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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Meeting Rooms 1 & 2, Thursday, 10 November 2016 at 2.00 pm
County Hall, New Road, Oxford

Peter G. Clark
County Director

November 2016

Contact Officer: ***Julie Dean, Tel: 07393 001089***
julie.dean@oxfordshire.gov.uk

Membership

Chairman – Councillor Ian Hudspeth (Leader, Oxfordshire County Council)
Vice Chairman - Dr Joe McManners (Clinical Chair, Oxfordshire Clinical Commissioning Group)

Board Members:

Councillor Anna Badcock *(South Oxfordshire District Council)*	Vice Chairman, Health Improvement Partnership Board
Eddie Duller OBE	Chairman, Healthwatch Oxfordshire
Dr Matthew Gaw	Vice-Chairman, Children's Trust
Councillor Mrs Judith Heathcoat *(Oxfordshire County Council)*	Chairman, Older People's Joint Management Group
Councillor Hilary Hibbert-Biles *(Oxfordshire County Council)*	Cabinet Member for Public Health
John Jackson	Director for Adult Social Services
Jim Leivers	Director for Children's Services
Dr Jonathan McWilliam	Director of Public Health
Dr Paul Park	Vice-Chairman, Older People's Joint Management Group
Rachel Pearce *(NHS England)*	Director of Commissioning Operations (South Central)
Councillor Melinda Tilley *(Oxfordshire County Council)*	Chairman, Children's Trust
Councillor Ed Turner *(Oxford City Council)*	Chairman, Health Improvement Partnership Board

In Attendance: Peter Clark, Head of Paid Service, OCC
David Smith, Chief Executive, OCCG

Notes:•Date of next meeting: 23 March 2017

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned….."*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chairman, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decisions of Last Meeting (Pages 1 - 8)

To approve the Note of Decisions of the meeting held on 14 July 2016 (**HWB5**) and to receive information arising from them.

6. Performance Report 2016/17 - Quarter 1 (Pages 9 - 26)

2:05
15 minutes

Persons Responsible:	Director of Public Health, Director for Adult Social Services, Director for Children's Services, OCC, Chief Executive, OCCG
Person co-ordinating reports:	Director of Public Health

To receive an update on performance against the outcomes in the Joint Health & Wellbeing Strategy set for 2016-17 (**HWB6).**

Action Required: to note the report.

7. Future Arrangements for the Children's Trust (Pages 27 - 32)

2:20
20 minutes

Persons Responsible:	The Children's Trust Board
Persons co-ordinating report:	Director for Children's Services/Chairman of Children's Trust

To note the future working arrangements for the Children's Trust Board following a review of its role in July 2016 **(HWB7).**

(The Board should note that each of the Boards will be required to review their Terms of

Reference for discussion and approval at the next meeting on 23 March 2017).

Action Required: The Board is asked to note the key change in focus for the Children's Trust Board and the intention to strengthen strategic partnership links between the Children's Trust Board and the Health & Wellbeing Board.

8. Director of Public Health's Annual Report 2015/16 (Pages 33 - 120)

2.40
15 minutes

Person Responsible:	Director of Public Health
Person giving report:	Director of Public Health

The Director of Public Health will present his Annual Report for 2015/16 (**HWB8**).

This is the 9th Director of Public Health Annual Report for Oxfordshire. The purpose of the Director is to improve the Health and wellbeing of the people of the county. This is done by reporting publicly and independently on trends and gaps in the health and wellbeing of the population and by making recommendations for improvement to a wide range of organisations. It is a statutory duty of a Director of Public Health to produce this report.

The Oxfordshire Joint Health Overview & Scrutiny Committee, at its meeting on 15 September 2016, discussed the report and congratulated Dr McWilliam on a very interesting, easy to read and comprehensive report. The Committee was pleased to see more documentation on actions taken, and campaigns undertaken by the Team during the year. In particular they welcomed the section on Health Checks. The Committee also commented that they would welcome even further information on these in the future, together with a view on what had been achieved.

Action Required: to consider the report and to advise Cabinet of any comments accordingly.

9. Health Inequalities Commission Report (Pages 121 - 270)

3:00
30 minutes

Person Responsible:	OCCG & Chair of Health Inequalities Commission
Persons giving report:	Chair of OCCG, Dr Joe McManners & Independent Chair of Health Inequalities Commission, Professor Sian Griffiths OBE

The headline report and full report of the Independent Health Inequalities Commission is attached at **HWB9**.

Action Required: to

(a) to receive and note the findings and recommendations of the Health Inequalities Commission;

(b) to consider how other sectors and communities not represented on the Board can be engaged in a meaningful discussion /action on health inequalities;

(c) as part of this, to particularly consider encouraging investment in community based programmes which increase residents' income and/or reduce their expenditure, such as debt, benefits or employment advice; and

(d) to discuss and agree a strategy for the Health & Wellbeing Board to monitor and assess progress against these recommendations.

10. Oxfordshire Safeguarding Children Board (OSCB)/Oxfordshire Safeguarding Adults Board (OSAB) - Annual Reports for 2015/16 (Pages 271 - 346)

3:30
30 minutes

Persons responsible: Independent Chairs of OSCB and OSAB
Persons giving reports: Independent Chairs of OSCB and OSAB

The OSCB and OSAB are required to report annually on the work of the Boards and of its partners, assessing the position of the partnerships in relation to the safeguarding of children and adults at risk within Oxfordshire. Paul Burnett, Chairman of OSCB and Sula Wiltshire, Acting Chair of OSAB will present the reports **(HWB10).**

11. Healthwatch Oxfordshire - Update (Pages 347 - 352)

4:00
10 minutes

Persons responsible: Healthwatch Oxfordshire (HWO)
Person giving report: Chairman, HWO

There will be a general update on HWO activities by Eddie Duller OBE, Chairman of HWO **(HWB11).** A quarterly update is also attached for the information of the Board

Action Required: to note the report.

12. Reports from Children's Trust Board, Joint Management Group & Health Improvement Partnership Board (Pages 353 - 362)

4:10
10 minutes

Attached are the written reports on activities since the last Health & Wellbeing Board meeting in July **(HWB12)** from:

- Children's Trust Board
- Joint Management Group for Adults
- Health Improvement Partnership Board

Action Required: to receive the reports.

13. PAPERS FOR INFORMATION ONLY (Pages 363 - 364)

The following papers are attached for the information of Board members at **HWB13**.

- Communications received by the Chairman – July 2016 to November 2016

4:20 Close of Meeting

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 14 July 2016 commencing at 2.00 pm and finishing at 3.50 pm

Present:

Board Members:	Councillor Ian Hudspeth – in the Chair Dr Joe McManners (Vice-Chairman) District Councillor Anna Badcock Eddie Duller OBE Councillor Hilary Hibbert-Biles John Jackson Dr Jonathan McWilliam Councillor Melinda Tilley James Drury (In place of Rachel Pearce)
Other Persons in Attendance:	David Smith, OCCG
Officers:	
Whole of meeting	Julie Dean, OCC

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Julie Dean, Tel: 07393 001089 (julie.dean@oxfordshire.gov.uk)

	ACTION
1 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
The Chairman extended a welcome to Members of the Board.	
2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	

Apologies were received from Cllr Mrs Judith Heathcoat, Cllr Ed Turner and Peter Clark.	
3 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest submitted.	Andrea Newman
4 Petitions and Public Address (Agenda No. 4)	
There were no requests to submit a petition or to make an address.	
5 Note of Decisions of Last Meeting (Agenda No. 5)	
The note of the last meeting which took place on 3 March 2016, was approved and signed as a correct record.	Julie Dean
6 Performance Report - end of year 2015/16 (Agenda No. 6)	
The Board received an update on performance against the outcomes in the Joint Health & Wellbeing Strategy set for 2015/16. <u>In relation to Priority 7, Target 7.1 – 'Reduce the number of people delayed in hospital from an average of 145 per day in 2014/15 to an average of 96 for 2015/16'</u>, David Smith reported that performance had increased considerably since the end of Quarter 4 (153) and at the end of June the figure was at 60. He added that this was the result of all in the system working together. In response to a question about the sustainability of this, John Jackson stated that the trend was continuing to be downwards. Moreover, Oxfordshire's performance was being observed elsewhere, for example, Simon Stevens had cited it as an example of good practice at the Chairman's Confederation and the Royal Berkshire Hospital, at a recent Board meeting, had expressed an interest in coming to Oxfordshire to observe practice. <u>In relation to Priority 3, Targets 3.6 and 3.8 – 'Reduce the assessed level of risk for high risk domestic violence victims managed through the MARAC (Multi-Agency Referral Risk</u>	

Assessment Conference)' and 'Monitor the proportion of MASH (Multi-Agency Safeguarding Hub) enquiries leading to a referral where information was shared with partner agencies.' – Cllr Melinda Tilley undertook to look into the possibility of raising the targets, stating that a review of MASH was underway and suggesting that it be taken to the Community Safety Partnership for discussion. It was **AGREED** to note the report.	Dr Jonathan McWilliam/Ben Threadgold/Cllr Melinda Tilley
7 Revised Joint Health & Wellbeing Strategy for 2016/17 (Agenda No. 7)	
The Board had before them for approval the draft revised Joint Health & Wellbeing Strategy for 2016/17, together with performance against outcomes in the 2015/16 Strategy. The Board addressed the comments on the draft Strategy made by the Oxfordshire Joint Health Overview & Scrutiny Committee (HOSC) at its meeting on 30 June, with the following responses: • The Strategy covered a broad spectrum of services with diverse accountabilities. Its aim was to keep a broad view of the impact of the Board on the population. This was done by using measurement of population via population outcomes which were listed in the performance framework and monitored regularly. The Board was open to suggestions about how to improve this. In response to specific questions raised by members of the Oxfordshire Joint Health & Overview Committee (HOSC) about the impact of service changes, the Board reminded HOSC that since the proposed Strategy had been compiled, the Comet Bus Service had been launched and discussions had taken place with Children's Centres and Housing Related Support. In addition, it was reported that 35 outcome measures from last year's Strategy were showing an improvement, which showed that it was making a difference and having an impact on the population; • Similarly, the STP, which did not exist as yet, would include NHS system-based plans covering 3 counties. The Joint HWB Strategy was solely Oxfordshire's document and is a population-based approach. There would be opportunity to clarify the ongoing relationship between the two strategic plans as the STP was	

developed, but in the meantime the need for the Joint Health & Wellbeing Strategy remained. • HOSC'S suggestion that it would be helpful to include a full summary of the previous year's performance in order to more fully understand the proposal outcomes was taken on board; • Similarly, the comment that there was too little detail on who implemented the work to meet the outcomes, and how they were held to account, was taken on board. • There was no charge for the reablement service, thus the information was complete and the service was for the population as a whole. During discussion, the Board **AGREED** the following actions: **(a)** more information from Public Health on the reasons why not all children were receiving meningitis inoculations; **(b)** with regard to Priority 2 'Narrowing the gap for our most disadvantaged and vulnerable groups', proposed outcome 2.5 'Reduce the persistent absence of children subject to Child in Need and a Child Protection Plan' – it was suggested that officers investigate if MASH could have an involvement; **(c)** there was a need to take action, without detracting from, or at the expense of the universal services, to analyse inequality gaps; for example in outcomes for people in ethnic groups. Appropriate targets could then be set with the aim of improving outcomes for those with the worst outcomes. It was noted that the Health Improvement Board was already doing this for some areas of their work and that this should become more widespread practice across all the Partnership Boards/JMGs; and **(d)** taking into account the above, and having considered the views of HOSC, the content of the Joint Strategic Needs Assessment (which had been presented to the Board at its March meeting), and the performance against outcomes in the 2015-16 Strategy, to accept the Strategy as the basis for its work in 2016-17.	))))))))) Dr Jonathan McWilliam/Ben Threadgold/Jackie Wilderspin)))))))))))))))

8 Oxfordshire's Sustainability and Transformation Plan 2016/17 (Agenda No. 8)	
David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group, gave a verbal update on the draft submission of the Oxfordshire's Sustainability & Transformation Plan 2016/17 to NHS England. He gave the update in two parts, the first being ongoing work across the 'BOB' (Buckinghamshire, Oxfordshire and Berkshire) footprint and the second, ongoing work specifically in Oxfordshire. With regard to the ongoing work across the BOB footprint, he reported that the draft submission had now been submitted to NHS England and he was the lead. The main priorities at this level were: (a) prevention – including the promoting of physical activity and the prevention of obesity; (b) changes to Urgent Care across the system; (c) capacity issues in maternity services; and (d) specialised commissioning. The STP leaders, chief executives of various organisations had raised a number of issues about the proposals that needed to be worked up, one of which was of governance and how the new structures would sit with Health & Wellbeing Boards across the BOB network. NHS allocation of new funding would be made across the BOB footprint and implications for local planning were unknown. A discussion then ensued about what the Board would aspire to in order to attain the most positive benefits and the merits of an enhanced prevention agenda was agreed. In relation to the ongoing work specifically in Oxfordshire, David Smith referred to the 'Big Conversation' which had just been launched, which comprised 6 public engagement events in various locations. In parallel to this, the NHS was in the process of working up detailed plans for care closer to home and how to link in community pharmacies, Social Care and the voluntary sector. Following clearance by NHS England and Central Government, the Oxfordshire Transformation Plan (the local part of the STP) would be out for consultation in the early Autumn. Dr McWilliam spoke about the merits of enhanced levels of a 'transformation shift to prevention across all NHS services. This needed to be a core part of the plans at both Oxfordshire and STP level if the pressures on the NHS were to be reduced and	

people were to have better and longer lives. This had to include NHS initiatives to embed prevention in all patients contacts and would need changes in the system to enable GPs and others to have time to devote to talking to patients about preventing illness. Other proposals likely to be in the consultation document would include enhanced levels of primary and community care closer to home, to prevent hospital admissions, which would enable GP surgeries, working as groups in a locality, to have access to technology and specialists. This would be supported by an agenda leading to the integration of social care and primary care. Building this up to suit the requirements of each location would require building based designs. With regard to process, David Smith stated that as the above would be a significant change to services, the Oxfordshire Health Overview & Scrutiny Committee (HOSC) would need to be formally consulted. Implementation would depend on the consultation process and the decisions coming out of it. Any formal decisions would be taken by the OCCG Board in February 2017 and implementation would take place after that in the next financial year and would take 3 to 4 years. He warned that change was required, otherwise there would be a very large deficit. In response to a question about plans for communication with residents in the localities, David Smith stated that every form of media communication would be used. District Councils would also be briefed. He added that HOSC was the only respondee who had the power to refer proposals to the Secretary of State via the Independent Review Panel. Eddie Duller advised that the consultation should be in plain English, adding that the public tended to be concerned mainly with its own locality and family needs. Healthwatch Oxfordshire were doing their best to inform the public of the forthcoming consultation via their website. James Drury advised that NHS England would need to sign off, as part of their NHS Service Reconfiguration Policy, stages 1 and 2 of the review. The Board **AGREED** to note the report.	All to note
9 Oxfordshire's Better Care Fund Plan 2016-17 (Agenda No. 9)	
John Jackson updated the Board on the development and submission of Oxfordshire's Better Care Fund Plan for 2016/17.	

The cover report and plan was attached at HWB9. The Board **AGREED** to receive the Better Care Fund Plan for 2016/17.	John Jackson/ben Threadgold
10 Oxfordshire Transforming Care Plan 2016-2019 (Agenda No. 10)	
Sula Wiltshire, Director of Quality and Lead Nurse, OCCG, and Kate Terroni, Assistant Director for Adult Social Care introduced the planning template and Action Plan (HWB10). John Jackson acknowledged the work done by the District Councils in supporting the move to supported living in Oxfordshire. This had enabled the development of some very creative schemes that had proved very successful for the wellbeing of the users and their families. It was **AGREED** to note the Plan.	David Smith/John Jackson
11 Healthwatch Oxfordshire - Update (Agenda No. 11)	
Eddie Duller gave a general update on Healthwatch Oxfordshire's (HWO) activities. He highlighted his concern about growing problems with patient accessibility to GPs and expressed a hope that this would be addressed as part of the Transformation Plan. The Board welcomed the HWO report on Female Genital Mutilation, which was due to be published in early September. In response to a request for information by a Board member on how much feedback had been received on the subject of repeat prescriptions and some reported incidences of a shortage of stock, Carol Moore, Chief Executive of HWO, stated that only two pharmacies in the south of the county had sent feedback and HWO had no additional concerns. James Drury explained that some of the large pharmacies who gathered in prescriptions had changed their business models thus causing some issues of availability. He added that a project was being rolled out to encourage the public to use the electronic facility open to them. The Board took the opportunity to thank Carol Moore, who was	

leaving the area, for all her hard work and wished her well in the future. The Board **AGREED** to note the report.	 All to note
12 Reports from Children's Trust, Older People Joint Management Group and Health Improvement Partnership Board (Agenda No. 12)	
The Chairmen of the Children's Trust and the Health Improvement Partnership Board, together with the Director for Adult Social Care, presented the written reports on activities since the last full Board meeting (HWB11). Cllr Tilley, Chairman of the Children's Trust, highlighted that there would be a review of the Children's Trust and its role at its next meeting. Also the new interim Chair of the Safeguarding Board was coming along. Cllr Anna Badcock, Chairman of the Health Improvement Partnership Board, highlighted its Healthy Weight Review which, she stated, had been very well run and had resulted in some very good solutions. The Board **AGREED** to note the reports.	 All to note
13 SUMMARY OF COMMUNICATIONS RECEIVED BY THE CHAIRMAN - FOR INFORMATION ONLY (Agenda No. 13)	
Noted.	

..... in the Chair

Date of signing .....

Oxfordshire Health & Wellbeing Board – 10 November 2016
Performance Report 2016/17

Introduction

1. Annex 1 shows 2016/7 performance for all priorities in the Health & Wellbeing strategy for quarter 1. Performance on priorities 1-4 is managed through the Children's Trust; performance on priorities 5-7 is managed through the Joint Management Groups for the Pooled Budgets for adult health and care services and performance on priorities 8-11 is managed through the Health Improvement Board. The Children's Trust is just completing a review of its roles and functions and has amended the datasets associated with priorities 1-4. The revised dataset will be reported in quarter 2.

2. Priority 4 is monitored via the Children's Trust in the annual education report – the 2016 annual report will be provided in February 2017 once the full set of attainment results are published.

Summary

3. The table below summarises performance on each priority. In total 48 measures are now reported, with 31 rated. 20 (61%) are on target, with 4 (12%) rated amber and 9 (27%) rated red. Looking across all the measures, performance is good, with half or more of the measures hitting their target for priorities 2, 3, 5, 6, 7, 8, 10 and 11. However in the following priorities over half of the measures have missed the target:
    a. Ensuring children have a healthy start in life and stay healthy into adulthood
    b. Preventing chronic disease

	Red	Amber	Green	Not Rated	Total
1. Ensuring children have a healthy start in life and stay healthy into adulthood	1	0	0	0	1
2. Narrowing the gap for our most disadvantaged and vulnerable groups	2	0	2	2	6
3. Keeping children and young people safe	0	0	2	0	2
5. Working together to improve quality and value for money in the Health and Social Care System	2	0	2	2	6
6 Adults with long term conditions living independently and achieving their full potential	0	0	5	1	6
7. Support older people to live independently with dignity whilst reducing the need for care & support	2	1	3	1	7
8 Preventing early death and improving quality of life in later years	2	0	4	1	7
9. Preventing chronic disease through tackling obesity	0	2	0	1	3
10. Tackling the broader determinants of health through better housing and preventing homelessness	0	0	1	5	6
11. Preventing infectious disease through immunisation	0	1	1	2	4
Total	9	4	20	15	48

4. The individual indicators rated as red are:
    a. Ensuring children have a healthy start in life and stay healthy into adulthood
        i. 1.1 Waiting times for first appointment CAHMS. 75% of children will receive their first appointment within 12 weeks of referral by the end 2016/17
    b. Narrowing the gap for our most disadvantaged and vulnerable groups
        i. 2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 77 to 60
        ii. 2.5 Reduce the proportion of children with SEN with at least one fixed term exclusion in the academic year. (Measured on an academic year)
    c. Keeping children and young people safe
        i. none
    d. Working together to improve quality and value for money in the Health and Social Care System
        i. 5.2 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages
        ii. 5.5 Increase the percentage of people waiting a total time of less than 4 hours in A&E.
    e. Adults with long term conditions living independently and achieving their full potential
        i. none
    f. Support older people to live independently with dignity whilst reducing the need for care and support
        i. 7.2 Reduce the number of older people placed in a care home from 12 per week in 2015/16 to 11 per week for 2016/177
        ii. 7.5 Increasing the number of hours people are able to access the reablement pathway to 110,000 hours per year (2,115 per week) by April 2017.
    g. Preventing early death and improving quality of life in later years
        i. 8.3 Take-up of invitation for NHS Health Checks should exceed national average (2015-16 = 51.7% nationally) and aspire to 55% in year ahead. No CCG locality should record less than 50%.
        ii. 8.7 Number of users on NON-OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.
    h. Preventing chronic disease through tackling obesity
        i. none
    i. Tackling the broader determinants of health through better housing and preventing homelessness
        i. none
    j. Preventing infectious disease through immunisation
        i. none

Steve Thomas
Performance & Information Manager (Social Care)
October 2016

Annex 1

Oxfordshire Health and Wellbeing Board
Performance Report

Priority One: Ensuring children have a healthy start in life and stay healthy into adulthood

	Baseline	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
1.1 Waiting times for first appointment CAHMS. 75% of children will receive their first appointment within 12 weeks of referral by the end 2016/17	54%	29%	R							CCG is monitoring performance and has plans in place to tackle this issue assured by the NHSE.

Priority Two: Narrowing the gap for our most disadvantaged and vulnerable groups

	Baseline	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
2.1 Reducing inequalities as measured by Public Health measure 1.01i - Children in poverty (all dependent children under 20)	10.7									Annual measure. Children in poverty (all dependent children under 20) – latest figure we have is for 2013 – 10.7% (significantly better than England average (18%)). Children (under 16s) in poverty – latest figure also for 2013 – 11.1% (significantly better than England average (18.6%)). 2014 figures not available
2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 77 to 60	77	87	R							The number of looked after children has risen to 622. This is a similar rate to our statistical neighbours, but significantly below the national level. The growth affects the number of placed out of county. The delivery of the residential part of the placement strategy has been delayed by 7 months due to the late completion of the Thame Assessment Centre. The fostering element of the placement strategy has been very successful - with a 41% increase in use of in-house foster placement and foster placement with family and friends since March 2013.
2.3 Reduce the level of care leavers not in employment, education or training	51%									Annual Figure
2.4 Increase the number of young carers identified and worked with from 2281 by 20%	2281	2387 (124 new)	G							124 new young carers were identified in first quarter.

2.5 Reduce the proportion of children with SEN with at least one fixed term exclusion in the academic year. (Measured on an academic year)	5.1%	7.1%	R							The provision of schooling is increasingly through a more autonomous academy led system. Not all academy schools or academy chains have a strategic approach to SEND provision and those schools can be isolated or experience a reduction in SEN support and direction. There are also growing concerns that SEND budgets are not being used appropriately but difficult to challenge as funding is not as transparent in academies.
2.6 Increase the proportion of children with a disability who are accessing short breaks services who are eligible for school meals	24%	44.4%	G							27 children receiving short breaks, 12 eligible for FSM

Priority Three: Keeping children and young people safe

	Baseline	15/16 figure	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
3.1 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) (PH OF 2.07ii)	152.3	152.3	132.7	G							
3.2 More than 70 schools receive direct support to implement effective Anti-Bullying strategies as evidenced by school action plans to tackle and reduce bullying through increased membership of Anti-Bullying Ambassador scheme, individual support from Anti-Bullying Co-ordinator and provision of training	70	146	28	G							18 primary and 10 secondary schools supported between 1 April and 31 July 2016 compared with 146 in 2015-16

Priority Four: Raising achievement for all children and young people

Monitoring Education Strategy measures:

	No	RAG
Early Years, including: • 62% of children in early years & foundation stage reaching a good level of development, updated now with 2016 data	70%	G
Levels of attainment and quality across all primary and secondary schools		
Closing the attainment gap, including:		
• Free School Meals gap o KS2 (%expected standard) New definition so no baseline. Data to be provided in February	No baseline	
• Free School Meals gap o KS4 (Progress 8) New definition so no baseline. Data to be provided in February	No baseline	
• Children at School Support o KS2 (% expected standard) New definition so no baseline. Data to be provided in February	No baseline	
• Children at School Support o KS4 (Progress 8) New definition so no baseline. Data to be provided in February	No baseline	

Priority 5: Working together to improve quality and value for money in the Health and Social Care System

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
5.1 Deliver the 6 Better Care Fund national requirements for closer working of health and social care			G							All requirements being met.
5.2 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages	tbc		R							Year on year performance showed a reduction at April (the most recent figures) but this is classed as red as the latest figure exceeds the target. Currently there is significant pressure on non-elective admissions overall and this may be reflected in future reports.
5.3 Increase the number of carers receiving a social care assessment from 7,036 in 2015/16 to 7,500 in 2016/17.	7,500	nya								Figure not currently available. Awaiting update in social care system
5.4 Increase % carers who are extremely or very satisfied with support or services received. 43.8 % baseline from 2014 Carers survey.	> 44%									Based on a national survey of informal carers of social care service users. Survey to be run in November
5.5 Increase the percentage of people waiting a total time of less than 4 hours in A&E.	95%	83.5%	R							We aim to improve performance in respect of the 95% A&E target through a number of initiatives including an extension of Ambulatory Care Pathways and the use of interface medics to bridge the gap between primary and secondary care. Further work is being carried out and we are striving to continue developing pathways to become increasingly effective and efficient. The Ambulatory Emergency Care service facility has been expanded to increase the number of patients that can be seen. We anticipate that this will have a positive impact from Q2 onwards.
5.6 Increase the percentage of people waiting less than 18 weeks for treatment	92%	92.2%	G							This figure is the overall position for all providers across all specialities. There has

following a referral										been under performance in some specialities that have caused the numbers to vary below target in some months but the year to date performance is on target at July.

Priority 6: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
6.1 20,000 people to receive information and advice about areas of support as part of community information networks.	20,000	16,785	G							
6.2 15 % of patients with common mental health disorders, primarily anxiety and depression with access to treatment.	15%	15.9%	G							
6.3 Improve access to psychological therapies so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery.	50%	50.6%	G							
6.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP.	60%	nya								
6.5 Increase the employment rate amongst people with mental illness.	16.75%	20%	G							
6.6 Reduce the number of assessment and treatment hospital admissions for adults with a learning disability to 6 or fewer	6		G							Figures under 5 are not reported to ensure confidentiality is maintained. Performance is on target. This measure will be revised next quarter in line with revised NHS England guidance

Priority 7: Support older people to live independently with dignity whilst reducing the need for care and support

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
7.1 Reduce the number of people delayed in hospital from current level of 136 in April 2016 to 102 in December 2016 and 73 in March 2017.	73	110	G							On track to meet target. The reduction attributed to the introduction of the 'new command-and-control' structures between the providers, which in turn has supplemented the DTOC pathway work ongoing since December 2015.
7.2 Reduce the number of older people placed in a care home from 12 per week in 2015/16 to 11 per week for 2016/17.	12	13	R							There has been an increase in care home admissions whereas the target was to reduce the number. This though has in part reflects a fall in the waiting lists.
7.3 Increase the proportion of older with an on-going care package supported to live at home from 60% in April 2016 to 62% in April 2017	63%	63.3%	G							New home care contracts began in May and fewer people are now waiting for care. Increased availability of care has meant the proportion of older people supported at home has increased beyond target. Within the Better Care Fund plan we agreed to purchase an additional 10% more home care in the year. This has been exceeded. This has helped reduce delays across the system (in hospital, at home and in reablement and other short term services)
7.4 66.7% of the expected population with dementia will have a recorded diagnosis	66.7%	66.3%	G							

7.5 Increasing the number of hours people are able to access the reablement pathway to 110,000 hours per year (2,115 per week) by April 2017.	2,115	917	R							A new reablement contract begins on October 1st bringing together several existing services, which will allow the service to deliver more care. However performance is 25% below what would be expected at this point in the year. The transition is being managed through a Joint Strategic Oversight Group and has involved increased monitoring of the outgoing supplier and joint work with the incoming supplier. Both the outgoing and incoming suppliers have met to co-ordinate and agree arrangements particularly around staff transfers and communication. All workstreams are progressing as expected and the services will remain a priority.
7.6 75% of people who receive reablement need no ongoing support.	75%	67%	A							
7.7 Monitor the number of providers described as outstanding, good, requires improvement and inadequate by Ofsted.	See below									

Provider CQC Ratings (as reported 1/7/2016) of providers inspected so far

	Care Homes			Social Care at home			Independent Health Care			NHS Healthcare			Primary Medical Services		
	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %
Outstanding	2	2%	1%	1	2%	1%	0	0%	9%	1	20%	5%	2	6%	4%
Good	69	65%	68%	45	74%	76%	3	100%	65%	3	60%	40%	28	82%	83%
Requires Improvement	36	34%	29%	15	25%	21%	0	0%	23%	1	20%	49%	4	12%	10%
Inadequate	0	0%	3%	0	0%	2%	0	0%	3%	0	0%	7%	0	0%	3%

There were no inadequate care providers, as rated by CQC, in Oxfordshire at the end of June. There are 542 inadequate providers nationally, including health services, covering 137 of the 152 adult social care authority areas. There are 391 inadequate social care providers nationally covering 117 local authority areas. Providers rated as 'good' or 'outstanding' are now in line with national figures.

Four of the eight new 'Help to Live at home' providers have been rated by CQC. 3 are good and 1 requires improvement. These providers deliver care to 450 service users, of whom 392 - or 87% are with providers rated as good

Priority 8: Preventing early death and improving quality of life in later years

Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
		Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
8.1 At least 60% of those sent bowel screening packs will complete and return them (aged 60-74 years) - and adequately screened	60%	0%								Data received for Q4 2015/16 indicates this is now at 59.9%. Data received 6 months in arrears.
8.2 Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%.	15%	5.0%	G							Q1 - all localities (except West Oxfordshire (2.6%) have similar proportions to Oxfordshire overall.
8.3 Take-up of invitation for NHS Health Checks should exceed national average (2015-16 = 51.7% nationally) and aspire to 55% in year ahead. No CCG locality should record less than 50%.	>51.7% (Aspire 55%)	35.1%	R							Q1 - some variance between localities. West Oxfordshire 76%, North Oxfordshire 48%, All others lower than Oxfordshire figure.
8.4 Number of people quitting smoking for at least 4 weeks should exceed 2015-16 baseline by at least 10% (15-16 baseline = 1923)	> 2115 by end year	551	G							Currently on-target to meet 2115 by end year.
8.5 Mother smoking at time of delivery should decrease to below 8% - Oxfordshire CCG	<8%	7.8%	G							
8.6 Number of users of OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.	> 4.5% 5% end year (Aspire 6.8% long term)	4.6%	G							This has improved and achieves the new target. It is not as high as the aspiration for the end of the year.

8.7 Number of users on NON-OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.	> 26.2% 30% end year (Aspire 37.3% long term)	20.8%	R							

Priority 9: Preventing chronic disease through tackling obesity

Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
		Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
9.1 National Childhood Measurement Programme (NCMP) - obesity prevalence in Year 6. No district population should record more than 19%	<=16%									
9.2 Reduce by 0.5% the proportion of people who are NOT physically active for at least 30 minutes a week (baseline for Oxfordshire 21.9% Jan14-15)	Reduce by 0.5% from baseline (21.9%)	23.4%	A							Updated PHOF Aug 2016. This has been classed as "amber" rather than “red” as it remains significantly better than England (28.7%)
9.3 Babies breastfed at 6-8 weeks of age (County) No individual CCG locality should have a rate of less than 55%)	63%	62.2%	A							Seeking to obtain these data at locality level (SL)

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness

Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
		Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
10.1 The number of households in temporary accommodation on 31 March 2017 should be no greater than level reported in March 2016 (baseline 190 households)	≥190									
10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.2% 2015-16)	75%	84.9%	G							
10.3 At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless.	80%									
10.4 Increase the number of households in Oxfordshire who have received significant increases in energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners	Needs a new target									
10.5 Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 90 (2015)	≥90									
10.6 At least 70% of young people leaving supported housing services will have positive outcomes in 2016-17, aspiring to 95%	<=70% Aspire 95%									

Priority 11: Preventing infectious disease through immunisation

Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
		Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 years and no CCG locality should perform below 94%	95%	95.0%	G							Seeking data at locality level
11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 years and no CCG locality should perform below 94%	95%	93.4%	A							Seeking data at locality level
11.3 Seasonal Flu <65 at risk (Oxfordshire CCG)	≥ 55%									
11.4 HPV 12-13 years (Human papillomavirus) 2 doses	≥ 90%									

Agenda Item:

Committee(s) Health and Wellbeing Board	**Date** 10 November 2016
Health and Wellbeing Board	**Public**
Subject: Review of Children's Trust Board	
Report of : Cllr Melinda Tilley, Chairman of the Children Trust Board	**For information**
Report Author : Tan Lea, Strategic Safeguarding Partnerships Manager	

Summary

The Children's Trust Board (the Board) has undertaken a review of its role, function and purpose.

As a consequence the Board agreed to realign its role and purpose and the way that it operates, with a particular focus on:

- Effective multi agency working at a strategic level across children's services by prioritising three key shared areas which all agencies agree that they can commit to actively working in partnership to exercise influence and ensure positive outcomes for children.
- Enabling Children, young people, their families and carers to shape and inform Children's Trust Board discussions and decisions.

- Developing the Children's Trust Board as a strategic body, able to influence policy and plans where they impact on children and young people.

Recommendation(s)

The Health and Wellbeing Board is asked to note the key change in focus for the Children Trust Board and the intention to strengthen strategic partnership links between the Children's Trust Board and the Health and Wellbeing Board.

Main Report

1. Introduction

1.1 At a workshop held on 27 July 2016, members were consulted on:

- The role and purpose of a Children's Trust Board
- The mechanisms for effective strategic partnership working
- The mechanisms for involving children, young people, their families and carers
- How the Children Trust Board could be established as a strategic body linking with key partnerships boards and structures across children's services and able to influence key plans, policies and agendas in relation to children and young people.

1.2 Following the workshop, officers drafted a proposal for the Children's Trust Board. The model was finalised and agreed with members at the Trust meeting on 29 September 2016 and is presented below.

2. Recommended role and purpose

2.1 Members agreed that the role and purpose of the Children's Trust Board should be to:

- Strengthen key areas of multi agency strategic planning for children and young people, whilst recognising the statutory role of individual agencies.
- Improve outcomes for children in relation to keeping safe, staying healthy, narrowing the gap and raising achievement under the priority areas outlined in section 3 below.
- Drive the integration agenda where there is evidence that integrated working will improve outcomes for children and young people
- Champion the involvement of children, young people their families and carers in partnership working with senior managers and politicians.
- Ensure the Health and Wellbeing Board and other partnerships are sighted on the key challenges facing children and young people in Oxfordshire.

3. The key partnership working mechanisms

3.1.1 A joint focus and three top priorities

Members agreed a joint, strategic focus on the following three priority areas, to be developed either through task and finish groups or existing groups, which will responsible to the Trust for delivering against agreed objectives.

Priority 1: Early Help and Early Intervention.
Led by Lucy Butler, Deputy Director, Children's Social Care, Oxfordshire County Council

Priority 2: Educational attainment for vulnerable groups of children.
Led by Janet Johnson, Children with SEN Manager, Oxfordshire County Council

Priority 3: Managing transitions into adulthood
A lead representing the Oxfordshire County Council Strategic Transitions Group

3.2 Involving children and young people

The newly launched Youth Forum will be a key communication and engagement vehicle for the Trust Board. Further consultation and scoping with the Forum will be undertaken to agree the mechanisms for active involvement with the wider Board.

3.3 A cohesive, coordinated and focussed approach

The Trust will meet four times a year, the agenda for three of the meetings will include a focus on at least one of the priorities listed above and also include time to consider emerging and core business[1]. The fourth meeting will be dedicated to business planning purposes, developing the Children and Young People's Plan and core Children's Trust dataset and potentially linking with other boards to align plans.

3.4 Linking with the Health and Wellbeing Board

The Board intends to use its links with the Health and Wellbeing Board more effectively and escalate children and young people's issues where these are wider than the remit of the partnership and input of the Health and Wellbeing Board would be valuable.

To achieve this the Children's Trust Board will ensure representation at all Health and Wellbeing Board meetings.

3.5 Analysis of need and priority setting

[1] Core business includes:
- Performance monitoring and management
- Updates from partnerships, organisations and members
- New and emerging national, regional and local policy developments and their impact on Business of the Trust.

The Board will use data and analysis from the Joint Strategic Needs Assessment to identify priorities for its business plan and revised Children and Young People's Plan (2017-20).

In line with this, a new revised data set and performance framework is being developed , This will form the basis of regular performance reporting to the Board.

3.6 Have the right membership and representation

The Board has reviewed and updated its membership to align with its new role and purpose.

Details of representative organisations is presented in Appendix 1.

4 Key actions for forward plan

- Publication of annual Business Plan
- Review and publication of Children and Young People's Plan (2017-18)
- Finalise the Children's Trust Performance dataset

5 Summary and Recommendations

This report presents the new role and purpose of the Children's Trust Board.

The Health and Wellbeing Board is asked to note this report and that a key function of the Children's Trust will be to strengthen strategic links between the two structures.

Report of: Councillor Melinda Tilley, Chair of Children's Trust Board

Contact: Tan Lea, Strategic Safeguarding Partnerships Manager, tel 0786 7923 287, or email on tan.lea@oxfordshire.gov.uk

Appendix 1:
Children Trust Board Revised Membership (by sector / organisation)

The Trust membership is drawn from each of the agencies or organisations as set out below:

- Oxfordshire County Council services for education and learning, children's social care, public health, joint commissioning
- City and District Council Members
- Oxfordshire Clinical Commissioning Group
- Thames Valley Police
- Oxfordshire Safeguarding Children Board
- Oxford Health NHS Foundation Trust
- Safer Oxfordshire Partnership
- Oxford University Hospitals NHS Trust
- Voluntary Sector representation
- Representation from schools and colleges
- Parents appointed by Healthwatch Oxfordshire as Healthwatch ambassadors
- Formal links to Oxfordshire Youth Forum

Membership will be reviewed and agreed annually

The Chairman
The Trust will be chaired by the Cabinet Member for Children, Education and Families Oxfordshire County Council.

The Vice Chairman
The Vice Chairman will be a representative from Oxfordshire Clinical Commissioning Group.

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DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT IX

Reporting on 2015/16
Produced: July 2016

Contents

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.

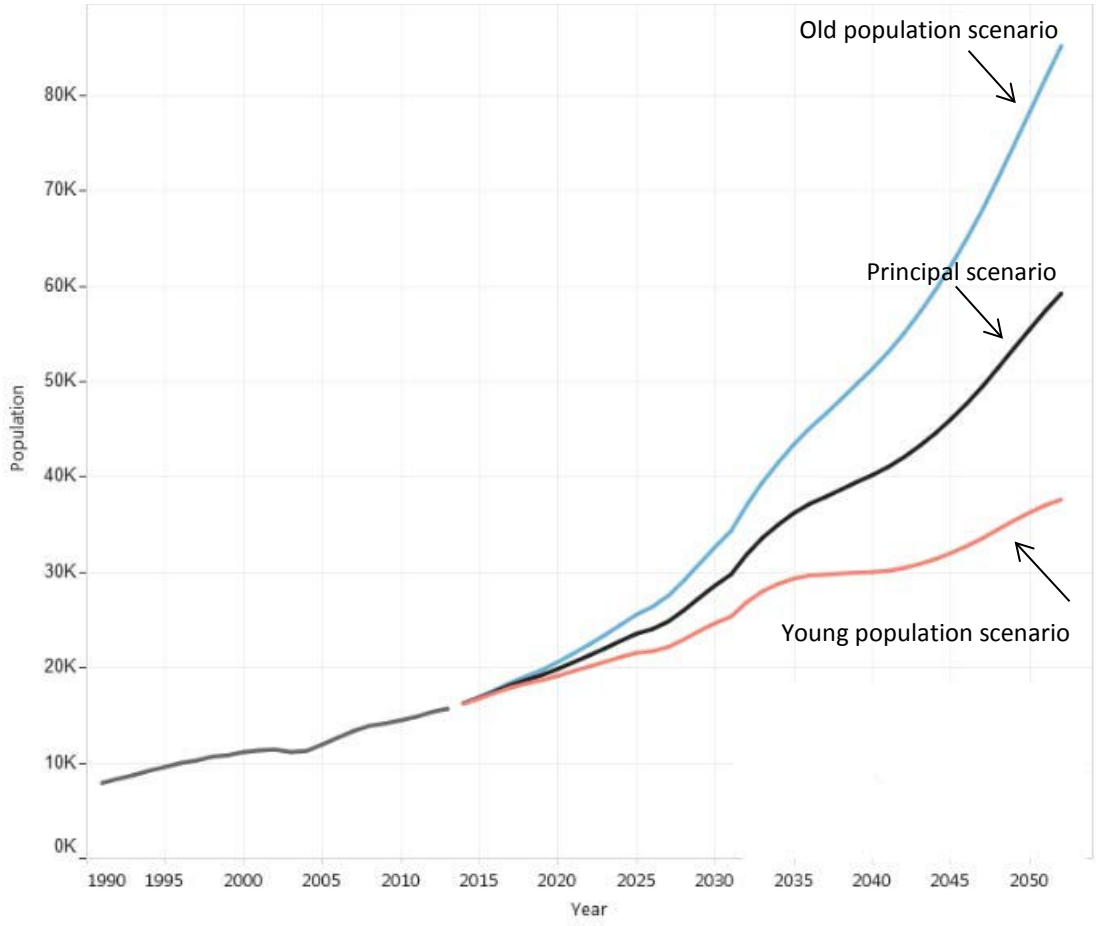
The demographic challenge isn't just about older people – there are issues for all age groups and for the changing composition of the population itself, particularly linked to changes in ethnic group composition. In this chapter I will look at each of these factors in turn.

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%
Oxfordshire Total	*115,600*	17.2%

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+.

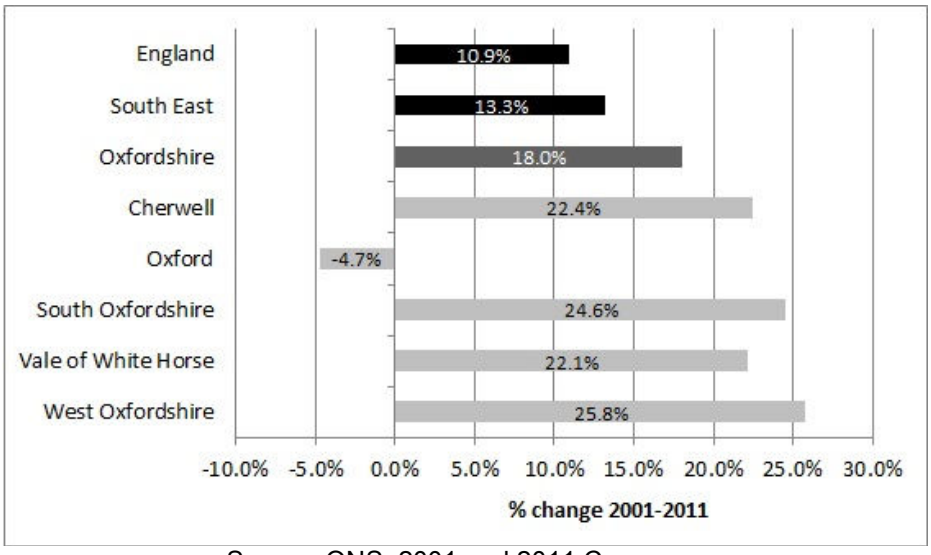
Oxfordshire wards where older people make up more than a quarter of the population

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.

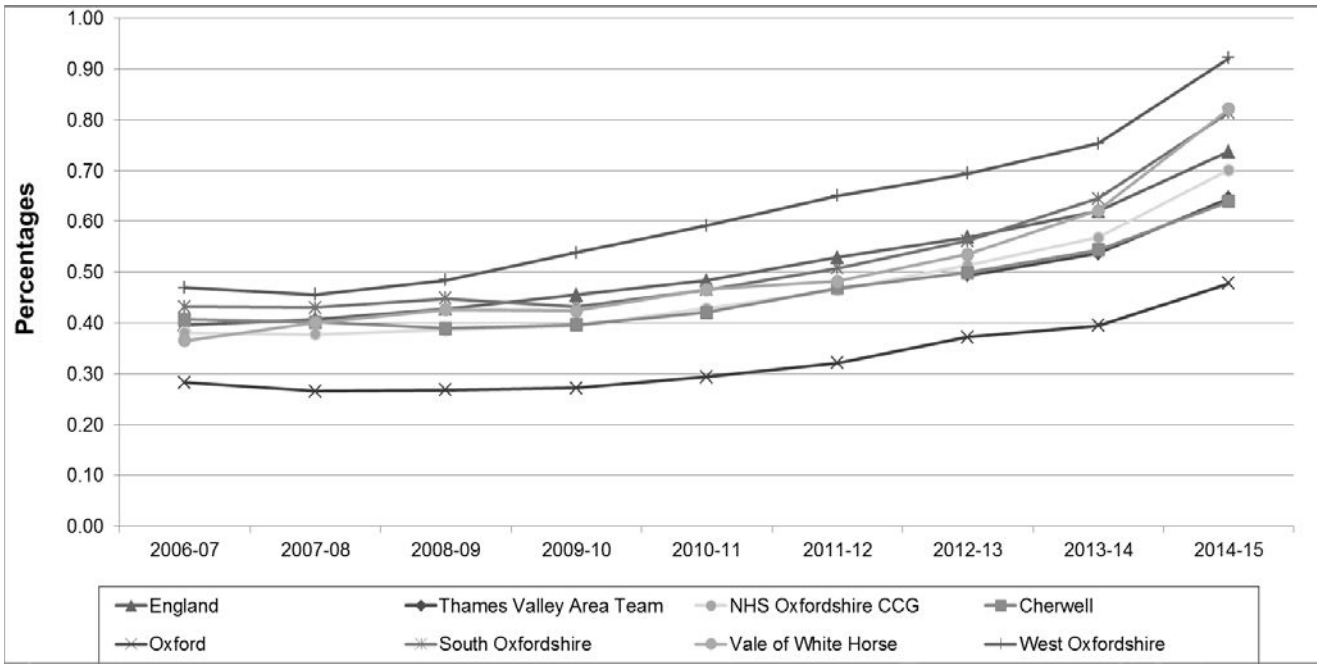
This means that the need for change to services will hit Oxfordshire harder and faster than elsewhere in the country. This puts more pressure on the 'Oxfordshire £' and means that our services will be hit harder and sooner than elsewhere, making the case for change even more compelling.

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.

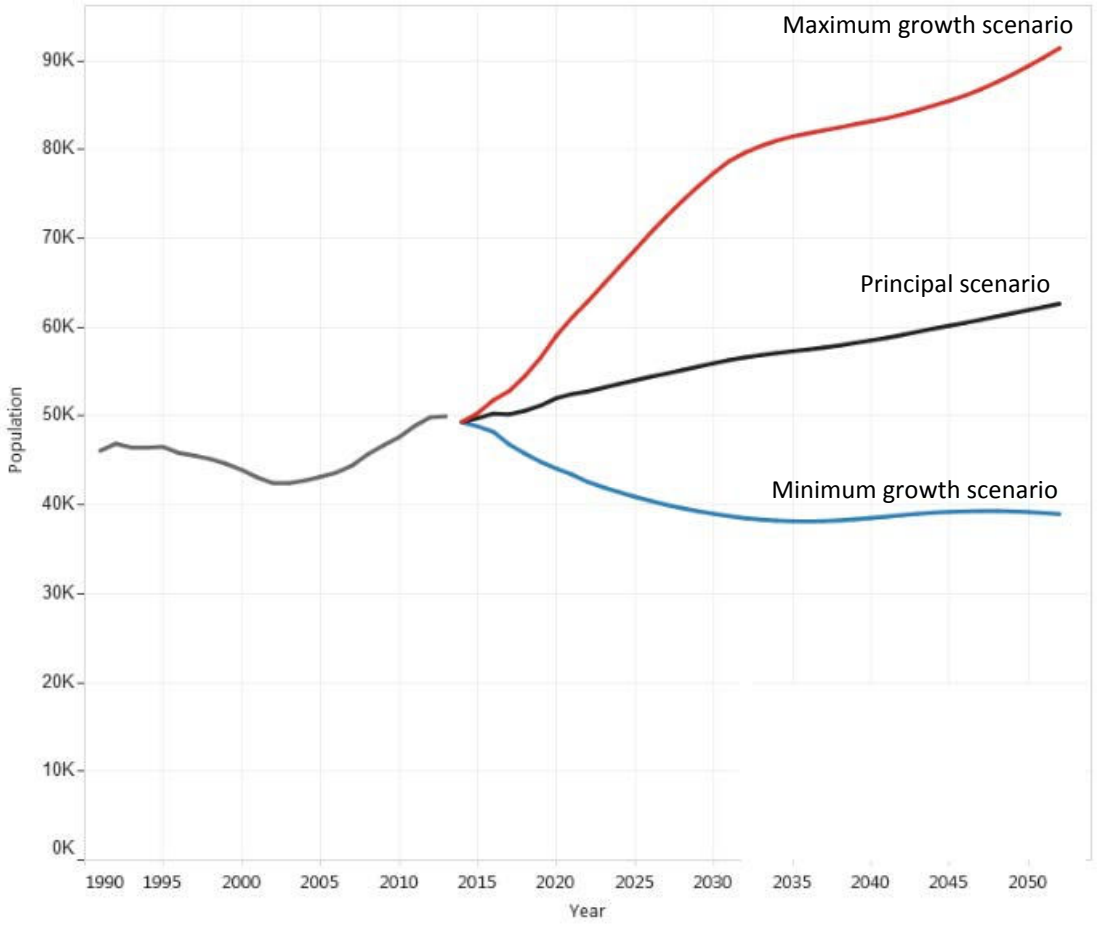
The Demographic Challenge and younger age groups

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.

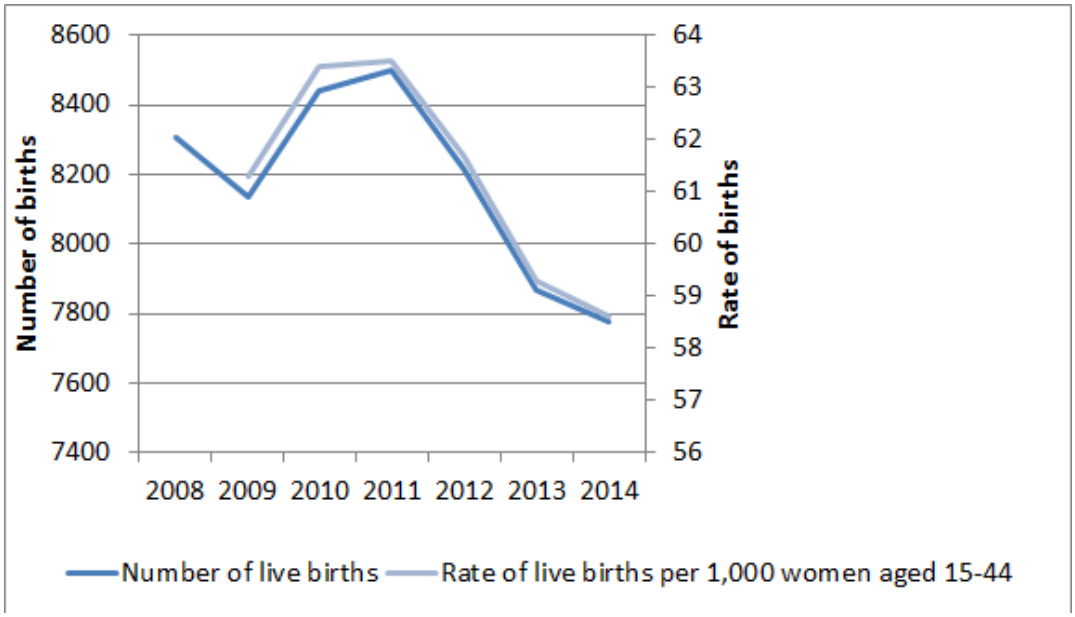
Change in Oxfordshire's population aged 0-5 (inclusive)



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.

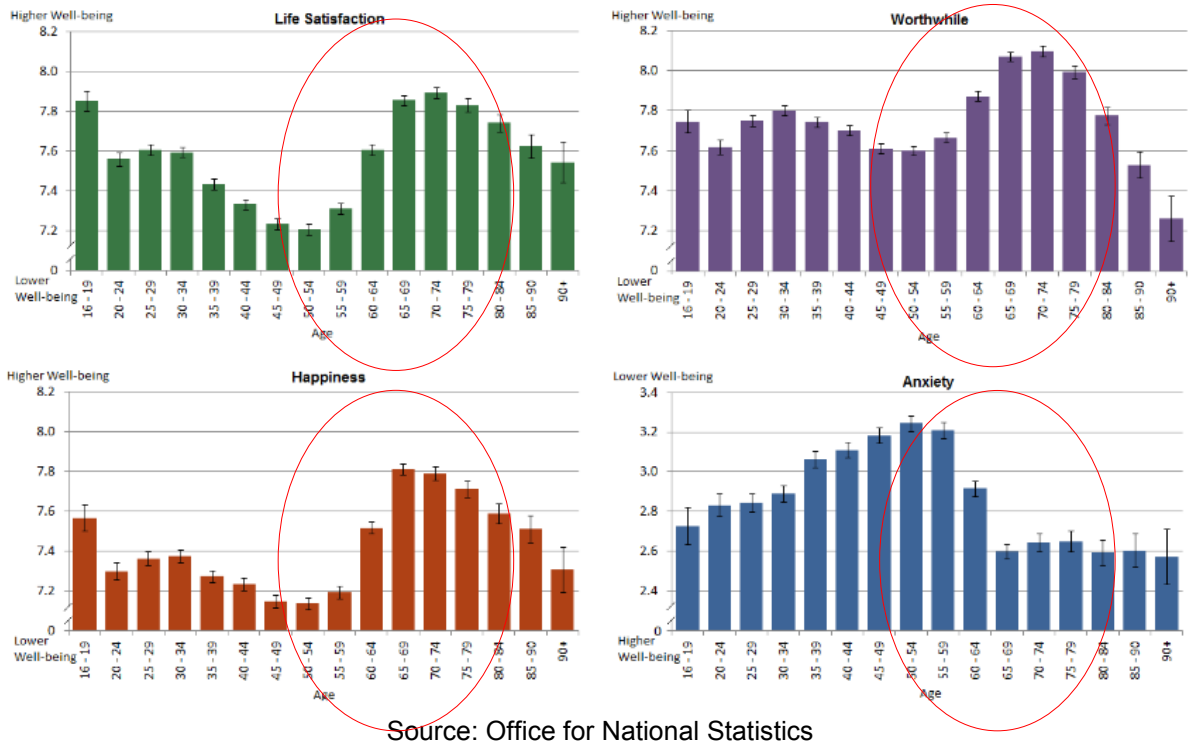
- ***Inequalities of take-up of lifestyles which prevent disease*** may be another key inequality to emerge. Those who make a series of small changes to their daily lives – simple things about more exercise, better diet and drinking less – will tend to have better health en masse than those who do not. 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.

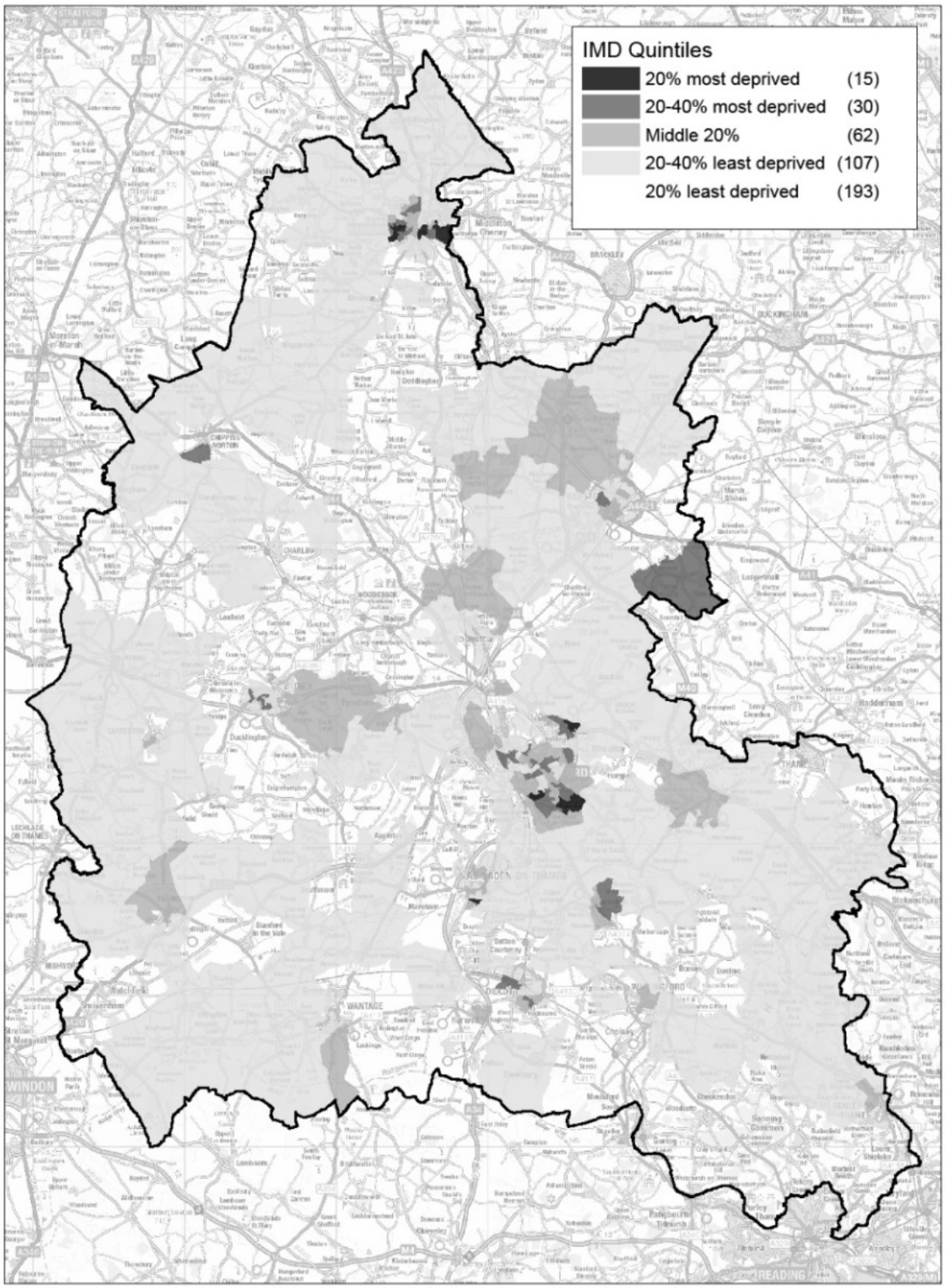
Breaking the Cycle of Disadvantage part 2: Update on data produced during the last year

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.

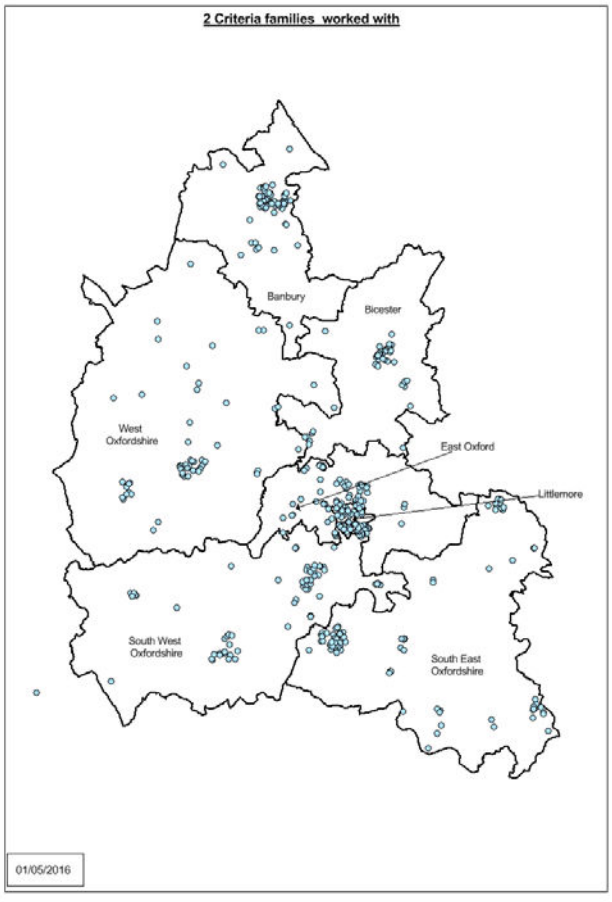
Conclusion: Breaking the cycle of disadvantage in Oxfordshire is all about targeting services to level the experience of all up to the best. Disadvantage in small areas of the County remains the biggest challenge, and services need to be designed to focus on them.

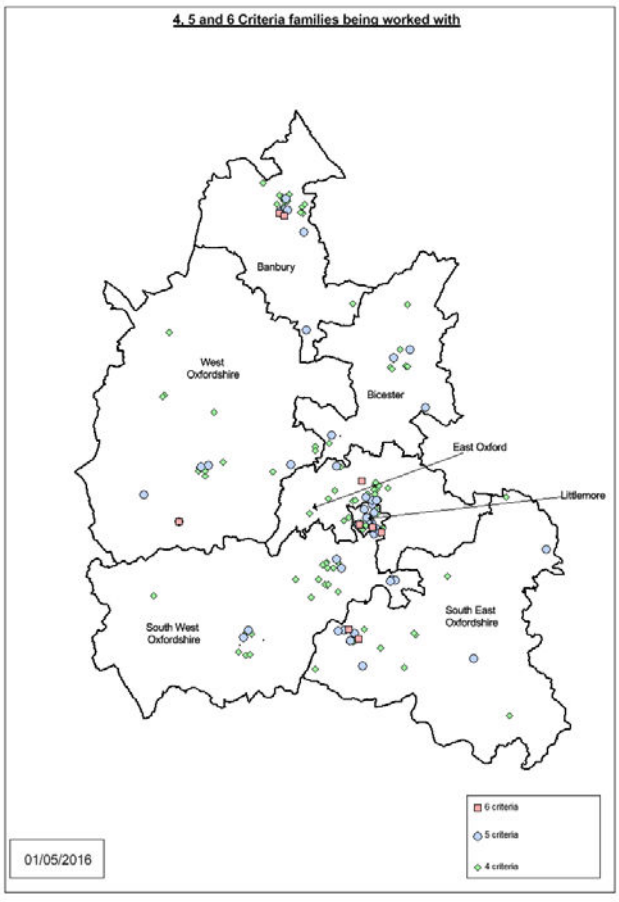
We can get more insight into the spread of individual high-need families by looking at the 'Thriving Families' data below.

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.

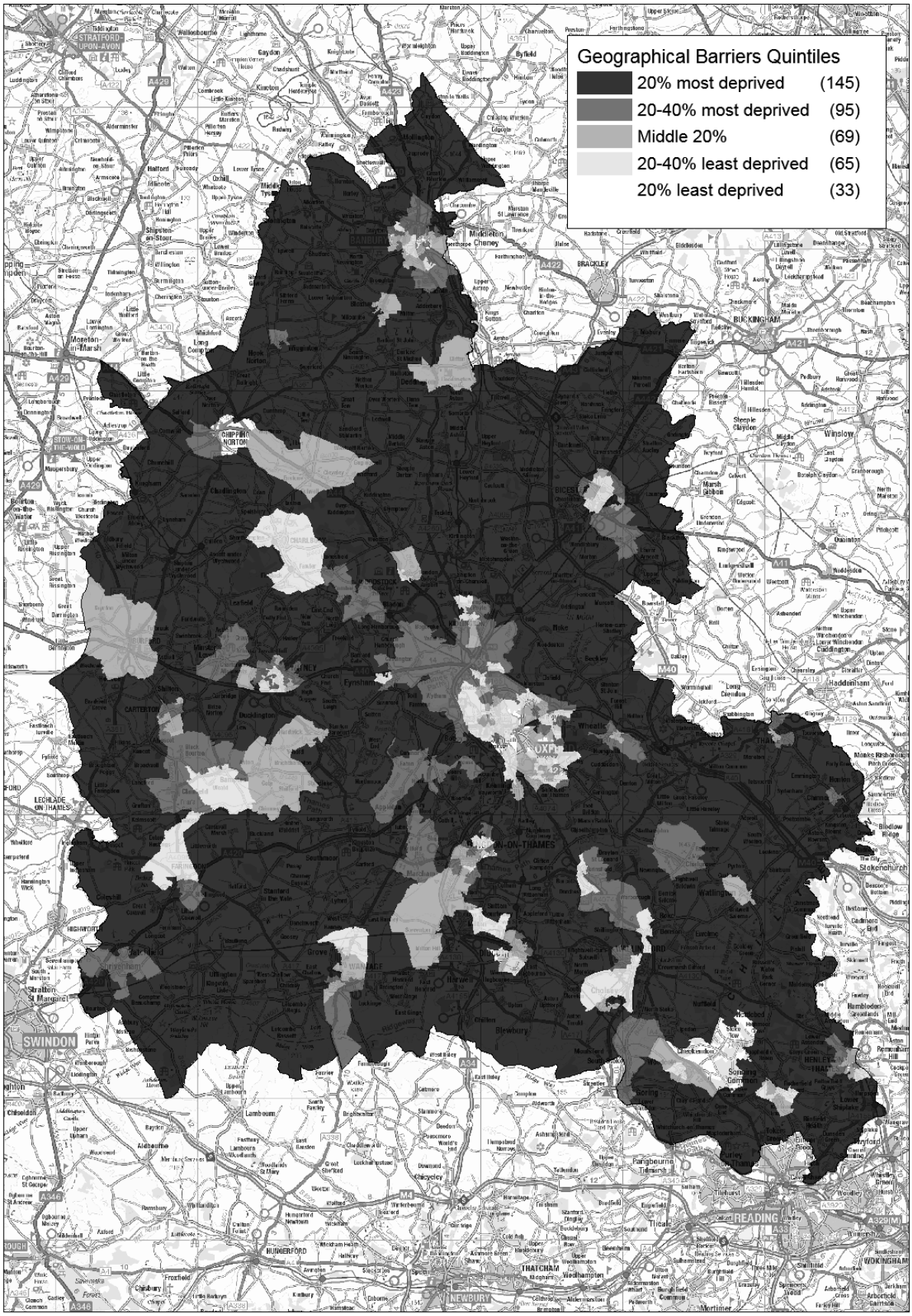
Conclusion: Because the 'Thriving Families' programme is reaching out to all parts of the County, urban and rural, and because it achieves demonstrable results, it is likely that this represents a decrease in disadvantage.

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.


Geographical Barriers Quintiles
20% most deprived (145)
20-40% most deprived (95)
Middle 20% (69)
20-40% least deprived (65)
20% least deprived (33)
STRATFORD-UPON-AVON
CHIPPING NORTON
BUCKINGHAM
Winslow
Haddenham
LECHLADE ON THAMES
HIGHWORTH
SWINDON
Lambourn
HUNGERFORD
NEWBURY
THATCHAM
READING
WOKINGHAM
Pangbourne
Tilehurst
Stokenchurch

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.

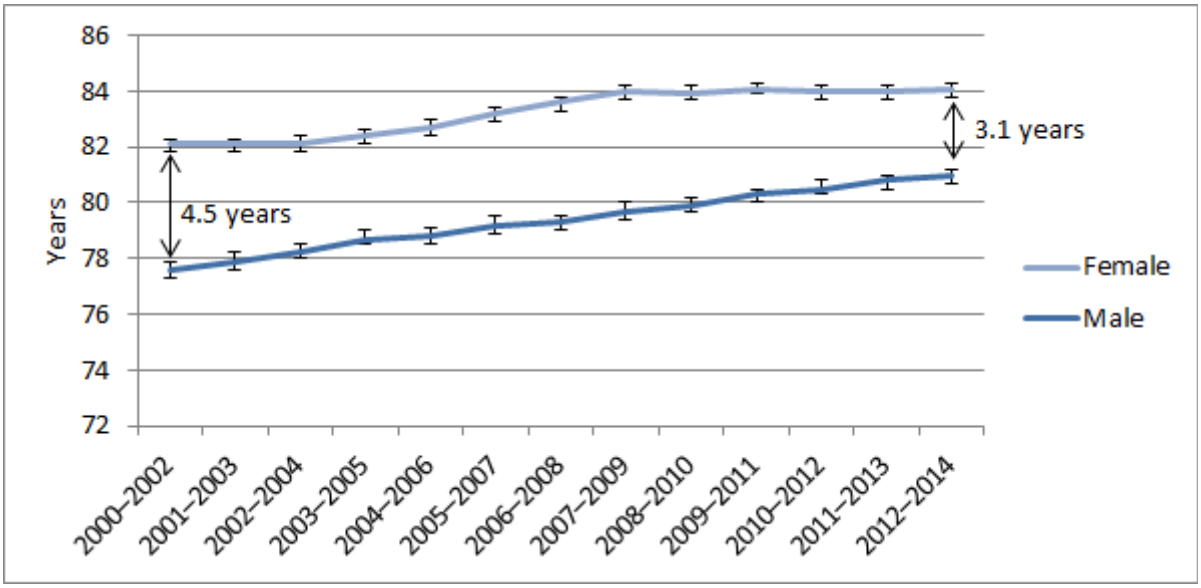
Conclusion: The rural nature of Oxfordshire presents a real challenge to providing services fairly across the County and this form of disadvantage needs to be monitored closely.

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

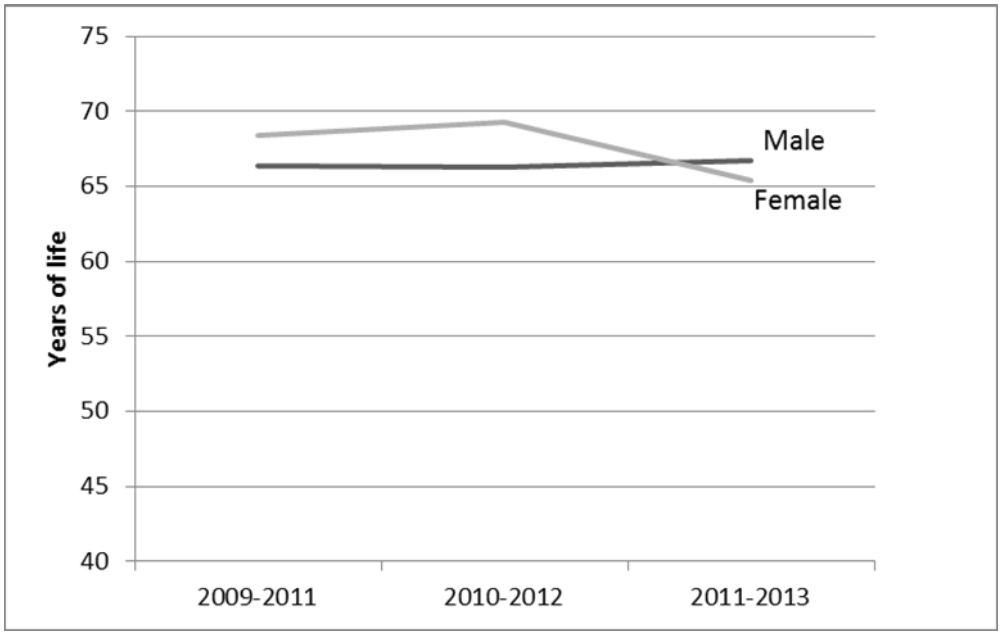
The question then arises, 'so how long can I expect to live in good health'. To answer this we have **healthy life expectancy** figures. Nationally, overall life expectancy has been increasing faster than healthy life expectancy in recent years***; this means people may have more years living in ill-health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

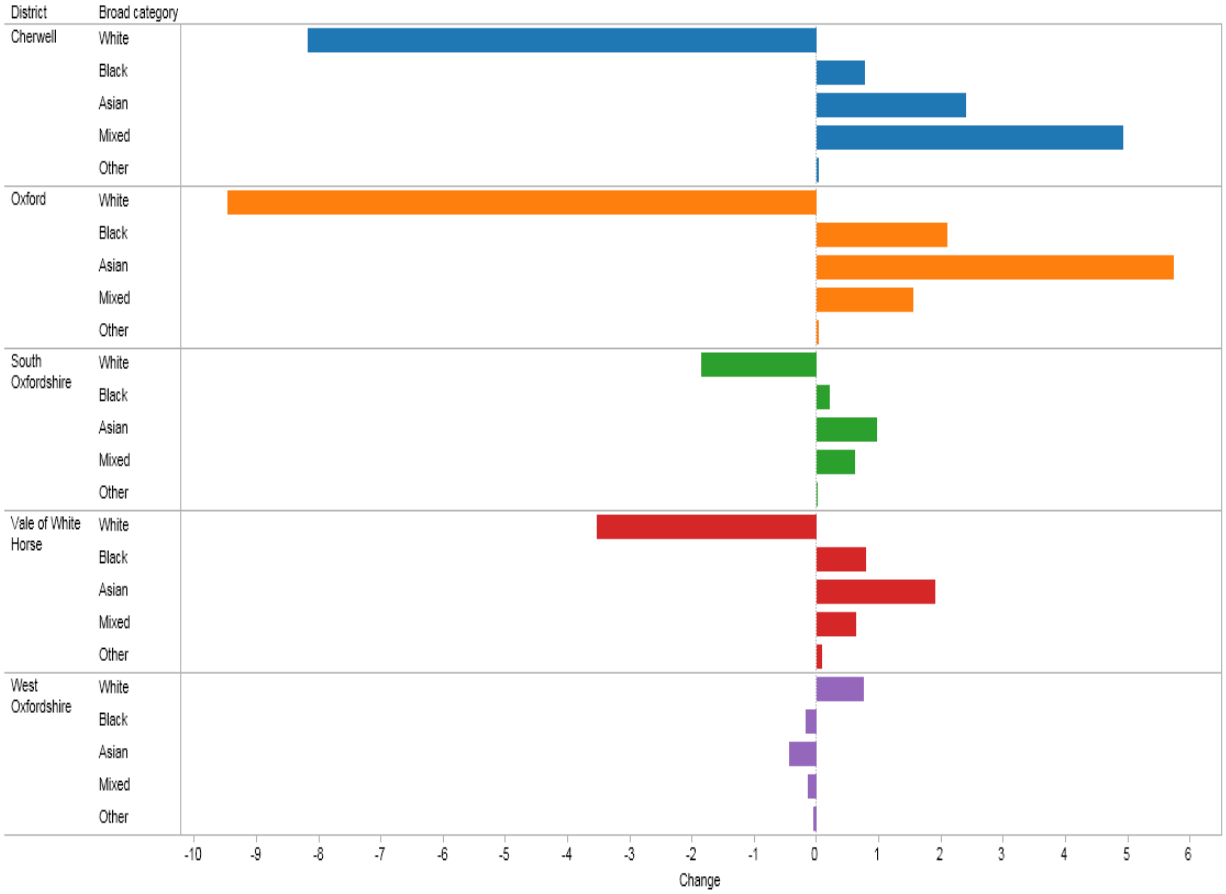
There were 13,200 people from mixed ethnic backgrounds, accounting for 2% of the population (up from 1.2% in 2001).

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:

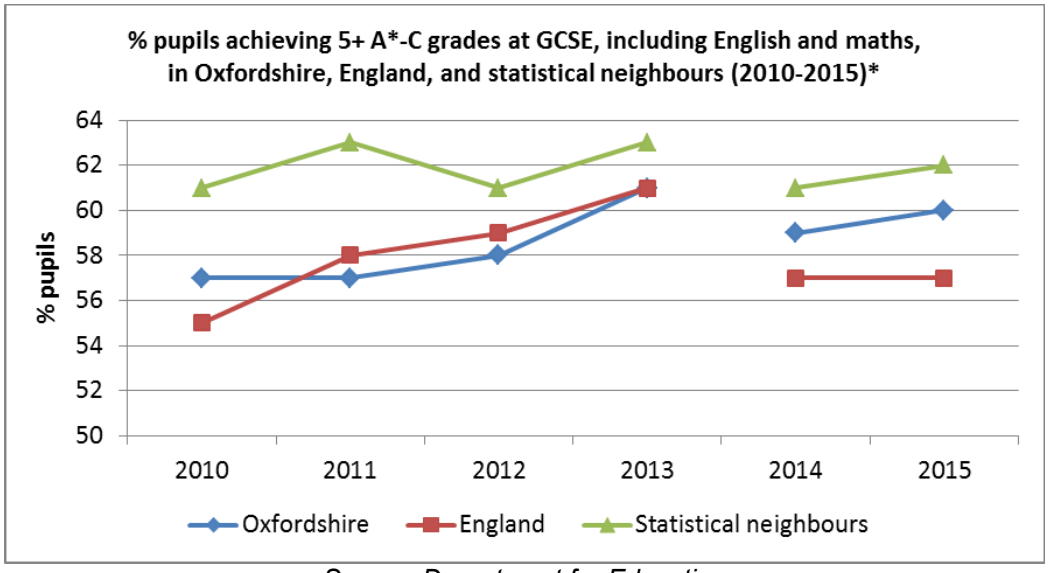
The increasing diversity of Oxfordshire's population remains a key factor in tackling disadvantage through targeting services.

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.

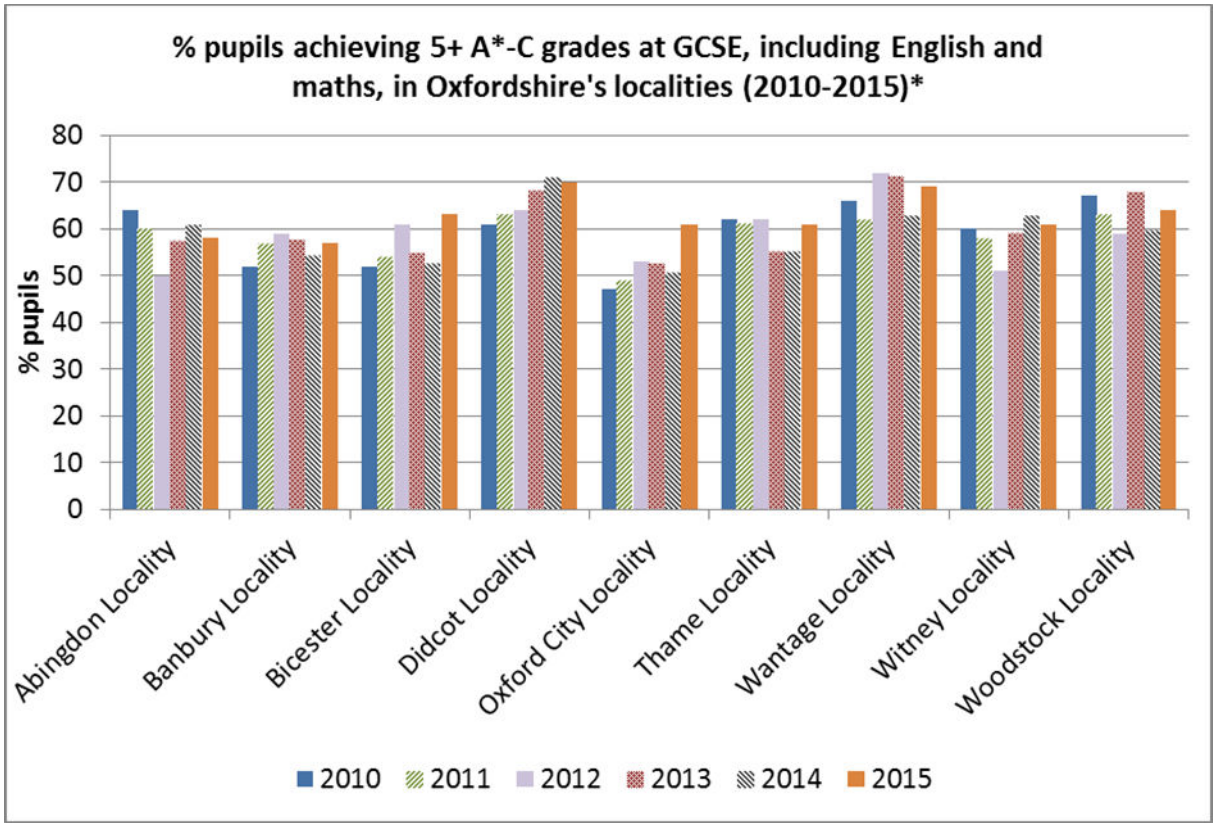


Source: Department for Education
**Before 2014 the measure was based on best entry; from 2014 it is based on first entry*
***NB vertical axis starts at 50 to aid legibility.*

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.



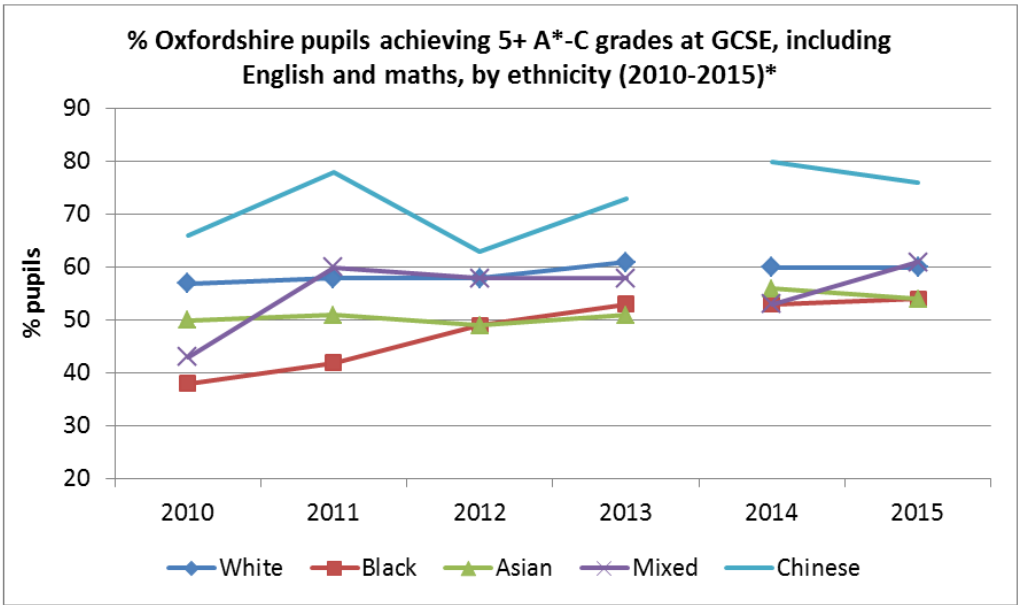
Source: Department for Education
**Before 2014 the measure was based on best entry; from 2014 it is based on first entry.*

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.

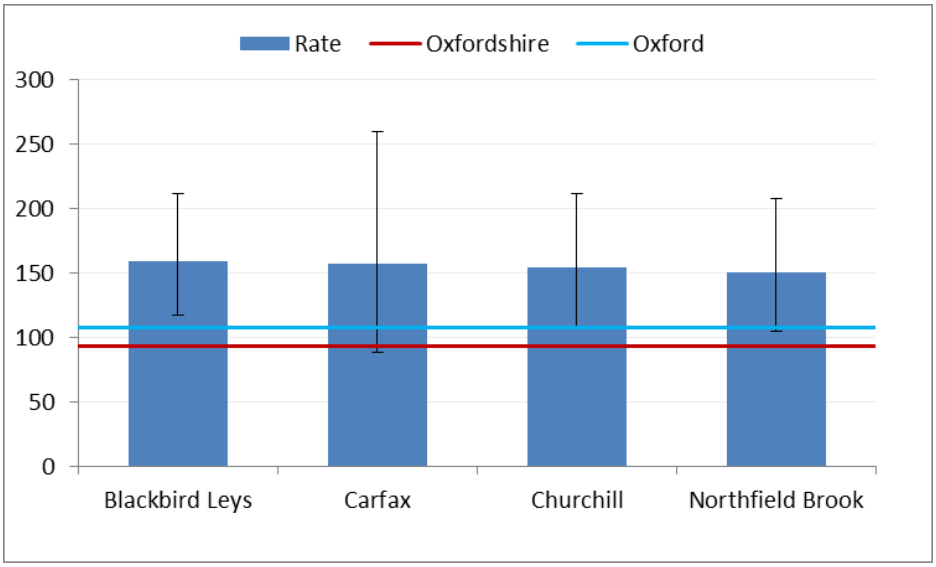
The performance of children receiving free school meals remains a matter of concern.

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.

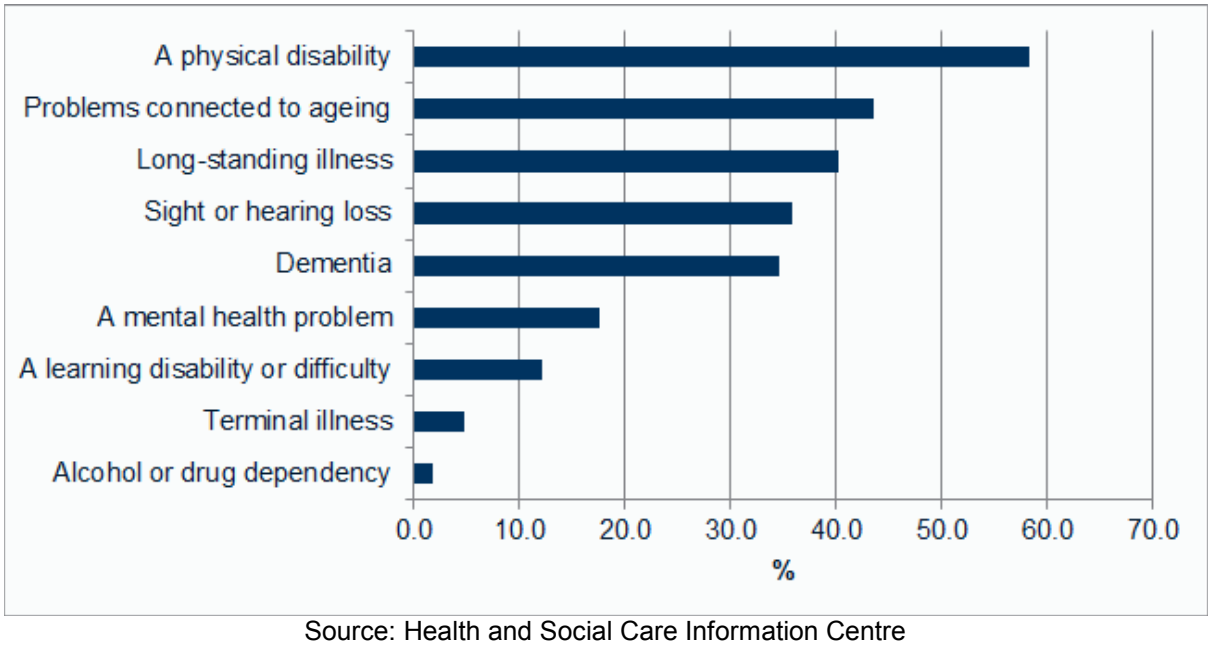
17,200 carers have had their needs assessed by Oxfordshire County Council's social care team during the year, some of whom will also have received a service from the council.

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:

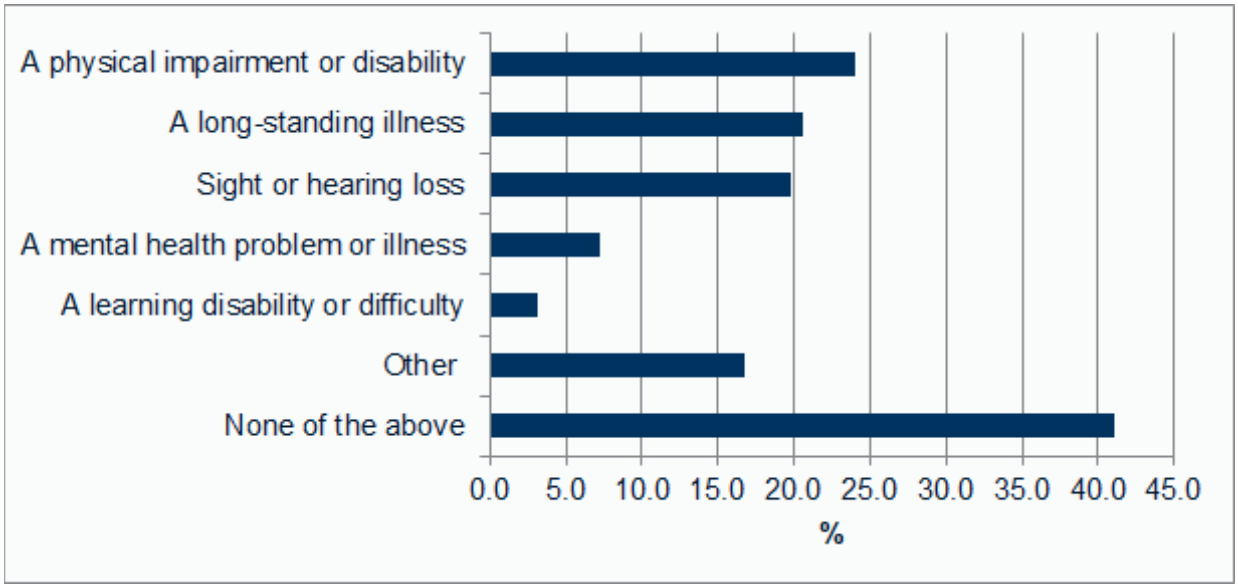
Carers in Oxfordshire, by health condition of the person they care for (2014/15)



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.

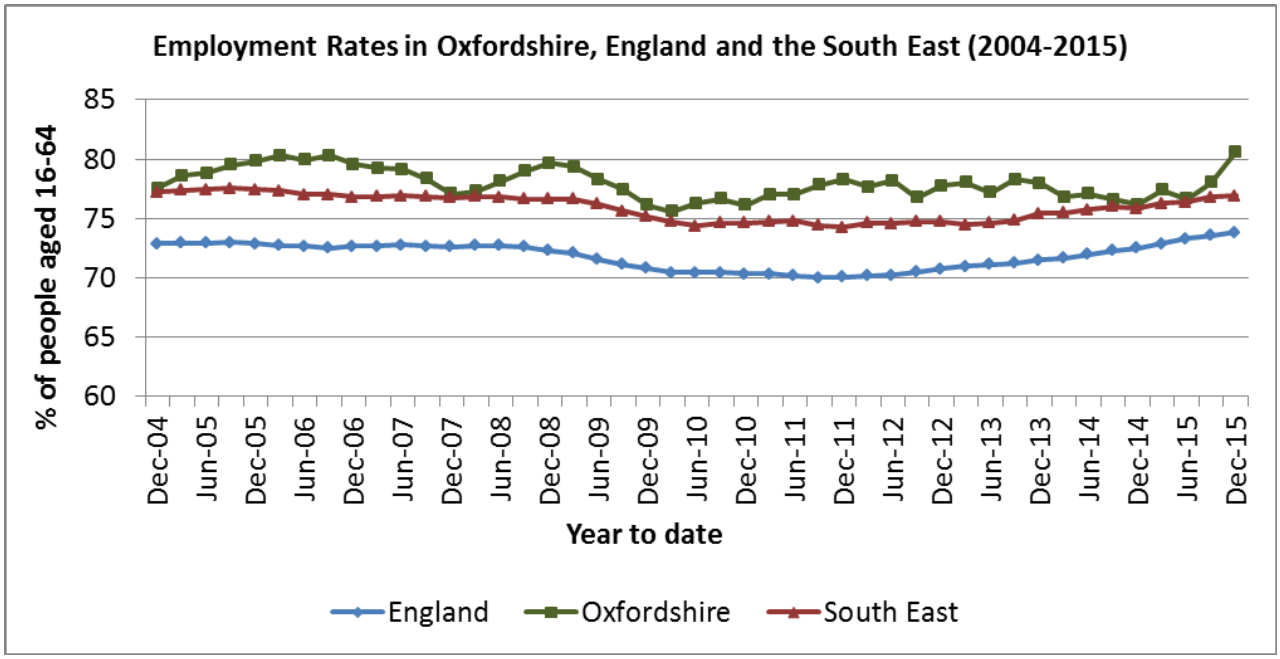
Our services perform well in terms of looking after carers and this is taken as a serious responsibility. We need to ensure that this position does not slip and that it is improved if possible – our carers and our services depend upon it.

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.

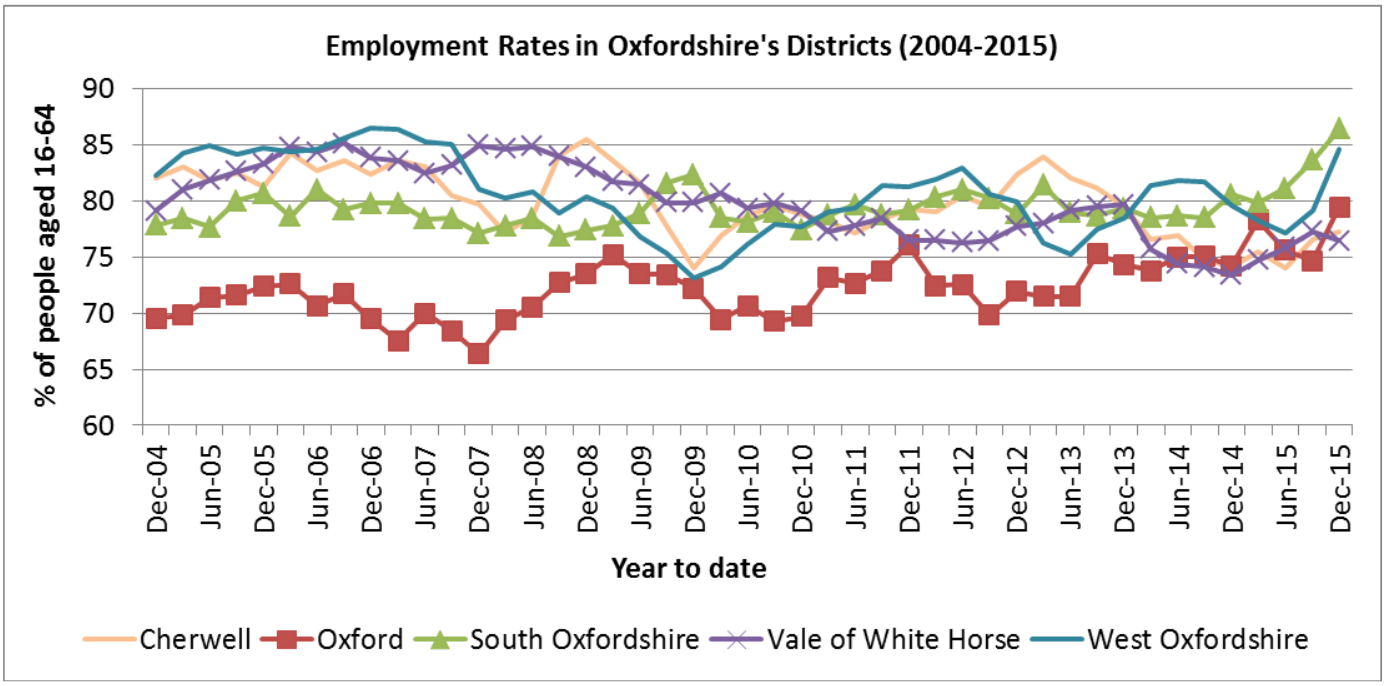


*Source: Annual Population Survey. *NB Vertical axis starts at 60 to aid legibility.*

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

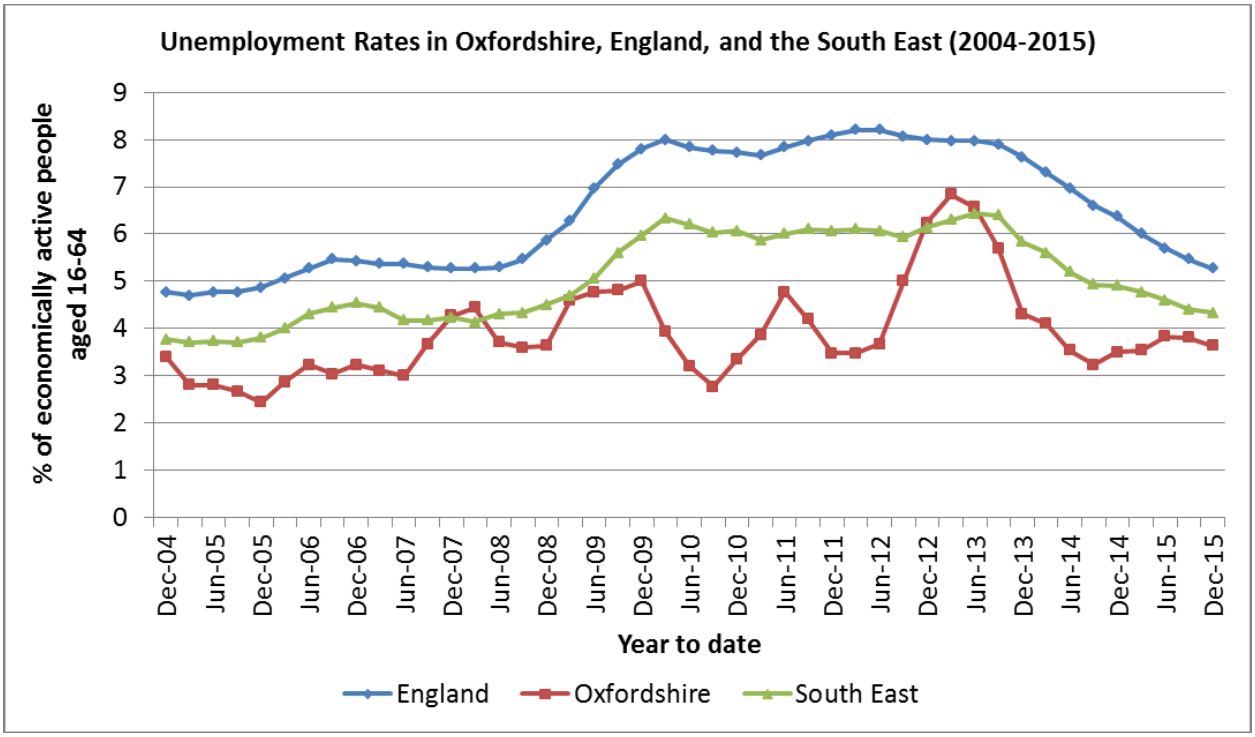
3.6% of economically active people aged 16-64 were unemployed, numbering 12,700 – a modest reduction over the year. This unemployment rate was significantly lower than the England average of around 5%.

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.

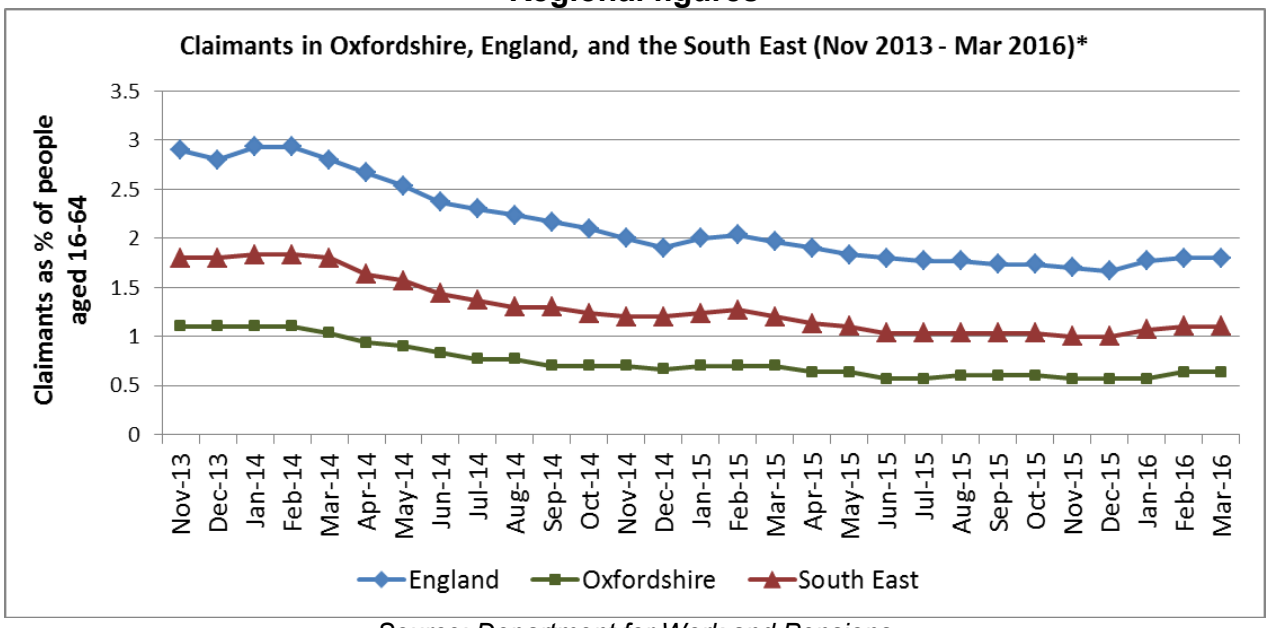
The charts below show the picture and illustrate that Oxfordshire performs better than national and regional figures.

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

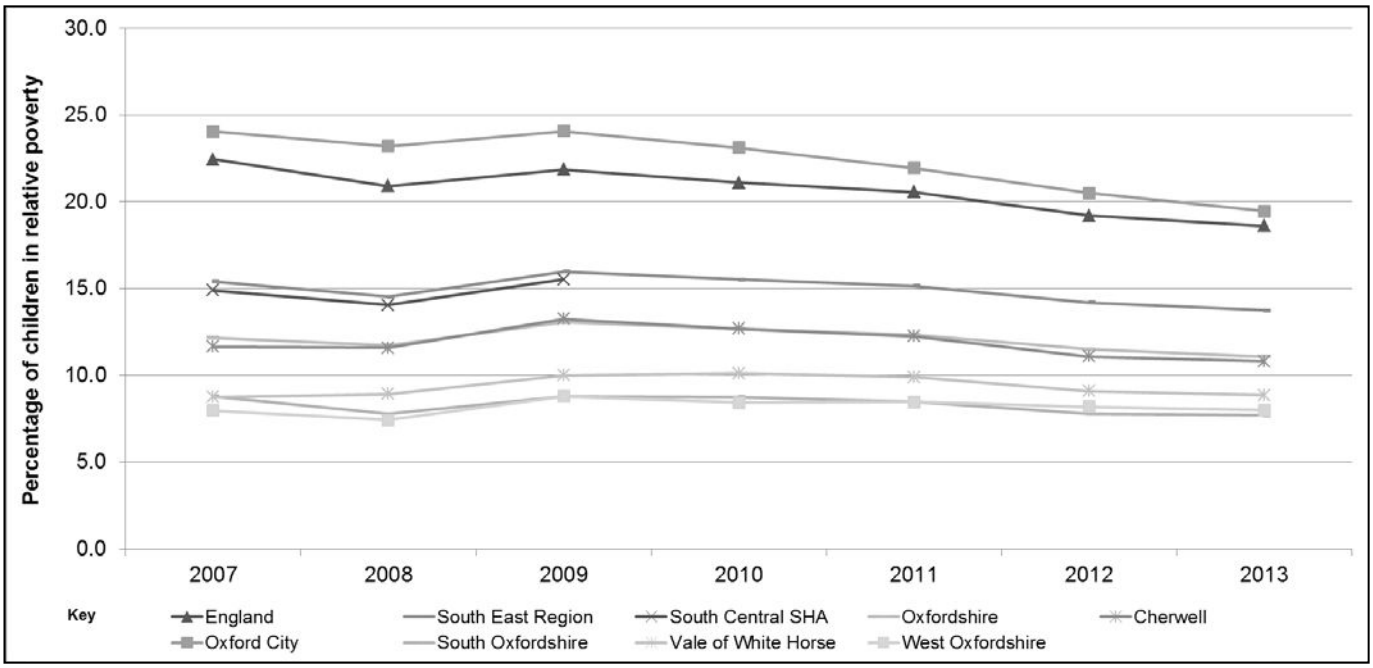
I will look at them one by one and pick out the key features.

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)

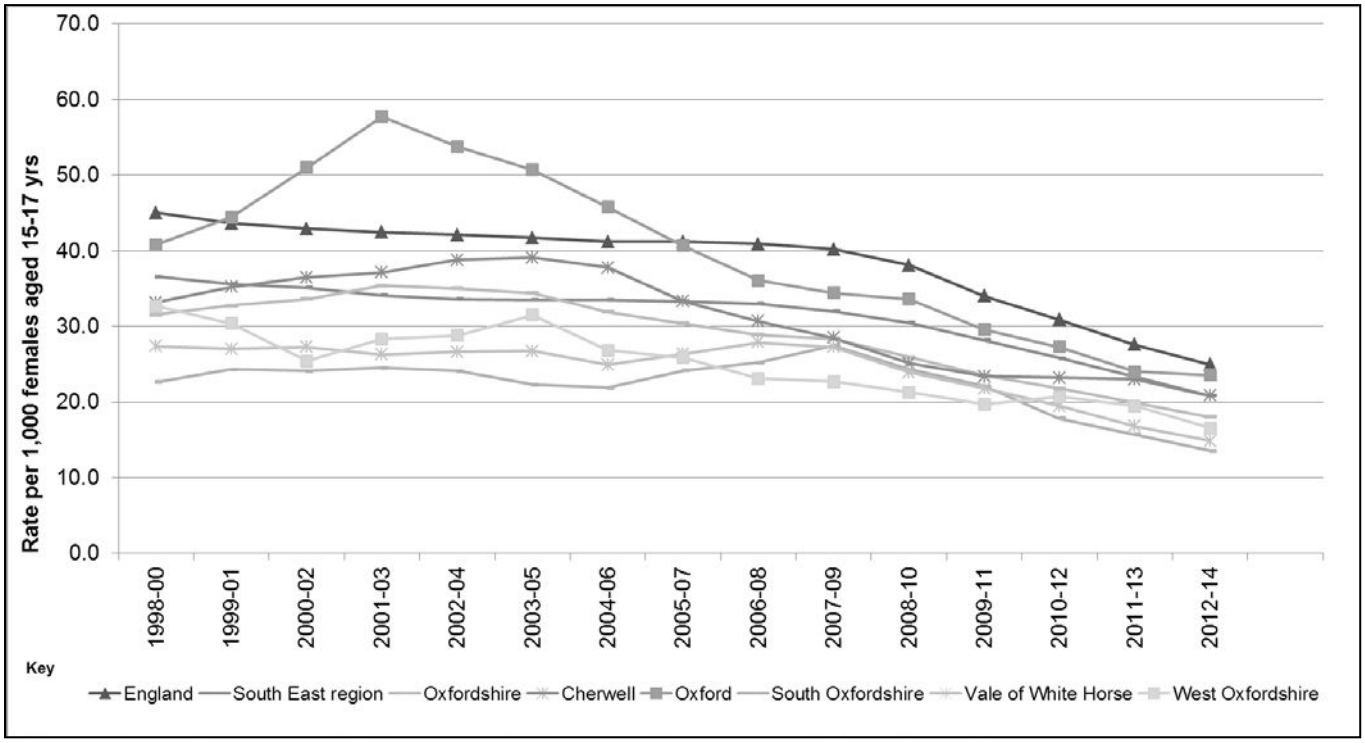
Indicator 2. Teenage Pregnancy

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)

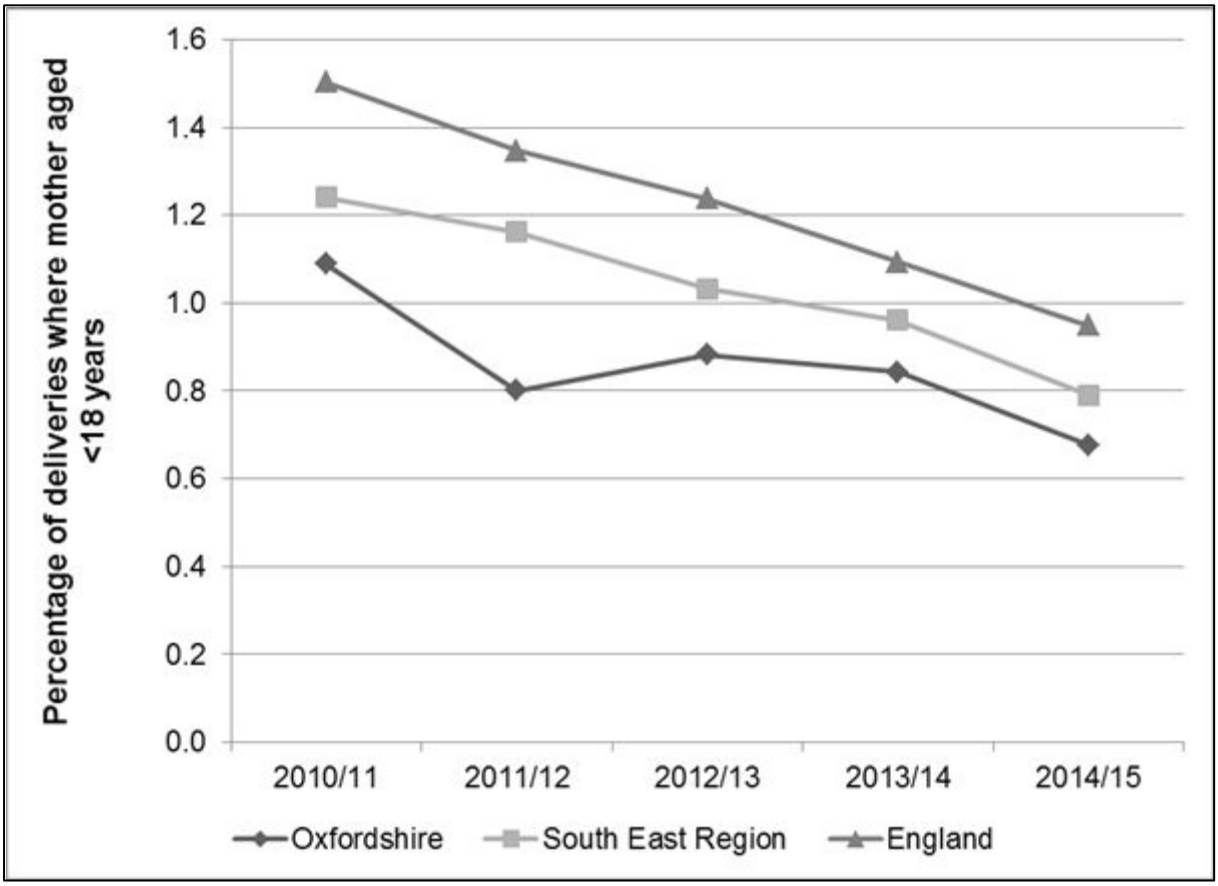
Indicator 3. Percentage of Teenage Mothers

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 then then both regional and national figures.



Source: Children & Young People Benchmarking Tool (PHE)

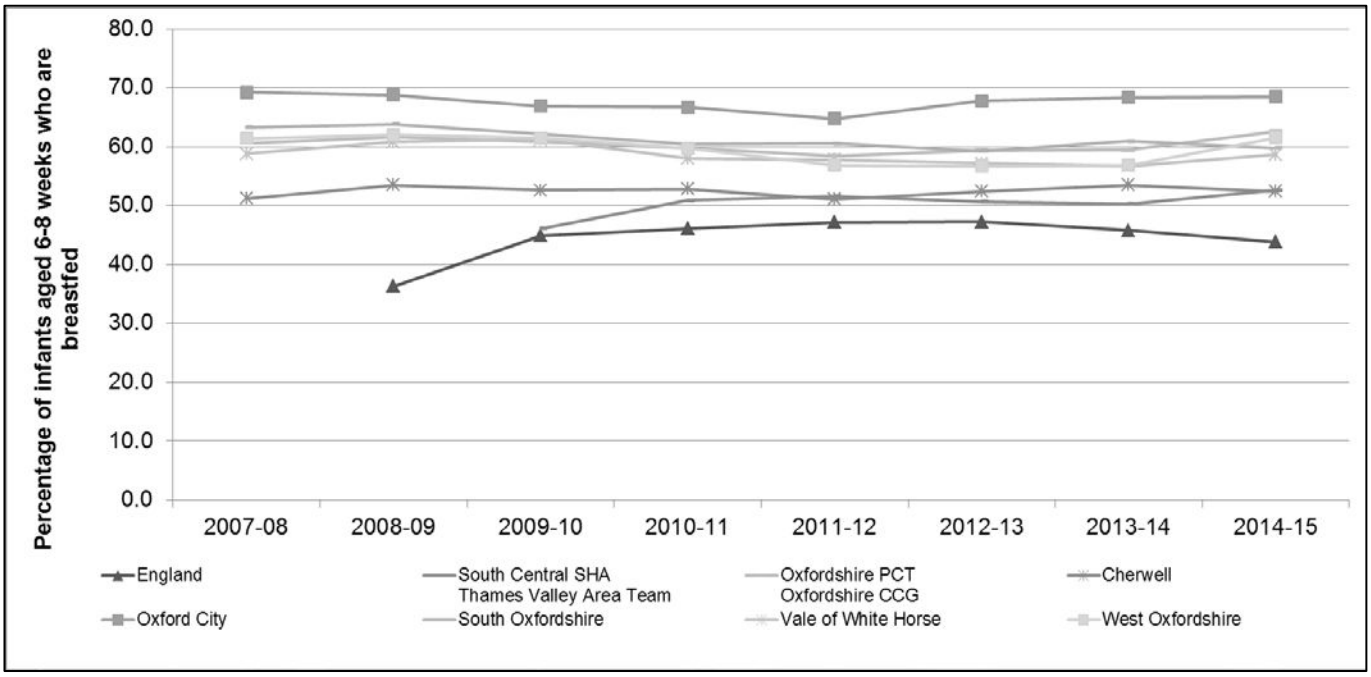
Indicator 4. Breastfeeding at 6 to 8 weeks

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

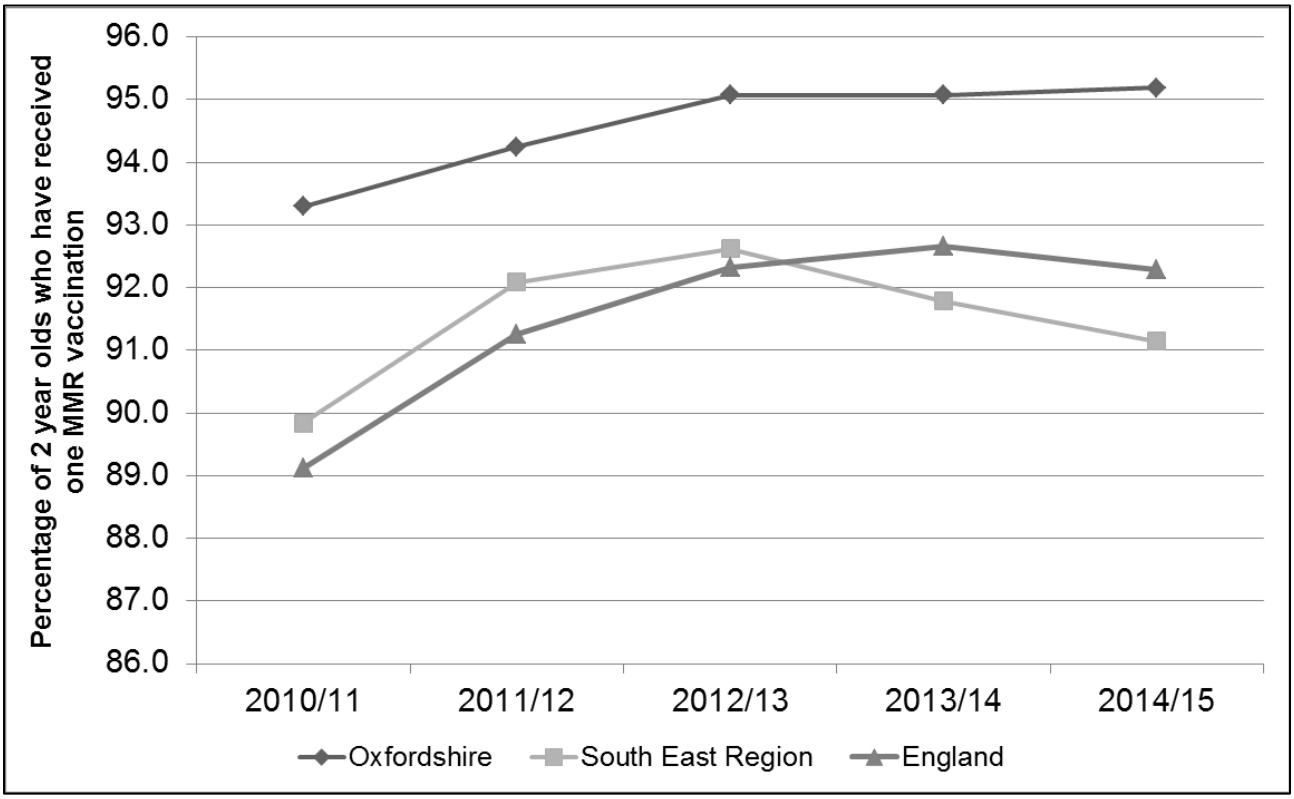
Indicator 5. Childhood Immunisation

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)

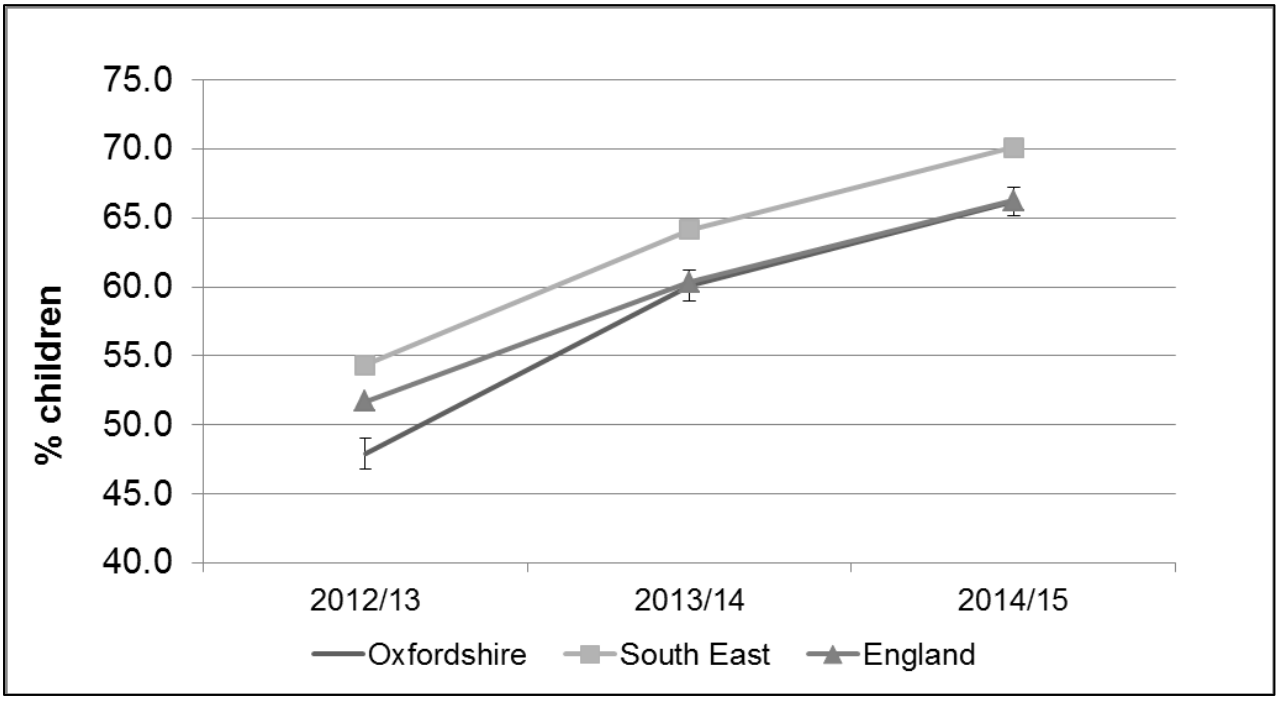
Indicator 6. School Readiness

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:

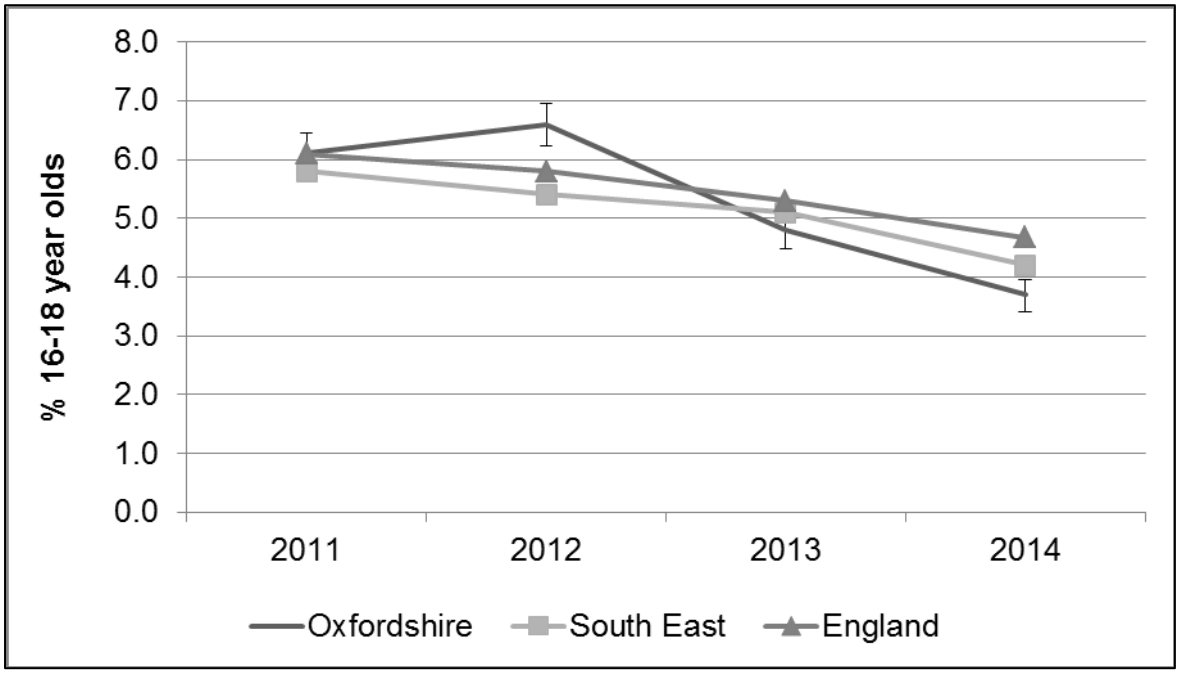
- Around 60% of Oxfordshire's state educated children achieve at least 5 GCSEs at grades A* to C including English and maths.
- This has been a success story in recent years. Oxfordshire used to lag below the national average and now we are around 3 percentage points above.
- This is a good result, but 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.

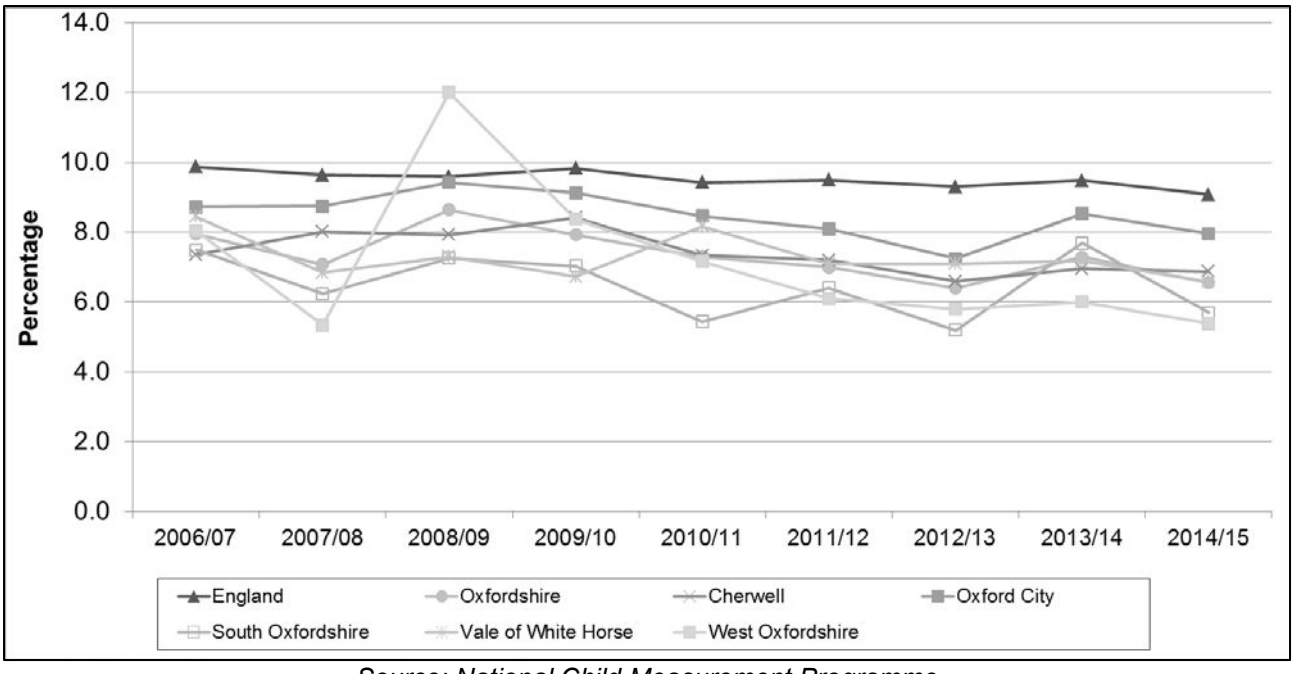
This is a useful indicator of children's life chances in terms of health. Obesity and overweight gradually increase with age which foreshadows the future likelihood of diseases such as diabetes, heart disease, some cancers and ultimately an early death. It is linked to levels of physical activity. Keeping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

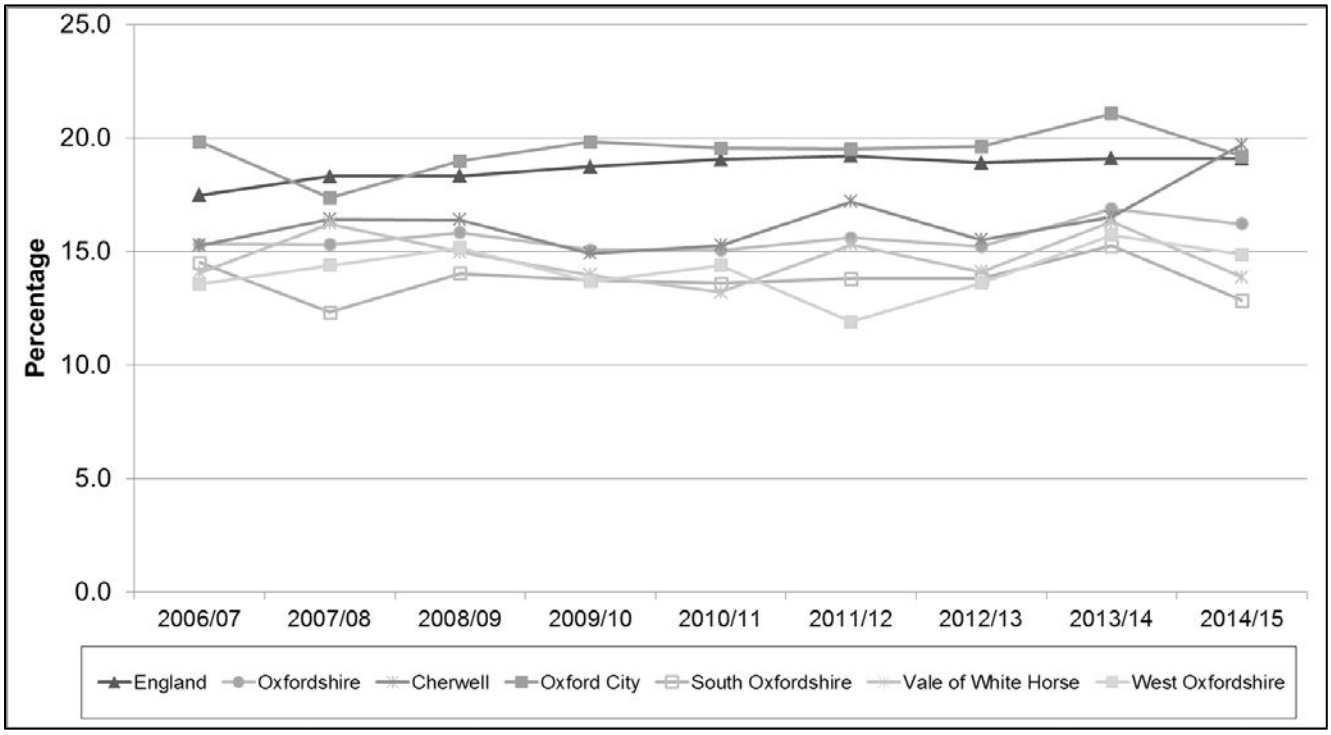
Indicator 10. Obesity in 10 to 11 year olds – (school year 6)

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

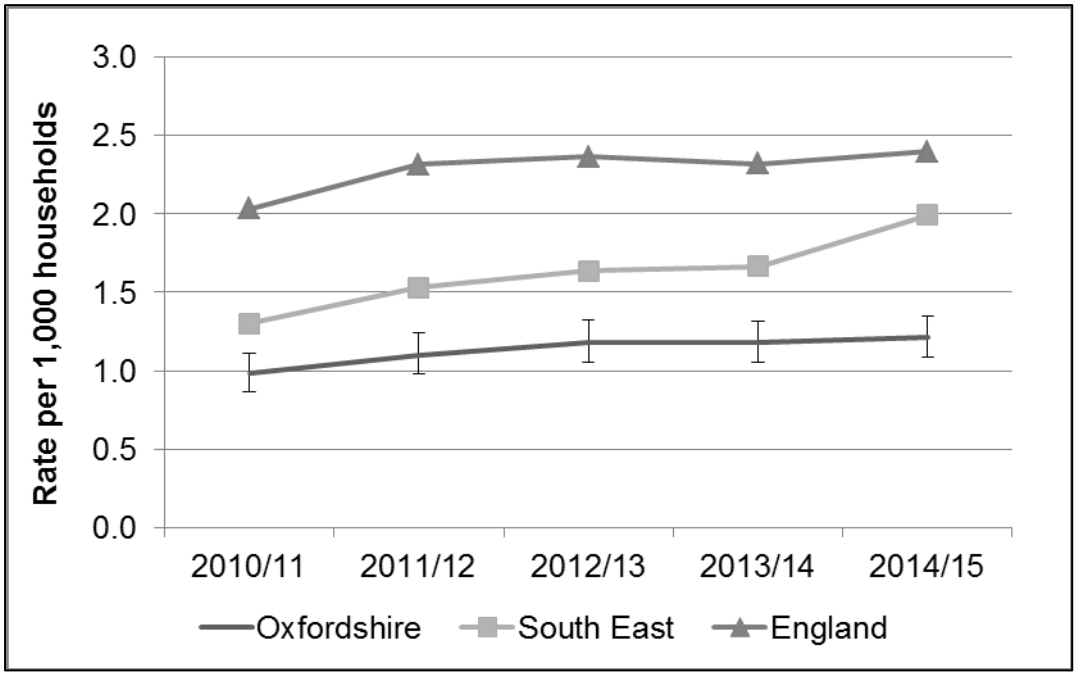
Indicator 11. Homeless Households

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:

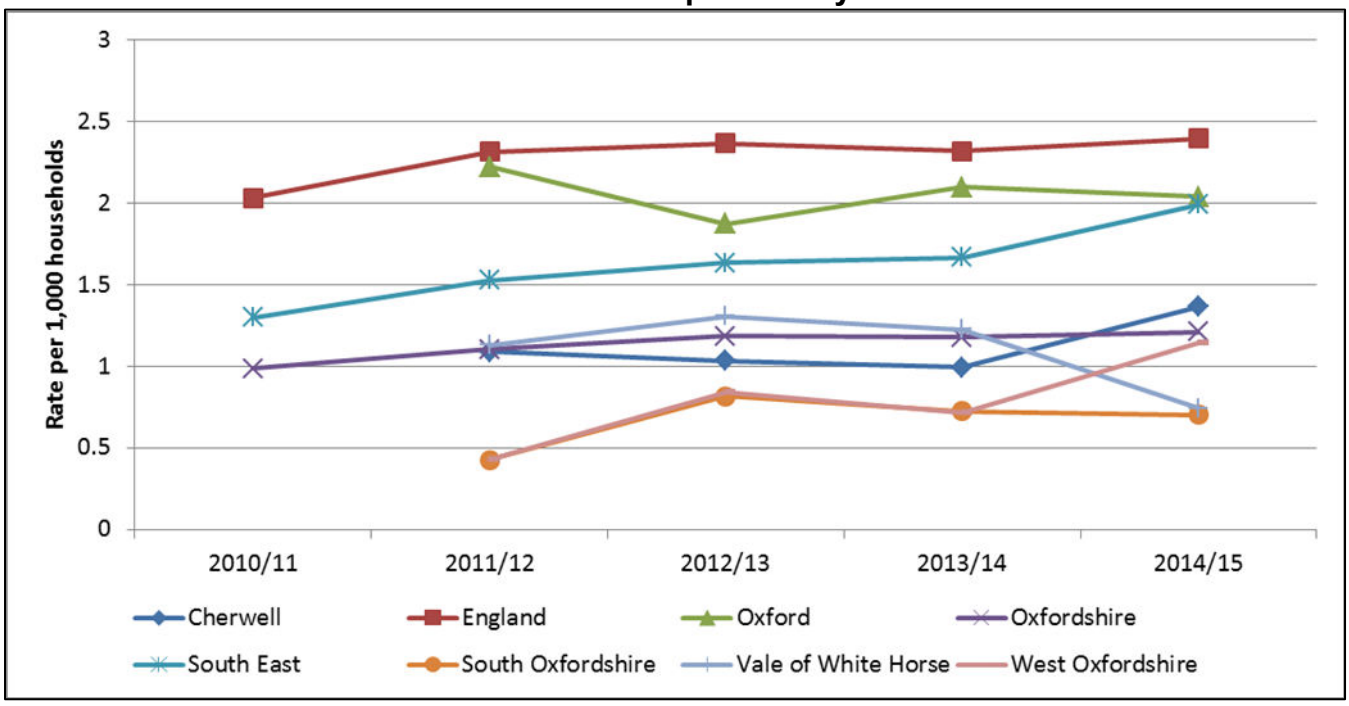
- The figure for Oxfordshire as a whole is low - just over 1 in a thousand households.
- Oxfordshire's figure outperforms national data which stands at just under 2.5 per thousand households.
- Oxfordshire performs better than similar local authorities.
- The general trend is rising slightly.

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.

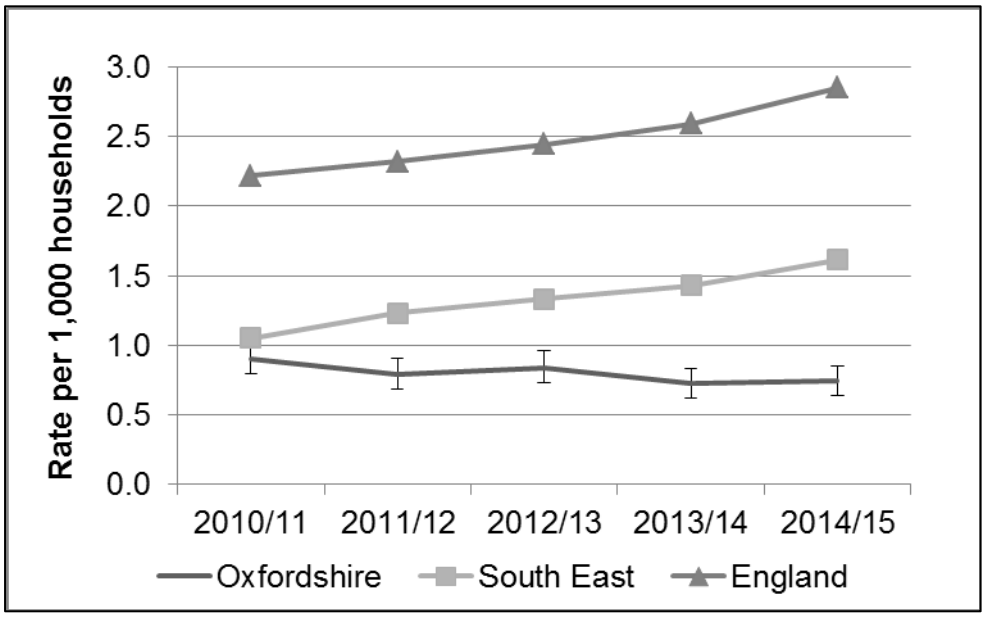
Indicator 12. Households in temporary accommodation

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

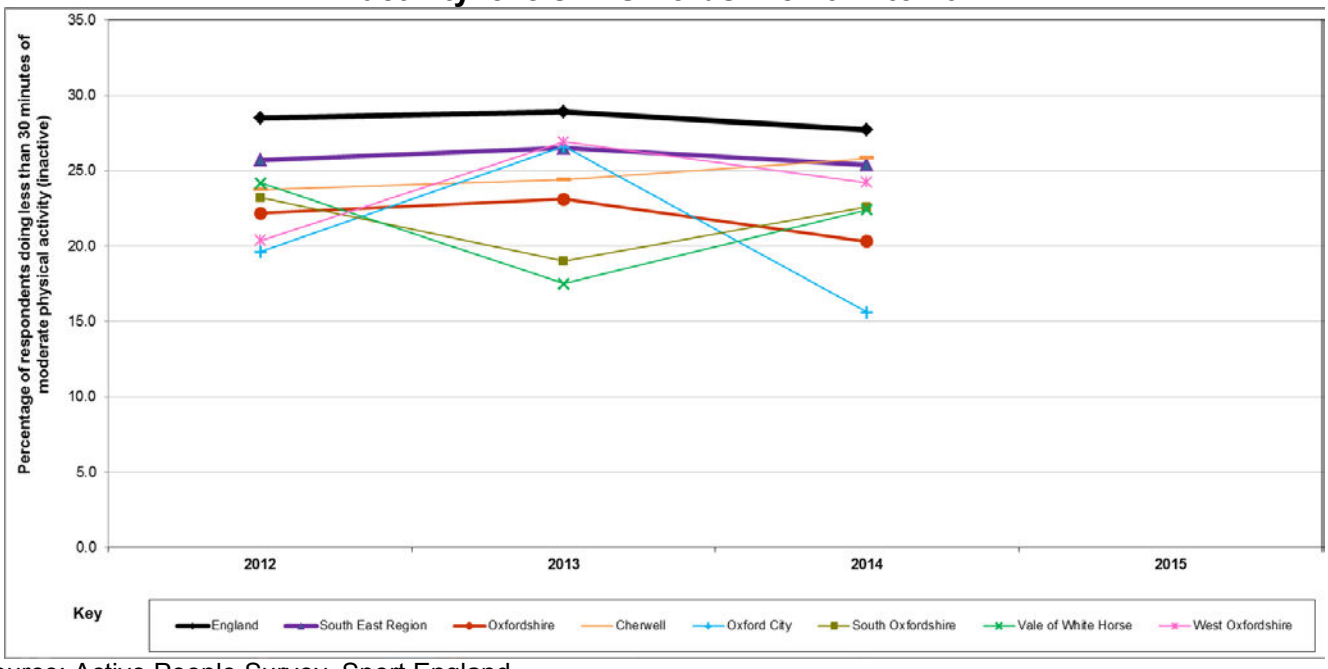
Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle.

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%.

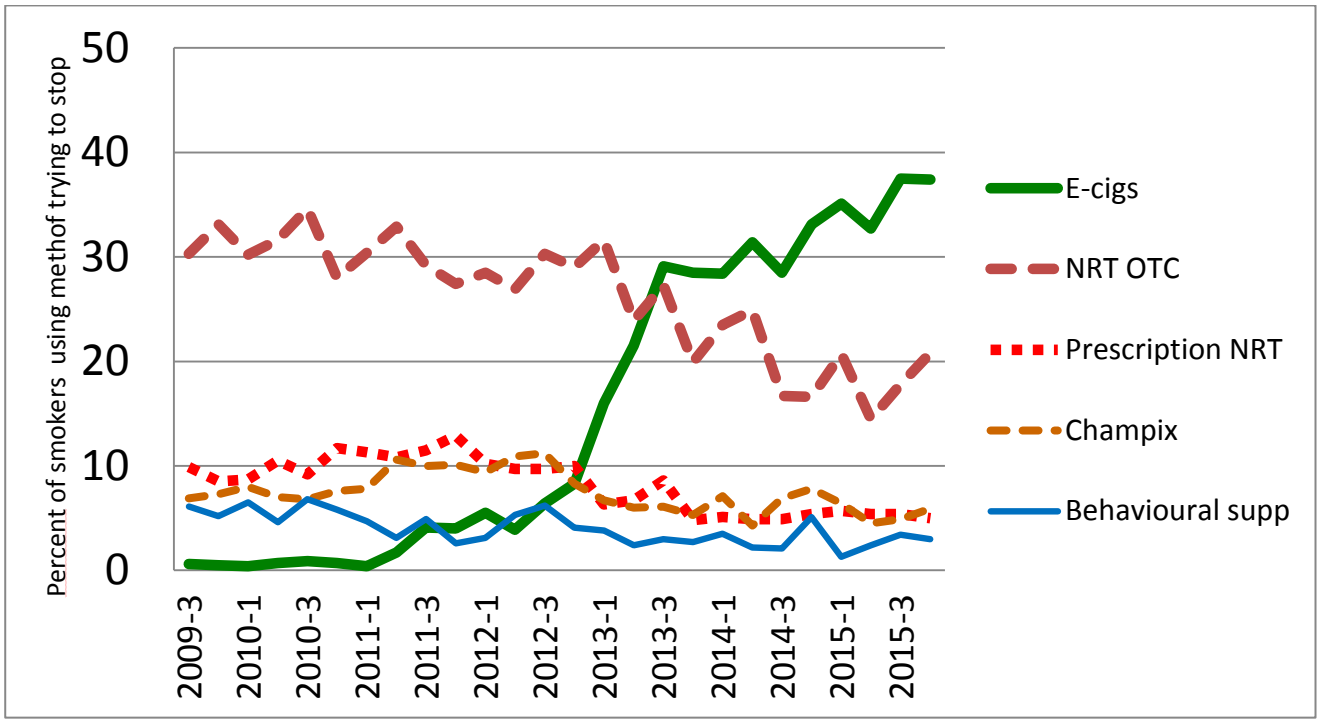
Stop Smoking Services
The decline in people accessing traditional stop smoking services seen in recent years continued last year both nationally and locally. The suggestion that the "easier quits" have already been made still holds true and that the challenge is to address the higher levels of smoking 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:

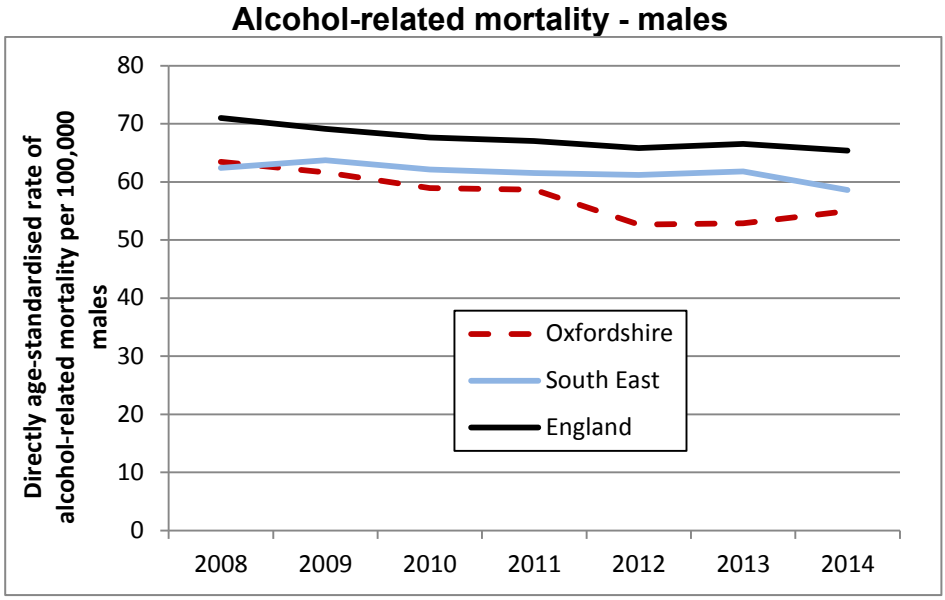
- In the UK there are around 1 million hospital admissions each year related to alcohol consumption.
- There are around 8,000 alcohol-related deaths in the UK each year.
- Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high 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.

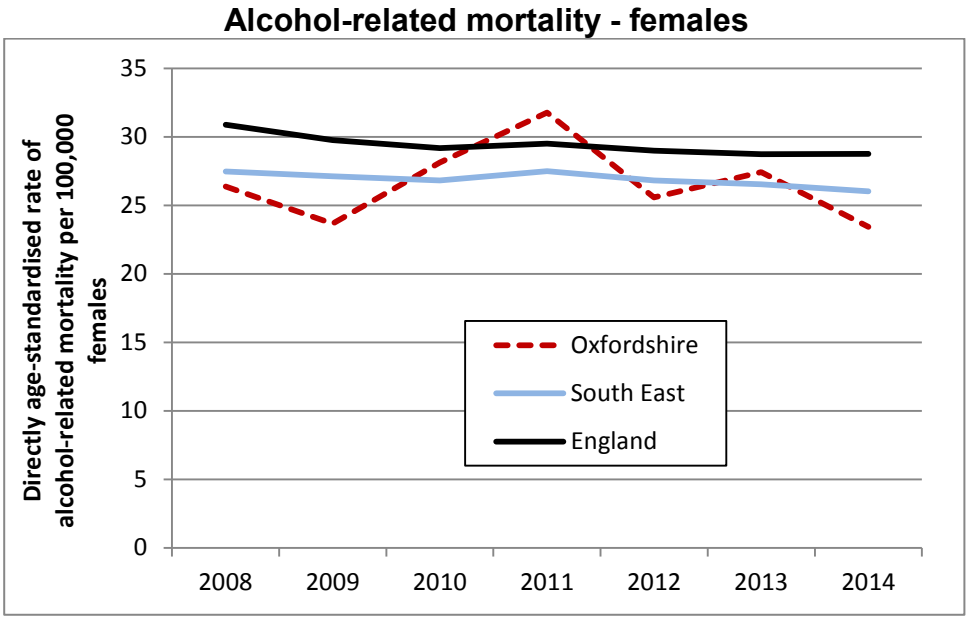
What has happened in the last year?

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).

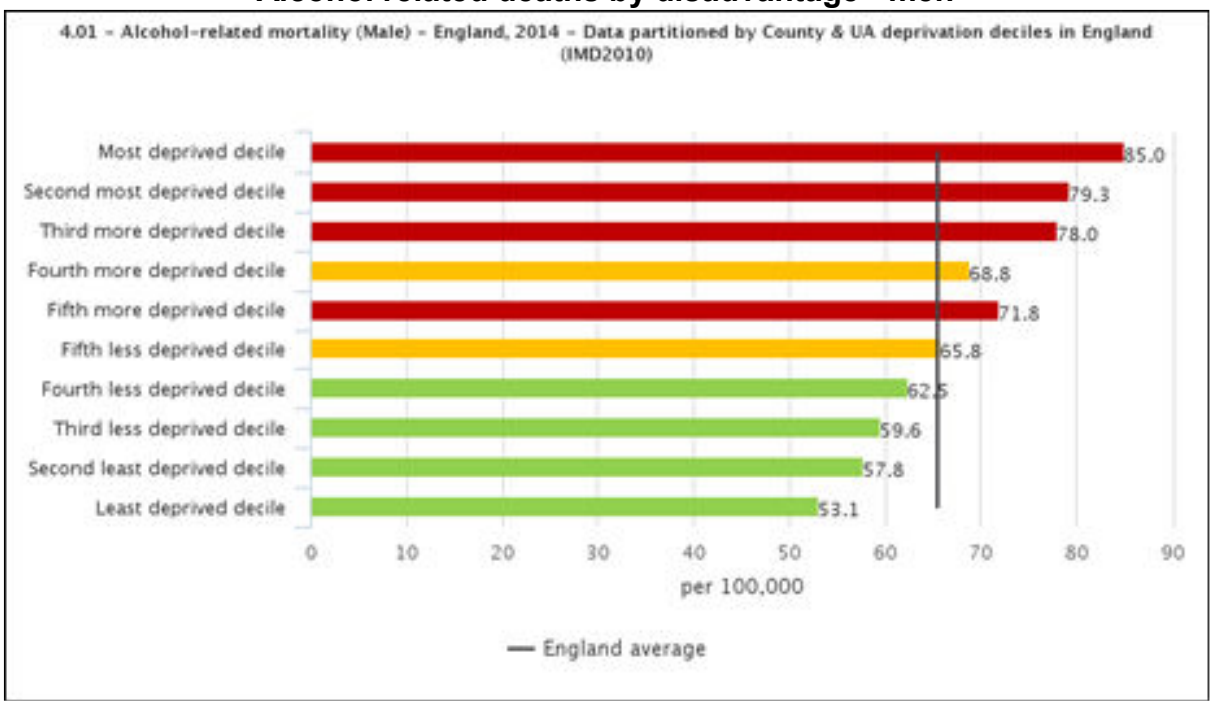


The charts show that:

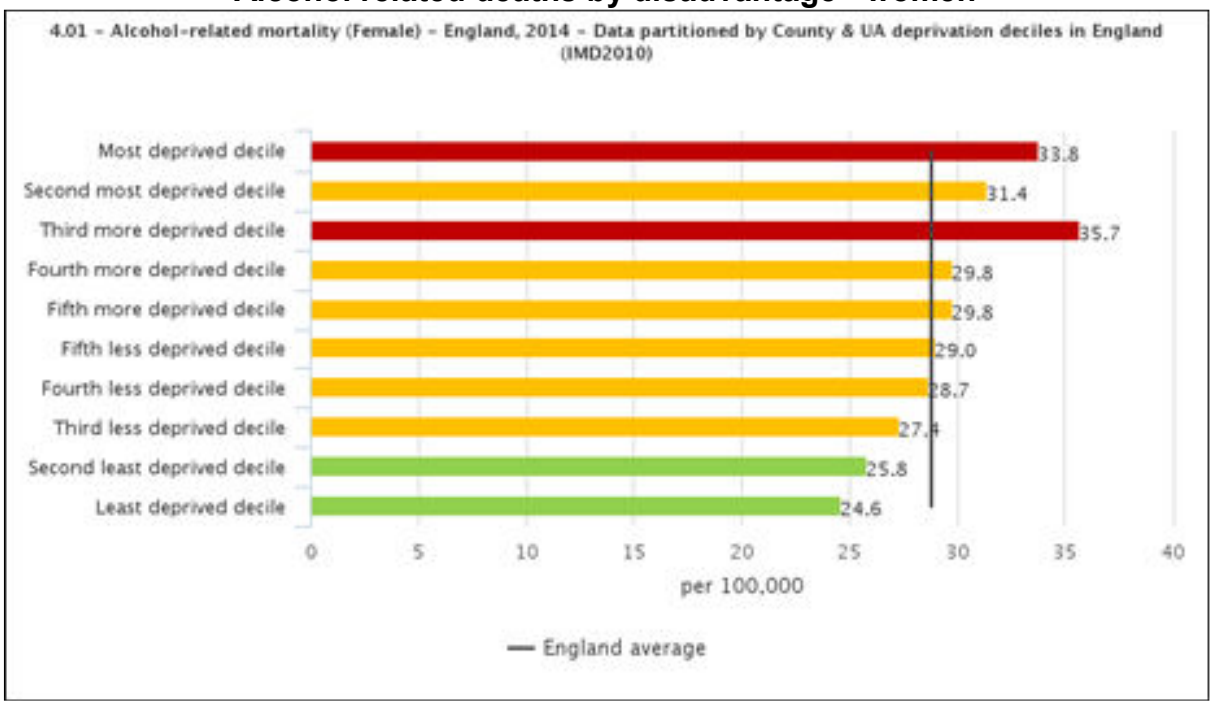
- Deaths related to alcohol are gradually falling across the board overall.
- Deaths in Oxfordshire are lower than national levels.
- Deaths in females are around half those of men.
- Male deaths in Oxfordshire rose slightly according to the latest figures and female deaths fell.

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

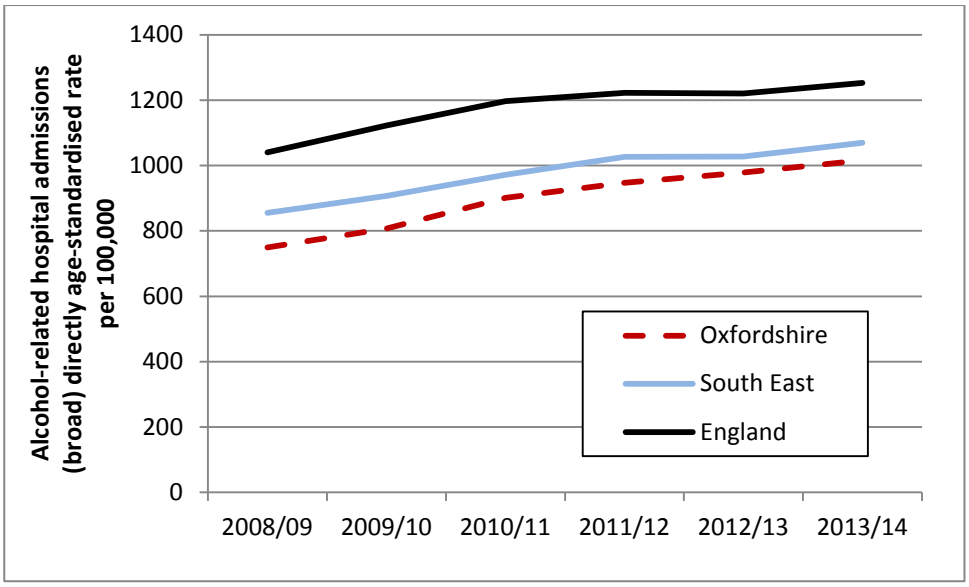


The charts show that:

- 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.

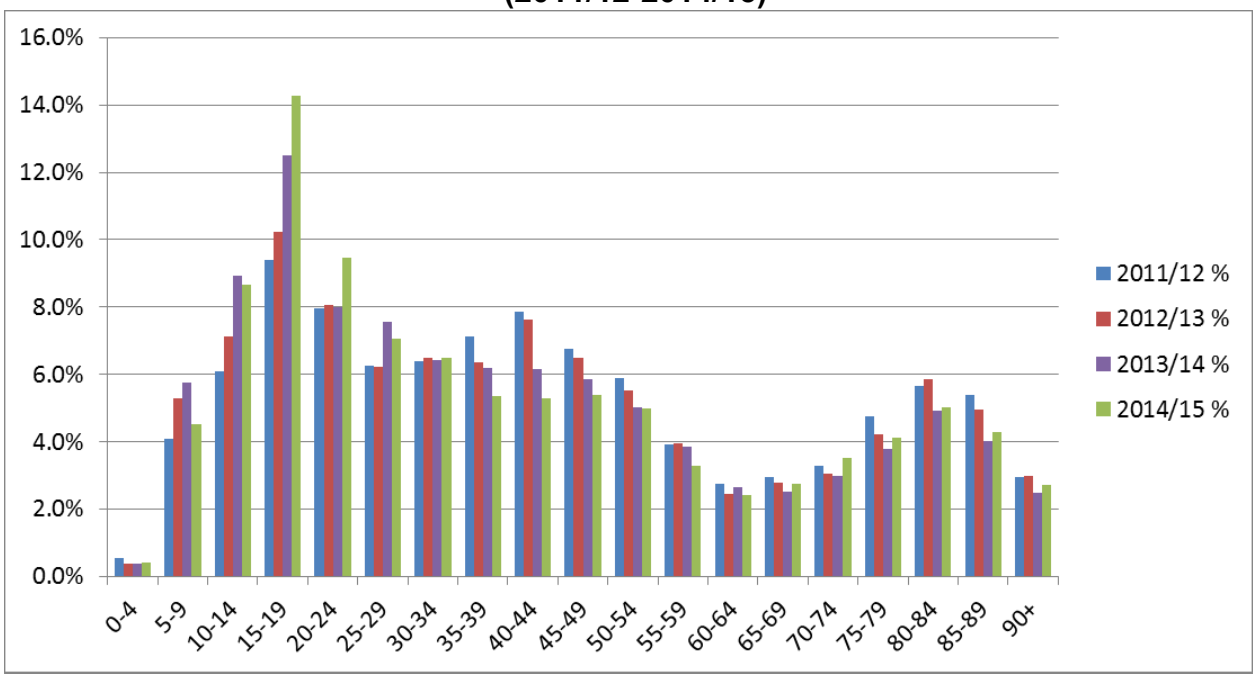
Children and Young People's Mental Health

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 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.

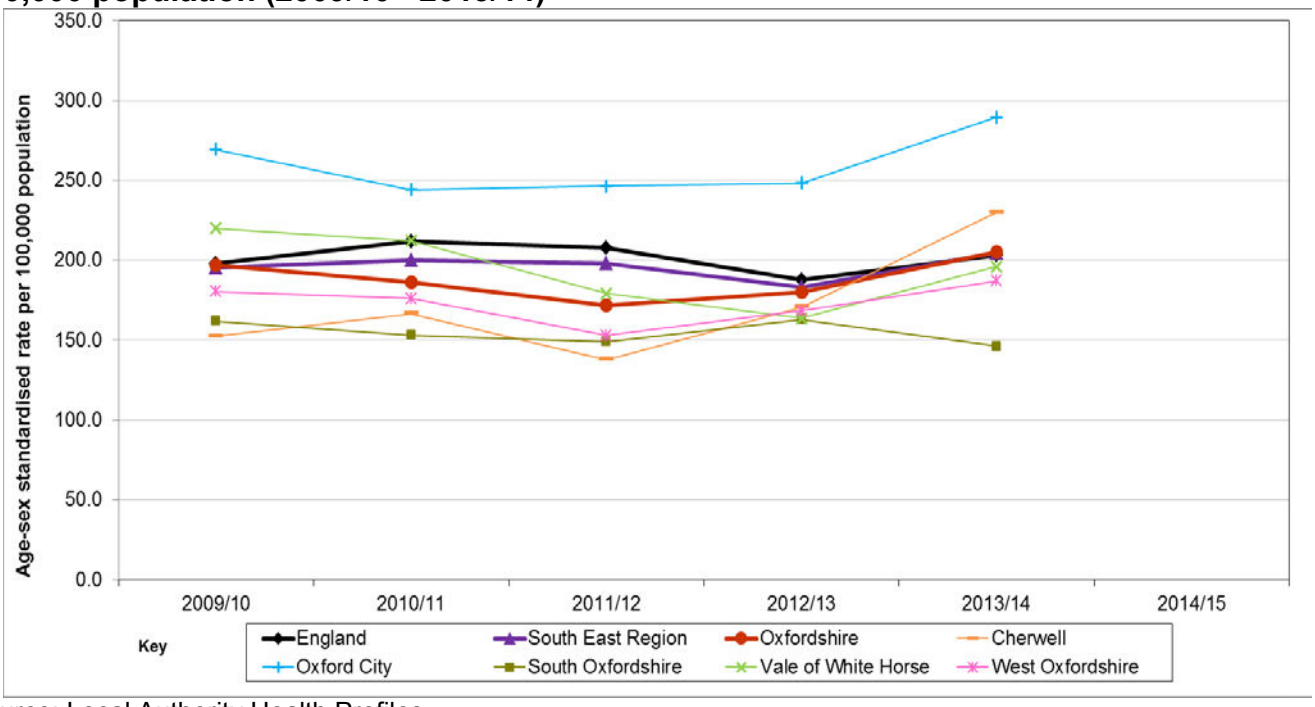
The rates for self-harm in all ages in Oxfordshire give us an idea of the local trends. During 2013/14 the number of emergency hospital admissions for intentional self-harm in Oxfordshire was 1,421. The rate of hospital admissions for intentional self-harm is rising in Oxfordshire, similarly to the regional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

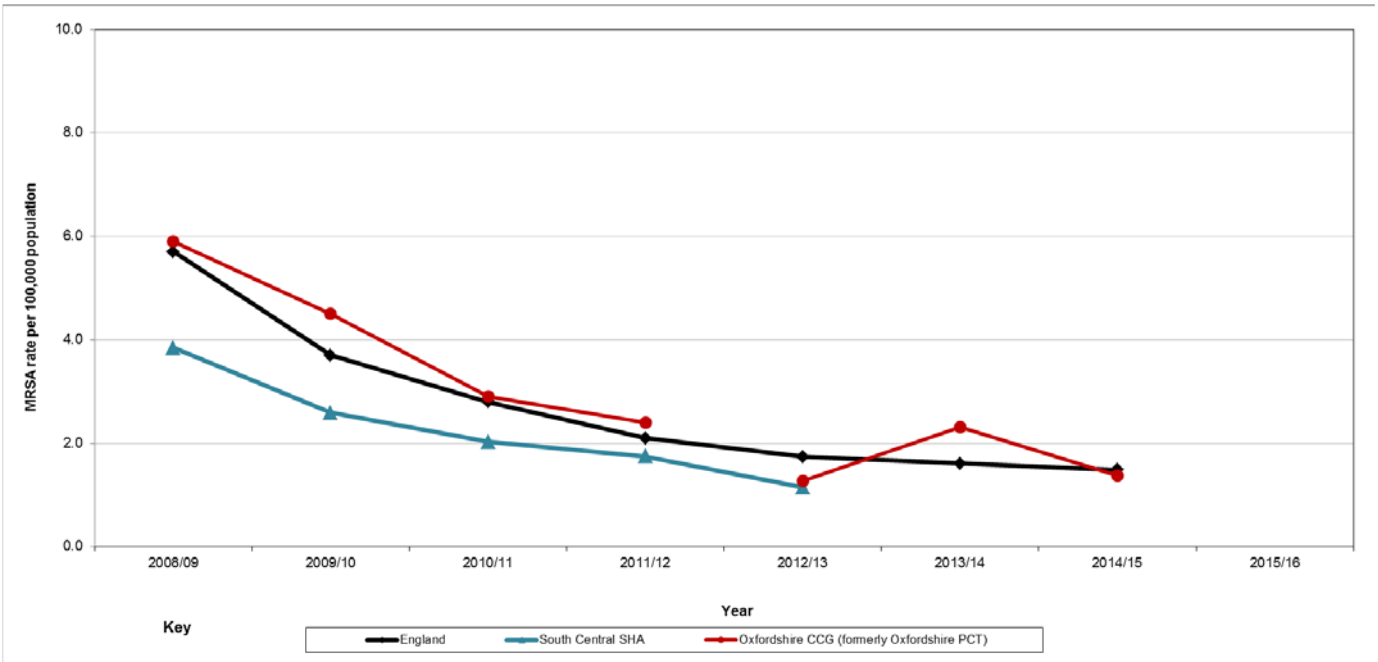
The key is to keep the specialist workforce we have now and to nurture this work carefully.

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.

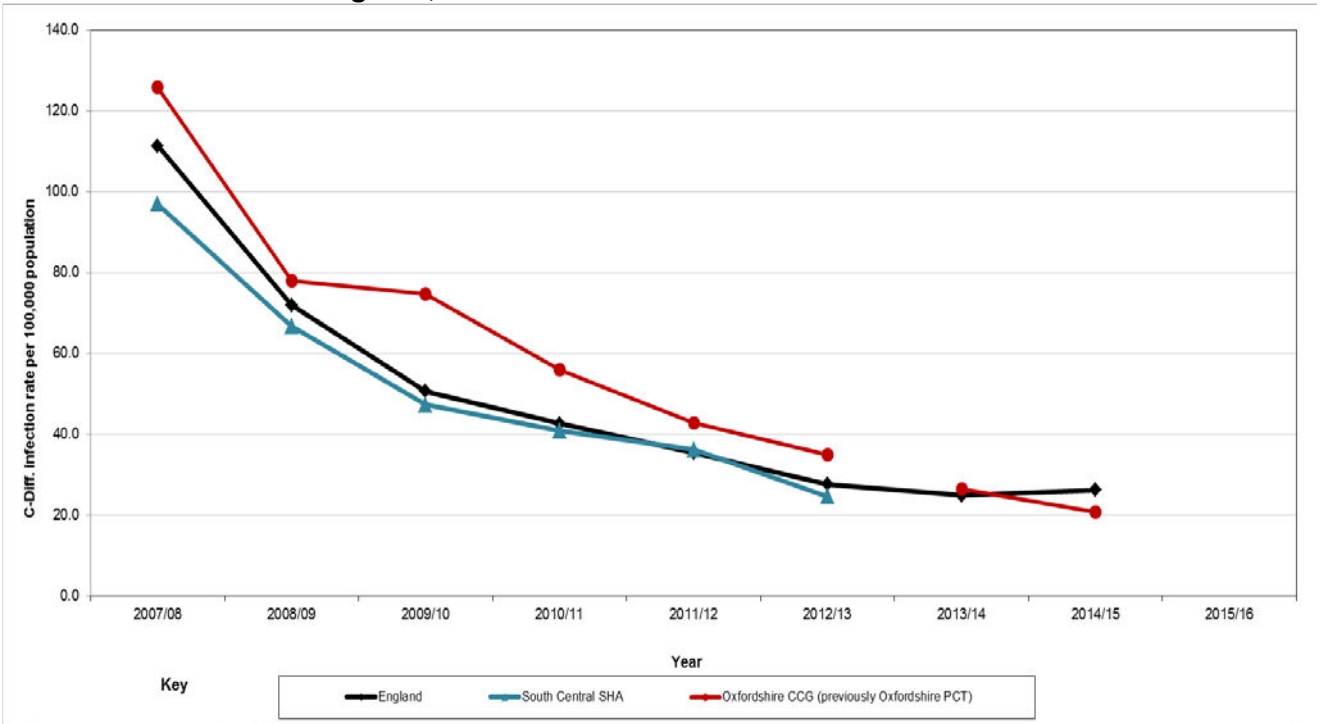
Clostridium difficile (C.diff)

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

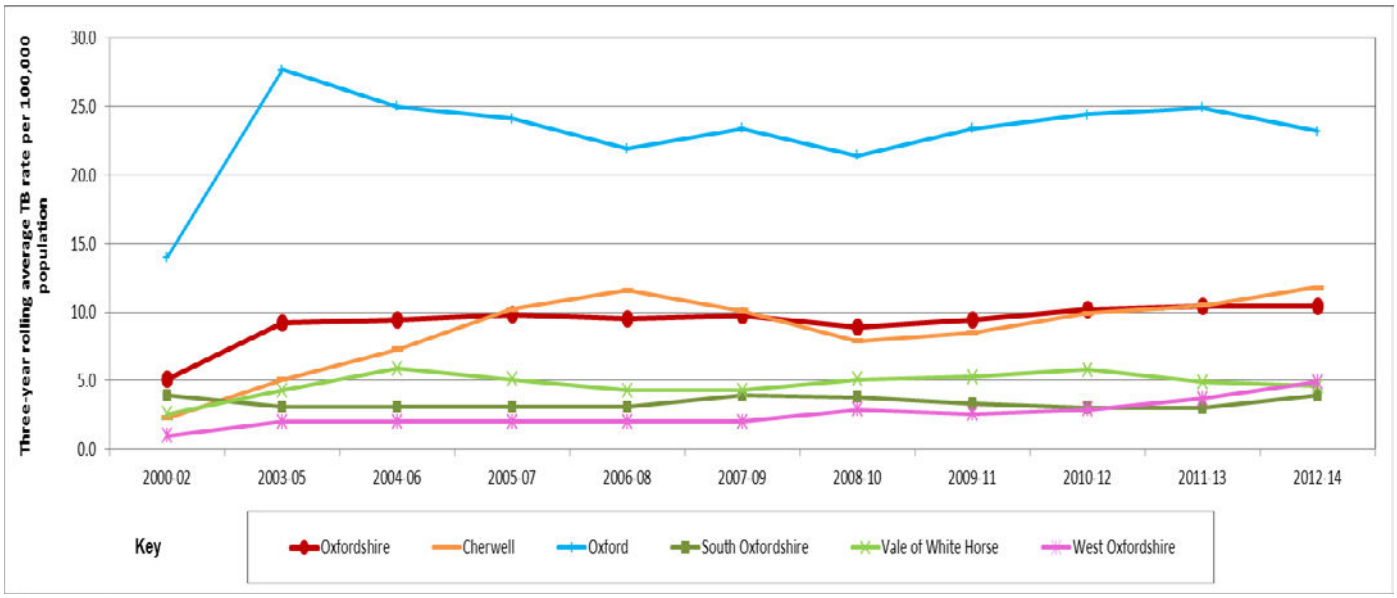


Tuberculosis (TB) in Oxfordshire

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.

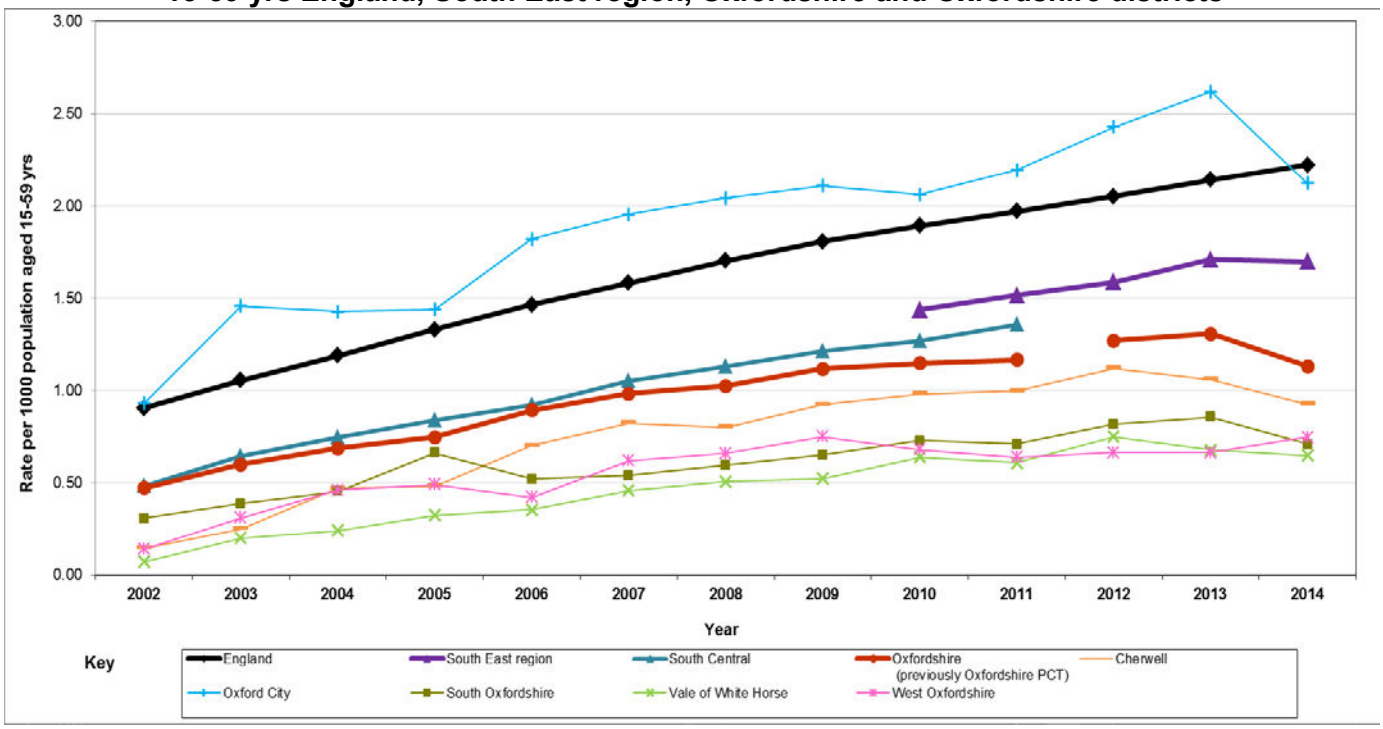
The rate of TB in Oxfordshire is lower than the National average and levels in Oxfordshire, Buckinghamshire and Berkshire combined. In the UK the majority of cases occur in urban areas amongst young adults, those coming in from countries with high TB levels and those with a social risk of TB. This is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

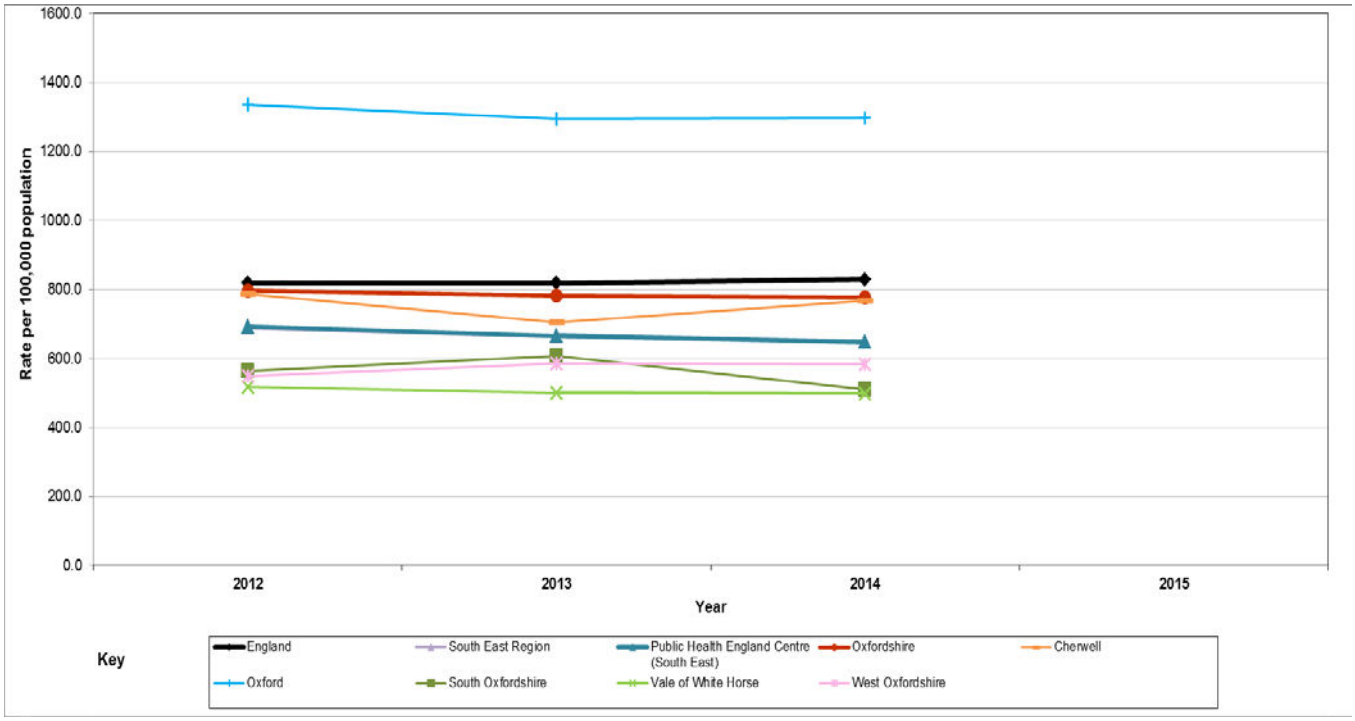
Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments. HIV cannot be cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly decreased.

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 2014England, 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.

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28 th OCTOBER 2016

Headline Report: Addressing Health Inequalities in Oxfordshire

Report from the Independent Commission on Health Inequalities in Oxfordshire

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Acknowledgements:

The Commission would like to thank

- The members of the Commission Support Group, convened by the CCG, who gave unstintingly of their expertise and advice, providing useful contacts for the Commission and its secretariat
- The co-opted members of the group, and members of its wider support network, who provided their support and specialist expertise at various stages of the evidence gathering. These include, but are not restricted to Patrick Taylor, Lonah Hebditch, Mandy Rose, Maggie Dent, Emily Phipps and Jackie Wilderspin.
- The members of the public who came along to the evidence sessions to provide their input and views
- The many people from across the statutory, voluntary and private sectors who produced written submissions, gave oral evidence, and attended the evidence gathering sessions.
- Professor Paul Johnstone, Clare Laurent and her team at PHE, Sir Michael Marmot and Poppy Jaman.
- Allison Thorpe for her secretarial support holding the process together

Their support and input were invaluable.

Section 1: Introduction:

"Right now, if you're born poor, you will die on average nine years earlier than others. If you're black, you're treated more harshly by the criminal justice system than if you're white. If you're a white, working-class boy, you're less likely than anybody else to go to university."

Source: Teresa May, Prime Minister

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. But as Sir Michael Marmot has highlighted, health inequalities are not just poor health for poorer people but affect us all – "it is not about them, the poor, and us the non poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone.'[i] Addressing health inequalities is a priority for the World Health Organisation [ii] and remains central to the UK government's health strategy, the Five year Forward View [iii], which provides guidance to the NHS. The open letter from the Secretary of State for Health in February 2016 makes it clear that all communities are expected to have plans in place to narrow the gap and reduce overall inequalities in their health. [iv] Local authorities, strengthened by the recent move of public health departments, have inequalities duties – introduced for the first time by the Health and Social Care Act 2012.

1.1 Background to the Commission Report

The Oxfordshire Commission on Health Inequalities was established at the request of the Oxfordshire Health and Wellbeing Board[HWB]. The HWB had recognized that in addition to the human costs, the cost of health inequalities to the NHS is unacceptable. It is currently estimated at £5.5bn nationally, and economic losses associated with health inequalities due to lost production, higher benefit payments and lost taxes have been estimated at £31-33bn. The economic benefits of addressing inequalities are clearly demonstrated in Appendix 1 which presents costs of illnesses and benefit analyses of interventions. Thus addressing inequalities will strengthen the economic well being of the county as well as the health of its population.

1.2 The Commission's Approach

Informed by the Marmot Review of 2010, the Commission (for membership see Appendix 2) adopted an approach, which would enable it to consider factors, which would make recommendations to:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

The overall aim of the Commission is to make recommendations that will reduce health inequalities. Its approach has been:

- To draw upon local experience and sound evidence for effective action, which resonates with local, national and international policy directions
- To identify activities that can address health inequalities in Oxfordshire, giving robust examples of current and emerging best practice

The Commission has considered what is currently being done to identify and tackle health inequalities in Oxfordshire, drawing on documentary and oral evidence provided by statutory, voluntary and charitable organisations in the county. This includes the Annual Reports of the Director of Public Health, the Joint Strategic Needs Assessment, the Sustainability and Transformation planning process and other reports already in the public domain. The evidence sessions have been held in public, to encourage and enable input from Oxfordshire residents, and to ensure transparency.

The Commission used a lifecourse model to inform its deliberations. A lifecourse perspective highlights both critical periods of risk and also the accumulation of risk over an individual's lifetime and directs attention to how health inequalities operate at every level of development – pre conception, childhood, working age, and into the latter years of life.[v.]

Each consultation session started with a presentation of the relevant available data on health inequalities, provided by the public health team.

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This Headline report presents the main recommendations of the full report, structured to reflect the process followed.

Recommendations 1-11 focus on the Common Principles (Box A) which emerged during the process of the Commission :

These principles should inform all policy, resource allocations and practice across the county if health inequalities are not to become further entrenched or grow:

Box A: Common Principles to address health inequalities

1.The profound influence and impact of poverty on health needs to be widely recognized and systematically addressed
2.Commitment to prevention needs to be reflected in policies, resources and prioritization
3.Resource allocation will be needed to reduce inequalities
4.Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organizations using the Health in All Policies approach
5.Data collection and utilization needs to be improved for effective monitoring of health inequalities

Recommendations 12-40 focus on common themes across the lifecourse, drawing together many of the threads common to the other sessions. (Figure 1). These recommendations take into account not only geographic communities but also communities of common interest, particularly vulnerable groups most likely to suffer from health inequalities.

FIGURE 1 :

Cross cutting themes

Recommendations 41-58 focus on stages of the life course

- ***Beginning well***: pre-pregnancy, the antenatal and perinatal period, and childhood,
- ***Living well***: the middle years
- ***Ageing well***: the latter years of life.

Section 2: Summary of recommended actions:

A Recommendations based on principles

2.1. The profound influence and impact of poverty on health needs to be widely recognised and systematically addressed

The difference in life expectancy between rich and poor is well known. Perhaps less well known but equally important… is the inequality in the years lived in good health.

Source: House of Commons Health Committee Report on Public Health, September 2016

The 2012 Social Value Act is an important piece of new legislation which places an onus on organisations spending public money to do so with an eye to improving social circumstances; spending it for the public good.

Source: PHE Resources to support local action on health inequalities. https://www.gov.uk/government/news/phe-resources-support-local-action-on-health-inequalities

Poverty and disadvantage lead to poorer health. Mitigating the relationship between poverty and health is essential if we are to address the entrenched inequalities already present within Oxfordshire, and prevent further generations of Oxfordshire residents becoming adversely effected by circumstances beyond their immediate control – the wider determinants of health.

Recommendations		***Responsibility***
1.	Statutory funding bodies need to do more to demonstrate their commitment to reducing inequalities. Their policies and plans should be scrutinized by HWB on an annual basis .	**HWB**
2.	Monitoring of the process of commissioning/service design to ensure it has taken inequalities into account in the design of new models of care and innovations such as vanguards needs to be undertaken regularly.	**CCG/service providers**
3.	Local indicators on progress towards reducing inequalities should be developed, with regular reporting to the Health and Wellbeing Board. This should be in place by the end of 2017	**PH department in OCC**

2.2. Commitment to prevention needs to be reflected in policies , resources and prioritization

An economic perspective is about more than counting the costs associated with poor health. It is about understanding how economic incentives can influence healthy lifestyle choices in the population.

Source: http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/promoting-health,-preventing-disease-the-economic-case

While strong local political leadership can bring enormous benefits for public health, there is also the potential for tension between political priorities and evidence-based decision making. Clearer standards should be introduced and monitored transparently to improve accountability and to make sure that services to underrepresented or politically unpopular groups are maintained at an appropriate level.

Source: House of Commons Health Committee, Public Health Report, September 2016

Numerous studies have shown that investment in primary and preventive care greatly reduces future health care costs, as well as increasing health[vi vii]. In England only 4-5% of health spend is

focused on prevention activities[viii]. The Marmot review recommends this should be at least 7% [ix]. We have no reason to doubt that this also applies in Oxfordshire and that the current level of investment in prevention across all sectors is inadequate. Investment in prevention by all agencies is essential if progress in improving the health and wellbeing is to continue and to ensure that existing health inequalities do not grow and become further entrenched. This is not just about investment in essential public health services, but more broadly across all investments in the socioeconomic conditions which affect health to ensure that all resources are invested effectively and take account of the opportunities in all contacts with services.

	Recommendations	***Responsibility***
4.	Greater investment is needed in prevention, innovation and service design both across the health and social care system and more widely to mitigate the impact of poverty and health inequalities. • All NHS partners should state clearly their investment in prevention. • The current level of spending on public health services through the ring fenced budget should be maintained • The HWB should track increased spending on prevention, (xi) and annually report to the public on progress made and outcomes achieved	***CCG*** ***NHS*** ***HWB/Councils*** ***HWB***
5.	The needs of disadvantaged groups should be monitored to ensure preventive programmes do not increase the inequalities gap, and that programmes delivered to all raise the health of all, including those who are most disadvantaged[x].	***HWB/STP partners***
6.	Core preventative services such as Health Visiting, Family Nurse Partnership, School Health Nurses and the Public Health agenda should be maintained and developed	***CCG***

2.3 . Resource re-allocation will be needed to reduce inequalities

"Cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities. "

Source: House of Commons Health Committee, Public Health post 2013, Second Report of Session 2016-7[xi]

Ensuring best value from investment is critical to the current and future health and wellbeing of Oxfordshire residents, and the future sustainability of the health and social care system. The

evidence submitted to the Commission suggests that there are existing unmet needs in Oxfordshire.

	Recommendations	***Responsibility***
7.	Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities. • The CCG should actively consider targeting investment at GP surgeries and primary care to provide better support to deprived groups, to support better access in higher need areas, and specifically address the needs of vulnerable populations. • The CCG should conduct an audit of NHS spend, mapping health spend generally and prevention activity particularly against higher need areas and groups, setting incremental increasing targets and monitoring progress against agreed outcomes. • The ring fenced funding pot for targeted prevention should be expanded in higher need communities, using a systemwide panel of stakeholders to assess evidence and effectiveness, with ongoing independent evaluation of impact, including quantification of impact on other health spend. [1] • An Innovation fund/Community development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations.	***CCG*** ***CCG*** ***CCG/STP*** ***CCG***

2.4. Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organizations

Whilst there was evidence of good partnership work in pockets in Oxfordshire, the Commission was also presented with many examples of where this could be made stronger. Addressing health inequalities in all policies should be given higher priority in Oxfordshire

"**Health in All Policies** is an approach to public **policies** across sectors that systematically takes into account the **health** implications of decisions, seeks synergies, and avoids harmful **health** impacts, in order to improve population **health** and **health** equity.

http://www.healthpromotion2013.org/health-promotion/health-in-all-policies

[1] This needs to engage people from the community and voluntary sectors, as well as people working in the statutory sector

	Recommendations	***Responsibility***
8.	The Health in All Policies approach should be formally adopted and reported on across NHS and Local Authority organizations, engaging with voluntary and business sectors, to ensure the whole community is engaged in promoting health and tackling inequalities. Regular review of progress should be undertaken by HWB	***All statutory organisations*** ***HWB***
9.	The presence of the NHS and of the voluntary sector should be strengthened on the Health and Well Being Board	***HWB***

2.5. Data collection and utilization needs to be improved for effective monitoring of health inequalities

''The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, we are concerned that robust systems to address unacceptable variation are not yet in place. The current system of sector-led improvement needs to be more clearly linked to comparable, comprehensible and transparent information on local priorities and performance on public health.''
Source: House of Commons Health Committee Report

Data collection on health inequalities in the county is patchy and not adequately utilized in policy and resource allocation decisions. During the process of consultation we found it difficult to get good data on Black and Ethnic Minority Communities in the county as well as on other disadvantaged groups[2]:

	Recommendations	***Responsibility***
10	The data on health inequalities available through PHE/NHS and other routine sources should be regularly reported to all statutory organisations and made available to the public.	**PH Dept**
11	Gaps in data collection on the health of BME communities, those with learning difficulties and other vulnerable groups at greater risk of poor health should be addressed and data used to inform resource allocation decisions. This includes encouraging all public sector organisations and organisations who do work on behalf of these organisations to be fully Equality Act compliant.	**HWB**

[2] This is a concern, given that this is one of the protected characteristics covered by the Equality Act. The Commission believe there is a need for focused effort encouraging all public sector organisations (and all organisations & parties who do work on behalf of those organisations) to be fully Equality Act compliant, as this would support good quality data collection that can then be used to inform decision making in a number of areas, including health inequalities.

Section 3: Cross cutting themes

When considering evidence across the lifecourse it became apparent that there were common themes which needed to be holistically addressed in efforts to reduce health inequalities .[see Figure 1]

3.1 Access

a. Better Access to financial advice :

Greater attention needs to be given to the wider arrangements for referring people to benefits advice programmes, as part of a sustained programme of activity which aims to improve financial situations, address debt, and promote financial inclusion.

	Recommendations	***Responsi***
12.	Benefits Advice should be available in all health settings, including GPs networked into local areas to support CABs	***CCG/NHS Partners***
13	A sub group working on income maximization should be established, and asked to report back to the HWB/CCG within a year	***HWB***
14.	District Councils should be approached to seek matched funding, dependent on existing contribution	***HWB***

b. Better access to services

All service providers need to ensure that services are as responsive as possible. For example, discharge arrangements from NHS care need to be appropriately tailored for people who are homeless. Services need to be sensitive to the cultural norms and beliefs of patients from minority ethnic communities.

	Recommendation	***Responsibility***
15	Indicators in the wider NHS performance framework should be utilized as part of routine monitoring for NHS organisations to yield useful, if limited, insights into inequalities and provide a metric that can be measured to assess progress in addressing inequalities.	***NHS organisations***

3.2 Housing and health

a.Better access to secure, affordable, decent accommodation for Oxfordshire residents

There is a growing body of evidence showing a correlation between poor housing and ill health. Warm, dry secure accommodation is associated with better health outcomes.

	Recommendations	***Responsibility***
16.	Public agencies, universities and health partners should work together to develop new models of funding and delivery of affordable homes for a range of tenures to meet the needs of vulnerable people and key workers. Specifically, public agencies should work together to maximise the potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing by undertaking a strategic review of public assets underutilized or lying vacant .	***Public agencies, universities and health partners*** ***Public agencies/HWB***
17.	Consideration should given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, addressing health inequalities in particular, and learning from other areas .	***HWB/CCG***

'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses. Rates of fuel poverty in Oxfordshire are unacceptably high .

18	In 2014 9.1% of households were fuel poor . This should be reduced in line with the targets set by the Fuel Poverty Regulations of 2014.	***HWB***

3.3 Action to reduce the harms of Homelessness

Homeless people experience severe health inequalities with an average life expectancy of some 30 years less than the rest of the population [xii]. They often suffer from tri-morbidities: the combination of poor physical health, poor mental health and substance misuse, with poor health as both a cause and an outcome of sleeping rough. In general, homeless people experience significant barriers in accessing services to support their health, requiring extra support to access routine and acute services.

Phased changes in the funding allocations for housing related support are expected to have a significant impact on the availability of accommodation for single homeless people across the county. We would encourage the District and County Councils to continue to work together to find a solution, which will ensure this already vulnerable population are not further disadvantaged and to regularly report on progress to the Health and Wellbeing Board.

	Recommendations	***Responsibility***
19.	All public authorities are encouraged to continue their collaboration and invest in supporting rough sleepers into settled accommodation, analysing the best way of investing funding in the future. Homelessness pathways should be adequately resourced and no cut in resources made with all partners at the very least maintaining in real terms the level of dedicated annual budget for housing support.	***HWB***
20.	The numbers of people sleeping rough in Oxfordshire should be actively monitored and reduced.	***HWB***

3.4 Rurality: reduce the health harms associated with rurality

Oxfordshire is a rural county, with approximately 50% of its population living in small settlements of less than 10,000 people. Health services such as major and community hospitals, out of hours GP services and ambulance services can be more difficult for village based residents to access, with limited or non existent public transport. For older people in particular, with limited access to public transport or poor mobility, rural living can have a negative impact on health and wellbeing, and isolation and loneliness diminish their well being.

	Recommendations	***Responsibility***
21.	An integrated community transport strategy should be developed[xiii]	***District and County Councils***
22.	A digital inclusion strategy, which explicitly targets older people living in rural communities should be developed and the % of older people over 65 with access to on line support regularly reported	***STP***
23.	Reports of isolation and loneliness in older people/people suffering from dementia in rural areas should be collated and monitored on an annual basis with a reduction achieved year on year utilizing advice in http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation .	***DPH***
24.	The recommendations from the DPH annual report should be implemented and monitored.	***DPH***

3.5 Supporting vulnerable populations

a. Improving access to services for Refugees

The Commission heard evidence on the health needs of refugees and migrants, including detainees in Campsfield House and agreed that special consideration should be given to the

needs of migrant families and refugees. Evidence to the Commission noted that this support needs to be kept under review,

	Recommendations	***Responsibility***
25.	Funding for locally enhanced services for refugees and asylum-seekers should be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers.	***HWB***
26.	Outreach work in communities with high numbers of refugees, asylum seekers and migrants, should be actively supported and resources maintained, if not increased, especially to the voluntary sector, to improve access to the NHS, face to face interpretation /advocacy and awareness raising amongst health care professionals	***HWB***

b. Improving access to Throughcare provision for prisoners

Prisoners, and ex- prisoners are a vulnerable ethnically diverse population, with a constantly moving and increasingly ageing population adding further complexity. A recent study has suggested that offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. [xiv]

	Recommendation	**Responsibility**
27	Robust pathways to community services for community rehabilitation (including Community Rehabilitation Companies)[3] on release, particularly for short term offenders, need to be developed	***HWB***

3.6 Lifestyle factors : Physical and Social well being :

The importance of lifestyle as a contributor to health is well known, and the Annual Reports of the Director of Public Health have sequentially described trends and targets which will not be repeated

[3] **Community Rehabilitation Company** (CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation.

in this report [see https://www.oxfordshire.gov.uk/cms/content/oxfordshire-public-health]. However, we wish to recommend some specific actions:

a. Physical activity :

The health benefits of physical activity are well documented: providing help with weight control, reducing the risk of chronic disease and improving mental health. In Oxfordshire, 41.6% of people participate in sport at least once a week, but disabled people, people over the age of 55 and people from lower socio-economic groups are less likely to participate.

	Recommendation	***Responsibility***
28.	A set of Oxfordshire-grounded targets for increasing activity should be developed, targeting people living in deprived areas, older people, and vulnerable groups .	***HWB***
29.	Continuing investment and coordination of existing initiatives should be maintained supported by social marketing and awareness-raising of the benefits of physical activity to targeted populations.	***PH Dept***
30.	The county should : • monitor and increase the number of disabled people participating in regular physical activity • achieve a measurable decrease in inactivity and in parallel an increase in mental well-being measures, measured using the Active People Survey and Health Survey for England datasets • demonstrate and increase a narrowing of the gap between the less socioeconomically privileged groups and the norm .	***PH Dept***

b. Smoking

Smoking is the single greatest cause of preventable illness and premature death in the UK. In Oxfordshire local figures show a current overall smoking prevalence of 15.5 but amongst routine and manual groups this rate rises to 30.6%.

	Recommendation	***Responsibility***
31.	Better data should be collected on smoking rates in different population groups including pregnant women, people with mental health problems, people in manual or routine occupations and other vulnerable groups to ensure that ,in addition to lowering the overall rates of smoking ,the inequalities gap between these groups and others is reduced.	***PH Dept***

c. Alcohol and drugs

C1. Alcohol:

Alcohol is more affordable and available than at any time in recent history. While most people who drink do so without causing harm to themselves or others, there is a strong and growing evidence base for the harmful impact that alcohol misuse can have on individuals, families and communities in Oxfordshire.

	Recommendation	***Responsibility***
32.	An alcohol liaison service should be developed in the OUHT	***NHS***
33.	A targeted project should be developed which aims to reduce drinking in middle aged people living in deprived areas	***PH Dept***
34.	Building on experience from Wantage, Community Alcohol Partnerships should be established across the county to address the problems of teenage drinking, particularly in Banbury as A&E data shows high numbers of under 18s attending the Horton ED for alcohol related reasons. [The partnership model brings retailers, schools, youth and other services together to reduce under age sales and drinking.]	***PH Dept***
35.	Support and develop schools interventions including support given to school health nurses as well as services such as those run by The Training Effect to increase capacity of young people to choose not to misuse substances.	***HWB***

C2 . Drugs

National data shows that people who misuse drugs and their families are most likely to live in socially deprived circumstances at the bottom end of the social gradient. Their needs are a fundamental health inequalities challenge. Yet there is no prevalence data for drug use, as such, as nobody knows exactly how many people are using illegal substances. This does not detract from the need to maintain and if necessary increase support to drug users and their families to meet their needs. Evidence available on Novel Psychoactive Substances [legal highs] suggests agencies also need support to develop a model of care

	Recommendations	***Responsibility***
36	Resources in the public health budget should be maintained to provide services and support for drug misusers and their families	***HWB***
37.	School based initiatives should be promoted for all age groups	***HWB***
38.	Policy and action should be targeted to continue to address - the rates of successful completion of drug treatment in non opiate users - the rate of parents in drug treatment - the rate of people in substance abuse programmes who inject drugs who have received a hep C vaccination - the rate of children facing a fixed period of exclusion due to drugs/alcohol use - NPS use	***HWB***

3.7 Mental health

Many people with mental health problems also suffer poor physical health and impoverished social conditions. Addressing their needs will reduce health inequalities within the county. Oxfordshire has one of lowest spends per weighted capita for mental health (FYFV) and did not increase the % allocation of funds to mental health in line with total increased allocation in funding. It has a higher than average excess under 75 mortality rate in adults with serious mental illness

	Recommendations	***Responsibility***
39	The under provision of resources for Mental health services should urgently be addressed	***CCG***
40	The implementation of the Five Year Forward Strategic View of mental health services for the county should explicitly state how it is addressing health inequalities and how additional resources have been allocated to reduce them.	***CCG/OH***

Section 4. Life course actions:

Future health inequalities are, to a large extent, determined from a child's earliest years, including its intrauterine development. This is due to biological factors as well as life circumstances. Early responses to what is happening shape future physical and psychological functioning, supporting children to thrive, learn, adapt and form good future relationships. The first few years of life can be critical for readiness to learn, educational achievement and ultimately wealth and economic status, a strong predictor of future health and wellbeing.

A. Maternal health

Evidence provided on perinatal mental health highlighted a significant gap: whilst Oxfordshire has a local pathway for mental health services, there is no service or access for women with severe mental illness and personality disorders, although such services are being developed in other parts of the region.

	Recommendation	***Responsibility***
41.	Perinatal mental health should be a priority with appropriate investment to improve access to perinatal mental health services across Oxfordshire	***CCG***

B. Children's health and wellbeing

Evidence presented to the commission suggested that more needs to be done to ensure that children are given the best possible start in life, recognizing that family circumstances can and do make a difference to health outcomes.

Nutrition is an important foundation for good health – and challenges exist in ensuring access to affordable healthy food for all families with young children. Evidence provided to the Commission, which drew on The Trussell Trust's 2016 report data, suggests that food bank use is at a record high across the country**.** We interpolate from national data that 2.5% of the population of Oxfordshire accessed 2 emergency food parcels per person in the last year.

Education is an important factor in future health, and ensuring that children are ready for school entry, are adequately fed during their school days, attend school regularly and their achievement monitored are all important ways in which inequalities can be addressed. We recognize that there is much good work ongoing within the county in these areas.

	Recommendations	***Responsibility***
42.	Use of food banks needs to be carefully monitored and reported to HWB	***HWB***
43	Child Health Profiles and other relevant routine data should routinely be reported from the perspective of addressing factors which could reduce health inequalities	***PH Dept***
44	New and creative ways to work with schools, such as Oxford Academy, should be explored and initiatives funded and evaluated through the proposed CCG fund	***HWB/CCG***
45	The current plans for closures of Children's Centres should be reviewed by March 2017 to ensure prioritization of effective evidence-based investment and good practice in early intervention for children and to ensure that the change of investment and resource allocation to young children and their families does not disadvantage their opportunities especially for those children & families from deprived areas and identified disadvantaged groups	***HWB***

4.2 Living well :

At every point in the adult's life there is an opportunity to improve health and wellbeing, prevent the development of new conditions, and minimize the impact of pre-existing conditions. Yet at this stage of the lifecourse, engagement with services is often minimal.

Being in work is good for health and economic productivity. The health of the workforce is an asset and programmes within workplaces as well as initiatives to reduce worklessness will contribute to reducing inequalities. The Commission heard of good examples both within the NHS and within the local corporate sector .

Using the workforce race equality standard is a useful measure of discrimination, harassment and access to career progression.

The Commission recognized that amongst the adult population some groups were particularly vulnerable to health inequalities, particularly those with learning difficulties

	Recommendations	***Responsibility***
46	Resources should be committed to ensure that prevention and lifestyle advice are embedded in all contacts with statutory service providers and the opportunity taken to include advice about healthier lifestyles and signpost support .	***CCG/NHS/HWB***
47.	Promoting the health of those in work should be a priority and examples of good practice shared by establishing a county wide network .	***HWB and partners, e.g. UNIPART***
48	The NHS workforce should engage in equity audit and race equality standards should be routinely reported	***NHS/STP***
49	The needs of adults with learning disabilities within the County should be reviewed in 2017 and targets set to reduce their health inequalities .	***NHS/HWB***

4.3 Ageing well

With significant improvements in healthcare and lifestyles, an increasingly large percentage of our population is made up of people aged over 65 years old.[xv] Older people are increasingly likely to require support from adult social care and social isolation becomes an important factor in older people's mental health. There is much that can be done to maximise the potential of older adults and enable them to live as independently as possible in their own community, i.e. provision of seasonal flu vaccination, falls prevention activity, tackling fuel poverty, and community development projects to reduce social isolation, particularly for people living in rural communities. (Box 1) More needs to be done to promote integrated health and social care addressing co – morbidities, particularly recognizing that depression and low mental health are major predictors of institutionalization

Box 1: From DPH annual report in 2016

1. Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Adult Social Care Directorate should continue to plan explicitly for services for an increasing population of frail elderly people. Further integration of health and social care services should include this topic as a priority.

2. The Clinical Commissioning Group and NHS England should work with GP services to consider loneliness as a risk factor for disease and consider how affected individuals could be signposted to use local resources such as befriending services and lunch clubs.

3. The Oxfordshire Clinical Commissioning Group should continue to develop improved services for dementia as a priority.

4. Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospitals Trust and Oxford Health Foundation Trust and NHS England should develop, as a priority, their joint work to collaborate in transforming the local health system. This is in order to provide new models of care closer to home, care focussed on prevention and early detection of disease, improved care for carers, prevention of hospital admission and speedy hospital discharge through improved community services, the modernisation of primary care and the funding of primary prevention services by the NHS.

5. Oxfordshire Adult Social Care Directorate should continue to analyse carefully the implementation of the Care Act and feed this information into future service planning.

6. The Director of Public Health should continue to commission NHS Health Checks and ensure that the offering and uptake of these services achieved by local GPs is kept at high levels. Poorly performing practices should be helped to improve the way Health Checks are delivered.

7. Oxfordshire Healthwatch should consider paying particular attention to dementia services and care for carers as part of their forward planning.

8.The Oxfordshire Health Overview and Scrutiny Committee should consider the issues raised in the care closer to home report carefully, and consider the issues raised in the DPH report, to ensure that proposals to re-shape services match demographic need and address health inequalities.

	Recommendations	***Responsibility***
50.	Health and social care systems should work together to agree how best to bring together local services to produce a more coherent transition between sectors when addressing inequalities, recognising that co-morbidities are common in this age group, and that many older people are acting as carers for their partners and family members.	***HWB***
51.	Shared budgets for integrated care should be considered and how this fits with the broader care packages available to older people. For example, looking at how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers.	***CCG/HWB***
52	Support for carers , including their needs for respite care and short breaks , should be supported with resources by all agencies	***DPH***
53	The recommendations from the 2016 DPH annual report are endorsed and	***HWB/OCC***

	the Commission wishes to ensure they are targeted to reduce health inequalities and progress reviewed by HWB in 2017	
54.	Support for services and stimulation should be provided to older people, especially those living on their own to avoid isolation and loneliness especially amongst those with dementia and in rural areas	***CCG/HWB***
55.	Strategic action should be taken to oversee increased access to support for older people in disadvantaged and remote situations: o physically through a better coordinated approach to transport across NHS, local authority and voluntary/community sectors o digitally through a determined programme to enable the older old in disadvantaged situations to get online o financially, through support to ensure older people, who are often unaware of their financial entitlements, are helped to access the benefits they are entitled to claim.	***HWB/CCG***
56	Building on existing experience , support the further development of Alzheimers friendly environments	***HWB***
57.	The current gap in provision of support for older people with mental health needs other than dementia needs to be addressed urgently.	***HWB***
58.	Promoting general health and wellbeing through a linked all ages approach to physical activity, targeting an increase in activity levels in the over 50s, especially in deprived areas, using innovative motivational approaches such as 'Good Gym' and Generation Games	***HWB/CCG***

Section 5: Next steps

The Commission has reviewed health inequalities in Oxfordshire and the many positive steps already being taken to care for the more vulnerable members of our community . Our objective has been to highlight that inequalities in health are unfair and unjust and that they need to be taken into account and action taken by all concerned with the health of our population.

The recommendations highlighted in this Headline report are more fully described and developed within the final report which will be presented to the Health and Well being Board in November 2016. Whilst it is easy to say that many of the structural elements of poverty and disadvantage are beyond the control of the county and its services it is also true to say that local action can make a difference. It is also easy to discount recommendations on the basis of poor financial data on costs and benefits of the recommendations, but this rigour is not applied to the commissioning of other routine services commissioned on a historical basis. We do know that addressing inequalities will save and improve lives for the most vulnerable in our communities and that gains will accrue over the lifetime of children who benefit from positive interventions .We also know that budgets are constrained, and we need to think creatively about how resources can be allocated or even reallocated.

The next steps for the Commission will be to promote the findings of the report and discussion of what can be achieved through local action . The areas for action can be reviewed using the tools produced by PHE to support local action (see above). Progress needs to be regularly reported to councils , NHS partners and the local population through the Health and Well Being Board.

	Overall Recommendations:	***Responsibility***
59.	**The suggested actions should be considered by relevant parties and prioritized, with a report on progress to the HWB by mid 2017**	***HWB***
60.	**The resources produced by PHE to support local action should be used as part of the formal review process.**	***HWB/all partners***

We would like to thank all those who have contributed to the process so far.

October 2016

Useful resources to support further action on health inequalities

Source: https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers

The Marmot Review, published in 2010, set out evidence for action across the wider determinants of health to reduce health inequalities. To help turn the Marmot recommendations into practical actions, in September 2014 PHE published the first series of evidence papers on the issue. The commitment to support local action on health inequalities has been continued with new Practice Resource papers that include evidence, information and tips on approaches that local partnerships can adopt on four topic areas:

- Opportunities for using social value act to reduce health inequalities in England
- Promoting good quality jobs to reduce health inequalities
- Reducing social isolation across the life course
- Improving health literacy to reduce health inequalities

Agenda Item 9

Report to the Oxfordshire Health and Wellbeing Board

November 2016

Health Inequalities Commission/Final Report

For: Discussion and Agreement of a Monitoring Process

Executive Summary
The report of the work of the Commission into Health Inequalities in Oxfordshire was commissioned by the Health and Well being Board in autumn 2015 . The Commission presents a Headline document which provides a summary of the recommendations, and the full report which gives more background information including evidence provided to the Commission .

Background
The Commission was established at the request of the HWB to support ongoing efforts to reduce health inequalities in the county and identify further action which could be taken . Health is inextricably linked to social determinants of well-being and the scope of the report is beyond the health services . The Commission drew on the work of Sir Michael Marmot and other leading figures, utilizing a lifecourse approach to inform its recommendations for reducing local health inequalities across the social gradient as well as at different life stages. In making its recommendations, it has drawn upon local experience and sound evidence for effective action, collected through a public call for evidence, and open evidence hearings in different parts of the county and supported by the CCG and OCC's public health team . The findings have as far as possible been triangulated with local, national and international policy directions including the Five Year Forward View and the Sustainability and Transformation processes, and local data sources such as the JSNA, DPH annual reports and other local reports. The recommendations in the report are made from the perspective of taking local action which can make a difference in the short and medium term.

Recommendation
The Board is asked to

1. Receive and note the findings and recommendations of the Health Inequalities Commission
2. Consider how other sectors and communities not represented on the Board can be engaged in a meaningful discussion /action on health inequalities.
3. As part of this , to particularly consider encouraging investment in community based programmes which increase residents' income and/or reduce their expenditure, such as debt, benefits or employment advice.
4. Discuss and agree a strategy for the HWB to monitor and assess progress against these recommendations

Author and Title:
Professor Sian Griffiths, OBE, Independent Chair
Presented on Nov 10th by Professor Sian Griffiths and Dr Joe McManners

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October 28th 2016

Recommendations for action on Health Inequalities in Oxfordshire

Oxfordshire Health Inequalities Commission

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Acknowledgements

The Commission would like to thank

- The members of the Commission Support Group, convened by the CCG, who gave unstintingly of their expertise and advice, providing useful contacts for the Commission and its secretariat
- The co-opted members of the group, and members of its wider support network, who provided their support and specialist expertise at various stages of the evidence gathering. These include, but are not restricted to Patrick Taylor, Lonah Hebditch, Mandy Rose, Maggie Dent, Emily Phipps and Jackie Wilderspin.
- The members of the public who came along to the evidence sessions to provide their input and views.
- The many people from across the statutory, voluntary and private sectors who produced written submissions, gave oral evidence, and attended the evidence gathering sessions.
- Professor Paul Johnstone, Clare Laurent and her team at PHE, Sir Michael Marmot and Poppy Jaman.
- Allison Thorpe and the secretariat who held the process together

Their support and input were invaluable.

"Right now, if you're born poor, you will die on average nine years earlier than others. If you're black, you're treated more harshly by the criminal justice system than if you're white. If you're a white, working-class boy, you're less likely than anybody else to go to university."

"If you're at a state school, you're less likely to reach the top professions than if you're educated privately. If you're a woman, you still earn less than a man. If you suffer from mental health problems, there's too often not enough help to hand. If you're young, you'll find it harder than ever before to own your own home."

Source: Teresa May, Prime Minister

Poppy Jaman, CEO of Mental Health First Aid England says:

"I am pleased to endorse the report of the Oxfordshire Commission on Health Inequalities .Mental wellbeing and good health are inextricably linked , and inequalities in socioeconomic conditions will adversely affect the health of the most vulnerable in society. Many people with mental health issues also experience poor physical health and impoverished social conditions. Holistic responses addressing a wide range of socio economic factors such as poor housing, in addition to improved health services , will help address the needs of those with mental health issues and will reduce health inequalities within the county. Implementing the recommendations within this report will be a step forward towards improving the mental wellbeing of Oxfordshire's population."

Professor Paul Johnstone, Regional Director, Public Health England, says:

'The report of the Oxfordshire Commission into Inequalities in Health comes at an opportune time .Whilst we are all living longer on average, recent data shows that the gap between the richest and poorest in enjoying a healthier, longer life has not closed and is arguable widening. As this report shows, Oxfordshire is no exception. These inequalities are costly and unsustainable – there is clear evidence that poorer deprived communities depend more on public services including the NHS. The cost of the effects of poverty- which is a big burden on the NHS amongst other services- are nationally estimated at £78bn or 4% GDP. The Brexit vote had many messages and addressing the deep divides in society is now a priority for the Government and must be one for all local areas . The Commission report , which I fully endorse, sets out steps which will address inequalities and I look forward to seeing their implementation'

Chairman's Letter

28 October 2016

To the Chairman,
Health and Wellbeing Board

I have pleasure in submitting the report from the Oxfordshire Commission on Health Inequalities. The Commission was established at the request of the Health and Wellbeing Board, recognizing that both the human costs and the economic costs of health inequalities to the NHS and to the county are unacceptable. Nationally, an estimated £5.5bn economic loss is associated with health inequalities and due to lost production, higher benefit payments and lost taxes the costs rise to £31-33bn. The county bears its share of these losses and addressing inequalities will strengthen not only the health of its population but also its economic well being.

Informed by the Marmot Review of 2010, the Commission adopted a life course approach, and makes recommendations to reduce local health inequalities across the social gradient as well as at different life stages. In making these recommendations we have drawn upon local experience and sound evidence for effective action, resonating with local, national and international policy directions including the Five Year Forward View and the Sustainability and Transformation processes and we have not repeated the work summarized in the Annual Reports of the Director of Public Health, the Joint Strategic Needs Assessment and other. We also recognize the importance of advocating national solutions in addition to implementing our local recommendations.

During the evidence sessions in different parts of the county we heard about excellent initiatives which target vulnerable populations and were given many examples of current and emerging good practice that can address health inequalities in Oxfordshire.

Our recommendations are made from the perspective of taking local action which can make a difference in the short and medium term. These recommendations will need the guardianship of

the HWB if they are to make a difference to the health of the population of Oxfordshire, particularly its most vulnerable members.

I would like to thank all those who participated in the process of producing this report – most especially the Commissioners and the support team. Without them and the sterling efforts of Allison Thorpe in keeping the show on the road the opportunity to highlight often hidden inequalities might have passed us by

Professor Sian M Griffiths OBE

Foreword

The Health Inequalities Commission was convened to gather and review the evidence on inequalities in health in Oxfordshire and, as a contribution to the development of the local strategy for health improvement, to identify areas for policy development likely to reduce these inequalities. We have carried out our task over the last 10 months, drawing on scientific and expert evidence, and peer review.

Throughout the process, we identified that unacceptable inequalities in health persist in Oxfordshire. These inequalities affect the whole of society and they can be identified at all stages of the life course from pregnancy to old age.

The weight of scientific evidence supports a socioeconomic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as to the material environment and lifestyle. It follows that our recommendations have implications across a broad front and reach far beyond the remit of the health services.

We have identified a range of areas for future policy development, judged on the scale of their potential impact on health inequalities, and the weight of evidence. These areas include: poverty, education, housing, transport and access to health and other services. Areas are also identified by the stages of the life course - mothers, children and families; young people and adults of working age; and older people - and by focusing on ethnic and gender inequalities. In our view, these areas offer opportunities over time to improve the health of the less well off. They are not totally inclusive of all possible actions, but reflect what we were told.

Navigating the Report

Section 1: Background to the Review

Section 2: The evidence and rationale for recommendations 1-11, which focus on utilizing the Common Principles (Box A) to address inequalities.

These principles should inform policy, resource allocations and practice across the county if health inequalities are not to become further entrenched or grow:

Box 1: Common Principles to address health inequalities

1. The profound influence and impact of poverty on health needs to be widely recognized and systematically addressed.

2.Commitment to prevention needs to be reflected in policies, resources and prioritization

3.Resource reallocation will be needed to reduce inequalities

4.Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organizations using the Health in All Policies approach

5.Data collection and utilization needs to be improved for effective monitoring of health inequalities

Section 3: the evidence and rationale for recommendations 12-40, which focus on common themes across the lifecourse, drawing together many of the threads common to the other sessions. (figure 1). These recommendations take into account not only geographic communities but also communities of common interest, particularly vulnerable groups most likely to suffer from health inequalities.

Section 4: the evidence and rationale for recommendations 41-58, which focus on stages of the life course

- ***Beginning well*** :pre-pregnancy, the antenatal and perinatal period, and childhood,
- ***Living well*** :the middle years
- ***Ageing well*** :the latter years of life.

We hope our report will provide a sound basis for policy development and resource allocations across the Oxfordshire health and social care economy.

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Section 1 : The Health Inequalities Commission

1.1 Introduction

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. But as Sir Michael Marmot has highlighted, health inequalities are not just reflected in poor health for poorer people but affect us all – "it is not about them, the poor, and us the non poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone.'[i] Addressing health inequalities is a priority for the World Health Organisation [ii] and remains central to the UK government's health strategy, the Five Year Forward View [iii], which provides guidance to the NHS.

The open letter from the Secretary of State for Health in February 2016 made it clear that all communities are expected to have plans in place to narrow the gap and reduce overall inequalities in their health. [iv] Local authorities, strengthened by the recent move of public health departments, have inequalities duties – introduced for the first time by the Health and Social Care Act 2012. (see Box 1)

Box 2: Letter from Secretary of State, February 2016

To re emphasize the relevance of the need to address the inequality gap, in February 2016, the Secretary of State for Health tasked the NHS to demonstrate:

1. **An evidence-based strategic approach** to reducing health inequalities based on sound governance, accountability and good partnership working, ensuring that reducing inequalities were integral to strategic and business plans.
2. **Systematic focused action** to reduce inequalities in access, outcomes and experience based on a defined and evolving set of metrics.
3. **Evidence of utilization and development of effective interventions** to reduce health inequalities, doing what is known to be effective, capturing innovation, sharing knowledge about what works and when action will impact.
4. **Improvement in prevention, access, and effective use of services** for Inclusion Health groups and families on the Troubled Families programme.

Source: Letter from Jeremy Hunt (Secretary of State), February 2016, accessed https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/506771/SofS_letter_health_inequalities_acc.pdf

Thus, inequalities have been repeatedly identified as an essential focal point in all work streams, and should therefore be explicitly considered in all policies.

1.2 Background to Convening the Commission: Health Inequalities in Oxfordshire

Overall, Oxfordshire is an affluent county with relatively low levels of deprivation[1]. However, there is considerable variation across the county. Two small areas in Oxfordshire are among the 10% most deprived in England[2] and a further 13 areas fall within the 10-20% most deprived in England[3]. People can experience inequalities due to a combination of factors, including their life circumstances and where they live. People experiencing inequalities generally live significantly fewer years than those with less disadvantaged circumstances or those living in more affluent areas. They also generally tend to experience poorer health. Some differences, such as those determined by ethnicity, may require specific interventions. Others are caused by social or geographical factors (also known as 'health inequities') and can be avoided or mitigated. (For an overview of health inequalities issues in Oxfordshire see table 1 and Appendix 2 and 3).

Table 1: Overview of health inequalities in Oxfordshire

Source: Emily Phipps, Public Health Team

Theme	Key Issues	Most Affected
Beginning Well	- Six Oxfordshire wards are in the top 10% of children in England living in poverty - Families with dependent children still face homelessness despite overall prosperity in the county - There are variations in the number of low birthweight babies born within the county, with deprived areas affected the most	- Families living in Oxford City and its wards - Families living in Cherwell and its wards

[1] *110/407 lower super output areas (LSOAs) are in the least deprived 10% nationally (Council, Joint Strategic Needs Assessment, 2016).*

[2] *These are in parts of Rose Hill and Iffley ward, and Northfield Brook ward (Council, Joint Strategic Needs Assessment, 2016). The former has moved into this category since 2010.*

[3] *This is down from 17 in 2010. These are concentrated in parts of Oxford City, Banbury, and Abingdon (Council, Joint Strategic Needs Assessment, 2016).*

[4] *The Fair Society Health Lives report recommends that overall investment in ill health prevention and health promotion needs to substantially increase to 0.5 per cent of GDP over 20 years.*

Table 1: Overview of health inequalities in Oxfordshire Source: Emily Phipps, Public Health Team		
Theme	Key Issues	Most Affected
	- Rising rates of childhood obesity in some areas - Poor educational attainment amongst children with free school meal status	
Living Well	- Highest proportion of long-term unemployed adults live in urban areas - Less people living in deprived areas attending NHS Health Checks - Increasing rates of hospital admissions directly or indirectly related to alcohol - Unpaid caring responsibilities falling on women - Carers from the BAME community less likely to access support - Fuel poverty and overcrowding unequally distributed across the county, mainly affecting urban areas	- Women across Oxfordshire - The BAME community - Adults living in Oxford and Banbury
Ageing Well	- Older people in rural areas less able to access services - Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived, despite overall prosperity in the county - Loneliness most affecting older	- Older people living in rural South Oxfordshire - Older people living in rural West Oxfordshire - Older people living in Banbury Grimsbury and Castle - Older people living in Oxford - Older women in Oxfordshire

Table 1: Overview of health inequalities in Oxfordshire Source: Emily Phipps, Public Health Team		
Theme	Key Issues	Most Affected
	people living in urban areas - Women in Oxfordshire more likely to require hospital admission due to a fall than men, and more than is seen nationally and regionally	
Cross Cutting Themes	- Lack of availability of social housing - Most homeless people are found in Oxford city - A higher number of urban older people and lone parent households are without a car, limiting their access to services - Lack of health needs assessments for minority groups	- Social housing clients in South Oxfordshire and Vale of White Horse - Homeless people living in Oxford - Gypsy and traveller communities - LGBTQ communities - People living on waterways

National data estimates health inequalities cost £5.5bn nationally, with economic losses associated with health inequalities due to lost production, higher benefit payments and lost taxes estimated at £31-33bn. The economic benefits of addressing inequalities are also substantial. (See Appendix 1).

Against this background, recognizing both the human and economic costs of health inequalities, the Oxfordshire Health and Wellbeing Board requested an independent enquiry into health inequalities in Oxfordshire: the Health Inequalities Commission ('the Commission')

1.3 The legislative framework for the Enquiry

There are three separate key duties associated with work on equity and health inequalities (see Box 3)

Box 3: Key legislation for health inequalities

The Health and Social Care Act 2012 introduced the first legal duties about health inequalities. It included specific duties for health bodies including the Department of Health, Public Health England, Clinical Commissioning Groups, and NHS England which require the bodies to have due regard to reducing health inequalities between the people of England. The Act also brought in changes for local authorities on public health functions.

The Equality Act 2010 established equality duties for all public sector bodies which aim to integrate consideration of the advancement of equality into the day-to-day business of all bodies subject to the duty.

The Social Value Act 2012 requires public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental wellbeing in procurement of services or contracts

The Equality Delivery System 2 (EDS2) supports the evidence base of public sector organisations to demonstrate compliance with the Equality Act 2010 general duty and specific duties, as well as the duty to reduce health inequalities (Health & Social Care Act 2012)

See also: https://www.england.nhs.uk/about/gov/equality-hub/resources/legislation/

The Commission recognizes, and has reflected upon, the existing legislative framework for health inequalities as part of its deliberations.

1.4 The context of the Commission:

The Commission was established to make recommendations that will reduce health inequalities in Oxfordshire. Informed by the Marmot Review of 2010, it adopted an approach that would enable wide consultation to access evidence, identify risk factors, and support the development of recommendations that would:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities

- Strengthen the role and impact of ill-health prevention

1.5 Objectives

The objectives of the Commission were to:

- raise the profile of health inequalities in Oxfordshire
- inform strategic planning and operational delivery by gathering evidence from multiple organisations and individuals in the county by advising on tangible actions
- produce a report for the Oxfordshire Health and Wellbeing Board , to be shared with other relevant bodies, with recommendations for concrete, achievable activities with monitorable expected outcomes.
- ensure the recommendations for action are based on the best available evidence so as to improve the likelihood of reducing health inequalities in Oxfordshire over the next decade.

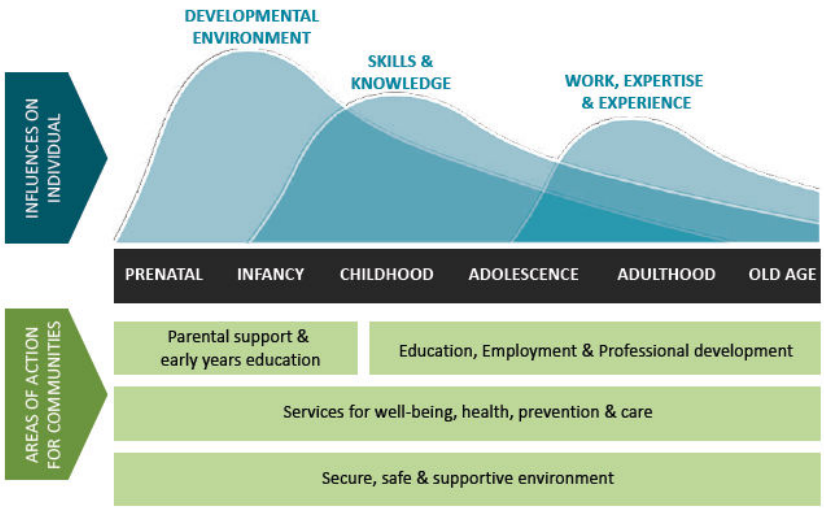
When implemented, these activities are expected to result in Oxfordshire attaining a sustainable reduction of preventable and unjust differences in health.

1.6 Scope of the Inquiry and approach

The Commission has considered what is currently being done to identify and tackle health inequalities in Oxfordshire, drawing on documentary and oral evidence provided by statutory, voluntary and charitable organisations and individuals living in Oxfordshire. (Appendix 5 and 6). This includes, but was not restricted to, the Annual Reports of the Director of Public Health, the Joint Strategic Needs Assessment, the Sustainability and Transformation Planning process and other reports already in the public domain.The evidence sessions have been held in public, to encourage and enable input from Oxfordshire residents, and to ensure transparency.

Throughout the process, the Commission took account not only of geographic communities but also of communities of common interest, particularly those most more vulnerable groups most likely to suffer from health inequalities, using a lifecourse model to inform its deliberations. A lifecourse perspective highlights both critical periods of risk and also the accumulation of risk over an individual's lifetime and directs attention to how health inequalities operate at every level of development – pre conception, childhood, working age, and into the latter years of life.[v.] (see figure 1)

Figure 1: The lifecourse model



Source: Google Images

Each consultation session started with a presentation of the available data on health inequalities at a specified stage of the life course :

- ***beginning well*** considered conception and childhood,
- ***living well*** considered the middle years and
- ***ageing well*** considered the latter years of life.

A fourth session considered ***cross cutting themes***, and it was this session that drew together many of the threads from the other sessions.

Section 2: The Common Principles

The difference in life expectancy between rich and poor is well known. Perhaps less well known but equally important… is the inequality in the years lived in good health.

Source: House of Commons Health Committee Report on Public Health, September 2016

Within any geographical area, differences in health can be observed across the population. There are many reasons for this: e.g.genetics, biological factors and age. Health inequalities refers to the situation where these differences in health status are consistent and systematic between different groups, and are produced or reinforced by social factors and therefore unfair.

The Commission's overarching assessment of health inequalities in Oxfordshire identified five common principles which need to inform all policy areas and underpin the recommendations of this report. By acting consistently on these principles, the Commission believes we can redress the ***inverse care law*** :[vi].

The **inverse care law** was suggested thirty years ago by Julian Tudor Hart in a paper for The Lancet,[vi] to describe a perverse relationship between the need for health **care** and its actual utilisation. In other words, those who most need medical **care** are least likely to receive it.

2.1 Principle 1: The profound influence and impact of poverty on health needs to be widely recognized and systematically addressed.

Mitigating the perverse relationship between poverty and health is essential if we are to address the entrenched inequalities already present within Oxfordshire, and prevent further generations of Oxfordshire residents becoming adversely effected by circumstances beyond their immediate control – the wider determinants of health.

Whilst Oxfordshire is overall a very 'healthy and wealthy' county, there are significant differences in outcomes across health, education and social care for some specific groups. For example:

- Children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in income deprived families
- Between 2014 and 2015, 11.4% of working age adults in Oxfordshire were economically inactive due to long term sick leave. The highest proportion of long term unemployed adults in Oxfordshire live in urban areas
- Fewer people living in deprived areas attend NHS health checks
- Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived in the country, despite the overall prosperity in the county.

Recognising that evidence has shown that poverty and disadvantage lead to poorer health, policy makers at national and local level need to take into consideration how to narrow the gaps and adjust resource allocation across health and social care, and in other areas relevant to the determinants of health, on the principle of budgeting to meet need. The statutory funding bodies will need to work together actively to mitigate the relationship between poverty and health.

While strong local political leadership can bring enormous benefits for public health, there is also the potential for tension between political priorities and evidence-based decision-making. Clearer standards should be introduced and monitored transparently to improve accountability and to make sure that services to underrepresented or politically unpopular groups are maintained at an appropriate level.

Source: House of Commons Health Committee, Public Health Report, September 2016

Oxfordshire, through the commissioning of this report, is explicitly accepting the need to address poverty and health inequalities through more investment in prevention, innovation and service design. Many other parts of the country are also focusing on identifying opportunities to prevent problems by improving local conditions and social relationships, for example the Southwark and Lambeth Early Action Commission (Box 4). Much of the learning from these other areas is also relevant to Oxfordshire.

Box 4: The Southwark and Lambeth Early Action Commission

Source: http://communitysouthwark.org/news-jobs/southwark-early-action-commission

The Southwark and Lambeth Early Action Commission aims to reduce demand for acute services and maintain wellbeing for all residents. Recognising that the underlying causes of most social problems can be traced to the same set of social and economic challenges they have looked for opportunities for local early action to prevent problems by improving local conditions and social relationships. The Commission has identified four goals for early action in Southwark and Lambeth. These are designed to address problems as early on as possible and focus on what can be done locally in the context of extreme budgetary constraints.

- ***Resourceful communities***, where residents and groups are agents of change, ready to shape the course of their own lives. To achieve this people need actual resources (but in the broadest sense), connections, and control.
- ***Preventative places***, where the quality of neighbourhoods has a positive impact on how people feel and enables them to lead fulfilling lives and to help themselves and each other.
- ***Strong, collaborative partnerships***, where organisations work together and share knowledge and power, fostering respectful, high-trust relationships based on a shared purpose.
- ***Systems geared to early action***, where the culture, values, priorities, and practices of local institutions support early action as the new 'normal' way of working.
- To help achieve these goals it will be important to find additional resources.

Recommendations		***Responsibility***
1.	Statutory funding bodies need to do more to demonstrate their commitment to reducing inequalities. Their policies and plans should be scrutinized by HWB on an annual basis .	**HWB**
2.	Monitoring of the process of commissioning/service design to ensure it has taken inequalities into account in the design of new models of care and innovations such as vanguards needs to be undertaken regularly.	**CCG/service providers**
3.	Local indicators on progress towards reducing inequalities should be developed, with regular reporting on progress to the Health and Wellbeing Board. This should be in place by the end of 2017	**PH department in OCC**

2.2. Principle 2: Commitment to prevention needs to be reflected in policies, resources and prioritization

Recognising budget constraints across the health and social care system, ensuring best value from investment is critical to the health and wellbeing of our population and to the future sustainability of our health and social systems. Numerous studies have shown that investment in primary and preventive care greatly reduces future health care costs, as well as increasing health[vii viii]. Yet investment in prevention is insufficient; with data suggesting that in England, only 4-5% of health spend is focused on prevention activities.[ix] A 2013 report by Monitor suggested that '*A 21st century NHS will need to deliver care that meets the health needs of today and focuses more on preventing illness and supporting individuals in maintaining active and healthy lifestyles."*[x] Effective prevention strategies benefit the individual, society as a whole, and the health and social care system. (Box 5)

Box 5: Getting Serious About Prevention: The Five Year Forward View

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. The warning has not been heeded….(p9)

If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness… (p7)

While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence based intervention strategies. We also need to make different investment decisions…. (p11)

Source: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

It is well recognized that spend on prevention should increase. [ix] Marmot recommends at least 7% of health spend being focused on prevention[4] [i]. Investment in prevention by all agencies is essential if progress in improving the health and wellbeing is to continue and to ensure that existing health inequalities do not grow and become further entrenched.

Box 6: Health of Oxfordshire residents: examples of potential intervention points for prevention

- Cherwell, Vale of White Horse and West Oxfordshire have significantly higher percentages of patients recorded as living with diabetes. However, around a quarter of people with type two diabetes are unaware of it, and undiagnosed.
- In Oxfordshire, fewer people living in deprived areas attend health checks
- There are increasing rates of hospital admissions directly or indirectly related to alcohol
- Women in Oxfordshire are more likely to require hospital admission due to a fall than men. The rate of admissions is higher than is seen nationally and regionally.

The evidence presented to the Commission suggests that prevention remains a poor relation in Oxfordshire. More upstream investment in prevention across the health and social care system is

[4] *The Fair Society Health Lives report recommends that overall investment in ill health prevention and health promotion needs to substantially increase to 0.5 per cent of GDP over 20 years.*

needed, if progress in improving the health and wellbeing of Oxfordshire residents is to continue, and to ensure that health inequalities which are already persistent within Oxfordshire (see Box 6 and Appendix 2 and 3) are not exacerbated.

This is not just about investment in essential public health services, but more broadly about ensuring that the prevention agenda is seen as a priority across the whole of the Oxfordshire economy and across all NHS organisations in particular as laid out in the 5 Year Forward View. (Box 5). Part of this will be through enhancing the ability to help people help themselves through consistent good quality advice. It is therefore imperative that every contact matters! Whilst many contributing factors to diseases are beyond the influence of the individual or of health services adopting healthier lifestyles and efficient systems for early detection and screening will promote longer healthier lives.

The Commission calls for a renewed focus on prevention, not just in the NHS, but across the whole of the Oxfordshire economy.

Recommendations		***Responsibility***
4.	Greater investment is needed in prevention, innovation and service design both across the health and social care system and more widely to mitigate the impact of poverty and health inequalities.	***CCG***
	• All NHS partners should state clearly their investment in prevention.	***NHS***
	• The current level of spending on public health services through the ring fenced budget should be maintained	***HWB/Councils***
	• The HWB should track increased spending on prevention, [xii] and annually report to the public on progress made and outcomes achieved	***HWB***
5.	The needs of disadvantaged groups should be monitored to ensure preventive programmes do not increase the inequalities gap, and that programmes delivered to all raise the health of all, including those who are most disadvantaged[xi].	***HWB/STP partners***
6.	Core preventative services such as Health Visiting, Family Nurse Partnership, School Health Nurses and the Public Health agenda should be maintained and developed	***CCG***

2.3 Principle 3: Resource reallocation will be needed to reduce inequalities

An economic perspective is about more than counting the costs associated with poor health. It is about understanding how economic incentives can influence healthy lifestyle choices in the population.

Source: http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/promoting-health,-preventing-disease-the-economic-case

"Cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities. "

Source: House of Commons Health Committee, Public Health post 2013, Second Report of Session 2016-7[xii]

Ensuring best value from investment is critical to the current and future health and wellbeing of Oxfordshire residents, and the future sustainability of the health and social care system. We heard evidence that budgets need to be allocated to redirect resources for the highest health and wellbeing dividend for the people of Oxfordshire. For example, The Thriving Families Scheme provides intensive support for families with complex social needs. Oxfordshire is an early implementer of the programme, and has demonstrated a cost saving of £3.22 to public services for each pound invested in the project [xiii]

However, the policy of using the resource allocation mechanism to reduce health inequalities is based on the assumption that additional expenditure translates into improved population health outcomes. This clearly depends on the quality and effectiveness of care delivered and whether it explicitly tackles current and future health needs.[xiv] The evidence submitted to this Commission demonstrates that there are unresourced unmet needs in Oxfordshire in addition to areas where reshaping resource allocations could deliver significant benefit in terms of reducing health inequalities (see Appendix 1, 2, 3 and 5). Too often, as Monitor highlighted, the pattern of health and social care expenditure nationally reflects history, rather than an objective assessment of the burden of disease, the 'best value' interventions, and the impact that the interventions can have on reducing health inequalities for our population. Mapping the burden of disease, and using this data to inform commissioning decisions, ensures that resources are focused to effectively respond to current and future population need. (Box 7)

Box 7: Mapping the distribution of need in Oxfordshire (examples)

- Whilst there are over 7700 people living with dementia in Oxfordshire, the five GP practices with the highest rates of patients living with the condition are Berinsfield Health Centre, Goring and Woodcote Medical Practice, The Wychwood Surgery, Islip Surgery, and Nuffield Health Centre
- GPs in Vale of White Horse, South Oxfordshire and West Oxfordshire look after a significantly higher proportion of patients with COPD, heart failure and history of stroke or transient ischemic attack (TIA) than GPs in Oxfordshire as a whole
- The current proposal for Syrian Refugee resettlement is that thirty families will be settled in Oxfordshire in the first year (10 in Oxford City, 6 in West Oxfordshire, 6 in Cherwell, 2 in South Oxfordshire, 6 in the Vale of White Horse). These patients can present with complex issues – medical problems that have gone untreated in countries of origin. They may also be suffering the physical and psychological effects of war, trauma, exile, and separation from families.
- The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed are treated in primary care. The most common method of treatment for common mental health disorders in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients. Having a mental health worker attached to or working alongside GP practices improves the knowledge, confidence and capacity of the other primary care professionals in the practice.

Ensuring health spend is adjusted to reflect the burden of disease, areas of deprivation, reverse the inverse care law, and focus resources for better access in higher need areas should be a priority. An audit of NHS spend is required, with the aim of ensuring that resources are allocated to reflect need, not history, and to promote a more holistic population health approach.

Recommendations	***Responsibility***
7. Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities.	
• The CCG should actively consider targeting investment at GP surgeries and primary care to provide better support to deprived groups, to support better access in higher need areas, and specifically address the needs of vulnerable populations.	***CCG***
• The CCG should conduct an audit of NHS spend, mapping health spend generally and prevention activity particularly against higher need areas and groups, setting incremental increasing targets and monitoring progress against agreed outcomes.	
• The ring fenced funding pot for targeted prevention should be expanded in higher need communities, using a systemwide panel of stakeholders to assess evidence and effectiveness, with ongoing independent evaluation of impact, including quantification of impact on other health spend. [5]	
• An Innovation fund/Community development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations.	

2.4. Principle 4: Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organizations using the Health in All Policies approach

Health in all Policies (HiaP), which is supported by central government and WHO, highlights the important links between health and broader economic and social goals in modern societies. It positions improvements in population health and reductions in health inequities as high priority, complex problems that demand an integrated policy response across sectors.

"**Health in All Policies** is an approach to public **policies** across sectors that systematically takes into account the **health** implications of decisions, seeks synergies, and avoids harmful **health** impacts, in order to improve population **health** and **health** equity.

http://www.healthpromotion2013.org/health-promotion/health-in-all-policies

The Commission believes that addressing health inequalities in all policies should be given higher priority in Oxfordshire. In doing so, it believes that explicit consideration should be given to

[5] *This needs to engage people from the community and voluntary sectors, as well as people* working in the statutory sector

ensuring that policies act to level up health status, by ensuring that policy decisions and resource allocations explicitly and effectively:

- ❖ target disadvantaged groups
- ❖ focus on narrowing the health divide, and
- ❖ act to equalize health opportunities across the social spectrum.

Stated policy intentions are not enough. Whilst there was evidence of good partnership work[6] in pockets in Oxfordshire, the Commission was also presented with many examples of where this could be made stronger by adopting a more explicit HIAP approach. In particular:

- ***Better coordination of housing and estate*** generally between local councils and healthcare providers, including consideration of affordability, transport and other infrastructural issues, is needed. The healthy new towns process offers a significant learning opportunity for this. Academic institutes need to be actively involved in the evaluation of the impact of the new towns, ensuring that the learning for new developments and existing developments is captured.
- ***Increased support and coordination for community groups and voluntary groups***. More sustained support for community groups is needed, along with recognition that volunteering has costs and those involved need support to maintain their resilience.
- ***Enabling change, not just signposting-*** the health and social care system, which includes the voluntary sector, needs to know what resources are available and be able to coordinate/signpost services, with sustainable funding. In particular, tasks which require a skilled or qualified professional should not be passed onto a volunteer without adequate training and support (see Box 8).
- Exploring ways of getting **acute expertise delivered into more community settings** so that relevant communities and groups can be targeted (into working better together) .One way to strengthen links would be to review membership of the HWB and increase representation from NHS Trusts as well as voluntary groups such as Age UK

Box 8 :Health Champions: Providing support to particularly disadvantaged groups e.g. migrants, particular geographical communities.
Recruiting paid or voluntary Health Champions in a range of settings – GP practices, leisure or community settings, allied health professionals, pharmacy counter staff or other workers like

[6] *For example, the Oxfordshire Street Triage Scheme has led to improved experiences and outcomes for people in Oxfordshire experiencing mental health crisis, and has reduced the rising numbers of section 136 detentions seen in previous years (Police)*

Fire and Rescue workers can provide support to people who would otherwise find it difficult to access services. Such programmes can offer personal support to motivated individuals on behaviour change. The Healthy Living Centre model shows the effectiveness of this.

More information at **www.altogetherbetter.org.uk**

Source: Jackie Wilderspin, Public Health Department

Initiatives, such as the Banbury Bright Futures programme (Box 8), which is in its sixth year provide robust evidence of the progress which can be made by systematic efforts to tackle evidenced disadvantage and health inequality.

Recommendations		***Responsibility***
8.	The Health in All Policies approach should be formally adopted and reported on across NHS and Local Authority organizations, engaging with voluntary and business sectors, to ensure the whole community is engaged in promoting health and tackling inequalities.	***All statutory organisations***
	Regular review of progress should be undertaken by HWB	***HWB***
9.	The presence of the NHS and of the voluntary sector should be strengthened on the Health and Well Being Board	***HWB***

Box 9: The Banbury Brighter Futures programme: Partnership in practice

Source: evidence provided to Commission by Ian Davies

The Programme has Six Themes to Deliver its Objectives

Programme Objectives	Theme	Key Priorities
➔ improve educational attainment through better numeracy skills and family engagement ➔ improve skill levels and educational attainment	Theme 1 Early Years, Community Learning and Young Peoples Attainment	Ensuring children get off to the best start in life, that young people, families and communities are supported in their aspirations and educational attainment
➔ improve skill levels and educational attainment ➔ improve employability, focusing particularly on young people	Theme 2 Employment Support and Skills	Working with local residents and businesses to support skills development, access to training and employment support.
➔ Target specific support to vulnerable people, families and children in need ➔ improve employability, focusing particularly on young people	Theme 3 Family support and young people not in employment, education or training	Supporting children, young people and families with complex needs.
➔ improve financial situations, addressing debt and financial inclusion ➔ good quality mixed housing, affordable and in well managed environments ➔ good access to amenities including shops, health centres and leisure facilities	Theme 4 Financial Inclusion and Housing	Ensuring there are accessible advisory and support services for those facing challenging financial situations and delivering high quality affordable housing options and opportunities
➔ improve life expectancy with improved overall health and well being ➔ reduce the clear inequality gaps with low life expectancy ➔ reduce high rates of teenage pregnancy	Theme 5 Health and Wellbeing	Improving life expectancy and reducing health inequalities through improved health and well-being
➔ build a safer more connected community where residents feel socially included	Theme 6 Safer and Stronger Communities	Reducing crime and anti-social behaviour and ensuring local residents feel safe

2.5. Principle 5: Data collection and utilization needs to be improved for effective monitoring of health inequalities

''The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, we are concerned that robust systems to address unacceptable variation are not yet in place. The current system of sector-led improvement needs to be more clearly linked to comparable, comprehensible and transparent information on local priorities and performance on public health.''
Source: House of Commons Health Committee Report

Data collection on health inequalities in the county is patchy and not adequately utilized in policy and resource allocation decisions. During the process of consultation we found it difficult to get good data on Black and Ethnic Minority Communities in the county as well as on other disadvantaged groups[7]:

- National data indicates that gypsy and traveller communities have poorer outcomes in terms of physical health, mental health, education, access to services and mortality. ([xv]) There is very little data available locally on the health of this community.
- Data on age and pregnancy status is more complete and accurate than data on race or religion
- No information was found on people living on waterways

We also failed to fully engage BME communities at the public meetings.

PHE offers access to a rich repository of data. There is a need to ensure that knowledge, understanding and access to this data is broadened, to ensure that policy and resource decisions reflect current and future population trends, rather than historical legacies of action.

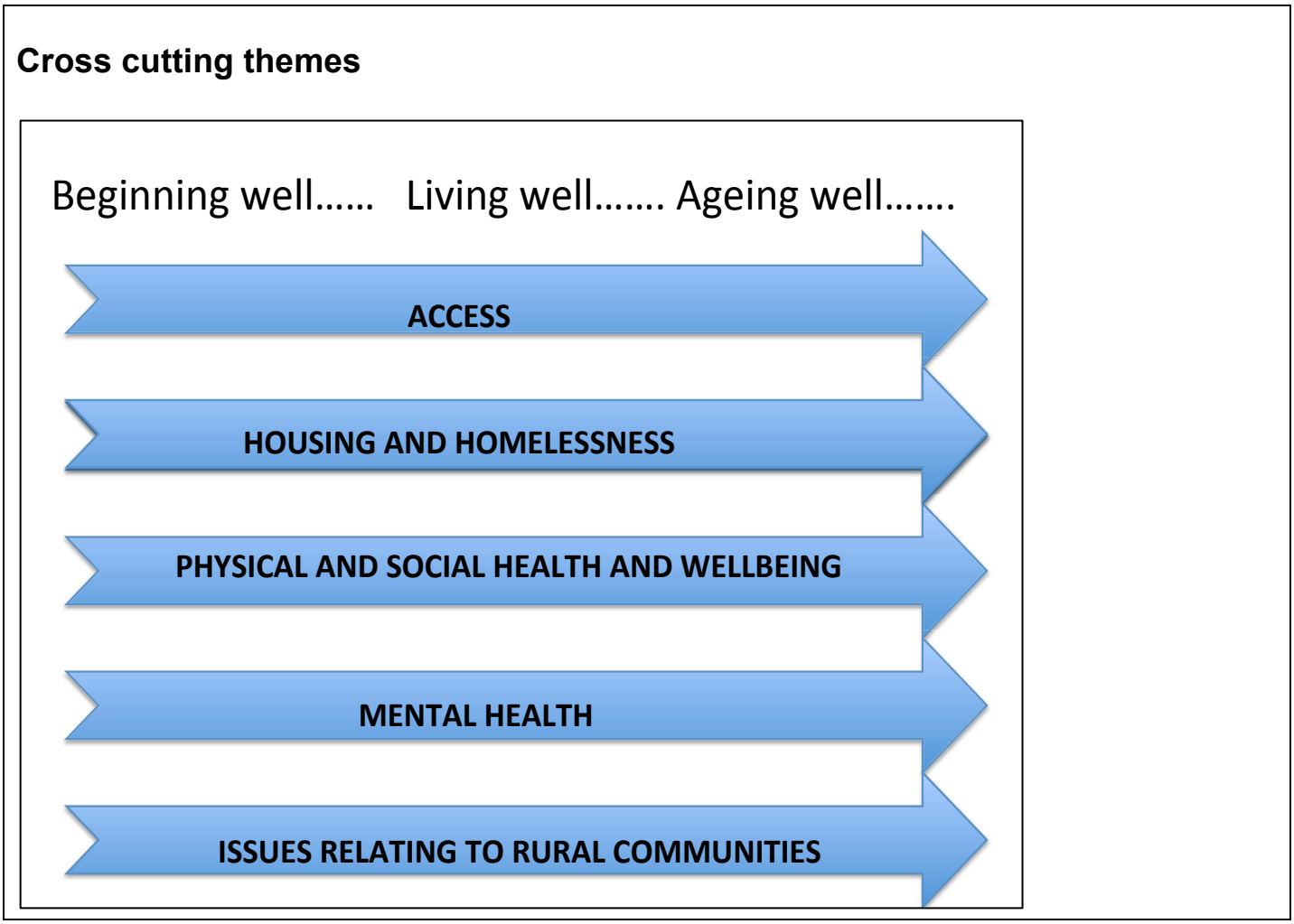
[7] *This is a concern, given that this is one of the protected characteristics covered by the Equality Act. The Commission believe there is a need for focused effort encouraging all public sector organisations (and all organisations & parties who do work on behalf of those organisations) to be fully Equality Act compliant, as this would support good quality data collection that can then be used to inform decision making in a number of areas, including health inequalities.*

Recommendations		***Responsibility***
10	The data on health inequalities available through PHE/NHS and other routine sources should be regularly reported to all statutory organisations and made available to the public.	**PH Dept**
11	Gaps in data collection on the health of BME communities, those with learning difficulties and other vulnerable groups at greater risk of poor health should be addressed and data used to inform resource allocation decisions. This includes encouraging all public sector organisations and organisations who do work on behalf of these organisations to be fully Equality Act compliant.	**HWB**

Section 3 : Cross- cutting themes from the Evidence Sessions

When considering evidence presented to the Commission, it became apparent that there were a number of common issues which cut across the lifecourse, affecting people's ability to access the services they needed, engage in physical activity and sustain social networks. These factors need to be holistically addressed in efforts to reduce health inequalities. (figure 2)

FIGURE 2 :



3.1 Access

a. Better Access to financial advice:

Encouraging maximisation of benefit is important to all groups in society. Universal benefits, for example Attendance Allowance and rate relief through the Lone Pensioners Allowance, are available to all who qualify, regardless of income or capital. Many people who would benefit from them are not aware of this, and if they do not identify themselves as poor even though on an objective measure they may be so, they do not claim.[xvi] More proactive work to encourage

benefit uptake especially in populations who may not be aware of their rights and entitlements should be undertaken. A number of small-scale initiatives already exist, e.g. Oxfordshire Welfare Rights, Benefits in Practice, and the excellent work done by the CAB. (Appendix 3, 5 and box 10) However, piecemeal funding arrangements hinder progress.

Box 10 : Benefits in practice

In addition to their mainstream services, the Citizens Advice Bureaux across the county each run programmes to offer benefits or debt advice locally. Each Bureau has to bid for funding for many of these programmes to run. One example is the Benefits in Practice scheme – a small scale programme which places the CAB advisers into a few GP practices in the City, Banbury and Carterton. The GP practices are selected based on local need and the service is always fully subscribed. Clients can be referred by their GP to get free advice and make their appointments through the Practice Reception. The scheme regularly delivers increases in benefits for clients who are helped to apply for money they are entitled to. Another recent programme in Oxford City has seen the local CAB offering advice on benefits as part of the Better Housing Better Health project, aimed at reducing fuel poverty. This was funded by a grant from the British Gas Energy Trust which was obtained by the Affordable Warmth Network. An early report showed that the CAB worker had been in contact with 73 clients through this scheme and generated £18k worth of benefits for them.

Greater attention needs to be given to the wider arrangements for referring people to benefits advice programmes, as part of a sustained programme of activity which aims to improve financial situations, address debt, and promote financial inclusion across all ages and stages of the lifecourse.

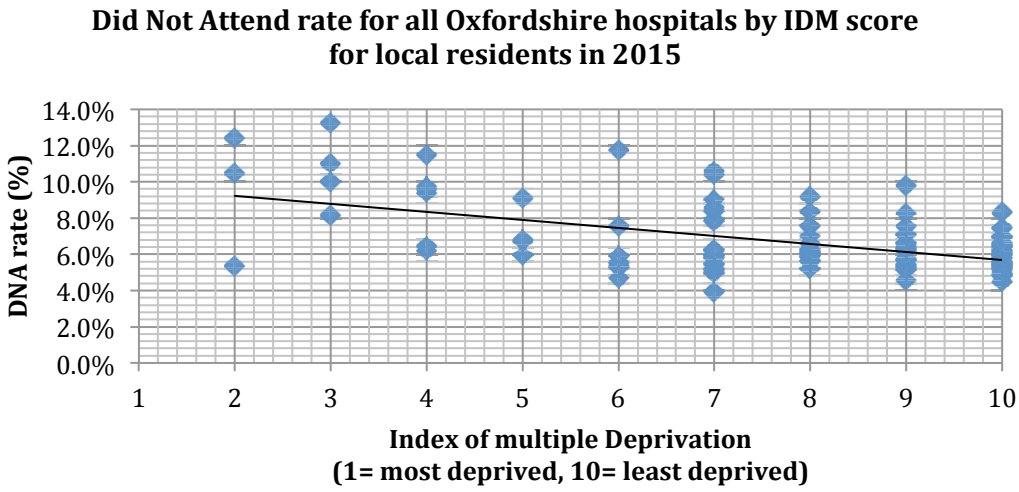
Recommendations		***Responsibility***
12.	Benefits Advice should be available in all health settings, including GPs networked into local areas to support CABs	***CCG/NHS Partners***
13	A sub group working on income maximization should be established, and asked to report back to the HWB/CCG within a year	***HWB***
14.	District Councils should be approached to seek matched funding, dependent on existing contribution	***HWB***

b. Better access to services

The pathway redesign work that is being progressed as part of the Oxfordshire transformation programme should be used to develop inclusive and responsive pathways for those groups that have greatest need and/or that traditionally find accessing services difficult. For example, discharge arrangements from NHS care need to be appropriately tailored for people who are homeless.

Analysis of all hospital appointments in 2015 for residents in Oxfordshire by IMD scores suggested that more affluent areas have lower DNA rates compared to more deprived areas of Oxfordshire[8]. (see figure 3 and appendix 3)[9]

Figure 3:



Source: Bethan MacDonald, Public Health Specialty Registrar, OUHT

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[8] *However, some caution is warranted in the interpretation of these results: In Oxfordshire there are more postcode areas designated as higher IMD scores (least deprived) compared to low IDM score areas; this is reflected in the number of data points for each IDM score shown in the chart below. This is a potential source of bias as fewer data points (as seen for lower IMD scores) gives a less precise estimate of average DNA rates, as indicated by the line of best fit. – see appendix 3*

[9] *For access to acute care, the analysis of Did Not Attend rates correlated to electoral wards that have different characteristics e.g. different socio-economic deprivation scores produced ambiguous results.(see Appendix 9) Other potential measures which could be considered include looking at outcomes and outputs by different population characteristics e.g. % of women from minority ethnic communities who accept invitations to undergo breast screening. It is therefore suggested that there is a need for an exercise to go through relevant indicators in the wider NHS performance framework to determine which can be broken down in this way to yield useful if limited insights into inequalities and provide a metric that can be measured to assess progress in addressing them . In addition, 'softer' measures, such as patient satisfaction should be considered.*

Where patients who are from groups with the greatest need have to attend hospital, all service providers need to ensure that services are as responsive as possible. This could range from ensuring that discharge arrangements from NHS care are appropriately tailored for people who are homeless, through to delivering services that are sensitive to the cultural norms and beliefs of patients from minority ethnic communities.

Recommendation		***Responsibility***
15	Indicators in the wider NHS performance framework should be utilized as part of routine monitoring for NHS organisations to yield useful, if limited, insights into inequalities and provide a metric that can be measured to assess progress in addressing inequalities.	***NHS organisations***

3.2 Housing and health[xvii]

a. Better access to secure, affordable, decent accommodation for Oxfordshire residents

An increasing body of evidence shows a correlation between poor housing and ill health. A Parliamentary Office of Science and Technology report estimated that poor housing conditions cost the NHS at least 600 million per year[xviii.] The quality of the home has a substantial impact on health; a warm, dry and secure home is associated with better health. In addition to basic housing requirements, other factors that help to improve well-being include the neighbourhood, security of tenure and modifications for those with disabilities.[xix.]

Whilst social housing has generally improved, private rental stock remains a cause for concern both nationally and in Oxfordshire. In terms of the indoor living environment, the JSNA reported that 12 of Oxfordshire's small areas are among the 10% most deprived nationally. These are located towards the northern, north-western, western, and south-eastern edges of the county, as well as in parts of Oxford City. A further 28 small areas are in the 10-20% most deprived nationally and are similarly spread around different parts of the county[xx. Fuel poverty, mould and damp in existing stock and overcrowding all have adverse implications for health and wellbeing. The latest data from 2013 estimates that some 21800 people in Oxfordshire live in fuel poverty, accounting for 8.2% of the total population. (Appendix 3 and JSNA pages 48- 60).

Although shelter is a basic human need, it is clear that Oxfordshire's health inequalities are caused and sustained to a significant degree by the high cost of housing relative to many people's

incomes, and the lack of availability of affordable housing. (see table 1) This also causes major recruitment challenges in the health and social care processes, which in turn has broader implications for supporting people to live longer, healthier lives.

Access to secure, affordable decent accommodation should be a basic human right. However, in Oxfordshire, as Table 1 demonstrates, for many people this is at present an aspiration, rather than a reality. The Commission would like to see this change in Oxfordshire – and calls on all public bodies and Councils to increase the number, affordability and quality of homes, pledging to promote this basic human right. This includes:

- Districts working together to plan for meeting housing need across the County as identified in Oxfordshire's Strategic Housing Market Assessment
- Public agencies, university and health partners working together to developing new models of funding and delivery of affordable homes of a range of tenures to meet the needs of vulnerable people and key workers.
- Public agencies working together to maximise potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing.

Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture

WHO Goal	Oxfordshire
Dwellings should provide adequate shelter from natural elements and hazardous substances, be of sound construction and in a reasonable state of report, weatherproof and adequately ventilated.	According to the latest Excess Winter Deaths Index data, South Oxfordshire was one of 4 areas (out of 67) in the South East that had a significantly higher ratio of extra deaths to expected deaths than anticipated (Council, District Data Service Chart of the Month, 2015). Excess winter deaths could be a reflection of fuel poverty or of increasing rates of illness during the winter months, and although is more likely to affect older people, does include data for all ages[10].
Housing ensures personal and household privacy, safety and	There is a wealth of evidence demonstrating the negative effects deprivation has on health and wellbeing. A common measure of deprivation is the Index of Multiple Deprivation, based on over 30

[10] Because of this, the Excess Winter Deaths Index can only be used to track trends and should not be used to attribute causation.

Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture	
WHO Goal	Oxfordshire
security: it should allow individuals to live without fear of intrusion, provide safety and allow safe entry and exit	separate indicators across 7 domains (income; employment; health and disability; education, skills and training; crime; barriers to housing and services; and living environment). Two LSOAs are among the 10% most deprived in England. These are in parts of Rose Hill and Iffley ward, and Northfield Brook ward (Council, Joint Strategic Needs Assessment, 2016). The former has moved in to this category since 2010. A further 13 LSOAs are among the 10-20% most deprived (down from 17 in 2010). These are concentrated in parts of Oxford City, Banbury, and Abingdon (Council, Joint Strategic Needs Assessment, 2016). Whilst this provides information on deprivation, with housing as one of the factors, it is insufficiently targeted to demonstrate whether housing in Oxfordshire achieves the WHO goal.
Dwellings should provide space appropriate to household size and composition: this includes space for individual and common purposes within accepted crowding ratios, allowing separation between uses	Across the county, the proportion of people living in households with more than one person per bedroom was higher in Oxford (38.5%) and Cherwell (35.1%) than in the other districts: 31.9% in South Oxfordshire, 30.5% in West Oxfordshire and 29.3% in Vale of White Horse (Council, Joint Strategic Needs Assessment, 2015). The scarcity of homes means that one in five of Oxford's residents live in a multi-occupation dwelling. High demand and high rental values in Oxford have meant that private landlords can charge high rents and some properties have been poorly managed and badly maintained. Oxford City Council is tackling this through its HMO Licensing Scheme which, since 2011, has seen around 3,000 homes improved by private landlords
Reasonable levels of basic services are available at the dwelling, including clean water, sanitation, waste disposal, access infrastructure and power	The latest data from 2013 estimates that 21800 people in Oxfordshire live in fuel poverty, accounting for 8.2% of the total population (Council, Joint Strategic Needs Assessment, 2016) Oxford had proportionately more people living in fuel poverty (12.4% or around one in eight people) (Council, Joint Strategic Needs Assessment, 2015). For the other districts, fuel poverty affected around 7% of people (approximately one in fourteen) (Council, Joint Strategic Needs Assessment, 2015).

Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture	
WHO Goal	Oxfordshire
Housing costs are reasonable and affordable, within accepted affordability limits to secure housing for all	Social housing rent in Oxfordshire is rising, and remains higher than in most of the other local authorities in England (Council, Joint Strategic Needs Assessment, 2016). Housing in Oxfordshire is generally expensive. In all districts of the county, median house sale prices are rising and remain higher than most other local authorities (Council, Joint Strategic Needs Assessment, 2016). The ratio of house prices to salaries is high and rising, and Oxfordshire is now one of the most unaffordable places in England to live (Council, Joint Strategic Needs Assessment, 2016). According to the Centre for Cities, Oxford is now the least affordable city for housing with average house prices now 16.2 times average annual salaries[xxii]
The location of dwellings allows access to social services, services and space for activities of daily life and economic opportunities, e.g. education, purchasing or growing food, recreation and employment	Car ownership, particularly in rural areas, is an important factor influencing access to services. More people living in rural areas own cars compared to those living in urban areas in Oxfordshire (see tables 2 and 3) (Statistics O. f., 2011). Over half of urban households consisting of a lone older person in Oxfordshire and over a third of urban lone parent households do not have a car (see figure 1) (Statistics O. f., 2011). Access to and use of outdoor green spaces has been demonstrated to have positive impacts on physical health, mental wellbeing and cognitive functioning (Council, Joint Strategic Needs Assessment, 2016). The latest data from March 2013 to February 2014 estimated that the proportion of people in Oxfordshire using outdoor space had fallen from 19.4% (in 2012/13) to 15.7% (Council, Joint Strategic Needs Assessment, 2016)
Tenure arrangements ensure reasonable continuity of occupation, providing stability for individuals, households, communities and neighbourhoods	In 2015, the greatest number of families with dependent children requiring support for unintentional homelessness were in Cherwell (47) and Oxford (60) (Government, 2015). Women in contact with secondary mental health services in Oxfordshire are slightly less likely than men to live in stable accommodation (Council, Public Health Surveillance Dashboard, 2015). Women in Oxfordshire in contact with secondary mental health

Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture	
WHO Goal	Oxfordshire
	services are also less likely to live in stable accommodation as compared to the national figures, although the significance of this has not been tested (Council, Public Health Surveillance Dashboard, 2015). Female adults with learning disabilities in Oxfordshire are slightly less likely to be in stable accommodation compared to men with learning disabilities, although the difference may not be significant (Council, Public Health Surveillance Dashboard, 2015).
Dwellings protect occupants from climate change, and extreme weather events, contributing to the reduction of greenhouse gas emissions	Data recently presented to the Oxfordshire County Council Health Improvement Board indicated that there were 90 rough sleepers in 2015-2016. The majority of these (56) were in Oxford with 21 in Cherwell, 5 in Vale of White Horse and South Oxfordshire and 3 in West Oxfordshire (Lygo, 2016). Living environment deprivation is measured by the Index of Multiple Deprivation and includes indicators such as lack of central heating, poor quality housing, air quality and road traffic accidents (Statistics O. o., 2015). The majority of lower super output areas that are in the top 10-20% most deprived in terms of environment are in Oxford City

b. Affordability of Housing

Housing in Oxfordshire is generally expensive. This is as a result of high demand for housing; and a shortage of affordable housing. The Oxfordshire Strategic Housing Market Assessment identifies the need for 100,000 homes between 2011 – 2031. In some areas, such as Oxford City housing supply is constrained by lack of available development land and across the county there is a need to invest in infrastructure to support new housing development. Oxfordshire's councils need to ensure that their joint work through the Oxfordshire Growth Board identify locations for housing and secure funding for infrastructure to sustainably meet housing needs across the County.

The availability of social housing in Oxfordshire varies between districts. In South Oxfordshire and Vale of White Horse in particular, there is demand for over half as much again of social housing

than currently exists (Council, Joint Strategic Needs Assessment, 2016). There are over 3,300 people on Oxford City Council's Housing Register.

But affordable housing does not just mean social housing. Recent changes to government housing policy, such as expansion of Right to buy to Housing Associations, requirements to sell high value council stock and reducing social housing rents will make it harder to invest in housing for social rent. Increasingly, new models of access to the housing market are being developed, which can open up home ownership to broader markets, e.g. shared ownership/rent schemes. There is a need for Oxfordshire to explore this market, and its potential for its residents, in greater detail. The Commission therefore calls on Councils to consider how best to promote access to affordable housing as a cross county priority.

In some areas significant progress has been made (box 11) – but other areas are lagging behind

Box 11: Delivering affordable housing in Oxford City

Oxford City Council is working in partnership with housing developers to deliver affordable homes; including

- £116 million Council Housing Ambition Programme to build new council homes and improve existing stock
- Substantial long term investment in large scale regeneration projects to deliver 1,700 homes across the city by 2019.
- The council delivered 116 affordable homes in 2014/15 with plans for another 354 to be delivered over the next 5 years
- Over the past decade, private developers and Housing Associations have delivered over 1,600 affordable homes in Oxford for social rent and shared ownership.
- The City Council is directly involved in bringing forward over 80 per cent of all significant housing schemes in the city in the next five years. For example, the City Council has secured funding for new infrastructure for schemes such as Oxpens and the Northern Gateway.
- The City Council has recently created a housing company to deliver new affordable homes, with a range of housing for sale and rent, to help address the city's acute housing need
- The City Council spends about £1.4m every year tackling homelessness, including by funding or providing outreach programmes, day centres, and education, training and employment opportunities.
- The City Council is joint-funding a £10m project with an investment partner and St Mungo's Broadway to buy about 50 homes near Oxford to house homeless families from the city.

c. Use of public land for affordable and specialist housing

The Commission was told that there are significant holdings in the statutory sector which are underutilized or lying vacant. A strategic review of such assets is needed to determine whether they could be used as part of a more strategic cross sectoral approach to developing affordable and specialist housing across the County.

All public bodies – councils, government departments, health bodies alike – must redouble their efforts to promote the supply of affordable housing. There is the potential to tap into the "One Public Estate" programme to address this. Although action is being taken, for example the review of health estate/creating affordable housing in Cherwell and West, actions tend to be separate activities and we recommend a county wide initiative engaging all sectors is established.

In doing so, recognition must be given that supporting affordable housing, both for social rent and key workers, will affect capital receipts for public asset holders, but that this reflects an important, and fully justified, long-term investment.

d. Learning from the New Towns

In September 2015, NHS England and Public Health England launched an ambitious new initiative to put health at the heart of new neighbourhoods and towns across the country. They were looking for partners to:

- develop at scale new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent; and
- show what is possible when we radically rethink how health and care services could be delivered.

Oxfordshire has two areas that have been accepted as partners: Barton and Bicester. Learning from the work undertaken in these areas, about what works for shaping new towns, and how to integrate new builds into existing community infrastructure driving positive health benefits for both communities will be essential. It is understood that Oxford Brookes university is already engaged with the Bicester initiative, which will, it is hoped ensure that the learning from this process facilitates future development. (Box 12)

Box 12: Bicester New Town

Planning of the Healthy New Town programme has taken a holistic approach to improving health and wellbeing by involving a wide spectrum of partners who can impact on all the determinants of health. The partnership group includes not just traditional providers of health and care from the primary, community and acute sector but developers and master planners who can influence how the built environment can influence health, sports agencies and leisure providers that promote active lifestyles, the voluntary sector that can promote community cohesion, and representatives from local patient groups who have identified some of the gaps in health and care that exist in Bicester.

The population based approach that the partnership has adopted means that it has considered how health and wellbeing can be promoted not just in the new housing developments but across the town as a whole; with a view to avoiding an increase in inequalities between existing and new communities. One of the programmes objectives is to ensure that it increase community connections across the town. Finally, the focus on using the programme as a test bed for innovative new approaches to promoting health and wellbeing, including the use of technology to support this, has been assisted by the inclusion of academic partners in the development of the programme to ensure that interventions are evidence based and that learning from the programme is robustly evaluated and disseminated.

This broad partnership of interested agencies has steered the programme to consider the wide range of opportunities to promote health and wellbeing, with a view to achieving an integrated approach to prevention which will involve workplaces, education, housing, planning, the voluntary sector, leisure providers, community groups as well as health and social care providers, in order to build a community where healthy lifestyles can become the norm. This is an approach that reduces the chance of health inequalities at the outset and addresses those which already exist.

The Commission strongly believes that the integration of the academic community into such schemes is essential, if the learning from development is to be applied both to future new developments and more broadly to inform further development and remodelling of existing housing stock and communities.

e. Social prescribing

In view of the recent national interest in social prescribing, and the encouraging results from Bromley by Bow, the Commission would wish to see consideration given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, and addressing health inequalities in particular. This has, we believe, the potential to become fully integrated as a patient pathway for primary-care practices and to strengthen the links between health-care providers and community, voluntary and local authority services that influence public health, including leisure, welfare, education, culture, employment and the environment (for example, urban parks, green gyms and allotments).

Recommendations		***Responsibility***
16.	Public agencies, universities and health partners should work together to develop new models of funding and delivery of affordable homes for a range of tenures to meet the needs of vulnerable people and key workers.	***Public agencies, universities and health partners***
	Specifically, public agencies should work together to maximise the potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing by undertaking a strategic review of public assets underutilized or lying vacant .	***Public agencies/HWB***
17.	Consideration should given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, addressing health inequalities in particular, and learning from other areas .	***HWB/CCG***

f. Fuel poverty

'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses. Rates of fuel poverty in Oxfordshire are unacceptably high.

Recommendation		***Responsibility***
18	In 2014 9.1% of households were fuel poor. This should be reduced in line with the targets set by the Fuel Poverty Regulations of 2014.	***HWB***

3.3 Action to reduce the harms of homelessness

Homeless people experience severe health inequalities with an average life expectancy of some 30 years less than the rest of the population [xxiii]. They often suffer from tri-morbidities: the combination of poor physical health, poor mental health and substance misuse, with poor health as both a cause and an outcome of sleeping rough. In general, homeless people experience significant barriers in accessing services to support their health, requiring extra support to access routine and acute services.

Although the County as a whole has a low rate of homelessness, Oxford City consistently has a higher rate than the rest of the county (see Appendix 3 and 5 and box 13). In general, homeless people experience significant barriers in accessing services to support their health, requiring extra support to access routine and acute services.

Box 13 Homelessness in Oxfordshire:

Levels of homelessness and rough sleeping are increasing across the country. City and District estimates for rough sleeping for 2015-2016 were as follows:

- City – 56,
- Cherwell – 21 (this is a 40% increase),
- South – 5,
- Vale – 5,
- West – 3.

The Health and Well-being Board's target to not exceed the baseline rough sleeping County-wide estimate (an alternative to street counts) of 68 set in 2014-2015, has been missed in 2015-2016 with an estimated figure of 90.

In November 2015, providers in the homelessness pathway estimated that between 55% and 85% of residents have mental health issues (including undiagnosed) and between 60% and 90% have substance misuse issues.

Phased changes in the funding allocations for housing related support are expected to have a significant impact on the availability of accommodation for single homeless people across the county. We would encourage the District and County Councils to continue to work together to find a solution, which will ensure this already vulnerable population are not further disadvantaged and to regularly report on progress to the Health and Wellbeing Board.

Recommendations	***Responsibility***
19. All public authorities are encouraged to continue their collaboration and invest in supporting rough sleepers into settled accommodation, analysing the best way of investing funding in the future. Homelessness pathways should be adequately resourced and no cut in resources made with all partners at the very least maintaining in real terms the level of dedicated annual budget for housing support.	***HWB***
20. The numbers of people sleeping rough in Oxfordshire should be actively monitored and reduced.	***HWB***

3.4 Rurality: reduce the health harms associated with rurality

Oxfordshire is a rural county, with approximately 50% of its population living in small settlements of less than 10,000 people. Health services such as major and community hospitals, out of hours GP services and ambulance services can be more difficult for village based residents to access, with limited or non existent public transport. For older people in particular, with limited access to public transport or poor mobility, rural living can have a negative impact on health and wellbeing. (Box 14) Older people living on low income are at higher risk of experiencing loneliness than those who are better off, with loneliness having been shown to have significant negative impacts on physical and mental health, quality of life and mortality [xxiv] (Appendix 3 and 5).

Box 14 Rurality and Ageing: Views from Age UK

In a predominantly rural county such as ours, population ageing is more rapid, and the populations of many villages, particularly in Cherwell and West Oxfordshire districts, are becoming rapidly older in age-group composition. This causes increasing demands on health and social care support, at a time where the social care workforce is already under great strain through historic lack of adequate funding. New ways of delivering social care should be investigated so that those who do not have resources to pay for their own care to a desired standard are not disadvantaged further with problems of securing accessible, decent quality care.

We believe that the initiative of some counties in promoting ***Village Companies*** is worth exploring: locally constructed companies and workforces drawn from a narrow geographical area, which may be more economically viable.

For rural communities access is the critical problem, and we see this on two levels:

-**Getting around**. The withdrawal of bus subsidies and reduced funding for community transport has exacerbated existing problems of isolation, exclusion and loneliness. Our perception is that the county has thus far approached the challenge piecemeal, for example with changes to patient transport eligibility taking place in parallel with but separately from other statutory areas of responsibility eg funding for transport to social care, funding of Dial a Ride. In straitened times the only way forward is for a strategic collaboration across the county, and the community needs to step up further to meet this challenge. We believe that the overview and strategy needs to be led at senior level by a community or voluntary sector leader, to knit together the existing patchwork quilt of provision of transport.

Digital access. The coverage of superfast broadband is patchy in the extreme. The capability of local communities to exploit the full potential of digital technology is variable, and many groups in society – such as the “older old” – have not yet acquired the skills and confidence to get online and maintain contact with the outside world, for shopping, official transactions, and social contact to maintain friendships and important relationships. This also calls for leadership – perhaps seeking help from the recent Minister for Digital Industries Ed Vaizey MP as a local MP in a rural constituency. It also calls for a more determined programme to help those not online to connect and use digital technology.

Recommendations		***Responsibility***
21.	An integrated community transport strategy should be developed[xxv]	***District and County Councils***
22.	A digital inclusion strategy, which explicitly targets older people living in rural communities should be developed and the % of older people over 65 with access to on line support regularly reported.	***STP***
23.	Reports of isolation and loneliness in older people/people suffering from dementia in rural areas should be collated and monitored on an annual basis with a reduction achieved year on year utilizing advice in http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation .	***DPH***
24.	The recommendations from the DPH annual report should be implemented and monitored.	***DPH***

3.5 Supporting vulnerable populations

a. Improving access to services for Refugees and migrant families

Special consideration should be given to the needs of migrant families and refugees. Evidence to the Commission noted that this support needs to be kept under review, recognizing that the intensive needs of first generation migrant families for support is unlikely to be required for future generations. (see box 15)

Box: 15 Oxfordshire Older Chinese People Centre (HAPPY PLACE)

Our Centre was established in 2003 and is located in West Oxford Community Centre. We welcome people who are over 50 years old to join us, particularly older Chinese people in Oxfordshire. Currently we have more than 100 registered members and the average age is around 70.

We aim to reduce isolation, exclusion, loneliness and depression caused by language and cultural barriers, and to promote health and independence amongst older people and carers.

The services and activities the Centre provides are:

- Language support
- Befriending and networking
- Exercise such as table tennis, dance and badminton
- Singing – karaoke
- Hot lunches
- Festival celebrations and day trips
- Health talks, information on social care and safety

Issues we face

Our Centre opens 3 hours on Mondays and 2 hours on Thursdays, but we can only afford a paid Co-ordinator for 3 hours a week. The West Oxford Community Centre is intending to increase our rent for hiring the hall too. Although we are funded by the County Council presently, the funding cut may be inevitable in the near future.

Aging is another issue. A lot of the older Chinese people are illiterate and they are very much relying on their family members and our Centre for support. Due to lack of resources, we are unable to provide outreach services for those who are too frail to come to the Centre and are living on their own.

On a positive note, we have one 94 years old lady is still attending our Centre regularly!

See also https://vimeo.com/180749504

A recent report to the OCCG board identified nine different factors, which would need to be considered when working with refugee families. (see Box 16)

Box:16 Factors to consider when working with refugee families

- Help with registering with general practitioners, dentists and opticians and information about the health care system as refugees will be unfamiliar with UK health care and how things work, and expectations may be different.
- Being aware of cultural factors and cultural adaptation to life in Oxfordshire.
- Country specific health issues – communicable and non-communicable disease.
- Physical and mental health problems arising from past experiences of the conflict in Syria; for example, torture and abuse, war related injuries and psychological trauma, family disappearances and family separation. The need for specialist provision of practitioners experienced in trauma related mental health problems.
- Care of pregnant women, child health, family planning, Immunisations. Primary care services often break down in situations of armed conflict.
- Impact on health of poverty and poor living conditions as refugees.
- The importance of organisations that can provide advocacy and social support.
- Language interpreting. It is important to use qualified interpreters. Family members should not be used.
- Allowing time and confidential space to discuss traumatic events.

Whilst these factors were specifically identified as relevant to the support of Syrian refugees, as part of the Syrian Refugee Vulnerable Persons Resettlement (VPR) programme,(see box 16) many of these factors resonate more broadly for working with ethnic minority and refugee populations, and in the case of Oxfordshire, particularly for working with residents from Campsfield House (see evidence from Ayslum Welcome and Refugee Resource). For example, evidence given to the Commission supported the provision of funding for locally enhanced services for refugees and asylum-seekers to be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers.

Box 16: The Syrian VPR programme

District Councils are coordinating the Syrian VPR programme in Oxfordshire, on behalf of the Home Office. The resettlement criteria are

- women and girls at risk
- survivors of violence and/or torture
- refugees with legal and/or physical protection needs
- refugees with medical needs or disabilities
- children and adolescents at risk
- persons at risk due to their sexual orientation or gender identity
- refugees with family links in resettlement countries

The resettled refugees are given five years Humanitarian protection status, with permission to work and access public funds and services, including NHS healthcare. At the end of the five years, refuges can apply to settle in the UK, or they may choose to return to Syria.

For the first year Oxfordshire District Councils are currently proposing to integrate thirty families (10 in Oxford City, 6 in West Oxfordshire, 6 in Cherwell, 2 in South Oxfordshire, 6 in the Vale of White Horse).

Source: OCCG July 2016 Briefing Paper: Syrian Vulnerable Persons Resettlement Briefing

Recommendations		***Responsibility***
25.	Funding for locally enhanced services for refugees and asylum-seekers should be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers.	***HWB***
26.	Outreach work in communities with high numbers of refugees, asylum seekers and migrants, should be actively supported and resources maintained, if not increased, especially to the voluntary sector, to improve access to the NHS, face to face interpretation /advocacy and awareness raising amongst health care professionals	***HWB***

b. Improving access to Throughcare provision for prisoners

Prisoners, and ex- prisoners are a vulnerable ethnically diverse population, with an increasingly ageing population adding further complexity to ensuring their long term health and wellbeing needs are met. A recent study has suggested that offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. [xxvi]

In Oxfordshire there are three secure establishments: HMP Bullingdon, IRC Campsfield and HMP Huntercombe. Health care provision in each of the prisons and the IRC aims to include primary care and secondary mental health services equivalent to that provided in the community.

Evidence provided to the Commission suggests that prisoners may experience particular challenges with throughcare arrangements – particularly offenders who have received short term custodial sentences, with access to sustainable housing and employment creating a potentially vicious circle. (Box 17)

Box 17: Offender and detainee health needs

Source: NHS England , Health and Justice Commissioning for Prisons and IRC in Oxford, June 2016 (unless otherwise indicated)

Offenders

- Offenders with addiction or mental health problems are more likely to need support with housing, education or employment to change their lives and prevent future victims, yet at the same time research shows these offenders will find it more difficult to access mainstream help than the general population
- Lifestyle issues:
    - National data suggests that approximately four times as many people smoke in prisons than smoke in the general population. These high rates of smoking damage health, causing marked health inequalities for offenders, and through second hand smoke, is damaging to the health of smoking and non smoking offenders, visitors and staff.[[xxvii]] National initiatives are underway to reduce smoking in prisons, including making them a smoke free environment within the next two years .
    - Drug users are estimated to be responsible for between a third and a half of acquisitive crime and treatment can cut the level of crime they commit by about half;
    - Alcohol is a factor in an estimated 53% of violent crime[3] and Accident and Emergency (A&E) data sharing and targeted interventions have been shown to reduce overall A&E violence related attendances in one study by 40%.

Detainees:

- Evidence from Europe and Australia on the health of migrant communities suggests that the most likely health problems will be communicable diseases such as TB, Chicken Pox and HIV.
- There is also evidence to suggest that certain ethnic groups including those most likely to be detained have higher prevalence rates for particular conditions including Asthma, Diabetes and Cardiovascular diseases.
- Certain conditions, including anaemia, dental caries, intestinal parasites, nutritional deficiencies and immunisation irregularities, appear more commonly in newly arrived refugees from developing countries. Also, people with darker skins and those whose mothers lacked adequate nutrition during pregnancy and breast-feeding are known to be at risk of Vitamin D deficiency.
- Mental health issues are reported to be one of the most significant health problems

Prison offers an opportunity for lifestyle advice and guidance however offenders often experience greater barriers to accessing services and ongoing support after release to meet those needs.

Recommendation		Responsibility
27	Robust pathways to community services for community rehabilitation [including Community Rehabilitation Companies[11]] on release, particularly for short term offenders, need to be developed,	***HWB***

3.5 Lifestyle factors : Physical and Social well being :

The importance of lifestyle as a contributor to health is well known, and the Annual Reports of the Director of Public Health have sequentially described trends and targets which will not be repeated in this report [see https://www.oxfordshire.gov.uk/cms/content/oxfordshire-public-health].

However, we wish to recommend some specific actions:

a. Physical activity:

The health benefits of physical activity are well documented: for example helping with weight control, reducing the risk of chronic diseases and improving mental health.

The national physical activity recommendations for adults are that they should achieve at least 150 minutes of at least moderate activity over a week. National data, collected through the Health Survey for England 2012, suggests that some 33% of men and 45% of women (over 16) failed to meet these guidelines, with the proportion of people who met the guidelines decreasing with age. National data also demonstrates an inequalities gap: 76% of men and 63% of women in the highest income quintile met the guidelines for aerobic activity, falling to 55% of men and 47% of women in the lowest quintile. [xxviii] In Oxfordshire, some 41.6% of people overall participate in sport at least once a week. [xxix] This varies greatly by demographic group, with disabled people, people over the age of 55 and people from lower socio-economic groups being less likely to participate in sporting activities (see table 3)

[11] ***Community Rehabilitation Company*** *(CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation.*

Table 3

Adult (16+) Participation in Sport (at least once a week), by year, and demographic breakdown

Indicator	Oxfordshire CC		South East		England	
	2005/06	2014/15	2005/06	2014/15	2005/06	2014/15
Male	43.9 %	44.0 %	41.9 %	41.8 %	39.4 %	40.7 %
Female	33.9 %	39.3 %	32.5 %	33.8 %	30.1 %	31.2 %
White British	38.6 %	41.9 %	36.8 %	37.5 %	34.4 %	35.5 %
BME	40.2 %	41.9 %	39.8 %	39.0 %	35.9 %	37.7 %
Disabled	17.6 %	24.7 %	17.5 %	19.7 %	15.3 %	17.2 %
Not Disabled	41.6 %	44.2 %	40.1 %	40.9 %	38.2 %	39.6 %
16 to 25	59.3 %	66.0 %	58.9 %	59.5 %	56.2 %	55.2 %
26 to 34	48.7 %	41.3 %	48.6 %	43.5 %	45.6 %	44.6 %
35 to 54	41.1 %	47.5 %	38.9 %	41.1 %	35.7 %	38.2 %
55+	20.4 %	23.5 %	21.6 %	23.3 %	18.9 %	20.9 %
NS-SEC 1&2	43.6 %	45.1 %	42.0 %	42.4 %	40.5 %	42.9 %
NS-SEC 3	34.3 %	34.8 %	35.0 %	34.6 %	32.5 %	33.1 %
NS-SEC 4	32.8 %	33.7 %	33.7 %	34.6 %	32.8 %	31.8 %
NS-SEC 5-8	30.7 %	33.3 %	29.8 %	27.5 %	27.2 %	25.9 %

Source: Active People Survey. Measure: Adult (16+) participation in sport (at least once a week) by year and gender, ethnicity, disability, age band and socio-economic class, one session per week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days). Time Period(s): 2005/06, 2014/15

Box 18 Physical activity

Oxfordshire Sport and Physical Activity (OxSPA) is the strategic partnership for physical activity and sport within Oxfordshire.
Within the partnership, primary schools are supported to deliver Change 4 Life Sports Clubs to those students deemed most in need of a specific intervention. Despite a limited capacity to deliver, all primary schools in Oxfordshire were given access to these clubs. However schools in particularly deprived areas or with concerning National Child Measurement Programme (NCMP) results were specifically targeted. In total, 68 schools have accessed Change 4 Life Sports Club training, with an average of 10 students attending sessions regularly. This means at least 680 of the most at risk children are accessing activity provision in an environment they're comfortable in, with a trained professional who already works at the school.

At present, 9 Oxfordshire secondary schools are taking part in an initiative to address female students' perceptions of physical education and physical activity, and explore how this impacts on whole school life as well as physical activity participation.

Source: OxSPA evidence to Commission

Inactivity increases with age, and this compounds the problem of premature decline in health in a rapidly ageing population. This demonstrates a clear health inequalities challenge. Yet many of the programmes which have been instituted in Oxfordshire suffer from lack of sustainable funding. The Strategic Physical Activity Group does important work, but it needs senior leadership and greater recognition in the health economy. This could be achieved by a prominent and respected figure in the field of physical activity made personally responsible for leading the achievement of the targets, both convening and chairing a new high-level group spanning the statutory sector, leisure and fitness organisations, business and industry, voluntary sector and community interests, represented at senior level. Without decisive, top level leadership it is likely that human and economic costs of inequalities will multiply and health gaps widen. It is crucial that health professionals themselves buy into the need to promote exercise and take opportunities such as prescription and every contact counts to make this happen. Their commitment cannot be taken for granted in this area.

Behaviour change will not occur without much stronger social marketing and awareness-raising. Such campaigns should address new ways of catching imagination and above all reach people through a sense of fun ("health by stealth").

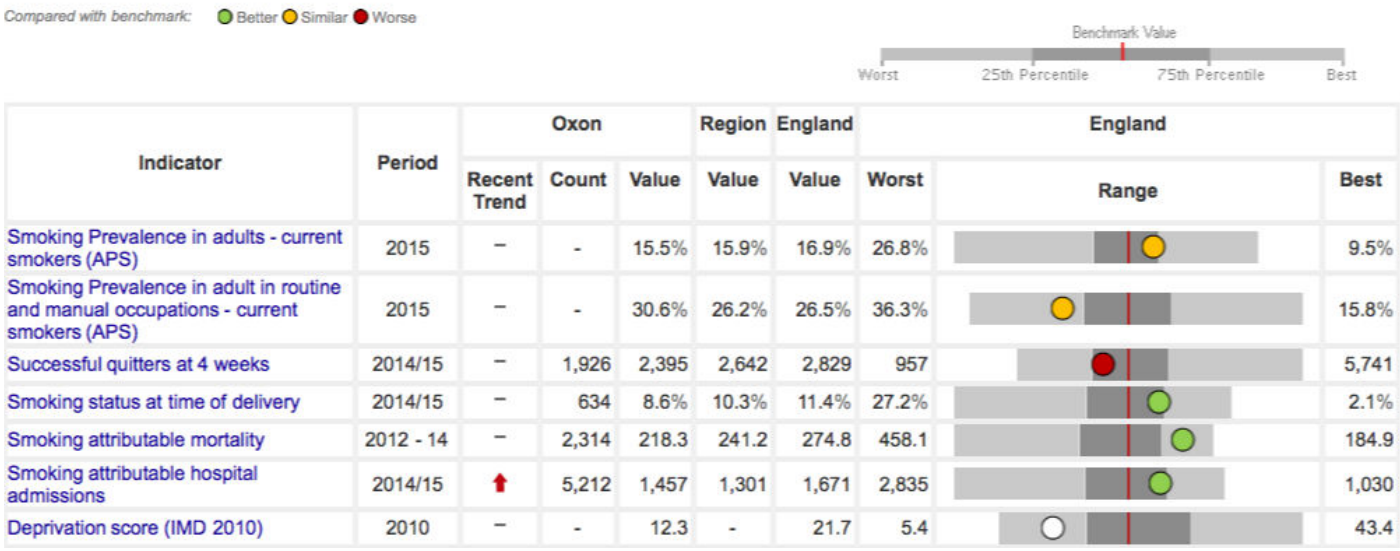
Recommendations		***Responsibility***
28.	A set of Oxfordshire-grounded targets for increasing activity should be developed, targeting people living in deprived areas, older people, and vulnerable groups .	***HWB***
29.	Continuing investment and coordination of existing initiatives should be maintained supported by social marketing and awareness-raising of the benefits of physical activity to targeted populations.	***PH Dept***
30.	The county should : • monitor and increase the number of disabled people participating in regular physical activity • achieve a measurable decrease in inactivity and in parallel an increase in mental well-being measures, measured using the Active People Survey and Health Survey for England datasets • demonstrate and increase a narrowing of the gap between the less socioeconomically privileged groups and the norm .	***PH Dept***

b. Smoking

Smoking is the single greatest cause of preventable illness and premature death in the UK. It is linked to more than 50 diseases and serious conditions, including cancer, coronary heart disease, stroke, circulatory diseases, chronic obstructive pulmonary disease (COPD) and asthma. According to 2014/15 data, there were some 5212 smoking attributable hospital admissions, with 2314 deaths attributable to smoking in Oxfordshire between 2012 and 2014. (see Figure 3) These figures show that smoking remains an important health issue in Oxfordshire – but they also mask important health inequalities. In Oxfordshire the local figures show a current overall smoking prevalence of 15.5%. For routine and manual groups this rate rises to 30.6. %. These figures are below the national average, but remain a cause for concern. Furthermore the local figures show that 7.9% pregnant women are recorded as smokers at the time they delivered their babies. These figures are slightly lower than those reported on the Tobacco Health Profile site[12].

[12] *Due to ONS announcing it would no longer produce the Integrated Household Survey (IHS) the questions formerly regarded as the IHS core (including smoking prevalence) will continue in the Annual Population Survey (APS). These are National Statistics and provide consistent time series. Local data replacse previously published IHS with APS equivalents. Due to differences in methodology the two "estimates" of smoking prevalence cannot be compared.*

Figure 3: PHE tobacco control local profile for Oxfordshire (source: http://www.tobaccoprofiles.info/tobacco-control 9 August 2016)



Indicator	Period	Oxon			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Smoking Prevalence in adults - current smokers (APS)	2015	–	-	15.5%	15.9%	16.9%	26.8%		9.5%
Smoking Prevalence in adult in routine and manual occupations - current smokers (APS)	2015	–	-	30.6%	26.2%	26.5%	36.3%		15.8%
Successful quitters at 4 weeks	2014/15	–	1,926	2,395	2,642	2,829	957		5,741
Smoking status at time of delivery	2014/15	–	634	8.6%	10.3%	11.4%	27.2%		2.1%
Smoking attributable mortality	2012 - 14	–	2,314	218.3	241.2	274.8	458.1		184.9
Smoking attributable hospital admissions	2014/15	↑	5,212	1,457	1,301	1,671	2,835		1,030
Deprivation score (IMD 2010)	2010	–	-	12.3	-	21.7	5.4		43.4

Smoking rates are also likely to be high among people with mental health problems, though no figures are available to verify this[13]. This should be addressed by local data collection.

Recommendation	***Responsibility***
31. Better data should be collected on smoking rates in different population groups including pregnant women, people with mental health problems, people in manual or routine occupations and other vulnerable groups to ensure that, in addition to lowering the overall rates of smoking ,the inequalities gap between these groups and others is reduced.	***PH Dept***

c. Alcohol and drugs

C1. Alcohol :

Alcohol is more affordable and available than at any time in recent history. While most people who drink do so without causing harm to themselves or others, there is a strong and growing evidence base for the harmful impact that alcohol misuse can have on individuals, families and communities in Oxfordshire.

13 *For discussion on smoking rates in prisons, see section 3.4c*

The misuse of alcohol impacts on individuals, families and communities in a range of ways. It can be a barrier to achieving the outcomes we wish for Oxfordshire in terms of improved economic performance, reduced worklessness, increased aspiration, reduced health inequalities, improved outcomes for children and families, and reduced crime and disorder. Health, social care services, and criminal justice agencies all have to invest significant amounts of money in providing services to respond to the effects of alcohol misuse.

The local health profile on alcohol suggests that in general Oxfordshire compares favourably with the national averages for alcohol related indicators, although it is slightly higher than the regional and England average for under 18 alcohol related hospital admissions (40.9 (Oxon) to 36.6 (England) and 34.5 (regional). (see figure 4 and appendix 3)

Figure 4: Alcohol health profile indicators for Oxfordshire

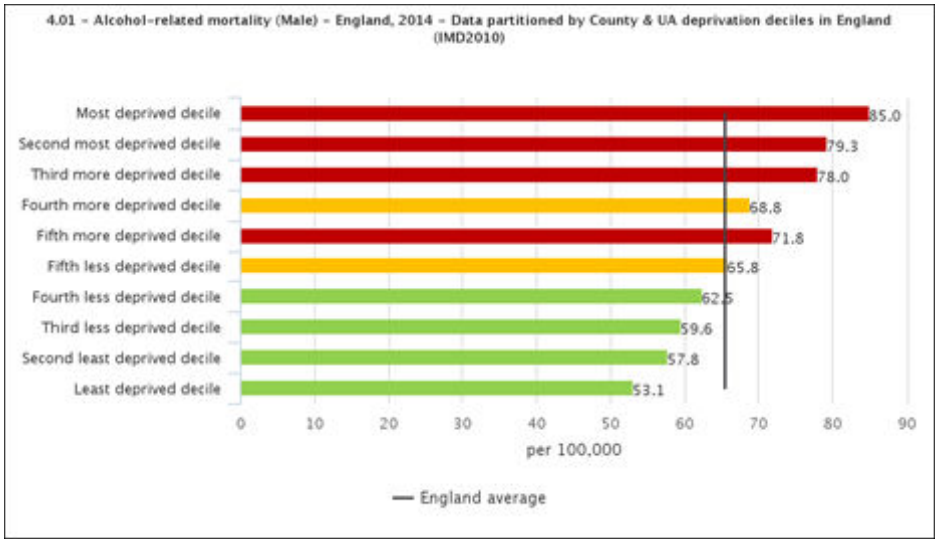
Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Indicator	Period	England	South East region	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
2.01 - Alcohol-specific mortality	2012 - 14	11.6	9.7	6.1	21.1	7.4	11.9	8.9	11.1	9.4	11.9	10.0	7.0	21.1	15.8	7.6	14.0	8.5	9.0	9.2	7.1	5.0
4.01 - Alcohol-related mortality	2014	45.5	40.8	31.8	55.7	34.7	41.8	38.2	44.2	42.4	47.8	41.9	37.9	61.6	51.3	42.8	50.0	37.8	43.5	40.7	36.2	32.2
10.01 - Admission episodes for alcohol-related conditions (Narrow)	2014/15	641	519	459	613	502	571	472	487	526	434	571	572	599	541	625	709	484	424	557	485	379
9.01 - Admission episodes for alcohol-related conditions (Broad)	2014/15	2139	1708	1727	1815	1636	1733	1605	1404	1702	1730	2106	1687	2021	1863	2541	2284	1755	1387	1695	1633	1270
6.01 - Persons admitted to hospital for alcohol-specific conditions	2014/15	364	280	253	485	224	302	260	298	274	220	246	285	509	327	393	494	253	215	284	261	158
5.01 - Persons under 18 admitted to hospital for alcohol-specific conditions	2012/13 -14/15	36.6	34.5	10.9	60.0	19.5	44.4	35.9	81.6	33.5	26.4	15.6	40.9	37.3	13.3	18.8	78.0	35.7	23.4	32.6	23.1	20.1

Source: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132984/pat/6/par/E12000008/ati/102/are/E10000025)

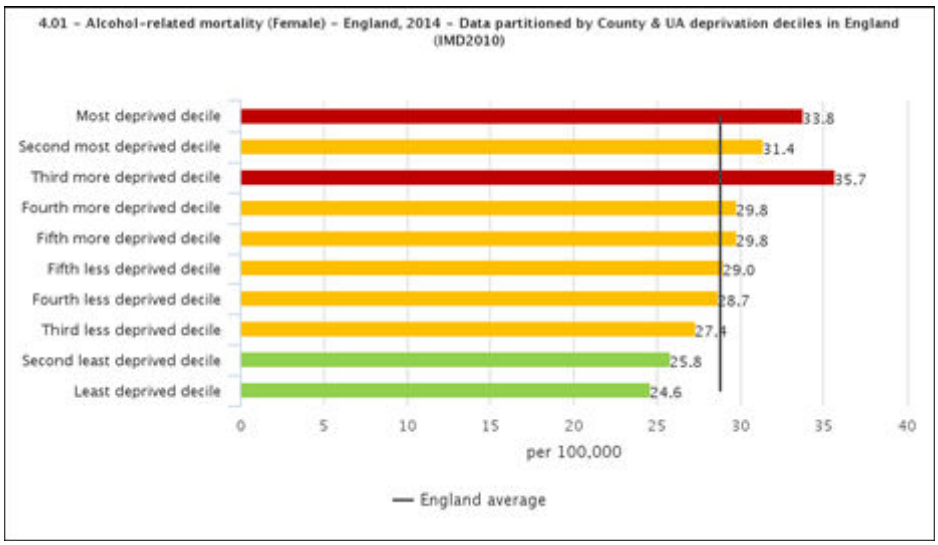
No local data was available for alcohol related deaths or hospital admissions by deprivation.
The Figures below show the alcohol related deaths for England by most/least deprived groups. Men show a greater difference between the best and worst off than for women. (Source: alcohol profile tool) There is no reason to suppose it is not a similar picture locally. (Figure 5)

Figure 5 :Alcohol related deaths by deprivation - men



Source: Jackie Wilderspin

Figure 6: Alcohol related deaths by deprivation - women

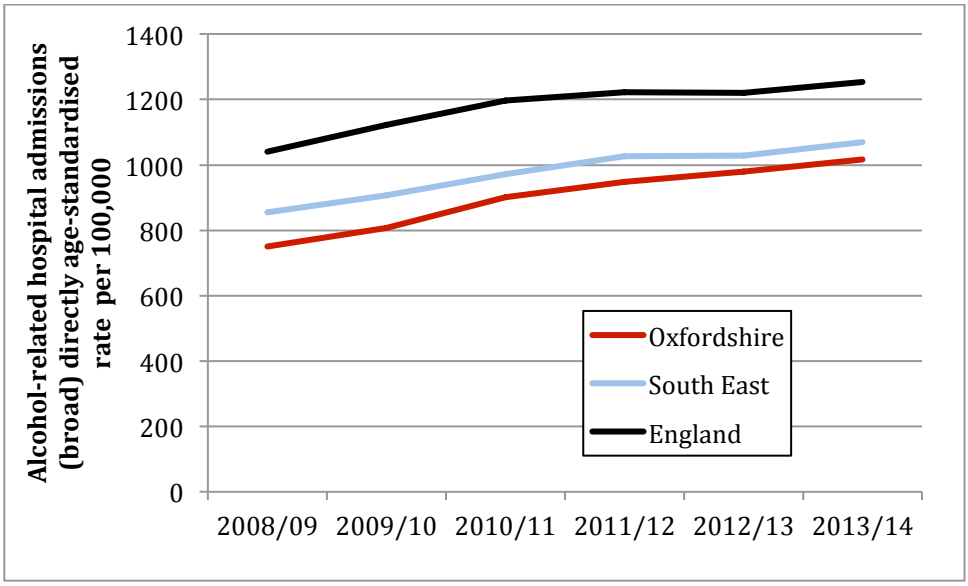


Source: J Wilderspin

In 2013/14 there was a continuing upward trend (3.9% increase on previous year) for **alcohol-related hospital admissions**[14] in England. (Figure 7) The annual increase was greater for women (+4.8%) than men (+3.3%) and it remains the case that rate of admissions among most deprived is 77% higher than rate in least deprived areas.

[14] *Alcohol-related hospital admissions (broad) - Persons admitted to hospital where primary diagnosis or any secondary diagnoses are an alcohol-attributable code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population European standard population.*

Figure 7 :Alcohol related hospital admissions



Source: Jackie Wilderspin

Recommendations		***Responsibility***
32.	An alcohol liaison service should be developed in the OUHT	***NHS***
33.	A project should be developed which aims to reduce drinking in middle aged people living in deprived areas	***PH Dept***
34.	Building on experience from Wantage, Community Alcohol Partnerships should be established to address the problems of teenage drinking, particularly in Banbury as A&E data shows high numbers of under 18s attending the Horton ED for alcohol related reasons. [The partnership model brings retailers, schools, youth and other services together to reduce under age sales and drinking.]	***PH Dept***
35.	Support and develop schools interventions including support given to school health nurses as well as services such as those run by The Training Effect to increase capacity of young people to choose not to misuse substances.	***HWB***

C2 . Drugs

National data demonstrates that people in deprived circumstances and their families are most likely to suffer from substance misuse, making this a fundamental health inequalities challenge. Yet there is no prevalence data for drug use, as such, as nobody knows exactly how many people are using illegal substances. Local health profiles compiled by PHE suggest that Oxfordshire may have:

- Lower rates of successful completion of drug treatment in non opiate users than both the England and SE England averages (29.9 versus 39.2 and 40.2 respectively – 2014 figures)

- A higher rate than the regional average of parents in drug treatment (99.8 per 100000 children 0-15 versus 78.8 regionally – based on 2011-2 data – but this rate is still below the national average)
- A lower rate of people in substance abuse programmes who inject drugs who have received a hep C test (70.7 versus 81.5 (e) and 85.4 (r) – 2014/5 data).
- A higher rate of children facing a fixed period of exclusion due to drugs/alcohol use (0.205 versus 0.1 (e) and 0.115 (r) (2013/4 figures)

Figure 8: Oxfordshire local health profile (Drugs)

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Indicator	Period	England	South East region	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
Successful completion of drug treatment - non-opiate users: % who do not re-present within 6 months	2014	39.2	40.2	54.0	38.2	43.9	35.3	44.9	54.3	41.8	31.5	32.4	29.9	37.4	44.0	52.2	49.0	44.7	34.5	28.4	33.6	35.7
Percentage who have taken drugs (excluding cannabis) in the last month	2014/15	0.9	1.0	0.2	4.2	0.6	1.2	0.4	1.2	1.3	0.9	1.6	0.9	1.1	1.6	0.7	0.7	0.9	0.7	1.3	0.8	0.3
Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24	2012/13 -14/15	88.8	80.5	42.8	92.8	33.2	82.9	84.6	92.5	104.9	44.2	92.0	77.5	115.6	37.3	46.8	90.4	79.0	75.5	80.9	80.2	24.7
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	46.9	53.2	36.5	51.9	51.3	52.2	52.8	38.8	57.4	44.0	53.6	47.5	53.0	54.9	50.4	52.3	55.4	55.7	60.4	32.1	*
Parents in alcohol treatment: rate per 100,000 children 0 - 15	2011/12	147.2	120.0*	136.8	202.2	70.5	218.4	*	*	120.5	*	75.5	135.7	*	92.7	103.6	55.6	124.8	125.0	101.9	108.0	63.5
Fixed period exclusion due to drugs/alcohol use: % of school pupils	2013/14	0.100	0.115	0.077	0.179	0.131	0.153	0.122	0.053	0.142	0.074	0.102	0.205	0.037	0.087	*	0.210	0.065	0.075	0.073	0.108	0.073
People who inject drugs	2011/12	2.49*	1.97*	1.16*	3.68*	0.73*	2.57*	1.93*	3.28*	1.81*	2.93*	1.78*	1.96*	4.14*	4.98*	1.56*	3.83*	1.15*	2.92*	1.34*	0.85*	0.85*
Persons in substance misuse treatment who inject drugs - Percentage of eligible persons who have received a hepatitis C test	2014/15	81.5	85.4	82.4	92.6	84.5	91.9	93.5	91.3	82.4	84.2	74.7	70.7	90.6	86.3	85.3	94.7	83.9	81.3	86.8	70.9	82.3
Percentage with 3 or more risky behaviours	2014/15	15.9	17.2	13.6	23.7	13.2	22.6	16.8	18.8	18.0	18.4	15.7	19.8	16.2	14.1	6.1	17.9	17.0	14.0	17.6	15.3	11.9
Parents in drug treatment: rate per 100,000 children 0 - 15	2011/12	110.4	78.8*	76.9	150.6	71.5	59.3	54.8	84.1	106.8	115.9	84.5	99.8	124.3	72.8	71.0	132.9	59.0	70.5	35.1	101.0	50.8
Persons entering substance misuse treatment - Percentage of eligible persons completing a course of hepatitis B vaccination	2014/15	8.7	8.4	16.7	5.6	13.4	4.1	4.8	10.5	9.2	5.1	6.9	9.5	4.4	12.5	28.8	17.5	4.5	3.3	7.2	3.4	6.7
Adults in treatment at specialist drug misuse services: rate per 1000 population	2013/14	5.0	3.1	3.2	7.6	2.4	3.6	2.2	4.1	2.7	3.5	3.1	3.7	6.1	5.4	5.4	5.5	2.4	2.5	2.4	2.8	1.8
Adults in treatment at specialist drug misuse services: rate per 1000 population	2014/15	4.8	3.0	2.8	7.5	2.3	3.7	2.0	3.5	2.9	3.9	2.7	3.4	6.1	5.4	5.1	5.2	2.4	2.6	2.2	3.1	1.8
Adults in treatment at specialist alcohol misuse services: rate per 1000 population	2014/15	2.1	1.4	2.1	2.9	1.0	1.8	1.1	1.8	1.6	1.5	0.7	0.8	5.5	0.8	1.4	2.1	1.2	0.9	1.0	1.5	1.1
Adults in treatment at specialist alcohol misuse services: rate per 1000 population	2013/14	2.3	1.6	2.8	3.8	0.9	3.1	1.2	2.6	1.4	1.4	1.4	1.3	5.7	0.7	2.1	2.4	1.3	0.9	1.2	1.6	1.3

-

Source: http://fingertips.phe.org.uk/search/drugs#pat/6/ati/102/par/E12000008 9 August 2016

The only robust data is the number of people who were in treatment with local services in March 2016 – for opiates (1550 people), non-opiates (118 people) or alcohol dependency (482 people). These numbers are not a reflection on the numbers of people who may be using these substances in the community as the motivation to enter and remain in treatment is a personal decision.

In addition, there is no reliable data on the use of Novel Psychoactive Substances. Recent investigations by the public health team have identified the use of synthetic cannabinoids in the homeless population as a cause for concern (this is also a problem in prisons). So-called "spice" is linked to very troubling behaviours and possible triggering of psychosis. Furthermore, information from the Forensic Mental health service suggests that there is use of NPS in the secure wards. Whilst the police are actively working to reduce supply, local action is difficult to envisage, given the increasing use of the internet as a source. The evidence collected by the Commission supports the development of a model of care for agencies who work with users of NPS to help them with treatment options, but this is an issue which we believe warrants more in depth exploration.

Recommendations		***Responsibility***
36	Resources in the public health budget should be maintained to provide services and support for drug misusers and their families	***HWB***
37.	School based initiatives should be promoted for all age groups	***HWB***
38.	Policy and action should be targeted to continue to address - the rates of successful completion of drug treatment in non opiate users - the rate of parents in drug treatment - the rate of people in substance abuse programmes who inject drugs who have received a hep C vaccination - the rate of children facing a fixed period of exclusion due to drugs/alcohol use - NPS use	***HWB***

3.6 Mental health

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities[xxx.] Many people with mental health problems also suffer poor physical health and impoverished social conditions. Addressing their needs will reduce health inequalities within the county. For example, Oxfordshire has higher than average excess under 75 mortality rates for people with severe mental illness. Recent data published by the Health and Social Care Information Service shows that people with mental health problems have a significantly different level of contact with physical health services compared with other patients.

Whilst this data estimates the mental health needs of UK populations, we have no reason to doubt it is applicable to Oxfordshire.

Box 19 : Estimated mental health needs of UK populations

In 2011/12:

- 78% of mental health service users accessed hospital services compared with 48% of non-mental health service users.
- 54% of those arriving at A&E came by ambulance or helicopter compared to 26% of non-mental health service users.
- A higher proportion of these patients were admitted and they stayed in hospital around 30% longer.
- 71% of those admitted were classified as an emergency compared with 40% of non-mental health service users.
- They also had more outpatient appointments.
- The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed are treated in primary care. The most common method of treatment for common mental health disorders in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients. Having a mental health worker attached to or working alongside GP practices improves the knowledge, confidence and capacity of the other primary care professionals in the practice.

Source Dan Leveson

Yet despite such compelling data, years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services. Oxfordshire has one of lowest spends per weighted capita for mental health (FYFV) and did not increase the % allocation of funds to mental health in line with total increased allocation in funding. The degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.

Implementing the 58 recommendations of the National Mental Health Task Force within the local context will help reduce inequalities. In particular, since data shows that Oxfordshire has the lowest spend per weighted population in the region, there is a need to ensure parity of esteem for

mental health in resource allocation. This means not only investing in the delivery of the recommendations from the national taskforce, but also addressing the challenges caused by years of under-investment.

Particular issues arise around access to mental health services. Better ways of tracking and responding to unmet need amongst hard to classify groups with complex individual problems need to be developed to monitor their well being.

	Recommendations	***Responsibility***
39	The under provision of resources for Mental health services should urgently be addressed	***CCG***
40	The implementation of the Five Year Forward Strategic View of mental health services for the county should explicitly state how it is addressing health inequalities and how additional resources have been allocated to reduce them.	***CCG/OH***

Section 4. Life course actions:

In addition to these cross cutting themes we identified actions at different points across the life course:

4.1 Beginning well :

Future health inequalities are, to a large extent, determined from a child's earliest years, including its intrauterine development. This is due to biological factors as well as life circumstances. Early responses to what is happening shape future physical and psychological functioning, supporting children to thrive, learn, adapt and form good future relationships. The first few years of life can be critical for readiness to learn, educational achievement and ultimately wealth and economic status, a strong predictor of future health and wellbeing.

a. Maternal health

Evidence provided on perinatal mental health highlighted a significant gap: whilst Oxfordshire has a local pathway for mental health services, there is no service or access for women with severe

mental illness and personality disorders as recommended in NICE 192 Antenatal and postnatal mental health (2014)., although such services are being developed in other parts of Thames Valley e.g. Buckinghamshire and Milton Keynes, so there is an inequity between different parts of the region. (see evidence from mental health network). IAPT and IPPS services cannot accept these women. They cannot access preconception care and do not meet the threshold for services if they are in early pregnancy but are well. This is despite the fact that there is a high risk of recurrence postnatally and the issues around continuing, amending, stopping medication are all important.

	Recommendation	***Responsibility***
41.	Perinatal mental health should be a priority with appropriate investment to improve access to perinatal mental health services across Oxfordshire	***CCG***

b. Children's health and wellbeing

Evidence presented to the commission suggested that more needs to be done to ensure that children are given the best possible start in life, recognizing that family circumstances can and do make a difference to health outcomes. Evidence to the Commission noted that Oxfordshire has historically had services for children, with IPPS[15] and OxPIP[16], and the level of primary prevention and early intervention possible through the extensive network of Children's Centres. However this is threatened by proposed cuts to Local Authority services.

Nutrition is an important foundation for good health – and challenges exist in ensuring access to affordable healthy food for all families with young children. Evidence provided to the Commission, which drew on The Trussell Trust's 2016 report data, suggests that food bank use is at a record high across the country**.** We interpolate from national data that 2.5% of the population of Oxfordshire accessed 2 emergency food parcels per person in the last year.

Data for "Children with free school meal status" is collected nationally, and is a good indicator representing children coming from relatively deprived households. In Oxfordshire, the number of

[15] *Infant-Parent Perinatal Service (IPPS) offers support to women who are experiencing or who are at risk of experiencing moderate mental health difficulties such as: parent-infant relationship difficulties; depression and low mood; anxiety and panic attacks; post traumatic stress disorder; obsessive compulsive disorder, and eating disorders*

[16] *Oxford Parent-Infant Project (OxPIP) provides intensive therapeutic support for parents and infants from pregnancy to 2 years who are in need of assistance to establish and build close and nurturing relationships*

children with free school meal status who achieve a good level of development at the end of their reception year is significantly worse than the number over the whole of England at 45.2% compared to 51.2% (England, 2015). We can interpret this as there being a difference in early years development between children coming from richer versus poorer families in Oxfordshire, and that this difference is worse in the county than for the whole country.

Table 3: Overview of the data for Beginning Well
Source Emily Phipps

Theme	Key Issues	Most Affected
Beginning Well	- Six Oxfordshire wards in the top 10% of children in England living in poverty - Families with dependent children still face homelessness despite overall prosperity in the county - Variation in the number of low birthweight babies born within the county, with deprived areas affected the most - Rising rates of childhood obesity in some areas - Poor educational attainment amongst children with free school meal status - Lack of access to mental health services for pregnant women with severe mental illness and personality disorders - the proportion of children aged 5 years old who are free from dental decay in Oxfordshire was 77.3 (2014/15) increased from 67.1 (2011-12), compared to the England figures which were 75.2 increased from 72.1	- Families living in Oxford City and its wards - Families living in Cherwell and its wards - pregnant women with severe mental illness and personality disorders - The national report of the survey indicates that decay levels are higher in local authorities where deprivation scores are higher.

Nationally, there is a robust evidence base showing that children who receive free school meals have lower achievement levels than those who are not eligible for free school meals. As a

county, we need to regularly review educational targets and the associated factors to ensure that progress is being made.

Education is an important factor in future health, and ensuring that children are ready for school entry, are adequately fed during their school days, attend school regularly and their achievement monitored are all important ways in which inequalities can be addressed . We recognize that there is much good work ongoing within the county in these areas. (Box 20)

Box 20 Working with the Oxford Academy
As a result of their presentation at the Health Inequalities Commission hearing, Oxford Academy were invited to participate in any of the health partnership groups in Oxford. They are now a member of the Leys Health & Wellbeing Partnership group

Recommendations		***Responsibility***
42.	Use of food banks needs to be carefully monitored and reported to HWB	***HWB***
43	Child Health Profiles and other relevant routine data should routinely be reported from the perspective of addressing factors which could reduce health inequalities, and promote access to health and other services	***PH Dept***
44	New and creative ways to work with schools, such as Oxford Academy, should be explored and initiatives funded and evaluated through the proposed CCG fund	***HWB/CCG***
45	The current plans for closures of Children's Centres should be reviewed by March 2017 to ensure prioritization of effective evidence-based investment and good practice in early intervention for children and to ensure that the change of investment and resource allocation to young children and their families does not disadvantage their opportunities especially for those children & families from deprived areas and identified disadvantaged groups	***HWB***

4.2 Living well :

At every point in the adult's life there is an opportunity to improve health and wellbeing, prevent the development of new conditions, and minimize the impact of pre-existing conditions. (Table 4) Yet at this stage of the lifecourse, engagement with services is often minimal.

Table 4: Overview of data on Living Well: (Source Emily Phipps)		
Theme	Key Issues	Most Affected
Living Well	- highest proportion of long-term unemployed adults live in urban areas - Less people living in deprived areas attend for NHS Health Checks - Increasing rates of hospital admissions directly or indirectly related to alcohol - Unpaid caring responsibilities falling on women - Carers from the BAME community less likely to access support - Fuel poverty and overcrowding unequally distributed across the county, mainly affecting urban areas	- Women across Oxfordshire - The BAME community - Adults living in Oxford and Banbury

Recommendations		***Responsibility***
46	Resources should be committed to ensure that prevention and lifestyle advice are embedded in all contacts with statutory service providers and the opportunity taken to include advice about healthier lifestyles and signpost support.	***CCG/NHS/HWB***

a. Workplace health

Being in work is good for health and economic productivity. The health of the workforce is an asset and programmes within workplaces as well as initiatives to reduce worklessness will contribute to reducing inequalities. The Commission heard of good examples both within the NHs and within the local corporate sector .(see Box 21)

BOX 21: The UNIPART STRATEGIC APPROACH TO WORKPLACE HEALTH AND WELLBEING

The basis of the UNIPART strategy is to:

- encourage and help all our people take personal responsibility for their own health and wellbeing to improve their quality of life and levels of personal resilience;
- support people, in particular line managers, in understanding the impact of their actions and decisions on the wellbeing of others; and
- identify workplace factors that may negatively impact the health and wellbeing of our people and seek ways to remove or mitigate it

However, some populations are particularly vulnerable. People with learning disabilities, for example, are underserved within the county. There are significant numbers of undeclared learning disabilities, e.g. dyslexia, autism. More needs to be done to support people who are already at a disadvantage with their complex needs as they will have less access to higher paid jobs. Using the Equality Act data and workforce race equality standards can be a useful measure of discrimination, harassment and access to career progression.

Recommendations	***Responsibility***
47. Promoting the health of those in work should be a priority and examples of good practice shared by establishing a county wide network.	***HWB and partners, e.g. UNIPART***
48. The NHS workforce should engage in equity audit and race equality standards should be routinely reported	***NHS/STP***
49 The needs of adults with learning disabilities within the County should be reviewed in 2017 and targets set to reduce their health inequalities .	***NHS/HWB***

b. Transitions

This report has chosen to use a life course perspective because it highlights the effects of different contexts and influences on stages of development, i.e. childhood, adulthood, and into older age. Transitions between these stages, e.g. from childhood to adulthood, create an important social context which can influence the resources and support available to individuals. Discontinuities in healthcare provision, social support, and access to services can have a profound impact on health and wellbeing, but can also be a determinant of future economic prosperity. [17] For example, becoming a parent can have a profound impact on the financial capabilities of a household – particularly if one parent stays at home to look after the children. This can have an impact throughout the rest of that person's life. Transitional points reflect a juncture of particular vulnerability, where individuals can fall through the gap. The Commission recognized that amongst the adult population some groups were particularly vulnerable to health inequalities, particularly those with learning difficulties. This is an issue that deserves separate consideration, particularly in the absence of affordable life care. The STP and other plans emphasize the move to self care and use of digital technology (i.e. apps). However, this is an approach which needs to be treated with caution, as some people will be left out, which could in turn worsen inequalities.

The evidence provided to the Commission suggests there are a number of areas where improvement can be made. Some of these areas have been considered separately, e.g targeting mental health support to areas of greatest need (see section 3.6)

However, the Commission recognized that amongst the adult population some groups were particularly vulnerable to health inequalities, particularly those with learning difficulties.

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17 *It is understood that the Oxfordshire STP will include a general principle that prevention should be embedded in all clinical contacts.*

4.3 Ageing well:

With significant improvements in healthcare and lifestyles, an increasingly large percentage of our population is made up of people aged over 65 years old.[xxxi] Older people are increasingly likely to require support from adult social care and social isolation becomes an important factor in older people's mental health. (Table 5) There is much that can be done to maximise the potential of older adults and enable them to live as independently as possible in their own community, i.e. provision of seasonal flu vaccination, falls prevention activity, tackling fuel poverty, and community development projects to reduce social isolation, particularly for people living in rural communities. More needs to be done to promote integrated health and social care addressing co – morbidities , particularly recognizing that depression and low mental health are major predictors of institutionalization.

Table 5: Overview of data on Ageing Well
Source Emily Phipps

Theme	Key Issues	Most Affected
Ageing Well	- Older people in rural areas are less able to access services - Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived, despite overall prosperity in the county - Loneliness affects older people living in urban areas most - Women in Oxfordshire more likely to require hospital admission due to a fall than men, and more than is seen nationally and regionally	- Older people living in rural South Oxfordshire - Older people living in rural West Oxfordshire - Older people living in Banbury Grimsbury and Castle - Older people living in Oxford - Older women in Oxfordshire

a. Disjoint between health and social services

One of the key issues highlighted to the Commission was the apparent disjoint between services provided by health and by social care. To respond to this, the Commission would urge the health and social care systems to work together to agree how best to bring together local services to produce a more coherent transition between sectors when addressing inequalities. Whilst shared budgets would appear to be one issue which should be considered, there is a need to think about how this fits with the broader care packages available to older people. For example, looking at

how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers.

There is also a need to protect investment in social care. At present, this is chronically underfunded. There is a need to look at its effectiveness, and ensure effective transitions from health to social care.

Ensuring that services are responsive to the specific needs of older people is essential, recognizing that for elderly people this may mean there are issues that could impact access to and benefit from services,

Recommendations	***Responsibility***
50. Health and social care systems should work together to agree how best to bring together local services to produce a more coherent transition between sectors when addressing inequalities, recognising that co-morbidities are common in this age group, and that many older people are acting as carers for their partners and family members.	***HWB***
51. Shared budgets for integrated care should be considered and how this fits with the broader care packages available to older people. For example, looking at how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers.	***CCG/HWB***

b. Supporting carers

Older carers make it possible for thousands of people to live dignified and fulfilled lives at home, and make a significant and positive contribution to the economy[18]. They deserve to be provided with the very best support to help them both in terms of their caring role, and in maintaining their own health and well-being. Whilst significant progress has been made, sadly, too often, they do not get all of the practical and emotional support they need, and often struggle on their own with the challenges of caring. Health and care professionals need to be guided to consistently respect carers as partners in care, listen to their views and wishes, and recognise and respond to their care and support needs. There is a need to ensure that available resources are maintained to support flexible breaks for carers, personalised to meet their individual needs.

[18] Figures released by Age UK in 2016 revealed that over the past seven years, the number of carers aged 80 and over has rocketed from 301,000 to 417,000 nationally.In Oxfordshire the figure is believed to be between 4,200 and 4,500, with more than half believed to be doing so for more

In his annual report the DPH has highlighted the challenges of the increasingly ageing population in the county and the need to address their needs (Box21) .

Box 21 : Recommendations from DPH annual report on support for the ageing community

1. Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Adult Social Care Directorate should continue to plan explicitly for services for an increasing population of frail elderly people. Further integration of health and social care services should include this topic as a priority.

2. The Clinical Commissioning Group and NHS England should work with GP services to consider loneliness as a risk factor for disease and consider how affected individuals could be signposted to use local resources such as befriending services and lunch clubs.

3. The Oxfordshire Clinical Commissioning Group should continue to develop improved services for dementia as a priority.

4. Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospitals Trust and Oxford Health Foundation Trust and NHS England should develop, as a priority, their joint work to collaborate in transforming the local health system. This is in order to provide new models of care closer to home, care focussed on prevention and early detection of disease, improved care for carers, prevention of hospital admission and speedy hospital discharge through improved community services, the modernisation of primary care and the funding of primary prevention services by the NHS.

5. Oxfordshire Adult Social Care Directorate should continue to analyse carefully the implementation of the Care Act and feed this information into future service planning.

6. The Director of Public Health should continue to commission NHS Health Checks and ensure that the offering and uptake of these services achieved by local GPs is kept at high levels. Poorly performing practices should be helped to improve the way Health Checks are delivered.

7. Oxfordshire Healthwatch should consider paying particular attention to dementia services and care for carers as part of their forward planning.

8.The Oxfordshire Health Overview and Scrutiny Committee should consider the issues raised in the care closer to home report carefully, and consider the issues raised in the DPH report, to ensure that proposals to re-shape services match demographic need and address health inequalities

Recommendations		***Responsibility***
52	Support for carers , including their needs for respite care and short breaks , should be supported with resources by all agencies	***HWB/All agencies***
53	The recommendations from the 2016 DPH annual report are endorsed and the Commission wishes to ensure they are targeted to reduce health inequalities and progress reviewed by HWB in 2017	***DPH*** ***HWB/OCC***

c. Addressing isolation

For older people, there is a particular need to provide services to address isolation. Social networks are changing rapidly. Competition for housing and jobs outside local areas has meant that family networks have become dispersed over wide areas, with social repercussions including loneliness at all ages. Alongside this, face to face engagement is being supplemented – and in some cases replaced – by more technological forms of interaction. Evidence presented to the Commission suggested there is a need to provide support services and stimulation to avoid isolation and loneliness especially amongst those with dementia and in rural areas.

Social prescribing is one method that has been used to good effect to encourage positive social interactions, particularly among those who do not enjoy good health. It is a method for the health-care system 'to access pragmatic solutions to meet the growing needs of people living with long-term physical and mental health conditions when medication is not always appropriate or necessary' (Social Prescribing Network 2016), linking patients with medical and non-medical sources of support within the community, such as opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. (see also Section 3.2e)

We would urge the statutory and voluntary sector to work together more. Examples such as VERA (Box 22) show that close working partnerships can have a significant positive impact on older people's lives.

Box:22 VERA – a good example of statutory services working closely with community groups

Thames Valley Police's Vulnerable Elderly Risk Assessment (VERA) identifies older residents at risk. In a new partnership with Age UK Oxfordshire local Police and Community Support Officers risk assess older people on their patch, using a scoring system which scores more highly for that resident's recent experience of crime or anti-social behaviour, their health needs and degree of mobility, and the availability of nearby family or close friends.

The highest scoring are then referred to the charity Age UK Oxfordshire which is able to connect those residents with services and opportunities that will give them more support from the community, such as befriending, visits, social clubs, classes and exercise opportunities on their doorstep, and access to information which will help them understand and take advantage of benefits and financial entitlements.

Recommendations

		Responsibility
54.	Support for services and stimulation should be provided to older people, especially those living on their own to avoid isolation and loneliness especially amongst those with dementia and in rural areas	***CCG/HWB***
55.	Strategic action should be taken to oversee increased access to support for older people in disadvantaged and remote situations: o physically through a better coordinated approach to transport across NHS, local authority and voluntary/community sectors o digitally through a determined programme to enable the older old in disadvantaged situations to get online o financially, through support to ensure older people, who are often unaware of their financial entitlements, are helped to access the benefits they are entitled to claim.	***HWB/CCG***
56	Building on existing experience, support the further development of Alzheimers friendly environments	***HWB***
57.	The current gap in provision of support for older people with mental health needs other than dementia needs to be addressed urgently.	***HWB***
58.	Promoting general health and wellbeing through a linked all ages approach to physical activity, targeting an increase in activity levels in the over 50s, especially in deprived areas, using innovative motivational approaches such as 'Good Gym' and Generation Games	***HWB/CCG***

Section 5: Conclusion :

The Commission has reviewed health inequalities in Oxfordshire and the many positive steps already being taken to care for the more vulnerable members of our community. Our objective has been to highlight that inequalities in health are unfair and unjust and that they need to be taken into account and action taken by all concerned with the health of our population.

Whilst it is easy to say that many of the structural elements of poverty and disadvantage are beyond the control of the county and its services it is also true to say that local action can make a difference. It is also easy to discount recommendations on the basis of poor financial data on costs and benefits of the recommendations, but this rigour is not applied to the commissioning of other routine services commissioned on a historical basis. We do know that addressing inequalities will save and improve lives for the most vulnerable in our communities and that gains will accrue over the lifetime of children who benefit from positive interventions .We also know that budgets are constrained, and we need to think creatively about how resources can be allocated or even reallocated.

Box 23 Useful resources to support action on health inequalities

The Marmot Review, published in 2010, set out evidence for action across the wider determinants of health to reduce health inequalities. To help turn the Marmot recommendations into practical actions, in September 2014 PHE published the first series of evidence papers on the issue. The commitment to support local action on health inequalities has been continued with new Practice Resource papers that include evidence, information and tips on approaches that local partnerships can adopt on four topic areas:

- Opportunities for using social value act to reduce health inequalities in England
- Promoting good quality jobs to reduce health inequalities
- Reducing social isolation across the life course
- Improving health literacy to reduce health inequalities

The next steps for the Commission will be to promote the findings of this report and discussion of what can be achieved through local action. The areas for action can be reviewed using the tools produced by PHE to support local action (see above). Progress needs to be regularly reported to councils, NHS partners and the local population through the Health and Well Being Board.

Overall Recommendations:	***Responsibility***
59. **The suggested actions should be considered by relevant parties and prioritized , with a report on progress to the HWB by mid 2017**	***HWB***
60. **The resources produced by PHE to support local action should be used as part of the formal review process. (Box 23)**	***HWB/all partners***

The recommendations from the Commission need to be considered both from a county wide and a local community level, adapted to fit their particular contexts and to be considered by each of the statutory authorities to ensure that they are maximizing opportunities to address health inequalities

This should be supported by research from Oxfordshire's extensive research community and the universities fully engaged to support implementation, assessment and evaluation of the recommendations in all sectors.

Monitoring and evaluation, particularly of the suggested new funding, will be needed across the health and social care system and reviewed on a regular basis by the Health and Well Being Board to ensure that there is a reduction in health inequalities in Oxfordshire.

We would like to thank all those who have contributed to the process so far.

October 2016

Appendices

Appendix 1: Economic impact estimates to support the business case for investment in the social determinants of health – evidence gathered by the King's Fund

Source: See relevant chapters of www.kingsfund.org.uk/publications/improving-publics-health

Measure of economic impact			
	Cost of illness	Cost-benefit analysis	Social return on investment
The best start in life	Each annual cohort of pre- term and low birth weight babies costs an additional £3bn from birth to the age of 18	Parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested, with savings to the NHS, education and criminal justice systems	
Healthy schools and pupils		Every additional four years of education return £7.20 in the value of health and other outcomes for every £1 spent Anti-bullying programmes can return £15 for every £1 spend in the long-run in terms of higher earnings, productivity and public sector revenue Smoking prevention programmes in schools can recoup as much as £15 for every £1 spent Every £1 spent on contraception to prevent teen pregnancy saves £11 in lower terminations, antenatal and maternity care	
Helping people to find good jobs and stay in work	Workplace injuries cost an estimated £13.8bn in 2010-11 and sickness absence contributes to an	Business in the Community estimates its programmes getting disadvantaged groups back into work returns £3 for every £1 spent Employee wellness programmes	

Measure of economic impact			
	Cost of illness	Cost-benefit analysis	Social return on investment
	overall cost of worklessness of £100bn per year	return between £2 and £10 for every £1 spent	
Active and safe travel	The overall cost to society of transport-related poor air quality, ill-health and accidents is at least £40bn, with accidents accounting for £9bn	For every £1 spent on cycling provision the NHS saves £4 in health costs Getting one more person to walk to school could pay back £768; and to cycle to work rather than by car between £539 and £641 in terms of NHS savings, productivity improvements and reductions in air pollution and congestion	
Warmer and safer homes	Poor housing costs the NHS at least £2.5bn per year due to illnesses related to damp, cold and dangerous homes Treating young people injured by accidents in the home costs almost £150m in A&E treatment Falls and fractures in the over-65s cost £2bn per year	Safety assessments and installation of safety equipment in homes would cost £42,000 for the average local authority and return £80,000 in reduced NHS costs, if 10% of injuries were prevented as a consequence Birmingham City Council's housing programmes (Decent Homes; Supporting People) returned £24m per year for a total outlay of £12m. Quickest paybacks were for reducing cold and reducing falls in elderly people	
Access to green and open spaces, and to leisure	Increasing access to parks and open spaces could reduce NHS treatment costs	Birmingham's 'Be Active' programme returned up to £23 in benefits for every £1 spent in terms of quality of life, reduced NHS	

Measure of economic impact			
	Cost of illness	Cost-benefit analysis	Social return on investment
services	by £2bn	use, productivity and other gains to the local authority	
Strong communities, well-being and resilience		Every £1 spent on health volunteering returns between £4 and £10 shared between service users, volunteers and the wider community	An assessment of 15 community health champion projects delivered an SROI of between £1 and £112 for every £1 invested
Public protection and regulatory services	In 2002 the average local authority incurred around £18–20m in NHS costs and a further £26–£30m in lost productivity and earnings due to obesity	Investing in a range of practical air quality improvements is likely to return on average a benefit of £620 for every £100 spent	
Health and spatial planning		'high standard' spatial planning is likely to return £50, £168 and £50 for planning interventions that promote walking, cycling and insulating homes respectively for every £1 spend on the planning process	

Appendix 2: Table of Key Health Inequalities issues by thematic area from Emily Phillps, Public Health Department

Theme	Key Issues	Most Affected
Beginning Well	- Six Oxfordshire wards in the top 10% of children in England living in poverty - Families with dependent children still face homelessness despite overall prosperity in the county - Variation in the number of low birthweight babies born within the county, with deprived areas affected the most - Rising rates of childhood obesity in some areas - Poor educational attainment amongst children with free school meal status	- Families living in Oxford City and its wards - Families living in Cherwell and its wards
Living Well	- highest proportion of long-term unemployed adults living in urban areas - Less people living in deprived areas attending NHS Health Checks - Increasing rates of hospital admissions directly or indirectly related to alcohol - Unpaid caring responsibilities falling on women - Carers from the BAME community less likely to access support - Fuel poverty and overcrowding unequally distributed across the county, mainly affecting urban areas	- Women across Oxfordshire - The BAME community - Adults living in Oxford and Banbury
Ageing Well	- Older people in rural areas less able to access services - Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived, despite overall prosperity in the	- Older people living in rural South Oxfordshire - Older people living in rural West Oxfordshire - Older people living in

Theme	Key Issues	Most Affected
	county - Loneliness most affecting older people living in urban areas - Women in Oxfordshire more likely to require hospital admission due to a fall than men, and more than is seen nationally and regionally	Banbury Grimsbury and Castle - Older people living in Oxford - Older women in Oxfordshire
Cross Cutting Themes	- Lack of availability of social housing - Most homeless people are found in Oxford city - A higher number of urban older people and lone parent households are without a car, limiting their access to services - Lack of health needs assessments for minority groups	- Social housing clients in South Oxfordshire and Vale of White Horse - Homeless people living in Oxford - Gypsy and traveller communities - LGBTQ communities - People living on waterways

Appendix 3: Data presented at each session

Beginning Well

1. Local Data

Poverty

Children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in income deprived families (Statistics O. o., Income Deprivation Affecting Children Index , 2015). The proportion of children living in poverty in the districts of Oxfordshire, the South East and England as a whole, can be found in figure 1 (England, Public Health Outcomes Framework, 2015).

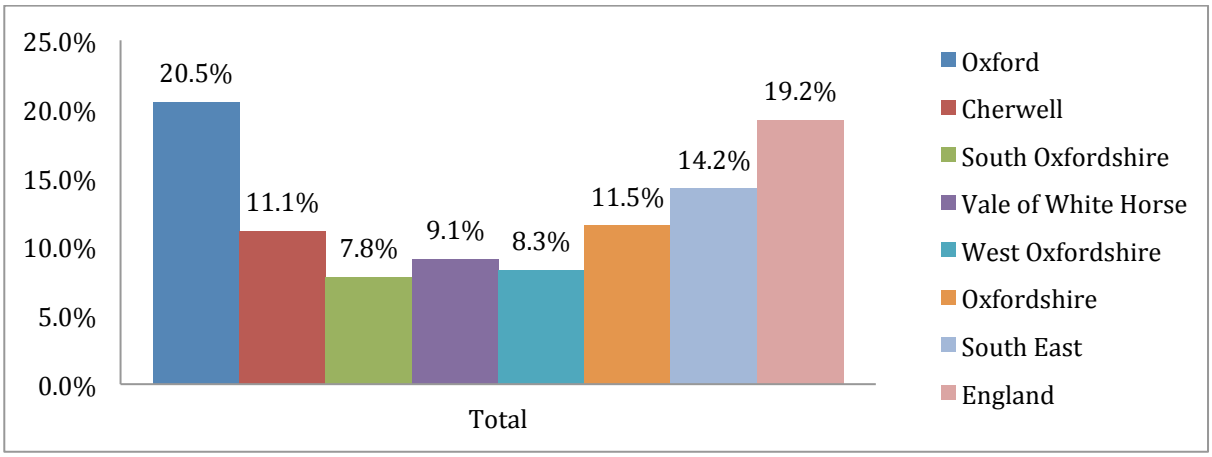

Figure 1 proportion of children living in poverty

Homelessness

In 2015, the greatest number of families with dependent children requiring support for unintentional homelessness were in Cherwell (47) and Oxford (60) (Government D. f., 2015). No pregnant women applied for support for unintentional homelessness during 2015 (Government D. f., 2015).

Conception and Birth

Obesity, smoking and extremes of maternal age (teenage conception or maternal age greater than 35 years) are all risk factors for poor maternal and infant outcomes. There are known strong links between obesity, smoking, teenage pregnancy and socioeconomic deprivation.

In England, there are 24.3 teenage conceptions for every 1000 girls aged 15 to 17 (England, Public Health Outcomes Framework, 2015). Although on the whole rates in Oxfordshire are below this, the areas with the highest rates of conceptions amongst girls aged 15-17 are in Iffley Fields, Holywell & St Mary's, and Banbury Grimsbury & Castle.

8.6% of mothers in Oxfordshire smoke at the point of delivery, which is better than the overall percantage in England, but is still of concern due to the recognised effects smoking has on foetal growth and child development (England, Public Health Outcomes Framework, 2015). District level data is not available for this indicator; however, we know that there is a strong link between smoking and deprivation (J, 2014), and so could estimate that most of these women are likely to live in the most deprived areas of Oxfordshire (Rose Hill, Blackbird Leys, Northfield Brook, Barton and Sandhills, Banbury Ruscote, Grimsbury and Castle and Banbury Neithrop).
The proportion of babies born with low birthweight in Oxfordshire is below the England average of 2.9% (England, Public Health Outcomes Framework, 2015). However, the areas with the greatest number of babies born with low birthweight are Cherwell (2.6%) and Oxford (2.6%), which are closest to the England average.

The breastfeeding initiation rate for the county is 82.1%, well above the England value of 74.3%. The highest rate of breastfeeding initiation in Oxfordshire is seen in West Oxfordshire (85.6%), which is considerably higher than the lowest rate seen in Cherwell (76.6%) (England, Public Health Outcomes Framework, 2015).

Infant and Maternal Mortality

Infant mortality rates (infant deaths under 1 year of age per 1000 live births) in Oxfordshire are not significantly different from the England wide or South East averages, when looking at the most recent crude rates from 2009-2013 (Exchange, 2013). Data is not available for the district levels.

Data on maternal mortality is not available for the county due to the confidential nature in which it is recorded and analysed. The UK Confidential Enquiry in to Maternal Deaths December 2015

report demonstrated no significant difference between the rates of maternal deaths in mothers living in the most deprived versus the least deprived areas of the UK (Marian Knight D. T., 2015). However, a difference had been shown in previous reports, with maternal mortality rates being higher amongst women living in most deprived areas (Marian Knight S. K., 2014). Thinking locally, this may mean that women living in the most deprived areas of Oxfordshire are at greater risk of maternal mortality than those living in the least deprived areas.

Child and Adolescent Health

Obesity amongst children in year 6 is rising across the county. The highest rate of obesity in year 6 children is seen in Oxford City, with 19% being obese (Council, Oxfordshire Joint Health and Wellbeing Strategy 2015-2019, 2015).

The number of children at the age of 15 in Oxfordshire who report being a current or occasional smoker is significantly worse than the England average (England, Children and Young People's Health Benchmarking Tool, 2015). The data for this is not available at district level; however, we could reasonably make a cautious assumption that these children are more likely to live in deprived areas, based on the recognised link between smoking and deprivation (J, 2014).

The number of young people hospitalised with injuries from self-harm in the county is rising. In 2015 there were over 100 admissions to the John Radcliffe and Horton hospitals, with most young people coming from the Oxford City, Vale of White Horse and Cherwell districts (Trust O. U., Hospital Episode Data, 2015). The cause for this rise is unclear, and could be due to changes in the way data is collected, increased awareness amongst young people and health care professionals, or the impact of trends such as social media and cyber-bullying.

Education

Data for “Children with free school meal status” is collected nationally, and is a good indicator representing children coming from relatively deprived households. In Oxfordshire, the number of children with free school meal status who achieve a good level of development at the end of their reception year is significantly worse than the number over the whole of England at 45.2% compared to 51.2% (England, Children and Young People's Health Benchmarking Tool, 2015). We can interpret this as there being a difference in early years development between children coming from richer versus poorer families in Oxfordshire, and that this difference is worse in the county than for the whole country.

The percentage of children in Oxfordshire achieving over five A* to C grades in English and Maths GCSEs is above the England average (59.4% compared to 56.8%) (Lygo, Educational Attainment Analysis Tables, 2015). However, rates are considerably lower than the England average in the most deprived areas of Oxfordshire. The areas with the lowest achievement are Blackbird Leys (33%) and Rose Hill and Iffley (33.8%) (Lygo, Educational Attainment Analysis Tables, 2015).

2. Protected Characteristic Data Sources

Pregnancy and maternity are protected characteristics under the Equality Act 2010. Data on pregnancy is available from Oxford University Hospitals Foundation Trust (OUHFT) from clinical coding. The most up to date data is available from the 2013 Equality Delivery System Monitoring Report for OUHFT, which recorded 14378 episodes of women patients being pregnant. This represents 13% of all female patient episodes and 7% of total episodes (including both male and female) in the trust that year (OUHFT, 2013).

3. Local Best Practice

Oxford University Hospitals Foundation Trust has a Public Health Midwifery service for expectant mothers with complex social or mental health issues. Out of all women who booked a pregnancy at the John Radcliffe Hospital in 2015, 926 women were identified as having relevant risk factors. Reasons for referral to the Public Health midwifery team include teenage pregnancy, mental health, domestic violence, drug and alcohol abuse, homelessness and poor social support.

The Thriving Families Scheme provides intensive support for families with complex social needs. Nationally, Oxfordshire is an early implementer of the programme, and has demonstrated a cost saving of £3.22 to public services for each pound invested in the project (Butler, 2015).
Various voluntary organisations provide housing and support services for teenage parents, women at risk of domestic violence and young people at risk (Council, Oxfordshire Directory of Housing Related Support Services, 2012). These services are distributed throughout the county. Oxfordshire County Council provides funding support for the ongoing functioning of these services.

Every secondary school in Oxfordshire has access to a school health nurse. They provide early and individual support to vulnerable children, and build capacity to generally facilitate a healthy lifestyle (both physically and mentally) within the school. Examples of key areas of focus include healthy eating, physical activity, sex education and positive relationships (Council, Oxfordshire Alcohol and Drugs Partnership Strategy 2015, 2015).

Living Well

1. Local Data

Working age adults

Oxford City has the highest proportion of working age adults that have never worked or are long-term unemployed, and the highest proportion of full-time students (Council, Public Health Surveillance Dashboard, 2015). Although Job Seekers Allowance (JSA) in Oxfordshire as a whole is low, the highest proportion of claimants live Oxford City (NOMIS).

Area	Economically active %	Unemployed %	JSA claimants %
Oxford	79.1	3.6	0.6
Cherwell	78.4	3.1	0.4
South Oxfordshire	86.5	2.6	0.4
West Oxfordshire	82.1	2.7	0.4
Vale of White Horse	79.9	2.8	0.4
Oxfordshire	81.1	3.6	0.5
South East	80.3	4.3	1
England	77.7	5.4	1.5

Table 1 Employment and JSA Receipts (NOMIS)

Between 2014 and 2015, 11.4% of working age adults in Oxfordshire were economically inactive due to long term sick leave (NOMIS). This is better than the total value for the whole of the South East of 18.1%. District level data for this is not available due to the small numbers involved.

Living with chronic disease and disability

GPs in Vale of White Horse, South Oxfordshire and West Oxfordshire look after a significantly higher proportion of patients with COPD, heart failure and history of stroke or transient ischemic attack (TIA) than GPs in Oxfordshire as a whole (Council, Public Health Surveillance Dashboard: COPD, 2016) (Council, Public Health Surveillance Dashboard: Heart Failure, 2015) (Council, Public Health Surveillance Dashboard: Stroke/TIA, 2016).

Cherwell, Vale of White Horse and West Oxfordshire have a significantly higher percentage of patients recorded as living with diabetes than the Oxfordshire average (Council, Public Health

Surveillance Dashboard: Diabetes, 2015). In the 2012 NHS Atlas of Variation for People with Diabetes, no significant relationship was found between type two diabetes and deprivation (NHS, 2012). The number of patients diagnosed with diabetes in general practices in Oxfordshire is also not significantly related to deprivation (England, Public Health Profiles). However, it is important to note that around a quarter of people with type two diabetes are unaware of it and remain undiagnosed, and so are not represented in these statistics (England, Adult Obesity and Type Two Diabetes, 2014). Nationally, risk of type two diabetes increases with age- less than 2% of people aged 16-34 are estimated to have diabetes, compared to 16.5% of those aged over 75 (England, Adult Obesity and Type Two Diabetes, 2014).

Oxford City generally has a lower proportion of residents with chronic diseases than other areas in the county. This is likely due to the high numbers of students residing there.

According to NHS Health Check data from 2014-2015, people older than 65 are most at risk of cardiovascular disease (Lygo, NHS Health Check Data Analysis, 2016). Under 75 mortality rate from cardiovascular disease increases with deprivation; 59.7 deaths per 100,000 in the least deprived group compared to 103.6 deaths per 100,000 in the most deprived group (England, Public Health Outcomes Framework, 2014). Men over 55 years are of higher risk of cardiovascular disease than women of the same age (Lygo, NHS Health Check Data Analysis, 2016). Proportionately it appears that females from more deprived areas are at higher risk of CVD than males (Lygo, NHS Health Check Data Analysis, 2016). However, when looking at NHS Health Check attendance data, more females attend health checks than men, and more people from the least deprived areas of Oxfordshire attend (Lygo, NHS Health Check Data Analysis, 2016). This may impact the reliability of this data.

Working age adults living with a physical disability are fairly evenly spread across the county (see table 2 below).

	18-64 year olds with moderate physical disability	18-64 year olds with serious physical disability
Cherwell	6,900 (7.9%)	2,000 (2.3%)
Oxford	6,900 (6.4%)	1,800 (1.7%)
South Oxfordshire	6,500 (8.1%)	2,000 (2.5%)
Vale of White Horse	5,900 (8%)	1,800 (2.5%)
West Oxfordshire	5,200 (8.1%)	1,600 (2.5%)
Oxfordshire	*31,400 (7.6%)*	*9,200 (2.2%)*

Table 2 Estimates of physical disability prevalence among 18-64 year olds in Oxfordshire and its districts (Council, Health and Wellbeing Report: Working Age Adults, 2015)

Alcohol

Over Oxfordshire, the number of A&E attendances with alcohol related problems (such as accidental injury and overdose) are the highest in patients from Oxford City and Banbury (C, 2015). Hospital admissions for alcohol-related conditions (such as colorectal and oral cancers) in Oxford and Cherwell are increasing; in 2012, rates of admission in Oxford city reached just under 750 per 100,000, a figure worse than the England average (England, Public Health Outcomes Framework, 2014). Rates in Cherwell have been climbing at a similar rate, and are now almost equal to the England average rate, having previously been significantly below average (England, Public Health Outcomes Framework, 2014). The reasons behind these figures are complex and could be due to factors such as changes to data collection strategies or increased diagnosis, and are under investigation.

Adult social care

The majority of adult social care clients are older people (3866). However, of the remaining adults aged 18-65, 668 clients have a physical disability, 1752 a learning disability, and 208 mental health or other care needs (Council, Health, 2015).

At the time of the 2011 Census, around 61,100 people in Oxfordshire said they provided some level of informal care to a relative or friend. Across the county, there were proportionately fewer carers in Oxford (7.7%) than in other districts: 10.3% in Vale of White Horse, 9.9% in both South and West Oxfordshire and 9.4% in Cherwell (Council, Joint Strategic Needs Assessment, 2015). Women are more likely to provide unpaid care than men- nearly a quarter of women aged 60-64, compared to around one in six men (Statistics O. f., England Census, 2011). Black, Asian and minority ethnic (BAME) carers are more likely to provide care for older or disabled loved ones but are less likely to access support from other services (Council, Health and Wellbeing Report: Working Age Adults, 2015).

Living with mental health problems

In 2013/14 Thames Valley Police made 347 Section 136 detentions across Oxfordshire[19]. This represented an increase of 19% from the previous year. During the first eight months of the

[19] Section 136 of the Mental Health Act enables the police to act if they believe that someone is suffering from a mental illness and is in need of immediate treatment or care. The police may take

2014/15 financial year there were 187 detentions. Across the county 44% of the detentions made between April 2012 and November 2014 were in Oxford. 36% were in Cherwell or West Oxfordshire. The remaining 20% were in South Oxfordshire or Vale of White Horse (Council, Joint Strategic Needs Assessment, 2015).

Women in contact with secondary mental health services in Oxfordshire are slightly less likely than men to live in stable accommodation (Council, Public Health Surveillance Dashboard, 2015). Women in Oxfordshire in contact with secondary mental health services are also less likely to live in stable accommodation as compared to the national figures, although the significance of this has not been tested (Council, Public Health Surveillance Dashboard, 2015).

Across the county, the rate of emergency hospital admissions for intentional self-harm was higher in Oxford than in other districts (248 per 100,000 people, significantly worse than the rate for England) (Council, Public Health Surveillance Dashboard, 2015).

7.5% of adults over the age of 18 in Oxfordshire were diagnosed with depression in 2014/2015 (England, Public Health Profiles). There is no significant relationship between diagnosed depression and deprivation in the county; however, this data does not account for people living with depression who are not in touch with their GP (England, Public Health Profiles).

Previously there have been concerns over the length of waiting times for talking therapies for mental health disorders in the county; because of this, waiting time targets are due to be introduced in April 2016 (Council, Director of Public Health Report 2015, 2015).

Living with learning disabilities

Female adults with learning disabilities in Oxfordshire are slightly less likely to be in stable accommodation compared to men with learning disabilities, although the difference may not be significant (Council, Public Health Surveillance Dashboard, 2015).

Adults living with learning disabilities are fairly evenly spread across the county (see table 3 below).

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that person from a public place to a place of safety, either for their own protection or for the protection of others.

	18-64 year olds with learning disability	18-64 year olds with moderate or severe learning disability
Cherwell	2100 (2.4%)	500 (0.6%)
Oxford	2700 (2.5%)	600 (0.6%)
South Oxfordshire	1900 (2.4%)	400 (0.5%)
Vale of White Horse	1800 (2.5%)	400 (0.5%)
West Oxfordshire	1600 (2.5%)	400 (0.6%)
Oxfordshire	10,000 (2.4%)	2,300 (0.6%)

Table 3 Estimates of learning disability prevalence among 18.64 year old in Oxfordshire and its districts (Council, Health and Wellbeing Report: Working Age Adults, 2015)

Overcrowding and Fuel Poverty

Across the county, the proportion of people living in households with more than one person per bedroom was higher in Oxford (38.5%) and Cherwell (35.1%) than in the other districts: 31.9% in South Oxfordshire, 30.5% in West Oxfordshire and 29.3% in Vale of White Horse (Council, Joint Strategic Needs Assessment, 2015).

Oxford had proportionately more people living in fuel poverty (12.4% or around one in eight people) (Council, Joint Strategic Needs Assessment, 2015). For the other districts, fuel poverty affected around 7% of people (approximately one in fourteen) (Council, Joint Strategic Needs Assessment, 2015).

Sexual health

Diagnosed HIV prevalence in the county (1.31 cases per 1000 people) is similar to the England value (2.22 cases per 1000 people) (England, Sexual Health Profile, 2014). HIV testing rates in Oxford are better than in other areas of the county, possibly due to the higher proportion of young people living in the area, and are increasing (England, Sexual Health Profile, 2014).

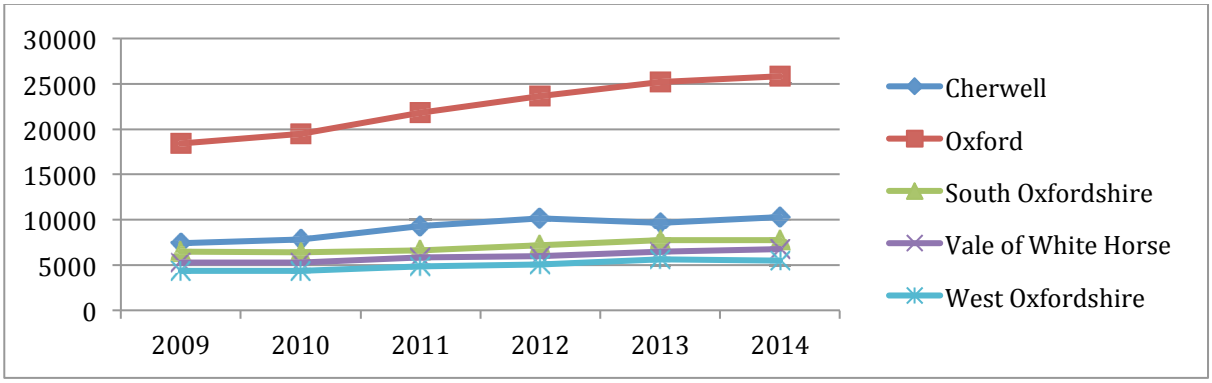


Figure 2 Number of HIV tests undertaken on eligible adults

Oxfordshire had 689 new STI diagnoses per 100,000 people in 2014 (England, Public Health Outcomes Framework, 2014). The greatest number of these cases are found in Oxford; the reasons behind this are complex, and could be to do with the higher proportion of young people living in the city, or the fact that people attending GUM clinic anonymously are allocated the clinic's postcode, which may distort data further.

2. Protected Characteristics Data Sources

Age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity are protected characteristics under the Equality Act 2010. Oxfordshire County Council produces regular briefing reports based on best available data. The latest report available was produced in November 2015, and contains a wealth of information on the variation of these factors across the county; the latest brief can be found here (Council, Equalities Briefing Summary, 2015). The quality and reliability of data used to generate this report varies by topic; for example, data on age and pregnancy status is more complete and accurate than data on race or religion.

3. Local Best Practice

The Oxfordshire Mental Health Partnership was established in December 2015 to coordinate activity between the Oxford Health NHS Trust and five local charities (Oxfordshire Mind, Response, Restore, Connection Floating Support and Elmore Community Services) in the support of patients with mental health problems (Trust O. M.). It is hoped that the partnership will increase joint working between agencies, improve user experience and lead to better outcomes.

Oxfordshire Exercise on Referral is a scheme provided by Oxfordshire Sport and Physical Activity offering tailored exercise programmes to Oxfordshire residents who are not currently active, but would like to use physical activity to manage a health condition (Activity). These conditions may include cardiovascular disease, obesity, mental health problems, musculoskeletal complaints and respiratory disease. Residents must be ages 16 or over and registered with a GP to be eligible for referral.

The Oxfordshire Street Triage Scheme is part of a Thames Valley wide initiative run between Thames Valley Police and NHS mental health services to provide support and ensure appropriate care for people who may come into contact with the police during an acute mental health crisis (Police). This innovative model has led to improved experiences and outcomes for people in

Oxfordshire experiencing mental health crisis, and has reduced the rising numbers of section 136 detentions seen in previous years (Police).

Oxfordshire Safer Communities Partnership is a county-wide strategy for preventing crime and anti-social behaviour. A Community Safety Practitioner (CSP) is currently posted in Oxford University Hospitals NHS Trust, providing advice and support for people experiencing homelessness, mental health crisis, domestic abuse and substance misuse issues. The CSP also act as a link between hospital professionals and community support mechanisms, and has been invaluable in protecting the safety of vulnerable adults across the county (C, 2015).

Ageing Well

1. Local Data

Location

Older people (over the age of 65) make up around 17% of the population in Oxfordshire (Office for National Statistics, 2014). Table 1 demonstrates the number of people aged 65 and over living in each of the districts in Oxfordshire (Office for National Statistics, 2014). Older people make up over a quarter of the population in 13 wards in Oxfordshire; the highest proportions can be found in Burford (32.5%) and Goring (28.7%) (Office for National Statistics, 2014). Oxford has seen a decline in the number of people aged 65-84 living there between the 2001 and 2011 census, whereas all other districts have seen an increase (Council, Needs Analysis for Older People (pending publication), 2016).

Table 4 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%
Oxfordshire Total	*115,600*	*17.2%*

The urban-rural profiles of Oxfordshire's districts for older people vary considerably (Statistics O. f., 2011 Census, 2011). National research has shown that older people in rural areas tend to be healthier overall than their counterparts in urban areas, but they face some specific challenges, particularly in their readiness and ability to access services (Council, Needs Analysis for Older People (pending publication), 2016). Figure 1 summarises the urban-rural profile for each district (Council, Needs Analysis for Older People (pending publication), 2016).

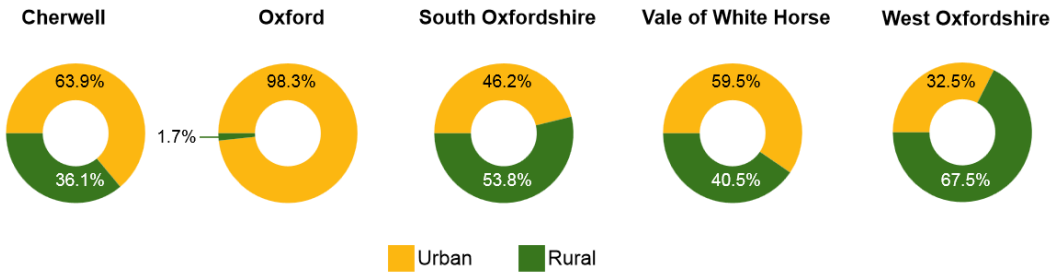


Figure 3 Older people living in urban and rural areas by district

Deprivation

Oxfordshire has relatively low levels of income deprivation affecting older people. However, parts of Banbury Grimsbury and Castle ward are in the top 10% most deprived nationally for older people (Council, Needs Analysis for Older People (pending publication), 2016). Looking at the whole county, it is estimated that around 13,900 people aged 60 and over are affected by income deprivation (Council, Needs Analysis for Older People (pending publication), 2016). A further 12 small areas are in the 20% most deprived nationally. These are concentrated in Banbury Ruscote and Neithrop, and Oxford City (in parts of Northfield Brook, Rose Hill and Iffley, Barton and Sandhills, Churchill, Carfax, St Mary's, and St Clement's wards) (Council, Needs Analysis for Older People (pending publication), 2016).

Life Expectancy

The average life expectancy of men and women at age 65 in Oxfordshire is better than the England and South East averages, as shown in figure 2 (Office for National Statistics, 2014). Trends in life expectancy for those aged 65 and over have changed for some districts between 2011/13 and 2012/14 for males and females, and are summarised in table 2 (Lygo, Trends in life expectancy at older ages local data analysis (internal), 2016). Cherwell has the lowest life expectancy for those age 65 and over for both males and females (Council, Needs Analysis for

Older People (pending publication), 2016). Although we cannot predict whether these trends will continue, they will be important to monitor in the coming years.

Figure 4 Life expectancy at 65 by district with England and SE benchmarks

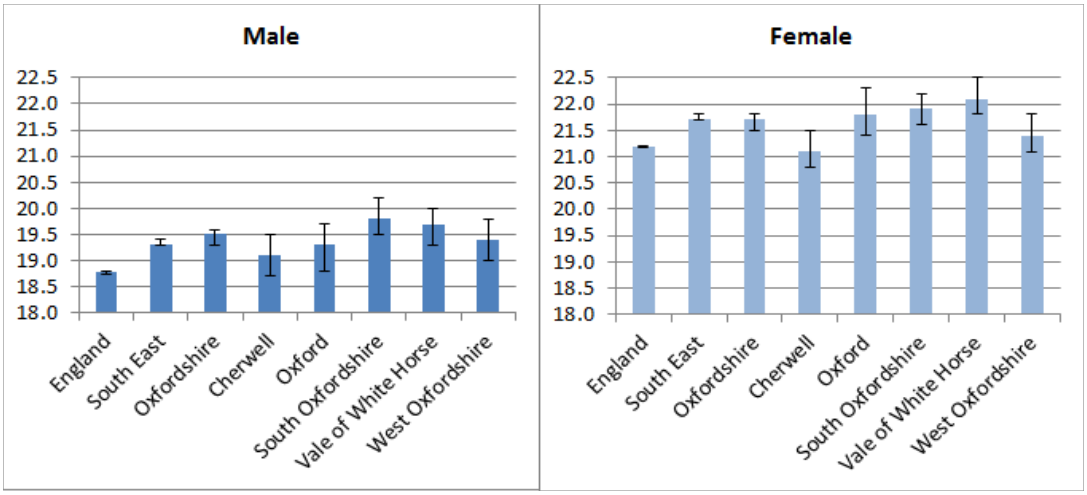


Table 5 Trends in life expectancy for those aged 65 and over in Oxfordshire districts

Local Authority	Change from 2011/13 to 2012/14 - Males	Change from 2011/13 to 2012/14 - Females
Cherwell	Fall	Fall
Oxford	Rise	Fall
South Oxon	No change	No change
Vale of White Horse	Rise	Rise
West Oxon	Rise	Fall

Loneliness

Older people living on low income are at higher risk of experiencing loneliness than those who are better off (Oxfordshire, 2012). Loneliness has been shown to have significant negative impacts on physical health, mental health, quality of life and mortality (Oxfordshire, 2012). The Office of National Statistics have published predictions regarding the prevalence of loneliness amongst people aged 65 and over in the districts of Oxfordshire (Statistics O. o., Log odds of loneliness for those aged 65 and over, 2011). Oxford has the highest predicted prevalence of loneliness and South Oxfordshire the lowest, however we cannot say whether this difference is significant or not.

Dementia

In 2014 the Alzheimer's Society estimated that there were over 7,700 older people with dementia in Oxfordshire (Alzheimers Society national prevalence data, 2014). A breakdown by local authority is shown in figure 2.

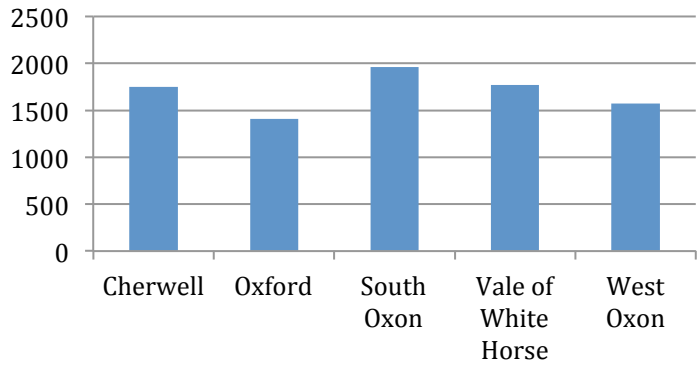


Figure 5 Number of people living with dementia by local authority

The five GP practices in Oxfordshire with the highest prevalence rates for dementia are demonstrated in table 3 (council, 2016). Although ward and district is noted, it is important to consider that the patients may live elsewhere.

Table 6 Oxfordshire GP practices with the highest rates of Dementia

Practice Name	Ward	District	Recorded rate of dementia
Berinsfield Health Centre	Berinsfield	South Oxfordshire	1.5%
Goring and Woodcote Medical Practice	Woodcote	South Oxfordshire	1.4%
The Wychwood Surgery	Ascott and Shipton	West Oxfordshire	1.4%
Islip Surgery	Otmoor	Cherwell	1.3%
Nuffield Health Centre	Witney South	West Oxfordshire	1.3%

Dementia and Alzheimer's disease were the leading cause of female mortality in Oxfordshire between 2011 and 2013, followed by ischemic heart disease and cerebrovascular disease (stroke) (council, 2016). Dementia and Alzheimer's disease were the second leading cause of mortality amongst men in Oxfordshire in the same period behind ischemic heart disease (council, 2016).

Falls

Nationally, falls are the most common cause of death from injury among older people. Non-fatal falls can result in fractures, and affect older people's ability to get around independently.

Older women in Oxfordshire have a higher rate of hospital admissions due to falls than men. This value is also higher than national and regional averages (Council, Needs Analysis for Older People (pending publication), 2016). Those in the oldest age groups (aged 80 and over) have a higher rate of admissions than the national and regional averages, and is higher than the rate seen in those age 65-79 (Council, Needs Analysis for Older People (pending publication), 2016). Residents of Oxford and Vale of White Horse had higher rates than other districts in the county, and are also higher than national and regional averages (Council, Needs Analysis for Older People (pending publication), 2016).

Hip Fractures

In 2014/15 there were over 700 emergency admissions for hip fractures among older people in Oxfordshire. Rates of hip fractures amongst older women in Oxfordshire are higher than older men, in line with national trends (Council, Needs Analysis for Older People (pending publication), 2016). The latest Local Health profile data shows no clear relationship between emergency hospital admissions for hip fracture in people aged 65 and over and the percentage of older people living in deprivation or living alone in a particular district in Oxfordshire (England, Local Health, 2016).

Winter Deaths

According to the latest Excess Winter Deaths Index data, South Oxfordshire was one of 4 areas (out of 67) in the South East that had a significantly higher ratio of extra deaths to expected deaths than anticipated (Council, District Data Service Chart of the Month, 2015). Oxford's value was also high but statistically similar to the regional average. The ratio of extra deaths to expected deaths amongst females for the county was higher than expected during this period, and may be driving the increases seen in South Oxfordshire and Oxford. Excess winter deaths could be a reflection of fuel poverty or of increasing rates of illness during the winter months, and although is more likely to affect older people, does include data for all ages. Because of this, the Excess Winter Deaths Index can only be used to track trends and should not be used to attribute causation.

2. Protected Characteristics Data Sources

Age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity are protected characteristics under the Equality Act 2010.

Data from 2014 estimated that women make up over half the 65 years and older population in Oxfordshire, likely due to their longer life expectancy than men (Council, Needs Analysis for Older People (pending publication), 2016). Disability-free life expectancy at age 65 for men in Oxfordshire between 2009 and 2011 was estimated to be 13.2 years (Council, Needs Analysis for Older People (pending publication), 2016). Oxfordshire was ranked 7th of 150 upper tier local authorities on this measure. For women aged 65, disability-free life expectancy was estimated to be 12.2 years (Council, Needs Analysis for Older People (pending publication), 2016). Oxfordshire was ranked 36th of 150 upper tier local authorities on this measure.

Table 5 demonstrates the differences between healthy life expectancy and total life expectancy for men and women, as well as the difference in life expectancy for the best and worst off in the county (Equity I. o., 2015). We can see that although men and women in Oxfordshire can experience more years lived in good health than the England average, there is still almost a decade difference between the most and least deprived in the county.

Data from the 2011 census indicated that older people in Oxford are slightly more likely than those in other districts to have a main language other than English. Their main language was most often a European language (spoken by 2.2% of Oxford's older people), a South Asian language (spoken by 1.8%), or an East Asian language (spoken by 0.7%) (Council, Needs Analysis for Older People (pending publication), 2016). Of those older people in Oxfordshire who did not speak English well or at all, over half lived in Oxford (Council, Needs Analysis for Older People (pending publication), 2016). Table 5 summarises the Oxfordshire wards with the largest proportions of BAME origin older people (Council, Needs Analysis for Older People (pending publication), 2016).

Table 7 Oxfordshire wards with largest proportions of BAME older people

Ward name	**% older people of BAME origin**
Cowley Marsh	22.1%
Iffley Fields	16.9%
St Clement's	13.8%
Blackbird Leys	12.2%
Northfield Brook	10.9%
Holywell,St Mary's	10.1%
Lye Valley	9.7%
Cowley	8.9%
Hinksey Park	7.8%
Barton and Sandhills	7.2%

Table 8 Comparison of life expectancy at birth and healthy life expectancy at birth

	Oxfordshire	**England**
Men – **healthy** life expectancy at birth (total life expectancy at birth)	67.7 (80.6)	63.5 (79.1)
Men – inequality in **healthy** life expectancy at birth (inequality in total life expectancy)	9.3 (5.6)	12.8 (6.6)
Women – **healthy** life expectancy at birth (total life expectancy at birth)	69 (84)	64.8 (83)
Women – inequality in **healthy** life expectancy at birth (inequality in total life expectancy)	8.8 (3.8)	12.5 (5)

3. Local Best Practice

In April 2016 Oxfordshire County Council are publishing a comprehensive needs assessment for older people living in the county (Council, Needs Analysis for Older People (pending publication), 2016). This will be invaluable for service planning and commissioning.

Oxford University Hospitals Foundation Trust has undertaken a wide variety of projects to improve accessibility of services to older people. This includes (Trust O. U., OUHFT Equality Delivery System 2 (EDS2) Evidence Review, 2015):

- Improving engagement with older people through the 'Seldom Heard' project
- A 'Carer's Surgery' to identify carers and provide structured advice and support
- The Trauma Directorate 'Dementia Care Bundle' including a patient care passport, orientation resources and reminiscence work
- A trust-wide Dementia Initiative Strategy to support identification, staff support, education and ongoing research in to dementia
- A Dementia Information Café providing interventions and advice from external voluntary organisations

There are many voluntary organisations working in Oxfordshire to improve the health and wellbeing of older people. Some of these include:

- Age UK Oxfordshire- provides information and advice for older people and coordinates various local projects
- Oxfordshire Volunteer Befriending Service- providing respite for carers living in the county
- Oxfordshire Advocacy- supporting older people to have their views heard and taken in to account regarding decisions affecting their lives
- Contented Dementia Trust- providing practical help and resources to people living with dementia and their carers
- Oxfordshire Befriending Network- a telephone befriending service to tackle loneliness amongst older people living in the county

Cross Cutting Themes

1. Local Data

Deprivation

There is a wealth of evidence demonstrating the negative effects deprivation has on health and wellbeing. A common measure of deprivation is the Index of Multiple Deprivation, based on over 30 separate indicators across 7 domains (income; employment; health and disability; education, skills and training; crime; barriers to housing and services; and living environment). Each

geographical area is ranked using this index on its level of deprivation relative to that of other areas (Government D. o., 2015).

Most of Oxfordshire's 407 lower layer super output areas[20] (LSOAs) are less deprived than the national average, with 110 being in the least deprived 10% nationally (Council, Joint Strategic Needs Assessment, 2016). Overall, nearly half (46%) of the county's population lives in areas that are among the least deprived 20% in England (Council, Joint Strategic Needs Assessment, 2016).

However, two LSOAs are among the 10% most deprived in England. These are in parts of Rose Hill and Iffley ward, and Northfield Brook ward (Council, Joint Strategic Needs Assessment, 2016). The former has moved in to this category since 2010. A further 13 LSOAs are among the 10-20% most deprived (down from 17 in 2010). These are concentrated in parts of Oxford City, Banbury, and Abingdon (Council, Joint Strategic Needs Assessment, 2016).

Education

Inequalities in education and skills have significant impacts on physical and mental health, as well as income, employment and quality of life (Equity U. I., 2015). There are recognised trends between poor education outcomes and health inequalities such as smoking, obesity and cancer (Council, Joint Strategic Needs Assessment, 2016).

Data for "Children with free school meal status" is collected nationally, and is a good indicator representing children coming from relatively deprived households. In Oxfordshire, the number of children with free school meal status who achieve a good level of development at the end of their reception year is significantly worse than the number over the whole of England at 45.2% compared to 51.2% (England, Children and Young People's Health Benchmarking Tool, 2015). We can interpret this as there being a difference in early years development between children coming from richer versus poorer families in Oxfordshire, and that this difference is worse in the county than for the whole country.

The percentage of children in Oxfordshire achieving over five A* to C grades in English and Maths GCSEs is above the England average (59.4% compared to 56.8%) (Lygo, Educational Attainment

[20] Standardised geographical area constrained by local authority boundaries with an average population of 1500, used to report small area statistics.

Analysis Tables, 2015). However, rates are considerably lower than the England average in the most deprived areas of Oxfordshire. The areas where children live who have the lowest achievement are Blackbird Leys (33%) and Rose Hill and Iffley (33.8%) (Lygo, Educational Attainment Analysis Tables, 2015).

Housing

The availability of affordable and safe housing is an essential determinant of health and wellbeing. A lack of such housing can lead to people facing considerable financial strains to afford rent or mortgage payments, delays in starting a family due to lack of money and space, and pressures on social relationships as families are forced to live further away from each other (Shelter, 2010). Living in sub-standard housing can negatively affect mental health and wellbeing, and the physical health impacts of living in damp or dirty conditions are numerous (Shelter, 2010).

The availability of social housing in Oxfordshire varies between districts. In South Oxfordshire and Vale of White Horse in particular, there is demand for over half as much again of social housing than currently exists (Council, Joint Strategic Needs Assessment, 2016). Social housing rent in Oxfordshire is rising, and remains higher than in most of the other local authorities in England (Council, Joint Strategic Needs Assessment, 2016).

Housing in Oxfordshire is generally expensive. In all districts of the county, median house sale prices are rising and remain higher than most other local authorities (Council, Joint Strategic Needs Assessment, 2016). The ratio of house prices to salaries is high and rising, and Oxfordshire is now one of the most unaffordable places in England to live (Council, Joint Strategic Needs Assessment, 2016).

People living in overcrowded conditions tend to experience poor health. In the 2011 census, a third of people (33.3%) in Oxfordshire reported living in a household with more than one person per bedroom. The proportion in Oxford and Cherwell were slightly higher than the rest of the county (38.5% and 35.1% respectively) (Council, Joint Strategic Needs Assessment, 2016).

Homelessness is also linked to significant poor outcomes in terms of health and wellbeing. A report from Crisis stated that on average, homeless people die at 47 years old, 30 years before the national average of 77 (Crisis, 2015). Although the county itself has a consistently low rate of homelessness, Oxford City has higher rates of people who are homeless or in temporary accommodation than the rest of the county (Council, Joint Strategic Needs Assessment, 2016).

This could be partly due to the number of homeless shelters and other facilities present in the city. Data recently presented to the Oxfordshire County Council Health Improvement Board indicated that there were 90 rough sleepers in 2015-2016. The majority of these (56) were in Oxford with 21 in Cherwell, 5 in Vale of White Horse and South Oxfordshire and 3 in West Oxfordshire (Lygo, Internal communication, 2016).

Work and earnings

Unemployment is linked to poor health outcomes in terms of both physical and mental health (Equity I. o., 2015). Oxford City has the highest proportion of working age adults that have never worked or are long-term unemployed, and the highest proportion of full-time students (Council, Public Health Surveillance Dashboard, 2015). Although Job Seekers Allowance (JSA) in Oxfordshire as a whole is low, the highest proportion of claimants live Oxford City (NOMIS).

Area	Economically active %	Unemployed %	JSA claimants %
Oxford	79.1	3.6	0.6
Cherwell	78.4	3.1	0.4
South Oxfordshire	86.5	2.6	0.4
West Oxfordshire	82.1	2.7	0.4
Vale of White Horse	79.9	2.8	0.4
Oxfordshire	81.1	3.6	0.5
South East	80.3	4.3	1
England	77.7	5.4	1.5

Table 9 Employment and JSA Receipts (NOMIS)

Between 2014 and 2015, 11.4% of working age adults in Oxfordshire were economically inactive due to long term sick leave (NOMIS). This is better than the total value for the whole of the South East of 18.1%. District level data for this is not available due to the small numbers involved.

Overall, Oxfordshire residents earn a higher income than the national average, but similar to the rest of the South East (Council, Joint Strategic Needs Assessment, 2016). No significant differences in average income are found at district level in the county (Council, Joint Strategic Needs Assessment, 2016).

Nationally the Citizen's Advice Bureau (CAB) has reported successfully solving 2 out of every 3 client's debt problems through its debt advice service (Team, 2015). They estimate that CAB clients accessing their financial services are on average £10 better off per week as a result of the information and support received (Team, 2015).

In Oxfordshire the Benefits in Practice scheme funds the provision of welfare rights advisors to work out of primary care settings across the county. The service aims to address debt issues and maximise patient's income in order to address health inequalities and improve health and wellbeing. In quarter one and quarter two of the financial year running from 2015-2016, 552 appointments were attended across Oxford, Banbury and West Oxfordshire (Austin, 2016). Total annualised gains for clients in each quarter ranged from £13,994.29 to £53,134.28, depending on site, number of appointments and individual client situation (Austin, 2016).

Fuel poverty

Living in a home that is too cold has significant impacts on health. These include (Earth, 2011):

- More cardiovascular and respiratory disease
- Higher rates of excess winter deaths
- Paediatric respiratory problems
- Mental health problems
- Exacerbation of arthritis and rheumatism
- Reduced dexterity leading to more accidents within the home

Fuel poverty has also been demonstrated to be associated with poor child educational attainment and family dietary opportunities and choices (Earth, 2011).

The latest data from 2013 estimates that 21800 people in Oxfordshire live in fuel poverty, accounting for 8.2% of the total population (Council, Joint Strategic Needs Assessment, 2016). This is broadly similar to the previous two years, and is also similar to the regional average (Council, Joint Strategic Needs Assessment, 2016). Oxford has the greatest proportion of people living in fuel poverty at around 1 in 10 people (Council, Joint Strategic Needs Assessment, 2016).

Car ownership

Car ownership, particularly in rural areas, is an important factor influencing access to services. More people living in rural areas own cars compared to those living in urban areas in Oxfordshire

(see tables 2 and 3) (Statistics O. f., 2011 Census, 2011). Over half of urban households consisting of a lone older person in Oxfordshire and over a third of urban lone parent households do not have a car (see figure 1) (Statistics O. f., 2011 Census, 2011).

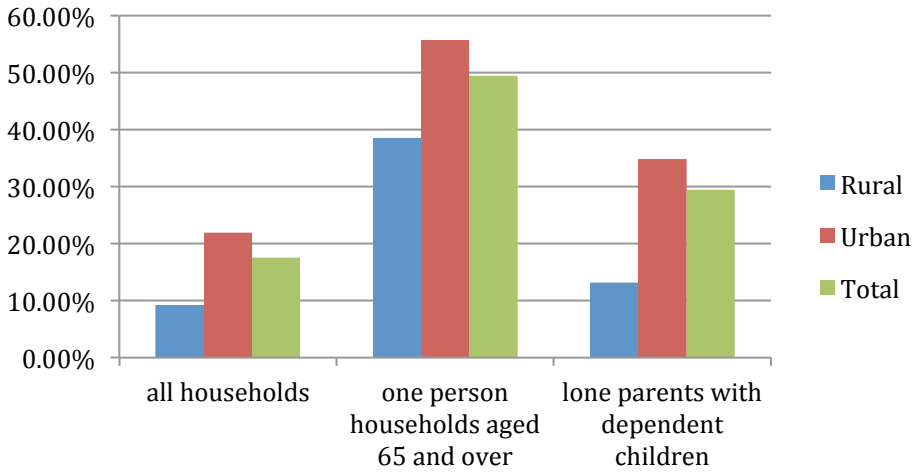
Table 10 Car ownership in urban wards

Urban Wards			
	With car	No car	% no car
Cherwell	1,515	2,373	61%
Oxford	2,333	3,716	61%
South Oxfordshire	1,732	1,624	48%
Vale of White Horse	1,878	1,898	50%
West Oxfordshire	882	891	50%
Oxfordshire total	8,340	10,502	56%

Table 11 Car ownership in rural wards (no wards in Oxford classified as rural)

Rural Wards			
	With car	No car	% no car
Cherwell	1,362	717	34%
Oxford	-	-	-
South Oxfordshire	2,011	1,203	37%
Vale of White Horse	1,297	874	40%
West Oxfordshire	2,092	1,454	41%
Oxfordshire total	6,762	4,248	39%

Figure 6 Percent of households without a car



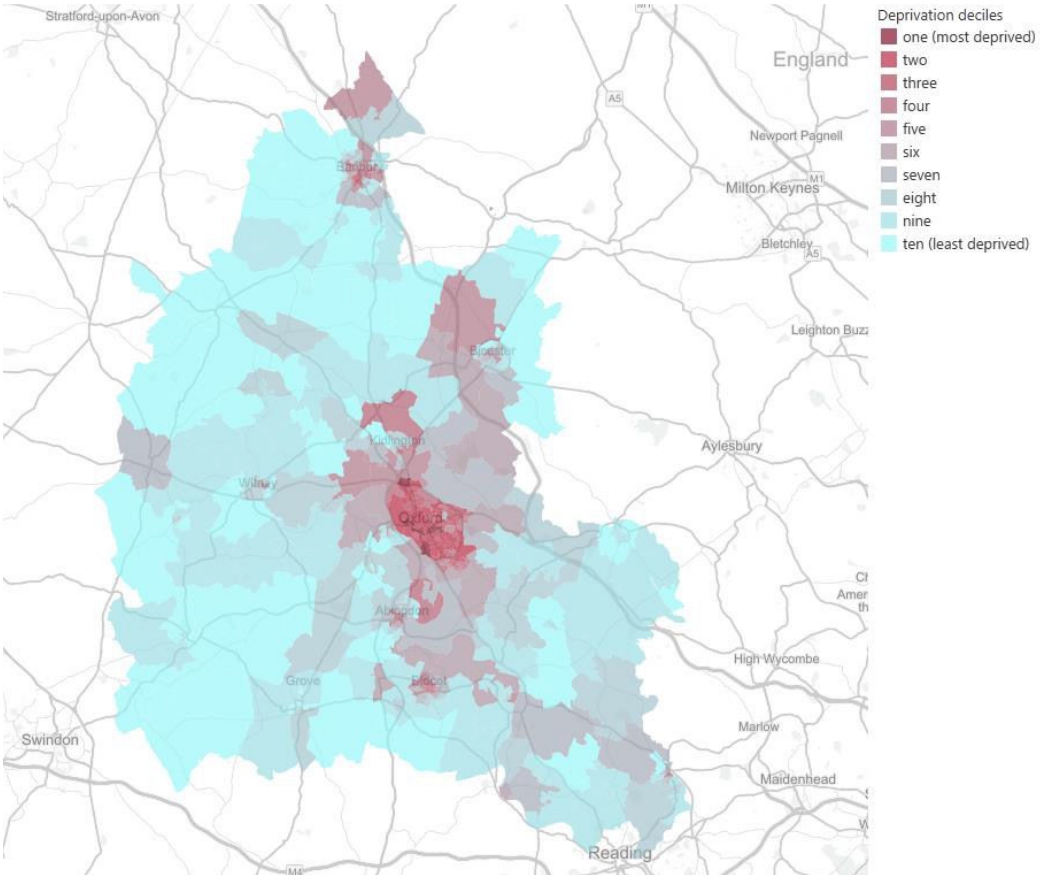


Figure 7 Map of outdoor environment deprivation in Oxfordshire (Council, Joint Strategic Needs Assessment, 2016)

Environment

Living environment deprivation is measured by the Index of Multiple Deprivation and includes indicators such as lack of central heating, poor quality housing, air quality and road traffic accidents (Statistics O. o., Index of Multiple Deprivation Technical Report 2015, 2015). The majority of lower super output areas that are in the top 10-20% most deprived in terms of environment are in Oxford City (see figure 2).

Access to and use of outdoor green spaces has been demonstrated to have positive impacts on physical health, mental wellbeing and cognitive functioning (Council, Joint Strategic Needs Assessment, 2016). The latest data from March 2013 to February 2014 estimated that the proportion of people in Oxfordshire using outdoor space had fallen from 19.4% (in 2012/13) to 15.7% (Council, Joint Strategic Needs Assessment, 2016). It is difficult to say whether this is a statistically significant difference or just due to small year on year changes, but nevertheless can be seen as a sign that use of outdoor space can be improved.

2. Protected Characteristic Data Sources

Gypsies and Travellers

Gypsies and Travellers are protected from discrimination by the Race Relations Amendment Act 2000 and the Human Rights Act 1998 (About the travelling community, 2016). The 2011 Census indicated that 600 people in Oxfordshire identified their ethnic background as White Gypsy or Irish Traveller (Council, Joint Strategic Needs Assessment, 2016). There are 6 permanent sites in Oxfordshire for gypsies and travellers, providing 89 pitches for caravans (About the travelling community, 2016). Oxon and Bucks Gypsy and Traveller Service currently provides support for residents of and local communities surrounding permanent and unauthorised sites (About the travelling community, 2016).

The last health needs assessment for this group was conducted in 2011 and found several barriers to accessing services including scepticism and negative views towards healthcare, concerns over a lack of same-sex practitioner GP appointments and fears of discrimination (Bagaria, 2011).

LGBTQ

The term Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) designates a community with a culture based on sexual or gender identity. Data on sexual orientation is not captured on national census but is included on the Integrated Household Survey. The 2014 survey indicates that 92.6%

of people in the South East identify themselves as heterosexual, 1% gay or lesbian, 0.5% bisexual and 0.4% other; the remainder chose not to identify their sexual orientation (Council, Joint Strategic Needs Assessment, 2016). Local level data is not available.

Other areas in England have conducted needs assessments for the health of the LGBTQ community (Devon, 2014) (Network, 2013) (Wirral, 2012). Common issues raised included:

- Sexual health
    - Higher rates of sexually transmitted diseases and cervical cancer
    - Women identifying themselves as lesbian less likely to access cervical screening
- Mental health
    - Greater proportions of the community reporting suffering from depression and anxiety than the general population
    - Higher rates of self harm and suicide attempts
    - Experiences of negative or mixed reactions from mental health professionals
- Risk behaviours

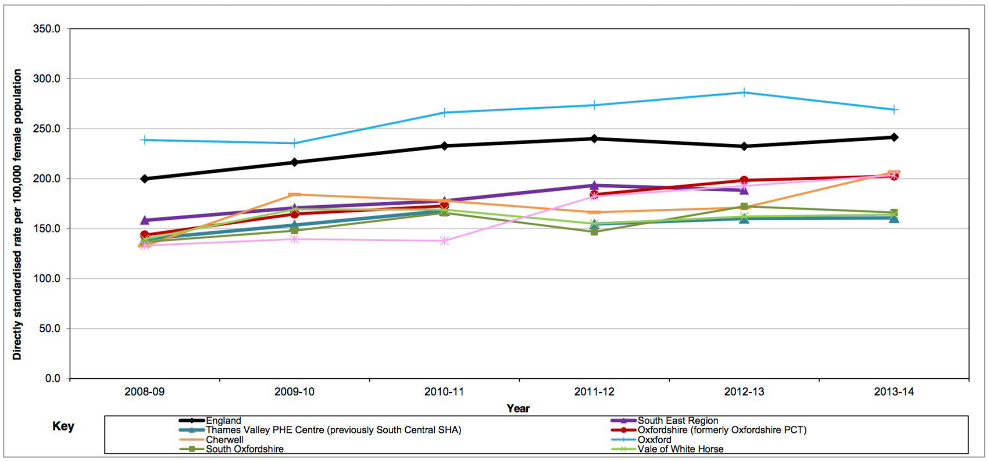
Alcohol data on hospital admissions (Source Emily Phipps)

Females:

Unique ref: B-005b

Directly age-standardised rate of alcohol-specific hospital admissions in females- 2005/06 to 2013/14
England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire

RAG rating: Needs monitoring



Definitions and data quality		
	Definition	Directly standardised rate per 100,000 - females admitted to hospital due to alcohol-specific conditions (all ages),. Does not include attendance at A&E. Conditions included are only those wholly attributable (100%) to alcohol (2014 version): E24.4 Alcohol-induced pseudo-Cushing's syndrome; F10 Mental and behavioural disorders due to use of alcohol; G31.2 Degeneration of nervous system due to alcohol; G62.1 Alcoholic polyneuropathy; G72.1 Alcoholic myopathy; I42.6 Alcoholic cardiomyopathy; K29.2 Alcoholic gastritis; K70 Alcoholic liver disease; K85.2 Alcohol-induced acute pancreatitis; K86.0 Chronic pancreatitis (alcohol induced); Q86.0 Fetal alcohol syndrome (dysmorphic); R78.0 Excess alcohol blood levels; T51.0 Ethanol poisoning; T51.1 Methanol poisoning; T51.9 Toxic effect of alcohol, unspecified; X45 Accidental poisoning by and exposure to alcohol; X65 Intentional self-poisoning by and exposure to alcohol; Y15 Poisoning by and exposure to alcohol, undetermined intent; Y90 Evidence of alcohol involvement determined by blood alcohol level; Y91 Evidence of alcohol involvement determined by level of intoxication. These should not be confused with alcohol-related conditions which include alcohol-specific conditions (listed above) plus the percentage contribution alcohol makes to other conditions e.g. stomach cancer, diabetes or ischaemic heart disease.
	Source	Public Health England Local Alcohol Profiles
	Numerator	Females, resident in the area, admitted to hospital where the primary diagnosis or any of the secondary diagnoses contain one of the listed conditions specific to alcohol misuse - females all ages, for relevant year.
	Denominator	Office for National Statistics (ONS) mid-year population estimates by five year age band (females).
	Strengths & Limitations	1. Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. All cases (100%) are caused by alcohol. 2. Hospital admission data can be coded differently in different parts of the country. In some cases details of patient's residence are insufficient to allocate patient to a particular area and in other cases patient has no fixed abode. These cases are included in England total but not in LA or regional figures. 3. In 2014, alcohol-attributable fractions applied to mortality and hospital admission data were updated to take into account new epidemiological evidence for the association between alcohol consumption and health-related outcomes. This exercise resulted in some important changes to the number of health conditions and external causes that are identified as being alcohol-related and also a recalculation of the attributable fractions for some of the existing health measures. Data for previous years back to 2008/09 are recalculated based on these new figures. 4. Children under 16 years were included if they had an alcohol-specific diagnosis (meaning alcohol consumption was a contributory factor in all cases). 5. Oxfordshire PCT no longer exists following Health & Social Care Act 2012. Data is not provided at a county level.
	Latest available data	2013-14
	Next available data	Jun-15, Jul-15, Aug-15, Sep-15, Oct-15, Nov-15, Dec-15, Jan-16, Feb-16, Mar-16, Apr-16, May-16, Jun-16: 2014-15, Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17
Epidemiological Facts	Time Trend	1. The general trend for alcohol-specific admissions rates in females is increasing across all areas. 2. There is more fluctuation at district level due to the relatively low numbers.
	Benchmarking Outside Oxfordshire	1. South Oxfordshire, Vale of White Horse and, until recently, Cherwell have significantly lower rates than England. West Oxfordshire is lower but not significantly so. 2. Rates in Oxford City are higher than England (and in 2012-13 they were significantly higher).
	Benchmarking within Oxfordshire	1. Oxford City has a significantly higher rate than Oxfordshire overall. It is also signficantly higher than South Oxfordshire and Vale of White Horse districts.
Expert interpretation and conclusions with additional information		1. National and local figures show an increase over the first part of this time period in the number of women admitted to hospital with "alcohol-specific" conditions. These conditions are a direct result of alcohol consumption and are often related to high consumption levels. This is defined as harmful drinking which includes alcohol dependency ("alcoholism"). Continued upward trends in the consumption of alcohol at a population level and the relative affordability of alcohol may mean that upward trends are likely to continue. 2. There is some variation across the local district areas - the rate of admission for women from Oxford City are higher than national and other district rates; the most recent data indicates this is now significant. Oxford hosts medical facilities for homeless people (many of whom are dependent drinkers) and this may partially explain the higher rates in Oxford. 3. There was a total number of 670 alcohol-specific admissions in women in 2013/14 in Oxfordshire. Individuals may have been admitted more than once so the number of people will be equal to or less than this. 4. The chart B-005a shows that admission rates for men with alcohol-specific conditions are higher than for women. Whilst the rates for men appear to be levelling off, in women the trend appears ot be upwards. 5. There should be a concentration on services that minimise the harm caused by alcohol. 6. The ready supply of cheap alcohol, relaxed licensing laws and public attitudes mean that persuading people to decrease consumption is unlikely to be effective. 7. Nonetheless we should persevere with prevention messages to the general population and continue to monitor this indicator, hence the RAG rating is amber.

Directly age-standardised rate of alcohol-specific hospital admissions in females- 2005/06 to 2013/14
England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire

Table

Year	England					South East Region					South Central SHA Thames Valley PHE Centre				
	Pop*	Num	Rate	LCI	UCI	Pop*	Num	Rate	LCI	UCI	Pop*	Num	Rate	LCI	UCI
2008-09		52315	199.7	198.0	201.4		6765	158.2	154.5	162.1			139.5		
2009-10		56945	216.2	214.4	218.0		7321	170.6	166.7	174.5		3230	153.5	148.1	158.9
2010-11		61538	232.5	230.7	234.4		7691	177.6	173.7	181.6		3593	167.8	162.3	173.5
2011-12	26974	63830	240.0	238.1	241.8		8417	193.3	189.1	197.5	1022	1537	154.5	146.8	162.5
2012-13	27160	62028	232.3	230.4	234.1		8245	188.4	184.3	192.5	1031	1602	160.1	152.3	168.2
2013-14	27332	64655	241.3	239.4	243.2	Data are no longer supplied at this level					1040	1620	160.7	152.9	168.8

Year	Oxfordshire PCT Oxfordshire						Cherwell						Oxford City					
	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En
2008-09			143.4			L		93	132.6	106.8	163	L		169	238.6	201.1	280.7	
2009-10		528	164.6	150.7	179.5	L		129	184.0	153.4	219.0			172	235.3	198.5	276.6	
2010-11		564	172.6	158.4	187.7	L		126	177.8	147.9	211.9	L		194	266.0	226.8	309.6	
2011-12	330.7	605	183.9	169.5	199.3		71.88	118	166.3	137.4	199.4	L	75.48	194	273.4	233.3	318.0	
2012-13	333.3	650	198.1	183.1	214.1		72.21	118	171.0	141.3	205.1	L	76.56	214	286.2	246.0	330.7	H
2013-14	335.5	670	202.6	187.5	218.7		72.61	150	206.7	174.6	242.8		77.09	205	269.0	230.2	312.0	

Year	South Oxfordshire						Vale of White Horse						West Oxfordshire					
	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En
2008-09		90	136.6	109.6	168.2	L		83	139.4	111	173.1	L		66	133.0	102.4	169.7	L
2009-10		98	147.9	119.8	180.6	L		101	169.2	137.6	205.9	L		68	139.5	109.2	175.4	L
2010-11		110	165.7	135.7	200.2	L		100	168.9	137.2	205.7	L		71	137.7	107.3	174.0	L
2011-12	68.54	98	146.6	118.8	178.9	L	61.23	94	154.8	124.9	189.7	L	69.07	99	182.1	147.7	222.1	L
2012-13	68.84	114	172.2	141.7	207.1	L	61.55	99	162.1	131.5	197.5	L	62.09	104	192.7	157.1	233.8	
2013-14	69.07	110	166.1	135.9	200.9	L	62.09	100	164.0	133.1	199.9	L	54.68	110	203.4	166.7	245.8	

EN is England
* figures in thousands
LCI is lower limit of 95% confidence interval.
UCI is upper limit of 95% confidence interval.

Following the Health and Social Care Act 2013, some NHS organisations changed - South Central Strategic Health Authority and Oxfordshire Primary Care Trust no longer exist. Data are now provided at a county level and Thames Valley Public Health England Centre is included for a more regional picture..

Key:

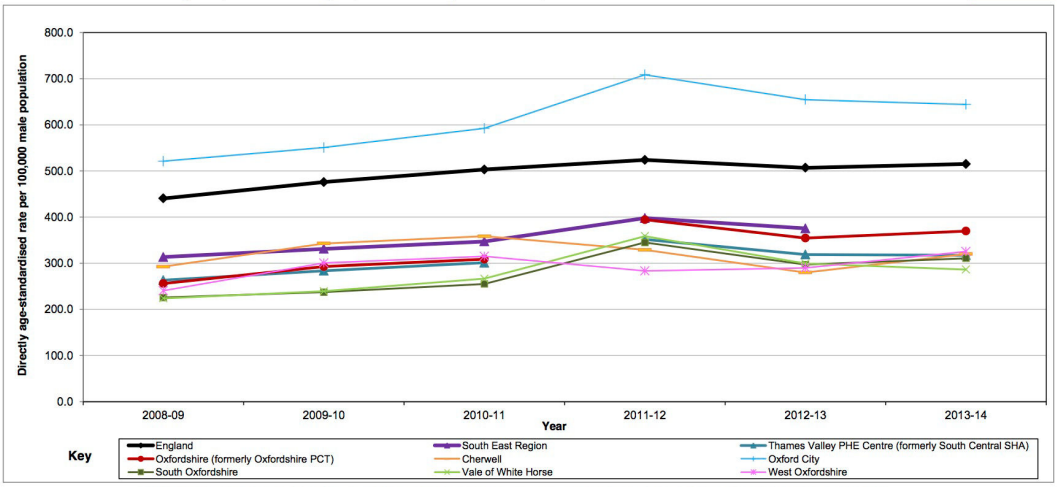
Rate suggests significantly higher rate compared to Oxfordshire rate.
Rate suggests significantly lower rate compared to Oxfordshire rate.
H suggests significantly higher rate compared to England rate.
L suggests significantly lower rate compared to England rate.

Males

Unique ref: B-005a

RAG rating: Needs monitoring

Directly age-standardised rate of alcohol-specific hospital admissions to males- 2005/06 to 2013/14
England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire



Definitions and data quality	**Definition**	Directly standardised rate per 100,000 - males admitted to hospital due to alcohol-specific conditions (all ages),. Does not include attendance at A&E. Conditions included are only those wholly attributable (100%) to alcohol (2014 version): E24.4 Alcohol-induced pseudo-Cushing's syndrome; F10 Mental and behavioural disorders due to use of alcohol; G31.2 Degeneration of nervous system due to alcohol; G62.1 Alcoholic polyneuropathy; G72.1 Alcoholic myopathy; I42.6 Alcoholic cardiomyopathy; K29.2 Alcoholic gastritis; K70 Alcoholic liver disease; K85.2 Alcohol-induced acute pancreatitis; K86.0 Chronic pancreatitis (alcohol induced); Q86.0 Fetal alcohol syndrome (dysmorphic); R78.0 Excess alcohol blood levels; T51.0 Ethanol poisoning; T51.1 Methanol poisoning; T51.9 Toxic effect of alcohol, unspecified; X45 Accidental poisoning by and exposure to alcohol; X65 Intentional self-poisoning by and exposure to alcohol; Y15 Poisoning by and exposure to alcohol, undetermined intent; Y90 Evidence of alcohol involvement determined by blood alcohol level; Y91 Evidence of alcohol involvement determined by level of intoxication. These should not be confused with alcohol-related conditions which include alcohol-specific conditions (listed above) plus the percentage contribution alcohol makes to other conditions e.g. stomach cancer, diabetes or ischaemic heart disease.
	Source	Public Health England Local Alcohol Profiles for England
	Numerator	Males, resident in the area, admitted to hospital where the primary diagnosis or any of the secondary diagnoses contain one of the listed conditions specific to alcohol misuse - males all ages, for relevant year.
	Denominator	Office for National Statistics (ONS) mid-year population estimates by five year age band (males).
	Strengths & Limitations	1. Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. All cases (100%) are caused by alcohol. 2. Hospital admission data can be coded differently in different parts of the country. In some cases details of patient's residence are insufficient to allocate patient to a particular area and in other cases patient has no fixed abode. These cases are included in England total but not in LA or regional figures. 3. In 2014, alcohol-attributable fractions applied to mortality and hospital admission data were updated to take into account new epidemiological evidence for the association between alcohol consumption and health-related outcomes. This exercise resulted in some important changes to the number of health conditions and external causes that are identified as being alcohol-related and also a recalculation of the attributable fractions for some of the existing health measures. Data for previous years back to 2008/09 are recalculated based on these new figures. 4. Children under 16 years were included if they had an alcohol-specific diagnosis (meaning alcohol consumption was a contributory factor in all cases). 5. Oxfordshire PCT no longer exists following Health & Social Care Act 2012. Data is not provided at a county level.
	Latest available data	2013-14
	Next available data	Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | **Jun-16** | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 2014-15
Epidemiological Facts	**Time Trend**	1. The general trend for alcohol-specific admissions rates among males was increasing across all areas. For the most recent data points all areas appear to have levelled off but it is too soon to tell if this will be a continuing trend.
	Benchmarking Outside Oxfordshire	1. Oxfordshire and all districts in Oxfordshire, except Oxford City, have a significantly lower rate than England. 2. Oxford City has a significantly higher rate than England.
	Benchmarking within Oxfordshire	1. Oxford City has a significantly higher rate of alcohol-specific hospital admissions for males than all other districts in Oxfordshire. 2. For the most recent data point (2013/14) Vale of White Horse has a significantly lower rate than Oxfordshire overall.
Expert interpretation and conclusions with additional information		1. National and local figures show an increase at the beginning of this time period; the most recent data points indicate that the number of men admitted to hospital with "alcohol-specific" conditions may be levelling off. These conditions are a direct result of alcohol consumption and are often related to high consumption levels. This is defined as harmful drinking which includes alcohol dependency ("alcoholism"). Continued upward trends in the consumption of alcohol at a population level and the relative affordability of alcohol indicated that the upward trend would continue. However the most recent data indicates a slight levelling but it is too early to know if this is a new trend. 2. There is variation across the district areas - the rate of admission for men from Oxford City are significantly higher than other districts in Oxfordshire and are significantly higher than national rates. Oxford hosts medical facilities for homeless people (many of whom are dependent drinkers) and this may partially explain the higher rates in Oxford but overall it must be concluded that there are higher rates in the general population of men. 3. There was a total number of 1165 alcohol-specific admissions for men in 2013/14 in Oxfordshire. Individuals may have been admitted more than once so the number of people will be equal to or less than this. 4. The chart B-005b shows that admission rates for women with alcohol-specific conditions are lower than for men ; however rates for women in Oxford City are now significantly higher than national figures. 5. There should be a concentration on services that minimise the harm caused by alcohol. 6. The ready supply of cheap alcohol, relaxed licensing laws and public attitudes mean that persuading people to decrease consumption is unlikely to be effective. 7. Nonetheless we should persevere with prevention messages to the general population and continue to monitor progress, hence the RAG rating is amber.

Directly age-standardised rate of alcohol-specific hospital admissions to males- 2005/06 to 2013/14
England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire

Table

Year	England					South East Region					South Central SHA / Thames Valley PHE Centre					Oxfordshire PCT / Oxfordshire (county)						Cherwell						Oxford City						South Oxfordshire						Vale of White Horse						West Oxfordshire					
	Pop*	Num	Rate	LCI	UCI	Pop*	Num	Rate	LCI	UCI	Pop*	Num	Rate	LCI	UCI	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En	Pop*	Num	Rate	LCI	UCI	En
2008-09		108459	440.4	437.8	443.1		12579	313.5	308.9	318.1			263.8				266.0						196	292.7	252.5	337			319	521.2	460.8	586.9			140	225.7	189.5	266.7			128	224.0	187	267			121	240.7	199.4	288.1	
2009-10		118102	475.9	473.1	478.6		13374	331.2	325.9	336.9		5993	283.6	276.4	290.9		930	292.5	274.2	312.4	L		234	342.6	299.6	390.5	L		341	599.8	538.6	665.8	H		152	237.3	200.8	278.6	L		136	238.4	200.8	283.1	L		149	300.6	253.8	353.5	L
2010-11		125684	503.2	500.4	506.0		14147	347.3	341.8	353.1		6464	301.2	293.8	308.6		1002	308.9	289.9	328.8	L		242	358.6	314.2	407.4	L		357	592.4	527.0	663.2	H		163	255.2	217.3	297.8	L		158	266.7	225.7	312.8	L		156	314.9	267.0	368.9	L
2011-12	26133.2	131517	524.0	521.1	526.8	1003	16262	398.0	391.8	404.2	1003	3267	351.0	339.7	364.4	324.1	1190	394.5	371.9	418.0	L	70.4	218	329.0	285.7	377	L	74.8	409	706.5	636.1	786.6	H	66.42	220	345.1	300.6	394.2	L	80.66	203	368.8	310	413	L	51.91	142	287.4	238.4	334.3	L
2012-13	26333.4	127850	508.9	504.1	509.8		15484	375.5	369.6	381.5	1012	3003	318.0	307.4	330.7	327.4	1120	354.5	333.7	376.2	L	70.6	191	280.7	241.3	325	L	76.0	418	654.5	587.5	726.5	H	66.71	190	297.1	256.1	342.8	L	61.21	178	299.7	257	347	L	52.95	150	290.1	245.3	340.7	L
2013-14	26534	130590	515.1	512.2	517.9			Data no longer supplied at this level			1021	3029	317.1	306.1	329.2	330.5	1165	369.8	348.8	391.9	L	71.0	215	320.1	278.5	366	L	77.7	415	644.1	578.5	714.7	H	66.95	200	310.8	269.1	357.0	L	61.55	169	286.5	244	334	L	53.31	170	325.5	278.0	376.9	L

EN is England
* figures in thousands
LCI is lower limit of 95% confidence interval.
UCI is upper limit of 95% confidence interval.

Following the Health and Social Care Act 2013, some NHS organisations changed - South Central Strategic Health Authority and Oxfordshire Primary Care Trust no longer exist. Data are now provided at a county level and Thames Valley Public Health England Centre is included for a more regional picture.

Key:

Rate: suggests significantly higher rate compared to Oxfordshire rate.
Rate: suggests significantly lower rate compared to Oxfordshire rate.

H suggests significantly higher rate compared to England rate.
L suggests significantly lower rate compared to England rate.

Appendix 4: Commission Members

Member	Biography
Professor Sian Griffiths OBE (Chair)	Trained as a doctor Professor Griffiths practiced as a service based public health physician at local, regional and national level in the UK. Sian co chaired the HKSAR governments inquiry into the 2003 SARS epidemic whilst President of the UK Faculty of Public Health. In 2005 she moved to her academic career as Director of the School of Public Health and Primary Care and Founding Director of Centre for Global Health at the Chinese University of Hong Kong.. She remains Senior Adviser on International Academic Development to the Vice Chancellor and Emeritus Professor at CUHK.In the UK she has been Associate Board member for Public Health England since 2014,chairing PHE's Global Health Committee .She is Visiting Professor at the Institute of Global Health Innovation at Imperial College, London, Trustee of the Royal Society of Public Health and chairs the Board of the Centre for Health and Development [CHAD]at Staffordshire University .
Allison Thorpe (project manager and secretariat)	Allison is a freelance researcher/Prince 2 project manager, with extensive experience of working on public health projects at a range of levels within the health system. Since 2010, when she was awarded a Global Research Report Fellowship for TDR/WHO, she has undertaken multiple time limited research projects on a broad range of areas. She is an experienced researcher, who has utilised quantitative and qualitative skills to undertake both academic studies, and more pragmatic outcome focused studies.
Dr Joe McManners	Joe has been a GP for 11 years. For the past 9 years, he has been a partner at a GP practice in Oxford where he has joint responsibility for the running of the practice. He is also a GP trainer. He was elected Oxfordshire CCG Clinical Chair in February 2014. Oxfordshire CCG is one of the biggest CCGs in the country with a population of 650,000 patients and a budget circa £700 million. Previously he had been the Clinical Director for Oxford City Locality, and a member of the CCG Governing Body. He previously was also Clinical Lead for older people. He is Vice Chair of Oxfordshire Health and Wellbeing Board.

Member	Biography
	His priorities as Chair of Oxfordshire CCG are; integrating health and social care for local population management, tackling health inequalities and building a sustainable primary care led system. He has a Masters degree in Public Policy in 2005, and is a King's Fund Associate in Clinical Leadership. For 7 years he was a Local Councillor in Oxford City, and for 3 of those years had executive responsibility for housing. In whatever spare time not taken up by work or family, he likes to relax by getting out cycling around Oxfordshire.
Professor Trish Greenhalgh	Trish Greenhalgh is Professor of Primary Care Health Sciences and Fellow of Green Templeton College at the University of Oxford. She studied Medical, Social and Political Sciences at Cambridge and Clinical Medicine at Oxford before training as an academic GP. She has previously worked at University College London (1986-2010) and Barts and the London School of Medicine and Dentistry (2010-2014). Trish leads a programme of research at the interface between the social sciences and medicine. Her work seeks to celebrate and retain the traditional and the humanistic aspects of medicine and healthcare while also embracing the unparalleled opportunities of contemporary science and technology to improve health outcomes and relieve suffering. Three particular interests are the health needs and illness narratives of minority and disadvantaged groups; the introduction of technology-based innovations in healthcare; and the complex links (philosophical and empirical) between research, policy and practice. She is the author of 250 peer-reviewed publications and 8 textbooks. She was awarded the OBE for Services to Medicine by Her Majesty the Queen in 2001 and made a Fellow of the Academy of Medical Sciences in 2014.
Cllr Ed Turner	Ed Turner is Deputy Leader of Oxford City Council, leading on Finance, Corporate Assets and Public Health. He has represented Rose Hill and

Member	Biography
	Iffley on the authority since 2002, overseeing a major regeneration project in his ward. Alongside his council role, he is Senior Lecturer and Head of Politics and International Relations at Aston University, Birmingham. He has published widely on German politics and, more recently, has developed a specialisation in the areas of housing and planning. He has served on three major national reviews of housing policy: the Harman Review, the Technical Housing Standards Review and, most recently, the Lyons Review. As such, he is particularly interested in the relationship between bad housing and poor health, and the role of housing improvement in narrowing health inequalities
Paul Cann	Paul Cann joined Age Concern (now Age UK) Oxfordshire as its Chief Executive in April 2009. Age UK Oxfordshire works at grassroots level to help older people and their families live in comfort, with support and enjoying opportunities to live life to the full. Paul read English Literature at King's College Cambridge, also holding a Choral Scholarship. After teaching for five years, he joined the Civil Service where he held a range of postings at the Cabinet Office, including working as a Private Secretary to successive Cabinet Ministers, including the Minister for the Arts. A subsequent spell in the private sector included working for 'The Independent' newspaper. He joined the charity world in 1992 as Director of the British Dyslexia Association and subsequently of the National Autistic Society. He was a Trustee of the disability charity Contact a Family for five years, a charity which supports carers and people with special needs or disabilities. From 2000 to his arrival at Age Concern Oxfordshire he was Director of Policy and External Relations at Help the Aged, where he had responsibility for research, policy, international strategy, media and external relations. He brought together research and policy, and was particularly involved in Help the Aged's work on pensioner poverty, social exclusion and care issues. As Director with responsibility for international affairs, he helped to reshape the charity's international programme and increased Help the Aged's own profile and activity.

Member	Biography
	From 2004-07 Paul held a Visiting Fellowship at the Oxford Institute of Ageing. In 2008 Paul was awarded the medal of the British Geriatrics Society for an outstanding contribution to the well-being of older people. In 2009 he was appointed an Associate Fellow of the International Longevity Centre and also in that year a Charter Member of the charity Independent Age. He co-edited 'Unequal Ageing (Policy Press, 2009), which examines in turn the injustice and inequalities experienced by older people in income, housing, health, and many other aspects of daily life. Paul chairs the Public Policy Panel of the national charity Age UK. He and Age UK Oxfordshire are founding members of the national Campaign to End Loneliness. He is a Board member of NDTi, an agency promoting social inclusion across all ages and stages. A keen singer and lover of the arts, and a Director of Creative Dementia Arts Network, (CDAN), Paul believes that "the arts" should be at the centre of our lives and public policy; taking part in the arts simulates, connects, fulfils us and makes us happy. The charity's project www.ageofcreativity.co.uk aims to promote and celebrate arts activities of all kinds and their value to older people across the UK and beyond.
Richard Lohman	Richard Lohman has been a director on the board of Healthwatch Oxfordshire and its predecessor 'Oxfordshire LINK' since 2008. Richard is a registered and qualified social worker with a Masters in Advanced Social Work with Adults. He was a founding member of Unison's National LGBT Committee and has 15 years NHS experience serving people undergoing homelessness. Richard is the Healthwatch representative on the Faculty of General Dental Practitioners Lay and Patient panel.
Andrew Stevens	Andrew joined the NHS in 1982 as a national general management trainee. After posts in North Wales and Manchester, he spent two years in a public and patient engagement role as Secretary of the Community Health Council in Swindon.

Member	Biography
	Andrew moved to Hampstead Health Authority in 1988 and undertook a variety of senior planning-related roles in the hospital and community sectors. He project-managed the Royal Free's first wave NHS Trust application before becoming the Trust's Director of Business Planning. Andrew joined what was then the Oxford Radcliffe Hospitals NHS Trust (ORH) in 1999. He was the ORH lead for its merger with the Nuffield Orthopaedic Centre, which resulted in the creation of the Oxford University Hospitals NHS Trust (OUH). Andrew heads up the Trust's planning, commissioning, IM&T and media and communications functions. He also leads the Trust's developing public health activities. He was the lead executive for the OUH's NHS Foundation Trust application process and for the implementation of the Trust's Electronic Patient Record.
Tamsin Jewell	Tamsin has worked with and for a wide range of organisations from charities like Crisis and Oxfordshire Mind to large international bureaucracies like UNAIDS. Social work trained, her career spans social and development work in the UK and internationally, with a focus on health – both mental and physical – forced migration and human rights. Tamsin has been at Elmore Community Services since April 2015.
Dan Leveson	Dan is currently Associate Director of Strategy and OD at Oxford Health NHS FT. He has a long history of working in international development and health, working for Oxfam GB and Goal, managing emergency and post conflict humanitarian programmes in Afghanistan, Ethiopia, Bosnia-Herzogovena, various countries in West Africa and the Democratic Republic of the Congo
Cllr Hilary Hibbert-Biles	Hilary has been a County Councillor since 2005. She has been a member of the planning committee at both District & County. Hilary has been the vice chairman of the County Council 2009-10 and the Chairman of the County Council 2010-11. She has also held the post of Cabinet Member for the Environment. She is also on the Health Improvement Board as well as the Health & Wellbeing Board and the Childrens Board (now called the Childrens Trust). She was a West Oxfordshire District Councillor from 2002-2014 holding cabinet positions

Member	Biography
	covering Health, Housing, Leisure & Tourism, Children & Young people. She enjoys spending time with her family and gardening. Hilary is married with two daughters and two grandchildren

Appendix 5: List of people who submitted evidence to each session and overall

Submissions to the Commission
Beginning Well • Teenage Cancer Trust • Children's Centres • James Plunkett • National Deaf Children's Society • OxSPA • Brighter Futures • Individual responses from Barton and Farringdon residents • Perinatal care Group • MIND
Living Well • Bicester Healthy New Town • Luther Street • Terrence Higgins Trust • West Oxon District Council • OxSPA
Ageing Well
• Susanna Pressel (Cllr) • Eynsham Medical Practice - Teresa Young • South Oxfordshire District Council and the Vale of White Horse District Councils, • Amalgamated responses from Oxford City Locality meeting – responses from GPs • Getting the picture and the Chinese Happy Centre • Age Concern Oxford • Cherwell District Council • Oxspa
Cross Cutting themes • Getting the picture and the Happy Place Centre • Oxford City Council • Gene Webb • Oxford County Council Transport Team • Oxford Child Poverty Action Group • Oxford County Council Department of Adult Social Services • Asylum Welcome • Citizens Advice Bureau • GP responses • Oxford Association for the Blind • Oxford Health • Luther Street • Good Food Oxford • Connections Floating Support Team • Clockhouse • Refugee Resources • Elmore Community Services

Appendix 6 List of organisations/people who presented to the commission

Organisations who presented to the Commission
Beginning Well
Perinatal group Brighter Futures Partnership The Oxford Academy Banbury Children's Centres OxSPA Community paediatrics team Yippee Meeting – Oxford Radcliffe Hospitals Patient Participation Group Meeting with Oxford County Council Youth Group
Living Well
Bicester Healthy New Town Luther Street Terrence Higgins Trust West Oxon District Council OxSPA Unipart
Ageing Well
Eynsham Medical Practice Getting the Picture and the Friendleys Age UK Generation Games Healthwatch UK
Cross Cutting themes

Housing and homelessness:

- Luther Street Medical Practice
- Connections Floating Support Team
- Oxford City Council

Transport

- Oxfordshire County Council
- Gene Webb – Member of the public

Ethnic inequalities

- Getting the Picture and Chinese Happy Centre
- Asylum Welcome
- Refugee Resource

Benefits:

- CAB

Social Care

- Adult Social Services

Physical and Mental health

- Oxford Health
- Clockhouse (dementia)
- Association for the blind

Other:

The Stroke Association

Elmore Community Services

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,H10,P01,P02,P03,P04,P05,P06,P07,P19,P20,P28,P21,P22,P23,P24,P25,P27,F01,F03,F02,F04,F05,F10,F11,F12,F13,F08,F09,F99,E15,E16,E17,E18,E19,E01,E02,E04,E05,E99,N00,N01,N02,N03,N04,N05,N06,N07,N08,N09,N10,N11,N12

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OSCB Annual Report 2015 - 2016

Oxfordshire Safeguarding Children Board
Annual report 2015-16

Contents

Annual Report Introduction

By Paul Burnett
Interim Chair

I am pleased to introduce the Annual Report for Oxfordshire Safeguarding Children Board 2015/16. The role of the OSCB is to make sure improvements continue to be made in protecting all children from harm across Oxfordshire. Safeguarding standards have been tested through the Stocktake Report on child sexual exploitation in 2015 and the Joint Targeted Area inspection in 2016. The findings from these reviews as well as our local knowledge have given Board members a clear view of how well child protection work is being managed but also clearer understanding of the pressures on the system due to the increased activity at the front door.

It is pleasing to see the commitment of colleagues across the safeguarding partnership, which has led to improvements in the transportation of vulnerable children, the services to our most vulnerable children who have been or are at risk of child sexual exploitation and progress made over the last year on work to support adolescents, which has included an increase of older children on child protection plans. It has also been invaluable to involve parents and victims in county wide learning events.

OSCB partners are mindful of ensuring that the needs of both younger and older children are met. Our quality assurance work highlights that we must address long term issues of neglect and protect children in families where domestic abuse, substance misuse and mental illness are prevalent. Going forward we need to keep a tight grip across the partnership on what is working well and where challenges are emerging and ensure organisations set clear baselines and targets for improvement.

Challenges lie ahead with the forthcoming Children and Social Work Bill 16/17. A new statutory safeguarding framework will be introduced, which will set out clear requirements, but give local partners the freedom to decide how they operate to improve outcomes for children. I believe that we are in a sound position as a Board to meet these requirements, provide scrutiny and give assurance that safeguarding children in Oxfordshire is at the forefront for all organisations.

Chapter 1: Local Safeguarding Context

Oxfordshire Demographics

There are 141,200 young people aged under 18 in Oxfordshire. This population has grown by 6% in the last ten years – mainly in urban areas where the majority of new housing has been developed. An estimated 14% of under18s are from minority ethnic backgrounds, with considerable differences across the districts, the figure rising to 35% in Oxford City.

Based on the IDACI (income deprivation affecting children) rankings, Oxfordshire is relatively prosperous and is the 14th least deprived upper tier local authority area (out of 152 in the country). There are areas of deprivation in the urban centres of Oxford and Banbury, with further pockets in Abingdon and Didcot.

Oxfordshire performs above both national and statistical neighbour averages for the proportion of both primary and secondary schools judged as good or outstanding. Despite this the proportion of outstanding schools in Oxfordshire continues to be lower than the national average. Persistent absence rates, permanent exclusions and fixed term exclusions in secondary schools continue to be a concern.

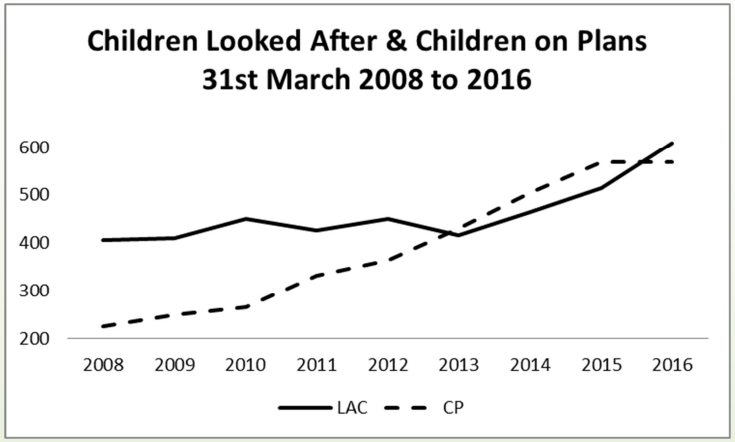
Early Help

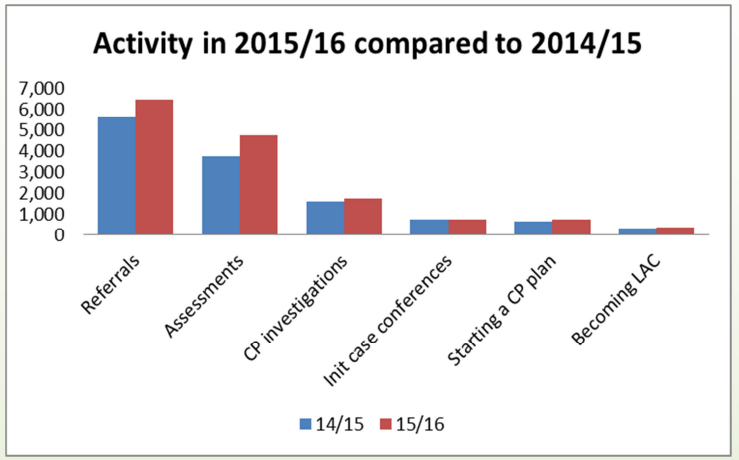
Early help assessments (CAFs) are completed and families are then supported by regular 'team around the child' (TACs) meetings to monitor progress. Support includes help for children where parents or carers misuse substances and help for those families when social care intervention ends. Last year early help work increased. There were 957 recorded CAFs and 912 recorded TACs; with schools predominantly taking the lead in this work. The number of under 5s reached in Oxfordshire i.e. seen at least once at an event or activity at any Oxfordshire children's centre in the financial year 2015-16 was 18,251 or 43.8% of the population of under 5s.

The Troubled Families initiative is working with the most vulnerable families. The initiative has identified 2,000 families with 925 having a named worker from a County Council service. Ofsted reported; '*It is intensive, well organised and cost effective and has led to clear improvement in the lives of particular families*.'
A longer term piece of work is underway to integrate early help and statutory work to support vulnerable children and families. The focus is on services for 'children in need' i.e. for those who meet the statutory thresholds for services but are not deemed to be at the level of significant harm which would warrant a child protection plan. The intention is to develop more robust early help and reduce the numbers of children who are escalated to children's social care.

Children with a child protection plan

Children who have a child protection plan are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of two or more of these. The plan details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how we will know when progress is being made. At the end of March 2016 there were 569 children subject to a plan. This was the same figure as 12 months previously and the first time in over 10 years that the figure did not rise. However this masks a considerable increase in activity. The graph below shows the increase in activity last year, which varies from 3 to 26%.





Activity levels are generally slightly below the national average, but above those of statistical neighbours and higher than we would expect for an authority which is the 14th least deprived in regard to children in the country. The OSCB has developed a 'report card' on the relatively high levels of activity within the system and a subsequent 'impact assessment' to consider what impact reduced budgets will have on the system.

20% of the child protection plans ended in the year because the child became looked after. The proportion of plans which did not end successfully (i.e. within 18 months and with the child remaining at home) has dropped in each of the last 3 quarters. So far this year 58% of children who become looked after have previously been subject to child protection planning looked after, 49% of them within the last 12 months.

The number of looked after children rose by 18% in the year. For comparison the national growth over the last 5 years has been 3% per annum.

Improvements that are made when a child is the subject of a child protection plan need to be sustained once the plan ceases. Understanding what happens once a child stops being the subject of a plan and ensuring improvements are sustained will be an area of focus in the coming year.

Children in care

Children in care are those looked after by the local authority. This rose by 15% in the year from 514 to 592. For comparison the national growth over the last 5 years has been 3% per annum. Despite this growth numbers remain comparatively low, the average for our statistical neighbours (the authorities that are most demographically similar to Oxfordshire) would by 600. 61% of all children becoming looked after had previously been the subject of a child protection plan - 49% within 12 months of their looked after episode beginning. 11% of children becoming looked after had been previously looked after. Understanding what happens once a child stops being the subject of a plan and ensuring improvements are sustained will be an area of focus in the coming year.

We want to ensure that where people are looked after, we keep our riskiest closest to home. We have managed to do this over the year. The number of children looked after and not placed in neighbouring authorities rose slightly (74 to 77). The biggest increase has been in children placed in foster care or with family and friends

Children leaving care

In Oxfordshire 346 care leavers (aged 17-21) are supported. 170 are in education, employment or training (49%). This is an improvement on last year and in line with the national average. Over a third of care leavers are in independent living, 14% with parents or relatives and 12% are in accommodation linked to their employment or training. None are in bed and breakfast or emergency accommodation.

Children who are privately fostered

The county council worked with a total of 140 private fostering arrangements. This is an increase from the previous year. International students make up the majority of referrals. There has been a decrease in the number of vulnerable children living with friends and distant relatives this has decreased from 28% last year to 23% this year. However, the county service remains focused on this group this year to ensure that the most vulnerable children are identified and supported. At the end of March 2016 the local authority were aware of 43 children living in a privately arranged foster placement, similar to last year (44) but up from 34 the end of March 2014.

Disabled Children

At the end of March 2015 there were 14 disabled children with a Child Protection Plan; this is in line with previous years

Children who offend

The children who are involved with Oxfordshire Youth Justice Service (YJS) often present with complex needs requiring significant support both in and out of custody. The YJS has the same amount of work as last year, 246 children received a substantive outcome (a caution or above) in 2014-15 and in 2015-16. The figures for the year 2015/16 (April to March) show “that the performance is satisfactory” and that we are “still better than both the regional and national rates”. There were 12 custodial episodes within the last year period. This is measured against the rate of young people per 1000 in the population. The custodial episodes arise out of serious episodes of offending/ repeat serious episodes of offending.

Children who are at risk of sexual exploitation

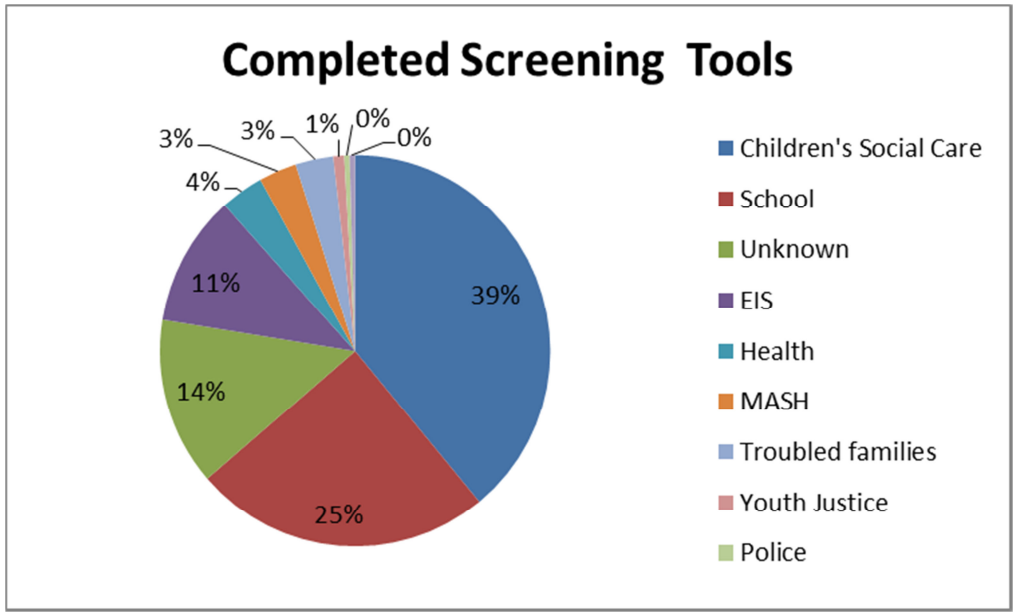
There are currently 280 children open to social care at the risk of CSE. 88 new assessments in 2015/16 identified a risk of CSE for a child in Oxfordshire. This reflected 2.5% of all social care assessments completed and was slightly below the national average of 3%. There was a 25% increase in CSE screening tools in the year (increasing from 178 to 223 There were 119 CSE crimes and a further 133 incidents which were not crimes (to the end of February). There were 13 arrests and 6 people charged. 11 child abduction warning notices were issued. The number of children open to social care at risk of CSE at the end of the year (280) was similar to the end of September (278). However within this the number on children in need plans has halved with a consequent increase in children not on any plan. This may reflect the increase in assessment activity (26% in the last year).

23 children had risk assessments (for sexual abuse or exploitation for sexually active young people and vulnerable adults) requiring referrals to a safeguarding organisation in the first 9 months of the year. 108 people in the first 9 months have accessed drug and alcohol services; 35 at tier 2 and 73 at tier 3. 22 children are currently at risk of CSE and not in full-time education. 40 children in 2015/16 accessed a school nurse. All sexually active young people and vulnerable adults accessing GUM and contraceptive services have had a risk assessment for sexual abuse or exploitation performed at each presentation as a new case. The Joint Targeted Area inspection praised this work in particular.

My support worker from the kingfisher team has helped me become the person I am today".

"I have grown enormously since the start of this. I've grown into a woman who is now confident in my abilities to move forward in life".

"I can now see what my future holds"



Children who are at risk of sexual exploitation going missing

This year 817 children have gone missing; this includes 115 children for whom a CSE screening tool has been completed (14%) and 100 looked after children (out of 864 children looked after at some point in the year in the year) - i.e. 12% of the looked after population.

Children who are at risk of sexual exploitation and known the to the youth justice service

Every young person known to the youth justice service is screened for CSE as a matter of good practice.17 young people, known to the youth justice service have been convicted for a sexual offence on the year out of the 38 young people convicted for a sexual offence last year.

Children who are at risk of poor mental health

Oxford Health NHS Foundation Trust Child and Adolescent Mental Health Services (CAMHS) continues to receive significant increases in referrals, this increase follows the national trend. During 2015/16 the Oxford CAMHS received 6,214 referrals of which 5,724 were accepted as appropriate referrals (92%) and 3,990 young people were assessed by CAMHS during this period. The numbers open to CAMHS continue to increase with a noted intensification in the complexity and presentation of children and young people.

Although CAMHS meet the target of seeing children who need to be seen urgently or as an emergency they are working very hard to reduce the waiting times for those children who are referred for a routine or non-urgent assessment and have plans in place to help reduce the waiting time for routine referrals. Following the DH report “Future in Mind”, the partnership review of CAMHS, and in line with the NHS England 5 year Transformation Plan, local services are undergoing transformation to move to a new service model which has been developed in partnership commencing April 2017.

There are strong relationships and developing partnerships between CAMHS and other agencies in respect of working together to safeguard children and young people from harm, to develop easier access to services including targeted and specialist mental health services, to increase resilience and self-help and to reduce waiting times to ensure access as quickly as possible and to the most appropriate intervention.

Children missing from home

The number of children who have gone missing from home has risen from last year (817 children compared with 694 last year). The number who went missing three or more times rose from 132 to 149 meaning the proportion of children who repeatedly went missing remained at 19%.

In summary: what does the data tell us?

- There have been more CAFs but the numbers of children under 5 reached by children's centres have gone down
- Increasing levels of activity across child protection plans; neglect being the most common reason for a child protection plan
- Lower levels of children becoming subject to a second or subsequent plan
- Increasing numbers of children in care; the highest level for many years.
- Half of the children becoming looked after had been on a child protection plan within the previous 12 months
- Increasing numbers of children missing from home
- Children at risk of sexual exploitation are being identified at the same rate and there is a higher use of the screening tool
- Children who offend: fall in numbers involved with youth justice service...however…increased custody rates
- CAMHS meet the target of seeing children who need to be seen urgently or as an emergency but they are working very hard to reduce the waiting times for those children who are referred for a routine or non-urgent assessment
- The implications of increased workloads on ensuring children are kept safe: the system is under pressure.

Chapter 2: Governance and accountability arrangements

About the OSCB

We are a partnership set up to ensure that local agencies co-operate and work well to safeguard and promote the welfare of children. We are responsible, collectively as a Board, for the strategic oversight of child protection arrangements across Oxfordshire. This means that we lead, co- ordinate, develop, challenge and monitor the delivery of effective safeguarding practice by all agencies. The impact should be evidenced in front line practice.

The Wood Report released in May 2016 will impact on the arrangements for safeguarding boards in the coming year. Changes to safeguarding boards are being outlined within the Children and Social Work Bill 2016-17. Presently the Board's remit is set out in the government guidance, Working Together 2015 and is to co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Oxfordshire. We aim to do this in two ways:

Co-ordinating local work by:

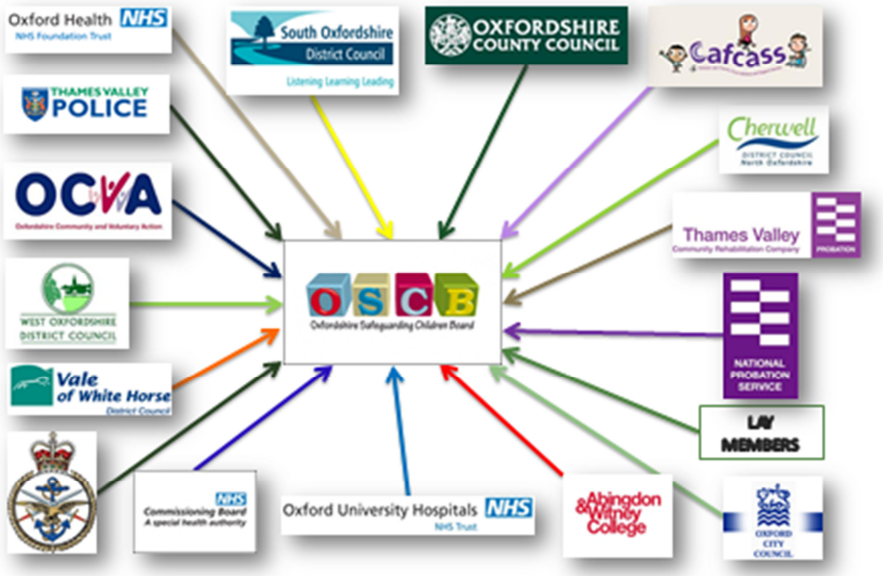
- Developing robust policies and procedures.
- Participating in the planning of services for children in Oxfordshire.
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done.

Ensuring that local work is effective by:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children.
- Undertaking Serious Case Reviews and other multi-agency case reviews and sharing learning opportunities.
- Collecting and analysing information about child deaths.
- Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

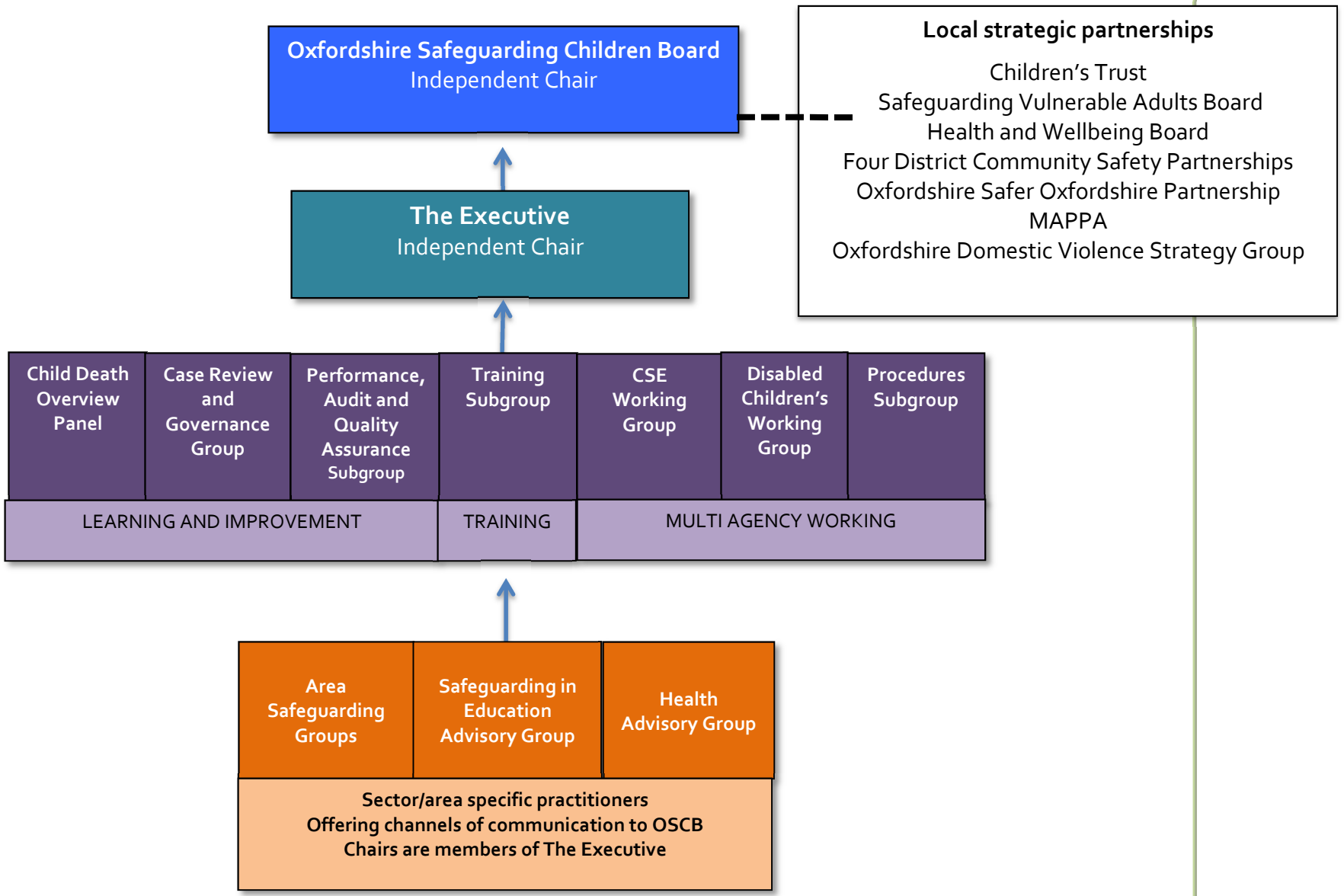
Board membership

Independent Chair	Thames Valley Police
Oxfordshire County Council: children's services, youth justice services, adult services, fire and rescue services	Children and Family Courts Advisory and Support Service
Oxford University Hospitals Foundation Trust	Community Rehabilitation Company
Oxfordshire Clinical Commissioning Group	National Probation Service
Oxford Health NHS Foundation Trust	Lay Members
NHS England Area Team	Representation from schools and colleges
Cherwell District Council	Representation from the voluntary sector
Oxford City Council	Representation from the military
South Oxfordshire and Vale of White Horse District Council	
West Oxfordshire District Council	



Structure

The main Board is supported by a range of sub-groups and other panels that enable its functioning:



How the Board works

Statutory body
We are a partnership set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare. The Board's job is to make sure services are delivered, in the right way, at the right time, so that children are safe and we make a positive difference to the lives of them and their family. We are not responsible or accountable, as a Board for delivering child protection services. That is the responsibility of each of our agencies separately and collectively but we do need to know whether the system is working.

Local Authority
Oxfordshire County Council is responsible for establishing an LSCB in their area and ensuring that it is run effectively. The Lead Member for Children's Services is the Councillor elected locally with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and children. The Lead Member contributes to OSCB as a participating observer and is not part of the decision-making process. During this period Councillor Tilley fulfilled this role.

Independence
As an independent Board we hold each other and our respective governance bodies to account for how they are working together. The Board's Independent Chair is directly accountable to the County Director at the County Council and works very closely with the Director of Children's Services.

The Independent Chair also liaises regularly with Thames Valley Police and the Police and Crime Commissioner, the Council's executive member for children's services and the Chair of the Health and Wellbeing Board in driving forward improvement in practice. Moreover, the Independent Chair maintains a close relationship with the Oxfordshire Clinical Commissioning Group and NHS Trusts. The OSCB is pleased to have strengthened representation from the voluntary and community sector during 2015/16.

Individual partners
Member agencies retain their own lines of accountability for safeguarding practice. Members of the Board hold a strategic role within their organisation and are able to speak for their organisation with authority and commit their organisation on policy and practice matters. On the Board we share responsibility collectively for the whole system, not just for our own agency. These governance and accountability arrangements are set out in a constitution.

Key Relationships

The Board is part of a set of strategic partnerships in Oxfordshire which provide oversight of the planning, commissioning and delivery of services to children. The Board has the specific oversight of safeguarding children within this partnership structure.

Protocols are in place to maintain healthy working relationships with the Children's Trust; the Safeguarding Adults Board; the Safer Oxfordshire Partnership and the districts' Community Safety Partnerships in particular. The newly created 'Strategic Partnerships' post within the Business Unit has developed these working relationships through formal protocols and operating frameworks for key safeguarding issues such as taxi licensing and the transport of vulnerable children, which need a wide ranging and strategic approach.

Oxfordshire Children's Trust
The OSCB has a strong relationship with the Oxfordshire Children's Trust, which is responsible for developing and promoting integrated frontline delivery of services which serve to safeguard children. The Chair of OSCB is a member of the Children's Trust and the Chair of the Children's Trust sits on OSCB. The Children's Trust has produced a Children and Young People's Plan which sets out its priorities, including a focus upon early help, and how these will be achieved. The Children's Trust and the OSCB share performance monitoring arrangements to ensure a cohesive approach and collective oversight.

The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by the Children's Trust. OSCB presents its annual report to the Children's Trust outlining key safeguarding challenges and any action required from the Children's Trust.

The Health and Wellbeing Board (HWB)
The Health and Wellbeing Board brings together leaders from the County Council, NHS and District Councils to develop a shared understanding of local needs, priorities and service developments. The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by the Health and Wellbeing Board. OSCB reports annually to the Health and Wellbeing Board and will hold it to account to ensure that it too tackles the key safeguarding issues for children in Oxfordshire.

Police and Crime Commissioner
The Police and Crime Commissioner (PCC) is an elected official charged with securing efficient and effective policing in the area. OSCB presents its annual report to the PCC outlining key safeguarding challenges and any action required of policing in the area. During 2015/16 the Police and Crime Commissioner actively supported the multi-agency work focussing on vulnerable adolescents at the OSCB annual conference.

Safer Oxfordshire Partnership
The Safer Oxfordshire Partnership aims to reduce crime and create safer communities in Oxfordshire. It has a co-ordination function. It is supported in this task by the district level Community Safety Partnership (CSPs), which develop local community safety plans for their areas and are accountable for delivery.

A core part of the role of Safer Oxfordshire is to distribute funding from the Police and Crime Commissioner to support our community safety priorities: training for domestic abuse champions across the county; raising awareness of Child Sexual Exploitation and Female Genital Mutilation with local practitioners; activities to engage young people and prevent them from engaging in Anti-Social Behaviour and from entering the criminal justice system; education and training opportunities for ex-offenders with drug and alcohol problems; and training on preventing extremism for frontline staff.

Priorities for 2016-17 are to reduce: anti-social behaviour; levels of re-offending, especially young people; the harm caused by alcohol and drugs misuse; the risk of extremism and hate crime; violence and serious organised crime and to protect those at risk of abuse and exploitation.

Health Economy
Oxfordshire's Clinical Commissioning Group (OCCG) is an important contributor to the OSCB. The OCCG and local health provider's work together to lead a health advisory group to engage health professionals in the safeguarding work of the board. The local area team (NHS England) supports this. The Oxford University Hospitals Foundation Trust and Oxford Health NHS Foundation Trust are key partners on the Board and important providers within the Oxfordshire safeguarding system.

Community safety partnerships
The community safety partnerships deliver projects that aim to cut crime and the fear of crime. Based in each district or city council area partners from the local authority, police, probation services, housing, fire and rescues services, the environment agency, the health sector and voluntary sector jointly tackle crime and safety issues. The OSCB partners have worked hard this year to align our safeguarding work. District colleagues are integral to the safeguarding work on child sexual exploitation; engagement with the community and voluntary sector and safer transport. Arrangements have been made for better representation on the Board of these key partners.

Oxfordshire Safeguarding Adults Board
The Board leads on arrangements for safeguarding adults across Oxfordshire. It oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. As a strategic forum it has three core duties: to develop a strategic plan; publish an annual report and commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these. Partners include adult social care, trading standards, the Police, probation services, fire and rescue services, health commissioners and providers, the voluntary sector and Bullingdon Prison.

OSCB voluntary and community sector members

We are the VCS (voluntary and charity sector) representatives on the Oxfordshire Children's Safeguarding Board (OSCB).

Clive Peters

Former Headteacher of an Oxfordshire Special School and Head of the Oxfordshire Physical Disability Service, he retired in 2007. He is presently a governor of two Oxfordshire schools, where he is the governor link for Safeguarding issues.

Clive is also a Trustee of the Oxfordshire Outdoor Learning Trust (OOLT) (www.oolt.org.uk) and of the Borien Educational Foundation for South Africa (BEFSA) (www.befsa.org)

Simon Brown

Simon Brown is CEO of The FASD Trust, an Oxford based charity, which he founded with his wife.(www.fasdtrust.co.uk) It has grown from humble roots in Witney to be the UK's leading charity in this field, supporting thousands of individuals and families affected by FASD (foetal alcohol spectrum disorders) not only in the UK, but increasingly overseas.

Simon is also one of the Directors of The Oxford Foundation for FASD, (www.oxfordfoundation-fasd.com) a project of The FASD Trust, engaging with professionals and encouraging research in the field of FASD. Simon has experience from engaging at Governmental level (see www.appg-fasd.org.uk) to on a personal level being a "service user" as dad of a child with special needs. Simon and Julia have 3 children, two of whom they originally fostered.

Romy Briant

Romy Briant has worked across the statutory and voluntary sectors. She qualified and worked as a social worker in child protection in South London, and subsequently worked as a volunteer in Oxford developing community projects and resources with a focus on special needs and inclusion. More recently she has been director of Relate Oxfordshire, Chair of Home-Start Oxford and founder trustee of Reducing the Risk of Domestic Abuse www.reducingtherisk.org.uk which she currently chairs. She has represented the voluntary sector in Oxfordshire on various Partnerships including OSCB.

She now deputises for Clive and Simon – and is voluntary sector representative to PAQA and to the Safer Oxfordshire Partnership Oversight Committee and the Oxfordshire Partnership.

Our collective role on OSCB is to ensure:

- The VCS' voice is heard
- The sector's local knowledge and expertise helps enable the Board to meet its and our safeguarding responsibilities
- Decisions being made draw on the cumulative expertise of the sector and take into account the unique and, in these times of austerity, increasingly valuable role that the sector plays in the provision of services to some of the most vulnerable members of our society.

We are mandated to bring our own voluntary sector perspectives to the Board and, where possible, to consult on substantial issues with the wider VCS. This is undertaken through on-line communication and regular meetings of OCVA's Children and Young People's Forum which is facilitated by Gillian Warson (gillian.warson@ocva.org.uk). Reciprocally we act as a channel of communication from the Board to the sector.

Lay Members

Working Together 2015 sets out a requirement for all LSCBs to have at least two Lay Members on their Board, operating as full members of the LSCB, participating as appropriate on the Board itself and on relevant committees. In 2015/16, the OSCB has been fortunate to have had two Lay Members representing the local community: Clare Periton and Modupe Adefala.

Clare and Modupe have continuously demonstrated their commitment to improving safeguarding outcomes for children and young people and have challenged (sometimes easier said than done) the views and assumptions of partners round the table. They have provided a public voice on the board, bringing diverse perspectives and local concerns to discussions.

Modupe Adefala has left the OSCB during this year but played an important role in board meetings often offering the voices of reason, challenge and calm. We thank her for the contribution that she has made. The post will be recruited to in 2016/17.

Clare Periton

Throughout my career I have been committed to contributing to safeguarding vulnerable people, and am grateful to be able to extend this commitment as a Lay Member on Oxfordshire's Safeguarding children Board. As a Lay Member, I am in a positon which is independent from any of the organisations that attend, it is therefore imperative that I exercise my right to ask questions and to make suggestions. I have been a board member for over 4 years and whilst I always attend with constructive, sometimes critical observations, I have always left impressed by the joint ambition of all agencies around the table to work and learn together to promote the welfare of children and young people and to do their upmost to protect them.

	Projection as at July 2015	Actuals as at July 2016
Funding streams	£	£
OCC Early Years funding	-14,465.00	-19,250.00
Public Health Risky behaviours	-31,625.00	-31,625.00
Contributions		
OCC Children, Education & Families	-196,610.00	-196,610.00
OCC Dedicated schools grant	-64,000.00	-64,000.00
Oxfordshire OCCG	-60,000.00	-60,000.00
Thames Valley Police	-21,000.00	-21,000.00
National Probation Service	-2,500.00	-2,500.00
CRC	-2,500.00	-2,500.00
Oxford City Council	-10,000.00	-10,000.00
Cherwell DC	-5,000.00	-5,000.00
South Oxfordshire DC	-5,000.00	-5,000.00
West Oxfordshire DC	-5,000.00	-5,000.00
Vale of White Horse DC	-5,000.00	-5,000.00
Cafcass	-500.00	-500.00
Public Health	0.00	0.00
Total income	**-423,200.00**	**-427,985.00**
Expenditure		
Independent Chair	36,000.00	40,715.00
CRAG chair	1,100.00	1,650.00
Business unit	270,000.00	255,000.00
Comms	10,000.00	10,000.00
Training & learning	50,000.00	53,000.00
Subgroups	10,000.00	12,366.00
All case reviews	75,000.00	65,000.00
Total expenditure	**452,100.00**	**437,731.00**
Use of reserves:	**28,900.00**	**9,746.00**

Financial arrangements

Board partners contribute to the OSCB's joint budget as well as providing resources in kind. The original funding for 2015/16 was projected to be £423,200 – the actual was £427,985. This increased a small amount due to extra funds to cover early years training. This figure does not include the funding of the Oxfordshire Child Death Overview Panel which is funded through Oxfordshire Clinical Commissioning Group. The Board has agreed to carry forward the low level of reserves from 2015/16 to the 2016/17 budget and is revising its forward plan.

Chapter 3: Progress made in 2015 /16

The OSCB child protection partnership in Oxfordshire is active and committed to ensure the wellbeing of the most vulnerable children. This section provides an account of progress made against priorities in the last year and assessment of where there is need for further work.

Aim 1: to provide leadership and governance

Priorities: partnership arrangements, community engagement and involving parents and carers

Why these priorities?

The OSCB is a transparent and effective partnership. It has an important role to challenge the Children's Trust to ensure that the Trust delivers effective services against a backdrop of reduced resources. The 'impact assessment' carried out by Board agencies in 2015/16 enabled services to fully consider the impact of cuts on the delivery of a range of services. This was a helpful assessment of the local provision. The Trust now has the responsibility to manage increased demand, reduced resources and remodelling of services.

The board extended its reach to secure robust safeguarding arrangements; fair representation; working protocols and clearly understood priorities. It placed a priority on increasing engagement with the voluntary, community and faith sector to promote key safeguarding messages through training and to increase representation on the board and its subgroups. OSCB partners also wanted to ensure that the voice of children, parents and carers remains central to safeguarding work.

Progress includes the new protocol for partnership arrangements working to support children across the county; new voluntary sector representatives on the Board and Subgroups; focus group with faith and community groups on raising awareness of child sexual exploitation; involving parents and victims in the OSCB's county wide learning events following serious case reviews and ensuring that the voice of children and parents is in the revision of the OSCB child sexual exploitation training materials, new community engagement framework across children and adult services.

What young people have told us

Sexting – views of young

Focus groups about sexting were carried out which highlighted that this is a concern for most young people. Many have seen explicit images and are aware of the risks involved, in terms of personal reputation, future prospects and also personal impact e.g. bullying, self-harm, low self-esteem. Knowledge of the law is inaccurate. There are gender differences with girls feeling in a 'no win' situation. Both boys and girls are affected by peer pressure, expectations and this is sometimes coercive. Young people felt current education isn't effective and isn't changing their behaviour. Recommendations included confidential, single-sex, relationships education delivered by those other than school staff.

HBT bullying including supporting Trans children and young people – views of young people

Last year's online bullying survey indicated that LGBT children and young people are the most vulnerable group in terms of bullying and feeling unsafe (young people identifying as LGBT are almost 12 times more likely to feel unsafe in the classroom). Anecdotal evidence from young people is that if their school openly acknowledges same-sex relationships and provides information about being transgender, this has a huge positive impact.
Young people (consulted at Oxford Pride) spoke about SRE being delivered without any discussion of same sex relationships. They described a lack of information meaning that they had to educate themselves by looking on the internet. Some young people described bullying and abuse as a result of their sexuality or gender. Several said they didn't feel safe to 'come out' at school. When asked what would help, inclusive SRE was mentioned several times – to have their gender or sexuality acknowledged would help them feel accepted and able to be themselves.

Over the last year there have been a number of sounding boards; workshops and the OXME.info website. Here is a short summary of views:
Young people want more confidential, single-sex, relationships education delivered by those other than school staff. They want it to better address single sex relationships and provide information on being transgender. They want more information so that they don't need to rely on the internet.

"*You know everything about me; I know nothing about you*." Young people, in particular those in care, want to know the professionals who know them. This builds trust.

Issues such as sexting, bullying, care plans and reviews as well as sexual health issues such as access to condoms, consent, safer sex have been raised by children in care

Concern that services for young people are being cut and having somewhere to go and 'hang out' that is "*warm and safe*"

Being able to air views – on line, face to face or in forums is important. They would value an Oxfordshire-wide forum for sharing views

Aim 2: to drive forward practice improvement

Priorities: working to address neglect, working to safeguard adolescents and monitoring the effectiveness of training.

Why these priorities?

Neglect is the most common reason for a child to be subject to a child protection plan; board members and practitioners are signed up to this as an area for improvement. Safeguarding adolescents is a priority due to issues arising through case reviews. Practitioners have identified the need for better sharing of information, more training and resources on these 'high risk' issues. Finally the OSCB is determined to improve the effectiveness and impact of training.

Neglect: what progress has been made?

Five work streams were identified;

- **Strengthening core groups** as part of the child protection planning process: simple things such as ensuring meetings take place as planned by arranging a 'deputy' to cover in a social worker's absence; ensuring that there is consistent, good quality administration so that all parties know what has been agreed.
- **The use of tool kits**: professionals are developing better 'tools' to support assessment, analysis and intervention across children's services. The scope of this work also includes a review of 'CAF/TAC' and how partner agencies are supported when working with families.
- **Transition and transfer**: The neglect pilot developed a 'transition's meeting' which is a forum where all cases requiring additional resources and services and cases moving in/out of the service through partner agencies or moving between social care teams are discussed. This good practice is to be rolled out.
- **Early identification of neglect**: Oxford Health NHS FT, Childrens Centres, Children's Social Care and Oxford University Hospitals are working together to improve identification of neglect as it has become clear that the current 'neglect tool' is not widely used across partner agencies.
- **Training** is being developed to support this new work.

Neglect pilot: working to support better outcomes for children on Child Protection Plans for neglect – what families told us…

'The North Pilot' ran in the north of Oxfordshire for 6 months in 2015. It sought to establish more effective ways of working to support better outcomes for children on Child Protection Plans for neglect. Interviews were conducted with six families that were involved in the pilot. Some of the key findings from **talking to families** are that: their engagement is the critical factor in enabling change; ensuring there is capacity for practitioners to deliver intensive support to support, and test a family's capacity for change is vital to instigating positive change in complex families and that planning for the needs of the whole family is vital to achieving better outcomes.

A day in the life of an Independent Reviewing Officer… a typical day full of many emotions.

Its 7.45am. Time to start. I have two hours before my first meeting of the day. There is an email to tell me the child protection plan from yesterday's conference is ready for me to approve. I review the tasks, the actions and the outcomes, which takes just under an hour.
I have two social work reports for today's second review of two children in care. The two young children currently have separate placements, which is better for them. Having given full consideration to other options the long term care plan is for them to become adopted although that decision will rest with the courts. A lot of work has been done with Mum. She has had a lot of support to improve her parenting but is not able to do this – it is a sad case as I have known the family for some time. I read the report thoroughly, thinking if any further questions need to be addressed and if any matters are unresolved.

After checking travel details I set off. I am seeing each child separately followed by mum. The first meeting is attended by the foster carer, her worker, the child's social worker and me. We also have a report from the nursery and the health visitor so can take on board many views. The child is at nursery today which enables the foster carer to concentrate on the meeting – I will of course be seeing them as part of this process. We talk through the care plan and the social worker confirms that the plan is for adoption.

It's now 12.30, a quick lunch before heading off to see the younger sibling, who is some 40 minutes away. Once I am inside and introductions are completed we begin. Both children have the same social worker which is as it should be; the child clearly knows who she is and gives a big smile. The child plays happily – laughing and chuckling throughout the meeting. I leave this meeting feeling that there are undoubtedly unresolved issues but they are happy and settled living in a well-structured, safe, stimulating environment.

The final part of this review is the meeting with mum at 3.30pm. I arrive back at the office with time to review the day so far. As I study my notes and the local authority's care plan I fully consider the decisions we are making. I am clear that Adoption is the best way to provide stability and security for the children. The social worker comes for a discussion prior to mum arriving. We are aware that we have distressing information to convey. We agree the best way to talk through the children's progress and the proposed care plan for them – we know that this will be hard news to hear.

Mum arrives in good time. Once in the meeting room we chat and she tells us about her plans for the day. I update her on the children's progress talking in detail about each child one by one. We then move onto the care plan. I begin by explaining the court process. I then tell her that assessments had been completed and that the local authority was recommending to the courts that the children are adopted. I make it clear that the decision rests with the courts. Mum says that she had seen this information - the social work report was ready some ten days ago. It is difficult for her and she becomes tearful but is controlled. I ask her if she feels able to support the plan. She says that she does as long as she has face to face contact with the children. The social worker lets her know the date that they were meeting in court and that this would all be discussed further. Once Mum has left the social worker and I discuss the meeting. We are both subdued as it is difficult news for Mum but we feel that our conversation went as well as it could. The decisions have not been taken lightly but they were in the best interest of the children.

I am now in the office; it's just after 4.30pm. I return to my emails and do some case notes. At 5.35pm I sign off for the day. It has been a typical day - full of many emotions.

Improving mental health services for young people

The OSCB Stocktake Report on child sexual exploitation in July 2015 recommended that there should be better access to therapeutic services for survivors of child sexual exploitation. **The Horizon service** was launched early 2016; this is a service for young people and their families who are experiencing distress as a result of sexual harm and works with partner agencies to provide a comprehensive and consistent service for those children who have experience sexual abuse and exploitation. This mental health service works alongside Safe!, a voluntary sector group, funded by the Police and Crime Commissioner and provides a range of services to young people in need. It is already proving to be a valuable part of the service provision in Oxfordshire. Adult Social Care are funding a new service to support vulnerable adult survivors to access therapeutic and other services.

Over the last year the Trust has further developed services for high-risk young people, offering several closely-coordinated services for young people who present with high-risk behaviours, or who come into contact with the youth justice system. The services include: **Forensic CAMHS** for young people who show a range of risky behaviours towards others; **Child & Adolescent Harmful Behaviour Service** (CAHBS) for concerns in relation to sexualised or sexually-harmful behaviour; **Criminal Justice & Liaison Service** for concerns in relation to mental health or neuro-developmental difficulty at the first point of contact with the youth justice system; **Horizon** which aims to restore sense of safeness and well-being for those experiencing distress as a result of sexual harm.

Other developments over the last 12 months include the offer from CAMHS to secondary schools to increase mental health professional input and resource within all Oxfordshire mainstream secondary schools. In partnership with OUH colleagues CAMHS have been piloting an Autism Diagnostic Clinic. The aims are to streamline the referral, assessment, diagnosis and maximise the health outcomes of children and young people through direct engagement with the specialist multidisciplinary professionals working within the CAMHS team, in collaboration with other disciplines within specialist paediatric neuro-disability services and children's community therapies.

The service is launching a new model specialist CAMHS **Eating Disorder Service** summer 2016 which aims to see and begin treating children in two weeks of referral.

Making sure that children in care and care leavers are safe, securely attached and in education

The county council has increased local capacity to respond to the most risky and vulnerable. The increase in the county's own pool of foster carers, particularly for the hard to place, is the most critical part of placement strategy. Over fifty new carers were recruited. The county developed a "Mockingbird" model of support for them, which enables a hub co-ordinator to support six to eight other carers. In addition a 'residential pathway' is being set up so that the County Council has the capacity to move young people around when the group dynamics are not working.

Ensuring that supported housing is offered to the most vulnerable is essential to a young person's safety. The county council and its partners have developed a robust "supported lodging scheme" for those young people who still want family links. The intention is to further develop this by training supported lodging hosts to deal with CSE risks. Part of this includes helping young people help themselves when they are in a particularly destructive cycle e.g. enabling them to be away from Oxfordshire.

The workforce is responsive and able to step in to prevent family or placement breakdown. The 'residential edge of care service' has at least 8 staff on every weekend providing support in the community which is due to double in 2016/17. They are able to work up to 10pm on weekday evenings. Similarly there is increasing support to foster carers in out of office hours.

The 'residential edge of care service' is now working with 270 families. They work with schools, especially for those who are persistently absent or have been permanently excluded, to keep children on the school roll and to develop alternative education across the county.

Making sure that children in care and care leavers are safe, securely attached and in education

Oxfordshire maintains a significant investment in specialist therapeutic and counselling services for looked after children recognising the importance of placement stability for securing good long term outcomes. There is an embedded understanding that placement breakdowns are both traumatic to our children and can put extreme pressure on budgets. For example adoption placement breakdowns can lead to children being placed in residential settings. The cost of one of these placements for one year is comparable to the full cost of the ATTACH service. The REoC service has now been set up to offer the same level of support to children on the edge of care to safeguard them, improve their outcomes and avoid significant placement costs.

There is a need for tighter evaluation of the impact and outcomes of all looked after children therapeutic provision moving forward. Partners will be developing a therapeutic model across the whole of corporate parenting which will measure the impact of interventions on initial, mid and long term outcomes. This will enable partners to assess whether interventions are having a sustainable impact. Partners are continuing to develop the tracking and monitoring of Strength and Difficulty Scores, and using outcomes stars so that children and families are feeding back whether interventions are making a difference.

Development of transgender work and work to combat HBT bullying

The county council's HBT toolkit has been updated to include guidance on supporting transgender students in school. The county council is currently working with Stonewall and with other local authorities to provide a national trans toolkit for schools which is due for publication in September. Local case studies are being written to supplement the national guidance which will also include a local pathway for support via CAMHS. A workshop on supporting trans children and young people was provided at the Managing Bullying Effectively workshop. Inclusive SRE training for schools and school health nurses has been provided to 7 primary and 18 secondary schools (including training delivered to 20 school health nurses). Training and insets on HBT bullying have been provided both centrally and to individual schools including a specialised inset on supporting transgender children. Other work includes the development of a drama piece by young people to raise awareness about HBT bullying; work with a local LGBT youth group to develop a film resource; work to develop inclusive SRE resources.

Understanding the impact that sexting has and how to support young people

National guidance on sexting to support schools with managing an incident has been promoted via the Safeguarding and Anti-Bullying networks. The Anti-Bullying Co-ordinator and Thames Valley Police have worked together to run the sexting project, involving 4 Oxfordshire schools. Recommendations include development of a resource pack, a survey and supporting schools to review their provision of Sex and Relationships Education to include education on sexting in the context of healthy relationships. Work is ongoing to develop resources and TVP are reviewing their procedures.

Ensuring the safe transportation of vulnerable children: Joint Operating Framework for Transporting Children/Adults with Care and Support Needs and Taxi Licensing in Oxfordshire

The Joint Operating Framework provides a single set of minimum standards for agencies with responsibilities for transporting children/adults with care and support needs in Oxfordshire, including addressing vetting, training, awareness raising, information sharing, policy alignment, enforcement activity and quality assurance and monitoring. The framework is shared by the county and district councils and Thames Valley Police.

It has been developed as a result of the learning from the Bullfinch investigation into historical child sexual exploitation in Oxford, the subsequent Serious Case Review into child sexual exploitation of Children A-F (published in March 2015) and the findings of the Stocktake Report set up to review Oxfordshire's current approach to tackling child sexual exploitation (published in July 2015).

Improving conversations on consent

Work has been done to understand the level of health practitioner 'knowledge and attitude' to consent. It was initiated as a result of the serious case review into child sexual exploitation and covered a wide range of professionals, including GPs. It considered how effectively consent is discussed with young people seeking sexual health advice. The findings were positive: the majority of health professionals have a good understanding of consent but some areas of improvement were identified. This has led to training for a range of professionals including independent school nurses and pharmacies who provide hormonal contraception; the development of resources for practitioners and improved access to safeguarding advice for Pharmacists through GPs and nurses. Sexual health professionals have worked on and now co-deliver the OSCB course on sexual health awareness and consent.

A day in the life of a Sexual Health Outreach Nurse.

My work is with young women, who are at risk of unplanned pregnancy, have the potential for poor sexual health and frequently have intimate relationship difficulties. They are all vulnerable in some way. Many could be described as "hard to reach" as they do not always recognise the risks they are exposed to. Most of the clients are under 18 but sometimes I work with young women who are under 24. They tend to be people who find it hard to access services due to where they live or though lack of confidence or mental health problems. Some are teenage parents; others may be in care or have left care; they may be receiving support from the youth justice service or there could be concerns that they are at risk of or experiencing sexual exploitation or abuse.

Referrals come from school health nurses, midwives and family nurses, health visitors, social workers, specialist nurses, the Kingfisher Team, and sometimes from colleagues within the Sexual Health Service in Oxfordshire.

My work takes place in a range of locations including schools and Pupil Referral Units (providing Governing bodies have agreed to my service in their school), client's homes, Early Intervention Hubs and Children's centres, GP surgeries and health premises. An acceptable location is negotiated with the client; most arrangements are made by text message. A typical consultation can take over an hour. During this time the reason for the referral is explored and information gathered about medical history, sexual history, social circumstances, family structures, friendships and support mechanisms noted. The aim of this first visit is to establish a good rapport and trust between client and practitioner. It is important to give the client a sense of self determination and choices in their care, whilst trying to give accurate and relevant advice, and maintaining professional curiosity. A risk assessment (Spotting the Signs) is always done for under 16s, and if indicated for under 18s, to explore any possible pressure or coercion in their relationships or other possible abuse. Supporting clients to manage the pressures experienced via the internet and social media is a growing part of my role. The concept of consent or agreement to sex is discussed fully. Domestic abuse within the relationship is also assessed using appropriate assessment tools, and referring on as required. The limits of confidentiality must be made clear from the outset as I will need to share information with other professionals if issues of concern arise in consultations.

The consultations can include advice about contraception methods, teaching clients how to use and issuing contraception (all methods apart from Intra Uterine Contraceptive Devices IUCDs), Chlamydia Screening tests, and arranging follow up visits as needed. Many of these young people have difficult lives and challenging circumstances, so being able to provide a listening ear is a very important part of the role. Suggesting other professionals who may be able to help and making referrals is part of my role. The ability to network, and understand the different priorities and agendas of different organisations/ services is an essential part of this role. At the end of each day I then have to document all of my appointments, including analysing what I have assessed, and planning future interventions. Documentation via electronic systems is invaluable, as this enables all professionals who come into contact with the client within the service to have up to date information.

Sometimes I only need to see a person once, but often I will work with them over a period of time to ensure they are safe, supported and can access other services before I discharge them. Some clients are referred but then decline to see me. When this happens I will inform the referrer that I have been unable to follow up the client – this is vital to ensure no child gets "lost" in a system, without the necessary interventions. It is rewarding when a young person can be helped to take some control and feel healthy and safe in their relationships.

Improving practice through safeguarding messages

Promoting awareness of child sexual exploitation

Say Something If You See Something and Hotel Watch are both national programmes to raise awareness of child sexual exploitation amongst key industries including taxis, hotels, guest houses and bed and breakfast providers and licensed premises and to ensure they know how to recognise signs of child sexual exploitation and when and how to report concerns. There is a county-wide roll out of both programmes which is being successfully led by the City Council and district councils and local police areas.

Promoting awareness of staying safe

The NSPCC's 'Speak Out Stay Safe' programme visits primary schools across Oxfordshire to give children the knowledge and understanding they need to stay safe from abuse. Delivered by volunteers it educates children about all forms of abuse and how to speak out about it safely. The programme has visited over 150 primary schools and reached 9,910 children across Oxfordshire. Children have said that the programme is: "*A fun way of learning*", "*It deepened my understanding about what ChildLine does and how it helps people*", "*It was good for learning about things you may not have known*"

One of the volunteers, Philippa Radford, is based in Oxfordshire and says:

"The Schools Service assemblies and workshops give children a chance to understand what is right and wrong. It teaches them that they have a choice and that they can get help if they need it. The programme protects children from harm by giving them all an opportunity in their school environment to listen, watch and discuss issues of abuse.
Volunteering is rewarding on many levels. I have especially enjoyed being part of a team, gaining new skills and knowledge. It is a wonderful opportunity to work with children to help prevent abuse. The primary schools and teachers are always welcoming and enthusiastic about our service."

Raising awareness of self-harm: 'Under My Skin' by the Pegasus Theatre

This is a Public Health funded pilot project to raise awareness of self-harm and support services for young people using a theatre based intervention provided by Pegasus Theatre. The play was performed in a total of 28 schools (including 1 special school) and reached a total of 5,049 young people in Years 8 and 9 in Oxfordshire. 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

Learning and improvement work

Resources for practitioners:

- ✓ Child development tool for assessing and tracking neglect
- ✓ Updated child sexual exploitation screening tool
- ✓ Medical advice for parents considering male circumcision
- ✓ Updated screening tool for female genital mutilation
- ✓ Revised self-harm guidelines
- ✓ New referral pathway for young people at risk of domestic abuse
- ✓ Mental health learning summary
- ✓ Homosexual, Bi-sexual and Transgender toolkit updated to include guidance on supporting transgender students in school
- ✓ National guidance on sexting to support schools with managing an incident
- ✓ Schools and settings prevent checklist

OSCB Training

The OSCB delivers over **150** free safeguarding training and learning events plus online learning each year. The training is overseen by a multi-agency subgroup. In 2015/16 the training reached over **9000** members of the Oxfordshire workforce.

Over 85% of delegates report that they have found the training good or excellent.

Most of the training is delivered by a volunteer training pool comprising members of the children's workforce and is free to the practitioner.

'Thank you to Oxfordshire's volunteer trainers!'

Learning events were run for over 1,000 practitioners

Child sexual exploitation: powerful presentation by a mother and (now adult) child on being a victim of child sexual exploitation. Practitioners received a summary of the review and were made aware of a training pack on the views of families which was put together following another review in to child sexual exploitation.

Adolescents and risk: learning from recent serious case reviews - this included a play from the Producers of Chelsea's choice about sofa-surfing, which vividly highlighted the risks that adolescents are exposed to. Professor Ray Jones set the context and Jenny Pearce highlighted the issue of consent and coercive behaviours.

Young people at risk of domestic abuse: learning from a serious case review / domestic homicide review launch of the new referral pathway for young people at risk of domestic abuse.

Aim 3: to quality assure and scrutinise the effectiveness of practice

Priorities: to test if the learning is embedded across the child protection partnership and to scrutinise how well partner agencies' arrangements can show improvements

Why these priorities?

The OSCB evaluates the effectiveness of the local safeguarding system to ensure that children and young people are kept as safe as possible. Over the last few years a significant amount of learning has been achieved. The OSCB is using its local framework to test this. The current priority is to scrutinise procedures for escalating safeguarding concerns; supervision of workers supporting vulnerable young people as well as the recording and reporting of multi-agency meetings.

What progress has been made?

OSCB Child sexual exploitation stocktake and report to the Department for Education;

The child protection partnership was jointly assessed this year on how effectively it responds to child sexual exploitation in Oxfordshire. In March 2015 the OSCB published the A-F Serious Case Review which identified a considerable amount of learning, which was communicated through two multiagency events. Following this the OSCB Independent Chair was asked by the Children's Minister and Ministers from the Home Office and Department of Health to provide an update on the impact of services to tackle CSE across Oxfordshire. This 'Stocktake report into progress made in tackling child sexual exploitation in Oxfordshire', which was supported by an Independent commentary by Sophie Humphreys, a government adviser, was published in July 2015.

The 'Stocktake' demonstrated that the partnership in Oxfordshire had moved a long way to address the problem of child sexual exploitation, identify collective solutions and produce some tangible evidence of impact. The independent government adviser commented, '*the key noticeable difference that was shared by all was that that the partnership is reflecting a more curious approach in its safeguarding arrangements*'.

In March 2015 following the successful Operation Reportage Investigation and criminal trial the OSCB commissioned a review of practice to identify any further learning. This review was signed off by the OSCB in October 2015. The review, like the Stocktake, listened to children and parents. It involved two multi-agency events for professionals and led to a learning summary for professionals, which was published January 2016.The review was able to demonstrate tangible progress in Oxfordshire and as one child said *'It wasn't just a job to them. They were in it for us.'*

Operation Reportage and the Learning Review to test Oxfordshire's approach to child sexual exploitation

Operation Reportage was the first major investigation following the establishment of the Kingfisher Team in Oxfordshire and led to successful prosecutions of a number of men involved in grooming and abuse of a number of children. The OSCB commissioned a learning review which identified significant improvements in how all the partner agencies were working and evidence of learning from the A- F Serious Case Review. Children were positive about the support they received from the Kingfisher Team. The process of the learning review included practitioner sessions which were in themselves important learning opportunities.

Children's voices and parents' voices were central to the learning review and their messages have been used in the development of the refreshed CSE strategy and action plan. A Children's voices training and development tool has been produced and published on the OSCB website.

Checking the effectiveness of joint working through audit

The three multi-agency audits domestic abuse, child sexual exploitation and 'Education, health and Care Plans' for children and young people with learning difficulties or disabilities (aged 0 to 25) highlighted some positive practice in safeguarding arrangements:

- ✓ Good child, young person and family involvement. It is recognised that parents and carers of the children are key partners in keeping them safe and that the needs of other children should also be taken in to account;
- ✓ Children are listened to, believed and drive planning; in particular health partners demonstrated strong evidence of the voice of the child through a persistent approach;
- ✓ Strong partnership between agencies. Good evidence of assessment; communication; information sharing;
- ✓ Dynamic meetings taking place behind plans and some examples of good immediate action.

The audits also highlighted a number of areas for learning and improvement, including:

- Management oversight; whilst the section 11 showed that there are supervision processes in place an audit of records has highlighted that managers need to help assess risk and look at the bigger picture;
- Using practice tools for risk assessment can support the work of practitioners, for example the neglect tool, CSE screening tool or working with drug using parents but they often don't get used or used inconsistently;
- Information sharing whilst there is significant evidence of good practice there are still some gaps – this includes being more vigilant as to when children and young people are subject to a child protection plan or identified as children in need;
- Points of transition between services; evidence suggests that there is room for improvement.

Scrutinising OSCB agencies' safeguarding practice

Each year the OSCB runs a safeguarding self-assessment for all statutory partners. This year the returns demonstrated good compliance and regard to safeguarding practice as well as positive direction of travel. A peer review was held with all partners to ensure that they had the evidence to back-up their self-assessments. Key multi-agency messages can be summarised as follows:

Escalation – the OSCB can be assured that agencies can reference their internal escalation process and/or adhere to the OSCB multi-agency escalation process. However, agencies struggled to quantify how much escalation goes on due to a lack of recording or the use of informal escalation pathways.

Supervision – the OSCB can be assured that agencies have supervision arrangements in place and most ensure that safeguarding issues form a standing item on their supervision.

Transport – relevant agencies are showing progress in improving arrangements to transport vulnerable children and intend to report more closely against the Oxfordshire's Joint Operating Framework for transporting children and adults with care and support needs in 2016.

Assurance of practice in Commissioned Services – there are mechanisms in place to check safeguarding practice within commissioned services. Areas for improvement (for providers, which by and large are from the voluntary and community sector) were noted as the need to:

- create ways of involving children & young people and their families in the development of policies and practices;
- better understand the PREVENT agenda and how to incorporate this into internal safeguarding policies and training;
- better understand the multi-disciplinary tools available and the participation in safeguarding processes, in particular, the Common Assessment Framework (CAF).

In 2016/17 the OSCB and the Oxfordshire Safeguarding Adults Board will undertake a single assessment of safeguarding practice for both vulnerable children and adults.

The Joint Targeted Area Inspection

The child protection partnership was jointly assessed this year on how effectively it responds to abuse and neglect in Oxfordshire. The headline judgement was that Oxfordshire now has '*a highly developed and well-functioning approach to tackling exploitation'* provides an important external judgement on an area of work that has been a key priority for the Oxfordshire Safeguarding Children Board in recent years. This builds on Ofsted's judgement in their last major inspection of children's services in 2014 that the OSCB was 'Good'. The report identified a wide range of key strengths and importantly recognised that key agencies have learned lessons from recent investigations into child sexual exploitation and have acted effectively to improve performance. Critically it confirmed that agencies in Oxfordshire understand the needs of children and young people and help them keep safe.

Key strengths identified by inspectors included:

- Strategic leadership from individuals, agencies and the Oxfordshire Safeguarding Children Board (OSCB);
- The Kingfisher Team which provides specialist multi-agency responses to children at risk of exploitation and its links to MASH – the multi-agency safeguarding hub;
- The responsiveness of local authority, police and health services;
- A high standard of inter-agency working with sexually exploited children and a clear commitment to safeguarding children at risk.

The report identifies 16 areas of key strength which include praise for:

- Significant investment from the local authority, police and health agencies;
- Effective leadership and commitment from senior leaders of all agencies led by the Director of Children's Services, the Council's Head of Paid Service and senior politicians;
- Strong collaboration between health providers
- The success of the OSCB in leading the development of robust multi-agency services to exploited children;
- Good oversight of practice by professionals across all agencies;
- Post-abuse therapeutic work
- Clear and coherent disruption activity to identify and tackle perpetrators;
- Work with hotels, taxi drivers and the wider community to identify and report signs of child sexual exploitation;
- Work with young people who repeatedly go missing.

Strengths outweighed areas for improvement. Critically areas for development matched those identified by partners in their own self-assessment of performance and action plans to address these matters are already well-developed. The key focus moving forward will be to translate success with CSE into consistently good standards of practice across all services. Most importantly there is a drive to further develop the 'front-door' into services and to secure consistently good standards of practice across all children's services. OSCB is playing a role in ensuring that the changes to MASH to make it a co-located and virtual partnership with the primary aim being to identify hidden harm will make it better. Attention will be paid to ensuring that the 'front-door' to services works well – that they are timely and offer feedback.

Chapter 4: What happens when a child dies in Oxfordshire

The Child Death Overview Panel (CDOP)

CDOP is a sub-group of the OSCB. It enables the LSCB to carry out its statutory functions relating to child deaths. It carries out a systematic review of all child deaths to help understand why children have died. Child deaths are very distressing for parents, carers, siblings and clinical staff. By focusing on the unexpected deaths in children, the panel can recommend interventions to help improve child safety and welfare to prevent future deaths. The findings are used to inform local strategic planning on how best to safeguard and promote the welfare of the children.

In 2015/16, 79 child deaths were reported to the Oxfordshire CDOP and were discussed with the Designated Doctor for child deaths. 35 of the child deaths reported were of children normally resident in Oxfordshire and 44 of the deaths were of children normally resident in other counties.

In 2015/16 the Oxfordshire CDOP reviewed the deaths of 39 children who usually reside in Oxfordshire. These reviews included 22 deaths that occurred in the year 2015-16 and 17 reviews that occurred before 2015-16 but had been carried over due to alternative processes and investigations that prevented completion of the CDOP process any earlier. The outcomes of panel meetings are twofold firstly to identify the classification of death and modifiable factors. Of the deaths reviewed in 2015/2016, 6 were identified as having modifiable factors.

Preventable child deaths can be defined as “those in which modifiable factors may have contributed to the death. These factors are defined as those which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths. http://www.workingtogetheronline.co.uk/chapters/chapter_five.html

The panel considers all the available information and makes a decision as to whether there were any modifiable factors in each case. These include factors in the family, environment, parenting capacity and service provision. Consideration should be made as to what action could be taken at a regional and or national level to prevent future deaths and improve service provision to children, families and the wider community. When considering modifiable factors the panel is required to make a decision on whether the factors contributed to or caused the death.

In the year 2015-2016 the CDOP panel concluded that in the 39 cases reviewed 6 modifiable factors were identified that contributed to or caused the death.

Modifiable factors identified were co sleeping; consanguinity; smoking and alcohol; suicide; home safety; drowning. As a result of the identified modifiable factors the following specific recommendations were made by the CDOP:

- Maternity Services to audit the advice given to mothers after the birth of their baby, until discharge, re safe sleeping
- Suicide cluster information should be sent to all agency representatives to share within their agencies. CDOP to be kept informed by the Lead Nurse Suicide prevention (Oxford Health) re developments in the service
- Anonymised details re blind cord deaths to share with ROSPA as part of a national data collection and child safety campaign
- Schools and community policing should review the advice they give re swimming and water safety

The Rapid Response Service

CDOP is advised of all child deaths and monitors the response when this involves a rapid response process. In Oxfordshire, the rapid response service, coordinated by a team in the Oxford University Hospitals NHS Foundation Trust commissioned by OCCG, is well established and assists in gathering as much information as possible in a timely, systematic and sensitive manner to inform understanding of why the child has died. In addition its primary role is to ensure bereavement support for the family is initiated and that processes are initiated where there may be other vulnerable children within the family. The rapid response coordination (RRC) team has an on-call rota to cover the service 24 hours a day 7 days a week including bank holidays. The RRC Team provides a safe, consistent and sensitive response to unexpected child deaths up to the age of 18, where the child dies in or is brought to hospital immediately after their death. This culturally sensitive approach provides support to the bereaved parents and family.

In collaboration with the Designated Doctor for Child Deaths (in working hours) the rapid response coordination team ensure families are provided with support in the event of a sudden and unexpected child death. They work collaboratively with other organisations including the Coroner's office, Schools, Youth Projects, Social Care, South Central Ambulance Service, Thames Valley Police, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, Helen and Douglas House Hospice and the child bereavement charity SEE SAW, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

The process ensures that the rapid response team makes a vital contribution not only to the CDOP review but to the immediate response provided in the event of an unexpected child death. This difficult and sensitive work provides robust support for families and professionals in the tragic circumstances surrounding a child death.

In every case in which the death of an Oxfordshire child is unexpected the CDOP officers arrange a professionals meeting. The Designated Doctor for child deaths chairs these rapid response meetings ensuring that the principles underlying the rapid response process are considered throughout by all agencies. These are set out by the DfE:

1. The family must be at the centre of the process, fully informed at all times, and treated with care and respect.
2. Joint agency working draws on the skills and particular responsibilities of each professional group.
3. A thorough systematic yet sensitive approach will help clarify the cause of death and any contributory factors.
4. The "Golden Hour" principle applies equally to family support and the investigation of the death.

Currently families do not attend the Rapid Response meeting however the role of the coroner is to keep them fully informed throughout the process. To this end the notes and actions of the Rapid response meeting are shared with the Coroner and a Coroners officer attends the meeting. In 2015/16, a total of 23 unexpected deaths were reported to the Oxfordshire CDOP and rapid response coordination team. Of these 10 were of children normally resident within Oxfordshire.

Update on recommendations from 2014/15

The CDOP considered issues arising from its review of all the deaths of Oxfordshire children in the year 2014/15. The outcomes of the recommendations by the panel are:

Schools to ensure that road safety education is provided to all pupils:

Road safety advice is provided in schools through a programme called 'footsteps' in Key Stage 1 and the 'Next Steps' in Key Stage 2.

OSCB to advertise training to health professionals re: the issues around young people and substance misuse:

The OSCB have held a learning event covering Substance misuse, this was a multi-agency event and was well attended with good representation across agencies.

Maternity staff to ensure mothers have information on safe sleep guidance and safe nappy sack storage.

The NSPCC leaflet is to be given to all new mothers for information and guidance. An audit on post-natal care and co-sleeping advice reported to the November 2015 CDOP showed that co-sleeping has been discussed with new mothers in 100% of cases, with 88% having been instructed on each contact. The audit tool will be altered in June 2016 to remove the measure for discussion 'at every contact' as this is felt to be unrealistic.

Guidance for schools dealing with suicide clusters to be produced:
Guidance has been produced. There is ongoing work around suicide reduction and development of suicide prevention work led by public health who will continue to inform CDOP of its work.

The importance of taking folic acid in pregnancy needs to be highlighted to new mothers:
Public Health Oxfordshire ran a 'Healthy Mother and Baby' campaign in the financial year 2015/16.

Review of serious cases

A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and
(b) either (i) the child has died;
or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Serious case reviews (SCR)

LSCBs must always undertake a review of cases that meet the criteria for a SCR. The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. OSCB has also been committed to undertaking smaller scale partnership reviews for instances where the case does not meet the criteria for a serious case review but it is considered that there are lessons for multi-agency working to be learnt.

There has been an exceptionally high volume of work on serious case reviews. During 2014-15 three serious case reviews were completed and one was amended and re-published. Seven new cases were brought to the attention of the OSCB for consideration; of these two serious case reviews were commissioned, one was subject to a learning review with partners and the remainder led to no further action by the OSCB. The OSCB has another two on-going serious case reviews: one which is waiting for a criminal investigation to complete and one which has been delayed due to an Independent Police Complaints Commission investigation which is now complete. All **case reviews** and **learning from reviews** can be found on the OSCB website.

The OSCB generates learning about how we can work better together. It takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies. Themes from reviews this year that are in common with other serious case reviews are:

- Challenges in dealing with inconsistent and neglectful parenting;
- Professionals' lack of challenge or curiosity in relation to self-reported explanations of harm to the child/ren;
- Loss of continuity of service (and records) when families move across boundaries;
- Effective risk management supported by systematic planning across the multi-agency partnership;
- The capacity of adolescents to protect themselves can be overestimated and a tendency to view teenagers as adults rather than children can mean that proactive steps to protect them are not always taken;
- Young people can 'slip through the net' by not meeting criteria for a number of services leaving them in need of help but without support.

Learning points for working together

- Agencies should feedback to Children's Social Care when they do not receive minutes of formal meetings (CP Conferences and Core Groups, and Strategy Meetings) within the required time;.
- Where there are agreed reasons to hold a professionals meeting without a parent, any professional from any agency should be able to request this;
- Effective multi-agency work requires careful joint planning, so that services do not overwhelm the family.

Story of Child J (serious case review / domestic homicide review published in March 2016)

Context

17 year old Child J was killed by her ex-partner in December 2013. A wide range of agencies had been involved with Child J and her family at various times. Child J's mother had quite serious problems of her own and Children's Social Care became involved with the family for two periods of time, alongside several other agencies who also attempted to provide help and support, but with limited long term success. She was for a period identified as a 'Child in Need' and at a later date subject to a 'common assessment framework'. Child J became more and more unsettled, her needs were not being met at home, she was missing school and it is apparent that she was very vulnerable with episodes of self-harm.

Child J became involved in a relationship with a young man (Adult L) who himself had a very damaging early life. Adult L was known to services and had a history of violence, including in intimate relationships. His relationship with Child J was highly controlling, emotionally and physically abusive. Many of the services were aware of the level of risk Adult L posed and her case was reviewed at the local 'Multi-agency risk assessment conference' meeting but attempts to help Child J to leave him were unsuccessful. There were often times when she was homeless or sleeping rough and would contact key professionals hungry and in distress. In the last few weeks of her life Child J was placed in supported housing. Despite attempts by staff to persuade her not to, she arranged to meet Adult L when she discovered she was pregnant. She was killed that night. Although she was reported missing it was several days before the seriousness of the risk to her was properly recognised by the statutory agencies.
Although some individuals worked very hard to help Child J, statutory assessments of her needs were inconsistent and individual work was not supported by a clear multi-agency plan either with Child J or in relation to Adult L.

Responding to the findings

The review highlighted two key findings: the continuing need for services to respond effectively to older children in need of protection and the importance of understanding the impact of domestic abuse within adolescent relationships. However, the review concludes that whatever the actions of agencies, there could be no guarantee that Adult L could have been prevented from killing Child J or any other young woman – either at that time or in the future.

Recommendations for individual agencies have been made as part of the review and these are listed in Annex C of the report. In addition, there are seven multi-agency recommendations for all local organisations with child protection responsibilities. The report highlights the importance of all statutory agencies and voluntary organisations, including housing providers, having a clear understanding of the risks facing older children who are the direct victims of domestic abuse within adolescent relationships.

There are also recommendations for strengthening agencies' approaches towards young people who pose a serious risk of harm to others and that it is vital that these are acted upon by law enforcement and child protection services. Thames Valley Police, Oxfordshire County Council and other agencies have already put in place changes to address the issues. A progress report can be found on the OSCB website

Chapter 5: Challenges and messages for the local child protection partnership

National drivers

- Implementation of the Wood Report;
- Implications of the Children and Social Work Bill 2016-17;
- Implications of reduced resources at a national level.

For the board

- Strengthen partnership arrangements as the Children's Trust function is reviewed;
- Continue to better engage with the voluntary and community sector;
- Continue work to check the impact of reduced resources and increased workloads on services to the most vulnerable;
- Test if learning is embedded from the serious case reviews which have been published in recent years.

For local multi-agency work

- Promote continuity and reduce risk. leaders in Local Authorities, Police and Health should initiate and lead the streamlining and refocusing of functions to provide local assurance, scrutiny and challenge of multi- agency safeguarding arrangements;
- Implement the new Children's services delivery model at a local level;
- Ensure good understanding of thresholds and use resources to understand and work with them;
- Be vigilant to emerging pressure points and concerns: breast ironing; cyber bullying; suicide clusters; safeguarding travelling families; transgender young people.

Key priorities

- Ensure that local partnership arrangements are understood and that the 'front door' for safeguarding concerns for children provides a swift and robust response to all children;
- Protecting younger children from the harm of neglect and parental risk factors;
- Protecting older children from harm;
- Testing if learning is embedded across the child protection partnership

Chapter 6: What next for child protection in Oxfordshire

Children's workforce: We know that the volumes of work in the system are high and that you feel that you are dealing with more complex cases than ever before. We are making service providers aware of this through an assessment of impact of reduced resources.

- Take time to go on training; to check out what we have learnt through case reviews already;
- Use your board representative to escalate concerns;
- Make sure you understand the changing 'front-door' to children's services;
- Keep up to date with emerging issues e.g. breast ironing; honour based abuse; child on child abuse and transgender issues.

Children: we value what you have to say. We understand that LGBT is something that you want to talk more about; that we need to find better ways to talk about healthy relationships, consent and sex; that what we understand as 'sexting' is something we need to be better at dealing with. We know that you want more opportunities to be heard and we will support 'Oxfordshire Youth Voice' to do that.

Key Messages to:

The community, faith and voluntary sector: we know that you want more training; better understanding of how to get early help and better understanding of how to work in partnership to provide early help through a CAF;

Our local community: safeguarding is a shared responsibility. Report a concern if you are worried.

Heads and Governors of schools:

- Take advantage of local safeguarding initiatives: the NSPCC Childline assemblies are still being rolled out in Oxfordshire;
- Check your pupil attendance and take action – we know that Oxfordshire schools could do better on this – know pupils' 'whereabouts';
- Get informed. Know how to deal with concerns like sexting; self-harm; radicalisation; transgender pupils; honour based abuse;
- Use the termly e-bulletin to stay up-to-date on safeguarding issues – this comes directly from the safeguarding in education subgroup of the OSCB and ties you in to current issues in the safeguarding system.

Glossary

CAF	Common Assessment Framework
CDOP	Child Death Overview Panel
CiCC	Children in care council
CRC	Community Rehabilitation Company
EIS	Early Intervention Service
FE	Further Education
HBT	Homosexual, bi-sexual and transgender
LAC	Looked After Children
LGBT	Lesbian, gay, bi-sexual, transgender
LIQA	Learning, Improvement and Quality Assurance (framework)
MAPPA	Multi-agency Public Protection Arrangements
NPS	National Probation Service
OCC	Oxfordshire County Council
OH NHS FT	Oxford Health NHS Foundation Trust
OSCB	Oxfordshire Safeguarding Children Board
OUH NHS FT	Oxford University Hospitals NHS Foundation Trust
PAQA	Performance, Audit and Quality Assurance
PPU	Public Protection Unit within the National Probation Service
QA	Quality Assurance
QAA	Quality Assurance and Audit (subgroup)
SCR	Serious Case Review
SRE	Sex and relationships education
TVP	Thames Valley Police
VCS	Voluntary and Community Sector

OSAB | *July 2016* | *Version 6*

Oxfordshire Safeguarding Adults Board 2015-16 Annual Report

Foreword

This is the first report of the Safeguarding Adult Board since the introduction of the Care Act. This report demonstrates the achievements in 2015 -16 which help to build a safer Oxfordshire. It also outlines the key priorities for 2016-17. During the year the independent chair, Sarah Mitchell, stepped down in order to focus on her substantive role with the Local Government Association. I would like to take this opportunity to thank Sarah for the huge contribution she made to the Board during her time in Oxfordshire. We wish her well in her future work.

The report contains contributions from partner organisations involved in safeguarding adults. Following a peer review the Board has reviewed its governance and its structure. There is a culture of trust and mutual understanding developing through greater partnership working as the Oxfordshire Board matures. This work has included joining the training subgroups of the Children's and Adults Safeguarding Boards. This should enhance an understanding of safeguarding across all age groups.

Adult abuse can take many forms; hate crimes, neglect and abuse which can be physical, psychological and financial. Through its partner organisations, the Board will create a culture of transparency which does not tolerate abuse and which takes all concerns seriously. We all have a responsibility to safeguard vulnerable adults and the Board will continue to oversee this work in 2016-17.

Sula Wiltshire
Interim Chair of the Oxfordshire Safeguarding Adults Board
Director of Quality/Lead Nurse, Oxfordshire Clinical Commissioning Group

What is the framework for safeguarding adults?
The Care Act 2014 – General Overview

The Care Act 2014 was introduced in April 2015. It is the most significant change in social care law in 60 years. The legislation sets out how care and support needs should be met. It introduces the right to an assessment for anyone in need of support, including carers and self-funders.

The Act sets out a legal framework for how adults at risk of abuse or neglect should be protected.

The safeguarding duties of local authorities are to:

- lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed (commonly called a Section 42 enquiry)
- establish Safeguarding Adults Boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy
- carry out Safeguarding Adults Reviews when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them
- arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

What is the framework for safeguarding adults?
The Care Act 2014 – Safeguarding Adults Boards

There has been a Safeguarding Adults Board (SAB) in place in Oxfordshire since 2009. The Care Act gave the SAB a statutory footing for the first time.

The Board has three main duties under the Care Act. The Board must:

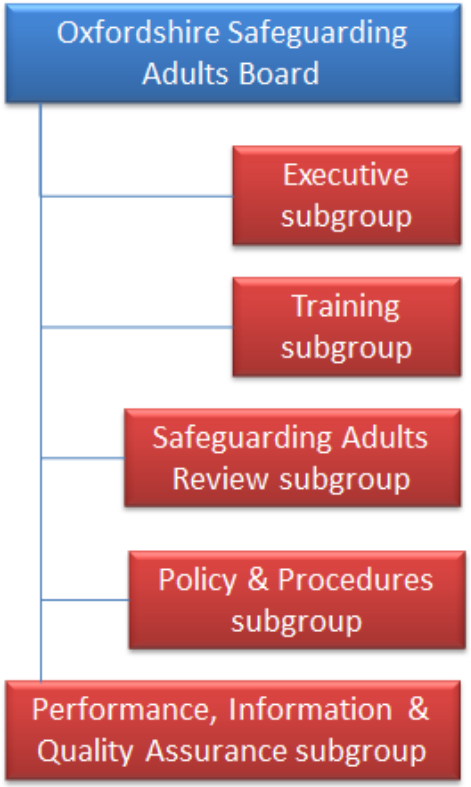
- publish a strategic plan for each financial year.
- publish an annual report detailing what the SAB has done during the year.
- conduct any safeguarding adults review in accordance with Section 44 of the Act.

In order to meet these objectives the board should:

- agree and review multi-agency safeguarding adults policy and procedure for protecting vulnerable adults, taking into account statutory requirements, national guidance and local learning from Safeguarding Adult Reviews.
- monitor incidents of abuse and neglect, reviews trends and regularly evaluate how agencies and providers safeguard vulnerable adults. This should be done by introducing rigorous quality assurance and scrutiny systems across partner agencies.
- agree case review protocol and review and learn from situations where safeguarding arrangements may have been inadequate.
- maintain a programme of training and development on safeguarding vulnerable adults for staff across agencies in the statutory, independent provider and voluntary sectors.
- promote public awareness of safeguarding as an issue for all citizens and engage the wider community in helping to prevent abuse and neglect and to report where they have concerns.

What is the framework for safeguarding adults?
Safeguarding Adults Board – how we operate

The Board is supported by five subgroups (see diagram).



Frequency of meetings

The Full Board, the Executive Group, the Performance, Information & Quality Assurance group (PIQA) and the Training subgroup meet quarterly. The Policy & Procedures subgroup meet bi-monthly and the Safeguarding Adults Review (SAR) subgroup meet monthly.

Membership

The Care Act requires that the Board includes representatives from the Local Authority, Police and the Clinical Commissioning Group. The Board membership in Oxfordshire also includes representatives from other agencies, such as the District Councils, both Probation services and the voluntary sector in order to further strengthen partnership working and develop the role and functions of the Board.

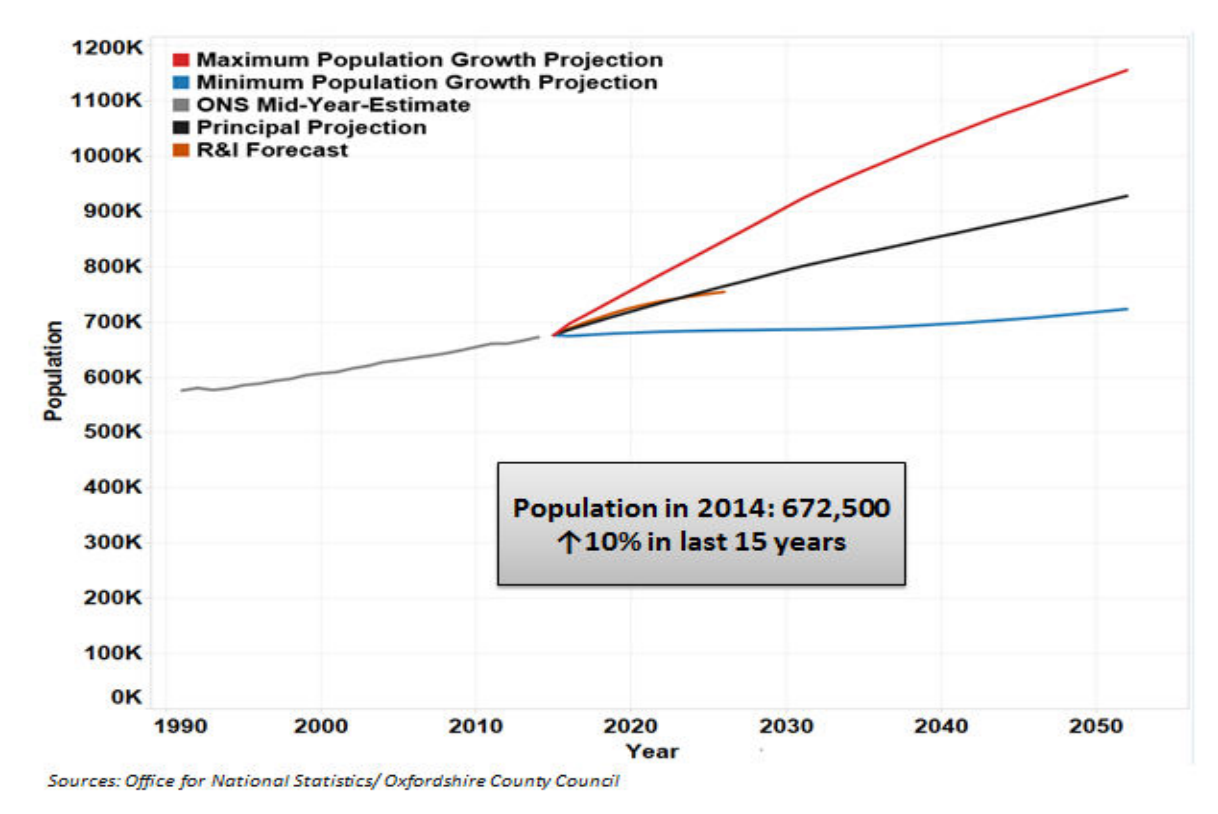
Links with other partnership groups

During 2015-16 a working protocol was developed, setting out how the various multi-agency partnerships work together to safeguard and promote the welfare of Oxfordshire residents, such as The Oxfordshire Health and Wellbeing Board and the Oxfordshire Safeguarding Children Board.

The protocol is waiting on final sign off by all partners and will be active from from summer 2016.

Who are we protecting?
The general population

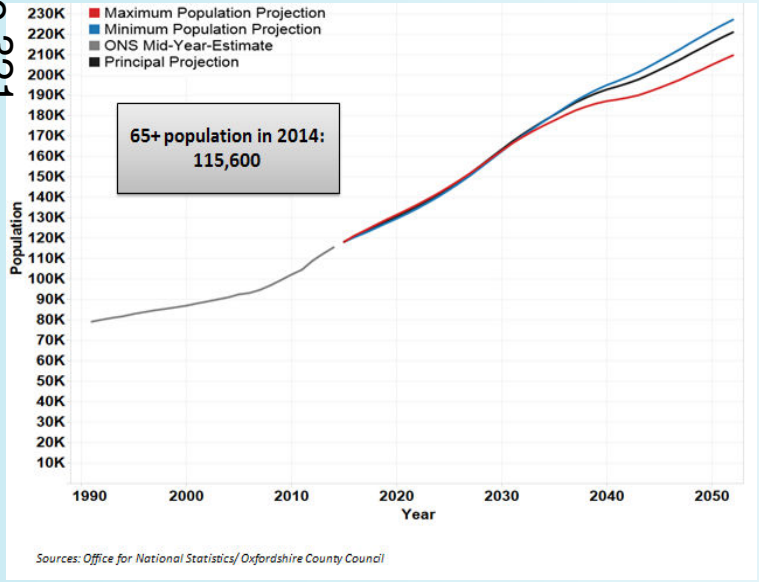
Oxfordshire is home to some 672,500 people. The population has grown by 10% in the last 15 years and a further increase of 13% is predicted over the next 10 years. Oxfordshire County Council's latest population forecast shows the county's population increasing by 86,000 (13%) from 2014 to 2026.

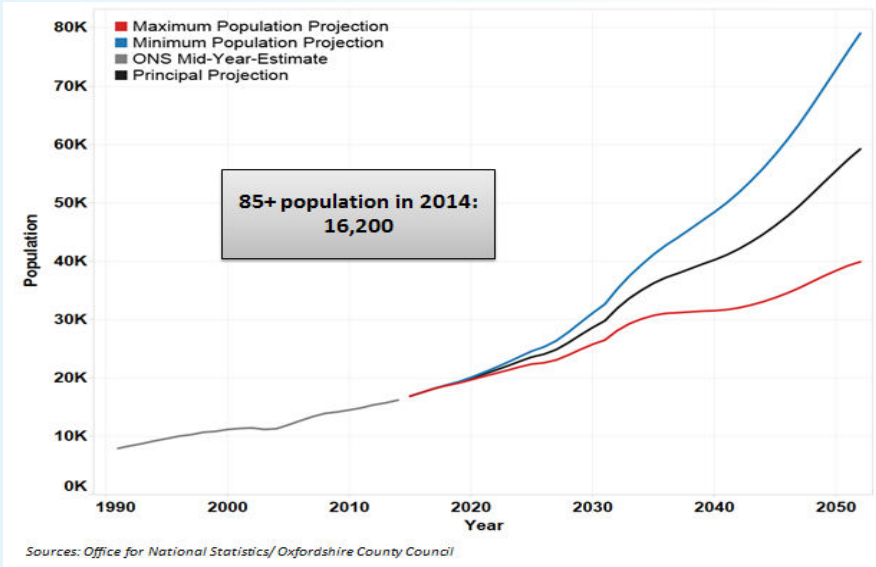


Who are we protecting?
An aging population

There were an estimated 415,800 adults aged 18-64 in Oxfordshire in 2014, representing an increase of 0.9% since 2011. In 2014 there were an estimated 115,600 people aged 65 and over, representing an increase of 11.4% since 2011.

Within this group, the number of people aged 85 and over was estimated to have increased by 10.3%, to 16,200. In 2014 those aged 65 and over made up an estimated 17.2% of the county's population (up from 15.9% in 2011); 85 and overs made up 2.4% (up from 2.2% in 2011). These proportions were slightly lower than in the South East (where 65 and overs comprised 18.6% of the population and 85 and overs 2.6%). They were similar to England overall (17.6% and 2.3%, respectively).





Who are we protecting?
Life Expectancy

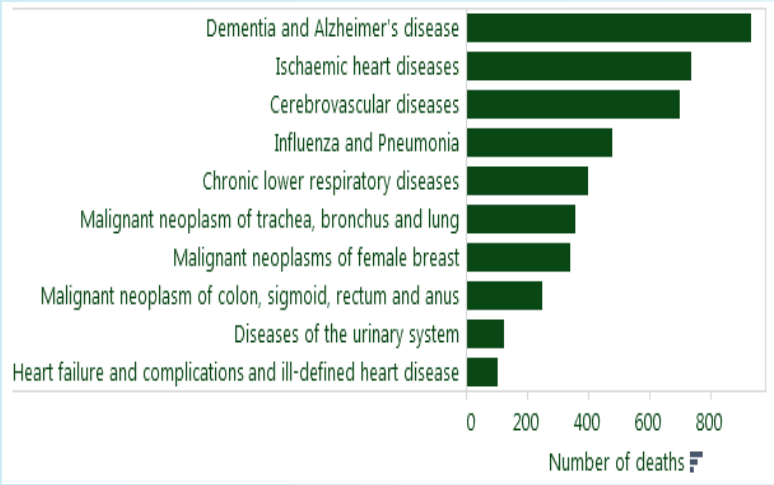
The Office for National Statistics publishes three-year rolling estimates of healthy life expectancy (the number of years of life a person spends in good health) at national, regional and county levels.

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.

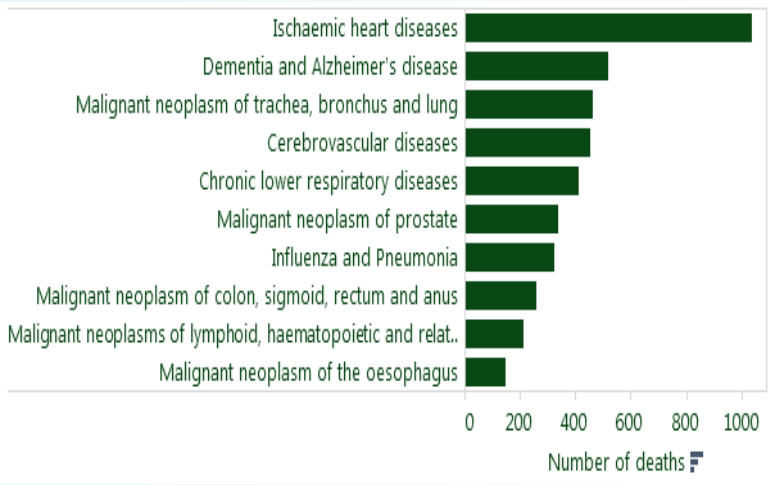
Healthy life expectancy in Oxfordshire is above the national average: for the period 2011- 2013 the average healthy life expectancy for a male born in England was 63.3; for a female it was 63.9.

Oxfordshire is similar to the national picture in terms of leading causes of death in males and females.

Female



Male



Who are we protecting?
Vulnerable Groups

At the time of the 2011 Census, 89,800 people in Oxfordshire said they were limited in their daily activities. This is nearly one in seven people in the county (13.7%). 94.3% of these were living at home. On average, Oxfordshire's people were less limited in their daily activities than in the wider South East, where 15.7% reported this. Levels across England were higher again, with 17.6% saying they were limited. Around two fifths of the people in Oxfordshire who were limited in their daily activities, said they were limited a lot (numbering 37,600, 5.8% of the county's population). Again, this was lower than the proportions seen in the South East (6.9%) and England (8.3%).

Nationally, people with serious mental illnesses and/or learning disability have higher mortality and morbidity rates and die on average 10 to 20 years younger than the general population.

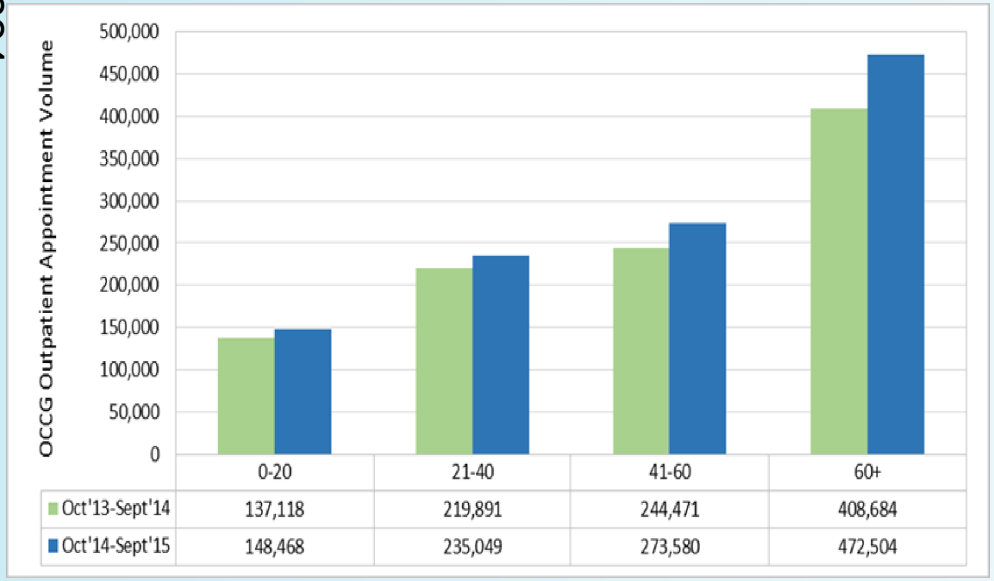
Physical Disability Estimated 30,000 people living with a physical disability in Oxfordshire.	**Autistic Spectrum Disorder** Estimated 6,850 people living with Autistic Spectrum Disorder in the county.
Learning Disability Estimated 2,600 living with a Learning Disability in the county, which is in line with national and regional trends	**Mental Health** Depression & anxiety - 42,600 people living with these conditions, which is a 15% increase since 2013-14. Significant diagnosed mental health disorders – Affects an estimated 5,600 people in the county, a 5% increase since 2013-14. This is in line with national figures

What are our services doing?
Health Services

As with social care services, there is increasing pressure on health services in Oxfordshire. The 74 GP practices in area have 720,029 registered patients.

In the year to end of Sep 2015 there was a:

- 10.6% rise in outpatient appointments
- 1.4% rise in A&E attendances
- 2.2% rise in emergency inpatient admissions



	0-20	21-40	41-60	60+
Oct'13-Sept'14	137,118	219,891	244,471	408,684
Oct'14-Sept'15	148,468	235,049	273,580	472,504

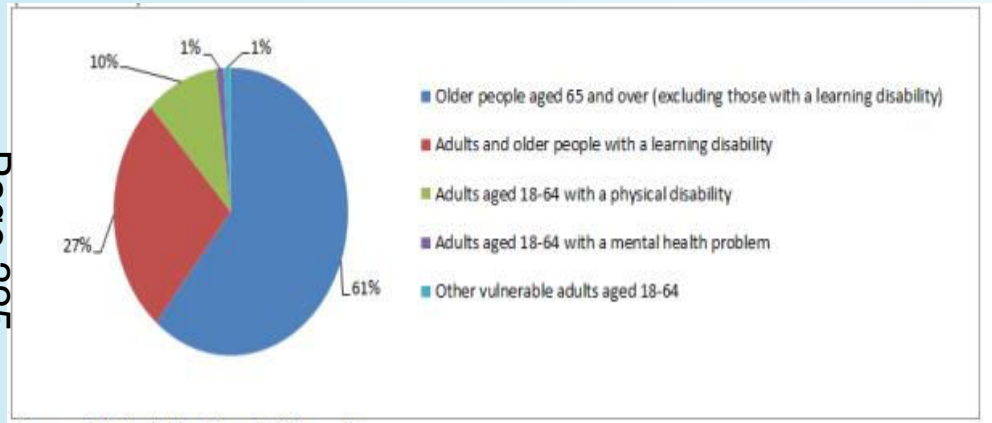
Mental Health Services

In 2014-15 slightly over 10,000 Oxfordshire residents were referred to Oxford Health mental health services and seen at least once. This represents a fall of around a thousand since 2013-14, but is similar to the number in the previous two years. Since some patients were referred more than once during the year, the number of referrals was around 13,500. This number is down on the previous three years.

Almost half of the referrals were for Oxfordshire Adult Mental Health Services (47%). One in five were to the Oxfordshire Older Adult Mental Health Services (20%). Significant minorities of referrals were for Oxfordshire Psychological Services (7%) and Eating Disorders Oxfordshire (2%). The remaining referrals were to other mental health services.

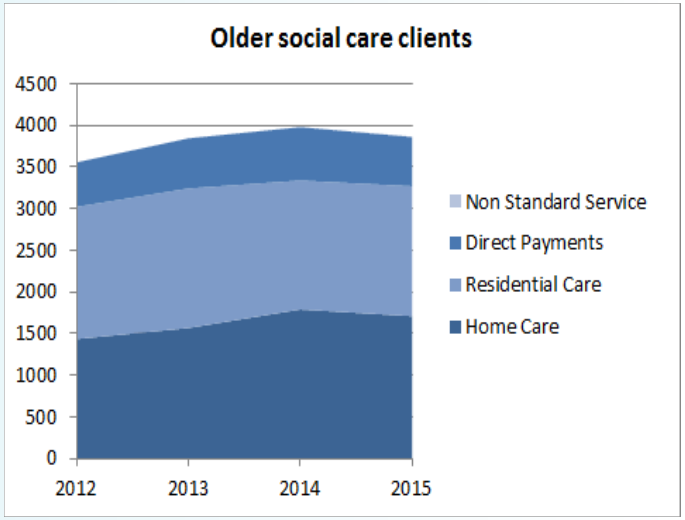
What are our services doing?
Adult Social Care

At the end of March 2015 there were 6,494 adults in Oxfordshire receiving long-term social care funded by the county council. A breakdown by client group is presented in the figure below. This shows that the majority of Oxfordshire's social care clients are older people, aged 65 and over.



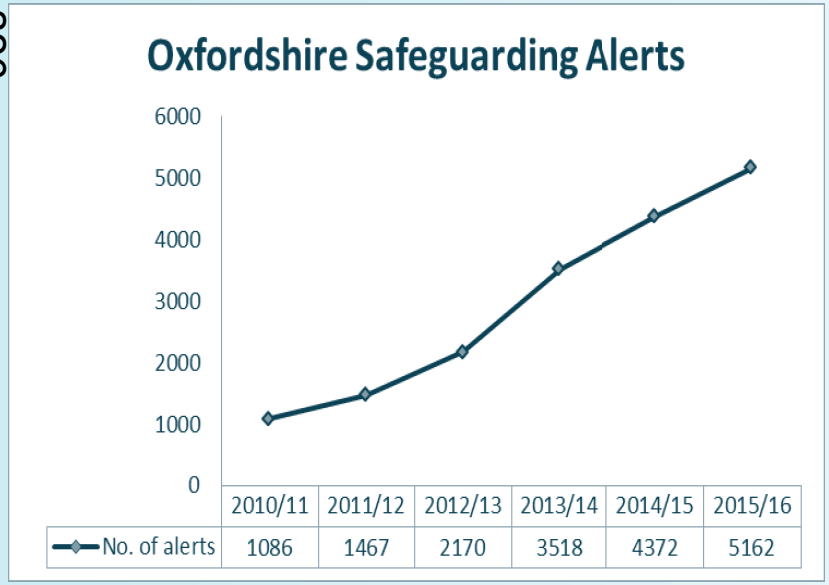
Source: Oxfordshire County Council

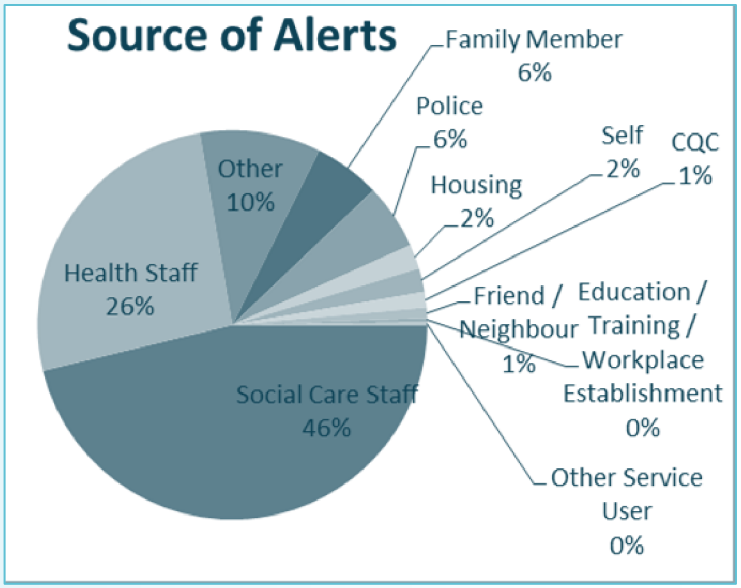
The majority of adult social care users are supported at home rather than in a care home.



How well are we doing?

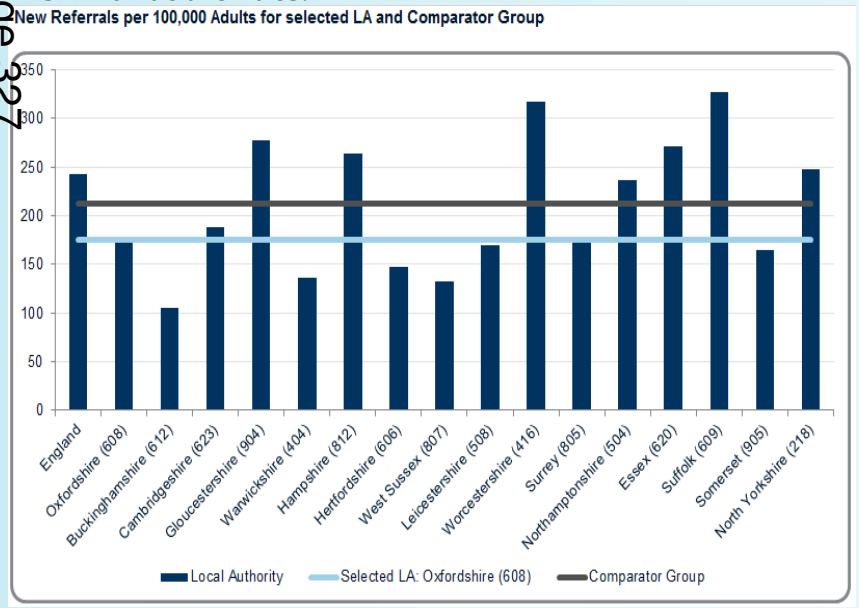
There was an 18% increase in safeguarding alerts (an alert is when someone contacts social services with a safeguarding concern over an adult) in 2014-15, increasing from 4,372 in the previous year to 5,162. This figure has consistently increased over the last five years and the number of alerts is now nearly five times the level in 2010/11. Nearly half the alerts come direct from care providers, a quarter from health with one in ten from family and friends or the person themselves. This demonstrates how the safeguarding of adults with care and support needs is everyone's business. More abuse took place in the home than in any other setting.





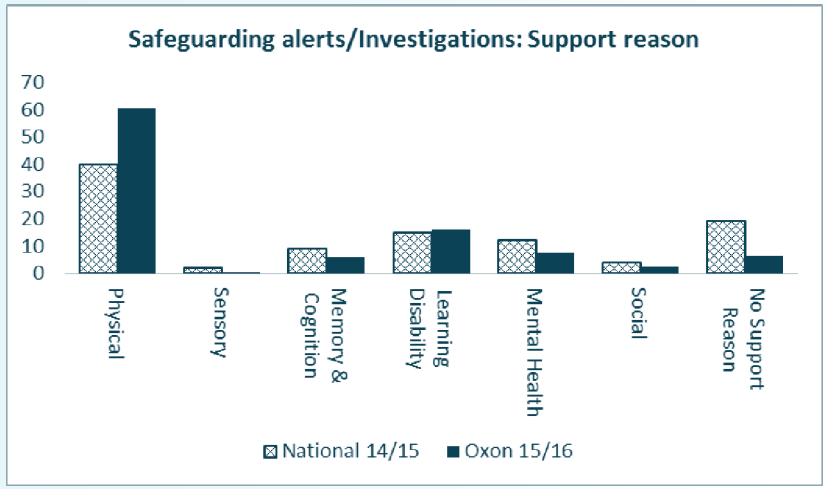
How well are we doing?

In 2014-15 there were 934 referrals - alerts where further work was needed. This equates to 176 per 100,000 population. This was slightly below the level of similar authorities (average 213) and the England average of 243. In 2015-16 there were 1542 enquiries. This is a 65% increase in cases that required further investigation. This equates to 291 enquiries per 100,000 population, which is above both the national rate for 2014-15 and that of similar authorities.



The pattern of support needs in Oxfordshire of people referred to safeguarding is slightly different from the national pattern. More people are in need of physical support , but fewer people who need support for mental health issues. This may in part be explained by high rates of recording of support reasons locally

In Oxfordshire in 2014-15 over half the risk is associated with the care provider. This dropped in 15-16 to 44% but is still above the national level and that of similar authorities.



How well are we doing?

Referrals / investigations

Section 42 of the Care Act places a duty on local authorities to make enquiries, or cause other agencies to do so, to establish whether action is needed to prevent abuse, harm, neglect, or self-neglect to an adult at risk of harm. This change means there is no directly comparable data on section 42 enquiries. However, we previously reported on safeguarding referrals, that is alerts where further work was needed.

During 2013-14, 3.75% of people supported within the safeguarding adults procedures were from **minority** ethnic communities. According to the 2011 census, 9.15% of Oxfordshire's residents come from non-white backgrounds. This discrepancy is largely explained by the difference between age groups. Whereas the proportion of adults under 65 from non-white backgrounds is 9.44% the proportion of adults over 65 from non-white backgrounds is 2.25%.

Ethnicity	No	%
White	1331	96
Mixed	5	0
Asian/Asian British	28	2
Black/African/Caribbean /Black British	17	1
Other Ethnic Group	6	0
Total recorded	1387	
Not known or not declared	155	11
Total	1542	

Last year in Oxfordshire 30% of all alerts progressed to a formal section 42 safeguarding enquiry. There were 1,542 such enquiries. 96% of referrals where an ethnicity was recorded were of white people; 2% were Asian or Asian British and 1% Black, African, Caribbean or Black British.

How well are we doing?

The Care Act amended the type of risks that should be reported on safeguarding cases. This means that direct comparisons are not possible with last year or other authorities. The first table below looks at only the categories of abuse which have not been changed, and the second table at all the categories including the new categories in the Care Act.

Comparing categories of abuse with national figures*

	National 14-15	Oxon 15-16
Physical	27%	24%
Sexual	5%	4%
Psychological/ Emotional	15%	13%
Financial and Material	17%	13%
Neglect and Omission	32%	46%
Discriminatory	1%	0%
Institutional	3%	1%

*The Care Act introduced new categories of abuse so at the time of writing there is no comparative national data from 2014-15 for the new categories. Self-neglect, modern slavery and sexual exploitation data has only been captured since Nov 2015.

Oxfordshire categories of abuse - including new care act categories for 15-16

Physical abuse	**21%**
Sexual abuse	3%
Psychological abuse	12%
Financial abuse	11%
Discriminatory abuse	0%
Organisational Abuse	1%
Neglect and acts of omission	41%
Domestic abuse	1%
Sexual exploitation	0%
Modern Slavery	0%
Self Neglect	10%

How have we responded to the national changes?

In the summer of 2015, OSAB took part in the Local Government Association's peer challenge process. The peer challenge for adults safeguarding is a constructive and supportive process with the central aims of:

- helping a council and its partners to assess its current achievements
- identifying those areas where it could improve.

The peer review is delivered from the position of a 'critical friend' to promote sector-led improvement.

The standards are centred on the following key themes:

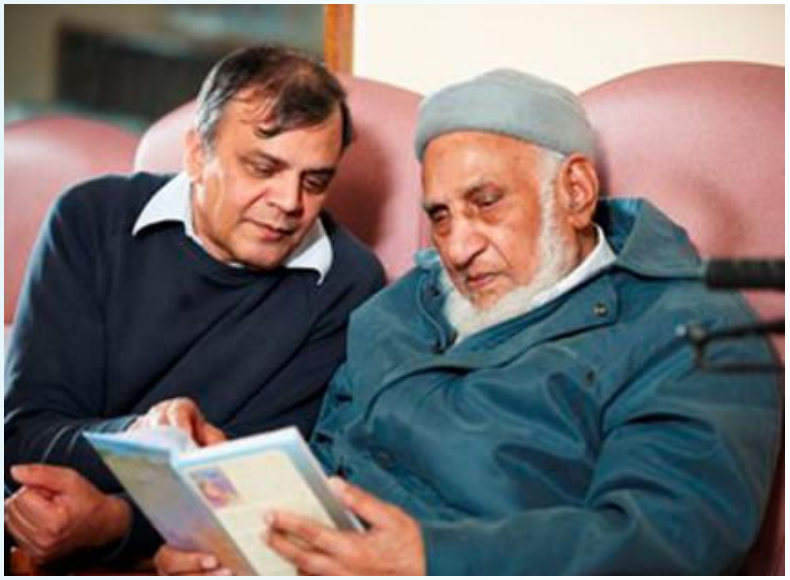
- Outcomes for and the experiences of people who use services
- Leadership, strategy and commissioning
- Service delivery, effective practice and performance and resource management
- Working together.

The Peer Challenge team members were asked to look at the Adult Safeguarding Board in the light of the requirements of the Care Act 2014. The review team members were provided with information on the Board and its subgroups for the preceding 12 months and spent three dates in Oxfordshire interviewing senior staff across all the Board partnership agencies and meeting focus groups of frontline staff, care providers and service users.

How have we responded to the national changes?

The review team felt that OSAB's strengths were:

- **Culture** – the Board member agencies were noted has having an open culture of working together on various levels.
- **Transparency** – the review team were impressed with how open and honest the professionals they met were
- **Evidence of innovation and good practice** – the Board had undertaken work to improve itself and use good practice from other areas to strengthen itself.
- **Commitment to continuous improvement**
- **Ability to deliver change** – the seniority of the Board members, their commitment to improving and the new programmes the Board was planning assured the review team that the Board had the ability to deliver the changes required.



How have we responded to the national changes?

The areas for development identified by the team were:

- **Governance –** It was recommended that the governance arrangements of the Board and its subgroups should be reviewed to ensure all statutory duties are clearly owned. The review also recommended work on the Board's relationship with other partnership groups, such as the Health & Wellbeing Board and the Community Safety Partnerships.
- **Vision, strategic plan and work programme –** The Board had not developed a strategic plan or a clear work programme at the time of the review. This has now been addressed.
- **Evidence –** The team found that the Board received a limited dataset. They recommended further development of multi-agency data and auditing processes.
- **Ensuring consistent practice –** The review recommended the development of a clear thresholds document for Oxfordshire, detailing what does and does not constitute a safeguarding issue that needs to be raised.
- **Capacity –** At the time of the review the Board was primarily funded by Adult Social Care with a contribution from the Clinical Commissioning Group. The review recommended a larger budget drawn from contributions across all agencies who are members of the Board.

Progress to date:

The Board produced and oversees action plan to address the areas for development. The report and action plan is also regularly scrutinised within the County Council's Management Team, led by the Head of Paid Service.

As of 31 March 2016, the two outstanding issues are the publication of this report and the development of multi-agency adult safeguarding training (due to be rolled out in late 2016).

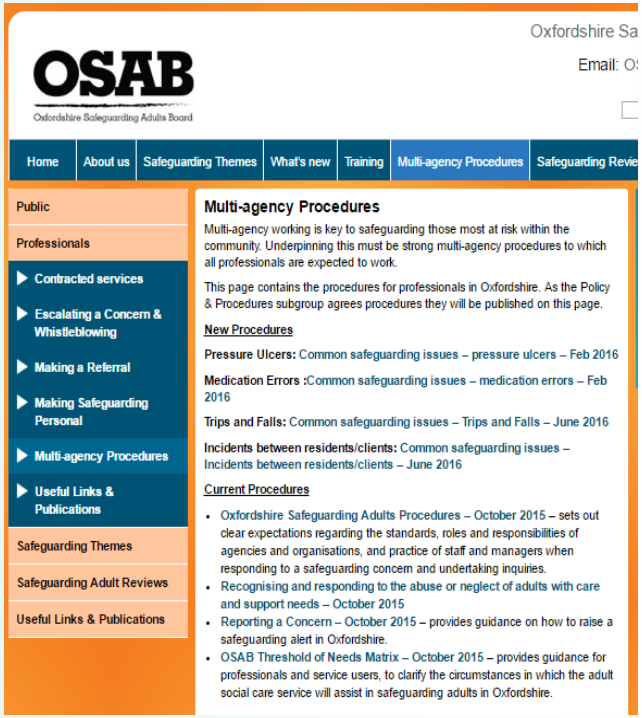
What have the subgroups been doing?
Policies and Procedures

As part of the programme to improve the Board, a new website was developed in 2015-16 . Designed to be simpler to navigate and easier to find, the new website has seen month on month increases in its use (monitored using Google Analytics). While no comparative data is available for the previous website, anecdotal feedback from professionals reports that the simplified layout makes it easier to find what you are looking for.

The Policy and Procedures subgroup of the Board has overseen a complete review of multi-agency safeguarding procedures and the thresholds document. The new manual is on the OSAB website.

The group also produced two documents focusing on common safeguarding issues; medication errors and pressure ulcers. Both were produced to help professionals make more informed judgements on when to raise a safeguarding alert.

These were produced in conjunction with the safeguarding team who helped steer the work of the group towards priority areas. In 2016-17 similar guidance will be produced for trips and falls, self-neglect and hoarding and modern slavery.



What have the subgroups been doing?
Safeguarding Adult Reviews

During 2015-16, ten cases were considered at the SAR subgroup for a possible review. Of these, three reviews were commissioned, two statutory SARs, one was a multi-agency review. None was completed before 31 March 2016, so recommendations cannot be included in this report. It is important that cases are picked up quickly and referred for consideration by the subgroup.

Connor Sparrowhawk and Mazars

Connor Sparrowhawk was a young man with learning disabilities who died in an inpatient unit in Oxford run by Southern Health NHS FT. His death was preventable. In October 2015 the Verita report into commissioning arrangements in the case of Connor Sparrowhawk was published. This was the second report into Connor's death. It focussed on whether the commissioning arrangements had a significant impact on the failures in care. The report identified specific areas of learning but found overall that the failings were in the frontline care delivery.

In December 2015 the "Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015" report was published. This report is referred to as Mazars. The report found that there had been a lack of investigation of unexpected deaths by Southern Health and very poor engagement with families.

In Oxfordshire a full review into all deaths of people with learning disabilities during the 4 year period is now being undertaken. Oxfordshire is piloting the Learning Disabilities Mortality Review (LeDeR) Programme which has been developed by the University of Bristol to look at the deaths of people with learning disabilities. In Oxfordshire the retrospective review and the LeDeR programme have led to the proposal that the Board establishes a Vulnerable Adults Mortality Review subgroup of the Adults board. This proposal is going to the June 2016 meeting.

Multi-agency Safeguarding Training

As recommended in the Peer Challenge Review, the Training Subgroup agreed to coordinate a multi-agency training programme. This has led to the development of the Training Strategy for 2016-17.

OSAB Training Strategy

The OSAB has agreed a training strategy for 2016-17 onwards. A summary is provided below

Purpose of the Strategy

The OSAB strategy is driven by the requirements laid out by the Care Act 2014, Sectors Skills Councils - Qualification Credit Framework, Care Quality Commission Safeguarding Protocol, Ofsted and the Department of Health. The OSAB training strategy will:

- Outline a framework of training to ensure that all people with contact with adults at risk receive the appropriate training required in order to fulfil their roles and responsibilities.
- Identify tools for quality assurance and effectiveness of training activities

Training Principles

The training facilitated by local providers and partners under this strategy will reflect the following principles:

- ***Adults at risk at the centre***
- ***Safeguarding adults is 'Everybody's Business'***
- ***Support performance improvement in safeguarding adults practice***

It is proposed that we will have three courses for practitioners and these will go live in 2016-17

How are we treating vulnerable people?
Dignity in Care Project

In 2015, Healthwatch Oxfordshire (HWO) partnered with Age UK Oxfordshire, the Health Experiences Institute at the University of Oxford and the Oxfordshire Association of Care providers to conduct a project into whether people in Oxfordshire felt they were being treated with dignity.

Why did Healthwatch and Age UK decide to do this piece of work?

A number of concerns about dignity in care had surfaced in several reports by community groups into experiences of their community, which were funded by and published through HWO. Similar concerns had been raised with Healthwatch by both Age UK and the Oxfordshire Rural Community Council. Healthwatch thought this project lent itself to a large-scale 'Enter and View' project. The Oxfordshire Association of Care providers wanted to work with Age UK Oxfordshire and HWO to highlight the importance of getting this right, and also to share good practice through an awards ceremony element.

Who did Healthwatch engage with and how?

The project began with a stakeholder workshop to get a better sense of what issues people had heard about dignity and what areas the project should cover. After this, a small reference group was formed in order to build interest and good will for the project, as well as to ensure that the project could function logistically. Members of this group included; Oxford University Hospitals NHS Foundation Trust, Oxford Health NHS Foundation Trust, Oxfordshire Clinical Commissioning Group, The Orders of St. John Care Trust, Oxfordshire County Council.

How are we treating vulnerable people?
Dignity in Care Project

What did Healthwatch do with our evidence?

Providers and commissioners were asked for a response to the report's findings and recommendations prior to publication. Some highlights from the commitments made for improvements include:

Oxfordshire County Council

The Council agreed to develop standards that promote dignity and are undertaking training of providers of home care to ensure staff work to this framework. Also agreed to commission an expanded advocacy service.

Oxford University Hospitals NHS Foundation Trust

OUH will also look at advocacy and training to ensure dignity and respect are fundamental to all care planning. Piloting a scheme to help increase direct contact care time, which includes a system for escalating concerns within the organisation.

Oxford Health NHS Foundation Trust:

Oxford Health will be delivering a full programme of initiatives designed to improve patient and carer involvement in planning their own care. Six-monthly review will be undertaken and reported at Board level.

What are organisations doing?
Oxfordshire County Council

Adult Social Care has a single point of contact for all referrals - the Health and Social Care Team. In 2015, we implemented a process to enable and encourage the residents of Oxfordshire to stay safe. Staff who took calls in the team asked the caller a series of questions about fire risk, people being distressed by receiving large quantities of junk mail, and distress from telephone cold calls. The information is collated and sent to either the Fire Service or Trading Standards .This has proved very successful and we intend to develop this further over 2016-17.

Adult Social Care launched the on line adult safeguarding alert form for all professionals. The benefit of the form is that it can be completed out of hours and reduces the necessity for professionals to make contact via the phone. The form includes questions directly linked to potential fire risk and issues which may necessitate Trading Standards involvement. Any information received is passed to the relevant agencies to progress.

In 2015, qualified practitioners were invited to take on the role of Making Safeguarding Personal Champion (MSP). The MSP champions' role is to support the learning/awareness of MSP in safeguarding. A MSP champion is responsible for disseminating the MSP knowledge and skills needed for all areas of work so that more workers in the sector build their confidence and understanding of MSP. Adult Social Care currently has 18 MSP champions across the county where evidence as to what has been done will be reviewed.

What are organisations doing?
Oxfordshire County Council

Meeting the Board's 2015-16 priorities

Ensure that people who use Health and Social Care services and their families are at the centre of any decisions about their care and support.

There has been significant work undertaken with individuals in receipt of direct payments to increase their understanding of making safe choices when commissioning their care and support. Updated information is now available and all staff have undertaken refresher training on direct payments. A full day workshop was organised for staff in 2015 run by Research in Practice for Adults (RIPFA) to support them in how to work collaboratively with families to ensure that they are at the centre of any decisions.

Implementation of the Peer Review Action Plan which covers governance arrangements, quality assurance and good practice issues, so that the Board is compliant with the Care Act.

In conjunction with the Quality and Contracts Team there is a quality assurance framework in place for providers. This includes a 'provider dashboard' which identifies those providers where there are concerns in respect of the quality of the care they provide. As part of the framework, Adult Social Care hold serious concerns and standards of care meetings with providers with representation from other agencies including the CQC. The purpose of the meetings is to address areas of poor quality. In November 2015, Adult Social Care launched the new IT system for all practitioners. This included the safeguarding module and the 'Making Safeguarding Personal' process.

In March 2016, the first care governance and change control meeting took place. Its function is to monitor overall performance in relation to Adult Social Care governance. It will also include discussion on the themes and trends that are identified in the reports.

What are organisations doing?
Oxfordshire Clinical Commissioning Group

The role of Oxfordshire Clinical Commissioning Group (OCCG) is to ensure the services which it commissions are delivering high quality care which safeguards vulnerable adults and children. OCCG hold providers to account through contractual mechanisms.

The CCG has oversight of the quality of commissioned services in Oxfordshire. This comprises patient safety, clinical effectiveness and patient experience. This scrutiny of health services informs the Safeguarding Adult Board. The CCG participates in Safeguarding Adult Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews.

An internal audit was carried out of the CCG's adult safeguarding function in 2015-6. The audit demonstrated standards are being met and provided assurance.

We have worked with GP practices to ensure they meet safeguarding requirements. We have assisted with policy development, education and practice development. The CCG has supported practices to fulfil the requirements of the new CQC inspection regime. These inspections have identified areas where further work is required.

The transformation of services and pressures on resources, along with the increased awareness of safeguarding will a present a considerable challenge in 2016-17. Strengthened partnership working, increased shared pathways and provision and multiagency training will be critical.

What are organisations doing?
Thames Valley Police

TVP very much recognise that there needs to be a shared approach towards achieving positive outcomes in protecting vulnerable adults and ensuring that any reports received are thoroughly and proportionately investigated. To this end; in the past year we have improved upon the training for our staff, not only within the specialist teams, but for the front line officers who are most likely to be the first responders to any reports. Training has enhanced officer's skills in investigation and safeguarding. Our SaVE training programme (Safeguarding, Vulnerability and Exploitation) has been delivered across Oxfordshire to enhance our initial response to ensure potential harm is identified at the earliest opportunity.

Domestic abuse is a thread that unfortunately effects many adults within Oxfordshire and is a priority for our Force. The development of the Domestic Abuse champions in our teams in Oxfordshire has enhanced officer's skills and provide a 'subject matter expert' within teams who can assist and guide their peers and colleagues. These individuals are afforded the opportunity to spend days with county specialist investigators in the Domestic Abuse Investigation team.

Collaborative working between the TVP specialist (DAIU) investigation team, Oxfordshire adult social care, partners and CPS has resulted in some significant serious investigations resulting in charging of offenders and prosecutions, including offences of modern day slavery, and investigations into potential neglect of duty in care homes. The partnership is strong in relation to how we work to prevent people coming to harm and to safeguard effectively when the risk is present. This is testament to our shared approach to outcomes.

The OSAB a priority for TVP, with appropriate membership at the Board and its subgroups.

What are organisations doing?
Oxford Health NHS Foundation Trust

In September 2015, OHFT was subject to a full comprehensive inspection from the Care Quality Commission. The CQC rated three domains out of the five quality domains – *caring, responsive and well led as* 'good', in the remaining two *safety and effective* were rated as 'requires improvement'. This gives an overall rating of 'Requires Improvement'. There is a full development plan in place with an aim that the safety and effective domains will become good. In 2015-16 there have been some specific areas of activity in OHFT to promote the safeguarding of patients and there is description of this activity below.

- **Historical Sexual Abuse:** A new process of being implemented to guide staff to respond effectively to people making disclosures.
- **Reducing harm from falls:** Over the last year the Older People and mental health wards have taken a series of actions to reduce the number of falls and level of harm to patients as a result of a fall.
- **Reducing Restrictive Interventions:** OHFT have a series of measure to reduce restraint to circumstances only when it is necessary for the person's safety or that of other people.
- **Reducing harm from pressure ulcers:** Prevalence of pressure damage is reducing as a result of the District Nursing Service trying different initiatives to raise awareness and improve competencies around the prevention and management of pressure ulcers.
- **Suicide:** OHFT employs a Suicide Prevention Lead Nurse. She works with the Suicide Prevention and Intervention Network (SPIN) in the Thames Valley. This includes the development of a support and co-ordination service for people bereaved or affected by suicide.

What are organisations doing?

Oxford University Hospitals NHS Foundation Trust

The team has provided safeguarding advice for 199 situations involving vulnerable adults. There have been 35 Safeguarding alerts made about Trust services. There have been 106 Deprivation of Liberties Safeguards (DOLS) applications.

Key challenges

- The rapidly growing and international nature of the safeguarding agenda for vulnerable adults; particularly surrounding modern slavery, human trafficking, FGM and the vulnerability of people from black and minority ethnic backgrounds.
- The complexity of DOLS applications and delay in assessments following the Cheshire West judgement.
- Domestic abuse and its impact on patients and staff.
- Safe and coordinated discharge of patients, particularly those who are vulnerable, require considerable family or paid carer support.

Key achievements

- Over 10,000 (84%) of our staff are up to date with their safeguarding training.
- The multi-agency discharge liaison hub has been developed in partnership with Oxford Health and Oxfordshire County Council. The hub enables patients previously affected by delayed transfers of care to temporarily move to a nursing home whilst a permanent package of care is finalised and put into place. This has enabled Trust staff and Care home staff to work closely together to safeguard vulnerable people.
- We have trained domestic abuse champions, learning disabilities champions and Safeguarding Leaders.
- A new Safeguarding specialist nurse has joined the team to assist with Mental Capacity Act and Prevent training.
- Partnership working with all the OSAB subgroups , MARAC and the Reducing the Risk Team.

Priorities for 2016-17

1.Empowerment

The Board will continue to work towards supporting people to manage risk in their own lives. This should be clear in all stages of Oxfordshire's safeguarding adults procedures.

There will be an emphasis on reducing focus on process and increasing focus on the individual. The Board will also ensure that there is a greater public awareness of safeguarding adults, while also managing expectations. A coordinated response is important to help increase the safety of vulnerable adults.

2. Protection

The Board will continue to work towards ensuring safeguarding adults procedures respond to abuse or neglect. We will be seeking assurance that care and support is fully compliant with the Mental Capacity Act.

This will be achieved by ensuring that there is a full range of policies, procedures and guidance in place to enable partner organisations to work together to respond to abuse and neglect. These policies, procedures and guidance will be reviewed regularly to reflect emerging developments in national guidance and legislation as well as national, regional and local learning, and new approaches to safeguarding practice. The Board will provide will provide information about what abuse and neglect is, how to recognise the signs and what they can do to prevent and then seek help and support.

Priorities for 2016-17

3.Proportionality

The Board will continue to work on ensuring that safeguarding adults policies, procedures and guidance are used in appropriate circumstances to inform a proportionate response to the concerns being raised.

This will be achieved by ensuring safeguarding adults policies, procedure and guidance are clear and explicit about the definitions and thresholds for intervention and what the potential alternatives are if these thresholds are not met. The Board will also ensure that thresholds are consistently applied by all partner agencies.

4. Prevention

The Board will seek assurance from all partner agencies that prevention is a core element in the development, commissioning and delivery of services. This includes raising awareness of the possibility of abuse ensuring staff are equipped to recognise early signs.

This will be achieved by ensuring the right people are recruited through safe recruitment mechanisms and that all staff receive appropriate training.

Strong risk management and early intervention will support those with care and support needs and reduce the risk harm.

Priorities for 2016-17

5.Partnership

The Board will develop joint working practices between and across organisations that promote coordinated, timely and effective responses for the individual at risk. The partnership aims to foster an approach that places the welfare of individuals above the needs of the system and promotes joint planning.

This will be achieved by ensuring the working relationships between partner agencies, including District Councils, are developed and sustained at a strategic and operational level and links to wider networks or Boards are clear. Learning from reviews will be shared amongst partner agencies and integrated in practice.

6. Accountability

The Board will work to ensure that the roles of all agencies and staff and their lines of accountability are clear. Agencies across the partnership will recognise their responsibilities to each other, act upon them and accept collective responsibility for safeguarding arrangements.

This will be achieved by using a self assessment framework for the Board and partner agencies. The Board will improve the performance management information available on safeguarding adults. This will include feedback from individuals who have been subject to safeguarding adults procedures. Board assurance activity will include assessing whether risk management is proportionate and coordinated.

healthwatch Oxfordshire

1 Introduction

This report summarises the key activities and areas dealt with by Healthwatch Oxfordshire (HWO) since the last Board meeting in July 2016.

In September Rosalind Pearce joined Healthwatch as Executive Director following Carol Moore's return to Canada.

2 Focus

2.1 Health Transformation

Over the past few months Healthwatch has been actively engaged local health transformation programmes:

- Oxfordshire Health Transformation – attending 'Big Conversation' events, Transformation Board, meeting with the OCCG communications and engagement teams
- Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP – Leadership Group (Healthwatch Oxfordshire represent the Healthwatchs in the BOB STP area). In July 2016 HWO made a Freedom of Information request for the draft plan, and now await the outcome of our appeal as this request was rejected.

2.2 Local matters in which we have been actively engaged with include:

2.3 Horton General Hospital – obstetric service, which was suspended temporarily at the beginning of October on safety grounds. Healthwatch Oxfordshire is satisfied that the decision was taken purely on patient safety grounds. The Trust has given assurances that it will continue to attempt to recruit suitable obstetricians, and we hope that this situation can be resolved as soon as possible. As I write the OUHT have announced that the closure will remain in place until March 2017, at the earliest. We will continue to monitor the situation closely.

2.4 Deer Park Surgery, Witney which will be closing at the end of March 2017. Healthwatch Oxfordshire voiced its concerns following the announcement that Deer Park Surgery in Witney. As well as giving radio and television interviews with BBC Oxford, we are attended meetings with the Patient Participation Group, Health Overseeing and Scrutiny Committee and Oxfordshire Clinical Commissioning Group. Healthwatch Oxfordshire is concerned first and foremost that patients, particularly vulnerable patients, must be supported to transfer surgeries and so have continuity of care. While we are also concerned about the impact on other GP surgeries in Witney we understand that they indicated to Clinical Commissioning Group that they could take additional patients subject to support from the CCG in respect of recruitment of doctors and premises. We will continue to monitor this.

The transfer of patients is planned for January onwards, to give GP surgeries time to plan and resource for additional patients. However, we aware that this is causing concern to some patients, particularly the elderly, and we have asked the CCG for more frequent and clear communication with patients can be achieved over the next three months. The concerns are:

- Patients will not move until the last moment and so not get the first choice practice;
- Witney surgeries will seek to 'close' their lists before all patients have transferred;
- The campaign, led by the Patient Participation Group, to keep the surgery open – it currently asking for a 12 month-extension to March 2018 – will give patients false hope and they may not transfer – so we have asked the OCCG to give a 'once and for all' statement on the closure

3 Outreach programme

July, August and September are particularly busy months for Healthwatch staff as they reach out to members of the public to listen to individuals' experiences of health and social care services. By attending local events such as fetes and fairs, play days, Banbury Canal Day, Patient Participation Group days across the county, we can reach a wide population. During these months, we spoke to over 220 individuals and seven different voluntary and community organisations.

4 We heard

Since April 2016 we have been reporting monthly 'This month we heard' on our website. We have now produced our first Quarterly Update, targeted at members and officers of local authorities, health and social care commissioning bodies and service delivery organisations across the county.

Since April we have spoken to at least 400 individuals and 16 organisations about their experiences of health and social care services in Oxfordshire. Monthly reports can be viewed on our web site www.healthwatchoxfordshire.co.uk

The main recurring themes we have been hearing included:

- Support and waiting times for people with mental health problems
- Waiting times and access to make an appointment with a GP
- Praise for many individual GP surgeries
- Long waits for some hospital outpatient services such as cardiology
- Poor communications from hospitals

A hard copy of the full Update is attached, available on our web site and here

Quarterly update Autumn 2016Final.p

5 Projects

5.1 Refugee Resource is looking at access to primary care services of refugees and asylum seekers. The report 'Primary health care services for refugees, asylum-seekers and vulnerable migrants in Oxford city: A study on the experiences of service users and service providers' was published on 16th September 2016. The report, which was produced with the support of Healthwatch Oxfordshire, explored the primary healthcare needs of asylum-seekers, migrants and refugees in the city of Oxford, as there was anecdotal evidence that this group was among those facing the greatest barriers in accessing services. This group, one of the most marginalised and disadvantaged in society, also tends to live in the most deprived areas. The study found that, with a few exceptions, most of the refugees, asylum-seekers and vulnerable migrants interviewed have had positive experiences of accessing primary health care in the UK. Most were very appreciative of the treatment received and the compassion and sensitivity shown by health care professionals toward them. Nevertheless, they face a range of linguistic, cultural and administrative barriers to accessing appropriate care.

The health care professionals involved in the study were all committed to delivering an equitable service for this patient group, and were clearly doing all they could to provide an exemplary service. Nevertheless, they also faced many challenges in meeting the needs of this group who can present with complex health issues related to their experiences of war, torture, exile and loss, as well as the challenges of adjusting to a new life in the UK, often with little or no English.

Because of the findings of this report, Refugee Resource has made several recommendations for the providers and commissioners of primary care services, including:

- Recognising that the health needs of this group is a key inequality issue that requires specific support and resources;
- Making funding available to allow those GP surgeries which see many migrants to offer an enhanced service with longer appointment times;
- Making interpreters more readily available;
- Carrying out awareness-raising/training among healthcare professionals to increase their understanding of the experiences and primary health care needs of this patient group;
- Outreach work in communities with high numbers of refugees, asylum-seekers and migrants to orient them to primary health care services.

5.2 Cruse Oxfordshire - a project assessing experiences of bereavement services in the north of Oxfordshire. The report was published on 1st November. The report findings are themed and focus on the need for bereavement services in Banbury and surrounds:

- **Information** on services for bereaved people needs to be timely, accurate, widely available and comprehensive.
- **Access to services**: this information should enable bereaved people to access the appropriate service for them, through an assessment process and sign-posting.
- **Capacity to respond to need**: people who have been bereaved need a rapid response from the service they choose which means the services need to have capacity, in terms of both people and accessible local venues.

Healthwatch Oxfordshire is keen that the service providers begin to work together to improve access to services through better awareness and coordination.

6 Projects reports in development

Project reports by Oxford Against Cutting and Oxford Parent and Infant Project (OXPIP) will be published by the end of 2016. These will be the last of the Healthwatch Oxfordshire supported voluntary sector reports because of the budget cuts for 2016/17 we are no longer able to fund research by local community and voluntary organisations.

7 Future

The coming months will see Healthwatch Oxfordshire:

Reflect on and respond to the Health Inequalities Commission Report

Continue to actively contribute to the health transformation agenda, focusing on ensuring that the patient and public voice has an opportunity to be heard

Develop our activity around social care particularly around the upcoming changes in home care and day care services

Plan to trial a targeted approach to Healthwatch Oxfordshire activity across a single geographic community

Continue to develop our engagement with Patient Participation Groups and Locality Forums and respond to what we are hearing about the concerns facing patients accessing GP services

Continue to raise our profile across the county

Plan our annual conference for the voluntary and community to be held on 7th February 2017

healthwatch Oxfordshire

Activity update, April to October 2016

What do we do?

Healthwatch Oxfordshire was set up on April 1 2013, as a result of the Health and Social Care Act 2012. Healthwatch Oxfordshire sits alongside 151 other local Healthwatch across the country.

Healthwatch Oxfordshire hears what children, young people and adults have to say about health and social care services, whether that is praise, criticism or ideas for improvement. We strengthen the collective voice of patients and the public, so that service providers and commissioners listen to what they have to say.

We then hold them to account on how they use the information we provide to shape, inform and influence service delivery and design.

Outreach

Healthwatch Oxfordshire maintains a busy programme of attending events across the county, ranging from community play days, markets, conferences, and even a football match at the Kassam Stadium, home of Oxford United, where we were able to speak to men about their health concerns.

Reaching people

Since April we have spoken to at least 400 individuals and 16 organisations about their experiences of health and social care services in Oxfordshire.

The main recurring themes we have been hearing included:

- Support and waiting times for people with mental health problems
- Waiting times and access to make an appointment with a GP
- Praise for many individual GP surgeries
- Long waits for some hospital outpatient services such as cardiology
- Poor communications from hospitals

Contact us

By phone: 01865 520 520

By email: hello @healthwatchoxfordshire.co.uk

Online
www.healthwatchoxfordshire.co.uk/share-your-experiences

Write to us:

Healthwatch Oxfordshire

The Old Dairy, High Cogges Farm

High Cogges, Witney OX29 6UN

Facebook: www.facebook.com/HealthwatchOxfordshire

Twitter: @healthwatchOxon

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Reports

Healthwatch Oxfordshire researches and writes reports on current issues in the local health and care services, and also supports other organisations to do the same.

So far this year, we have published reports on:

Experiences of using Minor Injuries Units in Oxfordshire. This report found that in general people were happy with the service they received from these units and were using them appropriately. However, we recommended that better signposting was needed to raise awareness of these units.

Gypsy and Traveller Community Experiences of Healthcare in Oxfordshire. seAp was awarded a grant from Healthwatch Oxfordshire to carry out a project looking into how members of the Gypsy and Traveller community in Oxfordshire access health services, and their experiences of the NHS. The project also looked at the experiences of the health professionals who treat and support the travellers to understand better the issues from their perspective.

Primary health care services for refugees, asylum-seekers and vulnerable migrants in Oxford city. This report was produced with the support of Healthwatch Oxfordshire, and explored the primary healthcare needs of asylum-seekers, migrants and refugees in the city of Oxford, as there was anecdotal evidence that this group, were among those facing the greatest barriers in accessing services. This group, one of the most marginalised and disadvantaged in society, also tends to live in the most deprived areas.

All reports are available online at http://healthwatchoxfordshire.co.uk/

Annual report

Healthwatch Oxfordshire's annual report was published in June and outlines our activities for the financial year 2015/16.

The report highlights how we have contributed to improvements in local health and social care services, through the publication of reports on **Dignity In Care**, and **Improving Discharges from Hospital**.

The full report is available on our website or we can send you a paper copy on request.

Join our mailing list

www.healthwatchoxfordshire.co.uk/join-our-mailing-list

Looking ahead

We have a workplan in place to enable us to fulfil our mission and work towards our vision, we will:

* Find out about local people's experiences of using local health and social care services.
* Use information about local people's experiences to provide independent and informed advice to relevant local and national organisations about how local services need to change.
* Help to hold those in charge of local health and social care services publicly to account for their agreement to improve services, and to formulate policy and strategy, in line with our advice.
* Provide advice and information to individuals about access to local care services.

Forthcoming work is planned to include a project to assess the affect on services of cuts by Oxfordshire County Council. We sit on the Health And Wellbeing Board, Health Improvement Board, Transformation Board, and Townlands Stakeholder Reference Group.

In addition to reporting to the Health Overseeing and Scrutiny Committee, we will continue to act as the Healthwatch Thames Valley representative on the BOB STP Leaders Group and NHS Thames Valley Priorities Committee, and CQC Quality Surveillance Group.

Agenda Item:

Committee(s) Health and Wellbeing Board	Date 10 November 2016
Health and Wellbeing Board	**Public**
Subject: Review of Children's Trust Board	
Report of : Cllr Melinda Tilley, Chairman of the Children Trust Board	**For information**
Report Author : Tan Lea, Strategic Safeguarding Partnerships Manager	

Summary

The Children's Trust Board (the Board) has undertaken a review of its role, function and purpose.

As a consequence the Board agreed to realign its role and purpose and the way that it operates, with a particular focus on:

- Effective multi agency working at a strategic level across children's services by prioritising three key shared areas which all agencies agree that they can commit to actively working in partnership to exercise influence and ensure positive outcomes for children.
- Enabling Children, young people, their families and carers to shape and inform Children's Trust Board discussions and decisions.

- Developing the Children's Trust Board as a strategic body, able to influence policy and plans where they impact on children and young people.

Recommendation(s)

The Health and Wellbeing Board is asked to note the key change in focus for the Children Trust Board and the intention to strengthen strategic partnership links between the Children's Trust Board and the Health and Wellbeing Board.

Main Report

1. Introduction

1.1 At a workshop held on 27 July 2016, members were consulted on:

- The role and purpose of a Children's Trust Board
- The mechanisms for effective strategic partnership working
- The mechanisms for involving children, young people, their families and carers
- How the Children Trust Board could be established as a strategic body linking with key partnerships boards and structures across children's services and able to influence key plans, policies and agendas in relation to children and young people.

1.2 Following the workshop, officers drafted a proposal for the Children's Trust Board. The model was finalised and agreed with members at the Trust meeting on 29 September 2016 and is presented below.

2. Recommended role and purpose

2.1 Members agreed that the role and purpose of the Children's Trust Board should be to:

- Strengthen key areas of multi agency strategic planning for children and young people, whilst recognising the statutory role of individual agencies.
- Improve outcomes for children in relation to keeping safe, staying healthy, narrowing the gap and raising achievement under the priority areas outlined in section 3 below.
- Drive the integration agenda where there is evidence that integrated working will improve outcomes for children and young people
- Champion the involvement of children, young people their families and carers in partnership working with senior managers and politicians.
- Ensure the Health and Wellbeing Board and other partnerships are sighted on the key challenges facing children and young people in Oxfordshire.

3. The key partnership working mechanisms

3.1.1 A joint focus and three top priorities

Members agreed a joint, strategic focus on the following three priority areas, to be developed either through task and finish groups or existing groups, which will responsible to the Trust for delivering against agreed objectives.

Priority 1: Early Help and Early Intervention.
Led by Lucy Butler, Deputy Director, Children's Social Care, Oxfordshire County Council

Priority 2: Educational attainment for vulnerable groups of children.
Led by Janet Johnson, Children with SEN Manager, Oxfordshire County Council

Priority 3: Managing transitions into adulthood
A lead representing the Oxfordshire County Council Strategic Transitions Group

3.2 Involving children and young people

The newly launched Youth Forum will be a key communication and engagement vehicle for the Trust Board. Further consultation and scoping with the Forum will be undertaken to agree the mechanisms for active involvement with the wider Board.

3.3 A cohesive, coordinated and focussed approach

The Trust will meet four times a year, the agenda for three of the meetings will include a focus on at least one of the priorities listed above and also include time to consider emerging and core business[1]. The fourth meeting will be dedicated to business planning purposes, developing the Children and Young People's Plan and core Children's Trust dataset and potentially linking with other boards to align plans.

3.4 Linking with the Health and Wellbeing Board

The Board intends to use its links with the Health and Wellbeing Board more effectively and escalate children and young people's issues where these are wider than the remit of the partnership and input of the Health and Wellbeing Board would be valuable.

To achieve this the Children's Trust Board will ensure representation at all Health and Wellbeing Board meetings.

3.5 Analysis of need and priority setting

[1] Core business includes:
- Performance monitoring and management
- Updates from partnerships, organisations and members
- New and emerging national, regional and local policy developments and their impact on Business of the Trust.

The Board will use data and analysis from the Joint Strategic Needs Assessment to identify priorities for its business plan and revised Children and Young People's Plan (2017-20).

In line with this, a new revised data set and performance framework is being developed , This will form the basis of regular performance reporting to the Board.

3.6 Have the right membership and representation

The Board has reviewed and updated its membership to align with its new role and purpose.

Details of representative organisations is presented in Appendix 1.

4 Key actions for forward plan

- Publication of annual Business Plan
- Review and publication of Children and Young People's Plan (2017-18)
- Finalise the Children's Trust Performance dataset

5 Summary and Recommendations

This report presents the new role and purpose of the Children's Trust Board.

The Health and Wellbeing Board is asked to note this report and that a key function of the Children's Trust will be to strengthen strategic links between the two structures.

Report of: Councillor Melinda Tilley, Chair of Children's Trust Board

Contact: Tan Lea, Strategic Safeguarding Partnerships Manager, tel 0786 7923 287, or email on tan.lea@oxfordshire.gov.uk

Appendix 1:
Children Trust Board Revised Membership (by sector / organisation)

The Trust membership is drawn from each of the agencies or organisations as set out below:

- Oxfordshire County Council services for education and learning, children's social care, public health, joint commissioning
- City and District Council Members
- Oxfordshire Clinical Commissioning Group
- Thames Valley Police
- Oxfordshire Safeguarding Children Board
- Oxford Health NHS Foundation Trust
- Safer Oxfordshire Partnership
- Oxford University Hospitals NHS Trust
- Voluntary Sector representation
- Representation from schools and colleges
- Parents appointed by Healthwatch Oxfordshire as Healthwatch ambassadors
- Formal links to Oxfordshire Youth Forum

Membership will be reviewed and agreed annually

The Chairman
The Trust will be chaired by the Cabinet Member for Children, Education and Families Oxfordshire County Council.

The Vice Chairman
The Vice Chairman will be a representative from Oxfordshire Clinical Commissioning Group.

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Health and Wellbeing Board
10th November 2016
Joint Management Group for Adults Briefing

On 24th May 2016, Oxfordshire County Council Cabinet approved the pooled budget arrangements with Oxfordshire Clinical Commissioning Group, and the move to a single joint management group in adults, replacing the four joint management groups used to meet to look at individual pooled budgets for older people, people with learning disabilities, people with mental health conditions and people with physical disabilities.

The Joint Management Group for Adults is chaired by the Cabinet Member for Adult Social Care. Senior representatives from Oxfordshire County Council and Oxfordshire Clinical Commissioning Group are the members of the Joint Management Group. The Group has the overall responsibility for managing four pooled budgets in order to ensure effective delivery of health and social care in Oxfordshire.

The Group met for the first time on 27th September and had discussions on performance, finance and activity for older people, learning disability, physical disability and mental health pools as well as cross pool issues.

The group also received an update on 'Sustainability and Transformation Plan for Buckinghamshire, Oxfordshire and Berkshire West'. Roadshows in Oxfordshire were successful in bringing a range of people together to discuss how to keep people healthy and provide the best care when they need. The public consultation is deferred to December 2016 to further develop the business case.

The group received updates on ongoing carers' consultation and daytime support and respite reviews. The review of daytime support in Oxfordshire will come up with a proposed model to support adults, which will be subject to public consultation from November. Respite review will be introducing significant improvements to the service and will not require public consultation.

The group also discussed the impact of national increase in the rate paid by funded Nursing care on pooled budgets, plans for moving to a compliant process for Oxfordshire and the potential to mitigate the pressure created by the increase.

The group approved outturn of the pools as at 31st August. Plans are in place to meet the overspend and pressures on the pools.

Fulya Markham, Policy Officer

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An update of the work of the Health Improvement Board
Report to the Oxfordshire Health and Wellbeing Board
November 2016

Since the last report to the Health and Wellbeing Board, the Health Improvement Board (HIB) has held 2 meetings in public and convened a workshop on Housing Related Support with a range of partners.

A summary of the business of these meetings is given below.

1. Health Improvement Board meeting, 7 July 2016.

Board members reviewed the end of year performance on all the priorities they oversee and discussed the final draft of the Joint Health and Wellbeing Strategy (JHWBS) prior to its presentation to the Health and Wellbeing Board. A target for successful move-on for young people leaving supported housing was agreed and is now in the performance framework. This is a new addition to the range of housing related targets in the JHWBS, all of which enable Board members to monitor housing and homelessness related activity across the county.

The Board also discussed the revised Healthy Weight Action Plan which has been expanded following the successful workshop in April. The plan covers healthy eating, increasing physical activity, environment issues that promote active travel and a focus on workplace wellbeing.

Councillor Jeanette Baker was welcomed as the new representative of West Oxfordshire District Council.

2. Housing Related Support workshop, July 2016

The members of the Health Improvement Board were joined by local councillors with responsibility for housing and officers from District Councils and the CCG to discuss plans for future commissioning of housing related support. Agreement was reached on a way forward.

As a result of this work an implementation plan is being developed jointly and will be agreed in November, after which conversations with providers about new arrangements can begin. A legal agreement for the new partnership arrangements is being drafted to come into effect from April 2017.

3. Health Improvement Board meeting, 20 October 2016

A very full agenda included discussion on the Government's Childhood Obesity Plan so that our local Healthy Weight Plan can be considered in the light of national policy. The Board also received annual reports on Health Protection, Air Quality and the Alcohol and Drugs Partnership. They then discussed the content of the Director of Public Health Annual Report.

A report on the work of partners engaged in developing the Bicester Healthy New Town was presented to the Board and was welcomed. A report on the Barton Park Healthy New Town will come to a future meeting.

Future meetings

Future plans for the Health Improvement Board include the following:

- A workshop to discuss the issue of Fuel Poverty and explore options to expand and sustain the work that addresses this locally.
- The Board and invited colleagues will also continue to make detailed plans for commissioning Housing Related Support
- The Board members have expressed interest in convening a workshop to discuss the recommendations in the Health Inequalities Commission report.

Jackie Wilderspin, November 2016

Communications received by the Chairman July - October 2016
Report to the Health and Wellbeing Board, November 2016

The Chairman of Health and Wellbeing Board receives correspondence from a range of partners and stakeholders. The Board agreed a process by which this correspondence can be responded to or directed to the most appropriate individual, organisation or group for action. The table below summarises activity from July to October 2016

Date received	Communication topic	Action taken
7.5.16	Establishment of the Banbury Citizenship project	Details were forwarded to local project leaders in Banbury
15.6.16	KEEN Oxford re. funding for physical activity opportunities for people with a learning and physical disability	Response sent recommending links with Oxfordshire Sport and Physical Activity (OxSPA)
13.7.16	National Energy Action enquiring about Oxfordshire's actions to address cold-related ill health to be included in their annual report.	A response was given outlining the work of the Affordable Warmth Network and the Health Improvement Board in this regard.
8.10.16	Mr. I. Ashley, local resident, asking for more details about the Joint Health and Wellbeing Strategy and outcome measures	An email response was given with links to relevant public documents.

Any questions on this report can be directed to jackie.wilderspin@oxfordshire.gov.uk

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