DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE ANNUAL REPORT 2005-2007

SUMMARY

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

The aim is simple: to galvanise action on four main threats to the future health, wellbeing and prosperity of Oxfordshire.

The four topics are:

- An ageing population – the "demographic time bomb"
- Breaking the cycle of deprivation of children and families
- Preventing obesity: a major cause of chronic disease
- Fighting infectious diseases

Progress made will be monitored in future reports.

Your comments are welcome. In the time available to produce this report it has not been possible to secure the views of everyone. I intend to update this report in the autumn to take account of further comments received.

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

I hope you enjoy the report and act upon it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire

March 2007

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INTRODUCTION

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

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

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

New opportunities for this role opened up in 2006 with the appointment of a Joint Director of Public Health by the County Council and NHS: the first time in over thirty years that a Director of Public Health has been appointed by local government.

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

What is the remit of this particular annual report?

This annual report marks a departure from the norm. Traditional reports concentrate on the year that has passed and make recommendations for the year to follow.

Because this report marks the beginning of a new era for public health in Oxfordshire, it aims to highlight the main challenges posed to the public health during the next ten to twenty years which are not yet receiving sufficient focused attention. **The overall thrust of the report will be to recommend that consistent and concerted action is required by a wide range of organisations working closely together across Oxfordshire to combat four main challenges**. These issues will be returned to and reported on year by year and it is hoped in this way that a sense of direction and continuity can be maintained which will lead to an improvement in the public's health.

The main challenges are:

- OLDER PEOPLE: The "demographic time bomb" – providing services for an ageing population.
- CHILDREN & FAMILIES: Breaking the cycle of deprivation of children and families
- OBESITY: Combating this "modern epidemic" caused by current lifestyles
- INFECTIOUS DISEASES: Infectious diseases, such as MRSA, pandemic influenza, TB and HIV

The need for further discussion

This report is a starting point. It sets out clear recommendations but it also forms the starting point for three months of further discussion with agencies and groups across the County. It has not been possible to discuss the issues raised in this report with all the groups and agencies I would have wished in the time available before publication. I intend, therefore, to produce an updated version of this report in the Autumn and to update the recommendations following further discussion. Nevertheless, I felt it was crucial to set out a clear set of priorities to guide planning for 2007/8 and into 2008/9.

Public Health: everyone's business

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

The content of this report

The first four chapters of this report set out the major challenges for the future. It also sets out progress made in 2005/6 and 2006/7 as reported by previous Directors of Public Health and details the recommendations made in key reports on topics such as 'Choosing Health' (Annex 1).

A comprehensive set of public health indicators will be made available for the autumn update which will allow progress to be monitored on a wide range of issues.

Progress against recommendations will be reported each year and new challenges (such as action to improve mental health) added as required. In this way, this document has been designed as a tool to be used. If its fate is to sit on shelves gathering dust, it will have failed. I hope you enjoy it and act on it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire

March 2007

CHAPTER ONE: An Ageing Population: the "demographic time bomb"

The Issue

England is undergoing a profound demographic change and Oxfordshire is no exception. The main features are:

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

This issue is well recognised locally. Recent reports by the Patient and Public Involvement Forums and Scrutiny Committees across the county flag up similar concerns. Organisations have begun to respond but more needs to be done.

This issue is wide, complex, difficult to deal with and politically sensitive. It touches on topics such as housing quality, rural transport, means testing, bed blocking, community hospitals, affordable housing for care workers, mental health problems, an ageing population of people with learning disabilities and the needs of carers. Given this list of thorny issues, organisations will need courage and determination to work together to tackle this problem.

The problem will not go away and remains, perhaps, the most serious issue for the future well-being of the county.

The size of the issue

The table below details population growth across Oxfordshire. It shows growth in the 85+ population in Oxfordshire of 126%, an increase of around 14,000 people. Not all parts of the county are affected equally. The impact is highest in Cherwell and lowest in the City.

Population Change in Oxfordshire 2004 – 2029

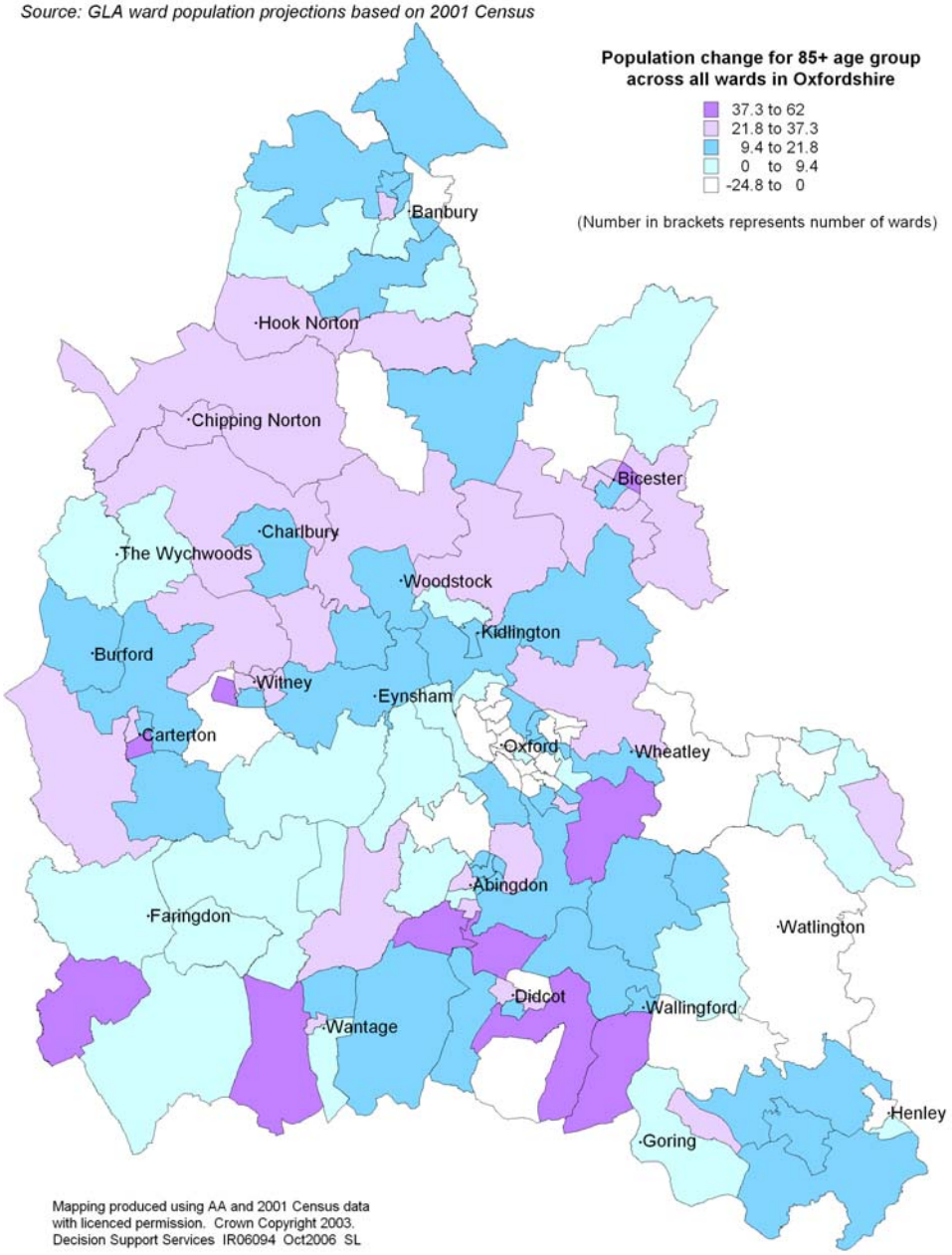
Geographical Area	AGE 65+			AGE 80+			AGE 85+		
	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029
Cherwell	18.8	34.9	85.6%	5.1	11.1	117.6%	2.2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

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

Ageing by ward

Population change for people aged 85 years and over (2006 to 2011)

Source: GLA ward population projections based on 2001 Census



Areas which have the highest level of growth need a targeted approach to ensure that services can meet growing demands. As the map clearly demonstrates, high growth areas are located in rural areas where transportation can be a barrier to service access.

A time of opportunity

It is clear that a sustained, long term, collaborative approach is needed. The public will have strong views on these issues and also need to be fully involved from the outset.

In Oxfordshire, we have two main assets on which to build:

Firstly, work has begun or is planned to tackle some of the complex issues described above. These initiatives are not sufficiently joined up yet, but they will make excellent building blocks.

For example, work has begun on:

1. Urgent care
2. Community hospitals
3. Supporting people in their homes
4. Better support for carers
5. A strategic approach to mental health problems

A second asset is the increasing willingness of organisations to work together in partnership. The Oxfordshire Partnership, Public Service Board and the increased prominence of Local Area Agreements all encourage greater collaboration across the county. In addition, the NHS and Local Authorities are keen to take a longer term approach to problems and to create a "Health and Wellbeing Partnership" to tackle these issues. At the same time, Local Strategic Partnerships in districts, the developments of practice based commissioning consortia and stronger locality working across the county holds the promise of better local services shaped for local people. In addition, the public and democratic voices are strong through Patient Forums and Scrutiny Committees.

In short, we know what the problem is. What we need to do it is becoming clear and a means of doing it is taking shape.

Barriers

It is important not to underestimate the barriers that will have to be cleared away if we are to be successful. Some longstanding areas of tension will need to be tackled head on. These include:

- Tensions arising from the way care is funded, especially means-tested social care and NHS care;
- Tensions between County priorities and local priorities;
- The possible need to move funding from one part of the county to another;
- The need to invest in long term preventive services in a short-term financial environment.

A way forward

We need to use 2007/8 to regroup organisations in Oxfordshire to tackle this issue. The solution must lie in working in partnership through the Local Strategic Partnership in a systematic and disciplined way. Key to success will be the development of a new Health and Wellbeing Partnership.

Recommendations

1. The Oxfordshire Partnership should agree to set up a Health and Wellbeing Partnership to lead a long-term countywide approach to plan for demographic change in older people by the end of June 2007. The first meeting of the Partnership should have occurred by September 2007.

2. The Oxfordshire Partnership should agree that this topic will form a main theme of the evolving Sustainable Community Strategy by September 2007.

3. Oxfordshire PCT should include the need to tackle the demographic time bomb in the strategy it is currently preparing. The PCT should then commission services specifically to meet the challenge of demographic change in the Local Delivery Plan (LDP) for 2008/9.

4. Specific targets for services should be agreed by the Health and Wellbeing Partnership and included in the refreshed Local Area Agreement by October 2007 so that progress can be explicitly measured.

5. The Health and Wellbeing Partnership should include an explicit preventative strategy as part of its work plan by October 2007. This should include the prevention of problems in older people and also in the adult population.

6. The Health and Wellbeing Partnership should calculate the economic impact of demographic change on older people in terms of service costs to NHS and Local Authorities by September 2007.

7. The Health and Wellbeing Partnership should commission work to quantify the savings to be made by investing in preventative services for elderly people from 2008/9 showing return on investment at 1 year, 3 years, 5 years and 10 years by October 2007.

8. The Health and Wellbeing Partnership should work during 2007/8 to ensure that explicit provision to tackle the demographic time bomb is included in public sector budgets for 2008/9 onwards, subject to the funding provided by central government and the impact on council tax for local authorities.

9. The Health and Wellbeing Partnership should identify the areas of greatest need within the county by October 2007. These should be defined as the parts of the county which will experience the greatest rates of growth of older people and parts of the county in which older people experience the highest

levels of poverty, whether rural or urban and use these to target resources in financial plans from 2008/9.

10. Scrutiny Committees should be encouraged to monitor progress against these recommendations throughout 2007/8.

11. The Health and Wellbeing Partnership should work with other strategic bodies in the county to influence the development of transport strategy, economic strategy, workforce strategy, housing strategy, carers strategy and mental health strategy by October 2007.

12. Practice Based Commissioning should agree its role in tackling demographic change in older people through prevention and service change by September 2007 and build this into a specific practice based commissioning plan for 2008/9 by December 2007.

CHAPTER TWO: Breaking the Cycle of Deprivation of Children and Families

Most children and young people in Oxfordshire are healthier than in many other parts of the country and can look forward to a bright future. A good start has been made on working together in partnership to improve the health and wellbeing of children. Despite this, there remain areas of stubborn inequalities across the county, poorer prospects and poorer health being handed down from one generation to the next. If we are to break this cycle of deprivation, further concerted action is required. This chapter sheds light on remaining inequalities and makes recommendations for action.

Variations in health outcomes

National statistics show that childhood deprivation is closely associated with poor health. Babies born in disadvantaged areas are more likely to have a mother who smoked while pregnant, be born prematurely or too small and are less likely to have been breast fed. They are at higher risk of health problems such as congenital abnormalities, disabilities, sudden infant death syndrome, infections such as chest infections or glue ear, asthma and to miss some immunisations. Sadly, they are also more likely to experience harm through accidents and neglect. Poor mental health is also a major concern. Levels of post natal depression tend to be higher among women who are young mothers, poor or unsupported due to lone parenthood or family breakdown. On average, children and young people in deprived areas experience higher rates of emotional and mental health problems such as depression and conduct disorders. The reasons why families experience deprivation and the mechanisms by which poverty affects health are multiple, complex and broader than income alone.

A good start has been made to tackle these problems in Oxfordshire through the Children and Young People's Board, but more remains to be done.

The remainder of this chapter details some of the biggest gaps in health that remain in Oxfordshire and recommends action to be taken.

Measure 1: Deprivation in Oxfordshire as a measure of child poverty

Oxfordshire has 19 small geographical areas in the top most 20% deprived in England in terms of Child Poverty. Most of these lie within the City of Oxford with two in Cherwell (Banbury) and one in the Vale of the White Horse (Abingdon area).

Five of these areas in Oxfordshire fall within the 10% most deprived in England and one of these is in the top 5%.

These five areas stand out as the most deprived. There will be other areas across the county where deprived areas are masked by areas of neighbouring affluence.

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

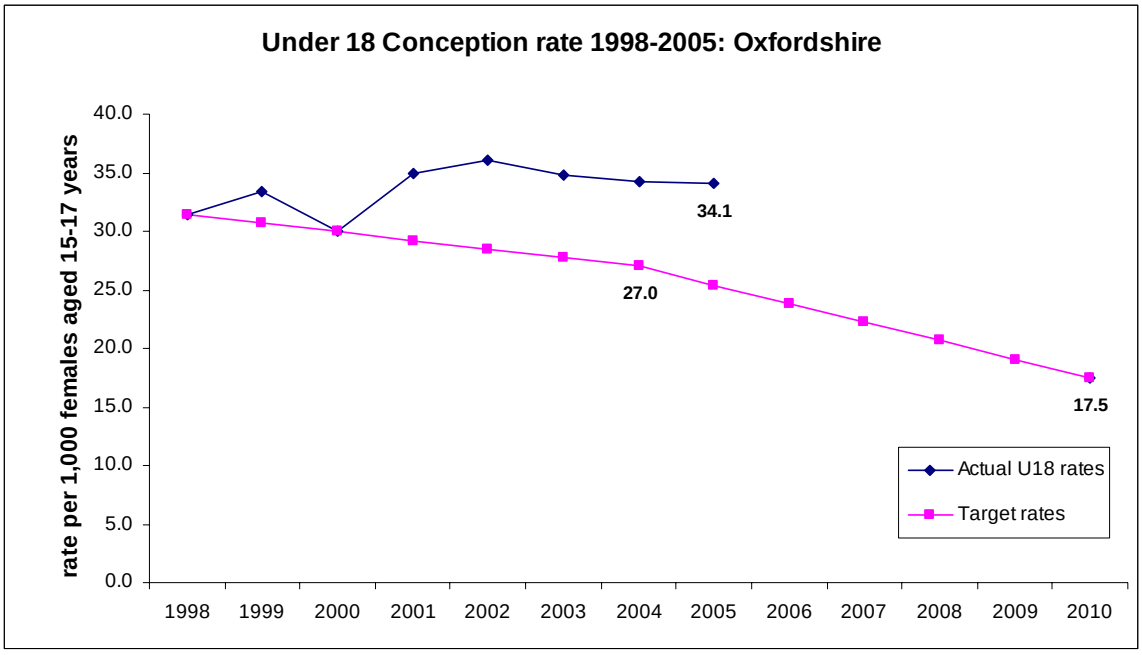
Measure 2: Life expectancy

In Oxfordshire there are considerable variations in health outcomes. Predicted life expectancy is a useful measure of this. Analysis shows that there is a 15 year difference in life expectancy between the best and worst wards in the county.

Measure 3: Teenage pregnancy

Teenage motherhood is strongly associated with deprivation and with cycles of deprivation down the generations. During the period 2003/2006 the percentage of babies born to women under 18 in the 30 least deprived wards in Oxfordshire was around 1% compared to 2.6% in the 30 most deprived wards. In other words, teenagers in the most deprived wards are two to three times more likely to have babies than teenagers in the least deprived wards.

Teenage conceptions



(Oxfordshire PCT: Decision Support)

Under 18 conception rates in Oxfordshire are below the national average and have just begun to show a slight downturn in the last two years. A strategy that continues to target the wards with the highest rates is crucial. There is no room for complacency.

Teenage Parents are more likely to stop schooling, therefore their health and that of their children may be affected in a cycle of poverty. Children born to teenage mothers are themselves more likely to become teenage parents. Targeting our efforts to break this cycle is of prime importance.

Measure 4: Breast feeding

Breast feeding has health benefits for both mother and baby. There are marked social and cultural differences in breast feeding rates nationally and locally. Rates are higher among women in professional and managerial groups and lower in disadvantaged areas by around 10 percentage points on average.

Table 3: The percentage of women initiating breast feeding in the most advantaged and most disadvantaged wards in Oxfordshire

LOCALITY	2003/2004	2004/2005	2005/2006
All wards	76.0%	75.3%	78.2%
30 least deprived wards	80.6%	76.4%	81.7%
30 most deprived wards	68.9%	69.7%	71.4%

For example: for the period 2003 – 2006 the percentage of women who initiated breast feeding in Henley South was 95% and the percentage in Blackbird Leys was 56.6%. This means that a baby born in Blackbird Leys is around 40% less likely to be breast fed than one born in parts of Henley.

Measure 5: Smoking

Smoking during pregnancy is associated with low birth weight while exposure to cigarette smoke puts children at risk of conditions such as chest infections, asthma, glue ear. The table below shows that mothers in the most deprived wards are between two and three times more likely to smoke than those in the least deprived wards.

Table 1. Percentage of women smoking at time of delivery 2003/2006 in the most advantaged and most disadvantaged areas of Oxfordshire

LOCALITY	% of smokers
All wards	9.6%
30 least deprived wards	5.5%
30 most deprived wards	14.2%

Measure 6: Unintentional injuries

Unintentional injury is a leading cause of death and illness among children aged 1-14 years. More children are admitted to hospital following accidents than for any other cause and accidents kill more children every year than illnesses such as meningitis and leukaemia. Preventing unintentional injuries is a key priority in improving health and reducing inequalities in health.

Overall, deaths from unintentional injury have decreased. However, there are persistent and widening inequalities. National data shows that children of parents who have never worked or who have been unemployed for a long time, are 13 times more likely to die from unintentional injury than children of parents in higher managerial and professional occupations. Oxfordshire figures show that, in the period 2003/2006, the rate of emergency admissions to hospital among children aged 0 – 4 years in the 30 least deprived wards in the county was 208 per 1,000 and, among children in the 30 most deprived wards, the rate was 306 per 1,000, around half as much again.

Measure 7: Educational attainment

Vulnerable groups of children (particularly children from some ethnic minority communities, looked after children and teenage mothers) are less likely to do well in terms of educational attainment.

Educational attainment is a useful indicator. It provides a very general summary of a child's progress to date and also points forward to future prosperity. Many factors go into achieving good educational attainment, from good parenting to good diet and good health as well as having high quality schools. Differences in attainment are a good way of identifying local areas where action is needed. A good education is key to breaking the cycle of deprivation.

The table below shows that, while GCSE attainment in the state schools as a whole between 2004/5 and 2005/6 went up, attainment for children in ethnic minority communities as a whole fell.

Group	% achieving 5+ A – C GCSEs 2004/05 (including English & Maths)	% achieving 5+ A - C GCSEs 2005/06 (including English & Maths)
All Pupils	45.3%	47.5%
Bangladeshi Pupils	32.0%	20.0%
Pakistani Pupils	34.0%	30.0%
Indian Pupils	43.0%	34.0%

(Oxfordshire Children and Young Peoples Board Briefing Paper 12/2006)

The tables below show further discrepancies in attainment between districts in the county. Pupils in South and West Oxfordshire achieve markedly better results than those in Cherwell and the city.

all pupils

	District				
	South	Cherwell	City	Vale	West
No of pupils on roll	1,765	1,325	1,020	1,123	1,265
% achieving 5 + A-C grades incl maths and English	56.8	38.6	39.4	46.5	54.5
Number of Pupils	1,003	511	402	522	689

There is also a further inequality in evidence. In all districts, girls out-perform boys in attainment in GCSEs by up to 13 percentage points. Again, the gap varies in size between districts.

boys

	District				
	South	Cherwell	City	Vale	West
No of pupils on roll	911	649	514	597	652
% achieving 5+ A-C grades incl maths and English	52.9	36.4	32.9	44.2	48
Number of Pupils	482	236	169	264	313

girls

	District				
	South	Cherwell	City	Vale	West
No of pupils on roll	854	676	506	526	613
% achieving 5+ A-C grades incl maths and English	61	40.7	46	49	61.3
Number of Pupils	521	275	233	258	376

A recent analysis of foundation stage students shows further disparities. Attainment in Oxfordshire is in line with national results overall. There is, however, a significant gap in attainment between children with postcodes in the 30% most disadvantaged areas of the county compared with the rest by up to 27%. This result is significantly greater than the national gap in attainment of 16%.

<u>What we have already achieved</u>

Oxfordshire already has in place sound structures which can take work forwards. In line with national arrangements for Children's Trusts, it has set up a Children and Young People's Board which links into Oxfordshire's Local Strategic

Partnership and has appointed a Director of Children, Young People and Families. Over time, this Board will influence the use of resources across all organisations and have the powerful opportunity to increase both the efficiency and the targeting of resources to improve life chances for children in Oxfordshire.

Children and Young People's Plan – The Children & Young People's Board has led the development of a plan. The aim for Oxfordshire is to be a place where every child and young person receives the help they need to:

- enjoy good physical and mental health;
- be protected from harm and neglect and grow up able to look after themselves;
- achieve educational success and enjoyment, have good opportunities for play and leisure and develop self confidence and life skills for a creative and positive adulthood;
- make a positive contribution to the community and society;
- live free from poverty, achieve their potential and make the most of their lives

The Plan describes the areas where there is a need to improve outcomes for children and young people and sets out what is going to be done to make these improvements.

Healthy Schools Accreditation The Healthy Oxfordshire Schools Programme has made excellent progress over the last two years and has succeeded in meeting challenging government targets ensuring that 50% of all Oxfordshire Schools have achieved Healthy Schools status with many more working towards validation. The aims of the NHSP are:

- To support children and young people in developing healthy behaviours
- To help to raise pupil achievement
- To help to reduce health inequalities and
- To help promote social inclusion.

A Healthy School promotes the health and wellbeing of its pupils and staff through a well planned, taught curriculum in a physical and emotional environment that promotes learning and healthy lifestyle choices.

Primary Child and Adolescent Mental Health Service (PCAMHS)

A new service to improve access to support for children and young people experiencing mental health difficulties and their families was launched recently. The service is jointly commissioned and funded by Oxfordshire PCT and Oxfordshire County Council. It provides a single point of contact for referral by all professionals who work with children and young people in Oxfordshire ensuring identification and intervention at the earliest opportunity followed by timely referral on to specialist services as necessary.

Recommendations

The future depends on our children.

These recommendations build on what we have already achieved. They set out proposals to break the cycle of deprivation within Oxfordshire.

1. The Oxfordshire Partnership should accept the challenge to break the cycle of deprivation in Oxfordshire's children as a priority for its developing Sustainable Communities Strategy by September 2007.

2. The Children and Young People's Board should agree a basket of indicators that will allow inequalities to be measured in the 13 agreed localities across the county. These indicators should be used over a prolonged period of time to measure trends in change. Indicators should be agreed by September 2007.

   Suggested topics are set out in the box below.

Suggested locality indicators for comparing and monitoring deprivation and inequalities in Oxfordshire's children

- Immunisation rates
- Breast feeding rates
- Smoking in pregnancy
- Admissions for childhood accidents
- PCAMHS referrals by locality
- Comparative school attainment measures
- Children in temporary accommodation
- Teenage conceptions
- Measures of illegal drug use

3. The Children and Young People's Board should identify between three or four geographical areas where need is greatest as a priority for action, based on the indicators described above by October 2007.

4. The Oxfordshire Partnership and Oxfordshire Public Service Board should incorporate targets for improvement in the locality indicators produced by the Children and Young People's Board into the Local Area Agreement for 2008-9 by October 2007.

5. All partner organisations who are members of the Children and Young People's Board should undertake a stocktake of currently funded initiatives in the defined localities of highest need and should assess whether this funding is currently put to best use. If not, steps should be taken to control the quality of public spending in the geographical areas with the greatest needs to bring about the greatest benefit. Local public and community groups should be part

of this approach. An assessment of the current situation and firm policies should be agreed by October 2007.

6. All partner organisations who are members of the Children and Young People's Board should include specific proposals in their funding plans for 2008-9 to target resources on the geographical areas of highest need by October 2007/8. This includes the Local Delivery Plan for 2008/9.

7. As part of the its partnership work, Oxfordshire PCT, should commission a clear range of priority community services for children and young people, working closely with practice based commissioning, targeting the agreed localities with highest need by December 2007.

8. Community services to be commissioned must include smoking cessation services, childhood immunisation, smoking in pregnancy, support for breast feeding, promotion of healthy schools and school sports and the reduction of obesity.

9. The Children and Young People's Board should carry out a specific piece of work to map local trends in illegal drug and alcohol use among children and young people in Oxfordshire and incorporate specific targeted plans into the 2008-9 planning cycle.

CHAPTER THREE: Preventing obesity: a major cause of chronic disease

The Issue

The number of obese individuals in England has tripled since the 1980s and all indications show that Oxfordshire is no exception. Nearly one in four people in the UK are obese*[1] - being obese reduces life expectancy by an average of 9 years.

In the worst case scenario, current levels of child obesity mean that the current generation of parents could outlive their children. Obesity makes its impact in many ways. It affects general mobility, leading to problems with joints and causes long-term diseases such as diabetes, stroke and heart disease as well as affecting individuals' self esteem. This preventable ill health costs the NHS over £1 billion per year and society as a whole up to £3.5 billion per year.

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

Current and projected levels of obesity cause great concern at national levels. Increasing obesity will inevitably result in ever-increasing calls upon NHS and local authority budgets. It is feared that obesity will jeopardise public spending plans: the simple truth is that, if obesity continues to increase, the knock-on effects will break the bank. At present we have insufficient accurate information about obesity locally but regional information is available.

Headline facts about Obesity in the South East

- Levels of obesity have nearly trebled in the UK in the last quarter century and currently stand at 21% of men and 24% of women.
- The national trend is mirrored in the South East but levels are significantly lower than the national level.
- The average population body mass index (BMI) is well into the overweight range, both nationally and regionally.
- Obesity itself is the tip of the iceberg. The average person in this country is classed as overweight. Obesity is increasing at an alarming rate in children and young people. In the South East, almost one in twenty children are obese and a further 15% of boys and 19% of girls are overweight.
- There are significant inequalities in obesity too. Twice the proportion of women in unskilled manual groups are obese, compared with those in professional groups.

[1] Obesity is defined as a body mass index (BMI) of 30+. BMI is measured by weight in kilogrammes divided by height squared

A small healthy lifestyle survey was completed in Oxfordshire in 2005 for the adult population. It confirms that obesity is a very real problem for Oxfordshire with just over half being overweight or obese.

Why is obesity on the increase?

The most likely explanation is a cocktail of complex social reasons. The UK is now seeing similar trends to those seen in the USA in recent decades. Some estimate that the UK is just 10 years behind the USA in trends.

The average diet has an increasing proportion of fat and sugar, often caused by increasing consumption of junk food, snacking and eating ready meals and fizzy drinks. Portion sizes are also gradually on the increase and an increasing number of meals along with super-sizing increases the total intake of fat. On top of that, high fat foods tend to be low cost and people face a barrage of advertising and marketing for these foods.

In addition, we all seem to have increasingly hectic lifestyles which make reaching for relatively unhealthy ready meals an easier option. While our lifestyles are hectic, they are, at the same time, increasingly sedentary. We take less exercise which makes the picture worse. **It is a simple equation; we eat more unhealthy food and we burn less of it in exercise and so we pile on the pounds**.

All of those tiny decisions we make add up and we all do it. One more chocolate biscuit and choosing the lift over the stairs has a long term impact. Obesity decreases life expectancy by up to nine years and substantially increases the risk of many diseases, including heart disease, cancer and diabetes. The type of diabetes impacting on adults is almost 13 times more common in obese women than women of normal weight.

What can be done about this problem?

Many factors contribute to the development of overweight and obesity but, in the end, the solution has to lie in thousands of people improving their diet and taking more exercise.

Because of the complex factors leading to obesity, the problem will not be reversed by any single approach. Successful strategies will need to change many aspects of people's lives and the current environment which encourages obesity. A sea-change is needed in the behaviour and culture of our society which builds changes in physical activity and diet into people's daily lives. This is not the nanny state in action: local authorities and the NHS have a duty to help improve health and wellbeing of the people of Oxfordshire and to make it easier for our citizens to fight the calories culture. There are also compelling financial arguments: we simply cannot afford the cost of extra hospital stays and need for social care which additional long term illness will bring.

The task is not easy because the causes of obesity are woven into the fabric of modern lifestyles. The only way forward is to help people gradually to make healthy choices from cradle to grave, starting with breastfeeding and continuing into a healthy and active old age. This can only be done through a long-term

commitment linking together the efforts of all organisations and the public at all levels from local to national.

What has been done so far?

A reasonable start has been made at national level, partly by the government and partly by activists such as Jamie Oliver! Public awareness about obesity and the causes of obesity is gradually improving. National work has started with the food industry to improve labelling and reduce the fat, sugar and salt content of ready meals. Critics say this activity is too little too late but, nonetheless, a start has been made.

The picture is similar at local level. Some of the building blocks we need are in place. Across the county there are examples of good practice and lots of green shoots, for example:-

- Oxfordshire Healthy Schools Programme is working to promote healthy eating and physical activity and, to that end, local programmes such as ours promote a balanced healthy diet and encourage physical activity throughout the whole school.
- Breastfeeding is an important foundation for a healthy diet. It is the perfectly balanced food for babies and protects against future disease. In Oxfordshire we are meeting our goal of increasing breastfeeding rates by 2 percentage points per year. Currently around 55% of Oxfordshire's mothers breastfeed – around 10% more than the national average.
- Oxfordshire has a good track record of coordinating work on exercise and nutrition, especially between District Councils and the NHS. The thrust of this work has suffered during a period of organisational change but will provide a building block for the future.

General Recommendations

All organisations in all sectors need to take obesity seriously as a major strategic challenge and deal with it consistently over the next two decades.

We need to start simply, choose a relatively small number of actions which are effective from cradle to grave. The programmes that look most likely to achieve this are:

1. Clear advice to pregnant women and young mothers in the most at risk groups
2. Promotion of breast feeding
3. Increased support for the Healthy Schools and school sports programmes
4. Work through the Oxfordshire Sports Partnership to increase the number of people participating in regular exercise
5. Transport policies which favour cycling and walking including school travel plans.
6. Improved access to leisure centres and exercise referral schemes
7. Support for older people's exercise groups
8. Consistent and improved information for the public about nutrition, exercise and diet.

Recommendations to make this happen in Oxfordshire

1. The Oxfordshire Partnership should adopt the topic of obesity as a main plank of an outline sustainable communities strategy by September 2007.
2. Partnership work should be revitalised across Oxfordshire. The Oxfordshire Partnership should set up a countywide exercise, nutrition and obesity strategy as part of the remit of the new Health and Wellbeing Partnership by September 2007. This should involve all local authorities and the NHS and should bring together existing partnership work. Close cooperation with the Children and Young People's Board will be essential. By October 2007 the partnership should:
    - agree priorities
    - set local targets for Oxfordshire
    - agree an action plan
    - influence public sector spending for 2008/9.
3. Accurate baseline date on obesity in Oxfordshire should be collected in schools and general practice by December 2007 so that progress against targets can be measured.
4. Practice Based Commissioning Consortia should work with the Public Health Team to set out the role of general practice and community nursing teams to cover advice to mothers, breast feeding, diet sheets, exercise referral, the role of medication and measurement by October 2007.

5. District Councils and the County Council have a key role to play including the health promotion role of Environmental Health Officers, provision of cycle lanes and working with the leisure industry. All Local Authorities should work individually with the Public Health Team to define their specific priorities and their role in a wider partnership by October 2007.
6. Oxfordshire PCT should commission an economic analysis of the return on investment for measures to combat obesity over 1, 3, 5 and 10 years. If favourable, the PCT should consider creating a long term budget line to fund initiatives beginning in the 2008/9 Local Delivery Plan.
7. Progress against the recommendations should be monitored by:
    - Oxfordshire Health & Wellbeing Partnership and the Oxfordshire Partnership
    - Oxfordshire Health Overview and Scrutiny Committee
    - Patient and Public Involvement Forums
    - Successive DPH Annual Reports

CHAPTER FOUR: Fighting Infectious Disease

The Issue

The last fifty years has been a golden age for combating infectious disease in the Western world. Antibiotics and immunisation programmes have made a huge impact in eradicating some diseases and making others seem toothless. However, the signs are that this tide is turning and, over the next decade, we will need to improve the way we fight infectious diseases. More needs to be done locally if we are to keep our cutting edge.

There are many reasons for these changing trends:

- New diseases continue to spring up and evolve. Recent examples are HIV and the anticipated flu pandemic.
- The world is a global village. Rapid travel across continents spreads diseases rapidly. The UK is not a fortress protected from the massive global impact of HIV and AIDS.
- Natural selection will favour superbugs. The bugs that survive and breed are the ones that can beat the antibiotics. We are seeing more and more resistant strains of bacteria. Tuberculosis is a good example of this and it is showing signs of resurgence. TB is something of a sleeping giant. Once known as "the captain of the men of death", we are in danger of becoming complacent about new vicious strains.
- Intensive use of hospital beds and new invasive procedures bring their own problems. People now pass through health care settings more quickly, have more moves between wards and, thanks to technological advances, have more invasive equipment within their bodies, for example special feeding through a vein. This gives organisms new opportunities to spread in new ways. Methicillin Resistant Staphylococcus Aureus (MRSA) is a good example of this and, combined with more resistant strains, is proving very difficult to tackle nationally.
- Changes in lifestyle play a part too. Sexual activity among young people makes it easy for sexually transmitted infections (STIs) such as Chlamydia and syphilis to spread. Signs that the "safe sex" messages of the '80's and '90's are being ignored give cause for extreme concern.

Examples of the challenges we face are set out below, looking more closely at Tuberculosis, MRSA and sexually transmitted infections.

Resurgence of Tuberculosis

In 2005 63 new cases of TB were recorded in Oxfordshire. More than half were reported in Oxford City.

The County and District picture is set out below.

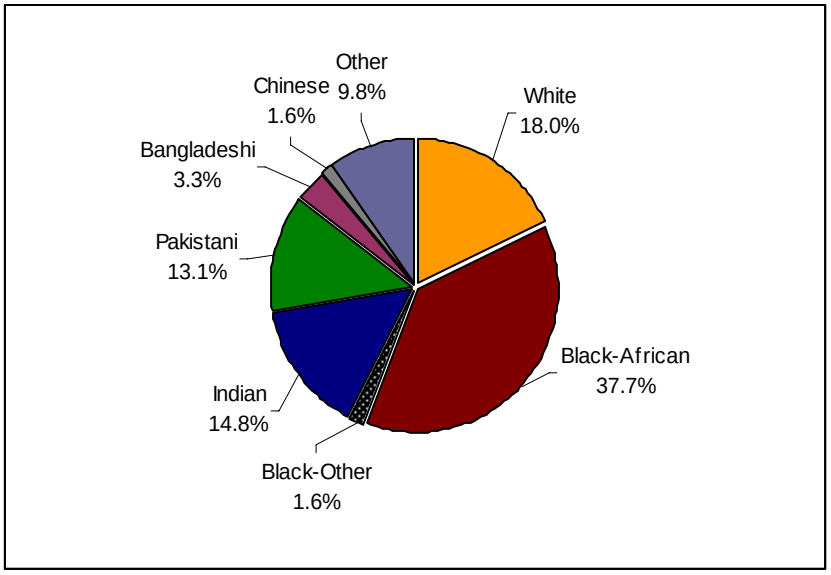
Incidences of tuberculosis in Oxfordshire 2005

Tuberculosis	Cases	Population	Rate per 100,000 people
Oxfordshire Total	63	613,585	10.26
Cherwell	8	134,415	5.95
Oxford City	44	136,873	32.14
South Oxfordshire	1	127,720	0.78
Vale White Horse	6	116,231	5.16
West Oxfordshire	3	98,346	3.05
Unidentified area	1		

Sources: Enhance Tuberculosis Surveillance, DSS Oxford Primary Trust population estimates for 2005.

The largest percentage of tuberculosis cases in Oxfordshire (more than one third of all reported cases) was among people of African origin. Compared with this, tuberculosis cases in other ethnic groups were relatively few with 18% of the cases among white people, 14.8% among people of Indian origin and 13.1% in the Pakistani community.

Percentage of tuberculosis cases by ethnic group. Oxfordshire, 2005.



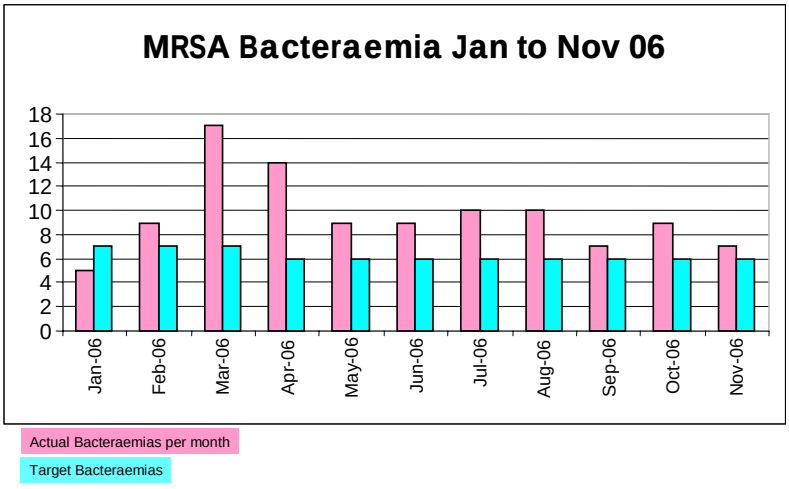
The incidence of tuberculosis in Oxfordshire in 2005 was 10.26 per 100, 000 residents, notably lower than in England, Wales and Northern Ireland (14.7) but markedly higher than in the South East region (7.9). Oxford City has the highest incidence in Oxfordshire (32.1). This is probably related to the variety and relative size of ethnic communities in Oxford City. Research shows that many people who have tuberculosis are infected while living overseas, especially in countries with a high incidence of the disease.

An enhanced tuberculosis surveillance scheme is in operation in Oxfordshire. We need to ensure it maintains the highest standards.

MRSA: an antibiotic resistant superbug

PCT leads for Infection prevention and control have been working with the Health Protection Agency and the Oxford Radcliffe Hospital on their improvement programme for reduction of MRSA.

Nationally, the situation is mixed with MRSA rates rising in some hospitals and falling in others but rates were rising slowly across the county up to October 2006). The government now sets target numbers of cases for MRSA in hospitals. The target will be missed by the Oxford Radcliffe NHS Trust in 2006/7. The health community must continue the aggressive approach that has begun, continuing to work together to reverse this trend.



Progress will be monitored weekly by an Oxfordshire taskforce.

Sexually Transmitted Infections (STIs) including HIV and AIDS: the Epidemic Continues

The state of the nation's sexual health has been described as a public health epidemic. The consequences of poor sexual health can have a long lasting impact on people's health and quality of life. In line with national trends the past year has seen increasing rates of most sexually transmitted infections and an ever increasing demand on local sexual health services.

New diagnoses of HIV reported from Oxfordshire hospitals, by route of transmission 2002-2004

	2002	2003	2004
Heterosexual sex	46	44	40
Other	9	22	18
Total	55	66	58

Hospitals: Churchill, Radcliffe Infirmary and Horton

Source: HPA

Diagnoses of selected STIs 2000-2005 in the Oxford Genitourinary Medicine Clinic

	2000	2001	2002	2003	2004	2005
Syphilis	3	4	10	9	33	34
Gonorrhoea	168	161	195	157	187	123
Chlamydia	1,023	1,067	1,010	867	1,194	1,213

Source: Genitourinary Medicine (GUM) Dept, Radcliffe Infirmary

The data shows a continuing rise in cases of syphilis and chlamydia. Rates of gonorrhoea are fluctuating. Health agencies must renew their efforts to work together to inform the public, promote safe sex, identify disease easily, take rapid action and follow up contacts rigorously.

Summary of Recommendations

General Recommendations

There are four building blocks we need to have in place. These are:

1. Accurate and shared surveillance of disease trends over time so that efforts can be targeted.
2. A concerted joint approach over time, spanning decades which sets aside conventional organisational boundaries. This must involve the Health Protection Agency, Primary Care Trusts, NHS Trusts, Practice Based Commissioners, Local Authorities and other partners. The aim would be to agree local work plans based on local surveillance data to protect against disease.
3. Working together to make most efficient use of resources, including the need for investment when required.
4. Monitoring and evaluating the results and regular public reporting of disease levels and controls.

Recommendations for the PCT Practice Based Commissioners (PBC) and the Health Protection Agency

1. Improve the health of children by commissioning immunisation programmes to target communities and groups with the lowest take up by December 2007.
2. The targeted TB service should be scrutinised to ensure that the maximum number of cases are identified and treated by December 2007.
3. The PCT and HPA should continue to work with the Oxford Radcliffe Hospital to commission improvements in quality of care to minimise superbugs such as MRSA. Weekly taskforce meetings should continue to implement national recommendations. Progress should be reported in public at each PCT and Trust Board throughout 2007/8.
4. The Oxfordshire Sexual Health Strategy should be reviewed and updated in partnership with the Health Overview and Scrutiny Committee and a new action plan put in place by March 2008.
5. PBC consortia should work with the Public Health team and the HPA to commission targeted services in general practice to improve immunisation rates, target sexual health services at young people and increase the range of sexual health services offered in the community by March 2008.

Recommendations for Practice Based Commissioning

1. PBC Clusters needs to ensure they have a work programme which includes access and uptake of immunisations and appropriate advice and referral for STIs by December 2007.
2. PBC should work with the PCT to commission appropriate services for Chlamydia screening and sexual health including GUM access, condom distribution schemes, education and information by December 2007.

Recommendations for Partnerships (LAA, HPA, secondary care)

1. The Oxfordshire Partnership should set up a Health and Wellbeing Partnership whose work programme would include the monitoring, management and overview of infectious diseases in Oxfordshire by September 2007. Public reports should be made to the Oxfordshire Partnership, PCT Board and, where appropriate, Local Authority and Scrutiny Committees.

CHAPTER 5: Coverage of Mental Health Issues

Initial discussions about priorities across the county frequently raise mental health issues as a gap.

Mental health issues are addressed in this report as follows:

Chapter 1: the challenge of dementia as part of the demographic time bomb.

Chapter 2: issues concerning childhood and maternal mental health related to inequalities and deprivation.

Chapter 3: promotion of positive mental health through exercise.

The coverage of mental health issues is therefore only partial.

During 2007/8 progress on the new Oxfordshire Mental Health Strategy will be monitored more closely. If mental health issues are not on the way to resolution, the topic will be a priority for the next report.

ANNEX 1: 2005/6 and 2006/7: years of transition

Towards the end of 2004/05, the three Directors of Public Health in the five PCTs across Oxfordshire, worked together to produce clear proposals for delivering on the Choosing Health Agenda during the year 2005/06 and into 2006/07. These plans were put forward within the LDP process to influence the future direction of PCT commissioning towards the prevention agenda. However, at that time financial constraints were significant and many proposed investments were not initially funded. However the plans sowed the seeds of the value of a shift to prevention and highlighted key service pressures and risks. This work led to some service changes being made during 2006/7, through in-year investment.

This annex will concentrate on some of the main developments which were brought about during 2006/07.

Antenatal & newborn screening programmes – Universal antenatal haemoglobinopathy screening was implemented in October 2006, Newborn haemoglobinopathy and cystic fibrosis bloodspot testing were both implemented in July 2006.

Retinopathy screening – Diabetic retinopathy is the most common cause of blindness in people of working age in industrialised countries. Up to 40% of people have some retinopathy when diabetes is first diagnosed. In its early stages, retinopathy causes no symptoms but it can be detected by examination of the back of the eye. It has been estimated that screening and treatment for diabetic retinopathy could prevent 260 new cases of blindness every year.

One of the first targets that has to be met is 80% of all people with diabetes should be offered digital screening for diabetic retinopathy by 2006 and 100% by 2007. Oxfordshire has offered screening tests for retinopathy for several years, however, this screening did not meet new quality assurance standards required for a full screening programme. During 2005/06, monies were allocated by commissioners to introduce a screening programme. Implementation has proved challenging as access requirements varied across rural and urban communities. The PCT is expected to meet the target of offering retinopathy screening to all diabetic patients by the end of 2007.

GUM extra clinics – Another key target for the PCT to achieve by March 2007 relates to access of GUM services. The Oxfordshire target is that 60% patients should to be able to access GUM Services within 48 hours. To achieve this, the PCT has funded additional clinics during 2006/7. Future investment will enable the service to increase the number of people being offered appointments within 48 hours so that by March 2008 all patients will have this opportunity.

Chlamydia screening - Genital Chlamydia trachomatis is the commonest Sexually Transmitted Infection (STI) in the United Kingdom, with 109,958 diagnoses in GUM clinics in 2005. Highest rates are seen in young people, especially men and women under 25 years.

Genital Chlamydia infection is an important reproductive health problem, because 10-40% of untreated infected women develop pelvic inflammatory disease (PID) and in some cases experience ectopic pregnancy or infertility. Significant proportions of cases, particularly among women, are asymptomatic and are therefore liable to remain undetected. Screening for genital Chlamydia infection will allow rapid treatment and reduce the spread of the disease thus reducing PID and ectopic pregnancy over time. Within Oxfordshire, implementation funding has been identified to commence by April 2007, LDP funding has been agreed for 2007/8.

Health Trainers – A Health Trainers service has been set up in Oxford to offer practical advice on health issues and to 'signpost' people to the help they need.

Pilot obesity measurements - Achieving the Public Service Agreement (PSA) target relies on effective action both nationally and locally by different agencies working together. Nationally, progress on meeting the target is being tracked through the Health Survey for England but there is no existing comprehensive and reliable data at local level on child obesity. As a result, local data in schools was required. This will give PCT's data to inform joint local planning and targeting of resources and interventions. It also enables tracking of local progress against the PSA target. Guidance provides advice on how to measure the height and weight of children in maintained schools in two age groups:

- the reception year (ages 4-5 years) and
- year 6 (ages 10-11 years).

The measurement is for the purpose of monitoring obesity prevalence among population groups and is not designed to screen individual children for referral. Last year, Oxfordshire PCT's piloted weight and height measurements in four schools. This enabled the PCT to plan more effectively for the coming year when all schools will participate in the scheme. Funding has been identified in the 2007/8 LDP to support this. Information will be submitted to the National Obesity database but will also inform and help partners target work through the Children and Young People's plan.