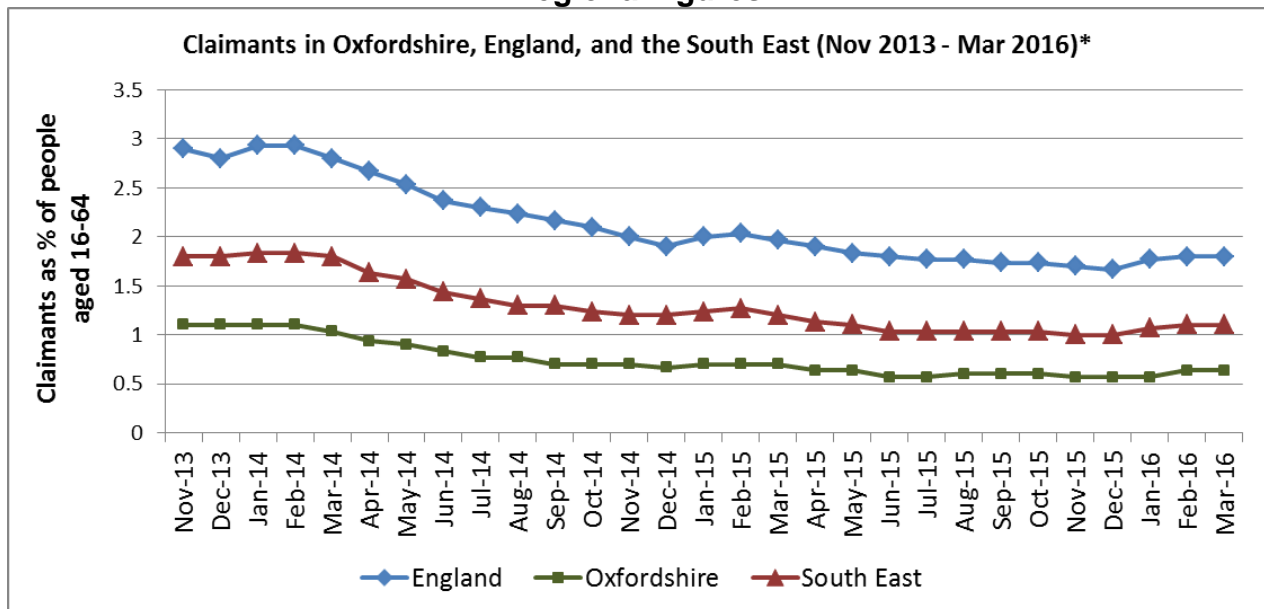
The charts below show the picture and illustrate that Oxfordshire performs better than national and regional figures.

Unemployment rates comparing Oxfordshire with national and regional figures



Source: Annual Population Survey

Unemployment Related Benefit Claimants comparing Oxfordshire with National and Regional figures



Source: Department for Work and Pensions

* This is part of an experimental statistics series running from November 2013, which includes data on all Job Seekers Allowance claimants and all out of work Universal Credit Claimants. Ideally only those Universal Credit claimants who are out of work and required to seek work should be included in the Claimant Count, but it is not currently possible to produce estimates on this basis. The Claimant Count therefore currently includes some out of work claimants of Universal Credit who are not required to look for work; for example, due to illness or disability.

Breaking The Cycle Of Disadvantage Part III: A Basket of indicators for Disadvantaged Children

Given the proposed changes to children's services in the County, I am keen to monitor the trends in children's life chances using reliable indicators so that we can assess any overall future impact.

The dilemma here is that the data we can rely on tends to come at County level, or District level at best. It will be important to find ways to dig into this data in future years to look more closely at these issues more locally - this is work that the Children's Trust might take on. As we look more locally the numbers will be smaller and will tend to vary, so data from service performance and informed opinion will come into play too. That said, it is important to establish a good baseline now, and that is what I am trying to do here.

The point of setting a baseline now is to draw a line in the sand that can be used to see if things are getting better or worse in future reports.

The indicators I have chosen look at outcome measures that together try to give a picture of children's life-chances in Oxfordshire.

The indicators are:

1. Percentage of children (under 16 years) in Low-Income Families
2. Under 18 conception rate per 1,000 female population aged 15-17 years
3. Teenage mothers (ie teenage conceptions which do not result in termination)
4. Percentage of Infants aged 6-8 weeks who are being breastfed
5. Percentage of 2 year olds who have received one MMR vaccination
6. School Readiness: the percentage of children achieving a good level of development at the end of reception
7. Percentage of pupils achieving 5+ A*-C grades at GCSE, including English and Maths
8. 16-18 year olds not in education employment or training
9. Percentage of children in Reception Year (4-5 year olds) who are obese
10. Percentage of Year 6 children (10-11 years) who are obese
11. Households accepted as homeless
12. Households in temporary accommodation

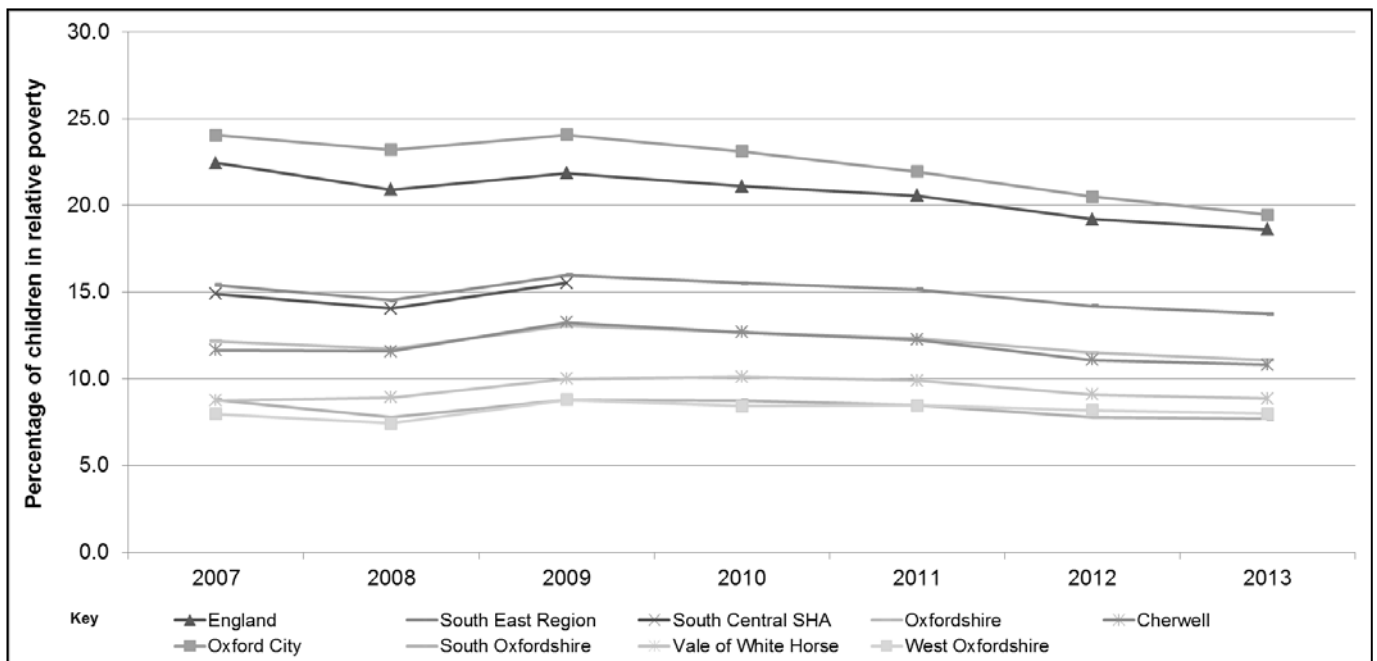
I will look at them one by one and pick out the key features.

Indicator 1. Child poverty

Features of the baseline data:

- The overall trend is downwards, in line with national trends.
- The County average is well below the national average.
- Only Oxford City has more children in poverty than the national average.
- Other Districts are well below the national average and are broadly comparable.

Percentage of children (under 16 years) in Low-Income Families Local Measure (2007 to 2013 - calendar years)



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

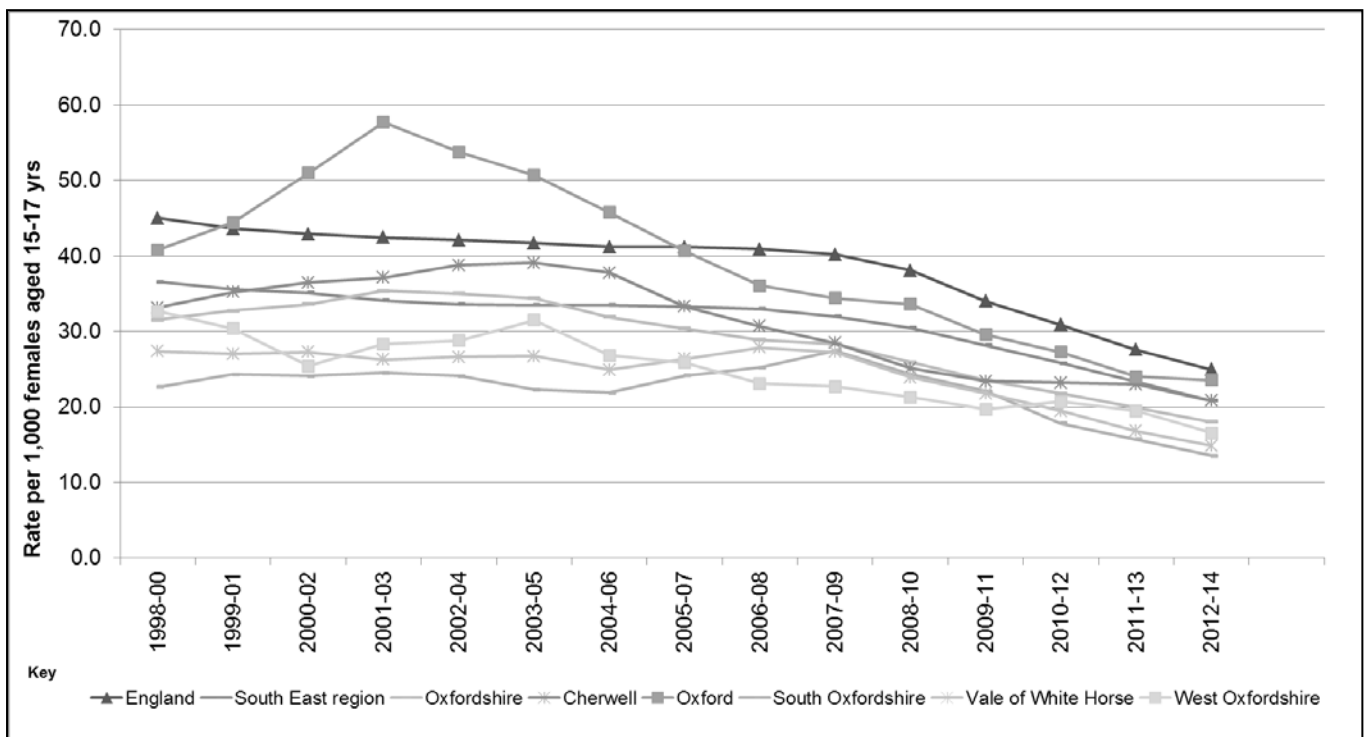
Indicator 2. Teenage Pregnancy

This measure includes all conceptions no matter whether the pregnancy ends in birth or in a termination.

Features of the baseline data:

- The overall trend is downwards in line with national trends.
- All Districts are below the national average.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998/2000 - 2012/14 (3-years combined)



Source: Office for National Statistics (ONS)

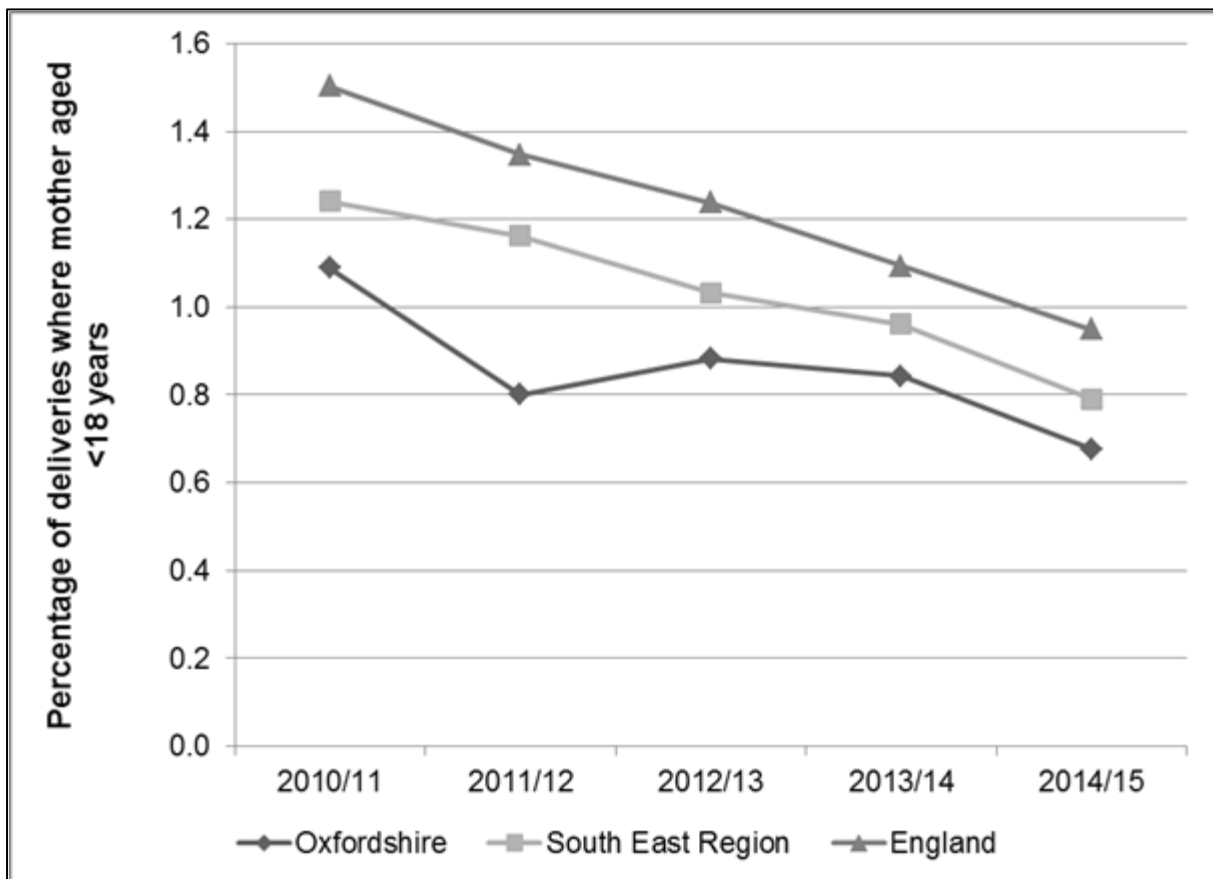
Indicator 3. Percentage of Teenage Mothers

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

It differs from teenage conceptions in that some teenage conceptions result in terminations. Because it is a percentage of all deliveries, it doesn't tell us as much as teenage conceptions per se. It also assumes that the number of deliveries to mothers aged over 18 stays fairly constant.

Features of the baseline data:

- The percentage of births to under 18s is very small – around 1 in 100 births nationally and around 0.7 per 100 births (7 per 1000) in Oxfordshire.
- The percentage is gradually reducing.
- Oxfordshire does better than both regional and national figures.



Source: Children & Young People Benchmarking Tool (PHE)

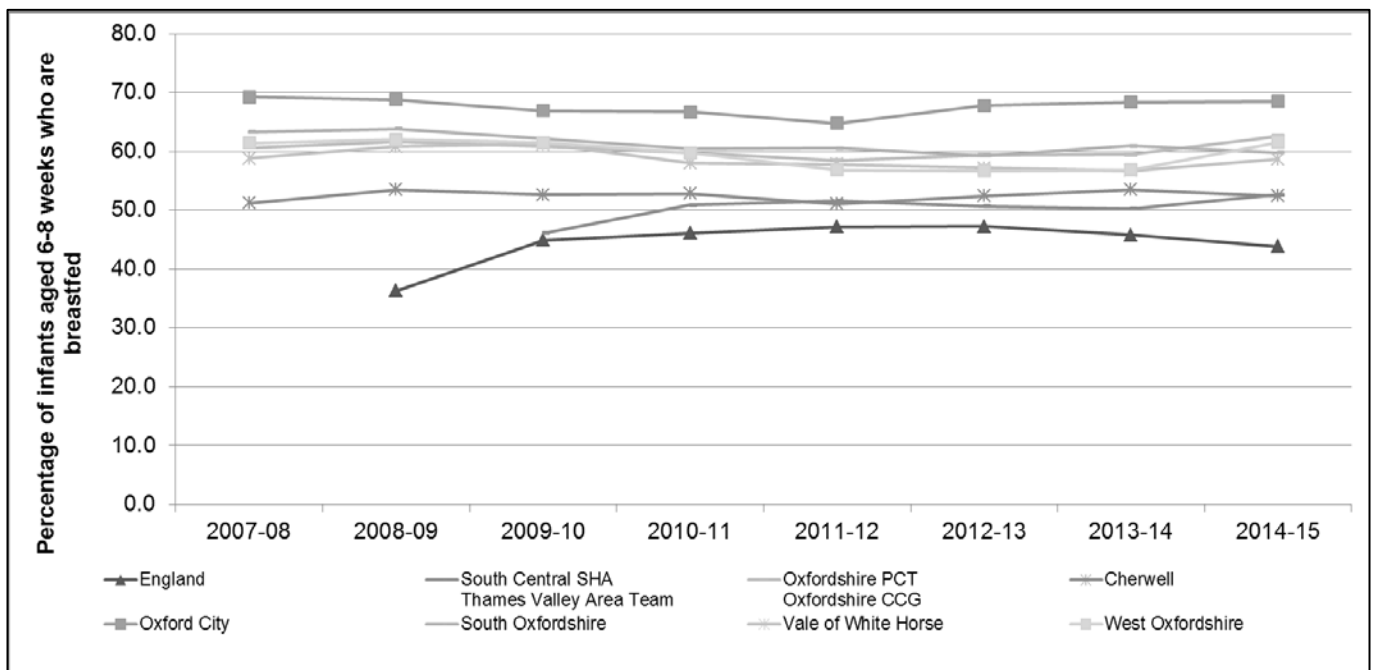
Indicator 4. Breastfeeding at 6 to 8 weeks

This is a good general measure of quality of care during pregnancy and it has a protective effect on the child. We should remember however that despite best efforts, some mothers cannot breastfeed.

Features of the baseline data:

- The County average of just over 60% is much higher than the national average of around 43%
- The City performs exceptionally well at almost 70%, however this is due to very high rates in North Oxford of around 80% which mask much lower rates in the more disadvantaged parts of Oxford.
- Cherwell has always lagged behind the rest of the County at just over 50% despite best efforts. The reasons for this are unclear.

Percentage of Infants aged 6-8 weeks who are being breastfed (totally or partially) - 2007/08 to 2014/15



Source: NHS England

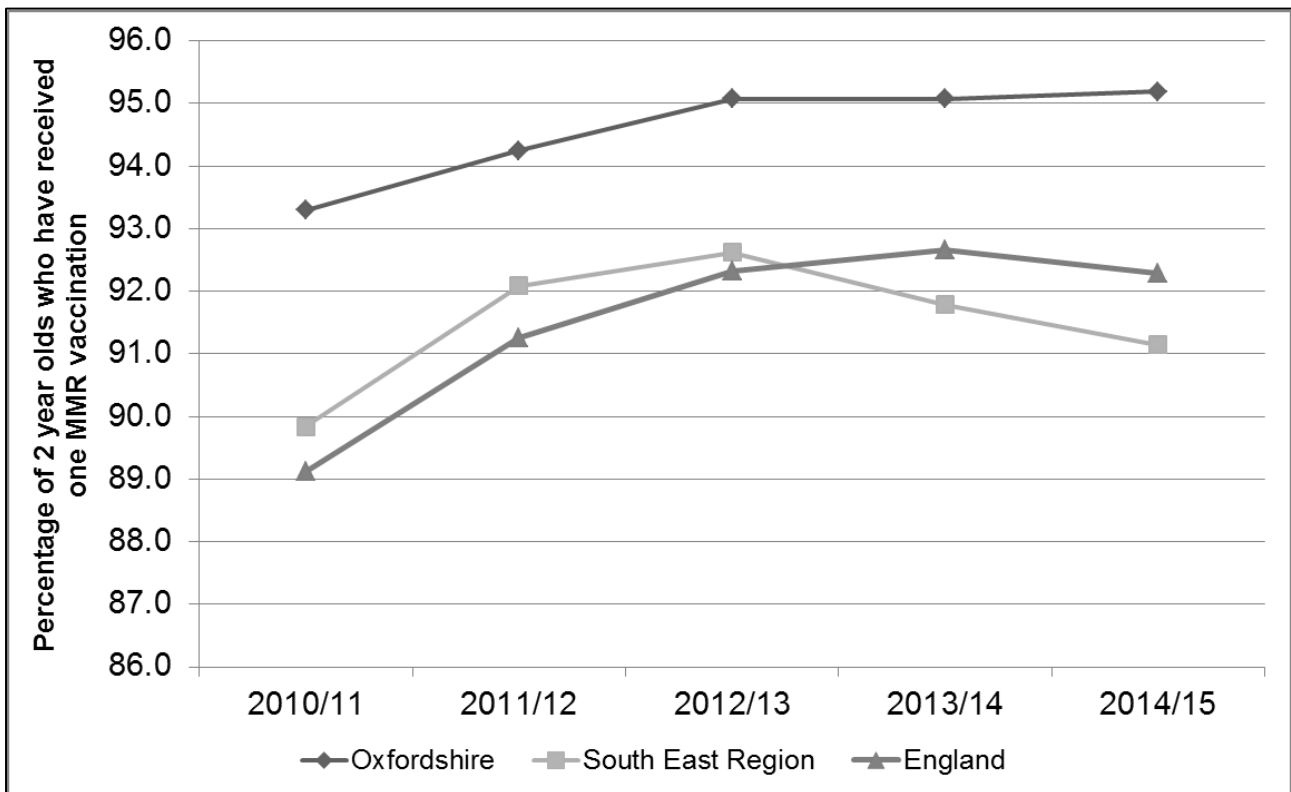
Indicator 5. Childhood Immunisation

This is a good general measure of the quality of general practice and the extent to which families cooperate to protect their children. There are many immunisation statistics – I have chosen immunisation for Measles Mumps and Rubella (called MMR) as it has a controversial past, and we have struggled to get the County average above the recommended 95%. This service is delivered by NHS England.

Features of the baseline data:

- The level of uptake is higher in Oxfordshire at around 95% than national and regional averages of 91% to 92%.
- The trend in Oxfordshire is rising slightly while it is falling slightly regionally and nationally.

Percentage of 2 year olds who have received one MMR vaccination



Source: Cover of Vaccination Evaluated Rapidly (COVER) data available from Health & Social Care Information Centre (HSCIC)

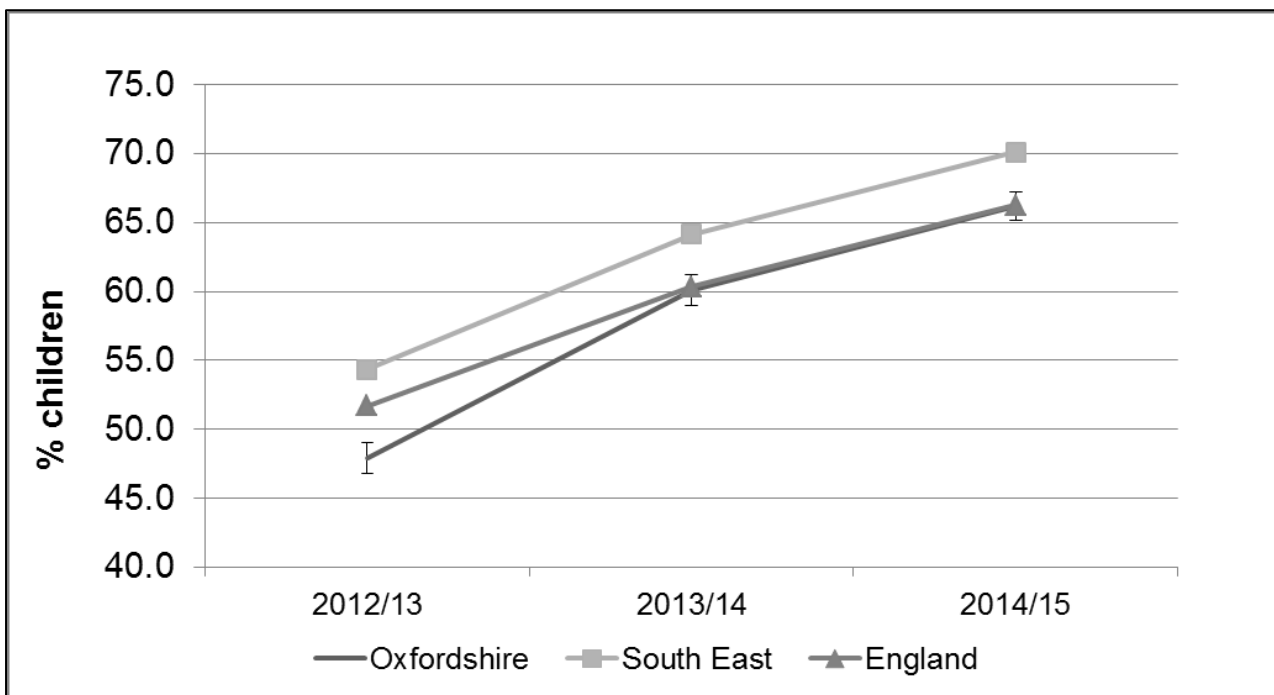
Indicator 6. School Readiness

This indicator measures school readiness at the end of reception year. It is a useful measure of future life chances of local children. The definition of school readiness is based on children reaching a sound level of development covering personal relationships, social relationships, emotional development, physical development and communication skills as well achieving learning goals in maths and literacy.

Features of the baseline data:

- Oxfordshire’s figure is the same as the national average at around 66%.
- It is below the regional average and there is room for improvement.
- All national and local trends have been upward in the last few years.

School Readiness: the percentage of children achieving a good level of development at the end of reception



Indicator 7: GCSE results

This is an excellent indicator of school achievement overall in state schools. It points forward to children’s overall ‘success’ in life. The chart for this is included earlier in this chapter.

Features of the baseline data:

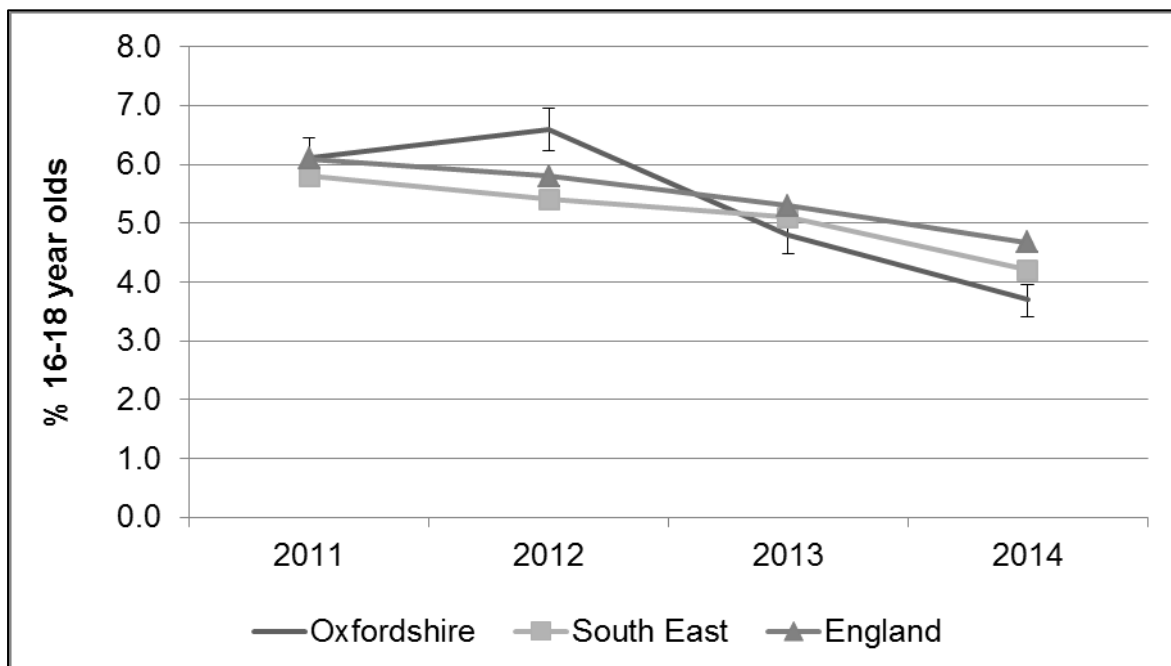
- Around 60% of Oxfordshire’s state educated children achieve at least 5 GCSEs at grades A* to C including English and maths.
- This has been a success story in recent years. Oxfordshire used to lag below the national average and now we are around 3 percentage points above.
- This is a good result, but there is still room for improvement as we are 2 percentage points behind similar Local Authorities (our statistical neighbours).

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

This is a direct measure of success in young peoples’ achievement in higher education and training, which foreshadows their economic success and that of the County.

Features of the baseline data:

- Progressively fewer young people are not in higher education or training.
- Oxfordshire’s figure is better than both the national and regional figures at just under 4%.
- This is a good result



Indicator 9. Obesity in children in reception year.

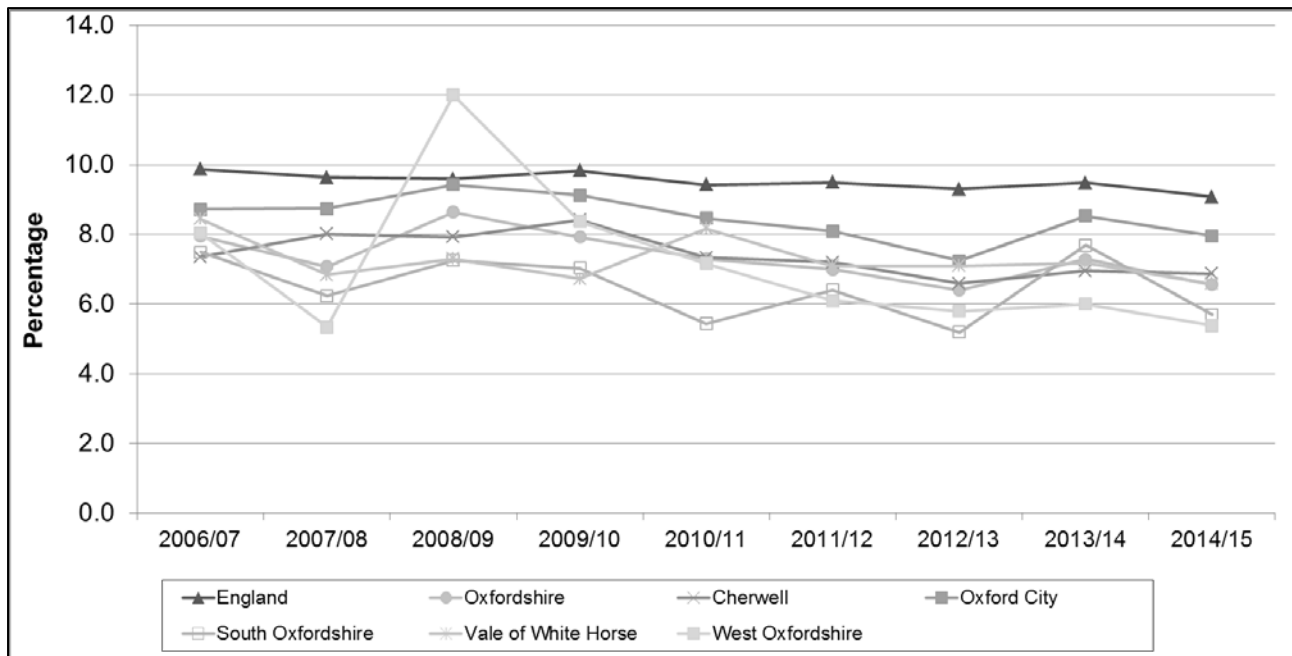
This is a useful indicator of children’s life chances in terms of health. Obesity and overweight gradually increase with age which foreshadows the future likelihood of diseases such as diabetes, heart disease, some cancers and ultimately an early death. It is linked to levels of physical activity. Keeping this figure as low as possible is crucial for the health of the next generation.

There is more detailed information on obesity in the next chapter.

Features of the baseline data:

- Overall Oxfordshire does better than national figures by about 2 percentage points.
- Oxfordshire’s current level of obesity in reception year is between 6% and 7%.
- However there are clear inequalities in this data, with Oxford City showing consistently higher levels than other Districts. The City’s figure is around 8% - still better than the national average.
- The remaining District’s figures fluctuate around the 6% mark.

Percentage of children in Reception Year (4/5 years) who are obese - 2006/07 to 2014/15 (Academic Years)



Source: National Child Measurement Programme

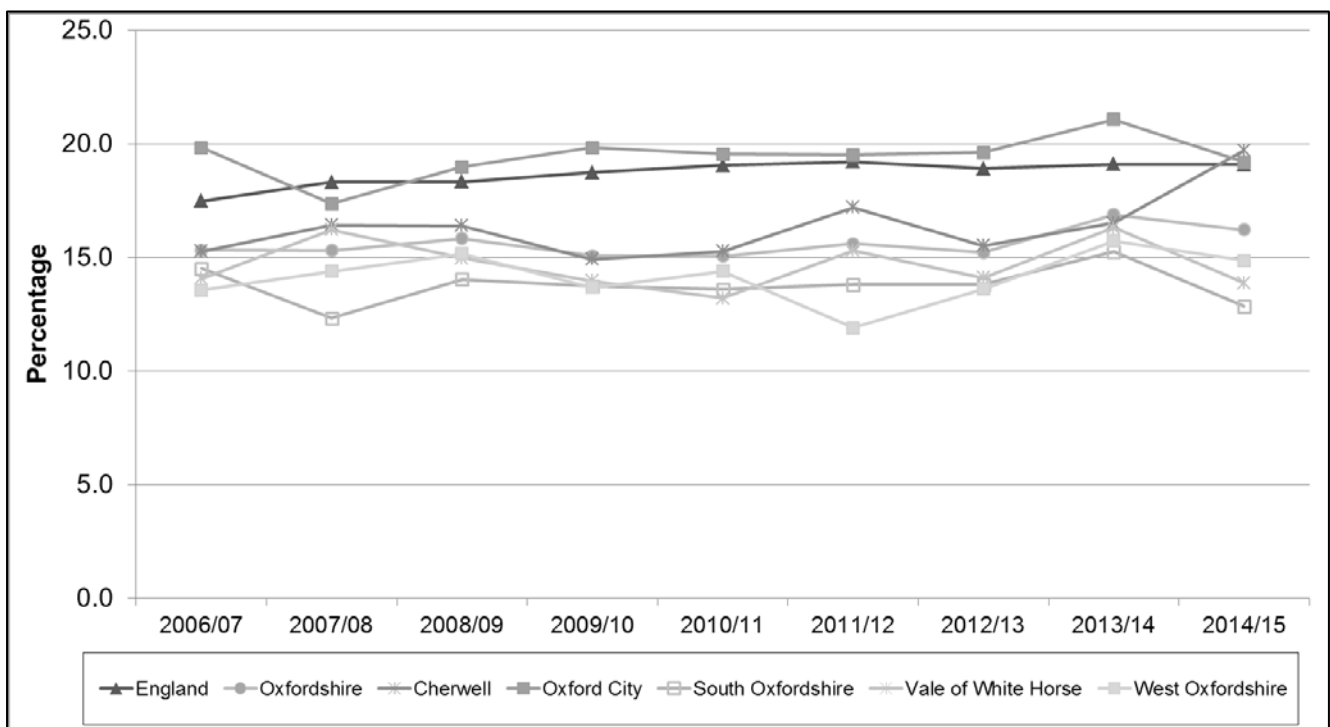
Indicator 10. Obesity in 10 to 11 year olds – (school year 6)

Seen alongside the data on obesity in reception year above, this figure tells the story of obesity and overweight in children as they grow older – gradually more slip from a healthy weight into overweight and obesity. This trend will tend to continue into adulthood and is the root cause of much later chronic disease. Obesity also magnifies the impact of all disabling conditions such as joint and mobility problems and so it also affects the need for social care.

Features of the baseline data:

- The County figure stands at around 16% having increased from 7% in reception year.
- The County figure is better than the England average by 2 percentage points.
- Until last year, the City’s figure was the worst – just above the national average.
- Last year showed a sharp rise in the figure in Cherwell. It is too early to say if this is a ‘real’ change or a ‘blip’ in the statistics, but it is important and we need to keep a close watching brief.

Percentage of Year 6 children (10-11 years) who are obese: 2006/07 to 2013/14 (Academic Year)



Source: National Child Measurement Programme

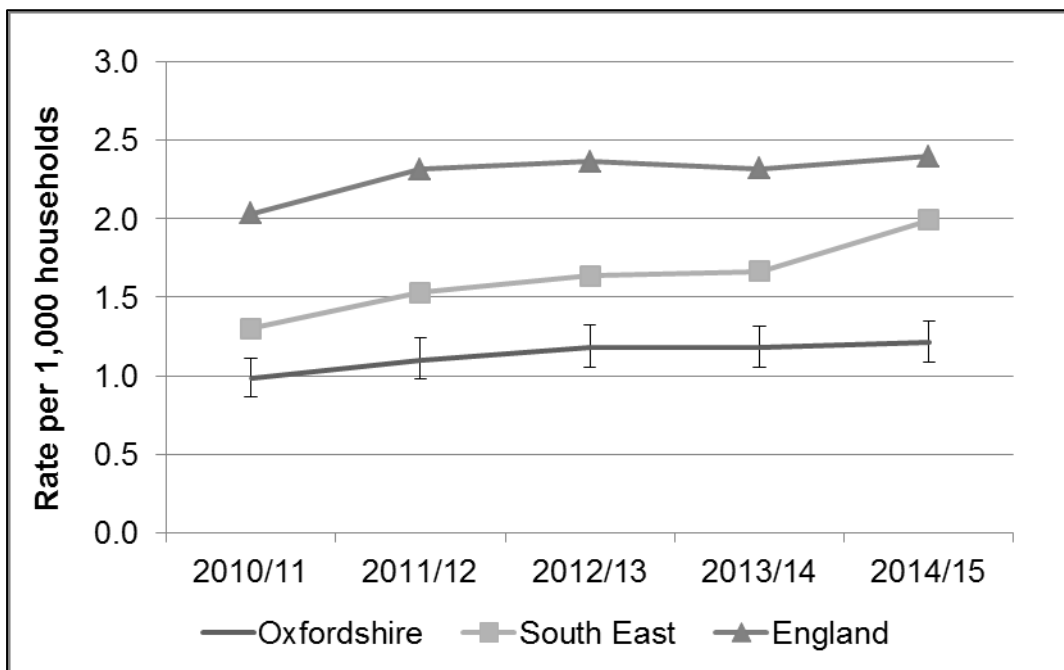
Indicator 11. Homeless Households

Being part of a homeless household has a serious impact on children and families. Young people who are homeless have markedly poorer life chances. This indicator gives us a general 'feel' for the trends in homelessness in the County.

Features of the baseline data:

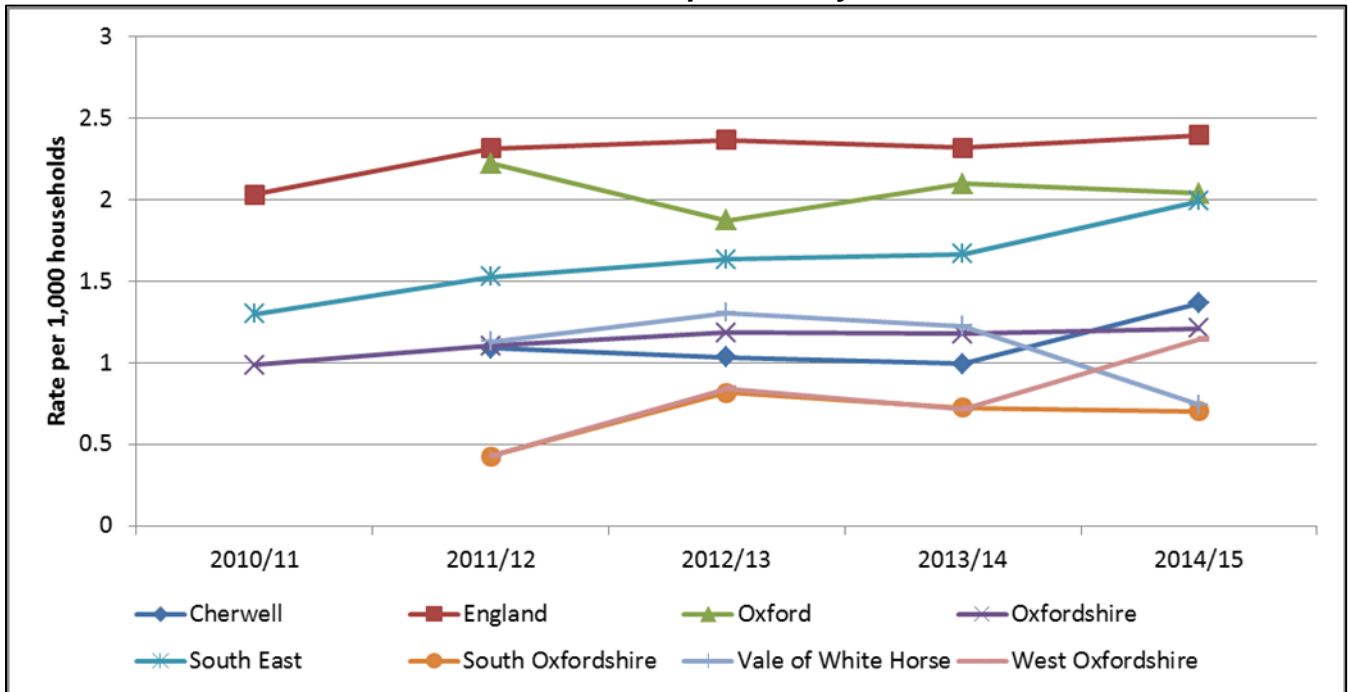
- The figure for Oxfordshire as a whole is low - just over 1 in a thousand households.
- Oxfordshire's figure outperforms national data which stands at just under 2.5 per thousand households.
- Oxfordshire performs better than similar local authorities.
- The general trend is rising slightly.

Homelessness acceptances per 1,000 households



The position on this indicator is not uniform across the county. For the sake of completeness, results for each district are shown below.

Homelessness acceptances by district



The chart shows that:

- The rate in all districts is lower than the England average.
- The City has had the highest rates for some years at around 2 homeless households per 1000 while the other districts cluster at one homeless household per 1000.

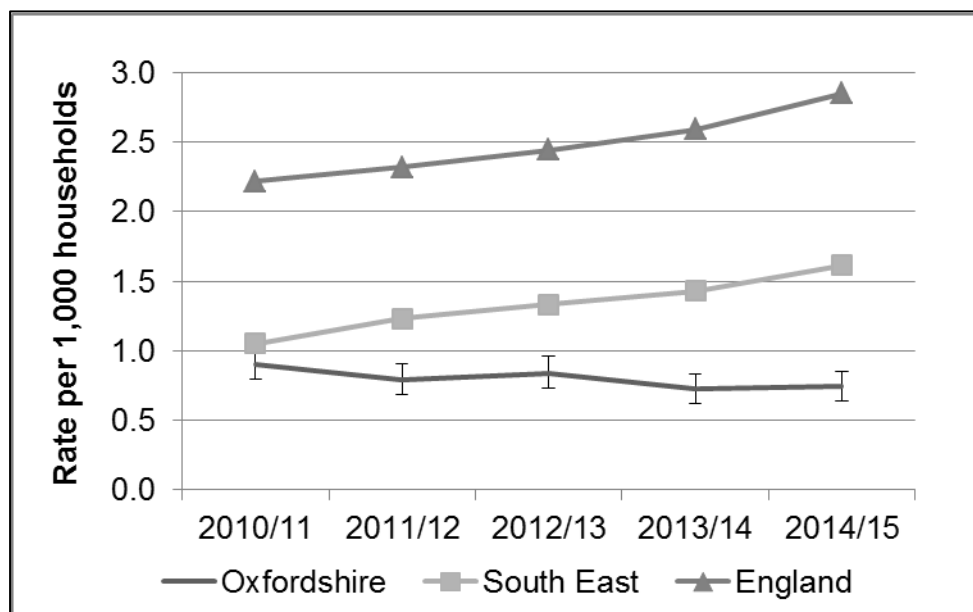
Indicator 12. Households in temporary accommodation

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

Trends in the baseline data:

- Oxfordshire's compares well with national figures and compares well with similar Local Authorities.
- Oxfordshire's figure stands at less than 1 per thousand households being placed in temporary accommodation and the rate is falling.
- This is in sharp contrast to the national figure which stands at almost 3 per thousand and is rising.

Households in temporary accommodation per 1,000 households



Breaking The Cycle Of Disadvantage: Summary and Recommendations

Summary

- Overall it has been a good year for reducing disadvantage.
- Progress has been made on last year's recommendations.
- School results are up.
- Employment is up.
- Child poverty and teenage pregnancy are down.
- In equalities in school results and employment have reduced.

However there are some early warning signs for women's health and childhood obesity levels are still too high despite comparing favourably with national figures.

It is vital that we maintain this momentum, particularly during times of change for children's services.

Establishing a basket of indicators for children is an important step forward – we now have a firm baseline against which to compare future developments.

We await the results of the Independent Commission on Health Inequalities so that we can add the Commissioners' insights to the overall picture.

The key to success remains:

Identify the Disadvantage
Put in place long term interventions to counteract it
Persist in this over decades
Monitor progress assiduously

We are making steady progress in Oxfordshire and it is vital that this is maintained in these times of change.

Recommendations

1. The report of the Commission for Health Inequalities should be studied carefully when it is published and all organisations should use it to challenge current practice and make appropriate changes to services.
2. Trends in disadvantage should continue to be monitored closely in Director of Public Health Annual Reports
3. The Children's Trust is requested to consider the basket of children's indicators proposed in this report and to drill down into indicators to uncover further inequalities at more local level using data from services.
4. The NHS's Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The NHS 'offer' should not be 'one size fits all'.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

Main Messages in this chapter

- Obesity remains the biggest lifestyle challenge in Oxfordshire and preventing it is a key requirement for reducing disease levels and early deaths.
- NHS Health Checks continue to perform well.
- Solid progress has been made in tackling alcohol problems and in combatting poor oral health.
- There has been a sea-change in the way people quit smoking tobacco through the use of e-cigarettes.

Obesity, Diet and Physical Activity

Why is obesity an issue?

Obesity is widespread, a quarter of children aged 2-10, and one third of 11-15 year olds and two thirds of adults are overweight or obese. This remains our greatest lifestyle challenge.

Overweight and obesity in adults is predicted to reach 70% by 2034.

This is a crucial issue because being overweight increases the risk of cardiovascular disease, diabetes and some cancers. It is also associated with poor mental health in adults, and stigma and bullying in childhood.

Obesity can cause:

- Heart disease, stroke and late-onset diabetes.
- Depression and anxiety, asthma, cancer, liver disease, reproductive complications, osteoarthritis and back pain.

There are also inequalities in levels of child obesity which was mentioned in chapter 3, with prevalence among children in the most deprived areas being higher than among children in the least deprived areas. If an individual is less well-off, he or she is more likely to be affected by obesity and its health and wellbeing consequences. The impact is uneven across ethnic groups – obesity is more prevalent among males in black ethnic minorities.

The consequences of obesity are costly to health and social care and have wider economic and societal impacts. The annual **cost** of obesity is estimated to be:

- £27bn to the economy through reduced productivity and increased sickness absence
- £6.1bn cost to NHS
- £352m cost to Social Care by way of additional disease, disability and mobility problems.

Obese people are over three times more likely to need social care than those who are a healthy weight.

Obesity reduces life expectancy by an average of 3 years whilst severe obesity reduces life expectancy by 8-10 years.

Where are we now?

Chapter 3 showed the local picture in children. The Oxfordshire picture is better than the national average and levels fell slightly last year. This is a good result but there is no cause for complacency.

We now have enough data about local children to show what happened between their being measured in reception year and again in year 6.

Children measured in Year 6 in 2014/15 are the same cohort as those who were measured in Reception Year in 2008/09. **The level of obesity for this cohort when in Reception Year in 2008/09 was 8.6% and is now 16.2% which clearly shows that obesity has doubled in this cohort of local children over a six year period as they have grown up.**

This indicates that we need to act to prevent obesity during pregnancy and in the very early years. Breast feeding is protective against obesity and makes an excellent start for children whose mothers are able to breastfeed.

The Adult obesity, Health Survey for England (HSE) 2014 showed that:

- 58% of women and 65% of men were overweight or obese. This is now the social norm.
- The prevalence of morbid obesity (the most severe category of obesity) has more than tripled since 1993, and reached 2% of men and 4% of women in 2014.
- Over three quarters of females aged 45+ were overweight or obese.
- Black women were considered to be most at risk of diabetes, with 60% having high risk, and a further 27% having increased risk.
- Amongst men, White groups had the highest mean BMI (27.4) and Asian groups the lowest (26.0).
- Amongst women, Black groups had the highest mean BMI (29.5) and Asian groups the lowest (26.2).
- For women, the prevalence of obesity increased with disadvantage, from 22% in the least disadvantaged areas, to 33% in the most disadvantaged areas. This relationship was not evident for men.

Obesity is everyone's business

Obesity is everyone's business and every organisation needs to play a role in tackling it. To help an individual stay slim requires multiple actions both locally and nationally with changes needed to food labelling, food marketing, and the design of local communities which encourage physical activity.

We have talked about the role of planning healthy communities in chapter 2. It is now time to look more closely at physical activity.

The Role of Physical Inactivity

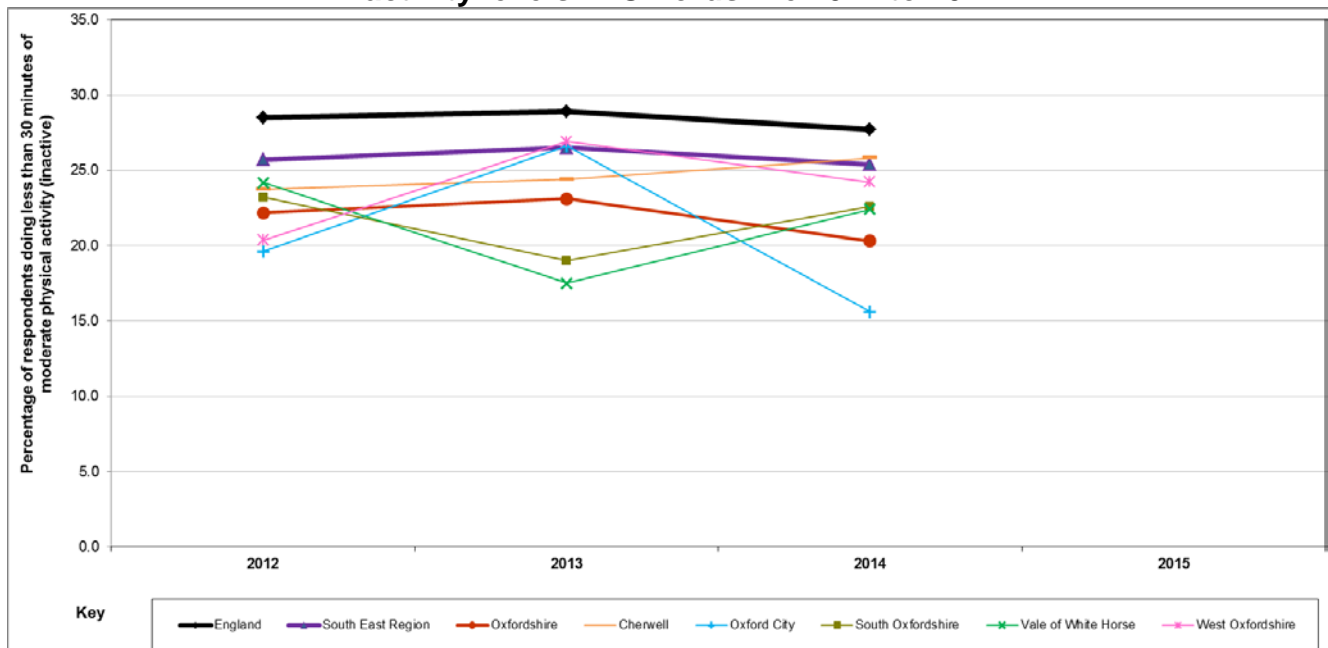
Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle.

The health benefits of a **physically active lifestyle** are well documented and there is a large amount of evidence to suggest that regular activity is related to reduced incidence of many chronic conditions such as diabetes, osteoporosis, colon cancer, breast cancer. Physical activity also improves mental health.

Physical activity contributes to a wide range of health benefits and regular physical activity can improve health outcomes irrespective of whether individuals achieve weight loss.

The chart below shows levels of inactivity across the County.

Inactivity levels in Oxfordshire 2012 to 2014



Source: Active People Survey, Sport England

It shows that in 2014, rates of inactivity in adults were better than for England, but still too high at around 20%. The England level is around 28% inactive.

Levels of physical activity levels amongst 5-15 year olds are falling. The proportion of boys who met the weekly physical activity guidelines fell from 28% in 2008, to just 21% in 2012. The proportion of girls who met the weekly physical activity guidelines fell from 19% in 2008 to 16% in 2012.

What did we say last year and what are we doing about it?

The Health Improvement Board is taking recommended action to review its physical activity strategy which brings together the action of District and County Councils, the NHS and other major partners. District Councils have a key role to play in their stewardship of green spaces and recreation facilities.

The Health Overview and Scrutiny Committee carried out a scrutiny of District council functions as recommended.

Less progress has been made by the NHS in improving the referral and treatment of physical disability. If we are to tackle obesity we need to see a real 'shift to prevention' and find new ways for clinicians, nurses and therapists to help people who are overweight more actively.

What should we do next?

The main challenge is to make work on prevention a mainstream activity in health services. There is an understandable tendency to concentrate on disease once it has happened rather than focus on preventive work from cradle to grave. It is hoped that the NHS's Sustainability and Transformation Plan will focus on preventative work over the next 5 years.

Recommendations regarding obesity, diet and physical activity

1. The prevention of obesity and its treatment should become a priority for the NHS and over the next 5 years actions should be put in place to train all health professionals to help in the fight against obesity. This should become part of the NHS's Sustainability and Transformation Plan.
2. The Health Improvement Board should continue to monitor partnership work on the prevention of obesity across the county.

NHS Health Checks

The NHS Health Check is a national cardiovascular risk assessment and prevention programme required by statute. It is delivered by local GPs and has been commissioned by the County Council since 2013.

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

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

In Oxfordshire, the Joint Health and Wellbeing Strategy set an aspirational target for 66% of those invited for NHS Health Checks to turn up for their Check. Nationally this same target has

now been set by Public Health England. We have not yet reached this target but we aspire to do so.

Last year in 2015/16 in Oxfordshire, GPs invited 38,293 people for a NHS Health Check and 19,212 people took up this invite and received a Check. The continued good performance of the NHS Health Check programme helped the Public Health Directorate achieve a quality premium payment from Public Health England.

Since the County Council took the responsibility for NHS Health Checks in 2013, 119,792 people have been offered a Check and 59,613 people have had a Check done. These Checks have helped the local health of the population by:

- **identifying 1,063 people who had high blood pressure and required an anti-hypertensive drug**
- **discovering 2,957 people who were at high risk of cardiovascular disease and required a statin**
- **detecting 251 undiagnosed cases of diabetes and 27 cases of chronic kidney disease, allowing people to manage their condition sooner and prevent complications**
- **referring 479 people to local weight management programmes, with 8,100 obese patients receiving brief advice**
- **offering 20,249 people brief advice to take up more physical activity, with 4,640 signposted to local physical activity services**
- **generating 434 referrals to smoking cessation services, with 5,777 receiving brief advice**
- **providing 2,125 people with brief advice to reduce their alcohol intake**
- **helping to reduce the increasing health and social care costs related to long term ill-health and disability.**

What We Said Before and What We are Doing About It

Last year we said that we would continue to work with GPs to improve the uptake of the offer of a free NHS Health Check. The Public Health team continue to work with GPs to improve the quality of delivery of the programme; this work was recognised by Public Health England with a nomination for a national award.

This work has helped embed the NHS Health Check programme as a reliable method of promoting the health of the local population and engaging with people in the community to think about their own health.

The Oxfordshire Clinical Commissioning Group recognise the value of the NHS Health Check programme and are looking to incorporate the programme in their bid to be part of the second

wave of the National Diabetes Prevention programme in 2017. They have also chosen the NHS Health Check programme as an indicator for their quality premium submission with NHS England. **This is all good progress.**

We also said we would continue to market the NHS Health Check programme and raise awareness in the local community. This has been met with some success - in a recent survey the NHS Health Check programme was the most recognised programme of services advertised by the County Council.

In the last year we launched a NHS Health Check results booklet for every person who received a Check. This gave people who received a Check a record of their results with information about services and lifestyles to refer to at their leisure.

Recommendations for NHS Health Checks

The NHS Health Check programme continues to perform well and is well received by the public. However we cannot be complacent and must continue the efforts to improve this programme. This includes:

1. Continue to market the NHS Health Check programme in new and innovative ways to further raise awareness in the local community.
2. Continue to work with GPs to improve the uptake of the offer of a free NHS Health Check, including improving the invitation process.
3. Better identify and engage with high risk groups to take up the offer of a free NHS Health Check.
4. Continue to work with partners to further improve the quality of the programme locally and add to the knowledge base supporting the programme nationally.

Smoking Tobacco

Smoking tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, vascular disease to respiratory diseases and events such as heart attacks and strokes, dementia, rheumatoid arthritis and macular degeneration - the leading cause of sight loss in people aged over 50.

In Oxfordshire the prevalence of adult smokers has seen a continued decline in the past few years. The prevalence of adults who smoke in Oxfordshire is currently estimated to be 14% which is better than the national prevalence (18%). **This is a good result.**

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

Regular smoking in young people in Oxfordshire has also seen a decline over the past years, which is positive. Current estimates are that 5.7% of 15 year olds are regular smokers; similar to the national average of 5.5%.

Stop Smoking Services

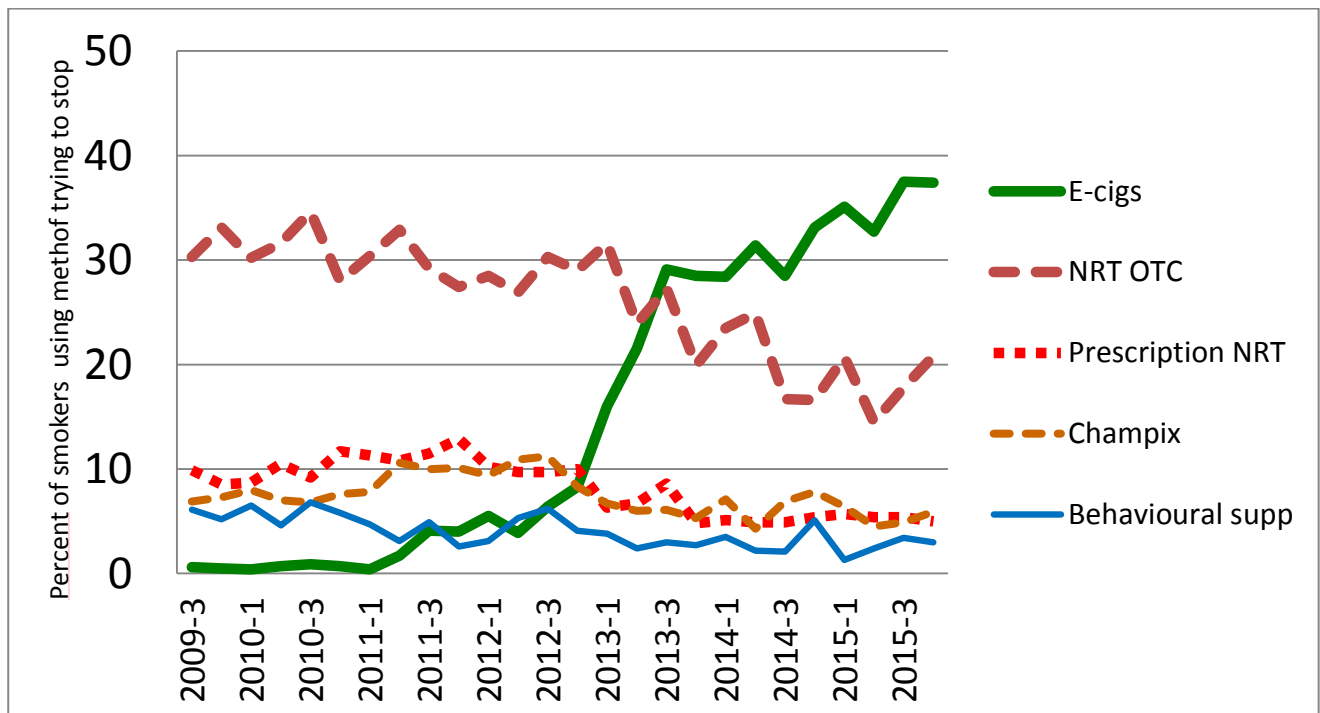
The decline in people accessing traditional stop smoking services seen in recent years continued last year both nationally and locally. The suggestion that the “easier quits” have already been made still holds true and that the challenge is to address the higher levels of smoking in more deprived and hard to reach groups.

The impact of the dramatic increase in use of e-cigarettes in the UK cannot be ignored as a significant contributor to the reduction in people accessing stop smoking services. E-cigarettes are now estimated to be the most common form of quitting aid in the country being used by nearly 40% of people attempting to quit using tobacco.

The use of e-cigarettes as a quit aid and the increasing usage has opened a debate in the public health community on a national and international scale. This has seen an increase in the perception in the wider population that e-cigarettes are as harmful to health as normal cigarettes which is not the case.

The chart below shows the dramatic rise in those using e-cigarettes as a means of quitting tobacco smoking as opposed to those helped by various nicotine replacement gums and patches.

Quit attempts by method of quitting



Different product types used by smokers in most recent quit attempt. In 11,000 adults who smoke and tried to stop or who stopped in the past year; method is coded as any (not exclusive) use.

Source: www.smokinginengland.info/latest-statistics

With the increasing amount of conflicting information for and against e-cigarettes becoming available in the public arena there has naturally been confusion for the public and health professionals alike. In response, **Public Health England published an evidence update which concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking. The report also concluded there is no**

evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers. This is further supported by a report from the Royal College of Physicians publish in April 2016 which states that e-cigarettes are an effective method for people wanting to quit tobacco and the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.

How we should move forward?

- More staff in health care should become 'level 1 quit- advisors' to encourage smokers they encounter to quit smoking no matter what illness they come for help with.
- The Public Health team should continue to work with GPs to engage with their patients to quit smoking.
- All health professionals should target hard to reach groups to explain the dangers of smoking and how to get support to quit.
- We need to maintain a watching brief on the effects of e-cigarettes in line with national guidance from Public Health England.

Recommendations regarding smoking

1. The Health Improvement Board should continue to monitor activities of local smoking services and wider agencies to help people quit smoking and also not start in the first place.
2. The Clinical Commissioning Groups and GP practices should develop services to target hard to reach and priority groups and continue to deliver brief interventions to quit as part of routine consultations.

Alcohol

Alcohol remains a risk to health in our society. The impact can be summarised as follows:

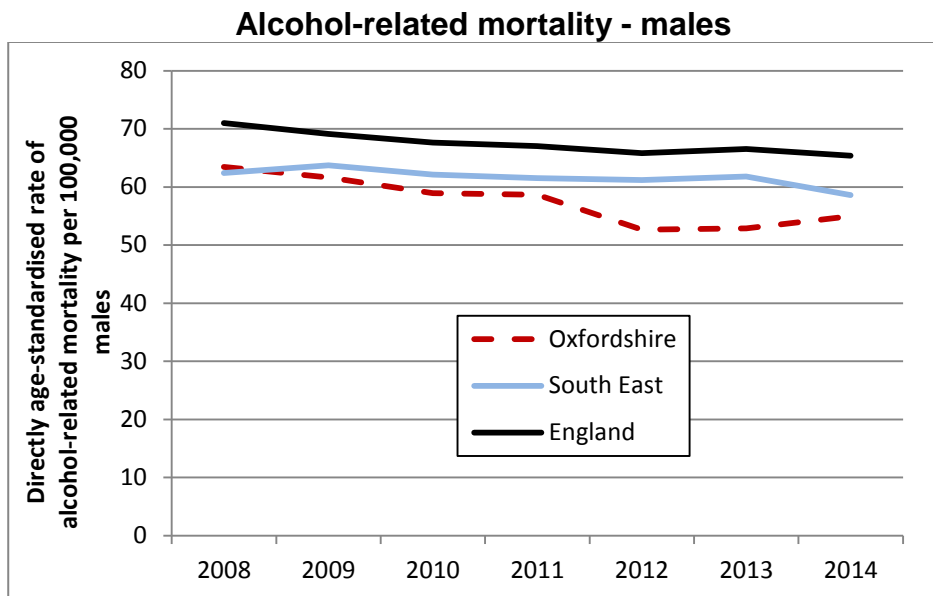
- In the UK there are around 1 million hospital admissions each year related to alcohol consumption.
- There are around 8,000 alcohol-related deaths in the UK each year.
- Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression.
- Males accounted for approximately 65% of all alcohol-related deaths in the UK.
- Alcohol now costs the NHS £3.5bn per year; equal to £120 for every tax payer.
- **The alcohol-related mortality rate of men in the most disadvantaged socio-economic class is 3.5 times higher than for men in the least disadvantaged class, while for women the figure is 5.7 times higher. This is a serious inequality.**
- In England and Wales, 63% of all alcohol-related deaths in 2012 were caused by alcoholic liver disease.

- The number of older people between the ages of 60 and 74 admitted to hospitals in England with mental and behavioural disorders associated with alcohol use has risen by over 150% in the past ten years, while the figure for 15-59 years old has increased by 94%.
- There is no absolutely safe drinking level – the Chief Medical Officer has warned that any alcohol consumption increases the risk of cancer.

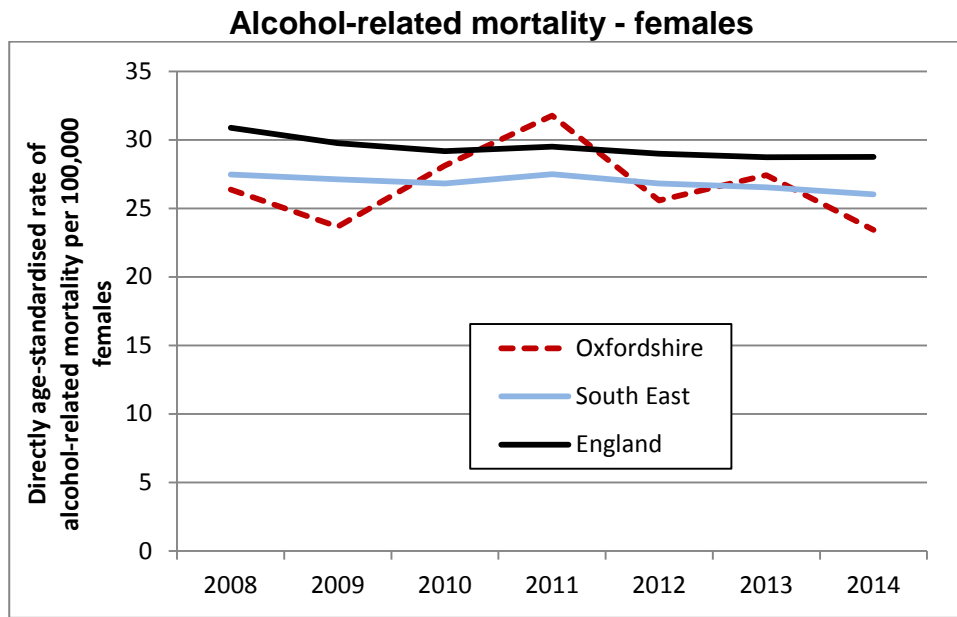
What has happened in the last year?

A review of the data presented in the Alcohol and Drugs Strategy has been carried out and the following conclusions have been drawn:

1. In 2014 there were an estimated 7,900 **deaths related to alcohol use** in England. The trends for both men and women are shown in the 2 charts below



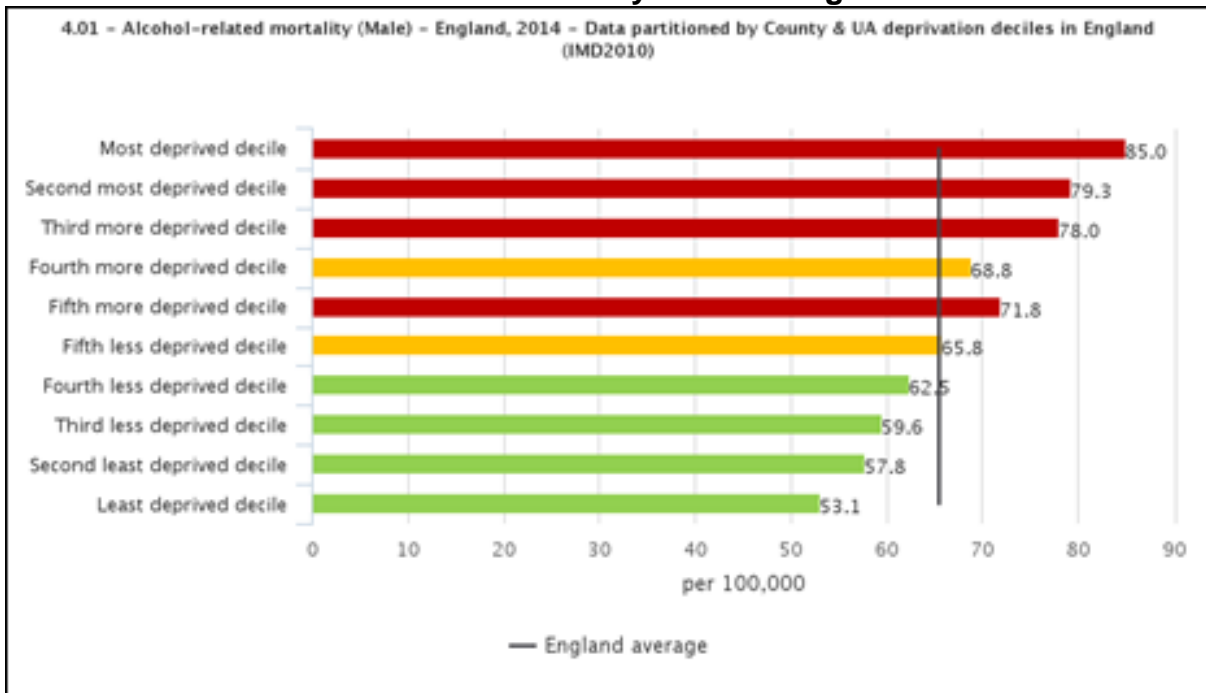
Alcohol-related mortality (males and females) - Deaths from alcohol-related conditions, all ages, directly age-standardised rate per 100,000 population (standardised to the European standard population).



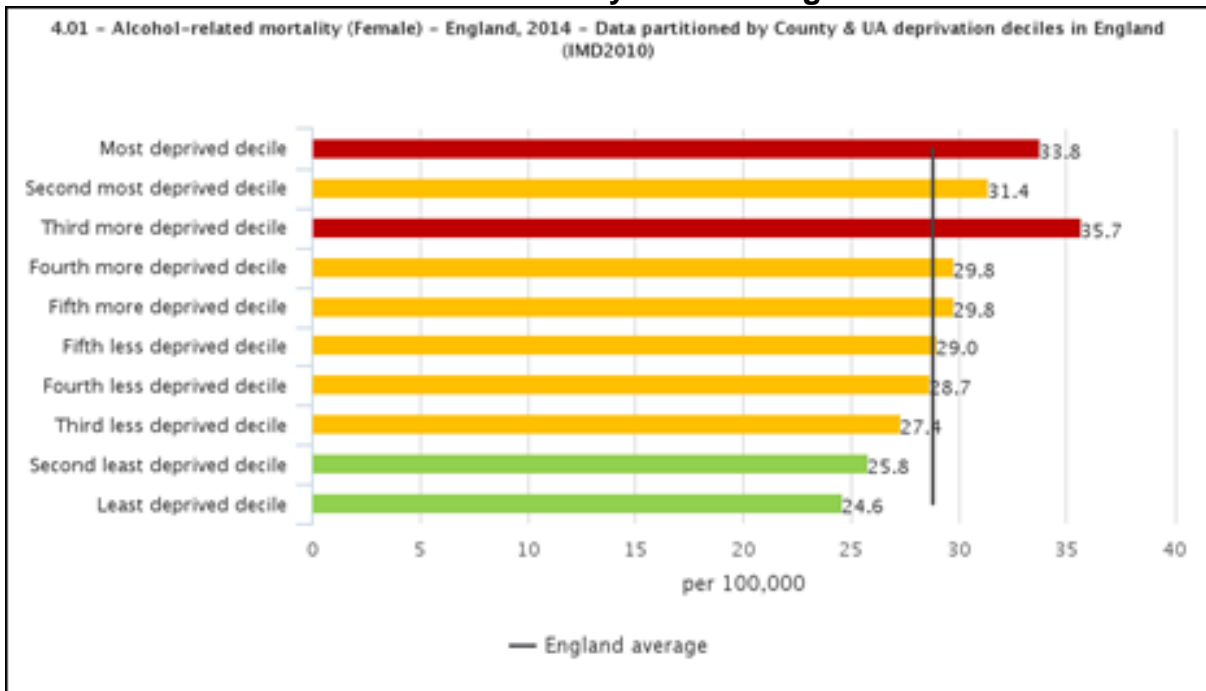
The charts show that:

- Deaths related to alcohol are gradually falling across the board overall.
 - Deaths in Oxfordshire are lower than national levels.
 - Deaths in females are around half those of men.
 - Male deaths in Oxfordshire rose slightly according to the latest figures and female deaths fell.
2. **Alcohol-related mortality by socio-economic class** is not analysed at a local level, but new figures have been published at national level. The charts below show the alcohol related deaths split for England by most/least disadvantaged groups. The chart for men shows a greater difference between the best and worst off than for women. The most disadvantaged tenth of the population are shown at the tops of the chart and the least disadvantaged at the bottom.

Alcohol related deaths by disadvantage - men



Alcohol related deaths by disadvantage - women

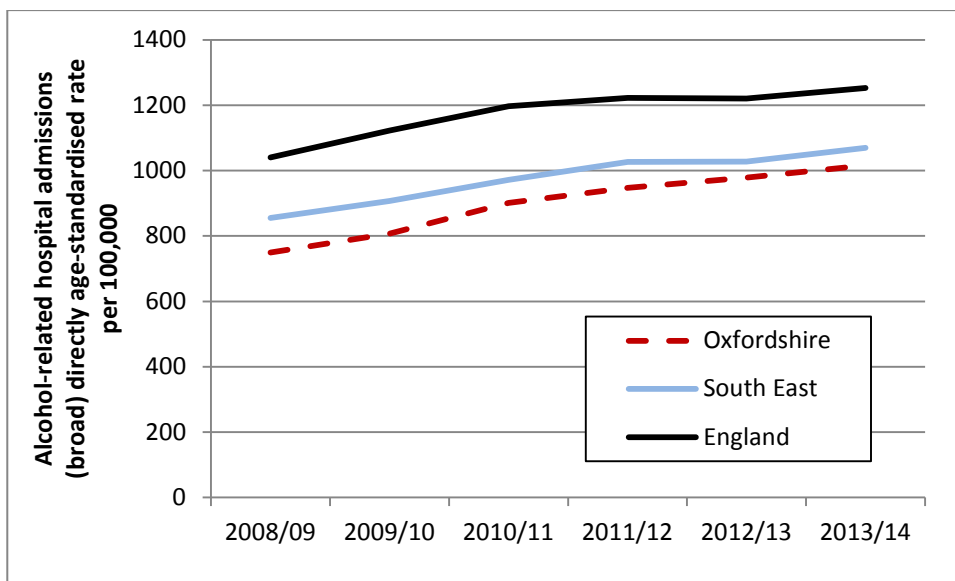


The charts show that:

- There is a strong inequality in deaths related to alcohol.
- In men death rates in the most disadvantaged 1/10 of the population reach 85 per 100,000 and in the least disadvantaged 53 per 100,000.
- In women, death rates in the most disadvantaged 1/10 of the population reach 34 per 100,000 and in the least disadvantaged 25 per 100,000.
- The pattern is stronger and the inequality greater in males than in females

3. Death rates may be gradually falling, but, In 2013/14 there was a continuing upward trend for **alcohol-related hospital admissions** in England. (almost a 4 % increase on the previous year) The annual increase was greater for women (+5%) than men (+3%) **and it remains the case that rate of admissions in the most disadvantaged is 77% higher than rate in least disadvantaged areas.**

Alcohol related hospital admissions



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

The recommendation focussed on giving people information so that they could make their own decisions about their drinking (particularly about binge drinking) rather than nannying them.

A summary of the work of the Alcohol and Drugs Partnership summarises the actions taken:

- Provision of Identification and Brief Advice (IBA) training for front-line staff and professionals across Oxfordshire.
- The promotion of the Dry January campaign targeting middle aged women.
- A major Alcohol Conference for professionals with presentations from a wide range of specialists.
- Exploring test purchasing initiatives with Thames Valley Police to target excessive intoxication in the night time economy.
- Work with the local hospitals to improve referral pathways for young people into support services.

Achievements in 2015-16

a) Identification of people drinking at high levels and giving them 'Brief Advice'

Training in how to identify opportunities to talk to people about their drinking and offer relevant brief advice is an effective evidence-based intervention. This can be delivered by a range of professionals in the health service and other settings. Six training sessions were commissioned by the County Council's Public Health team in the last year. The training was offered in locations across the County and has been well attended by a range of professionals.

In addition a 'Train the Trainers' session was provided to Oxfordshire Fire and Rescue Service. This was a bespoke session combining 'giving brief advice' for alcohol and helping people to quit smoking. The session was also very well received.

b) An Alcohol Conference was held to get the facts more widely known

The County Council held a highly successful Alcohol conference in December 2015, with over 140 delegates attending. The day included a number of guest speakers, including a keynote address from Professor Kevin Fenton, the National Director for Health and Wellbeing at Public Health England.

Participants came from a wide range of Council departments, partner organisations and local services including Community and Residential Treatment Services, Housing services and services for the homeless, Oxford University Hospitals Trust, Oxford Health NHS Foundation Trust, Medical Centres and GP Surgeries, Pharmacies, Thames Valley Police, Oxford Brookes University, Community Dental Services, Public Health England, Mental Health services and charities, Oxfordshire Domestic Abuse Service, Oxford Jobcentre Plus and criminal justice services.

The conference was very well received with 90% of those who filled in the evaluation questionnaire stating that they found the event to be relevant to their learning needs, and 93% felt it increased their knowledge and understanding of alcohol use and the associated risks.

c) Alcohol workers in a hospital setting

Public Health commissioners are working in partnership with Oxfordshire Clinical Commissioning Group (OCCG) to boost hospital-based early intervention and advice.

d) Campaigns

The focus of the 'Dry January' campaign this year was on women, particularly those aged 35 and over and who may be drinking regularly at home. The campaign was conducted on social media, Healthy Oxon Facebook and Twitter channels and through radio. The campaign promoted the health benefits of taking part in Dry January and then continuing to have 2 alcohol free days a week. The campaign also promoted use of the DrinkAware App to record drinking, and sign up for Dry January to go 'booze free for 31 days'.

Recommendations

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

Oral Health

Tooth decay has been falling over the last half century, largely due to better brushing with fluoride toothpastes and more awareness of oral health in general. This is a welcome continued trend.

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

The picture in children

The latest available data from the 2015 oral health survey of five year old children shows that 77% of 5 year old children in Oxfordshire are now free from any dental decay which is higher than the national average of 75% and improved locally from 67% since the 2012 survey. Whilst this is encouraging there is room for improvement - the number of children who are decay free is significantly lower in Oxford than the other districts at 67%.

The major sources of the sugar which causes decay in children are found in soft drinks and cereals. The announcement of a levy on sugary drinks is a positive step in reducing sugar intake. However, locally we will need to continue to work to educate children and parents about the impact of diet choices on their teeth and wider health.

The picture in adults

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

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

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

Last year's recommendations focussed on the need to monitor closely a new oral health promotion service commissioned by the County Council which completed its first year of operation on 31st March 2016. This service has in collaboration with wider dental services aimed to prevent oral health problems in children and adults.

The new service has achieved the following:

- Setting up an accreditation scheme for pre-school settings for 26 locations to help young children with oral hygiene
- Training 40 school health nurses in oral health promotion to promote a 'whole-school' approach to oral health in education, such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting evidence-based, age-appropriate, oral health information for parents, carers and children, including details on how to access local dental services.
- Delivering 106 oral health promotion sessions and events in the community.
- Training 38 people who work with young children in oral health to better understand the causes of decay, how to look after your teeth and signposting to local dental services
- Training 117 people who work in the community with adults to promote oral health including understanding the causes of poor oral health in adults, how to maintain good oral health and how to access local dental services.
- Delivering oral health promotion in local workplaces including BMW, Siemens, The John Radcliffe Hospital and in Oxfordshire County Council
- Carrying out promotional events during National Smile Month and National Mouth Cancer Awareness Month.
- Establishing a lending service of health promotion resources for use by local services.

Recommendations for oral health

1. The NHS should ensure that improvements in access to NHS dentistry are maintained including complex care for older people.
2. Providers of care home facilities should be aware of maintaining good oral health in their clients which can significantly affect their quality of life. They should also ensure that their clients have access to dental services to help maintain a pain free mouth.
3. Work should continue with school health nurse and health visitor services to embed oral health promotion into children's health from 0-19, to give a healthier start to life.

Chapter 5: Mental Health

Main messages in this chapter:

- **The demand for young peoples' mental health services is rising.**
- **New services have been put in place and these need to be monitored carefully.**
- **Levels of self-harm in young people appear to be rising and require careful monitoring.**
- **Mental health conditions should not be seen as distinct from physical conditions.**

This year I want to report on two aspect of mental health I have not reported on before that are a cause for concern. These are:

Mental Health in Young People and Self Harm.

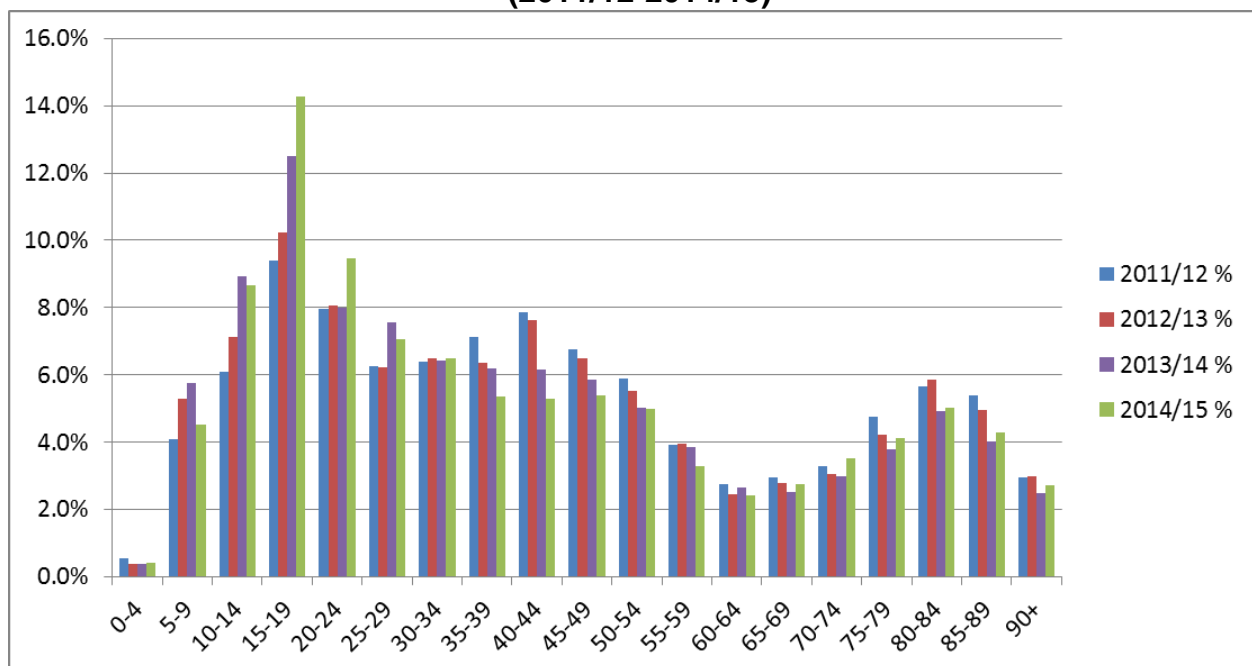
I will discuss each in turn.

Children and Young People's Mental Health

The chart below records the number of mental health referrals by age group to our local services, and two facts leap out:

- 1) The highest number of referrals is in teenagers
- 2) The number is steadily growing, particularly for young people aged 15 to 19.

Oxford Health mental health referrals for Oxfordshire residents, % in each age band (2011/12-2014/15)



Why should this be?

The first question to answer is:

What are emotional disorders in children and young people and why are referrals for treatment going up?

This is not an easy subject. Emotional disorders in adults are difficult enough to define and count. In children the situation is more difficult because:

- Childhood and adolescence covers a wide range of different stages that can't be grouped easily.
- Disorders and treatments vary greatly with age. The whole topic is tangled up with the overall development of the individual.
- Mental health problems don't always express themselves in the same way as in mature adults. Underlying problems can show themselves through changes in behaviour, changes in mood or changes in activity level – or mixtures of them all.
- To some extent, society creates and modifies the categories of what is deemed to be a disease and these vary over time.
- What may have been dismissed as poor or unusual behaviour in the past is now recognised as an emotional disorder.

To some extent the rise in referrals is a positive development – we want to encourage young people to come forward to talk about problems at an early stage as this gives better outcomes in the long term.

In her 2013 Annual Report the Chief Medical Officer concluded that there was in fact an increase in emotional problems in young people. The possible reasons are unclear, and may or may not be connected to the new pressures young people face as they are the products of a digital world. New stresses may be present in social media, such as cyber-bullying. Also the digital world is 24/7 – there is no respite unless it is self-imposed.

What is the local picture?

Teenagers' mental wellbeing

The recent 'What About YOUth' survey found that a majority of children aged 15 in England reported having high or very high life satisfaction. On average, boys reported higher life satisfaction than girls. Young people from Black and Minority Ethnic (BME) backgrounds reported lower levels of life satisfaction than those from a White background. Poorer life satisfaction was also seen among young people who were living in more disadvantaged areas, who were in worse health, or who had experienced bullying.

The same study showed that mental wellbeing among children aged 15 in England was better among those who were:

- living in less deprived areas
- had a more positive perception of their body-image
- had high life satisfaction
- were in better health
- consumed more fruit and vegetables
- exercised more

What builds psychological resilience in Children and Young People?

The Chief Medical officer quotes the following list of factors which build resilience in young people and so helps them withstand the stresses and strains of modern life. These are:

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

In contrast, when these factors are deficient, the individual's resilience is likely to be lowered.

Mental health problems in Children and Young People

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

Most serious and enduring mental health problems emerge during this time, and if detected and treated early, outcomes are improved. There is evidence that dealing with anxiety and depression effectively the first time it occurs in young people, helps to prevent recurrence and the likelihood of them suffering mental health problems in later life.

The most disadvantaged communities have the poorest mental and physical health and wellbeing. **Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%.** Parental unemployment is also associated with a two- to three-fold greater risk of emotional or conduct disorder in childhood.

Looked After Children (LAC) experience significantly worse mental health than their peers, and a high proportion experience poor health, educational and social outcomes after leaving care. It is estimated that between 45 and 60% of Looked After Children aged 5 to 17 have mental health difficulties: over four times higher than the average.

Approximately 40% of young people who have a learning disability may also have a mental health disorder. The mean percentage of disabled children in English local authorities has been estimated to be between 3% and 5.4%. If applied to the population of Oxfordshire this would equate to between 3,946 and 7,102 children experiencing some form of disability.

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

What is the local picture and what are we doing about it?

Children and young people's mental health services have been under pressure for some time. Local services work with around 3,500 young people at any one time, with more than 5000 referrals every year, the majority of whom are aged 10-15 years old.

Analysis of the data is hampered by the lack of standardised reporting systems, and so performance cannot be readily compare from place to place.

The CQC rated local services as good, but they were nonetheless creaking as evidenced by increases in waiting times – and so a review was undertaken in 2015 which made a range of recommendations, the thrust of which was:

- To involve young people in service design.
- To reduce waiting times.
- To use online and self-help tools.
- To catch disease earlier in a school setting, teaming mental health support workers with our school health nurses.
- To train frontline services to identify symptoms and provide direct help or make more accurate referrals.
- To improve the service offer to Looked After Children and 'children on the edge of care'.

What progress has it made and is it working?

The new service has now been launched. It is too early to judge whether it has improved matters. This is more difficult to judge than normal, because we aren't trying to reduce referrals per se, we are trying to help more young people in more effective ways using new technology and through strengthened partnerships between professionals. The key changes that aim to make a difference include:

- A dedicated specialist Eating Disorder Service.
- A new therapeutic team specifically working with young victims of child abuse and Child Sexual Exploitation.
- Dedicated workers in every secondary school working with School Health Nurses to provide support, training and direct interventions.
- A new team to work with children who are Looked After and those young people who are on 'the edge of the care'.

Recommendation for Children and Young People's Mental Health

This is an important issue. Progress made by the new service should be reported on in the next Director of Public Annual Report.

Self-harm

Self-harm is defined as *'intentional self-poisoning or self-injury, irrespective of type of motivation or intent'*. Self-harming behaviour in England has increased in recent years with an increased number of young people needing hospital admissions as a result of injury or poisoning. Relationship issues are often cited as a main contributing factor in self-harming behaviour.

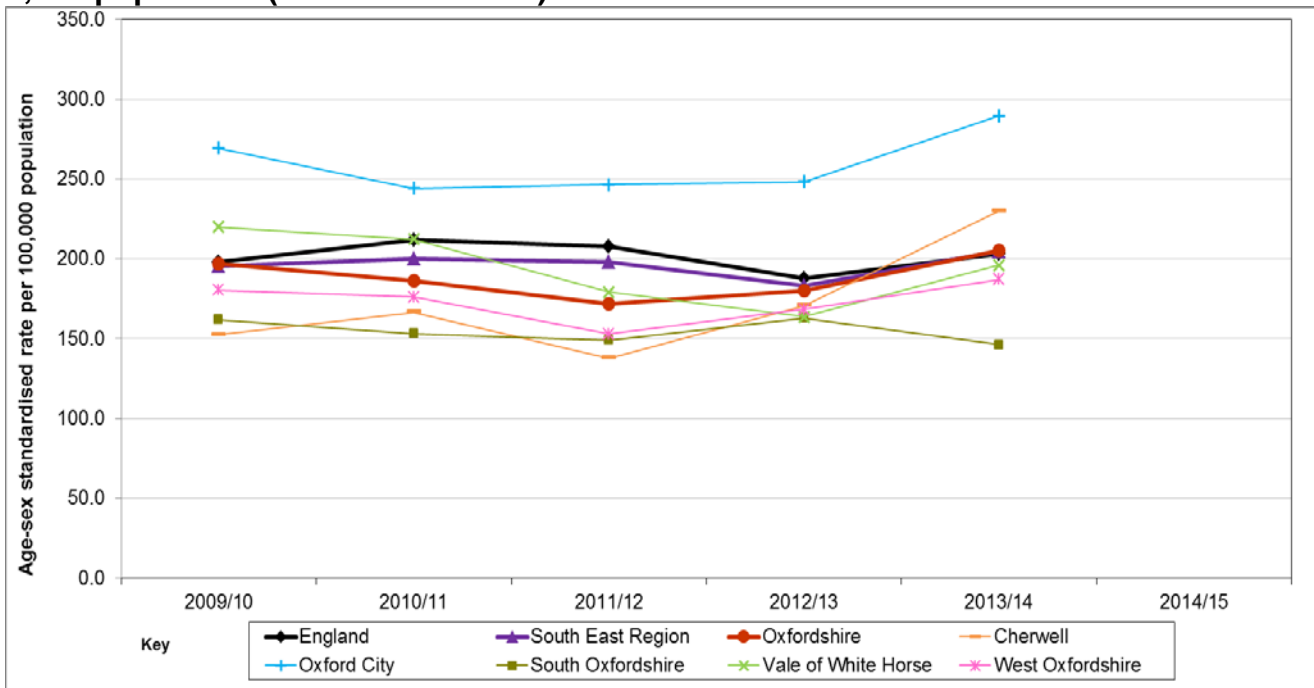
The rates for self-harm in all ages in Oxfordshire give us an idea of the local trends. During 2013/14 the number of emergency hospital admissions for intentional self-harm in Oxfordshire was 1,421. The rate of hospital admissions for intentional self-harm is rising in Oxfordshire, similarly to the regional and national picture.

However, looking at longer term trends in self-harm shows that overall rates in those aged 15 and over have fallen overall since 2000 but have risen in recent years.

The peak ages for self-harm are 15 to 24 in females and 20 to 29 in males.

The data in the chart below looks at hospital admissions for self-harm and covers all age groups. It will not include patients who attended Accident and Emergency (A&E) or Minor Injury Unit (MIU) or who were not admitted to hospital; it is likely to be an underestimate of the true rate of self-harm in our population.

Age/ sex-standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population (2009/10 - 2013/14)



Source: Local Authority Health Profiles

The chart shows that:

- Oxfordshire's rate is broadly in line with the national rate and rose with it during 2013/14.
- The overall trend is however fairly static from 2009/10 to 2013/14.

- Admission rates are higher in Oxford City than elsewhere in the County, other Districts are on average just below the national levels.

Young people who self-harm are more likely to be vulnerable such as being a Looked After child or in the youth justice system. Those who self-harm have an increased risk of death by subsequent suicide, and over half of people who die by suicide have self-harmed previously. A survey of young people and professionals found that self-harm was a topic that was least likely to be addressed due to fear of stigmatisation and not having adequate confidence in how to access support services. Furthermore, these young people felt that the issue of self-harm should be addressed within school and an open dialogue should be sought.

Report of a local County Council initiative

An initiative was launched by the County Council in 2015 to try to help the situation based on our knowledge that:

- efforts to raise awareness of self-harm and how to access support in adolescents may contribute to improved overall wellbeing and reduce the risk of suicide
- Approaches using theatre as a form of raising awareness and reducing stigma of mental health issues have been successful previously.
- Within Oxfordshire, rates of admissions to hospital for unintentional and deliberate injuries in 0-14 year olds and 15-24 year olds, is higher than the national average.
- Local surveillance using data from Oxford University Hospital Trust identified that during 2014 there were monthly increases in the numbers of admissions to hospital for self-harm in both female and male young people from homes across the county.

What did we do?

The County Council's Public Health team commissioned a local Oxfordshire theatre company, Pegasus, to perform a play on self-harm in secondary schools across the county. This involved interviewing young people who had self-harmed as well as working in partnership with Schools, School Health Nurses, Educational Psychologists and Child and Adolescent Mental Health Services.

The play was called 'Under My Skin'. Its aims were to:

- Give young people vital information about coping with feelings around self-harm, stress and the relevant services that can support them.
- Reduce the stigma of discussing self-harm and accessing support
- Highlight the School Health Nursing service as a first port of call in schools for young people and professionals who have concerns over self-harm.
- Give professionals information and subsequent confidence about how to support a young person, and who to refer onto.

The evaluation of the play showed that:

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

As a result, we will commission the play again for the academic year 2016/2017.

Recommendations for self-harm

1. Self-harm is a serious issue. Self-harm levels in Oxfordshire should be closely monitored.
2. The new Child and Adolescent Mental Health Service should work with partners to improve the detection of self-harm and offer coordinated support to young people.

What we said last year and what has happened since?

Last year's report described a range of improvements planned for mental health services as a whole, called for close monitoring of a newly-let contract for adult services and recommended that the Health Overview and Scrutiny Committee and Healthwatch keep a close eye on the quality of services.

This has been achieved, and the Clinical Commissioning Group is about to bring forward new plans to improve mental health services further and to join up services for physical and mental health more closely.

These are welcome developments which again call for continued surveillance.

Recommendation

Future Director of Public Health Annual reports should continue to focus on mental health issues and mental health services in the county.

Chapter 6: Fighting Killer Diseases

Main messages for this chapter:

- **We need to make sure our specialist services for fighting major outbreaks of disease such as Ebola stays strong and resilient.**
- **Infectious diseases do not go away. They simply change and return in new guises. Constant vigilance is needed to stay ahead of the curve. Good teamwork and cooperation across organisations is essential.**
- **The threat of antibiotic resistance is real and everyone has a role to play**

Part 1. Epidemics: Ebola, Flu Pandemics and Antibiotic Stewardship

Never had it so good?

We are fortunate to live in times where major illness and large numbers of deaths due to communicable diseases are seen as a problem in poor and developing countries far away or something suffered by our ancestors.

This has been a fortunate consequence of improvements in the quality of our living conditions and the advances in modern medicine. However we cannot be complacent about the risks of this changing and the risk of a pandemic and drug resistant bacteria becoming a very real issue.

Most of us live our daily lives unaware of the continued surveillance and planning of many national and local organisations that protect us. The recent Ebola outbreak in Africa was a reminder to everyone how new dangers can arise at any time and present a very real risk to the planet as a whole. Many lessons were learnt from this event nationally and internationally to help us prepare for the next outbreak, wherever it may arise.

This means we need to continue to prioritise the work we do in the background day in, day out, to prepare for the worst while hoping for the best. Directors of Public Health work closely with Public Health England and the NHS across the Thames Valley to make sure that our response is up to the mark. Oxfordshire County Council has the lead role for all Councils in the Thames Valley for making sure this is done.

As I stated last year the right response isn't fear and panic, it is systematic and calm planning and organising ourselves NOW so that we can fight back when the need arises. This is still the case and we still need to remain vigilant.

We have been fortunate in the past few years that the **influenza** seasons have been relatively mild. However it is important that we do not forget the potential that flu has to cause serious illness and death in young children, old people and those with poor health. Since the flu pandemic in 2009 we have seen a year on year decline in the numbers of people getting a flu vaccine. To protect these groups from flu it is still important that people understand that the risk of flu has not gone away and that it is important for people at risk to get a flu vaccination every year.

Another cause for concern is the rising threat of **antibiotic resistance** and the rise of “superbugs”. Antibiotics are important drugs for both humans and animals in fighting bacterial infections which were once life threatening. Bacteria are highly adaptable in responding to antibiotics. Widespread misuse of antibiotics and inappropriate prescribing has led to increasing numbers of bacteria which are resistant to antibiotics which used to be effective.

The risk of bacteria which cannot be treated by antibiotics of any kind is a very real and pending threat not only in the UK but throughout the world. This has been brought into sharp focus by the recent development of a resistant strain of Gonorrhoea which is spreading in small clusters in England. Whilst this strain has not been reported yet in Oxfordshire it is could do so in the future.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections.

How Do We Keep This Work Going?

Success depends on several key elements:

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

The key is to keep the specialist workforce we have now and to nurture this work carefully.

Part 2. Infectious and Communicable Diseases

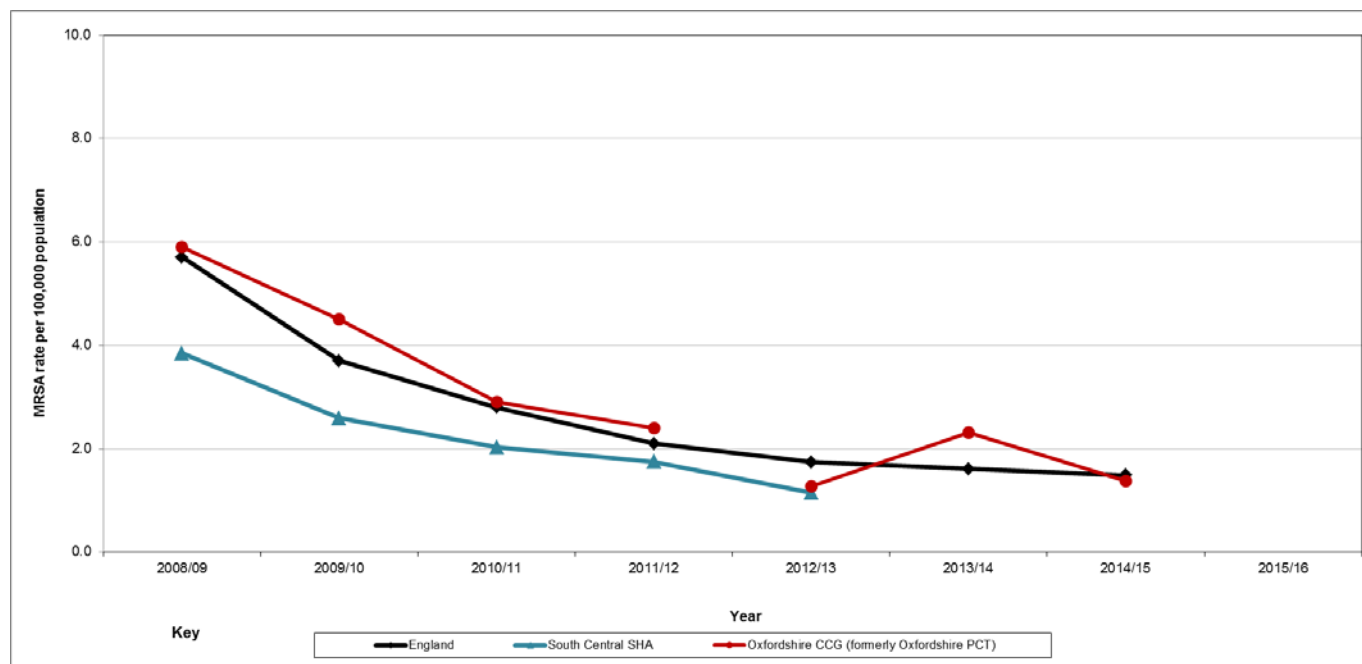
Health Care Associated Infections (HCAIs)

Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.diff.) remain an important cause of sickness and death, both in hospitals and in the community. While these infections do not grab headlines as much as they used to it is vital that everyone remains vigilant to limit the increase of these infections.

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through invasive procedures or chronic wounds) it can cause blood poisoning (bacteraemia). It can be difficult to treat in people who are already very unwell so we continue to look for the causes of the infection and to identify measures to further reduce our numbers. MRSA has fallen gradually in Oxfordshire in response to the direct measures taken by hospital and community services to combat it. The local situation is shown below.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 – 2014/15) England, South Central SHA and Oxfordshire



This shows that infectious diseases can be tackled, often by traditional hygiene measures. Nationally there is a zero tolerance policy and rate of MRSA is still higher than we would like. There have been improvements in the rate of MRSA in Oxfordshire over the past few years. While the levels in Oxfordshire had increased slightly in 2013/14 to be higher than the average for Thames Valley and England they have reduced to be similar to National levels in 2014/15. The recent slight increase reaffirms that continued vigilance is required by all hospital and community services to address this increase.

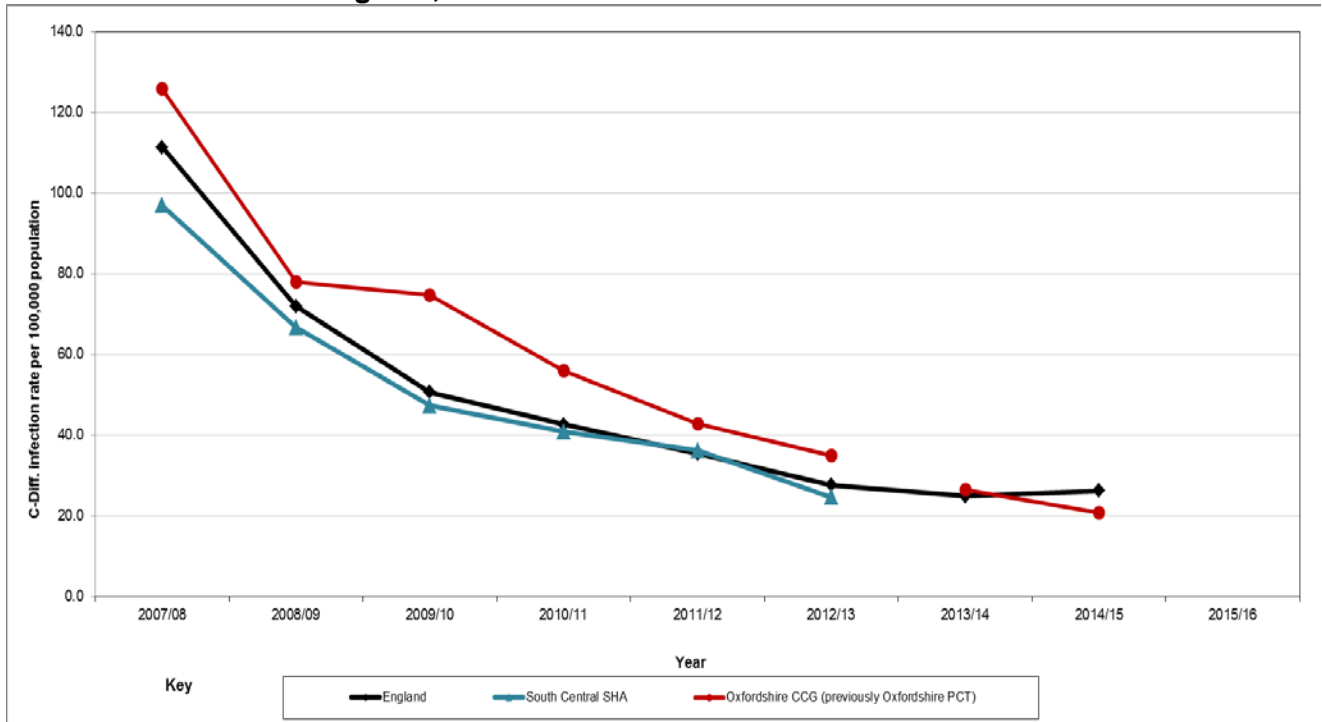
Clostridium difficile (C.diff)

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

A focussed approach on the prevention of this infection is resulting in a steady reduction in cases since 2007/08 as shown in the chart below. This is in line with regional and national trends. There has been a continued improvement in the rates of C.diff in Oxfordshire.

The reduction in C.diff involves the coordinated efforts of healthcare organisations to identify and treat individuals infected and also careful use of the prescribing of certain antibiotics in the wider community. There are still on-going concerted efforts locally to continue to improve the rate of C.diff infections.

**Clostridium Difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2014/15)
England, South Central SHA and Oxfordshire PCT**

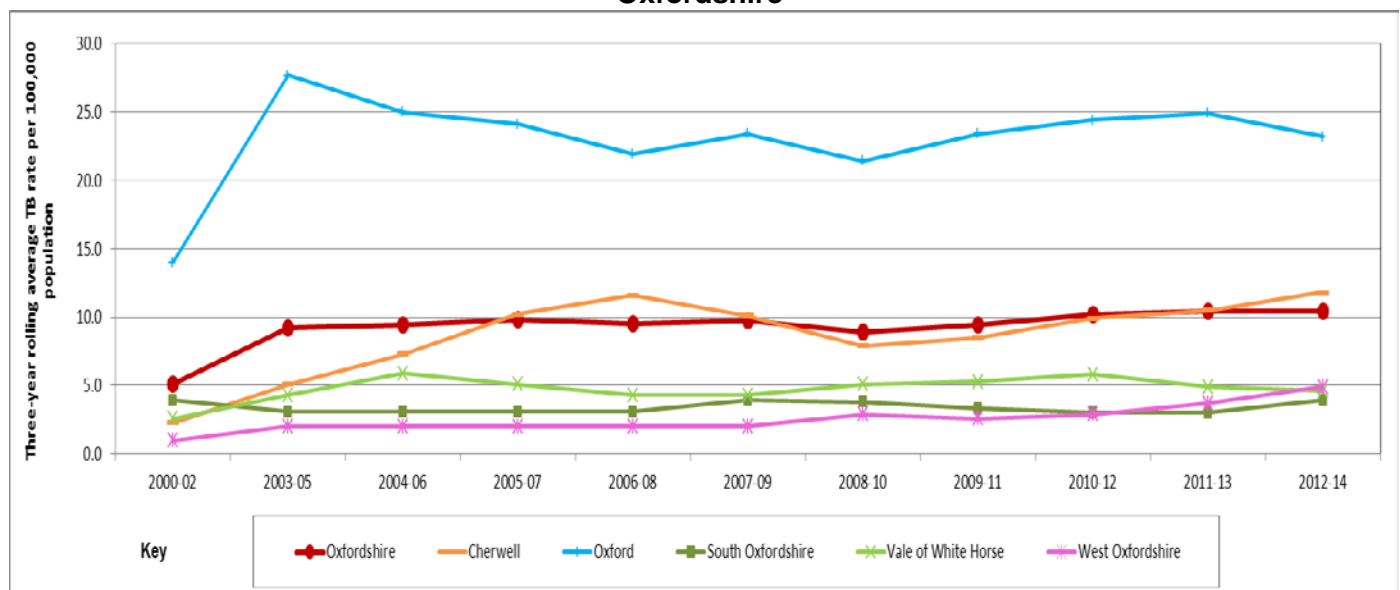


Tuberculosis (TB) in Oxfordshire

TB is a bacterial infection caused by Mycobacterium Tuberculosis which mainly affects the lungs but which can spread to many other parts of the body including the bones and nervous system. If it is not treated, an active TB infection can be fatal.

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

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



The levels of TB in the UK have been relatively stable over the past years. Much effort has gone into improving TB prevention, treatment and control.

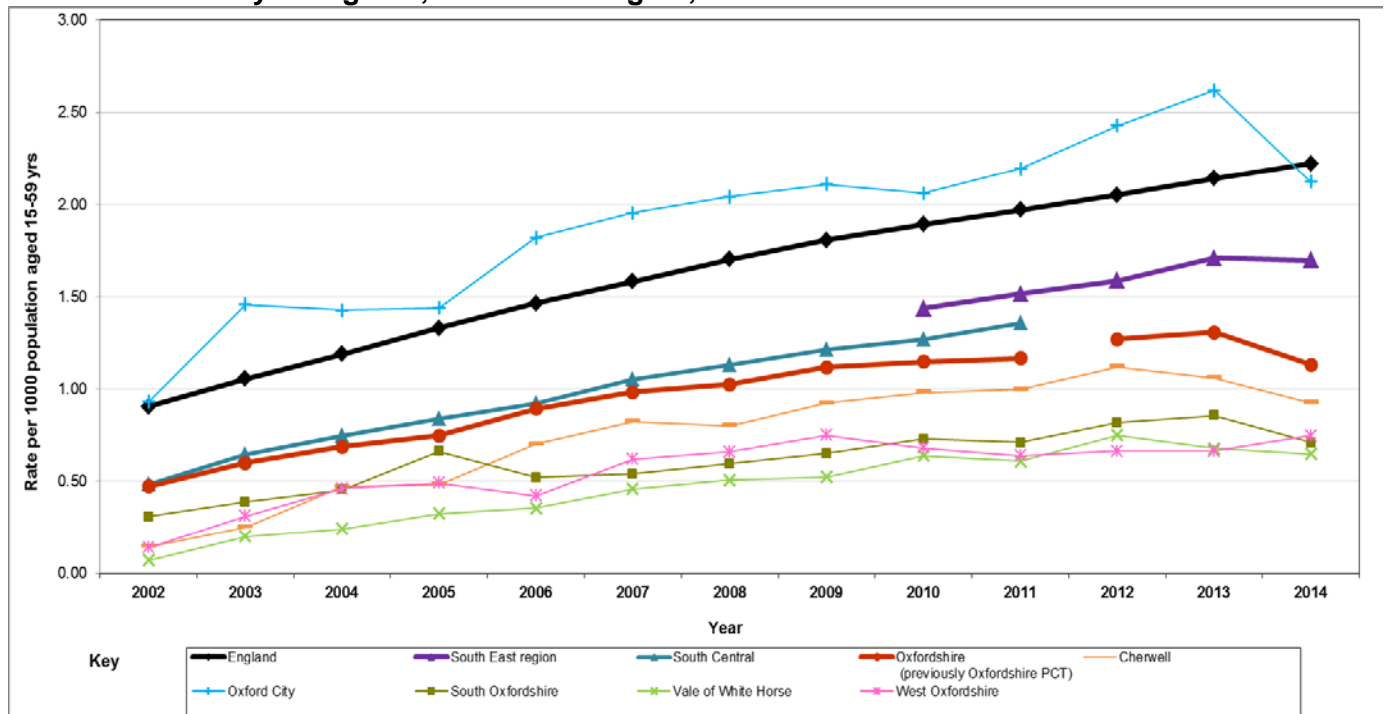
The rate of TB in Oxfordshire is lower than the National average and levels in Oxfordshire, Buckinghamshire and Berkshire combined. In the UK the majority of cases occur in urban areas amongst young adults, those coming in from countries with high TB levels and those with a social risk of TB. This is reflected in the higher rate of TB in Oxford compared to other Districts in the county.

Public Health England has developed a TB strategy to address TB nationally. TB control boards have been established to look at regional levels of TB and services to provide treatment. In Oxford the Clinical Commissioning Group are implementing a latent TB screening programme as part of a national initiative to identify and treat new entrants from high TB prevalence countries.

**Sexually transmitted infections
HIV & AIDS**

Whilst HIV does not raise the public alarm it used to, it still remains a significant disease both nationally and locally. HIV is now a long term condition so we would expect there to be more people living with HIV long term. 2014 data shows that there are 457 people diagnosed with the infection living in Oxfordshire, 231 out of 457 live in Oxford City. This trend is shown in the chart below and shows a decrease over the last year across the County.

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



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

- Providing accessible testing for the local population. In 2014/15 the sexual health service delivered 4,251 HIV tests across the service.
- Through community testing, we have 'HIV rapid testing' in a pharmacy as an initial step. This test gives people an indication as to whether they require a full test; the rapid test takes 20 minutes and gives fast results, although a fast tracking to the sexual health service for a full test is required to confirm diagnosis.
- Prevention and awareness. Educating the local population about safe sexual practices and regular testing in high risk groups.

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

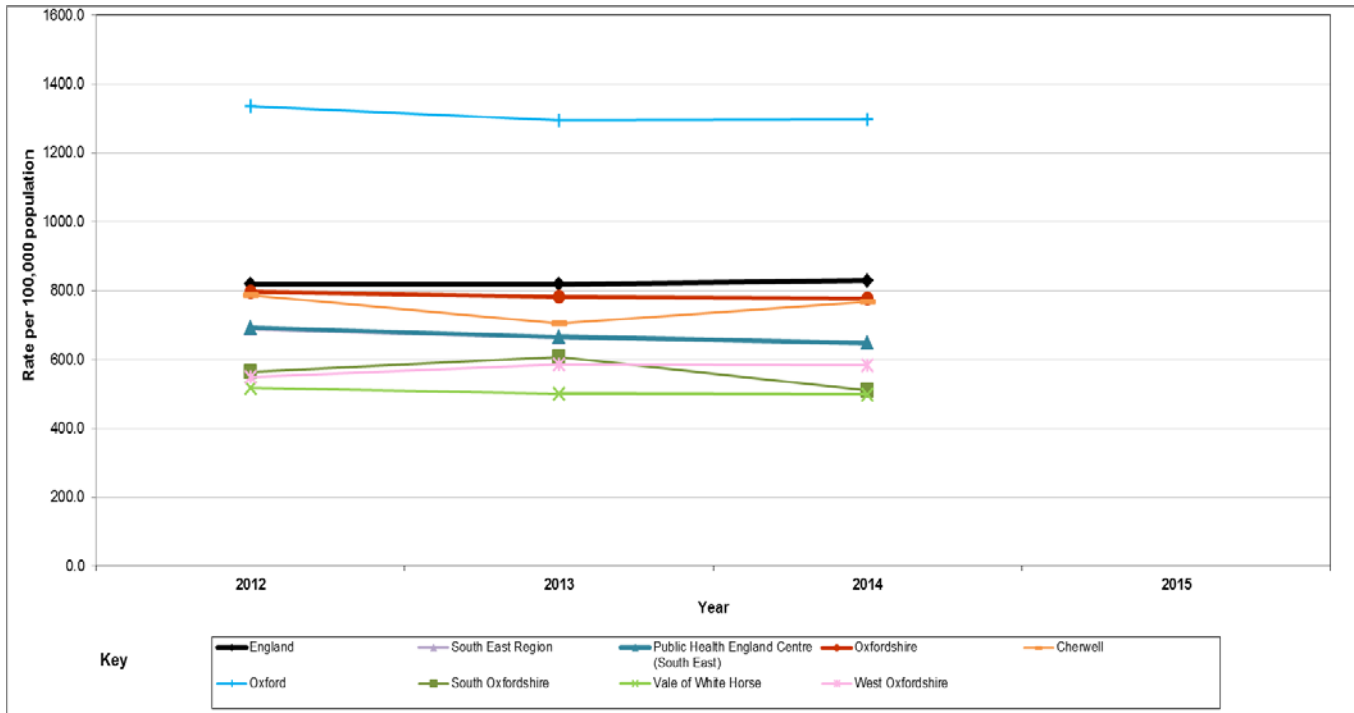
Sexual Health

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

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

- Gonorrhoea – is below national average for Oxfordshire as a whole and all districts except in Oxford City. An investigation of recent increases revealed that an apparent increase was a consequence of oversensitive tests resulting in false positive diagnoses. New methods of validation should reduce the number of false positive cases.
- Syphilis - is continuing to fall and is below national average in all areas of the County.
- Chlamydia –levels are lower than national average in all Districts – but we continue to have difficulties in persuading young people to come forward for testing despite, best efforts.
- Genital Warts – rates are now lower than the national average which is an improvement. Oxford City is significantly higher (reflecting the younger age group) but the trend is generally stable. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.
- Genital Herpes – rates are lower than national average except in the City which has higher levels. However the total number of cases in the year is small. Again this reflects the predominantly younger population in the City.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2014
England, South East Region, PHE South East Centre, Oxfordshire and districts within Oxfordshire



The integrated sexual health service which began in 2014 has seen increasing activity levels and this is to be welcomed. This service has improved access to contraceptive and sexual health services at the same time.

In the first year of operation, the sexual health service delivered

- 28,283 Genito-Urinary Medicine consultations
- Provided 19,059 tests for STIs and HIV
- Positively identified 2,215 STI and HIV infections
- Provided 15,888 consultations for family planning
- Fitted 9,809 contraceptive devices
- Prescribed 897 Emergency Hormone Contraceptives

The service has successfully established itself in the community as a range of accessible locations across the county where the local population can access all their sexual health services in the one location.

In line with best practice a partnership of local stakeholders was established in February of 2015. This group still continues to work together to identify and address priorities locally to further improve on the decline in STIs in Oxfordshire.

Recommendation

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