DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT II

Reporting on 2007-2008

Recommendations for 2008-2009

SUMMARY

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

The aims are simple:
1. To report on progress made in the last year and set out challenges for the next year
2. To continue to galvanise action on five main threats to the future health, wellbeing and prosperity of Oxfordshire

The five main long-term threats are:
- Breaking the cycle of deprivation
- An ageing population – the "demographic time bomb"
- Mental health and wellbeing: avoiding a Cinderella service (newly added this year)
- Preventing obesity: a major cause of chronic disease
- Fighting killer infections

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

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

I hope you enjoy the report and act upon it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire
March 2008

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INTRODUCTION

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

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

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

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

Eighteen months ago a Director of Public Health was appointed by local government and the NHS for the first time in thirty years. A first Annual Report was produced and was generously received by a wide range of audiences. This report attempts to build on that momentum.

What is the thrust of this particular Annual Report?

This report aims to keep the main threats to the public health firmly in the spotlight as action will need to be taken over the next ten or twenty years to meet these challenges.

The aims are:

1. To report on progress made in the last year and set out challenges for the next year
2. To continue to galvanise action on five main threats to the future health, wellbeing and prosperity of Oxfordshire – mental health has been added this year.

The thrust of the report is to recommend and encourage consistent and concerted action by a wide range of organisations working closely across Oxfordshire to tackle five main challenges: without this we will not succeed.

These issues will be returned to and reported year by year, to maintain direction and continuity and so lead to an improvement in the public's health.

The five main challenges are:

- Breaking the cycle of deprivation
- An ageing population – the "demographic time bomb"
- Mental health and wellbeing: avoiding a Cinderella service)
- Preventing obesity: a major cause of chronic disease
- Fighting killer infections

Public Health – everyone's business

Good health and wellbeing are not created in a vacuum. Good health is closely related to a wide range of factors such as employment, quality of neighbourhoods, a feeling of purposefulness and having a part to play in society. These factors are, in turn, linked to issues of housing, transport infrastructure and all contribute to the general economic prosperity of the county. For these reasons the recommendations made in this report are wide ranging and are not confined to traditional areas such as health services and social care.

The Contents of this Report

The first chapter takes an overview of progress made during the last year and sets out the type of actions we will need to take to move from good to great. The following five chapters concentrate on the five major challenges for health in Oxfordshire and recommendations are made at the end of each chapter.

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

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire

March 2008

CHAPTER 1: Progress Report for 2007/8 and for 2008/9 and beyond: The Challenges

This section takes a broad overview of health and wellbeing in Oxfordshire during 2007-8, highlights the successes and sets out the type of action we will need to take in the future, asking "Can we go from good to great?"

2007-8: Strong Green Shoots and Notable Achievements

ACHIEVEMENTS IN 2007-8 I: OUTRIGHT SUCCESSES

Teenage Pregnancy

1. There has been a big improvement in teenage pregnancy figures. Teenage pregnancies fell substantially to the lowest rates for ten years – a success for sustained targeting of the worst hit areas.

MRSA *(Methicillin Resistant Staphylococcus Aureus)*

2. Cases of the super bug MRSA have fallen. Last year there were around five cases on average per month in the county, compared with double that number in the previous year. This is a tribute to partnership work across whole NHS.

Quitting Smoking

3. More people have quit smoking than ever before. This remains the best thing individuals can do to improve their health. Around 4,000 smokers will have quit during this year – this is due to a well-established team working with partners and using new innovations to reach out to people.

Inequalities

4. There are early signs that the inequalities gap in Oxfordshire has just begun to close. The latest figures show that the gap in death rates between the best 20% of wards and the worst 20% of wards narrowed, comparing 2003-5 with 2004-6 (looking at deaths per 100,000 population).

5. This finding is supported by new figures on overall deprivation: we now have one fewer small area in Oxfordshire in the bottom 20% of areas nationally (12 instead of 13).

Fewer deaths from circulatory disease *(e.g. heart attack and stroke)*

6. The odds of dying early from circulatory diseases have fallen over the last decade by almost 40%, from 109 per 100,000 under 75s in 1996 to 67 per 100,000 under 75s in 2006.

Flooding

7. The floods were a terrible blow to Oxfordshire during the year. Many people lost a great deal and families are still affected. Despite this, our combined emergency services were judged to have performed well by external agencies such as the Government Office for the South East and South Central Health Authority.

More accessible sexual health services

8. In the last year the proportion of people accessing our Genito-Urinary Medicine (GUM) service within 48 hours has increased from 50% in October 2006 to 100% in January 2008. This will help to reduce the spread of all sexually transmitted diseases.

Financial balance

9. The NHS was in financial balance throughout 2007-8. This makes a fantastic difference to the public's health because it gives a platform for stability. It allows the NHS to act as a credible partner in the county and new investment means it can hit the crucial issues faster.

Award winning service: the Primary Child and Adolescent Mental Health Service (PCAMHS)

10. This new direct referral service helping children with mental health problems received a national award recognising its excellence. This is another example of partnerships between County Council, PCT and mental health services bringing dividends for health.

ACHIEVEMENTS IN 2007-8 II: INFRASTRUCTURE – LINING UP THE BATTLESHIPS

Organisations are like battleships. They take time to line up, but once in line and moving in one direction they form an impregnable fleet, rather than a scattered flotilla. Lining up the battleships is key to the long term public health. The backroom work needed to do this deserves recognition. Notable achievements include:

Tackling educational attainment

1. Poorer than expected levels of attainment in schools have been recognized as a major issue and firm action is being taken by the County Council and schools in Oxfordshire.

Community hospitals

2. We are at last seeing more light than heat produced around the future of our community hospitals. It isn't all plain sailing, but the 'care outside hospitals programme' is making progress locality by locality and work in Bicester is looking promising.

Main planks in place for working together

3. The Public Service Board has done a good job in pulling together a new Local Area Agreement through which all organizations agree to meet targets by working together. Also, a Health and Wellbeing Partnership has been created to take forward a broad range of health issues in adults.

A sense of "place"

4. We are gradually working more closely together in our communities, towns, areas of growth and deprived areas. This way of working is promoted further in this report. (Chapter 2, Part II)

Joining up our strategies

5. Three key strategies were aligned much more closely during 2007-8. These were the strategies of the County Council, the PCT and the Sustainable Community Strategy, hosted by the Oxfordshire Partnership. This is clear evidence of strengthening joint work.

Lining up the budget cycles

6. The budgetary priorities of County Council and Primary Care Trust came much closer together in 2007-8. Areas of shared concern such as breaking the cycle of deprivation and tackling the demographic time bomb featured in both.

Lively and effective scrutiny

7. Throughout 2007-8 the Health Overview and Scrutiny Committee has fulfilled its role as scrutineer and watchdog very successfully. Thorny topics such as the Horton Hospital, hospital cleanliness and a range of public health issues have been vigorously grasped, helping us all to stay focused on the big issues.

ACHIEVEMENTS IN 2007-8 III: GOOD THINGS IN THE PIPELINE

Some excellent work was done in 2007-8 which will pay dividends during the next year.

New approaches to obesity

1. New ways of working with organisations like Weight Watchers are being lined up to give us brand new options in the fight against obesity (Chapter 6).

Redesigning psychological services

2. A new service will shortly go live which will fill a longstanding gap in speedy, focused help for people with common mental health problems such as anxiety and depression (Chapter 4).

Universal services for our children

3. For the first time ever the community health services our children receive are being looked at in a scientific way across the county. The aim will be to level up the worst to the level of the best. This should be another blow to break the cycle of deprivation (Chapter 3)

Practice based commissioning – coming of age

4. After extensive groundwork, local GPs look as if they will be in a position to take over some of the commissioning reins so that local health services can be designed to help local people.

The Future: from Good to Great

Health is good on average in Oxfordshire but, compared to similarly prosperous counties, it could be better. Achievements in 2007/8 have been good but there are no grounds for complacency. We need to go from Good to Great. Being better will require a joint effort from all organisations. This section highlights some of the main challenges.

THE IMMEDIATE CHALLENGES TO SUCCESS

Breaking the Cycle of Deprivation

1. We have begun to work well together on this, focusing on children and families – we now need to dig in for a decade of sustained effort. (Chapter 2, Part I)

2. To achieve a permanent reduction in deprivation and poverty in specific parts of Oxfordshire, we now need to focus on deeper partnerships around specific places, to include all age groups. This approach is developed further in Chapter 2 Part II.

The Demographic Time Bomb: the Importance of Prevention

3. It has been established that the increasing number of older people will cost more in service provision year on year. Some have begun to doubt whether these extra services AND investment in promoting independence and preventing disease can be afforded. This conclusion must be challenged and it is imperative that we find new ways of empowering local communities to find their own solutions, especially in rural areas. This theme is developed in Chapter 3.

Mental Health

4. This report in Chapter 4 highlights the issues we face to improve mental health as a priority area in the county. The challenge here is how to keep its profile high in Oxfordshire when more pressing national targets pull our attention away.

Laying to rest Longstanding Problems

5. There are a number of persistent problems which we haven't yet solved in Oxfordshire but which have been solved elsewhere in the country. These act like black holes sucking in precious management effort. A current example is around hospital admission, delayed transfer of care and discharge into the community (Chapter 3).

Getting Real Results for Oxfordshire: Outcome Measures and Holding Ourselves to Account

6. Good work on outcome measures in children's services has allowed clear trends to be measured over time in this report. We need to extend this approach as a priority to services for older people and mental health and strengthen our partnerships so that we hold each other to account for making lasting change.

CHAPTER 2: Breaking the Cycle of Deprivation

Part I: Children and Young People's futures in the balance
Part II: A sense of place: the need to go deeper

Part I: Children and Young People's futures in the balance

The first Director of Public Health Annual Report pointed out clearly that, although our children and young people are healthier than the national average, there remain areas of stubborn inequality within this county where poor prospects and poor health are handed down from one generation to the next. The report called for a major effort to break this cycle of deprivation. This finding was supported and emphasised during the year by a governmental inspection called the Joint Area Review. This call has been heard loud and clear by the County Council, the PCT, and the Children and Young People's Board, and action has begun.

In addition, we now have a further year of outcome measures painting a picture of the health of children, young people and families in more detail.

Overall, the figures show both ups and downs. It is as if the future of children's health and wellbeing in this county is poised on a knife edge. Further action taken now by statutory bodies may well be enough to tip the balance towards lasting future prosperity. If this is to occur, we need to target the areas worst affected, level up results across the whole county, and stick to this policy doggedly for the foreseeable future.

This chapter summarises the facts, highlights the good work and positive initiatives taken during the year and makes recommendations for further action.

The Facts

Measure 1: International and National Comparisons and Inspections

International and national comparisons show that we are right to concentrate on the health of children and young people. For example:

- In 2007 UNICEF completed a comprehensive assessment of the lives and wellbeing of children and young people from twenty-one industrial nations. The UK came bottom of the league table overall and was in the bottom third of the rankings for five of the six areas of measurement[1].
- Compared with other age groups, the health of young people aged 10-19 is a cause for concern nationally[2]. Measures of mental health, sexual health, obesity

[1] UNICEF, Child Poverty in perspective: An overview of child well – being in rich countries, *Innocenti Report Card 7,* 2007. UNICEF Innocenti Research Centre, Florence

[2] Viner, R. & Barker, M. (2005) Young people's health: the need for action. BMJ 2005; 330; 901 – 903 doi:10. 1136/bmj.330.746.901 Downloaded from bmj.com 13/02/2008

and hence chronic disease are all worsening amongst young people. Behaviours such as smoking and drug and alcohol use increase sharply in this age group. There has been a significant increase in sexually transmitted infections amongst young people and, on average, teenage conception rates are much higher than in other Western European countries.

- The Joint Area Review of children's services in Oxfordshire conducted in December 2007 by Government will publish its report in June 2008. Initial feedback suggests we need a specific strategy for 14-19 year olds and need to improve educational attainment at key stages 1 and 4.

Measure 2: What Our Children and Young People Say

A survey of over 6,500 children and young people was carried out in Oxfordshire. The findings show a mixed picture, but we can conclude that we have no reason for complacency around our children's lifestyles and that disadvantaged groups need targeted support. For example:

- 4 out of 5 (80%) of all children and young people said they were **very/quite** healthy – a good result. Children and young people at primary school (52%) are more likely to feel **very** healthy than children and young people at secondary school (31%).
- Some groups of children and young people are **less likely** than average to say they feel "very healthy", including those who:
  - live in temporary accommodation
  - receive special help for learning and/or behaviour
  - say they are doing very badly or quite badly at school
  - say they plan to leave school as soon as possible
  - look after their own baby or child.
- Those most likely to say they would like **more** information on health topics include: those who go to Breakfast Clubs, those who live in temporary accommodation and those who look after their own baby or child, and Asian children and young people.
- 9% of Year 7-11s say they smoke twice or more per week; 14% of Year 7-11s say they drink alcohol twice or more per week. 6% of Year 7-11s say they buy alcohol twice or more per week.

Measure 3: Child poverty (income deprivation affecting children)

Last year this report highlighted the inequalities in key health outcomes between children living in the most deprived small areas in Oxfordshire and children born in the rest of the county.

In 2004 the five areas in the table below were identified as the most deprived in the county, using a measure of child poverty called income deprivation which measures the proportion of families with children under 16 who are in receipt of one or more specific state benefits.

Table 1

Deprived Small Areas within Oxfordshire in terms of income deprivation compared with All Small Areas in England: 2004			
DISTRICT NAME	**AREA NAME**	**DEPRIVATION RANK OF ALL AREAS IN ENGLAND (where 1 is most deprived and 32,482 least deprived)**	**RANK AS %age OF ALL AREAS IN ENGLAND**
Oxford	Northfield Brook 69	1,497	4.6% from bottom
Oxford	Barton & Sandhills 13	1,814	5.6% from bottom
Oxford	Northfield Brook 68	2,409	7.4% from bottom
Cherwell	Banbury Ruscote 50	3,125	9.6% from bottom
Oxford	Blackbird Leys 18	3,200	9.9% from bottom

Table 1 and 2 show that in 2007 almost twice as many small areas are in the top 10% most deprived areas in England in terms of income deprivation compared with 2004 (9 instead of 5). Northfield Brook 69 has been replaced by Barton and Sandhills as the most deprived area in the county. Banbury Ruscote no longer features as one of the most deprived areas but Banbury Grimsbury and Castle is one of 5 areas in which deprivation has increased to the point where it is now amongst the most deprived areas in England.

These stark figures illustrate well the cycle of deprivation in parts of Oxford and Banbury.

Table 2

Deprived Small Areas within Oxfordshire in terms of income deprivation compared with All Small Areas in England: 2007			
DISTRICT NAME	**AREA NAME**	**DEPRIVATION RANK OF ALL AREAS IN ENGLAND (where 1 is most deprived and 32,482 least deprived**	**RANK AS %age OF ALL AREAS IN ENGLAND**
Oxford	Barton & Sandhills 13	1012	3.1% from bottom
Oxford	Cowley Marsh 32	2283	7.0% from bottom
Oxford	Northfield Brook 69	2440	7.5% from bottom
Oxford	St. Mary's 87	2579	7.9% from bottom
Oxford	Rose Hill and Iffley 76	2700	8.3% from bottom
Oxford	Churchill 25	2851	8.8% from bottom
Cherwell	Banbury Grimsbury and Castle 36	3018	9.3% from bottom
Oxford	St. Clement's 79	3059	9.4% from bottom
Oxford	Blackbird Leys 20	3122	9.6% from bottom
Oxford	Northfield Brook 68	3334	10.3%

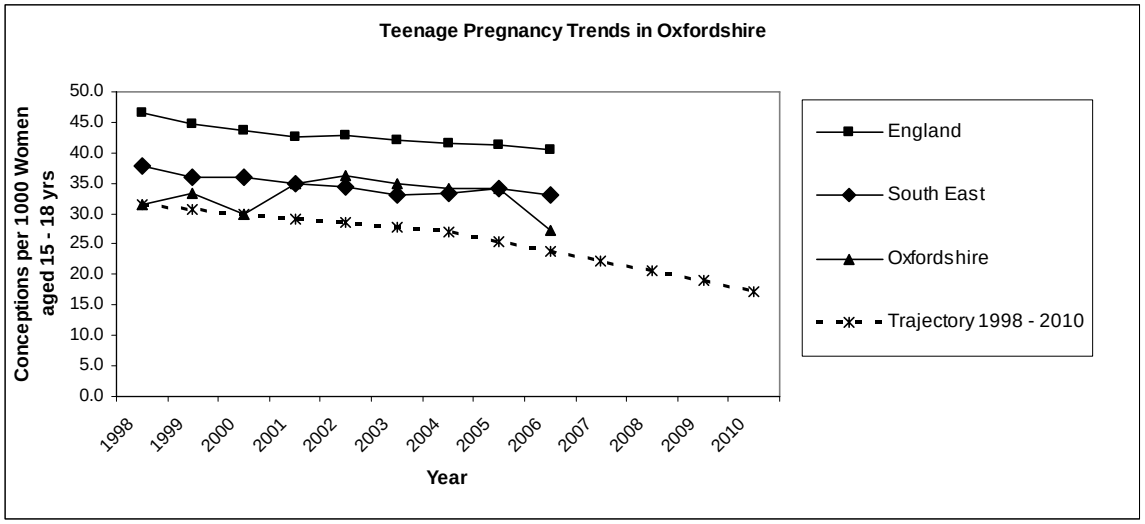
Measure 4: Measuring Rural Deprivation

During 2007/8 good work was carried out by the Children and Young People's Board to measure deprivation in Oxfordshire's rural communities and act on it. This information has been used to target the work of a mobile Rural Children's Centre in 13 rural communities and has been widely praised. The plan is to tackle these needy areas alongside the more urban areas and to continue to measure and target this form of deprivation.

Measure 5: Teenage conceptions

After three years of intensive work to target wards with the highest levels of teenage conceptions, figures in Oxfordshire are now much improved. During the last year teenage pregnancy rates have fallen substantially, as shown in Figure 1. This is a tribute to targeted initiatives such as free availability of the 'morning after' pill, initiatives in schools and innovative work such as the condom card scheme allowing early access to contraception. This really is one of the high spots of public health in the county during 2007-8. If this trend continues we will be consistently out-performing results in England and the South East and will be back on trajectory to meet our challenging county target.

Figure 1: Teenage conceptions in Oxfordshire 1998 – 2006



Source: Teenage Pregnancy Unit

Measure 6: Breast feeding

The good news is that breast feeding initiation rates (mothers starting to breast feed shortly after delivery) have increased steadily in the 30 most deprived wards in this county over the last four years and now stand at around 76%. Rates in the thirty least deprived wards have fallen slightly which causes some concern, but on balance it is encouraging that this important inequalities gap is narrowing.

Table 3: Inequalities in Breast Feeding in Oxfordshire 2003-2007

LOCALITY	2003/2004	2004/2005	2005/2006	2006/2007
All wards	76.0%	75.3%	78.2%	77.2%
30 least deprived wards	80.6%	76.4%	81.7%	78.3%
30 most deprived wards	68.9%	69.7%	71.4%	76.7%
INEQUALITY GAP	11.7%	6.7%	10.3%	1.6%

Measure 7: Smoking in Pregnancy

The overall picture has worsened slightly during the year. For the period 2003/2006 women in the most deprived wards were almost three times more likely to smoke in pregnancy than those in the least deprived wards. In 2004/2007 slightly more women living in the least deprived wards smoked whilst pregnant whilst the proportion of smokers in the most deprived wards decreased slightly.

Table 4: Percentage of women smoking at time of delivery in the most advantaged and most disadvantaged areas of Oxfordshire

	% of smokers	
LOCALITY	2003/2006	2004/2007
All wards	9.6%	10.8%
30 least deprived wards	5.5%	7.8%
30 most deprived wards	14.2%	13.8%

Measure 8: Unintentional injuries[3]

The overall picture has improved substantially with injury rates in children and young people falling within the most deprived wards to narrow the inequalities gap in the county.

Table 5: Unintentional injuries in children and young people in Oxfordshire 2003-2007

LOCALITY	2003/2006 injury rates	2004/2007 injury rates
30 least deprived wards	208/1000	201/1000
30 most deprived wards	306/1000	277/1000
INEQUALITY GAP	98/1000	76/1000

Measure 9: Childhood Immunisations

Childhood immunisation is one of the cornerstones of good public health and has led to a significant reduction in childhood deaths and disease over the decades. It is imperative that immunisation rates are maintained at high levels.

[3] The term unintentional injury is preferred to accidental injury as the latter implies that events are inevitable and unavoidable. A significant proportion such injuries are regarded as being preventable.

Overall, 97% of 2-year olds in Oxfordshire receive their primary immunisations which is a good result. Performance varies between our 13 children's services localities. The range between localities was 92% to 99%.

Immunisation rates are lower for the Measles, Mumps and Rubella (MMR) vaccine with only 5 out of 13 localities achieving more than 90% coverage. This mirrors the national picture. The range was 83% to 94%.

Measles is particularly worrying. Local cases have shown that this is an entirely preventable disease with rare serious complications.

Measure 10: Emotional well being – mental health referrals

Data from the acclaimed new Primary Child and Adolescent Mental Health Service (PCAMHS) shed light on the emotional wellbeing of children across Oxfordshire. The table below shows the rate of referrals for each of the 13 children's services localities across the county. A very familiar pattern emerges, the highest rates of referral being found in Oxford South East, followed by Banbury, Headington and Wheatley and Abingdon/Berinsfield.

Table 6: Mental Health Referrals by Locality in Children and Young People

Locality	Number of referrals	Referral rate per 1000 population aged 0 - 19
Abingdon/Berinsfield	279	**19.04**
Banbury	334	**22.63**
Bicester/Kidlington	284	17.40
Carterton/Burford/Chipping Norton	223	17.50
Didcot	104	13.01
Headington/Wheatley	169	**20.78**
Henley/Sonning Common/Woodcote/Wallingford	82	7.28
Iffley & Cowley	26	2.68
North Oxfordshire/Cumnor/Botley	120	9.07
Oxford South East	246	**36.72**
Thame/Watlington	74	8.83
Wantage/Faringdon/Grove	98	7.61
Witney/Eynsham/Woodstock	138	10.80

The highest rates are shown in bold. This is evidence of the cycle of deprivation at work and further justifies targeting specific localities to break the cycle.

Measure 11: Emotional wellbeing – feeling safe

A further measure of overall emotional wellbeing is how safe our children and young people feel in their daily lives. As part of Oxfordshire's children and young people's survey, schoolchildren were asked how safe they felt. Perception of safety is always

difficult to interpret. In this survey, 5% of children and young people reported that they did not feel safe at home. More significant are the subgroups of children who feel the least safe. Again, a familiar picture of deprivation emerges, the children who feel the least safe are those who:

- live in temporary accommodation
- care for their own baby or child
- smoke or drink or buy alcohol regularly.

Measure 12 Obesity

In June 2007 a programme to monitor the numbers of children who are overweight or obese was established. Children in reception and year 6 in Oxfordshire primary schools had their height and weight recorded and BMI calculated. The results, which are all slightly better than the national picture, are shown below. On all measures, boys were slightly more obese and overweight than girls.

Table 7: Percentages of Obese & Overweight Children in Oxfordshire and nationally (national figures in brackets) 2007

	Reception	Year 6
Overweight	12% (13%)	13 % (14%)
Obese	8% (10%)	15 % (17%)

Measure 13: Locality Profiling - pulling it all together

A wide range of health measures were pulled together across 13 localities in Oxfordshire. Table 8 below simplifies the results, "1" being the poorest performing locality followed by "2" and "3". The localities with the poorest results are shown in bold.

This table shows that the cycle of deprivation bites hardest in Oxford South East and Banbury localities.

The Children and Young People's Board used these data to target three areas for focused work to break the cycle of deprivation. These were Oxford South East, Banbury and Abingdon/Berinsfield.

Table 8: Summary table of inequalities between 13 localities in Oxfordshire 2007

LOCALITY	MEASURE								
	% not in education or training	% mothers who smoke	% who begin breast feeding	% who maintain breastfeeding	Uptake of primary immunisation	Uptake of MMR immunisation	% smokers 16 yrs+	Emergency admission rate	Teenage conception hotspots
Banbury	**3**	**2**	**2**	**2**				**1**	**3 =**
Bicester/Kidlington							2		
Witney/Eynsham/ Woodstock									
Carterton/Burford/ Chipping Norton						3			
Iffley & Cowley	2				2				1
North Oxfordshire/ Cumnor/Botley					3				
Oxford South East	**1**	**1**	**1**	**1**			**1**	**2**	**2**
Didcot							3		
Abingdon/ Berinsfield		**3**	**3**	**3**					**3 =**
Henley/Sonning Common/ Woodcote/ Wallingford					1	1		3	
Wantage/Faringdon/ Grove									
Thame/Watlington						2			
Headington/ Wheatley									**3 =**[1]

Measure 14: Educational attainment

Deficiencies in educational attainment within Oxfordshire have been well recognised and firm action has begun to improve the situation. This should be applauded and supported.

It is important that gaps in attainment are carefully summarised and monitored. This section sets out the existing gaps so that improvements can be measured year on year. It is particularly important to look beyond the overall county figures as these mask a range of inequalities.

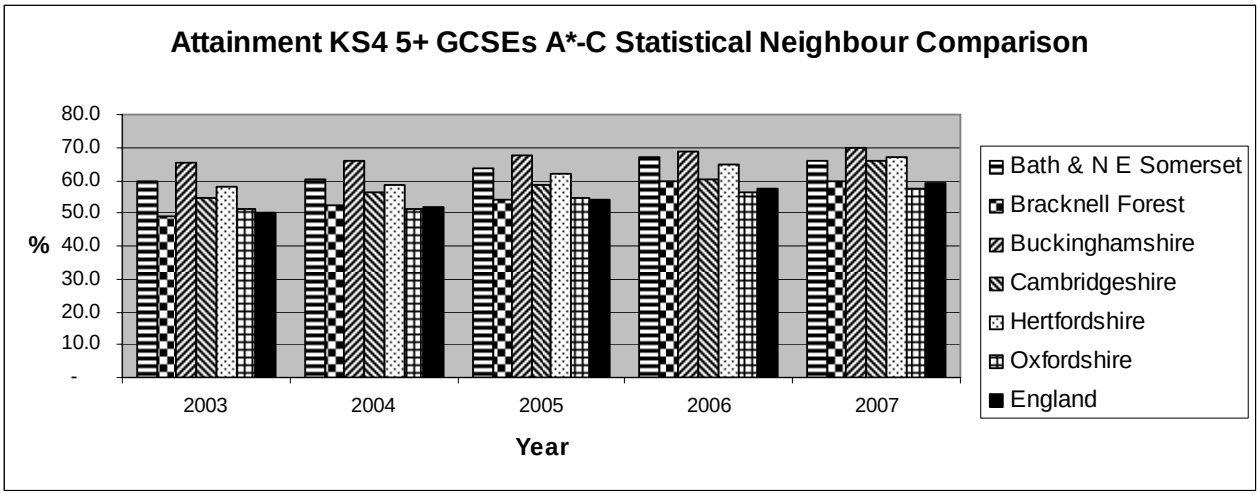
It is important, however, that this does not turn into a witch hunt, blaming individual schools. Educational attainment is a symptom of underlying problems, rather than a problem in itself. Because we have a shared responsibility for this situation, all organisations and parents across the county need to see these figures and contribute to turning this situation around.

In this section the main comparator used is exam results achieved by our 15-16 year olds at Key Stage 4 (KS4) of the national curriculum. The specific measure is the number of pupils achieving five or more GCSEs at A* to C grades – abbreviated to 5+ GCSEs A*-C.

a) Inequality in attainment compared to similar counties in England

Attainment at KS4 in Oxfordshire compares poorly with the national average of 60.1% (England) and when compared with our statistical neighbours. Figure 2 shows the trend in attainment at KS4 Level 2 (5+ GCSEs A*-C) in Oxfordshire compared to national and statistical neighbour trends. The black bar shows the average for England and the bar to immediate left Oxfordshire. In 2003 attainment in Oxfordshire was 1% above the national average, whilst attainment has risen in Oxfordshire in the last 5 years, it has failed to match the national trend and has fallen behind to around 2% below the national rate. Over the last 5 years attainment in Oxfordshire has risen by just under 6% while the national rate of attainment of 5+ GCSEs A*-C at Key Stage 4 has risen by almost 9%. It is possible to surpass this and in Bracknell Forest and Cambridgeshire attainment has risen by around 10% and 12% respectively.

Figure 2



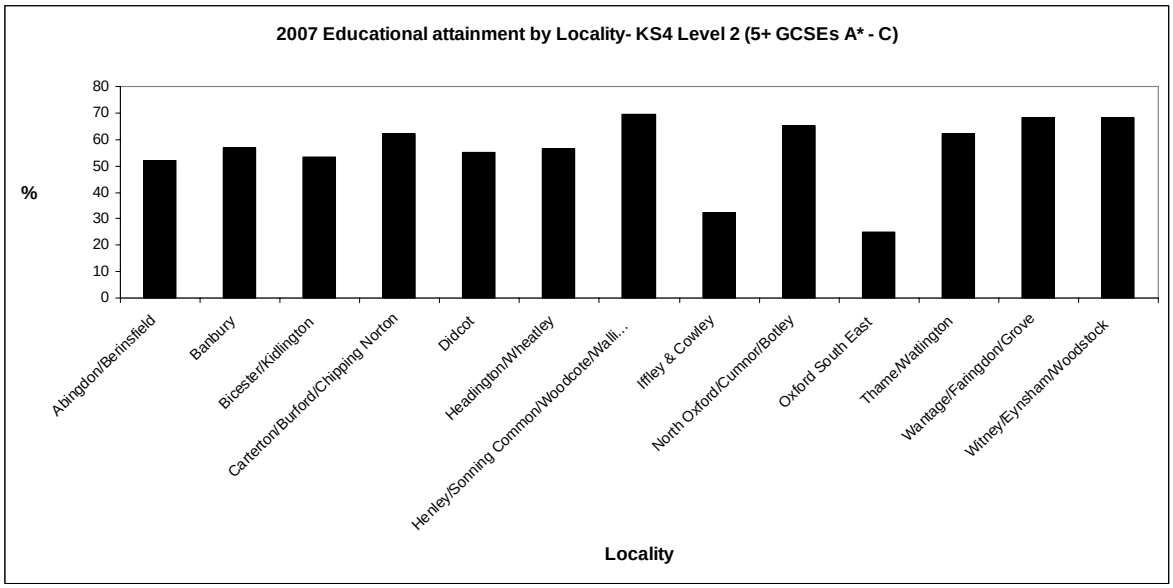
b) Geographical inequalities in attainment

There are also wide disparities in attainment across the county. The percentage of pupils achieving 5+ GCSEs A*-C ranges from 25.1% of pupils in Peers School to 79.0% of pupils in Gillotts School in Henley. In 47% of schools pupils failed to achieve the national average.

In Banbury School, Drayton, Peers, Oxford Community School, St Gregory the Great and Larkmead less than 50% of pupils achieved 5+GCSEs A*-C. These schools are in areas identified as having poor health outcomes such as high rates of teenage conceptions.

Table 9 shows KS4 attainment in 2007 for pupils across the 13 children's services localities.

Table 9: Inequalities in Educational Attainment in Oxfordshire by Locality 2007



Even within a county with lower than average performance, the results in Oxford South East and Iffley and Cowley stand out as particularly poor.

c) Gender inequalities in attainment

Last year's report identified the gap in attainment between boys and girls with girls markedly out-performing boys. In 2007 62% of girls achieved 5+ GCSEs A*-C at KS4 compared to 53% of boys. Only 23% of boys achieved 5+ GCSEs A*-C in Drayton School compared to 78% of boys in Bartholomew School. **In 22 (65%) schools, the percentage of boys achieving 5+ GCSEs A*-C was below the overall national average of 60.1%.**

The percentage of girls achieving 5+ GCSEs A*-C ranged from 26% of girls in Peers School to over 79% of girls in Gillotts School. In Drayton School, Peers School, Oxford Community School, St Gregory the Great and Larkmead School fewer than 50% of girls achieved 5+ GCSEs A*-C**. In 10 (29%) schools the percentage of girls achieving 5+ GCSEs A*-C was below the overall national average of 60.1%.**

d) Black and minority ethnic groups and inequalities in attainment

Table 10: Percentage of pupils in BME groups achieving KS4 (5+ GCSEs A* - C inc. E&M) in Oxfordshire 2005/6 to 2007/8

	2005/06	2006/07	2007/08	2007/08 Target	On target this year?	2008/09 Target
Bangladeshi	26%	20%	55.6%	39%	Yes	43%
Black African	35%	44%	39.2%	42%	No	46%
Black Caribbean	23%	29%	18.2%	29%	No	33%
Indian	43%	34%	44%	49%	No	53%
Pakistani	34%	30%	35.4%	37.5%	No	39%

Source: JAR/CYPP Annex 3 Performance Indicators. Update 18/01/2008

Oxfordshire has set target levels of attainment for its pupils from black and minority ethnic (BME) groups. These look at a specific level of attainment at Key Stage 4 which counts five or more passes at GCSE at grades A*-C including English and maths (5+ GCSEs A*-C inc. E&M). It can be seen from Table 10 that only the Bangladeshi subgroup met their target for attainment.

e) Inequality between state schools and independent schools

Non Maintained Schools (those schools funded by sources other than the Local Authority, including funding by parents) performed markedly better than our Local Authority funded schools.

Attainment at KS4 5+ GCSEs A*-C was considerably higher amongst the 23 non maintained schools than in schools funded by the Local Authority. In nearly 80% of non maintained schools at least 80% of pupils achieved KS4 5+ GCSEs A*-C, in around 60% of attainment was over 92% and 25% achieved 100%. On average, around nine out of ten pupils in non-maintained schools achieved 5+ GCSE A*-C compared with around six out of ten pupils in Local Authority funded schools.

Table 11: Inequality in outcomes at GCSE comparing maintained and non-maintained schools in Oxfordshire 2007

	Maintained schools (funded by LA)	Non maintained schools* (not funded by LA)	All schools
5+GCSEs A* - C	57.4%	90.8%	64.4%

* Not including Hillcrest School (Special School), IQRA School, North Oxfordshire Academy (new, so not yet included) and St Clare's (which follows Baccalaureat)

Progress This Year

The Children and Young People's Board (CAYPB) has taken significant steps forward this year to help break the cycle of deprivation. It has:

- Recognised school attainment as a major priority and begun to take action

- Identified areas of deprivation for focused action
- Agreed a range of outcome measures
- Succeeded in reducing teenage pregnancy and
- Secured additional funding from both County Council and PCT targeted at breaking the cycle of deprivation.

Recommendations

1. The CAYPB should intensify the targeting of services to areas of deprivation during 2008/9 and beyond.

2. The CAYPB should ensure that action to reduce inequalities in school attainment is maintained as a priority during 2008/9 and beyond.

3. The Director of Public Health should report on progress made using the agreed outcome measures at the end of 2008/9.

4. The PCT should recurrently fund the full year effect of the "Operational Plan proposal" for children and breaking the cycle of deprivation in budgets from 2009/10 onwards.

Part II: Breaking the Cycle of Deprivation: A Sense of Place - the need to go deeper

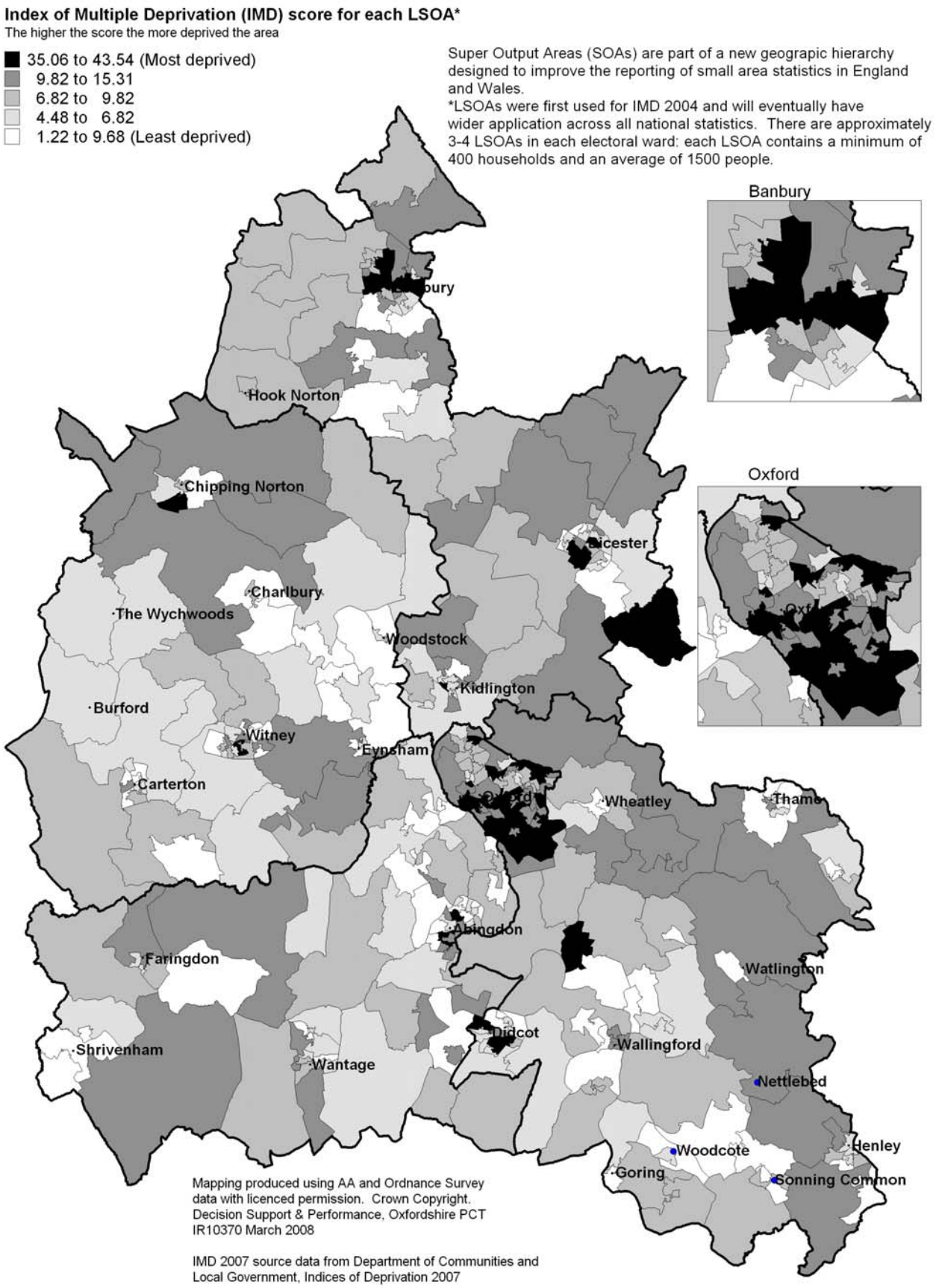
So far, the work on breaking the cycle of deprivation has concentrated on children, young people and families. Part I of this chapter highlights the good work done and the hill still to be climbed. It has been especially important to select three places in the county for targeted action.

BUT this alone will not break the cycle of deprivation.

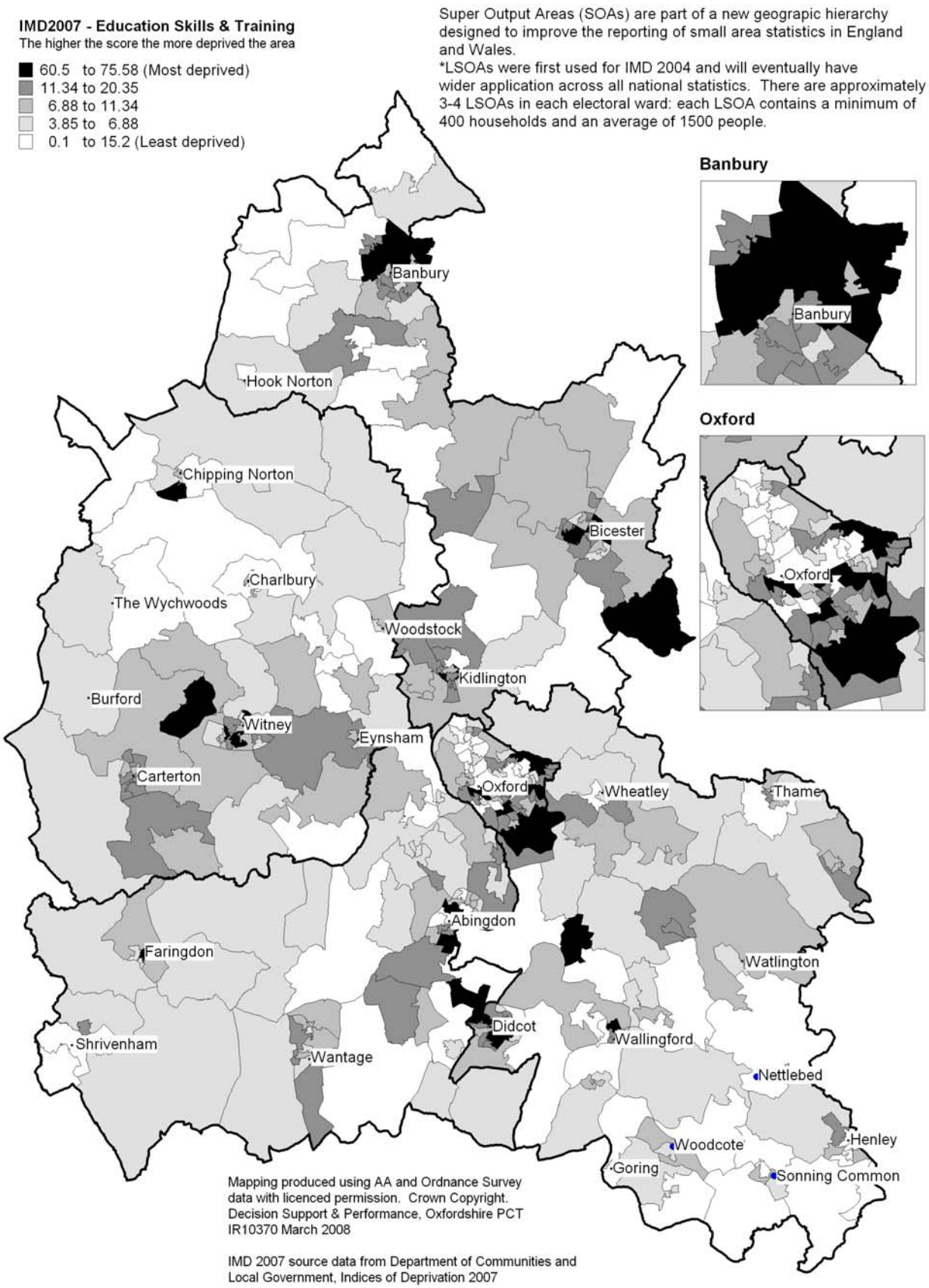
The causes of deprivation are deep, complex and wide ranging. Our response to them needs to match. This can be seen if we look at the three maps on the following pages. Each shows a different facet of deprivation:
Firstly a measure of overall deprivation given by the "Index of Multiple Deprivation";
Secondly deprivation in terms of education, skills and training; and;
Thirdly deprivation in terms of measures of crime and disorder.

Each map shows small areas called Super Output Areas. The maps group them into five groups from 'worst' to 'best'.

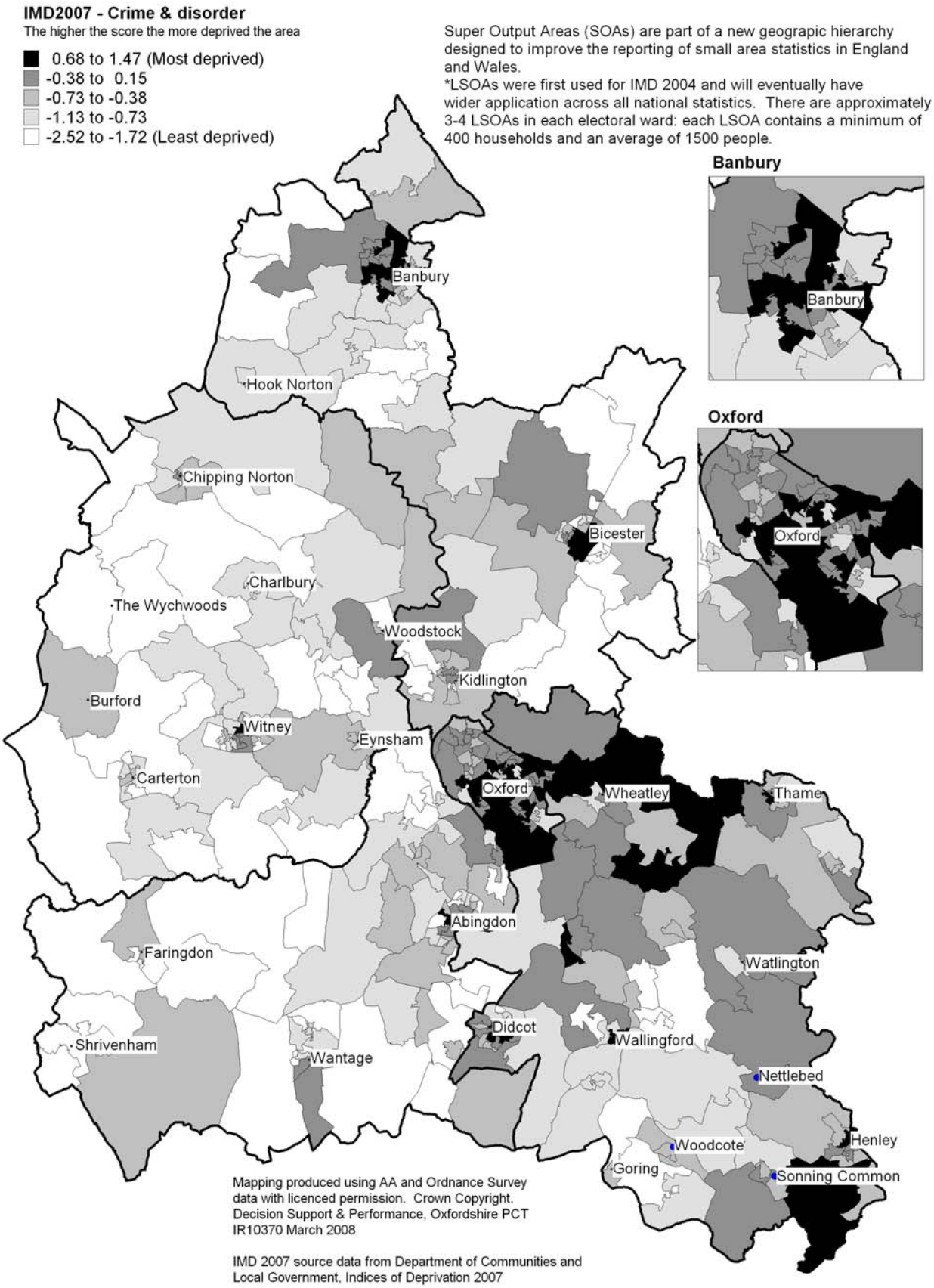
Index of Multiple Deprivation 2007 - Lower Super Output Areas (SOAs) in Oxfordshire county



Index of Multiple Deprivation 2007 - Lower Super Output Areas (SOAs) in Oxfordshire county Education Skills and Training domain



Index of Multiple Deprivation 2007 - Lower Super Output Areas (SOAs) in Oxfordshire county Crime & Disorder domain



How do we tackle these problems?

Our best chance of solving these issues in the long term may well be through taking the following five steps.

1. Select specific, enduring hotspots of deprivation and agree these as priorities for all organisations.
2. Work carefully in those places to define the specific problems.
3. Involve local people from the outset in defining the problems and working on solutions.
4. Bring the combined force and will of every organisation across Oxfordshire to focus on shared targets and outcome measures that will achieve real results.
5. Monitor and challenge performance against targets at the very highest level.
6. A modest initial resource may be all that is needed. The consensus view is that a good deal of money already flows into these areas: it needs to be focused and used more productively. This initial resource required is needed to appoint a dedicated manager to each separate place selected for action to make sure real change occurs.

Which areas?

Looking at these maps and the data in the previous section on children, young people and families, the first two areas seem to select themselves. These are the deprived parts of Oxford City and Banbury. A third area could be selected following debate, possibly choosing one of our market towns or areas of growing housing and population. Abingdon/Berinsfield might be selected to fit with work planned for children and families. Bicester and Didcot are also possibilities.

The prize to be won

If we can bring these areas up to the current county average, we will leave a legacy behind in Oxfordshire that is truly worthwhile.

What will need to be combined?

To work successfully in these places, we would need to combine a number of current workstreams. Examples of these are set out below:

Work of the Children and Young People's Board	Universal community health services for children	Skills Partnership	SEEDA Area Programme
Community Safety Partnership – work on hotspots	Improvement plans for the built environment	Focused mental health services	Primary care development and Practice Based Commissioning
Public involvement	Independent living in older people	Local authority community forums	Parish Councils
Health Trainers and Health Advocates	Equality and Diversity projects, especially for BME communities		

Leadership

It will be critical for the Oxfordshire Partnership, Public Service Board, all Local Authorities, the PCT and Thames Valley Police to support and take an active leadership role if this initiative is to work.

Proposed timescales

An outline timescale for a three year programme is shown below:

YEAR 1: gaining agreement, making appointments, aligning budgets, testing political will, carrying out stock takes, achieving real public involvement, setting priorities, clear targets and outcome measures

YEAR 2: making it run – solid workstreams are now in place. Progress is monitored carefully.

YEAR 3: outcome measures demonstrably improve; work plans are embedded into mainstream working.

What about rural areas?

Rural areas are important for the long-term health and wellbeing of the county. The problems, however, seem to be different in character and tend not to endure down the generations to affect the long-term prosperity of whole wards in the county. This report does propose targeting rural areas in other ways. For example:

- we are tackling the cycle of deprivation in rural communities through the acclaimed mobile rural children's centre
- this report calls for a major initiative to promote independence and health in older people in rural communities across the county (Chapter 3)

It is important not to underestimate the cost to the whole county of these enduring areas of deprivation. The cost saps the tax base of our county and is borne by social services, the NHS, the police force and district Councils. All parts of the county, including all rural areas, will benefit from a focus on place.

Recommendations

1. Leaders of Oxfordshire's Public Services, the Oxfordshire Partnership, Oxfordshire County Council and Oxfordshire Primary Care Trust should debate during the first quarter of 2008/9 whether or not to support this approach and fund it as set out above.

2. Inclusion of a third locality should also be debated and agreed during the first quarter of 2008/9.

CHAPTER 3: Older People and the Demographic Timebomb: Impatient for Change

The Issue

England is undergoing a profound demographic change and Oxfordshire is no exception. The growth in the number of older people has been accepted as one of the major challenges to the wellbeing of this county. This is a long-term issue and the main features stand repeating. They are:

1. The number of older people is increasing, particularly over-85s
2. The proportion of older people in the population is increasing. This means that the working population will be increasingly stretched to fund public services for the retired.
3. The increase in older people will be uneven across the county, affecting some of our most rural communities.
4. The economic impact on services will be severe – doing nothing is not an option. We cannot continue to provide our current range of services in the same way – they will simply not be affordable.
5. Change is, therefore, necessary. This is a long-term issue requiring a long-term solution; all organisations in Oxfordshire will need to come together to grapple with it.

The Size of the Issue

Looking at the actual population projections for the county is the best way of focusing the mind on this issue. These are shown in Table 1 below. They show that the growth in the 85-plus population in Oxfordshire during the next 25 years will more than double, increasing by more than 14,000 people. The impact is highest in Cherwell and lowest in Oxford City, with particular peaks in some of our most rural wards.

Table 1: Population Projections for Older People in Oxfordshire 2004-2029

Geographical Area	AGE 65+			AGE 80+			AGE 85+		
	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029
Cherwell	18.8	34.9	85.6%	5.1	11.1	117.6%	2.2	5.5	150.0%
Oxford City	17.2	23.0	33.7%	5.4	7.5	38.9%	2.3	3.9	69.6%
South Oxfordshire	20.5	32.5	58.5%	5.8	11.5	98.3%	2.6	5.8	123.1%
Vale of White Horse	18.8	29.4	56.4%	5.2	10.6	103.8%	2.2	5.4	145.5%
West Oxfordshire	16.2	28.0	72.8%	4.7	10.1	114.9%	2.1	5.2	147.6%
Oxfordshire	**91.5**	**147.8**	**61.5%**	**26.2**	**50.8**	**93.9%**	**11.4**	**25.8**	**126.3%**

Source: Office for National Statistics: Subnational population projections based on 2004 mid-year estimates
These show what the population will be in the future, given the current trends

Report of progress made

This section sets out where progress has been made and where there has been a lack of progress.

Progress made

This can be summarised as follows:

1. This topic is now recognised to be of major importance by Oxfordshire County Council and the Primary Care Trust. It features in the strategic priorities of both organisations and has attracted specific additional funding.
2. A Health and Wellbeing Partnership has been set up to tackle this and other priorities. A Joint Older People's Strategy Group has been redesigned to take these issues forward, reporting to the Health and Wellbeing Partnership. This has taken a year to complete. On all topics stronger joint working between adult services and the PCT has been notable.
3. Detailed needs assessments have been carried out or commissioned on all aspects of ageing: we have no shortage of information.
4. The climate of debate around community hospitals and related topics has improved through the PCT's work on 'Care Outside Hospitals'. The approach of looking at one community at a time shows promise and we look forward to new services in Chipping Norton and Bicester.
5. Further analysis has shown that common conditions in the elderly such as heart disease, stroke and hip fracture are amenable to preventative action although, at present, a fourth common disease, dementia, does not show the same promise, but new approaches to early identification and treatment may slow the progress of the disease and reduce its overall impact.
6. A range of service improvements have come about or are in the pipeline which will have a beneficial effect on older people's health. These are:
   a) a countywide obesity strategy (Chapter 5)
   b) improvement in tackling hospital superbugs (Chapter 6)
   c) a new initiative to prevent heart disease in our most deprived communities
   d) agreement on how best to tackle chronic diseases such as diabetes
   e) the success of the dedicated respiratory disease service
   f) new work on day centres and extra-care housing
   g) work by Age Concern, the Rural Community Council and others to assist local people to find solutions for themselves. This includes a range of initiatives such as health walks, community lunches and self-help transport schemes.

Lack of progress

1. We have set up a Health and Wellbeing Partnership with subgroups and have completed more analysis on people's needs. This is important work but it is slow going. We need to keep up our effort on work so that we achieve concrete results during the next year.

2. Work on older people needs to be in sharper focus. This engine will not run without a set of clear targets and initiatives at its heart. During the next six months we should agree baseline data, outcome measures and action plans specifically designed to meet the demographic challenge in our population, including older people suffering from dementia.

3. Prominent by its absence is a means of promoting the independence and preventing the health problems of older people across Oxfordshire. It is clear from the demographic data that services will be hard pressed to stand still, let alone fund new initiatives for prevention. And yet, this must happen……

   Therefore:

   Beginning next year it is critical that we agree **a model for promoting independence and preventing ill health community by community**, rural and urban, across Oxfordshire. We need to find a way to let a thousand flowers bloom within a clear framework - **and** we need to show whether it is effective, affordable and sustainable. Turning this around, **we need to find a way of assisting our citizens to stay independent and healthy for longer** that really works. This is in line with new Government policy set out in two important papers: "Putting People First" which came out last autumn, followed by January's "Transforming Social Care". These documents give Directors of Adult Social Care a clear lead role in bringing partners together to improve prevention and promote independence. These initiatives also came with a welcome £5 million from Government to facilitate this programme over the next three years.

4. During the next year, we need to agree how best we join up our services so that older people experience a smooth transition between primary care, community hospitals, Social and Community Services and our acute hospitals. Our performance on this topic remains poor, as is shown in our 'delayed transfer of care' figures.

5. Demographic growth continues to affect other care groups such as people with learning difficulties. This remains a gap for specific action.

The Way Forward

We should focus uncompromisingly on the major issues. The most prominent are:

- Achieving a smooth pathway through the statutory organisations for older people when they are ill or in need of care
- Finding practical ways of working with older people to promote independence and healthy living, working through communities
- Persevering with a partnership approach to bring together all organisations across Oxfordshire. This will prepare the ground for future work on thorny issues such as transport, access to services, support to carers and affordable housing.
- Continue to make budgetary provision for demographic growth in the budgets of the PCT and County Council, rising as growth projections rise
- Set clear outcome measures so that we can monitor progress more clearly

Recommendations

1. The Health and Wellbeing Partnership should agree a clear set of outcome measures for older people and use these to measure progress by January 2009.

2. Oxfordshire PCT and Oxfordshire County Council should continue to make explicit budgetary provision for demographic growth in 2009/10 budgets linked to year on year population projections.

3. The Director for Adult Social Services for Oxfordshire should lead work to pilot work to promote independence and prevent disease by facilitating active citizenship among older people in Oxfordshire. This work should be started in at least four rural communities and one urban community during 2008/9, for evaluation in 2009/10. It should be taken forward by the reconstituted Older People's Partnership Programme Board and progress reported to the Health and Wellbeing Partnership, PCT and OCC. The Health and Wellbeing Partnership should agree an affordable and sustainable model for the county during 2009/10.

4. Recommendations relating to mental health in general (Chapter 4) also apply to this chapter.

5. The Director of Public Health should use the agreed outcome measures to monitor progress made annually.

CHAPTER 4: Mental Health and Mental Wellbeing in Oxfordshire: Avoiding a Cinderella service

Last year's Annual report set out an intention to review mental health in Oxfordshire. Consultation and feedback exercises also clearly indicated that the people of Oxfordshire regard mental health as a priority and mental health services as clearly lacking in places. Together we now must develop mental health well-being and mental health treatment services in Oxfordshire in line with what the people of Oxfordshire and all the stakeholders involved in providing mental health care have agreed needs to be done. This is now being augmented by a detailed review across South Central Health Authority of clinical pathways in mental health.[4]

The recently published mental health strategy[5] not only sets out the main issues and problems facing mental health in Oxfordshire but also clearly states the priorities for Adults, Older People and Children as well as the shared objectives agreed to by all partnership organisations and an Appendix listing clearly defined actions. **We know what we need to do, together we must now get on with executing and implementing our shared strategy.**

In addition, we need to answer 3 more questions to ensure a comprehensive approach to implementing the strategy;

- Are we looking broadly enough at mental health and, in particular, mental well-being?
- Are we giving mental health enough prominence and priority?
- Are there specific gaps in services across all sectors that need to be addressed within services?

The main thrust of this chapter is to:

- Give an overview of the current state of mental health in Oxfordshire, summarising good work under way
- Focus in on three identified gaps, each of which relates to the above three questions. The three gaps are:

a. Scope gap – we have in train reasonable plans for mental health services once people become ill but we have a serious lack of planning to promote mental wellbeing and to prevent illness.
b. Action gap. We need to boost the priority given to mental health and mental wellbeing commissioning.
c. Service gaps – there is a consensus on gaps in current services that need to be addressed.

[4] NHS Next Stage Review in South Central Health Authority – report from the South Central Mental Health Clinical Pathway Group, December 2007
[5] Oxfordshire Mental Health Strategy 2007-12 (2006)

A Brief Summary of Mental Health and Wellbeing in Oxfordshire

1. Defining mental health and wellbeing

The World Health Organisation defines mental health as:
"A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community."

This is a very positive definition. It is deeply rooted in all aspects of society and has implications for family life, the economy and the aspirations of our people, as well as having implications for health and social services.

2. Why is mental health both important and complex?

Good mental health and mental wellbeing underpin and interact with the wider physical and social aspects of health and wellbeing. For example:

- Mental health problems are common and have a significant impact upon health: one in six of the adult population experiences mental illness at any one time. This is an estimated quarter of all disease suffered at any one time.
- Poor mental health and stress-related illness have a significant impact on economic productivity. It has been estimated that they cost the economy nationally £77 billion a year.[6]
- Mental health problems cover a bewildering range of presentations across the age groups. These can include disturbed behaviour in children, stress at work, maternal depression and general feelings of discontent as well as more severe forms of mental illness such as schizophrenia and dementia.
- There is a strong interaction between mental, physical and social health and wellbeing – there is growing evidence of the link between how physical conditions and psychological conditions interact and blur.[7]
- Poverty and inequality occur as a result of mental illness, and poverty and inequality cause or exacerbate psychological problems. Promotion of mental wellbeing will increase self-esteem, community cohesion, and economic prosperity.
- People with mental health problems have high use of all health services for mental and physical health problems. There is a strong practical, economic argument for ameliorating these problems.
- Mental health problems carry a high social cost to the individual, their relationships, their families, wider society and thus the economy.
- People with mental health problems in black and minority and socially excluded groups experience additional disadvantages.

[6] Mental Health and Wellbeing in the South East (2006)
[7] NHS Next Stage Review in South Central Health Authority – report from the South Central Mental Health Clinical Pathway Group, December 2007

- Mental health can be looked at through different "lenses" resulting in different "models" of mental health which tend to push action in different directions. The three most common ones are:
  - A social model which leads one to tackle problems of society such as poverty, factors leading to drug and alcohol misuse, bullying in schools etc.
  - A medical model which tends to look at individuals as having diseases which require cures.
  - A person-centred model which is most concerned with how an individual lives a productive life while managing episodic or longstanding symptoms. Practical problems are to the fore, such as how to stay in work, how to keep up family and social networks and how to contribute to society.

In short, tackling mental health problems will benefit our citizens, communities and society and will help health services, local authorities and other statutory bodies to achieve their objectives.

A brief summary of mental health in Oxfordshire in facts and figures

1. Mental Health in Children and Young People

Measures 10 and 11 in Chapter 3 touch on aspects of mental health and behavioural disorders in children and young people, highlighting the association with areas of deprivation. Measure 2 in Chapter 3 highlights the high prevalence of behaviour which is risky to good mental health such as reported regular drinking in 14% of children in Years 7 to 11

Table 1 sets out the main mental illnesses affecting children and young people in Oxfordshire and their frequency.

Table 1: Prevalence of common mental disorders in Oxfordshire's children and young people 2008-03-18

Condition	**Estimated prevalence between ages 5 – 10 (numbers of children**	**Estimated prevalence between ages 11-16 (numbers of children)**
Hyperkinetic disorders	700	680
Autistic Spectrum disorders and other uncommon disorders including eating disorders	570	680
Emotional Disorders	1,050	2,420
Conduct Disorders	2,140	3,190

Around 10.000 children and young people are affected.

2. Mental Health in Adults of Working Age

The table below shows the very high frequency of common mental disorders in adults of working age and the tremendous demands placed upon GP services. For example, a massive 76,000 people in Oxfordshire suffer from a range of milder conditions such as anxiety and depression at any one time. The 'weekly prevalence' column shows the number of people per thousand suffering from a condition in an average week

More serious disorders are by no means rare: at least five out of every 1,000 adults of working age in the county suffer from more severe and enduring conditions such as schizophrenia and bipolar disorders – that is at least 2,400 Oxfordshire residents.

Table 2: Prevalence of mental illness in the community and impact on primary care in Oxfordshire

Condition	Weekly prevalence per 1,000 adults	Estimated number of patients of working age in Oxfordshire	Estimated number of patients aged 16-64 consulting their GPs annually in Oxfordshire
Mixed anxiety and depression	88	40608	-
Generalized anxiety	44	20312	-
Depressive episode	26	12315	-
All phobias	18	8421	-
Obsessive-compulsive disorder	11	5599	-
Panic disorder	7	3255	-
All neurosis	164	76206	26130
Functional psychosis e.g. schizophrenia & bipolar disorders	5	2454	1919
Alcohol dependence	1-69 depending on severity	35158 (mild), 1852 (moderate), 319 (severe)	1348
Drug dependence	37	20178	1025

Source: ONS survey of psychiatric morbidity among adults living in private households, 2000 and weekly returns database, Birmingham Research Unit of the RCP, based on 2005/2006 baseline population

3. Mental Health in Older People

The author of the recently completed needs assessment of the mental health of older people in Oxfordshire[8] summarises the situation as follows:

"The predominant mental illnesses that affect older people are dementia and depression/ anxiety. Most older people with mental illness manage by themselves or with the help of close family and friends at home. However, depending on severity, mental illness in old age can impact at every level of the health and social care system. The burden of mental illness is projected to increase by 25% over the next decade due to the increasing prevalence of frail elderly aged 85 years and over." [9]

The familiar impact of the demographic time bomb and the need to care for our carers emerges once again. To underline needs of carers, the wards in Oxfordshire with the highest percentage of people providing unpaid care is set out below in Table 3. This pattern will apply to mental health problems – just as it does to physical problems.

[8] Mental Health Needs Assessment for Older People in Oxfordshire compiled by Uy Trong Hoang (2007)

[9] Personal communication – Uy Trong Hoang (2008)

The predominance of small towns, villages and rural areas is once again seen as critical to the long term future of older people in the County.

The needs of older people with mental health problems should be seen as part and parcel of the needs of all older people set out in Chapter 3. Recommendations in Chapter 3 apply equally to this group.

Table 3: Wards with the highest proportion of unpaid carers in Oxfordshire

Wards in Oxfordshire with highest % of people providing unpaid care			
1. Kidlington North	(Cherwell)	5. Sonning Common	(South Oxfordshire)
2. Faringdon and The Coxwells	(Vale of White Horse)	6. Chinnor	(South Oxfordshire)
3. Sunningwell and Wootton	(Vale of White Horse)		
4. Chiltern Woods	(South Oxfordshire)		

4. Vulnerable Groups with Mental Health Problems

Across the age ranges there are specific vulnerable groups in this county who are in need of targeted services. These include:

- Looked after children
- Prisoners
- Refugees and asylum seekers
- Travellers
- Black and ethnic minority groups
- The armed forces, veterans and their families
- Communities living in areas of high social deprivation
- Carers
- Students

Why is now the right time to intensify action in Oxfordshire?

We must ensure the current green shoots do not wither. A number of factors are now in alignment that should help to ensure this. These are:

1. Oxfordshire PCT is now well established and has balanced its books
2. Strong partnership arrangements have been established across the county and now need to be made to deliver
3. It has been accepted that we need to tackle deprivation head on. Mental health is a powerful contributor to the cycle of deprivation
4. Oxford and Buckinghamshire Mental Health Trust have completed their recent reorganisation
5. Practice based commissioning is better established in the county and some of its leaders are championing mental health services. GPs are powerful advocates for mental health
6. The NHS Next-Stage review (Darzi review) has mental health in a prominent place
7. We are now better organised to tackle long-term conditions such as chronic mental health disorders
8. We have an existing county strategy which stands as a useful framework

9. The universally celebrated feeling of goodwill accompanying the putting together of the mental health strategy is a real asset
10. We have a well-established voluntary sector
11. We have an excellent regional model for wellbeing which we can take off the shelf and apply
12. Users and carers are well placed to contribute actively
13. Relationships between health services and social care services for children and adults are strong and healthy
14. Planning for older people is becoming more coherent
15. A number of strong new services are in place or are being planned. For example:
    - The "Improving Access to Psychological Therapies Service" (IAPS) which holds out the prospect of quick, effective referrals to these services for common conditions.
    - The launch of the nationally acclaimed The Primary Child and Adolescent Mental Health Service (PCAMHS) service.
    - A healthy joint finance arrangement between the NHS and Local Authorities which is ripe for expansion.
    - Practice Based Commissioner plans to supplement existing services.

In summary, there has never been a better time to succeed. Turning this around, there has never been a less acceptable time to fail. We must not risk a false dawn.

<u>The 3 Gaps in detail</u>

These three gaps have been identified by asking the three questions raised in the introduction to this chapter in turn. These were:

- Are we looking broadly enough at mental Health and, in particular, mental well-being?
- Are we giving mental health enough prominence and priority?
- Are there specific gaps in services across all sectors that need to be addressed within services?

1. The gap in scope.

From the discussion above it can be seen that good mental health involves promoting mental wellbeing and preventing mental health problems arising. We should see a wide range of work across the county as contributing to good mental health including:

- Breaking the cycle of deprivation
- Promoting community safety
- Tackling drugs and alcohol
- Promoting good diet and physical fitness
- Health promoting schools delivering high levels of educational attainment
- Generic work to improve health in older people

Our current strategy leans too much towards a mental health <u>service</u> strategy, concerned mainly with what happens once people become ill and are service users.

We now need to bring together a range of work under the banner of promoting mental wellbeing. We should immediately begin work on this using an excellent practical model produced by the public health team in the South East Regional Office[10].

2. The action gap.

There is a widespread view that, although steady, focused work is being taken forward, it should be more comprehensive, higher priority, higher profile and executed more quickly. How we achieve this is a matter of some debate. What is certain is that the issue needs to be resolved in the first quarter of 2008-9, the action being led by the Oxfordshire PCT. As with older people's services, there is a need to agree a basket of outcome indicators so that future progress can be monitored.

3. The service gap.

In preparing this report a consistent range of concerns about current services were cited by interviewees. Some of these should be addressed by new services currently being planned, such as the psychological therapies service.

The concerns are worth summarising here as they will need to be factored into our current mental health strategy if not yet given sufficient prominence:

- The need to tackle the social causes of mental health problems by including mental health issues in breaking the cycle of deprivation
- Lack of a mental health and wellbeing strategy
- The potential benefit of early effective identification and intervention for mental health problems, especially in children, young people and the elderly
- Long waits for treatment of common, milder conditions and an over-emphasis on medication rather than patient-centred care
- Variations in the quality and uniformity of GP and primary care services across the county, pointing to the need for a minimum standard for all
- The need to clarify "who is responsible for what" between GPs and Community Mental Health Teams
- The high threshold of need required to access specialist Community Mental Health Teams, resulting in a "needs gap" between primary care and more specialist services
- The variable quality of child and adolescent specialist services and difficulties in accessing these uniformly from primary care
- The need to integrate medicine and psychiatry more fully so as to avoid treating psychological problems with physical treatments
- The need to manage long-term mental health conditions in the same way as physical conditions such as diabetes
- The need for the Drug and Alcohol Action Team (DAAT) to play a more active role in mental health topics

[10] Mental Health and Wellbeing in the South East (2006)

- The need to address the "Demographic Timebomb" in caring for people with dementia, the demand for which will inevitably increase
- The need to integrate older people's mental health issues with service planning for all older people
- The need to improve race equality by making sure that mental health services are accessible fairly to all
- The need to take care of our carers who make service delivery possible
- The need to target specific vulnerable groups as set out previously

It is clear that the healthy growth of the current green shoots described earlier on in this chapter are under severe threat unless we close the three main gaps identified in this chapter. But most of all, we will have to face the inevitable conclusion:
"If not given sufficient priority by health and social services, mental health issues drift down the priority list to become Cinderella services."

This is a scenario we need to avoid by supporting and strengthening work across Oxfordshire.

Should work on mental health form a fourth separate commissioning priority for Oxfordshire PCT?
This report was asked to make specific recommendations to the PCT on this subject. The conclusion is **mental health should be fully integrated with the PCT's existing priorities BUT there must also be a step change in the profile and priority given to mental health services within each strategic priority.**

The Table below illustrates how work on mental health services should be fully integrated into the planning mechanisms of all organisations, including those of the PCT.

Table 4: Illustrations of how work on mental health topics should be fully integrated into wider service planning

Mental health topic	**Integration route**
Mental health and social deprivation	Breaking the cycle of deprivation
Drugs and alcohol issues in mental health	Mainstream work of the Drug and Alcohol Action Team
Equality issues in mental health	Generic approaches to equality
Maintaining healthy lifestyles to prevent mental health issues	Generic strategic obesity and exercise strategies
Child and adolescent mental health services	Generic children's services
Chronic and enduring mental health conditions	Care pathways for long term physical conditions
Mental health and older people	Generic work on older people

Recommendations

1. Oxfordshire PCT, through its Director of Commissioning, should lead work with partners to determine how to achieve a step change in the profile, priority and prominence given to mental health commissioning and implementing the mental health strategy. This should be reported to the PCT board by July 2008 and then to the Health and Wellbeing Partnership.

2. Oxfordshire PCT, through its Director of Commissioning, should lead work with partners to agree a basket of mental health and mental wellbeing outcome measures using the existing mental health strategy so that progress made can be reported to the PCT board and the Health and Wellbeing Partnership by January 2009.

3. Outcome measures for mental health services and for mental wellbeing should be reported by the Director of Public Health (DPH) in the DPH Annual Report by March 2009.

4. A detailed commissioning plan to improve mental health services should be drawn up, led by Oxfordshire PCT and reported to the PCT board by September 2008 and then to the Health and Wellbeing Partnership.

5. The Director of Public Health should coordinate the production of a Mental Wellbeing programme as part of the commissioning programme for mental health in Oxfordshire by December 2008 and should appoint a specific lead officer for this work.

6. The Director of Public Health should report in detail on alcohol problems in Oxfordshire in the next DPH Annual Report by March 2009.

7. All recommendations for all older people set out at the end of Chapter 3 also apply to mental health and vice versa.

CHAPTER 5: Preventing Obesity: a major cause of poor mobility, heart disease and diabetes

The Issue

The first Director of Public Health Annual Report set out the reasons why obesity[11] is a cause of deep concern. The reasons are as follows:

- The number of obese individuals in England has tripled since the 1980s and Oxfordshire is no exception. Nearly one in four people in the UK is obese – being obese reduces life expectancy by an average of nine years. Obesity makes its impact in many ways. It affects general mobility leading to problems with joints and causes long-term diseases such as diabetes, stroke and heart disease, as well as affecting self-esteem.

- This preventable ill health costs the NHS over £1 billion per year and society as a whole up to £3.5 billion per year.

- Obesity does not affect all equally; it is more common in women and in manual workers. It is therefore another cause of health inequalities.

- If obesity continues to increase, the knock-on effect on NHS and local authority budgets will break the bank.

- Obesity itself is the tip of the iceberg. The average person in this country is classed as overweight.

Call for Action

Last year's report called for a wide range of actions which can be summarised as follows:

1. We should take a cradle to grave approach encompassing:
   - Promotion of breast feeding
   - Sport and healthy eating in schools
   - Improved access to leisure centres and exercise referral schemes
   - Better public information
   - Workplace schemes for adults of working age
   - Support for older people's exercise groups

2. This work has to be carried out in partnership with many organisations, especially community NHS services, general practice, schools and district councils.

3. We need better baseline data to be collected as there is a serious lack of local information. Without this we will not know if we are making an impact.

[11] Obesity is defined as Body Mass Index (BMI) of 30 plus. BMI is measured by weight in kilograms divided by height in metres squared.

Progress made

Cradle to grave:

Practical work has begun as part of an umbrella obesity strategy

- Children are benefiting from the HENRY programme which aims to improve diet in really young children by giving parents first-rate information. This has been targeted at Rose Hill in Oxford City.
- Young people have been engaged through the help of Oxford FM and Jack FM. Eight interactive workshops were held with young people to debate hot issues about healthy eating and lifestyles and blogs were used to involve young people in discussion.
- Adults, including older people, have been targeted through the "slimming on referral" scheme. Five hundred places have been provided with commercial slimming organisations such as weight watchers, Slimming World and Rosemary Conley. A further two thousand places are in the pipeline.
- Weight management programs have begun in the workplace. The PCT is being used as a trial for weight management advice to staff. If this works, it could be extended to other partner organisations. Given the number of people employed by the NHS and local government, this could produce real benefits.
- A series of other new initiatives to support breast feeding, schools, general practice and sports partnerships are planned for next year, using additional funding from the PCT. These will need to be carefully evaluated to identify what works.

Partnership in Action

An obesity strategy has been put together through workshops across the county and is truly inclusive. The role of District Councils through leisure centres, green spaces and play areas is pivotal.

Tip of the Iceberg

All of these actions are noteworthy and it is very good that a start has been made. BUT we are only beginning to scratch the surface. Helping people to combat overweight and obesity will be a long haul well into the next decade.

Better Measurement

Unless we can measure obesity we won't know what we're doing and we won't know what works. During the last year school children have been carefully measured so that we can monitor year-on-year obesity rates. The current picture in Oxfordshire's school children is reported here and will provide an invaluable baseline.

	Reception	Year 6
Overweight	12% (13%)	13 % (14%)
Obese	8% (10%)	15 % (17%)

It is also important that we collect data on obesity in adults. It has proved difficult to persuade GPs to measure enough people to give us good data this year as collecting statistics isn't always at the top of priority lists in general practice. It is important that we do better next year as without data this quickly becomes the blind leading the blind.

Recommendations for further action

1. The Oxfordshire Obesity Strategy should continue to be implemented as planned and progress reported within the PCT and to the Health and Wellbeing Partnership by January 2009.

2. Oxfordshire PCT should recurrently fully fund current part year plans for "cross cutting themes" which include exercise and obesity plans. These plans should be built into recurrent budgets from 2009/10 onwards.

3. The Obesity Strategy action plan should be improved to include further commissioning for the private sector and as yet untackled areas such as the built environment, transport and green spaces by January 2009.

4. Further progress should be monitored in successive DPH Annual Reports by March 2009.

CHAPTER 6: Fighting Killer Infections

This chapter highlights key infections which threaten health in Oxfordshire. It reports progress and recommends action. It focuses on:

- resurgent diseases such as tuberculosis
- diseases of modern lifestyle such as sexually transmitted infections
- 'new' diseases such as HIV
- the super bug Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C Diff)

Tuberculosis (TB)

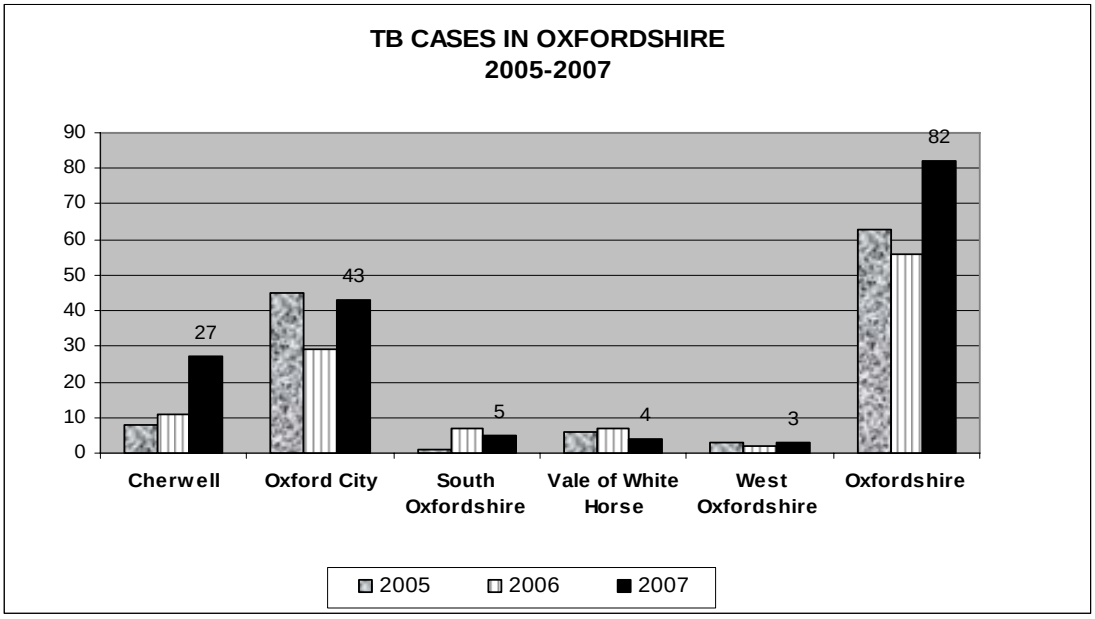
The previous report alerted people to the increased threat of TB. Since then the number of infections has continued to rise from 56 in 2006 to 82 cases in 2007. This scenario is repeated nationally. Cherwell District Council and Oxford City have the highest rates in the county. The rise in cases in Cherwell was caused mainly by two specific outbreaks of disease.

Table 1 Tuberculosis in Oxfordshire 2005-2007

	2005		**2006**		**2007**	
	Number	Rate per 100,000 population *	Number	Rate per 100,000 population*	Number	Rate per 100,000 population *
Oxfordshire	63	10.26	56	9.22	82	13.50

*based on ONS mid 2006 estimates

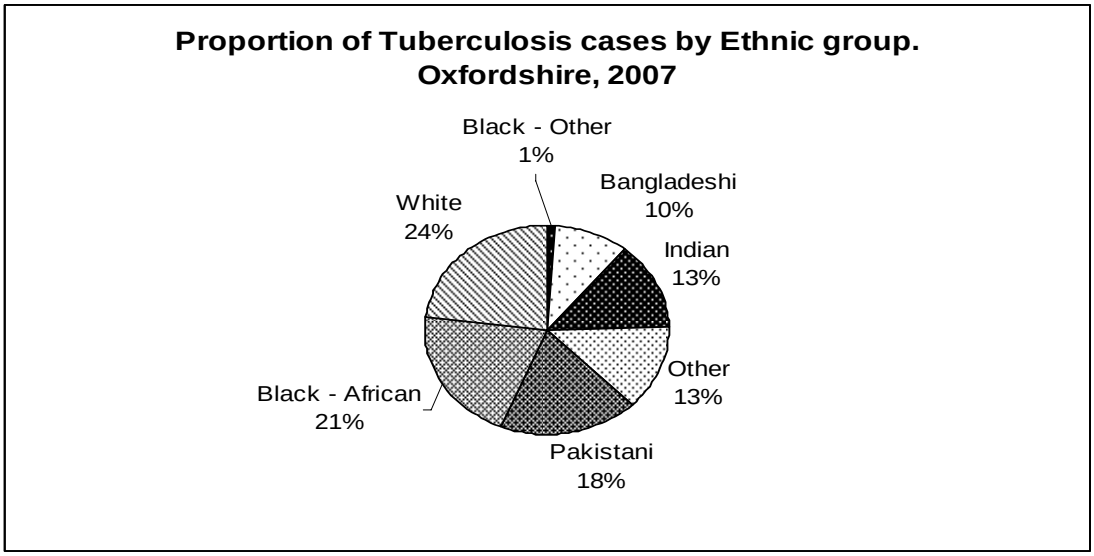
Figure 1



Source: Thames Valley Health Protection Unit

People are at higher risk if they were born or have lived in parts of the world with a high prevalence of TB. 70% of the cases detected in Oxfordshire last year were in people born outside the UK which is similar to the national position. Other risk factors include being homeless and being in prison.

Table 2



Progress made

Highlighting the issue in last year's report led to PCT investment so that Oxfordshire's TB service has more than doubled in size. There has been good joint work with our community nursing teams and with our local Health Protection Unit. Our management of outbreaks has been commended nationally. Spread of cases in the community was well-controlled and in all cases treatment was judged to be early and effective.

Public health action: this is how we will fight TB in Oxfordshire

- Surveillance – we maintain high quality surveillance of new disease using good intelligence and a high index of suspicion.
- Prevention – immunisation to newborns and school children at higher risk of infection, improved awareness among communities at risk especially the homeless, prisoners and IV drug users.
- NB: studies have shown that immunising <u>all</u> teenagers against TB is not an effective way to prevent disease.
- Early diagnosis – Recruitment of an additional two TB nurses as well as developing an integrated TB and Respiratory disease service will help by enabling quicker referral, assessment and commencement of treatment.
- Treatment – Ensuring that best practice guidelines are adhered to and patients are supported in ensuring they comply with the long duration of treatment and in managing side effects.

In summary, we cannot insulate ourselves from the global rise in TB but we are now prepared for the fight.

Sexually transmitted infections and HIV

Syphilis, Gonorrhoea and Chlamydia

The number of new diagnoses of sexually transmitted infections in the United Kingdom rose by nearly 2% in 2007 to over 375,000. The most common infection is Chlamydia, with the highest rates of infection in the 16-19 year old women and 20-24 year old men.

Table 3: Diagnoses of selected STIs in the Oxfordshire Genito-Urinary Medicine (GUM) clinics 2004-2007

	2004	**2005**	**2006**	**2007***
Syphilis	29	37	16	16
Gonorrhoea	200	137	136	138
Chlamydia	1551	1599	1653	1167

* - Incomplete data, Likely to increase as data are finalised.

Source: Körner (KC60) reports of complicated and uncomplicated STIs, STI Department, Centre for Infections

Cases of syphilis rose slightly since last year although the long-term trend is down. A similar picture was seen for gonorrhoea. Long term trend data for Oxfordshire and nationally show a decrease in the incidence of sexually transmitted illnesses like syphilis and gonorrhoea from the highs of the early 90's. Chlamydia however continues to be increasingly detected. This could be because of increased awareness and testing leading to more diagnosis and treatment. This will eventually lead to a fall in spread and a fall in long term complications such as infertility.

HIV

In 2006, there were an estimated 73,000 individuals in the United Kingdom living with HIV infection, more than a third of whom are unaware that they are infected. This fact will apply to Oxfordshire's population too. It is this group of people who are infected but unaware that they are infected who are most likely to continue to spread the infection. There were an estimated 364 Oxfordshire PCT residents accessing care for HIV infection in 2006. The number of people being cared for will continue to rise, as life expectancy increases thanks to advances in treatment. Ensuring that populations at risk of infection are tested at the earliest opportunity will help early treatment and also stop the spread of infection.

HIV is now very firmly established in the heterosexual community. For example, the rate of infection in pregnant women in Oxfordshire is about two per 1,000 women tested. All sexually active residents need to be aware of this fact.

In 2006, an estimated 7,800 new diagnoses of HIV were made nationally. The number being newly diagnosed yearly appears to be stabilising. The number of new diagnoses in Oxfordshire has mirrored this pattern, standing at 40 cases for the first six months of the calendar year.

Table 4

New diagnoses of HIV infection reported from clinics within Oxfordshire, 2003-2006

	2003	2004	2005*	Jan – Jun 2006*
HIV infection - new diagnoses	95	80	79	71

* - Incomplete data. Number will increase as data are finalised.
Source: HIV new diagnoses, STI Department, Centre for Infections

Because sexually transmitted infections often have few symptoms and are easily spread, it is vital that cases are recognised early and contacts tested and treated vigorously. It is a priority for the PCT to ensure that no individual should have to wait for over 48 hours to see a Genito-Urinary Medicine (GUM) specialist. The sexual health strategy for Oxfordshire for the next five years is complete and is about to be actioned. It will demonstrate a commitment to better sexual health in Oxfordshire while reducing inequalities experienced by the most deprived.

Public health action:

The action being taken is in line with the rest of this report. We need to:

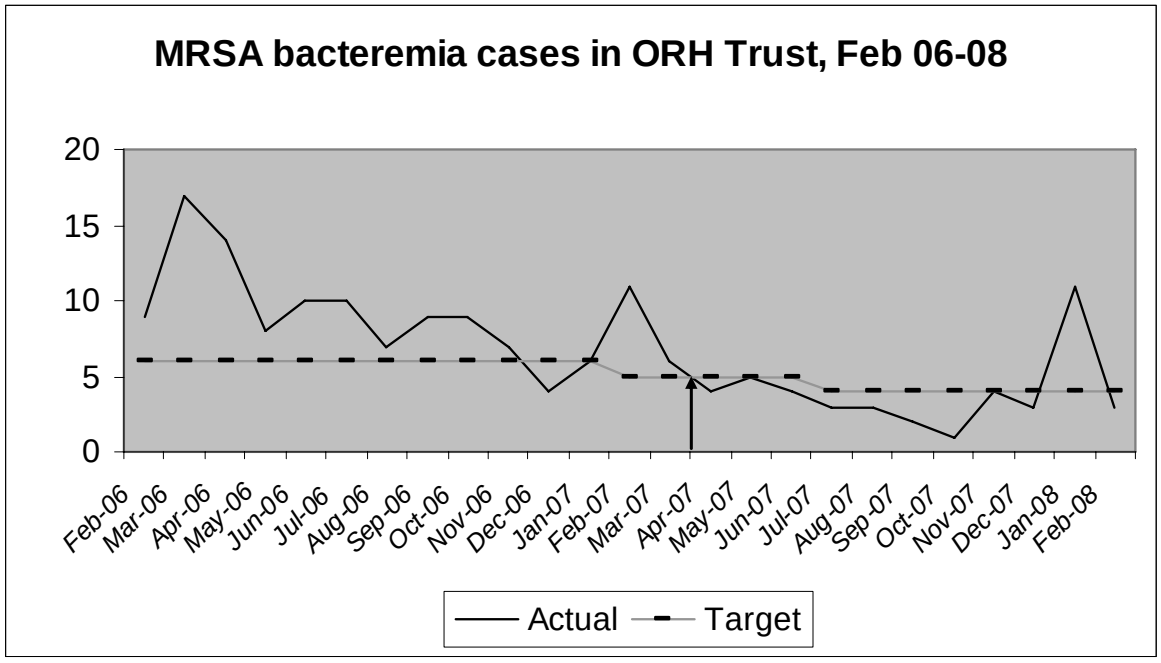
- Improve public awareness, focusing on good education and outreach to young people
- Target hot spots and areas of social deprivation
- Target vulnerable groups such as prisoners and injecting drug users
- Increase the number of young people who are screened and treated for Chlamydia infection.

Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile infections

These infections are an important yet preventable cause of sickness and death. Increased interventions and prolonged hospital stays in an older and more unwell population play an important role in the genesis of such infections. The PCT is working with the Health Protection Agency and NHS Trusts to bring the numbers down. The key to success lies in vigilance, improved infection control and careful management of infected patients and outbreaks.

MRSA is a bacterium commonly found on the skin. If it gains entry into the blood stream, (e.g. during surgery or other invasive procedures) it can cause bacteraemia (blood poisoning). It can be difficult to treat as it is resistant to commonly used antibiotics.

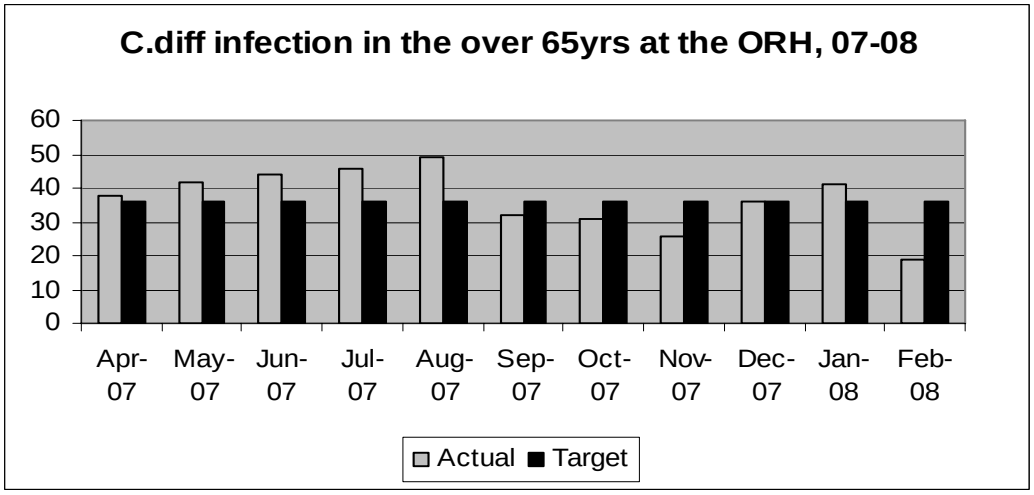
Table 5



The data above show good progress compared with 2006-7. We have not seen more than four patients with bacteraemia per month over the last eight months except for an abrupt increase in January of this year. This is being thoroughly investigated.

Clostridium Difficile (C Diff) is an important cause of hospital acquired diarrhoea. This bacterium can reside harmlessly in some people's intestines. However certain antibiotics can disturb the balance of bacteria in the gut which results in the C. diff bacteria producing illness. This illness can be particularly severe in the elderly and the infirm.

TABLE 6



The data above indicates that in the past 12 months, the number of cases of C. diff infection has exceeded the monthly target six times but levels have again reduced since 2005.

Measures to reduce C. diff infection include proper hand washing before seeing a patient as well as early isolation of infected patients and decontamination of affected areas and equipment. Firm targets are being set across Oxfordshire to bring these infections down during 2008-9.

Recommendations

1. The Director of Public Health should monitor trends in killer infections annually in the Public Health annual report.

2. Oxfordshire PCT should set contracts with NHS Trusts which clearly specify standards and targets for hospital acquired infections and penalties fixed should these targets be missed for 2008/9. Parallel standards and targets should be set for the PCT's community services.

3. The Director of Public Health should monitor infection rates closely for the first half of 2008/09 and service improvements should be included and funded as a priority in the PCTs Operating Plan for 2009/10 and beyond.

4. Referring back to measles, mumps and rubella (MMR) immunisation rates in Chapter 2, the Director of Public Health and the Health Protection Agency should monitor uptake rates of measles vaccine closely and take action to improve uptake by March 2009.

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