

## Public Health Strategy for Oxfordshire 2007 – 2012

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## **Public Health Strategy for Oxfordshire 2007 - 2012**

### **Strategic Aims:**

- **To improve overall life expectancy in all parts of Oxfordshire by 1 year by 2012,**
- **To tackle health inequalities and so reduce the gap in all-age, all-cause mortality rates by 10% by 2012 between the top 20% and bottom 20%**
- **To “add life to years” by improving health and well-being.**

### **Rationale:**

The broad role of the Director of Public Health for Oxfordshire and the Public Health function is to take forward programmes for health improvement for the whole population and for all appropriate organisations. This Public Health Strategy seeks to bring the proposals together in one place. It is hoped and expected that features of this strategy and the action that results will appear in a range of other plans.

### **Introduction**

The Oxfordshire Local Area Agreement sets out the plan to develop a Public Health Strategy for the County in 2007-08. This document sets out a draft for discussion.

In March 2007 the Director of Public Health for Oxfordshire, Jonathan McWilliam, published his Annual Report for 2005-07 and issued a challenge for health improvement in the county. The need for longer term perspectives, ever more effective partnership working and a shift in emphasis towards prevention were at the heart of the report which focussed on four main areas:

1. An ageing population – the “demographic time bomb”
2. Breaking the cycle of deprivation of children and families
3. Preventing obesity: a major cause of chronic disease
4. Fighting infectious diseases

This Public Health Strategy sets out to provide a framework for action. This action will need to be taken by many organisations and partnerships across the county. This document provides some of the evidence of need and sets out a menu of interventions that will make a difference. We are aiming to secure tangible outcomes and have suggested some potential indicators that can be used to measure progress.

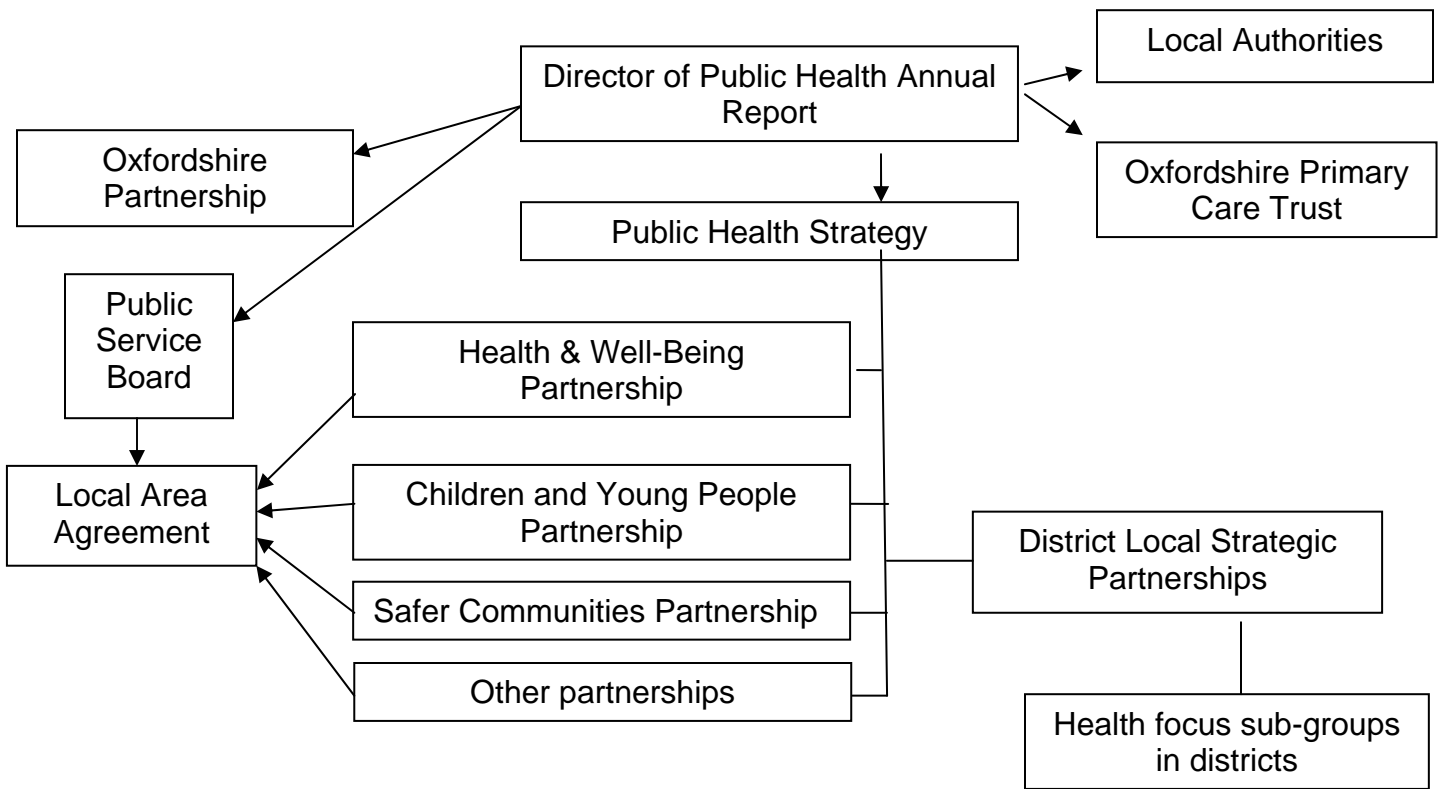
There are no action plans in this strategy as it is envisaged that each organisation or partnership will include the relevant actions in its own plans. These will include the Local Area Agreement, Children and Young People Partnership Board, district Local Strategic Partnerships, Oxfordshire PCT, Community Safety partnerships and so on. The overall progress in achieving the outcomes will be monitored by the Health and Well-Being Partnership, part of the Oxfordshire Partnership.

The Health and Well-Being Partnership Board is being established in the county and will have its first meeting in September 2007. This strategic level board will provide the opportunity for key stakeholders (the Primary Care Trust, Oxfordshire local authorities,

the voluntary sector and service-user representatives) to come together as commissioners of services to agree key outcomes and the strategic direction to deliver them. The Board will also monitor delivery, including this Public Health Strategy. Full terms of reference will be agreed at the meeting in September and will be included in the final version of this document.

The diagram below illustrates some of the network of organisations and partnerships that have a part to play in improving health in the county.

### Networks for Health Improvement in Oxfordshire



This draft is for discussion and feedback is welcome. The aim is to have a final version by December 2007. Please contact Jackie Wilderspin, Head of Partnerships and Health Inequalities at Oxfordshire PCT with your comments and ideas for the development of this strategic framework [jackie.wilderspin@oxfordshirepct.nhs.uk](mailto:jackie.wilderspin@oxfordshirepct.nhs.uk)

## **Section 1 – Longer and healthier life for the adult population. Meeting the challenge of the “demographic time bomb”**

### **1.1 The current state of health in Oxfordshire**

#### **Morbidity and Mortality**

- Life expectancy in more deprived wards is significantly lower than the county as a whole.
- Population projections show the number of older people will continue to grow, especially in rural districts.
- There are specific areas of the county with significant levels of deprivation
- Nationally Black and Minority Ethnic (BME) groups have worse health than the general population and people with mental health problems and/or learning disabilities are more likely to experience major illness, to develop serious health conditions at an earlier age and to die of them sooner than other people

#### **Lifestyles**

- Over 3300 people gave up smoking in Oxfordshire in 2005-06 but significant numbers still smoke, especially in deprived communities
- Obesity rates are rising across localities and age groups
- High rates of obesity were found nationally in people with mental health problems and learning disabilities
- Only 23.4 % of the population report taking moderate intensity exercise at least 3 times a week
- Alcohol consumption is giving cause for concern in terms of the health impact and the association with crime and disorder
- Sexually transmitted infection rates are rising and there are still high levels of teenage pregnancy in parts of the county

#### **Older People**

- It is estimated that by 2010 there will be nearly 15000 people aged over 85 in Oxfordshire, and over 24 000 by 2028
- It is anticipated that 30% of people aged 85 and over will suffer from some form of dementia
- Nearly 4000 people aged over 65 attended A&E in 2006-07 following a fall. 800 people in this age group had a broken hip as a result of a fall in 05-06
- Around 1000 people are given intensive support to live in their own homes so that they don't need to be admitted to hospital or nursing homes in 2006-07
- Nearly 9% of the population in the county are unpaid carers, many aged over 65 and providing over 50 hours care a week

#### **Long term conditions**

- There are over 17700 people with diabetes in Oxfordshire and the numbers are rising

- Diabetes is more prevalent in the South Asian and Black Caribbean communities and is highest in the Bangladeshi community
- Mortality rates for cancer in Oxfordshire are significantly lower than the country as a whole, except for breast cancer.

### **Determinants of Health**

Tackling a range of issues is essential if the overall aim of improving health is to be achieved. Deprivation and poor environments have a profound impact on health outcomes and improving these factors is essential if inequalities are to be reduced. Other determinants having a profound impact on health outcomes include ethnicity and disability. Many of these issues are already recognised in partnership working in the county, but there is still much to be done if the target in reducing the gap in life expectancy in the county is to be achieved.

These issues include

- Housing and homelessness, housing stock condition
- Fuel poverty
- Education and Training
- Crime and fear of crime
- Low income and employment
- Environment
- Transport and access to services
- Access to support and assistance to enable independent living
- Low levels of participation in physical activity across age groups
- Access to appropriate services and support for people from BME communities and people with disabilities

### **Health needs in different areas of Oxfordshire.**

The heterogenous nature of Oxfordshire can be reflected in many ways, but one useful characterisation was recently included in the Community Life briefing paper for the Sustainable Community Strategy. This set out the following distinctive characteristics:

- **Urban Oxfordshire** - Oxford city
- **Major towns** of Banbury, Bicester, Witney, Abingdon, Didcot
- **Market towns** (19 smaller towns serving rural communities)
- **Rural settlements** (villages, hamlets and isolated dwellings)

There are different health and well-being priorities for various areas of Oxfordshire and it is important to highlight these. The recent publication of Health Profiles for the county and district areas highlighted the generally good health of the population but closer inspection shows inequalities of outcomes affecting particular parts of the county. ([www.communityhealthprofiles.info](http://www.communityhealthprofiles.info) , SEPHO 2007)

It is important to plan appropriate initiatives in different parts of the county and to ensure that inequalities issues are tackled in the areas of greatest need. One size definitely does not fit the whole county. The data from the Health Profiles for Oxfordshire and other available information highlights the following local priorities:

## Health profiles for districts of Oxfordshire

(Source: [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info) )

	<b>Cherwell</b>	<b>Oxford City</b>	<b>South Oxon</b>	<b>Vale of WH</b>	<b>West Oxon</b>
<b>Smoking</b>	170 deaths a year	175 deaths a year	170 deaths a year	170 deaths a year	130 deaths a year
<b>Diabetes</b>	Over 4200 people have diabetes (3.1%)	At least 4300 people have diabetes, (2.9%)	At least 3700 people have diabetes,(2.9%)	At least 3600 people have diabetes, (3.1%)	At least 3000 people have diabetes, (3.1%)
<b>Obesity</b>	It is estimated that 1 in 5 adults are obese.	It is estimated that 1 in 5 adults are obese.	It is estimated that 1 in 5 adults are obese.	It is estimated that 1 in 5 adults are obese.	It is estimated that 1 in 5 adults are obese.
<b>Activity</b> (% of respondents in Active People Survey 2006)	Only 24% participated in at least 30 minutes of moderate intensity activity 3 times a week.	Only 20.5% participated in at least 30 minutes of moderate intensity activity 3 times a week	only 22.3% participated in at least 30 minutes of moderate intensity activity 3 times a week.	Only 25% participated in at least 30 minutes of moderate intensity activity 3 times a week.	Only 25.7% participated in at least 30 minutes of moderate intensity activity 3 times a week
<b>Older People</b> (estimated increase from 2004 – 2029)	150% increase in the number of people aged over 85	69.6% increase in the number of people aged over 85	123% increase in the number of people aged over 85	145% increase in the number of people aged over 85	147% increase in the number of people aged over 85
<b>Homelessness</b>	310 households were statutorily homeless in 2004-05 out of a total of 3767 on the housing register (8.2%)	376 households were statutorily homeless in 2004-05 out of a total of 3525 on the housing register (10.7%)	98 households were statutorily homeless in 2004-05 out of a total of 2043 on the housing register (4.8%)	114 households were statutorily homeless in 2004-05 out of a total of 1981 on the housing register (5.8%)	94 households were statutorily homeless in 2004-05 out of a total of 2847 on the housing register (3.3%)
<b>Binge drinkers</b>	Approximately 15% of the adult population are binge drinkers	Approximately 23% of the adult population are binge drinkers	Approximately 14% of the adult population are binge drinkers	Approximately 14% of the adult population are binge drinkers	Approximately 14% of the adult population are binge drinkers
<b>Violent crime</b>	Violent offence rates were 17.5 per 1000 population in 2005-06 (2332 offences in a population of 133535)	Violent offence rates were 24.1 per 1000 population in 2005-06 (3503 offences in a population of 145077)	Violent offence rates were 11.2 per 1000 population in 2005-06 (1431 offences in a population of 127926).	Violent offence rates were 11.5 per 1000 population in 2005-06 (1334 offences in a population of 116234).	Violent offence rates were 9.6 per 1000 population in 2005-06 (934 offences in a population of 96994).

## Life expectancy by ward

Life expectancy (based on 2000-04 deaths) – Oxfordshire wards

Source: APHO and Department of Health. From 'Health Profile for (name of area) 2006 © Crown Copyright 2006.'

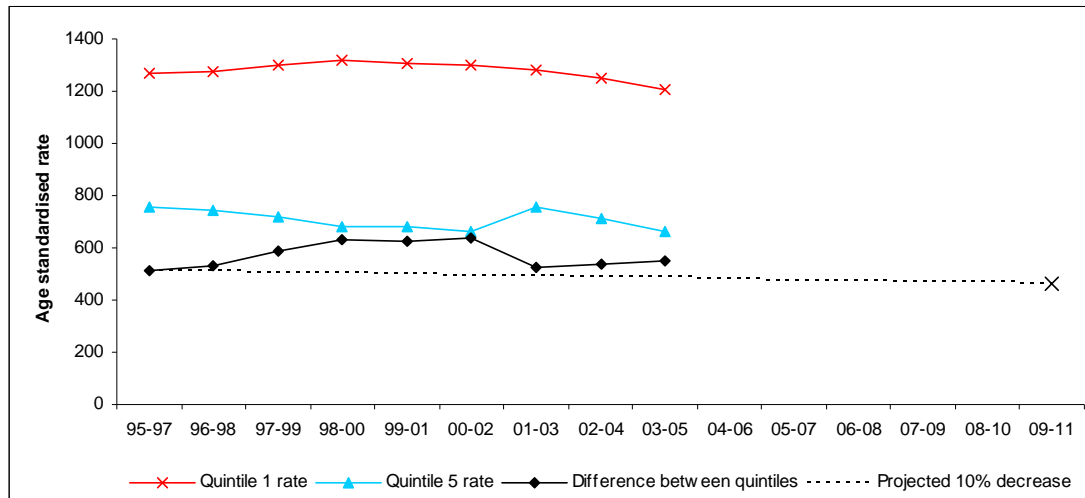
(NB this table is to be replaced by a graph to illustrate these figures.)

Local authority area	Top 20% life expectancy range and top 5 wards	Bottom 20% life expectancy range and bottom 5 wards
Oxfordshire	<b>82 yrs (with confidence intervals 79.30 – 84.8) to 88.7 yrs (79.0, 98.4)</b> Didcot Ladygrove, Burford, Kidlington North, Abingdon Dunmore and Bicester South	<b>73.1 years (70.4, 75.8) to 78.5 years (77.0, 79.9)</b> Sandford, Caversfield, Carfax, Otmoor and Blackbird Leys)
Oxford City	<b>81.1 yrs (with confidence intervals 79.7, 82.6) to 81.9 yrs (80, 83.9)</b> St Margaret's (Headington Hill & Northway, Quarry & Risinghurst, North and Summertown	<b>75.1 yrs (72.4, 77.8) to 77 yrs (75, 79)</b> Carfax (Blackbird Leys, Northfield Brook, Barton & Sandhills and Iffley Fields
Cherwell	<b>82.4 yrs (with confidence intervals 79.6, 85.1) to 84.9 yrs (82.2, 87.5)</b> Kidlington North, Bicester South, The Astons & Heyfords, Sibford, Amrbrosden & Chesterton and Fringford	<b>75.1 yrs (73.3, 76.8) to 78.3 yrs (75.8, 80.8)</b> Caversfield, Otmoor, Banbury Grimsbury & Castle, Banbury Neithrop, Bicester Town and Deddington
South Oxfordshire	<b>82.2 yrs (with confidence intervals 81.0, 83.3) to 88.7 yrs (79.0, 98.4)</b> Didcot Ladygrove, Forest Hill & Horton, Chiltern Woods, Goring, Berinsfield and Sonning Common	<b>73.1 yrs (70.4, 75.8) to 78.5 yrs (77.0, 79.9)</b> Sandford, Didcot All Saints, Crowmarsh, Shiplake, Cholsey & Wallingford South, Wallingford North
Vale of White Horse	<b>82.1 yrs (with confidence intervals 80.4, 83.9) to 83.8 yrs (80.9, 86.7)</b> Marcham & Shippon, Abingdon Peachcroft, Blewbury & Upton, Shrivenham, Greendown and Kennington & South Hinksey	<b>77.3 yrs (75.9, 78.8) to 79.3 yrs (76.5, 82.0)</b> Faringdon & The Coxwells, Stanford, Abingdon Caldecott, Hendreds, Wantage Segsbury and Sutton Courtenay & Appleford
West Oxfordshire	<b>82 yrs (with confidence intervals 79.3, 84.8) to 85.4 yrs (82.3, 88.4)</b> Burford, North Leigh, Witney West, Stonesfield & Tackley, Charlbury & Finstock and Milton under Wychwood	<b>77.8 yrs (74.9, 80.7) to 78.7 yrs (77.0, 80.4)</b> Chadlington & Churchill, Kingham, Carterton South, Chipping Norton, Brize Norton & Shilton and Freeland & Hanborough

## 1.2 How can we make a difference?

The main aim of the work must be to ensure that the gap is narrowed between those experiencing the worst outcomes and everyone else. General health improvement has resulted in longer life expectancy for the whole population, but analysis shows that in Oxfordshire the fall in mortality rates for the top 20% (quintile 5 on the graph below) of the population has been at a faster rate than for the bottom 20% (quintile 1). The difference between the quintiles is rising, moving away from the target line showing a trajectory for a 10% decrease by 2012. It is essential that this widening of the gap is reversed by aiming to bring outcomes for the least well-off in line with the rest of the population.

*Trends in all-age, all-cause mortality for the best and worst quintiles in Oxfordshire*



*Source of population data: CACI ward projections (1995-97 to 2000-02); Oxfordshire County small area projections (using GLA model) (2001-03 to 2003-05); ONS (England & Wales populations).*

*Source of mortality data: ONS Public Health Mortality File for Oxfordshire*

There are areas of work that need to be addressed by individual organisations and others need to be implemented by partnerships. Addressing the following priorities will make an impact on achieving long and healthy life for the adult population in Oxfordshire.

1a. Target, sustain and increase funding to improve health outcomes in areas of greatest need and among populations with greatest need, to take account of access to health care, demographic change and to shift the emphasis to prevention of ill health and accidents.

1b. Work with partners to improve equity of access and outcomes for BME communities and people with disabilities

1c. Prevent premature deaths and tackle inequalities in the incidence of Cancer and Circulatory Disease through a range of interventions:

- In primary care – target interventions for secondary prevention using registers of risk groups; ensure equitable and appropriate prescription of statins and anti-

hypertensive drugs; provide high quality cancer screening programmes and encourage uptake.

- Support people to change to healthier lifestyles to prevent CHD, cancer and stroke and target more deprived or vulnerable communities through Health Trainer Services.
- Support people in the process of giving up smoking and enforce smoke free legislation and under age sales legislation.
- Develop a Joint Obesity Strategy with appropriate action plans for all ages. Ensure that clear, practical help is available to help people to shop, cook and eat more healthily and promote exercise and activity as part of everyday life e.g. walking, cycling, gardening, dancing and sport.

1d. Work in partnership to provide information and interventions to reduce risk of accidents in the home and on the roads.

1e. Develop interventions and campaigns to highlight and reduce the health impact of drinking too much alcohol, either on a regular basis or through binge drinking.

1f. Work together to reduce drug misuse and provide integrated programmes of treatment, care and support for adults with substance misuse problems. Improve access to community-based early intervention services.

1g. Provide appropriate support services for people with mild to moderate mental health problems and promote mental health.

1h. Continue to improve access to GUM clinics and further develop the campaigns to increase awareness of sexual health issues, including access to Chlamydia screening.

1i. Work together across the programmes of the Oxfordshire Partnership to tackle the factors which lead to poor health including

- Fuel poverty
- Homelessness
- Poor housing condition in all sectors
- Access to training and education
- Increasing economic prosperity
- Access to benefits and financial advice
- Crime and fear of crime.

1j. Monitor rates of infection of communicable disease and prevent spread by tracing contacts, training professionals, offering interventions etc. Provide information on how spread of disease can be prevented.

1j. Work with partners to ensure an immediate response to major incidents

1k. Work through partnerships to reduce crime and fear of crime, make special provision for the most vulnerable, promote community cohesion and reduce social exclusion.

1l. Sustain and further develop partnership working on domestic violence

1m. Monitor the pilot Alcohol Arrest Referral Scheme and develop appropriately. Develop interventions to tackle binge drinking based on evidence of best practice.

1n. Work together to support carers and provide health and respite services to meet their needs.

1o. Assess the health needs of offenders in the community and work to improve health outcomes for this group.

### 1.3 Outcomes and Possible Indicators of success

<b>Outcome</b>	<b>Possible indicator*</b>
People will live longer	All-age, all-cause mortality
Differences in life expectancy between groups will be reduced	Differences in all-age, all-cause mortality by ward and ethnicity
Fewer people will die from preventable diseases	Standardised years of life lost Mortality from causes amenable to health care Premature all-cause mortality Under 75 mortality from leading causes
Adults will live healthier lives (aged 18-65)	Rates of chronic or acute alcohol related illness Vascular risk score Breast and cervical screening rates
Older people will live healthier lives (aged over 65)	Healthy life expectancy at 65 Immunisation rates for winter flu Accidental injury through falls Vascular risk score
More people will be non-smokers	Prevalence rates Quit rates
More people will maintain healthy body weight and lead active lives	Overweight and obesity rates for adults
More people will live independently for longer and be able to look after themselves and their families	Intensive home support to enable people to live at home. Any community based services to enable people to live at home Support for carers
Differences in life expectancy for people with severe mental illness and/or learning disabilities will be reduced	Self reported measures of health and well-being Mortality rates for people with severe mental illness & learning disabilities compared with the rest of the population.

\*Analysis of all indicators would relate to the gap between those with the best and worst outcomes and an intervention should only be considered successful if the gap was being reduced.

**Note for consultation on Section 1:**

1. Is there more to be added to the analysis of the current state of health in Oxfordshire?

2. Are there other ways in which you think we can make a difference to life expectancy and quality of life that you would like to add into section 1.2?

3. The recently published draft *Health and Social Care Outcomes - Accountability Framework* from the Department of Health (DH 2007) has been used to formulate the table above. What are your views on the proposed outcomes and indicators?

In particular your comments are invited on

- The feasibility of using the possible indicators already listed
- More suggestions of indicators used by your organisation
- Outcomes and possible indicators relating to reducing the impact of crime, poor housing, substance misuse, long term conditions, major incidents or emergencies or other determinants of health.
- Specific outcomes and indicators relating to specific vulnerable or minority groups.

## **Section 2 Long and Healthy Life for Children and Young People – Breaking the cycle of deprivation of children and families**

### **2.1 The current situation**

The Children and Young People Plan provides a comprehensive analysis and action plans for improving outcomes for children and young people in Oxfordshire. This section of the Public Health Strategy is largely based on the excellent work that is already underway through the Children and Young People Partnership Board and seeks only to highlight it and draw attention to the inequalities issues. If this attention can widen the work to improve health outcomes for children, young people and families in the county then the aim of this strategy will be achieved.

The recent draft Briefing Paper on Children and Young People in Oxfordshire ([www.oxfordshireobservatory.info](http://www.oxfordshireobservatory.info)) to inform the development of the Sustainable Community Strategy included the following information:

“A detailed joint agency needs analysis was undertaken in 2005 as part of a Best Value Review of Children’s Services. This work informed the development of Oxfordshire’s CYPP. Since then information has been collected on performance against the indicators in the Outcomes Framework. This exercise brought together valuable information from the Council, District Councils, Voluntary Services, Police, Connexions and Health. Further work is underway to update the needs analysis to inform the development of 2007/08 Action Plans.

Information on the needs analysis has been supplemented by feedback from children, young people and families on an ongoing basis throughout the year including the recent survey of the views of 5,000 children and young people in Oxfordshire.

Key issues arising from the needs analysis:

- overall Oxfordshire is a wealthy county but there are 13 areas with deprivation in the bottom 20% nationally. Outcomes for children and young people are significantly poorer in these areas than in the rest of the county;
- overall children and young people experience good levels of health. However there is a gap in life expectancy between the ‘best’ and ‘worst’ wards
- there is a need to develop integrated early intervention and preventative approaches for children who are “at risk” of harm, care, truancy, exclusion, offending;
- educational achievement in Oxfordshire is in line with national and there has been a significant improvement in achievement at secondary levels however; the educational achievement and enjoyment of vulnerable groups remains a priority for improvement.”

(Source, Briefing paper on Children and Young People, [www.oxfordshireobservatory.info](http://www.oxfordshireobservatory.info) )

Data from the Health Profiles for Oxfordshire and other available information highlights the following local priorities and differences across the county:

	<b>Cherwell</b>	<b>Oxford City</b>	<b>South Oxon</b>	<b>Vale of WH</b>	<b>West Oxon</b>
<b>Child Poverty</b> (% of under 16's living in families receiving means-tested benefits)	3,000 (10.9%) children live in low income households from a total child population of 27691	Over 4800 (22.8%) children live in low income households from a total child population of 21457	Over 2000 (7.8%) children live in low income households from a total child population of 25959	Around 1900 (8%) children live in low income households from a total child population of 23788	Over 1300 (6.7%) children live in low income households from a total child population of 19372
<b>GCSE attainment</b> (England average 57.5%)	GCSE achievement is lower than the England average with 49.4% young people achieving 5 or more GCSEs at A* - C grade in 2005-06	GCSE achievement is lower than the England average with 43.8% young people achieving 5 or more GCSEs at A* - C grade in 2005-06	GCSE achievement is above average with 65.6% young people achieving 5 or more GCSEs at A* - C grade in 2005-06	GCSE achievement was 55.4% young people achieving 5 or more GCSEs at A* - C grade in 2005-06	GCSE achievement is above average with 63.5% young people achieving 5 or more GCSEs at A* - C grade in 2005-06
<b>Teenage Pregnancy</b>	There was a total of 290 conceptions in a population of 7477 girls aged 15-17 from 2002-04 which is a rate of 38.8 per 1000  Some wards have higher than average teenage pregnancy rates.	There was a total of 367 conceptions in a population of 6825 girls aged 15-17 from 2002-04 which is a rate of 53.8 per 1000  Some wards have higher than average teenage pregnancy rates.	There was a total of 157 teenage conceptions in a population of 6512 girls aged 15-17 from 2002-04 which is a rate of 24.1 per 1000	There was a total of 173 teenage conceptions in a population of 3512 girls aged 15-17 from 2002-04 which is a rate of 26.6 per 1000	There was a total of 142 teenage conceptions in a population of 4926 girls aged 15-17 from 2002-04 which is a rate of 28.8 per 1000

(Source: [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info) SEPHO 2007)

Much more detailed analysis of the health and well-being of children and young people in Oxfordshire can be obtained through the work of the Children and Young People Partnership Board on [www.oxfordshire.gov.uk](http://www.oxfordshire.gov.uk)

## 2.2 How can we make a difference?

As with the work for the adult population, the main aim of the work for children and young people must be to ensure that the gap is narrowed between those experiencing the worst outcomes and everyone else. The analysis above highlights real differences being experienced around the county and it is only by bringing outcomes for the worst off up to the level of the rest of the population that we can achieve the aims set out for this strategy.

There are areas of work that need to be addressed by individual organisations and others need to be implemented by partnerships. Addressing the following priorities will make an impact on achieving longer and healthier life for children and young people in Oxfordshire. This list of interventions that will help to meet the target is largely drawn from the current CYP Plan for Oxfordshire and reflects many of the priorities under discussion at the CYP Partnership Board.

2a Target, sustain and increase resources to improve health outcomes to areas of highest need

2b Ensure that there are comprehensive antenatal and newborn screening programmes and childhood immunisation programmes available to all.

2c Promote breastfeeding and ensure that increases in initiation rates narrow the gap in inequalities in the county.

2d Implement co-ordinated, multi-agency health promotion programmes in settings for children, young people and families including schools, early years settings, GP practices, clinics, youth centres including a focus on:

- healthy schools
- healthy eating, including locally sourced school meals;
- increasing the number of children who walk or cycle, including to school;
- improve sports facilities including in schools;
- improve targeted access to dental services.

2e Develop a Joint Obesity Strategy with appropriate action plans for all ages

- Ensure that clear, practical help is available to help people to shop, cook and eat more healthily
- Promote exercise and activity as part of everyday life e.g. walking, cycling, gardening, dancing and sport.
- Make oral health promotion part of the healthy eating campaigns and ensure access to dental services is also improved.

2f Ensure all schools have School Travel Plans to increase the number of young people who walk or cycle to school

2g Work together to reduce drug and alcohol misuse and provide integrated programmes of treatment, care and support for young people with substance misuse and alcohol problems. Improve access to community-based early intervention services. Campaign to stop sale of alcohol or cigarettes to under age young people.

2h Improve access to services to promote children's mental health and emotional wellbeing by:

- implementing a preventative multi-agency strategy to promote children's mental health and emotional wellbeing;
- establishing a new Primary Care Child and Adolescent Mental Health Services, with a focus on early intervention and support;
- increasing the availability of services for particular groups of young people (including with conduct disorders, learning disabilities, Travellers, children in prison, refugees and asylum seekers, children looked after, young carers, and parents with mental health problems);
- implementing a training programme in emotional wellbeing across all schools and settings;
- completing the review of Tier 3/4 services.

2i Improve support to reduce teenage pregnancy:

- improve the quality of sex and relationships education at school, college and in work based learning;
- target areas of high need and young people in "at risk" groups;
- improve access to information and advice and services.

2j Ensure that teenage parents are provided with good support on a range of issues to help them in their role as parents and to meet their needs as young people.

2.k Work with parents and carers to strengthen support to encourage families to make healthy choices for themselves and their children, including through Children's Centres and extended schools.

2l Commission and sustain multi-agency initiatives to reduce accidents, building on the success of IMPS, Junior Citizen and other work.

The Children and Young People Plan Review of Year 1 sets out a range of proposed action to deliver the improvement required and should be read in conjunction with this strategy.

### 2.3 Outcomes and possible indicators of success

Work is currently being finalised by the Children and Young People Partnership Board to establish a basket of indicators which can be used in Oxfordshire to monitor progress. It is likely that the final version of this basket of indicators will be used in this Strategy.

The outcomes and possible indicators listed in the table below are from the recently published draft *Health and Social Care Outcomes - Accountability Framework* from the Department of Health (DH 2007).

Outcome	Possible indicator
Pre-school children will live healthier lives (conception to 5yrs)	Smoking in pregnancy Breastfeeding initiation Breastfeeding continuation Dental caries
School age children will live healthier lives (age 5 – 18)	Sexual health – Chlamydia and gonorrhoea rates Accidental injury rates Teenage pregnancy rates Completed immunisations by age 18
More children will maintain healthy body weight and be physically active	Overweight and obesity rates for children
Overall life expectancy in the county will increase and the inequalities gap will narrow.	Life expectancy at birth Gap in life expectancy Infant mortality

**Note for consultation on Section 2:**

1. Are there other ways in which you think we can make a difference to outcomes for children and young people that you would like to add into section 2.2?

2. The recently published draft *Health and Social Care Outcomes - Accountability Framework* from the Department of Health (DH 2007) has been used to formulate the table above. What are your views on the proposed outcomes and indicators?

In particular your comments are invited on

- The feasibility of using the possible indicators already listed.
- More suggestions of indicators used by your organisation.
- Outcomes and possible indicators relating to reducing the impact of substance misuse, alcohol misuse, smoking and other determinants of health for children and young people.
- Specific outcomes and indicators relating to specific vulnerable or minority groups.

### **Section 3 Preventing obesity: a major cause of chronic disease**

The challenge of addressing the rising impact and threat of obesity was the third main area of work outlined in the Director of Public Health Annual Report. The possible interventions to meet this challenge have been included in both section 1 and 2 of this strategy and will not be expanded in a separate section here. Different approaches will be needed for children and young people, adults of working age, older people, those from BME communities and people with learning disabilities, and these will be set out in detail in the forthcoming Obesity Strategy.

### **Section 4 Fighting infectious diseases**

The Director of Public Health's Annual Report also states that the threat from new or recurrent infection should be met with improvements to partnership working and joined up responses to emergency situations. There are references to some strands of this work in sections 1 and 2 of this document, namely

- Immunisations for children and young people and for older people
- Sexually transmitted infections including Chlamydia and gonorrhoea.
- Health care associated infection
- The threat of pandemic flu, TB, HIV and other major emergencies.

More explicit analysis and action plans are already set out in the PCT Strategy, the Sexual Health Strategy (which includes HIV) and the work of the Oxfordshire Emergency Planning group. Value will be added to this work wherever possible through the implementation of this strategy.

#### **Next steps for discussion on this document.**

There are specific questions inviting responses at the end of sections 1 and 2 of this document. More general comments and suggestions are also invited. The process for reaching a final version of the strategy will include the following steps:

1. Discussion and consultation through the following channels from Aug – November :
  - Healthier Communities and Older People Programme Board
  - Health and Well-Being Partnership
  - District councils and District Local Strategic Partnerships
  - Children and Young People Partnership Board
  - Safer Communities Partnership
  - PCT Clinical Executive and working group on the Operational Plan
  - Oxfordshire County Council Management Team
  - Patient and Public Involvement forum
  - Public Health Scrutiny Group
2. Second draft for discussion at Oxfordshire Partnership Steering Group, October 07

3. Final version December 2007.

### **References and Sources of Further Information**

Director of Public Health for Oxfordshire Annual Report 2005-2007

<http://www.oxfordshirepct.nhs.uk/about-us/how-the-pct-works/trust-board/board-papers/2007/March/documents/DPHAnnualReport.pdf>

SEPHO 2007 Local Health Profiles - [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info)

DH 2007 - Health and Social Care Outcomes - Accountability Framework

<http://www.dh.gov.uk/en/Consultations/Closedconsultations/index.htm>

Briefing papers for the Oxfordshire Sustainable Community Strategy, particularly those on Health, Care and Well-being and on Children and Young People.

([www.oxfordshireobservatory.info](http://www.oxfordshireobservatory.info))