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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

Thursday, 3 March 2016 at 2.00 pm
Meeting Rooms 1 & 2, County Hall, New Road, Oxford

Peter G. Clark
Head of Paid Service

February 2016

Contact Officer: ***Julie Dean, Tel: (01865) 815322***
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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)*	Interim 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: 14 July 2016

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 (01865) 815270 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

To approve the Note of Decisions of the meeting held on 5 November 2015 (**HBW5**) and to receive information arising from them.

6. Performance Report for 2015/16 Quarter 3

2:05
15 minutes

Persons Responsible:	Director of Public Health, Director for Social Services and Director for Children's Services, OCC; Chief Executive, OCCG
Person coordinating reports:	Director of Public Health

There will be a review of current performance during Quarter 3 on all outcomes in the Joint Health & Wellbeing Strategy **(HWB6)**.

Action Required: to note the report.

7. Joint Strategic Needs Assessment (JSNA) - Annual Report

2:20
25 mins

Persons responsible:	Director of Public Health
Persons giving report:	Director of Public Health and John Courable, Research & Intelligence Manager, OCC

To consider the annual report **(HWB7)** on trends in local data which impact on health and wellbeing.

Action Required: to accept the draft annual JSNA report.

8. Devolution for Oxfordshire

2:45
25 minutes

Person(s) responsible: Head of Paid Service and Leader of the Council, OCC; Chief Executive and Clinical Chair, OCCG

Persons giving report: Chairman of HWB, Chief Executive, OCCG, Head of Paid Service and Director of Public Health, OCC

There will be an oral update on discussions and proposed process**.**

9. Health Inequalities Commission - Update and Plan

3:10
10 minutes

Person responsible: Clinical Chair, OCCG
Person giving report: Clinical Chair, OCCG

A briefing on the Oxfordshire Health Inequalities Commission 'Calls for Evidence' is attached at **HWB9.** Dr Joe McManners, Clinical Chair, OCCG will give an oral update on the first public session of the Commission which took place on Friday 26 February.

10. Personal Health Budget Local Offer and Roll-Out Plan

3:20
10 minutes

Person responsible: Chief Executive, OCCG
Person giving report: Chief Executive, OCCG

A report is attached at **HWB10.**

11. Oxfordshire's Sustainability Transformation Plan 2016/17, Better Care Fund and OCCG's 2016/17 Operational Plan

3:30
20 minutes

Persons responsible: OCCG and OCC
Person giving report: Director for Adult Social Services, OCC & Director ` ` `of Strategy & Transformation, OCCG

A combined paper is attached at **HWB11** outlining current plans and giving an update on progress.

12. Closer to Home - Health and Care Strategy and Transformation Board update

3.50
30 minutes

Persons responsible: OCCG and OCC
Person giving report: Director for Adult Social Services, OCC

The Strategy will be presented **(HWB12).**

There will also be a presentation given by the Chief Executives of Oxford Health and the OCCG, updating the Board on work being undertaken by the Transformation Board.

13. Healthwatch Oxfordshire - Update

4:20
10 minutes

Person 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 **(HWB13).**

14. Shared Working Protocol with Safeguarding Boards

4:30
10 minutes

Persons Responsible: Key Partnership Heads, Independent Chairs of Safeguarding Boards, Head of Paid Service, OCC
Person giving report: Head of Paid Service, OCC

A protocol setting out a framework within which the Oxfordshire Health & Wellbeing Board, Oxfordshire Safeguarding Children's Board, Oxfordshire Safeguarding Adults Board, Oxfordshire Safer Communities Partnership and Oxfordshire's Community Safety Partnerships will work together to safeguard and promote the welfare of people living in Oxfordshire. It outlines their distinct roles, responsibilities and governance arrangements and refers to their relationship with other partnership forums in Oxfordshire.

The attached draft protocol (**HWB14)** has been developed in response to concerns raised in the Serious Case Review for Children A-F about unclear governance arrangements and lines of accountability.

Action Required: to discuss and comment on this document and to agree it in principle. A final version will be approved when all other relevant

Boards/Partnerships have had the opportunity to review it.

15. Reports from Children's Trust, Joint Management Group & Health Improvement Board

4.40
10 minutes

Attached are written reports on activities since the last Health & Wellbeing Board meeting in November **(HWB15)** from:

- Children's Trust
- Older People Joint Management Group
- Health Improvement Partnership Board

Action Required: to receive the reports.

16. PAPERS FOR INFORMATION ONLY

The following papers are attached for the information of Board members at **HWB16**:

- Communications received by the Chairman – November 2015 to February 2016

4:50 Close of Meeting

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 5 November 2015 commencing at 2.00 pm and finishing at 4.30 pm.

Present:

Board Members:	Councillor Ian Hudspeth – in the Chair Dr Joe McManners (Vice-Chairman) Councillor Anna Badcock Eddie Duller OBE Councillor Mrs Judith Heathcoat Councillor Hilary Hibbert-Biles John Jackson Jim Leivers Dr Jonathan McWilliam Rachel Pearce Councillor Melinda Tilley City Councillor Ed Turner
Other Persons in Attendance:	David Smith, OCCG; Peter Clark, OCC
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: (01865) 815322 (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. He also welcomed Rachel Coney for Agenda Item 8; Sarah Breton for Agenda Item 9; Sarah Mitchell and Seona Douglas (for Agenda Item 10); and Maggie Blyth (for Agenda Item 11).	

2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
An apology was received from Dr Matthew Gaw (Oxfordshire Clinical Commissioning Group).	Andrea Newman
3 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest.	Andrea Newman
4 Petitions and Public Address (Agenda No. 4)	
Paul Cann, Chief Executive, Age UK, Oxfordshire addressed the Board with reference to Agenda Item 16, 'OCC Budget Savings Options 2016/17'. Mr Cann urged the Board and Oxfordshire County Council (OCC) not to ignore the needs of an estimated 40 – 50k older people living in the County. His view was that the savings options that had been put out to consultation, if implemented, would prove economically counter – productive to good outcomes. He made reference specifically to problems such as social isolation, more hospital admissions and the health risks associated with weak social care connections. He urged the Board and OCC to stop and reflect before making the cuts and to commission an analysis of evidence and likely impact of change. Mr Cann also asked the Board to consider creating a community fund from reserves to support communities when dealing with the realities of reduced money. The Chairman thanked Mr Cann for his address, noting that the budget savings options were, in effect, part of a pre-consultation prior to the finalisation of the budget proposals which depended primarily on the Government's settlement.	
5 Note of Decisions of Last Meeting (Agenda No. 5)	
The note of the meeting held on 16 July 2015 was approved and signed as a correct record. Cllr Anna Badcock asked for clarification on the Board's agreement that organisations should take collective responsibility	Julie Dean

to ensure that appropriate Health provision was included into housing developments where possible and appropriate (Item 7, page 4). Dr McWilliam explained that, in his independent Annual Report, he had felt it important to highlight the need to adopt the principle of collective responsibility but had not intended that this be interpreted as creating additional bureaucracy. He expressed also his understanding of how difficult that was to achieve in practice but nevertheless required attention. Cllr Hilary Hibbert informed the Board that a National Childhood Obesity Strategy is expected to be published in January 2016. Also, that an announcement has been made that the Public Health Grant to local authorities is to be reduced.	
6 Performance Report for Quarters 1 & 2 2015/16 (Agenda No. 6)	
The Board reviewed current performance during quarters 1 and 2, 2015/16 against the outcomes as set out in the Oxfordshire Health & Wellbeing Strategy (HWB6). Cllr Ed Turner commented that hospital admission statistics generally continued to be of concern despite strong interventions being put in place to try to reduce them and wondered if there was a need to have less rigorous targets in this area. Dr McWilliam responded that more challenging targets can be a way of focusing in on the problems inherent in that particular area. Cllr Hilary Biles added that aspirational targets could be achieved as evidenced by past success in meeting some very challenging breast feeding targets. Cllr Mrs Judith Heathcoat drew the Board's attention to a reduction in performance in relation to the reablement targets, commenting that they had been noted by the Older People Joint Management Group. It was **AGREED** to note the report.	Dr Jonathan McWilliam/Ben Threadgold
7 Health Inequalities Commission (Agenda No. 7)	
Earlier this year the Board had endorsed the intention of Dr Joe McManners, Deputy Chair of the Board and OCCG Clinical Chair to launch a multi-agency Health Inequalities Commission for Oxfordshire to answer the question 'what does Oxfordshire need to do over the next five years to reduce health inequalities?' The Board now had before them an update (HWB7) on progress	

which included the appointment of an independent Chair to the Commission, Professor Sian Griffiths, a proposed framework for the Commission to work to and the appointment of a multi-agency support Group. The Board **AGREED** to note the report.	Dr Joe McManners
8 Healthwatch Oxfordshire - Update (Agenda No. 8)	
Eddie Duller, OBE, Chairman of Healthwatch Oxfordshire gave a general update on activities since the last meeting of the Board (HWB8). Rachel Coney, Chief Executive of HWO, reported on the previous night's event when they launched their newly published Dignity in Care report. Dr McManners, who had attended the event commented that this was a good report which was inspiring for carers both formal and informal. He added that he had taken away from the event the need to attain an open culture for users, carers, families and friends to feel comfortable about giving feedback about care given. The Board **AGREED** to note the report and its recommendations.	Eddie Duller
9 Children & Adolescent Mental Health Services (CAMHS) - Transformation Plan (Agenda No. 9)	
In August 2015 the Department of Health had announced new funding for CAMHS. This equated to £1.1m recurrently for Oxfordshire, including £320k for a dedicated Community Eating Disorder Team. Sarah Breton, Strategic Commissioner for Children & Young People, OCC, introduced the Oxfordshire Children & Adolescent Mental Services (CAMHS) five year Transformation Plan (HWB9) which had been submitted to NHS England in October. Peter Clark drew the Board's attention to paragraph 10.3 of the report which referred to the development by a multi-agency project team of a Sexual Abuse Pathway. The project was now entering the implementation phase and would be part of the CAMHS service. Recruitment was currently underway and the	

service would be operational for all new referrals from 1 November 2015. The Board **AGREED** to endorse the report.	Jim Leivers/Sarah Breton
10 Oxfordshire Safeguarding Children Board (OSCB) - Annual Report 2014/15 (Agenda No. 11)	
Maggie Blyth, Chair of the Oxfordshire Safeguarding Children Board (OSCB), presented the Annual Report for 2014/15. The OSCB is required to report annually on the work of the Board and its partners, assessing the position of the partnerships in relation to the safeguarding of children at risk within Oxfordshire (HWB11). Maggie Blyth drew the Board's attention to the increased activity in every part of the system. There had also been an increase in the complexity of cases and activity in the overall system, examples of this being language schools entering into the system and the numbers of children accessing primary health care and child social care without there being any links into the child protection settings. There had been a 43% increase in the number of victims of child sexual abuse, a substantial number of older children entering into the system and also adolescents who were now part of the child protection system. The underlying theme was of neglect with a significant number of children on Child Protection Plans with links to mental illness, domestic abuse etc. There had also been a 100% increase in safeguarding self-assessments over the year, making this aspect very high on the agenda. With regard to page 18 of the report (page 139 of the Agenda) Cllr Mrs Heathcoat asked what working relationships/links had been made with the Safeguarding Vulnerable Adults Board. Maggie Blyth undertook to provide a response to this. It was noted that the MASH (Multi-Agency Safeguarding Hub) had the capacity to deal with referrals from family centres. Jim Leivers responded that this area required a reassessment and possible remodelling to ensure that all agencies were clearer about which cases requiring intervention needed to be supported by MASH. Maggie Blyth reported that the language school issue had been raised with the DoE as education guidance doesn't necessarily cover these arrangements.	

Peter Clark commented on the thorough nature of the report and the work underway to publicise the report particularly with respective agencies to ensure that they had regard of it, owned and were aware of its expectations. The Board thanked Maggie Blyth for her very good report and **AGREED** to: (a) note that the child protection partnership was working effectively across Oxfordshire, but that there were severe pressure points in relation to the increased complexity of cases and activity in the system; and (b) ensure that the OSCB Annual Report is submitted to all governing bodies of member organisations represented on the Health & Wellbeing Board.	))))) Maggie Blyth))
11 Increase in Child Protection Cases - Report Card (Agenda No. 12)	
The Board considered a report card (HWB12) which set out the growth in activity in the Child Protection system and its impact across the partnership. This issue had been previously discussed at the Children's Trust and the Oxfordshire Safeguarding Children Board in September. The Board was asked to consider any additional measures to mitigate against the risks set out in the report card. Jim Leivers introduced the report and stressed that in order to meet issues relating to safeguarding children, there was a need to configure services in a different way and talks to address this were underway. Cllr Hudspeth spoke of the impact that the recent child sexual exploitation inquiry and the multi-agency approach with Health, Thames Valley Police and other bodies had had on the public consciousness. This in turn has had a significant impact on available resource. He stressed that Oxfordshire was a very safe place to live in for a child, as evidenced by the statistics, which were well below the national average. Maggie Blyth agreed that the recent annual OSCB report had showed that the system was working in Oxfordshire. Discussion amongst members of the Board raised the following points: • Oxfordshire was doing well in this sphere. However, child neglect tended to be a 'hidden' in society as a whole. The new CAMHS services should have a positive effect on the	

situation; • the number of repeat Child Protection Plans was rising, despite Oxfordshire operating a larger than average term in which to carry them out. This was due to work on raising awareness; • the 'joining up' of Children's Services would continue to be developed. There was a need to address the transitional arrangements for vulnerable children moving into adulthood. In addition, OCC was looking to join up the assessment process undertaken with MASH in order to make it a totally integrated service with 'one front door'; and • awareness raising sessions, conducted by the Oxfordshire Fire & Rescue Service took place with primary school aged children and were repeated a year or so later. Parents were encouraged to be aware of, and to give notification of any changes in their child's behaviour. IT was **AGREED** to note the report.	Jim Leivers
12 Oxfordshire Safeguarding Adult Board (OSAB) Annual Report 2014/15 and OSAB Peer Review (June 2015) (Agenda No. 10)	
Sarah Mitchell, Chair of Oxfordshire Safeguarding Adult Board (OSAB) and Seona Douglas, Deputy Chair, gave a presentation which highlighted the establishment of the new Board, the key actions from the recent Peer Review and priorities from the Annual Report. Councillor Mrs Heathcoat thanked Sarah Mitchell and Seona Douglas for the presentation which highlighted where some of the gaps were and gave a template of action to be taken. She pointed out that she had been a little disappointed that the signing up to action by partners serving on the Board had not been as strong as it could have been. Sarah Mitchell commented that, she had been quite impressed with the ambition, enthusiasm and discipline of the partners. Arrangements were good for delivery and she was confident that there would be results in a year's time. Dr McManners commented that it was important to get the prevention measures correct in order to combat neglect in older people living alone, asking what had been put in place. Sarah Mitchell, responding to a question about combatting neglect by saying that it was important that all agencies had visibility; the geographical patches where these people might be living were known; that all services were put in place and properly implemented and that the metrics and performance indicators	

were also in place; and there are easy referral routes. She added that it was crucial for the Board to ensure that professionals, families and communities were aware of the risks. It was **AGREED** to note the report and to: (a) ensure the report is discussed within member agency Governance meetings; (b) note the increased pressure on Adult Social Care with the rising number of safeguarding alerts; (c) challenge the progress of the Care Act implementation within the member agencies; and (d) consider how the Health & Wellbeing Board can satisfy itself that members agencies are carrying out their duties with due regard for the safeguarding of vulnerable people. and, in respect of the Peer Review (June 2015), to note the Action Plan currently being implemented as a result of the recommendations of the Peer Review.	))))) Sarah Mitchell/Seona Douglas)))))))))))
13 Reports from Sub-Groups (Agenda No. 13)	
The Chair/men of the Children's Trust, the Older People Joint Management Group and the Health Improvement Partnership Board briefly presented their written reports on activities since the last full Board meeting (HWB13). It was **AGREED** to note the reports.	All to note
14 Oxfordshire's Health & Social Care Transformation Plan (Agenda No. 14)	
David Smith, Chief Executive, OCCG, gave a presentation on the emerging system-wide plans for transformation of the way in which Oxfordshire's Health and Social care system will be delivered to address population growth, demographic demands and pressures on available resources now and in future years. The paper (HWB14) also provided an overview of the governance arrangements for the programme and indicative development and implementation timescales. If this dialogue with key stakeholders proved to be possible, there would be a consultation on the proposals next year.	

Mr Smith addressed a number of comments and queries from the Board including the following: - whether the plans would address health inequalities in the county, particularly in relation to Oxford City. Mr Smith responded that there was a need to address levels of inequality via the Health Inequalities Commission and the Oxford Federation for General Practice and Primary Care; - the models of care would differ in each locality and a balance was required between what was required on a broad scale and at local level. There will be some services which could not be replicated across every service in Oxfordshire; - in relation to the time-scale for providing more intermediate/home care, certain services had already shifted via merging multi-disciplinary units, for example in Abingdon. The time-scale for spreading this to all of Oxfordshire was at least five years, potentially longer; - the level of ambition of primary care – it was envisaged that primary care would manage the whole pathway for, say, diabetes, with diabetes consultants based in primary care localities. From a prevention point of view this would enable the diabetes condition to be picked up earlier and would include care currently only provided in acute care; - although broadband delivery was now better than before, and there is extensive use of technology in community care, it was still five years away from the receipt of a seamless reception across the county. Black spots needed to be considered in the proposals. - it was hoped that the work of the Transformation Board would encompass rural areas fully, in particular those areas where there was no public transport to the hubs. Mr Smith responded that he and his colleagues in other agencies were very much focused on this issue and other issues such as how to obtain a better link with the City and District Councils about the whole panoply; particularly with regard to housing. In that context it would be better to address certain issues in the localities. At the end of the discussion it was **AGREED** to thank David Smith for his presentation and to receive the report.	David Smith/Dr Joe McManners

15 OCCG 2016/17 Commissioning Intentions (Agenda No. 15)	
The Board noted the OCCG's Commissioning Intentions for 2016/17 (HWB 15). David Smith asked members of the Board to send him an email if they had any particular issues or queries with regard to the Intentions.	All to note
16 OCC Budget Savings Options 2016/17 - Consultation (Agenda No. 16)	
The Board considered a paper outlining the options being consulted upon to deliver savings plans in the County Council. Members of the Board were asked to consider the impact of the savings options and to make their comments as part of the consultation process. David Smith commented that the OCCG would form a response to OCC in their capacity as a statutory body. He pointed out that a difficulty with more integration and devolution was that OCC and OCCG's planning processes were not sufficiently integrated. The intention was for OCCG to have a conversation on some of the issues OCC was consulting on, in order to gain a better understanding of the risks, and a mitigation plan could follow. Talks with OCC had already begun. It was **AGREED** to note the report.	All to note
17 Devolution (Agenda No. 17)	
The Chairman gave a verbal update on the recently submitted expression of interest to the Government submitted by OCC, OCCG and the Local Enterprise Partnership, on the devolution of particular powers to Oxfordshire. The reaction had been a positive one. Since then there had been a dialogue about the possible integration of Health, Wellbeing and Social Care and looking at what that might mean. Further proposals were currently being considered about the direction of travel in relation to making improvements in the alignment of services. This included consideration of how to use the Board to work better with the District Councils and other planning bodies in order to provide better services by, for example, the avoidance of duplication and the promotion of preventative services.	

In response to a question, Dr McWilliam reported that, in this particular situation, there were no formal proceedings to follow. Discussions were ongoing. A key factor was that each constituent body would need to consider the proposals. Dr McManners added that a key benefit to the proposals was the opportunity to share integrated plans and budgets, to enable a return on investment. It was **AGREED** to note the report.	All to note
18 PAPERS FOR INFORMATION ONLY (Agenda No. 18)	
Noted.	

..... in the Chair

Date of signing .....

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Health & Wellbeing Board
Performance Report
2015/16 Quarter 2

Introduction

1. Annex 1 shows performance at the end of quarter 2 for all priorities in the Health & Wellbeing strategy. 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.

2. Priority 4 - is monitored via the Children's Trust. Attainment at all key stages is in line or above the national average. At all Key Stages the gap between disadvantaged and other pupils in Oxfordshire has narrowed this year due to increased performance of the disadvantaged group. However, the disadvantaged gap remains significantly wider than that nationally.

Summary

3. The table below summarises performance on each priority. In total 68 measures are reported, with 44 rated. 21, nearly a half are on target, with 9 (20%) rated amber and 14 (just under a third) rated red. Looking across all the measures performance is good (with half or more measures on target for on priorities 2, 3, 5, 6, 9 and 10, whereas in the following priorities most measures are rated red:
    a. Ensuring children have a healthy start in life and stay healthy into adulthood
    b. Support older people to live independently with dignity whilst reducing the need for care & support
    c. Preventing early death and improving quality of life in later years
    d. Preventing infectious disease through immunisation

	Red	Amber	Green	Not Rated	Total
1. Ensuring children have a healthy start in life and stay healthy into adulthood	1	0	0	1	2
2. Narrowing the gap for our most disadvantaged and vulnerable groups	1	1	2	4	8
3. Keeping children and young people safe	1	0	3	4	8
5. Working together to improve quality and value for money in the Health and Social Care System	1	2	5	2	10
6 Adults with long term conditions living independently and achieving their full potential	0	1	5	2	8
7. Support older people to live independently with dignity whilst reducing the need for care & support	4	3	1	2	10
8 Preventing early death and improving quality of life in later years	4	1	1	1	7
9. Preventing chronic disease through tackling obesity	0	0	2	1	3
10. Tackling the broader determinants of health through better housing and preventing homelessness	1	0	2	3	6
11. Preventing infectious disease through immunisation	1	1	0	2	4
Total	14	9	21	22	68

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 8 weeks of referral by the end 2015/16
    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 74 to 70
    c. Keeping children and young people safe
        i. 3.2 Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan.
    d. Working together to improve quality and value for money in the Health and Social Care System
        i. 5.2 Reduce the number of avoidable emergency admissions to hospital for older people per 100,000 population from a baseline of 15,849 in 13/14
    e. Living and working well: Adults with long term conditions, physical or learning disability or mental health problems 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. 7.1 Reduce the number of people delayed in hospital
        ii. 7.2 Reduce the number of older people placed in a care home
        iii. 7.3 Increase the proportion of older people with an on-going care package supported to live at home from 62.7% in April 2015 to 63.0% in April 2016
        iv. 7.5 Increasing the number of people accessing reablement from the community.
    g. Preventing early death and improving quality of life in later years
        i. 8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)
        ii. 8.4 At least 3650 people will quit smoking for at least 4 weeks
        iii. 8.6 The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months
        iv. 8.7 At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months
    h. Tackling the broader determinants of health through better housing and preventing homelessness
        i. 10.1 The number of households in temporary accommodation on 31 March 2016 should be no greater than level reported in March 2015
    i. Preventing infectious disease through immunisation
        i. 11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94%

Steve Thomas
Performance & Information Manager, Joint Commissioning
February 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

	Target	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 8 weeks of referral by the end 2015/16	61%	Not yet available		50%	R					
1.2 Support secondary schools to have a school health improvement plan which includes smoking, drug and alcohol initiatives.	100%									Annual measure

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

	Target	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)	<10.9									Annual measure
2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 70	74	83	R	83	R					This has remained the same although 12% increase in LAC in period
2.3 Reduce the level of care leavers not in employment, education or training	< 47%									Annual measure
2.4 Increase the number of young carers identified and worked with by 20% from 1825 at April 1, 2015 to 2190.	2190	1945 - 120 new	G	2056 - 231 new	G					365 new young carers need to be identified by March 2016. In the first quarter 120 or 33%
2.5 Reduce the number of children with SEN with at least one fixed term exclusion in the academic year. (Measured on an academic year)	5.1%	2.7%	G	nya						346/12989 Term 1. Figure provided last time for 14/15 academic year
2.6 Increase the proportion of children with a disability who are accessing short breaks services who are eligible for school meals	24%	39.5%	G	30.0%	G					30 children receiving short breaks, 9 eligible for FSM
2.7 Reduce the number of first time entrants to Youth Justice Service from 208 in the calendar year 2014	< 208									Annual measure
2.8 Reduce the number of young people convicted of a violence against a person offence excluding common assault (defined as a gravity score of 4 and above)	< 18	7	R	11	A					Data is YTD. Equates to 14% of all violent offences compared with 13% last year

Priority Three: Keeping children and young people safe

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
3.1 Set a baseline for and then increase the amount of times the Independent Chair is satisfied that the core group minutes show that the objectives of the CP Plan are being progressed by the Core Group. Baseline 48.6%	48.6%	72.8%	G	72.2%	G					New measure. Will be examined going forward. Data is YTD
3.2 Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan. Baseline 48%.	48%	52%	G	42%	R					Significant decrease in the outcomes achieved Data is YTD. Baseline 48%; increased to 52% in Qtr1, but is now 42%
3.3 Increase the proportion of neglect cases where the neglect tool is used.										Figures are available for neglect tools recorded on social care system only. Tools used in other organisations but may not be recorded on social care systems. Report card on use of neglect tool being drawn up.
3.4 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) (PH OF 2.07ii)	135.4	156.0	R	137.0	G					
3.5 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	46	G	46	G					28 primary & 18 secondary schools supported
3.6 Reduce the assessed level of risk for high risk domestic violence victims managed through the MARAC (Multi-Agency Referral Risk Assessment Conference)	< 80%	75%	G							

3.7 Female Genital Mutilation (measure to be confirmed)	tbc	tbc								Specific measure to be agreed
3.8 Monitor the proportion of MASH enquiries leading to a referral where information was shared with partner agencies.	32%	33.5% 557/ 1663		31.9% 543/ 1701						

Priority Four: Raising achievement for all children and young people

The Annual Educational Attainment Report was discussed at the recent Children's Trust meeting.

- Attainment at all key stages is in line or above the national average.
- At all Key Stages the gap between disadvantaged and other pupils in Oxfordshire has narrowed this year. In all instances, this is due to increased performance of the disadvantaged group. However, the disadvantaged gap remains significantly wider than that nationally.

Monitoring Education Strategy measures:	
4.1 Early Years, including: • *62% of children in early years & foundation stage reaching a good level of development*	
4.2 Levels of attainment and quality across all primary and secondary schools	
4.3 Closing the attainment gap, including: • *Children eligible for Free School Meals* • *Special schools* • *Children with Special Educational Needs*	
Monitoring Oxfordshire Skills Board measures:	
4.4 Creating seamless services to support young people through their learning –from school and into training, further education, employment or business	
4.5 Up-skilling and improving the chances of young people marginalised or disadvantaged from work	
4.6 Increasing the number of apprenticeship opportunities	

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		G					All are on track
5.2 Reduce the number of avoidable emergency admissions to hospital for older people per 100,000 population from a baseline of 15,849 in 13/14	15,849	16,782	R	17,212	R					In 2015/16, our main provider implemented an Ambulatory Care scheme in order to reduce emergency admissions. However, this activity is still recorded in the national data we use as emergency admission meaning figures show as increased activity.
5.3 Increase the number of carers known to social care from 16,265 (March 2015) to 17,000 by March 2016	17,000	16,546	G	17,233	G					Target already exceeded
5.4 Increase the number of carers receiving a social care assessment from 6,042 in 2014/15 to 7,000 in 2015/16	7,000	1,131	G	3,337	G					Over 2,200 carer assessments in the last quarter. Target of 1750 for the quarter
5.5 Increase the number of carers receiving a service from 2,226 in 2014/15 to 2,450 in 2015/16	2,450	304		972						Figure is below target due to unforeseen consequence of the Care Act. Only carers with a personal budget or direct payment can be counted as receiving a service and have to be assessed, whereas previously they could directly access direct payments from GPs. Figure excludes most services that support carers e.g. over 4000 people receive the alert service, which provides an alarm to a call centre. A recent review of such services showed that in 88% of cases these reduced carers levels of stress and anxiety

5.6 Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95% based on an average from the first three quarters of 2014/15 which is 91.3%	95%	96.2%	A	93.7	A					
5.7 Increase the percentage of people waiting less than 18 weeks for treatment following a referral:										
• Admitted patients target 90%	90%	88.8%	A	89.0%	A					Not met due to pressures in a number of specialities including Trauma & Orthopaedics, Ophthalmology, Gynaecology and ENT. This is the figure for all providers of whom Royal Berks FT are struggling to meet all Referral to treatment standards. Performance from the OUH is higher
• Non-admitted patients target 95%	95%	96.0%	G	96.1%	G					On track
• Of patients who do not complete the pathway target 92%	92%	94.3%	G	93.7%	G					On track
5.8 Monitor complaints and compliments people raise about health and social care with the Clinical Commissioning Group and the County Council. Set a target to increase next year as a measure of transparency and openness to learning										An annual report covering the number of complaints, key issues and how we have responded will be provided

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	9078	G	19,808	G					On track.
6.2 15% of patients with common mental health disorders, primarily anxiety and depression will access treatment	15%	14.6	A	14.4	A					Figure was below target at Q2, but is now above target and on track for year end.
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%	52.3	G	54.0	G					On track
6.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP	60%									Annual measure only which will be available in the summer
6.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2013/14 baseline: 951.4 per 100,000 population)	< 951.4	980	R	944	G					On track
6.6 Increase the employment rate amongst people with mental illness from a baseline of 9.9% in 2013/14	9.9%	Not yet available		Not yet availabl e						Negotiations on-going on exact measure and target. Performance on all reported measures of employment for people with mental illness is better than 9.9%
6.7 Reduce the number of assessment and treatment hospital admissions for adults with a learning disability to 8 in 2015/16 from 20 in 2014/15	8		A		G					On track

6.8 Reduce the length of stay of hospital episodes for adults with a learning disability so that by March 2016 no one has been in a NHS Assessment & Treatment Unit for more than 2 years. It is acknowledged that 2 years remains an unacceptable length of stay and are working to develop a new approach which will improve the pathway.	0		G		G					On track

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 an average of 145 per day in 2014/15.to an average of 96 for 2015/16	96	154	R	173	R					Oxfordshire is currently undertaking an exercise to "rebalance the health and social care system" by moving a number of patients to newly commissioned intermediate care beds and using freed up capacity to manage front door pressure more effectively and improve throughput from hospital. The impact of this initiative which will run to March 16 will be used as part of the long-term balancing the system to achieve a permanent reduction in delays.
7.2 Reduce the number of older people placed in a care home from 11.5 per week in 2014/15 to 10.5 per week for 2015/16	10.5	13.7	R	12.8	R					In the first 6 months of the year 312 people have been placed in care homes – this is equivalent to 12 people per week. The rate is above target and higher than the same period last year. This is in part due to capacity issue within the market for home care provision, as care homes are used as an alternative to home care. However, relative to other authorities, Oxfordshire performs well on this measure and was in the top quartile nationally in preventing permanent care home admissions.
7.3 Increase the proportion of older people with an on-going care package supported to live at home from 62.7% in April 2015 to 63.0% in April 2016	63%	62.6%	A	62.1	R					More people than planned have been supported in care homes with the increase in admissions described above

7.4 Over 67% of the expected population (5081 out of 7641) with dementia will have a recorded diagnosis (provisional baseline 59.5% or 4948 people)	67%			65.3	G					On track
7.5 Increase the number of people accessing the reablement pathway including										
• Increasing the number of people accessing the reablement pathway from a hospital pathway to at least the national average.	1945	420	A	834	A					1945 people accessed reablement from hospital last year. This is marginally above the national average. To maintain this level would require just fewer than 980 in 6 months. In quarter 1 there have been just fewer than this, but episodes traditionally increase over winter
• Increasing the number of people accessing reablement from the community. Our target for the year is 1875.	1875	198	R	394	R					A multi-agency project has been set up to improve access to reablement and the performance of the whole reablement pathway. Work streams include developing a commissioning pathway, and improving the interface between the different parts of the reablement pathway. The recommendation for a single provider service from hospital delivered by a combined service from both current providers was agreed and the providers are developing a plan to implement this change.
7.6 Reduce the proportion of people who do not complete their reablement episode from 20.3% in 2014/15 to 17% in 2015/16	17%	18.4%	A	18.8%	A					Significant improvement compared to last year, but not yet at target level.
7.7 Monitor the number of providers described as outstanding, good, requires improvement and inadequate by CQC and take appropriate action where required.										See below

7.8 Increase the number of people supported through home care by social care in extra care housing by 10% (from 114 to 125)	125	107	R	110	A					Figure is beginning to rise (and has subsequently risen again in October).
7.9 Increase the proportion of people on the end of life pathway who die in their preferred place.										Not yet available

Provider CQC Ratings (as reported 2/11/2015) 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	0	0%	0%	0	0%	1%	0	0%	8%	0	0%	2%	5	9%	4%
Good	40	55%	60%	11	50%	70%	1	25%	68%	25	89%	47%	31	54%	81%
Requires Improvement	33	45%	35%	11	50%	27%	1	25%	21%	3	11%	45%	14	25%	11%
Inadequate	0	0%	4%	0	0%	3%	2	50%	3%	0	0%	7%	7	12%	4%

Multi agency bi monthly care governance and quality meetings are held with the Care Quality Commission to review their reports alongside the council's own contract reports, safeguarding alerts and complaints to see all the intelligence held on the provider market and what further action is needed in working with these providers.

The council reviews all providers it has contracts with at least annually and agrees action plans with any provider which is not delivering care to an acceptable standard. The action plans are then regularly reviewed by the Contracts and Quality Team.

The major issues identified by both the Contracts & Quality Team and the Care Quality Commission are around specifically the capacity and capability of staff in these sectors.

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	60%	59.2	A							Data for Q2 are not yet available.
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%	G	11%	G					Cumulative Q3 North East: 13.1% North: 13.3% City: 17.6% South East 17.6% South West 18.1% West 11.2%
8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)	66%	42%	A	46%	R					Cumulative Q3 North East: 47.1% North: 58.8% City: 41.9% South East 41.2% South West 47% West 63.9%
8.4 At least 3650 people will quit smoking for at least 4 weeks (Achievement in 2014/15 = 1955)	3650	477	R	992	R					
8.5 The number of women smoking in pregnancy should decrease to below 8% (recorded at time of delivery). (Baseline 2014/15 = 8.1%)	<8%	7.8%	G	8.5%	A					
8.6 The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months (baseline 7.8%)	7.6%	6.2%	R	5.6%	R					Please note that the completion data is from 01/03/2014 to 312/01/2015 and representations are up to 30/09/2015 (end Q2)
8.7 At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months (baseline 37.8%)	39%	29%	R	28%	R					

Priority 9: Preventing chronic disease through tackling obesity

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
9.1 Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2013/14 this was 16.9%). No district population should record more than 19%	< 16%									
9.2 Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active People Survey)	< 22%			21.9%	G					
9.3 63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual CCG locality should have a rate of less than 50%	63%	60.9%	A	63.8%	G					No CCG locality under 50% (Q1 & Q2). However, some practices across most localities have less than 50%

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
10.1 The number of households in temporary accommodation on 31 March 2016 should be no greater than level reported in March 2015 (baseline 192 households)	< 192			218	R					
10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 91% in 14/15)	75%	84.8	G	86.1	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 (baseline 83% in 2014/15 when there were 2454 households known to services). Reported 6-monthly	80%			82%	G					
10.4 More than 700 households in Oxfordshire will receive information or services to enable significant increases in the 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.	<700									
10.5 people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 70 (2014/15)	<70									
10.6 A measure will be included in the performance framework to monitor the success of supporting vulnerable young people in appropriate housing following monitoring to establish a baseline.										Baseline to be established and outcome to be discussed in March 2016

Priority 11: Preventing infectious disease through immunisation

	Target	Q1		Q2		Q3		Q4		Comment
		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 (currently 95.2%) and no CCG locality should perform below 94%	95%	95.1	G	94.5	A					Data for CCG localities are not available for Q2
11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94%	95%	92%	A	91%	R					Data for CCG localities are not available for Q2
11.3 At least 60% of people aged under 65 in "risk groups" receive flu vaccination (2014/15 = 51.9%)	60%									
11.4 At least 90% of young women will receive both doses of HPV vaccination. (2014/15 =91.7%)	90%									

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Joint Strategic Needs Assessment Annual Report 2016

Introduction

The Joint Strategic Needs Assessment (JSNA) provides information about Oxfordshire's population and the factors that affect people's health, wellbeing, and social care needs.

This annual report is a summary of the suite of online resources that are available through the JSNA webpages on Oxfordshire Insight.

The JSNA covers a wide range of topics and many different statistics. It provides context by:

- Monitoring past trends and identifying changing patterns of need
- Comparing Oxfordshire against national, regional, and local benchmarks
- Explaining how different measures relate to health, wellbeing, and social care needs

The report is organised according to the following broad JSNA themes:

- **Population and population groups (chapters 2 and 3)**
  The number of people living in Oxfordshire, broken down by key characteristics, such as age, sex, and ethnicity
- **Wider determinants of health (chapter 4)**
  Factors with known links with health and wellbeing, such as deprivation, education, and employment
- **Morbidity and mortality (chapter 5)**
  The number of people with diseases and long-term conditions, and the main causes of death
- **Lifestyles (chapter 6)**
  Lifestyle behaviours and characteristics, such as smoking, drinking, drug use, and obesity
- **Service demand (chapter 7)**
  The number of people receiving certain health and social care services

Updated statistics have been provided wherever available. New local analysis for this version of the JSNA includes:

- Small area analysis of healthy life expectancy and disability-free life expectancy
- Analysis of new deprivation data
- Small area analysis of income and house prices
- Analysis of new data from the latest survey of carers
- Further local analysis of road casualty data

The JSNA is closely linked to the following sources of data and analyses of Oxfordshire's health and wellbeing needs:

- The Annual Report from Oxfordshire's Director of Public Health
- Performance data presented to the Health and Wellbeing Board and the Health Improvement Board in Oxfordshire
- Oxfordshire's Market Position Statements on Care Homes, Extra Care Housing, and Home Support Services
- The Oxfordshire Safer Communities Partnership's Strategic Intelligence Assessment

Contents

1. Executive Summary

This section summarises key findings from the JSNA report. Sources are included in footnotes throughout the relevant sections of the report.

Population

- There are thought to be around 672,500 people living in Oxfordshire
- The population has grown by more than 10% in the last 15 years
- It is expected to continue growing, due to increases in life expectancy and more people moving into the county

Population Groups

- Most people in Oxfordshire are from White British or Irish backgrounds but the county is becoming more ethnically diverse over time
- Oxfordshire remains a relatively rural county, even though two thirds of residents live in urban areas
- Levels of disability are low in Oxfordshire, compared to national averages, but around 90,000 residents report being limited in their daily activities

Wider Determinants of Health

- Oxfordshire is the 11th *least* deprived of 152 upper tier local authorities in England but some small areas experience high levels of deprivation
- The majority of residents own their own home but an increasing proportion rent privately
- Education and employment outcomes in Oxfordshire continue to exceed the national average

Morbidity and Mortality

- Oxfordshire tends to be relatively healthy compared with other parts of the country
- Common conditions include high blood pressure, diabetes, asthma, and common mental health disorders like depression and anxiety
- The leading causes of death in Oxfordshire are dementia (for women) and heart disease (for men)

Lifestyles

- Levels of excess weight are relatively low in Oxfordshire. Even so, around three in five adults, and over a quarter of Year 6 children, are overweight or obese
- Physical activity levels are high relative to other areas, with 63.1% of adults achieving the recommended 150 minutes per week
- An estimated 13.6% of adults in Oxfordshire smoke, and 10.4% of 15 year olds – a figure which is higher than the national average

Service Demand

- As of 1st January 2016, there were 77 General Practitioners (GP) practices in the Oxfordshire Clinical Commissioning Group (OCCG) area, with around 720,000 registered patients
- Demand is increasing across a range of secondary health care services
- At the end of March 2015 there were 6,494 adults in Oxfordshire receiving long-term social care funded by the county council. There were 515 looked after children, and 569 children who were the subject of a child protection plan

Limitations of the Data

In many cases up-to-date data are not available on the topics covered in the report. Therefore, some of the analysis uses older data, proxy measures, extrapolations, or regional and national data. These are likely to yield less accurate figures.

Projections and forecasts should also be treated with caution and not as a 'crystal ball', since future needs will be affected by various factors that are unpredictable at this point in time.

In general, there will always be a certain amount of error in the data and this often affects local data to a greater extent, where confidence intervals are wider than at national level.[1] This can limit the ability to make comparisons or evaluate trends in the data.

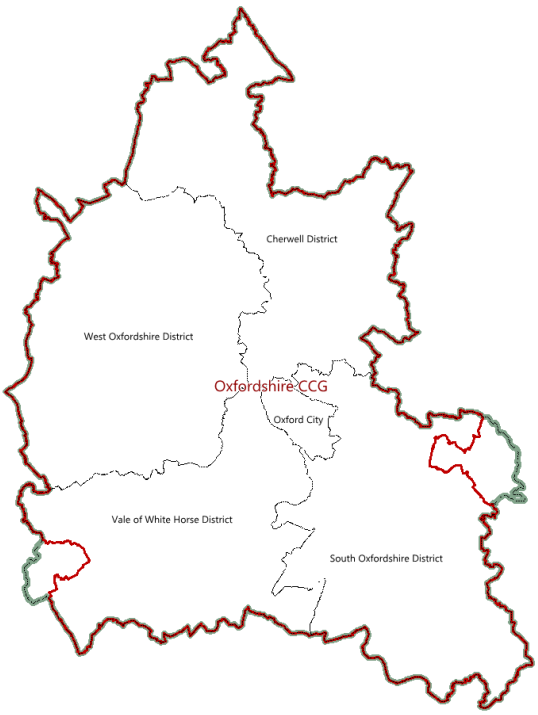
Throughout the report figures are often rounded to the nearest 100 (and percentages to one decimal place) to avoid giving a false sense of accuracy. Discussion focuses on differences that are statistically significant (the term 'significant' is used in this technical sense throughout the report).

It is not always possible to provide subgroup breakdowns, for example by district, sex or ethnicity. This is sometimes because no data are available at this level of detail, or because the numbers become too small to analyse robustly. However, subgroup analysis is provided where possible.

Geographical Boundaries

The administrative boundaries of Oxfordshire and its five districts are only partly coterminous with those of Oxfordshire Clinical Commissioning Group (OCCG) and its localities. The figure below maps the OCCG boundary (in red) with the Oxfordshire boundary (in green) and District boundaries (in black).

Figure 1: Map of Oxfordshire, Districts, and Oxfordshire Clinical Commissioning Group



Source: NHS South, Central and West Commissioning Support Unit (January 2016)

[1] Confidence intervals reflect the range within which statistics are true to reality, usually to a confidence level of 95%.

When interpreting the data in this report, it is important to remember that the county population and the OCCG population are different (although they are likely to overlap to a large extent).

Firstly, as is clear from the map above, there are small areas in the South East and South West which do not fall within the OCCG area.

Secondly, crucially, the OCCG boundaries are based on the location of GP practices rather than where people live. This means that some people living outside Oxfordshire will be registered with GP practices in the OCCG area. Conversely, some Oxfordshire residents will be registered with GPs located outside the county – and some may not be registered with a GP at all.

The Office for National Statistics estimates that in mid-2014 there were 658,700 people living within the boundaries of the OCCG area, and 672,500 people living in Oxfordshire. This compares with 720,029 people registered with GP practices within the CCG area as of 1st January.[2]

Analysis conducted in Autumn 2015 showed that 97% of patients registered with GPs in the OCCG area had an Oxfordshire address.[3] Since this would give a figure that exceeds the latest population estimates by over 25,000, it is likely that several thousand individuals who are not living in the area may still be on GP registers. Nevertheless, it seems reasonable to assume that around 97% of the CCG population is made up by Oxfordshire residents.[4] It is less clear what proportion of Oxfordshire residents are in the CCG's GP-registered population, although this is also likely to be high.

In summary, although there is likely to be a very large overlap between the CCG population and the county population, caution should be taken in extrapolating the data from one to another as it is unclear exactly to what extent each population includes the same individuals.

Unless otherwise stated, data presented in the report are for the county of Oxfordshire rather than patients registered with GPs in the CCG area.

To view geographies used in the 2011 Census, including counties, districts, and wards, please visit the interactive map on Oxfordshire Insight.

Areas for Future Development

Over the past two years Oxfordshire County Council's Research and Intelligence Team has published in-depth analyses of the needs of children and young people, and the needs of working age adults. The Team plans to publish a further in-depth analysis of the needs of older people in 2016 to supplement the JSNA. The content and presentation of the JSNA will also continue to evolve, in response to feedback from those who use it.

[2] Health and Social Care Information Centre: http://www.hscic.gov.uk/

[3] Analysis based on data from the Health and Social Care Information Centre's Statistics on Number of Patients Registered at a GP Practice – October 2015 (by LSOA): http://www.hscic.gov.uk/searchcatalogue?productid=19077&topics=2%2fPrimary+care+services%2fGeneral+practice%2fGP+registered+population&sort=Relevance&size=10&page=1#top

[4] This is justified if we assume that similar proportions of patients from inside and outside the county remain on GP registers, despite having moved away.

2. Population

This section describes the changing size and profile of Oxfordshire's population. Further resources are available online, by visiting the JSNA – Population webpage.

2.1. Population Size

In June 2015 the Office for National Statistics (ONS) released population estimates for mid-2014.[5] These put Oxfordshire's population at 672,500, continuing a trend of growth. The county's population is estimated to have risen by 2.9% since the 2011 Census (when it stood at 653,800 residents) and by 10.7% since the 2001 Census.

The estimated rate of population growth in Oxfordshire has been similar to that of the wider South East and slightly higher than for England overall. Across the county, estimated population growth between 2011 and 2014 has been highest in Oxford (4%).

Figure 2: Estimated population change in Oxfordshire and its Districts (2011-2014)

Area	2011 Population (Census)	2014 Population (ONS Mid-Year Estimate)	% change 2011-2014
Cherwell	141,900	144,500	1.9%
Oxford	151,900	158,000	4.0%
South Oxfordshire	134,300	137,000	2.1%
Vale of White Horse	121,000	124,900	3.2%
West Oxfordshire	104,800	108,200	3.2%
Oxfordshire	653,800	672,500	2.9%

Source: Office for National Statistics – 2011 Census and population estimates for mid-2014

To compare population change in different parts of England and Wales, take a look at the data visualisation on population change produced by the Office for National Statistics.

Oxfordshire's population is expected to continue to grow. The number of births in the county is expected to exceed the number of deaths and, meanwhile, more people are expected to move in than out.

Oxfordshire County Council produces two tools for estimating future population change:

- The **population forecasts**[6] are based on information about housing numbers, taken from current district local plans. More details of the methodology used can be found in the population forecasts report.

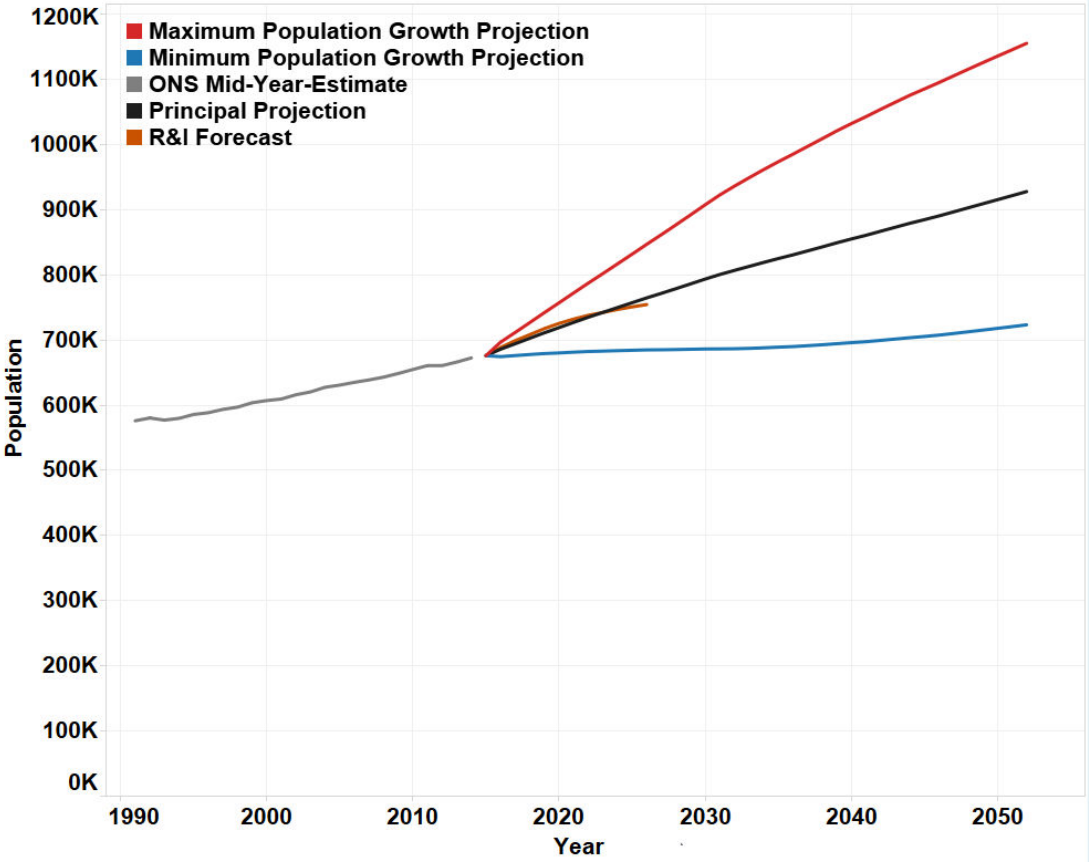
[5] ONS population estimates for mid-2014: http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2014/mid-year-population-estimates-for-the-uk-2014.html. Percentages are based on raw ONS figures rather than the rounded figures included in the JSNA.

[6] Oxfordshire County Council's Population Forecast (May 2015) – summary report: http://insight.oxfordshire.gov.uk/cms/system/files/documents/OxfordshireCC%20PopulationForecasts%20May%2015.pdf; data visualisation: https://public.tableau.com/views/May2015Forecasts/Story1?:embed=y&:display_count=no&:showVizHome=no

- The **long range population projections**[7] 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.[8] The projections cover the period up to 2052, based on five growth scenarios. They represent the range of variation considered feasible for changes in life expectancy, fertility, migration, and housing growth. Unlike the population forecasts, these are independent of district local plans. More details of the methodology used can be found in the population projections report.

Oxfordshire County Council's latest population forecast shows the county's population increasing by 86,000 (13%) from 2014 to 2026. The principal projection shows a larger increase, of 9,400 (14%). However, this could be considerably higher or lower, depending on factors such as life expectancy, fertility, migration, and housing growth.

Figure 3: Population change in Oxfordshire (1991-2052)



Source: Office for National Statistics population estimates/ Oxfordshire County Council Research & Intelligence population forecast (May 2015) and long-range projections (autumn 2014)

You can explore the data using the interactive population forecasting story, and the interactive population projections dashboards, on the Oxfordshire Insight website.

Overall, the projected growth in Oxfordshire's population can be expected to increase the need for different forms of health and social care in the county.

[7] Oxfordshire County Council's Population Projections (Oct 2014) – summary report: http://insight.oxfordshire.gov.uk/cms/long-range-population-projections-summary-report-autumn-2014; data visualisation: https://public.tableau.com/views/Summer14ProjectionsDashboard/Dashboard1?:embed=y&:showVizHome=no

[8] Oxfordshire Strategic Housing Market Assessment, 2014: http://insight.oxfordshire.gov.uk/cms/strategic-housing-market-assessment-2014

2.2. Life Expectancy

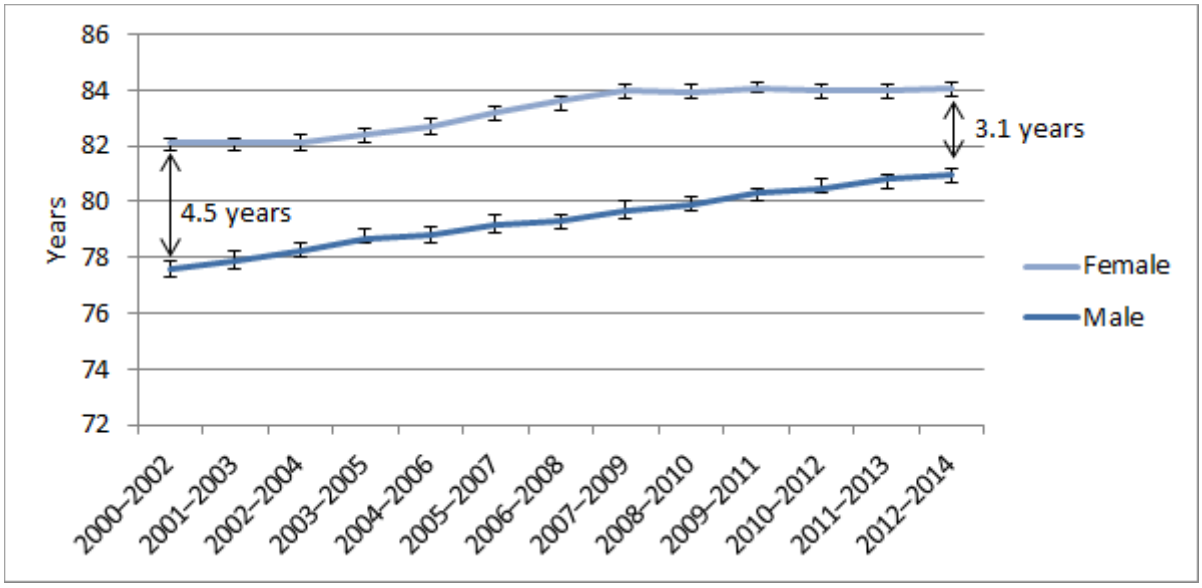
2.2.1. Overall Life Expectancy

Life expectancy at birth predicts the average number of years a person born could expect to live if they were to experience that area's age-specific mortality rates. In practice, death rates of the area may change in the future and people may live in other areas for at least some part of their lives. In line with falling mortality rates, life expectancy has been increasing in the UK for some time.

Life expectancy for a boy born in Oxfordshire was estimated to be 81.0 years, *if 2012-14 mortality rates persist throughout their lifetime* (as mentioned above, this is unlikely in practice).[9] For a girl born in Oxfordshire, life expectancy was estimated at 84.1 years.

Over the past 15 years, both male and female life expectancy at birth have increased significantly. However, in recent years, female life expectancy has plateaued, whilst male life expectancy has continued to increase. This has contributed to a narrowing of the gap between male and female life expectancy from 4.5 years in 2000-2002 to 3.1 years in 2012-2014.

Figure 4: 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.*

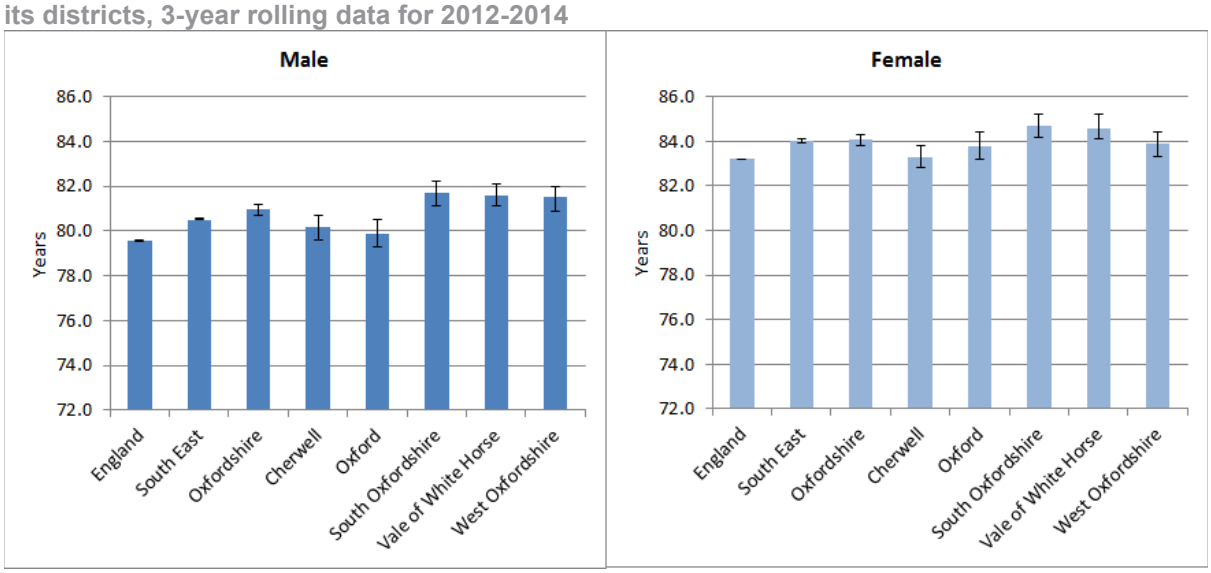
For the 2012-14 period, life expectancy for both sexes was higher in Oxfordshire than the national average. *Male* life expectancy was also higher than the regional average (whereas *female* life expectancy was similar to the regional average).

All of Oxfordshire's districts ranked among the top 50% of unitary and lower tier local authorities in England, for *male* life expectancy at birth. Three districts were ranked among the top 15%: South Oxfordshire (ranked 35th of 346 authorities), Vale of White Horse (ranked 37th) and West Oxfordshire (ranked 49th). However, male life expectancy in Oxford was significantly lower than the county average, at 79.9 years, respectively.

[9] Life expectancy data is taken from the ONS release *Life expectancy at birth and at age 65 by local areas in England and Wales, 2012 to 2014*: http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2012-14/index.html

For *female* life expectancy at birth, Cherwell was the only district ranked in the bottom 50% of unitary and lower tier local authorities in England (ranked 184th of 346 authorities). The other districts were among the top 50% and two were among the top 20%: South Oxfordshire (ranked 57th) and Vale of White Horse (ranked 65th).

Figure 5: Male and female life expectancy at birth in England, the South East, Oxfordshire and its districts, 3-year rolling data for 2012-2014



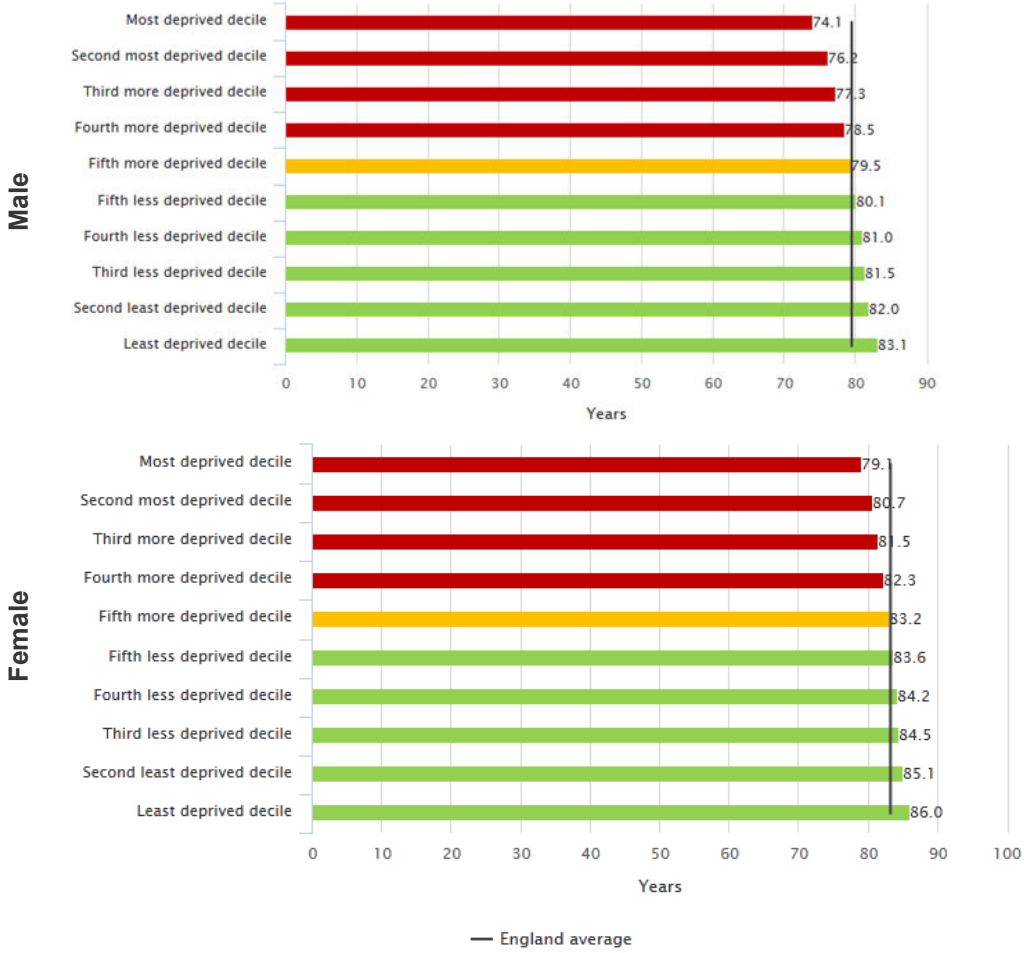
Source: Office for National Statistics. *NB the vertical axis starts at 72 years, not 0 years.*

Nationally there is an established link between life expectancy and socioeconomic group: those with higher levels of education, more highly skilled occupations, and larger salaries, are more likely to live longer.[10] Men in the most advantaged socioeconomic group now have a longer life expectancy than the average woman, for the first time.[11] The figure below shows the national differences in estimates of male and female life expectancy, by decile of deprivation.

[10] Trends in life expectancy by socio-economic position by the National Statistics Socio-economic Classification, England and Wales, 1982-1986 and 2007-2011: http://www.ons.gov.uk/ons/rel/health-ineq/trend-in-life-expectancy-by-socioeconomic-position-by-the-national-statistics-socioeconomic-classification--england-and-wales/1982-86-to-2007-11/index.html

[11] Most affluent man now outlives the average woman for the first time (ONS, October 2015): http://visual.ons.gov.uk/most-affluent-man-now-outlives-the-average-woman-for-the-first-time/

Figure 6: Male and female life expectancy at birth in England, by deprivation decile, 3-year rolling data for 2011-13



Source: Public Health England

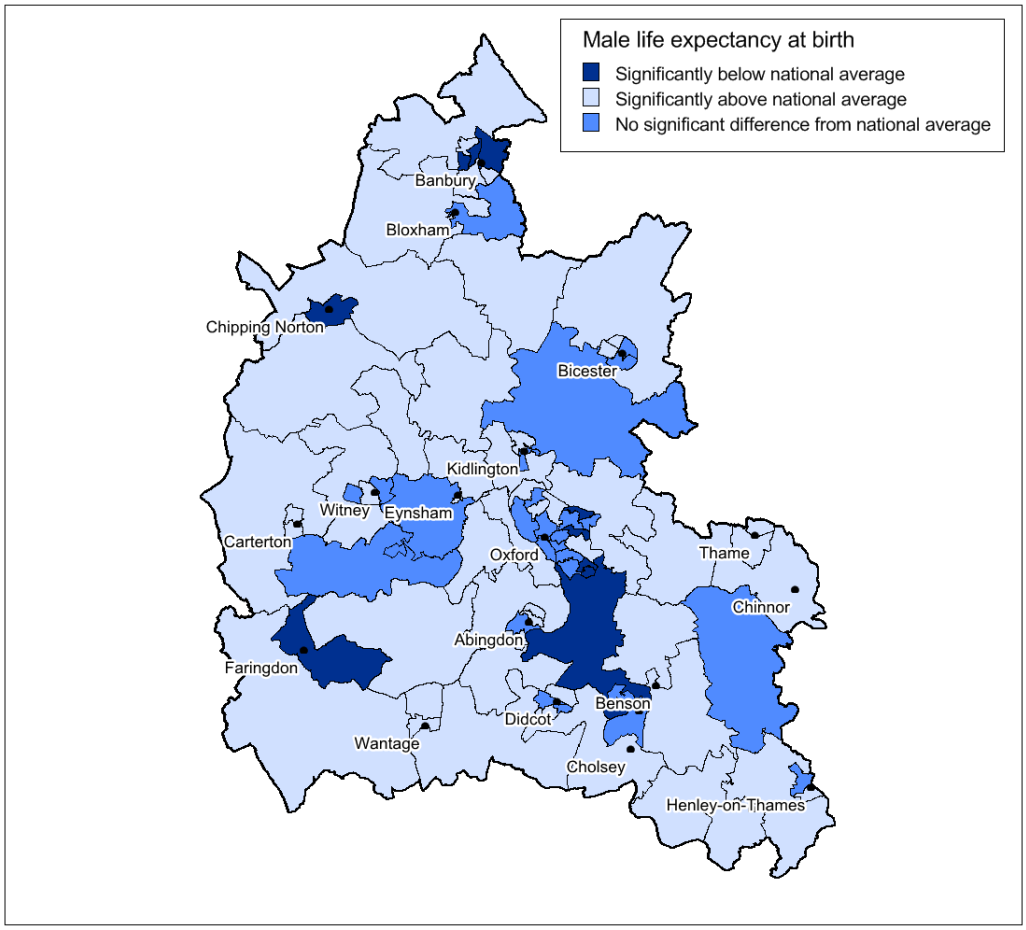
In Oxfordshire, pooled data for the period 2009-2013 show that male life expectancy at birth was estimated to differ by 5.6 years between those living in the most and least deprived areas of the county.[12] The confidence level for this figure is 95% within the range 4.4-6.9 years. The level of inequality was significantly lower than in England overall.

Meanwhile, the inequality in female life expectancy at birth was estimated at 3.8 years, with 95% confidence within the range 2.2-5.4 years. Again, this was significantly better than the national average.

The maps below show how life expectancy is thought to differ across areas of the county.

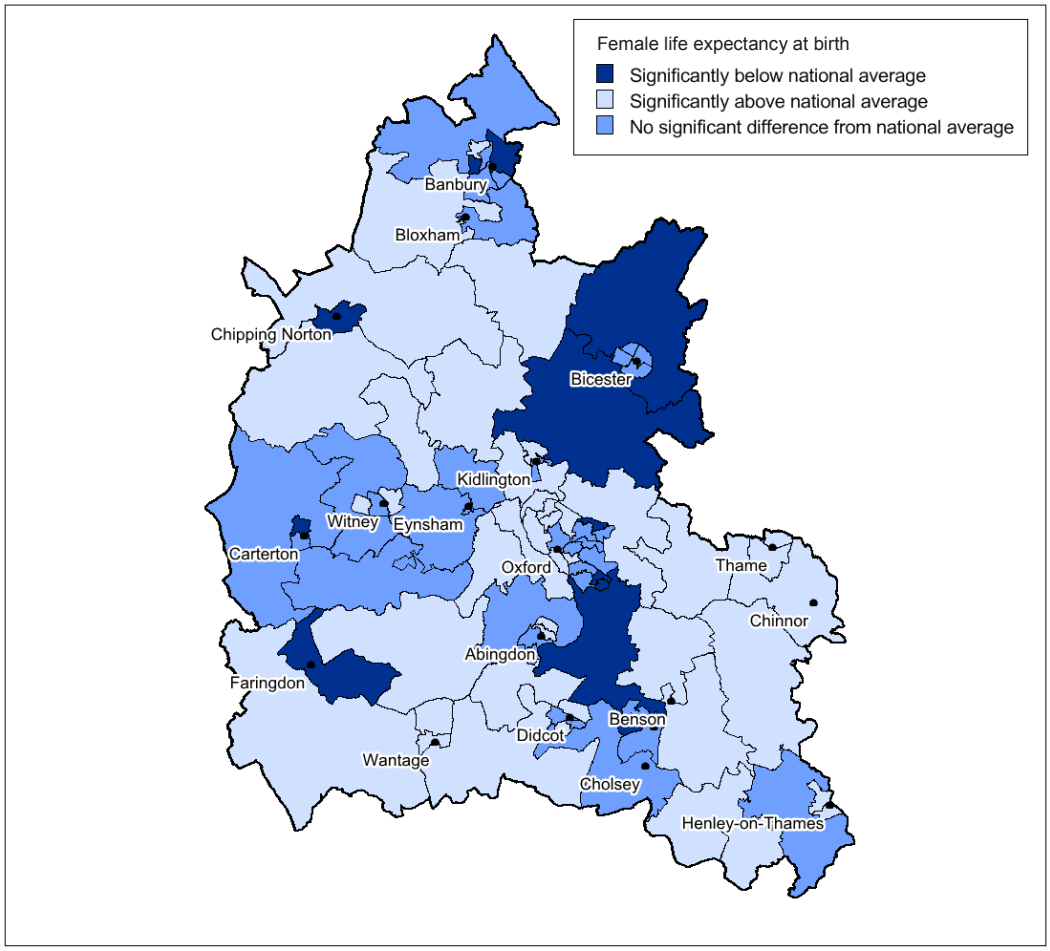
[12] Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within upper Tier Local Authorities: 2009-2013 (ONS, November 2015): http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/inequality-in-health-expectancies-using-imd-2015-small-area-deprivation-scores--2009-13/stb-he.html#tab-Main-points-

Figure 7: Male life expectancy in Oxfordshire's 86 Middle Layer Super Output Areas



Source: Office for National Statistics

Figure 8: Female life expectancy in Oxfordshire's 86 Middle Layer Super Output Areas



Source: Office for National Statistics

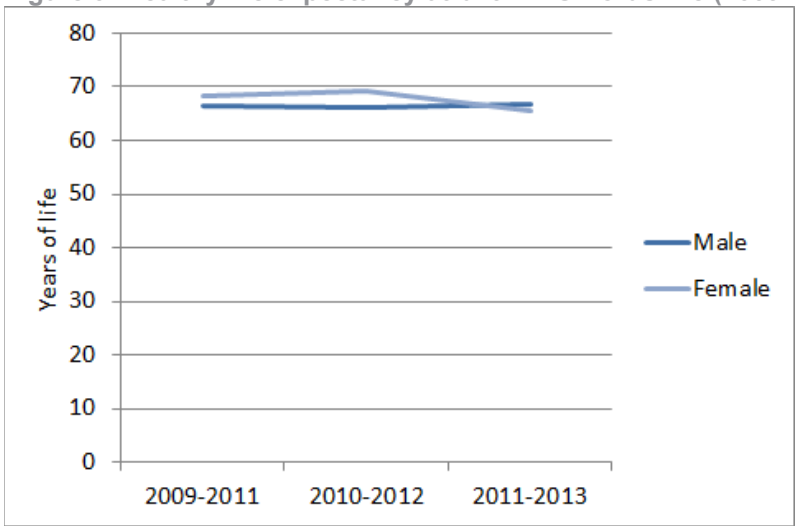
2.2.2. Healthy Life Expectancy

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.[13] 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.[14]

The latest three-year rolling data, covering the period 2011-2013, shows that a child born in Oxfordshire could expect to live in good health until the age of nearly 67, if male, or a little over 65, if female. Again, the figures relate to current mortality rates which are, in practice, likely to change over an individual's lifetime. The difference between male and female healthy life expectancy was not statistically significant. The trend over time also shows a broadly stable pattern, although female healthy life expectancy decreased between the 2010-12 and 2011-13 periods.

[13] ONS subnational health expectancies: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Subnational+Health+Expectancies
[14] Marmot Indicators 2015: http://www.instituteofhealthequity.org/projects/marmot-indicators-2015

Figure 9: Healthy life expectancy at birth in Oxfordshire (2009-11 to 2011-13)



Source: Office for National Statistics subnational health expectancies

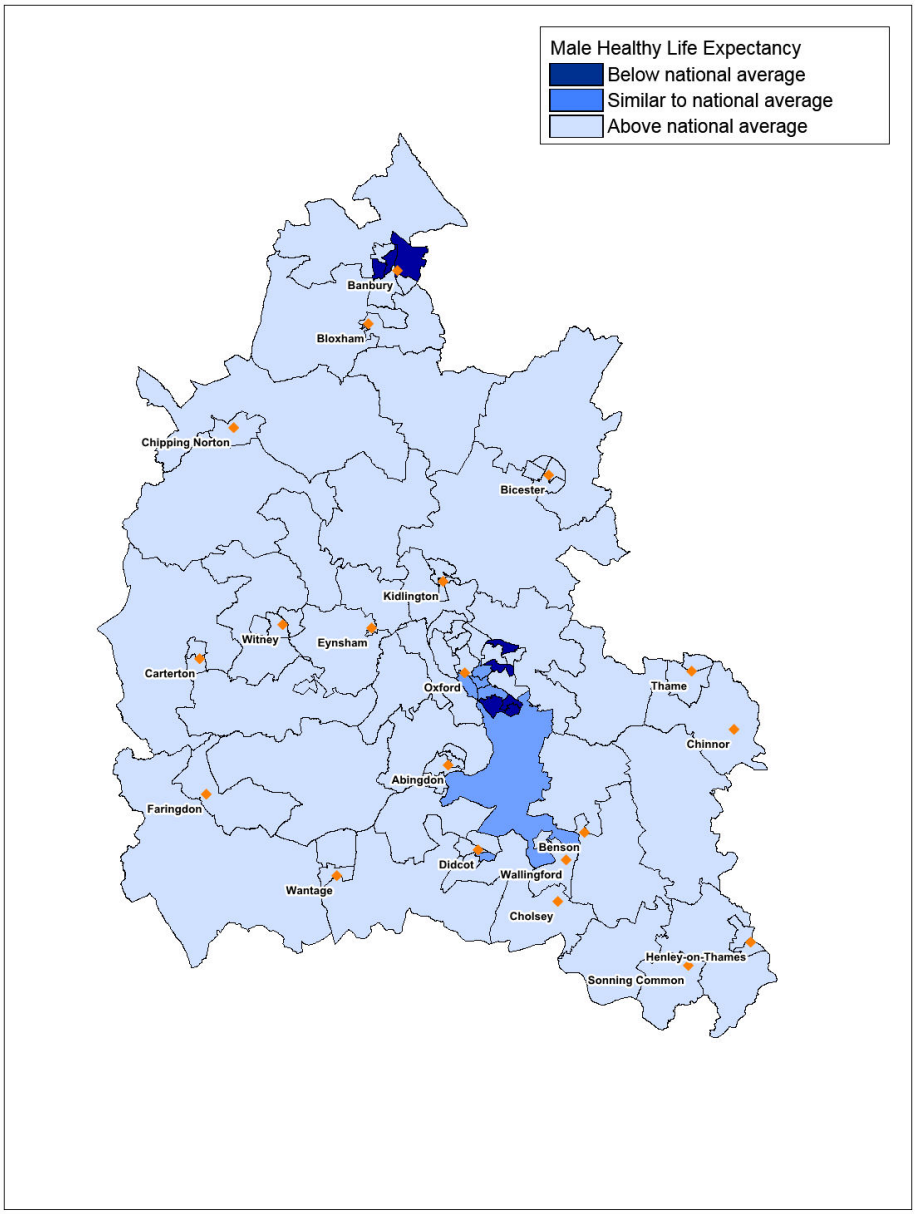
Healthy life expectancy in Oxfordshire is above the national average: for the period 2011-2013 the average healthy life expectancy for a boy born in England was 63.3; for a girl it was 63.9.[15] Healthy life expectancy in Oxfordshire is statistically similar to the South East average (65.6 for a boy and 66.7 for a girl).

Pooled data for the period 2009-2013 allows analysis of healthy life expectancy at birth at neighbourhood ('middle layer super output area') level.[16] This shows that most neighbourhoods in Oxfordshire have healthy life expectancies above national averages (some are among the best in England). However, a small number are below national averages, as shown by the darker shading on the maps below. For both men and women, these areas tend to be concentrated around parts of Oxford and Banbury.

[15] ONS Health Expectancy statistics: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Health+Expectancy#tab-sum-pub

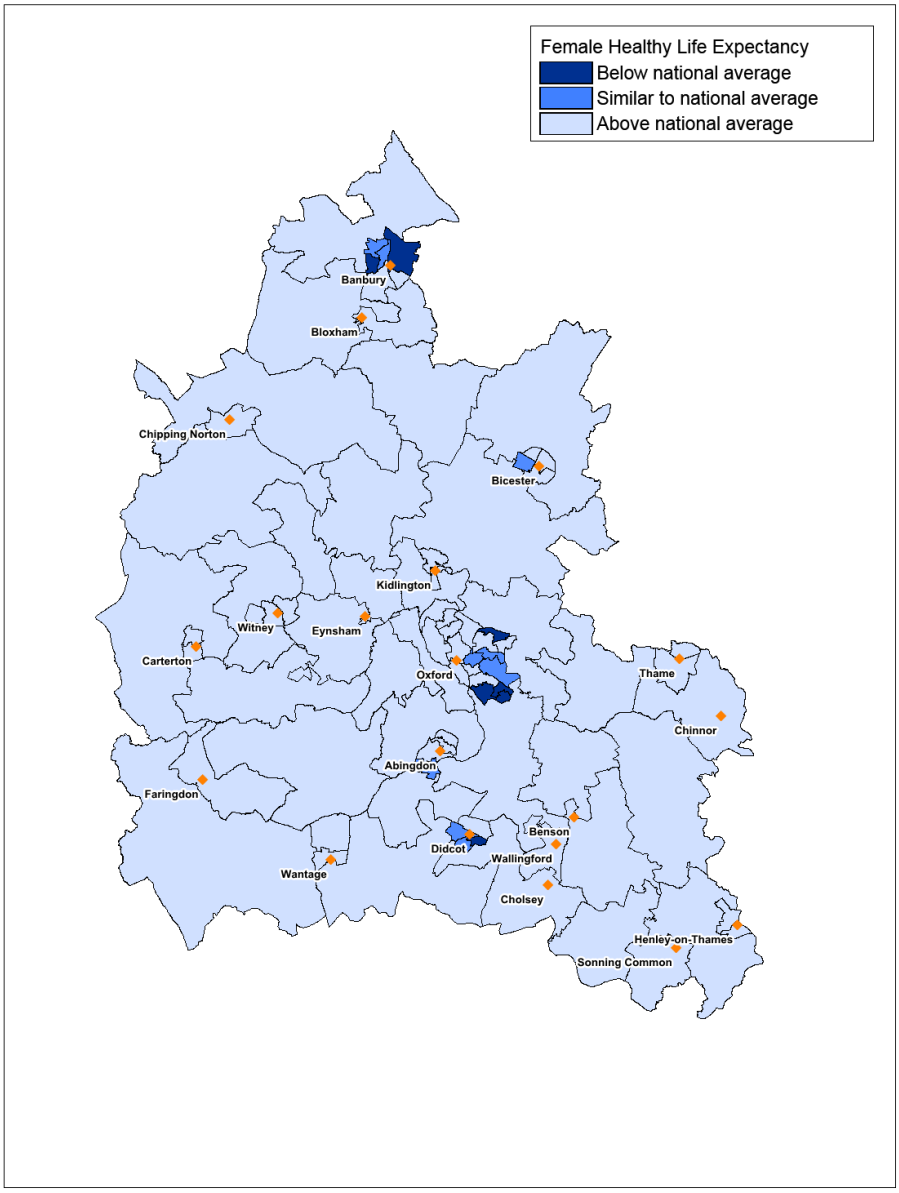
[16] ONS Health Expectancies at Birth for Middle Layer Super Output Areas (MSOAs), England, 2009-2013: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/2009-2013/index.html

Figure 10: Male healthy life expectancy at birth, mapped at Middle Layer Super Output Area (2009-2013)



Source: Office for National Statistics health expectancies statistics

Figure 11: Female healthy life expectancy at birth, mapped at Middle Layer Super Output Area (2009-2013)



Source: Office for National Statistics health expectancies statistics

In Oxfordshire, for the period 2009-2013, male healthy life expectancy at birth was estimated to differ by 9.3 years between those living in the most and least deprived areas of the county.[17] The confidence level for this figure is 95% within the range 7.9-10.8 years. The level of inequality was significantly lower than in England overall.

Meanwhile, the inequality in female healthy life expectancy at birth was estimated at 8.8 years, with 95% confidence within the range 6.9-10.7 years. Again, this was significantly better than the national average.

[17] Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within upper Tier Local Authorities: 2009-2013 (ONS, November 2015): http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/inequality-in-health-expectancies-using-imd-2015-small-area-deprivation-scores--2009-13/stb-he.html#tab-Main-points-

2.2.3. Disability-Free Life Expectancy

Disability-free life expectancy (DLE) is defined as the lifetime free from a limiting persistent illness or disability. This is based upon a self-rated assessment of how health limits an individual's ability to carry out day-to-day activities. Similarly to healthy life expectancy, disability-free life expectancy in England has been increasing more slowly than overall life expectancy over the past 10 years; this means people are expected to have *more* years living with a disability in the future.[18]

For the period 2009-2011 disability-free life expectancy at birth in Oxfordshire was 67.6 years for boys and 69.3 years for girls.[19] Trends since 2006-2008 suggest that disability-free life expectancy is increasing for both sexes, although changes are not always statistically significant, due to relatively wide confidence intervals locally.

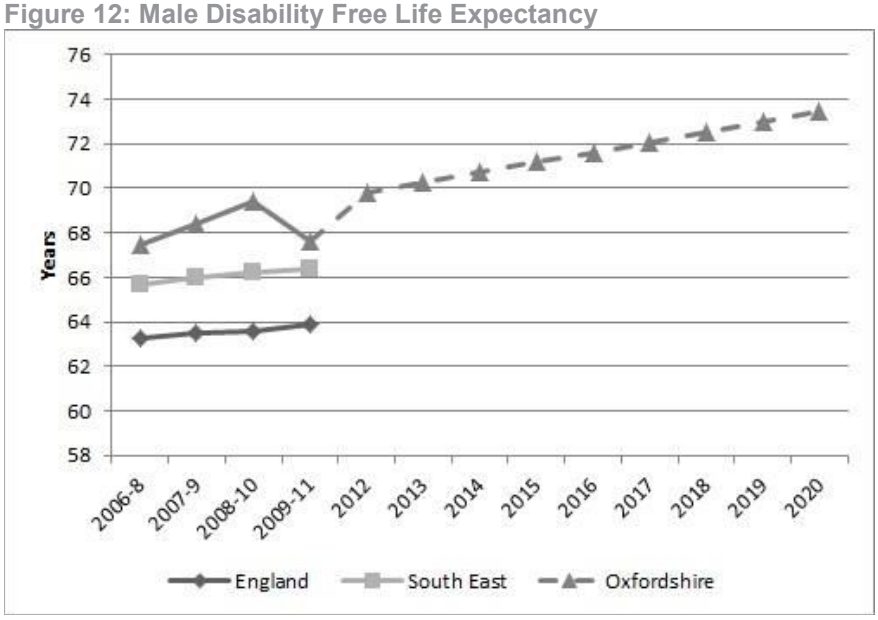
Disability free life expectancy in Oxfordshire remains significantly above the national average. Male disability free life expectancy has consistently been in the top 10% of the 150 upper tier local authorities in England since 2006-8. Female disability-free life expectancy has been in the top 20%.If current trends were to continue, male disability-free life expectancy could increase to around 73 by 2020, and female disability-free life expectancy to around 72.[20]

[18] Marmot Indicators 2015: http://www.instituteofhealthequity.org/projects/marmot-indicators-2015

[19] ONS subnational health expectancies: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Subnational+Health+Expectancies Again, the figures relate to current mortality rates which are, in practice, likely to change over an individual's lifetime.

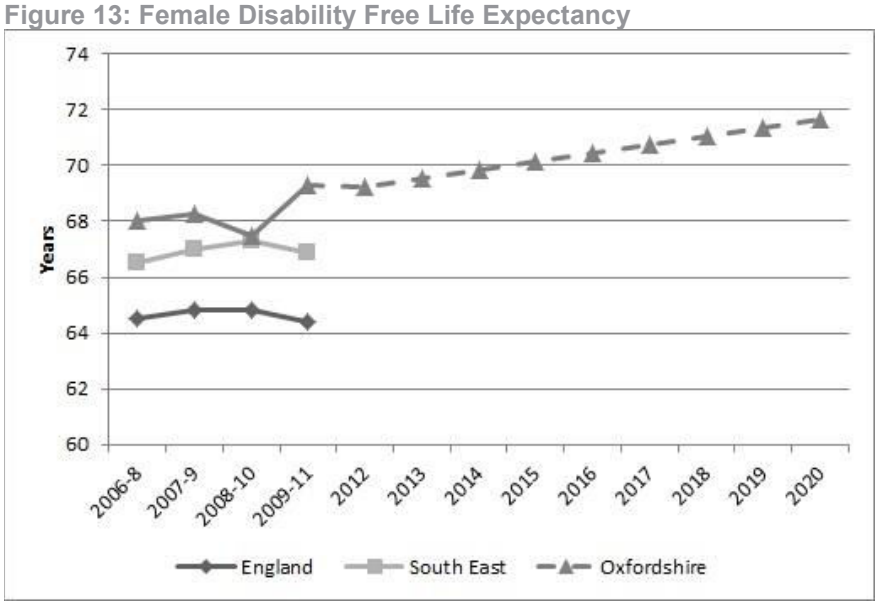
[20] Projections for disability free life expectancy use Oxfordshire County Council's Research and Intelligence team's overall life expectancy projections and apply trends in disability free life expectancy from the period 2006-2008 to 2009-2011, based on ONS estimates. The changing ratios between overall life expectancy and disability free life expectancy are projected forward for both boys and girls. According to the projections, male disability free life expectancy outpaces female disability free life expectancy from 2012 onwards; this is because both male disability free life expectancy and overall male life expectancy have tended to increase at a faster rate than the female equivalents. However, the projected figures should be treated with caution, since trends are taken from just four estimated data points, and there is uncertainty about how patterns of life expectancy and disability free life expectancy will change in the future.

Figure 12: Male Disability Free Life Expectancy



Source: Office for National Statistics subnational health expectancies/ OCC projections

Figure 13: Female Disability Free Life Expectancy

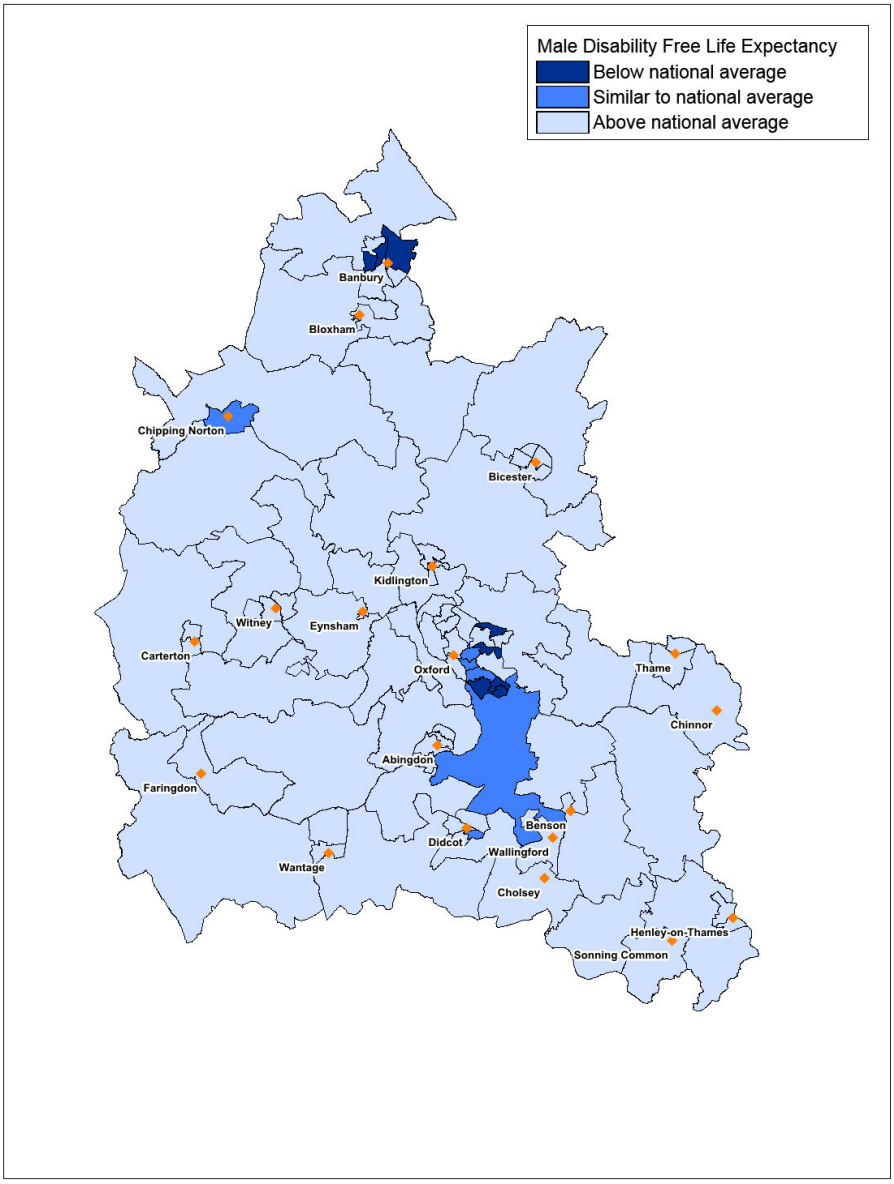


Source: Office for National Statistics subnational health expectancies/ OCC projections

Pooled data for the period 2009-2013 allows analysis of disability-free life expectancy at birth at neighbourhood ('middle layer super output area') level.[21] This shows that most neighbourhoods in Oxfordshire have disability free life expectancies above national averages (again, some are among the best in England). However, a small number are below national averages, as shown by the darker shading on the maps below. As for healthy life expectancy, these areas tend to be concentrated around parts of Oxford and Banbury.

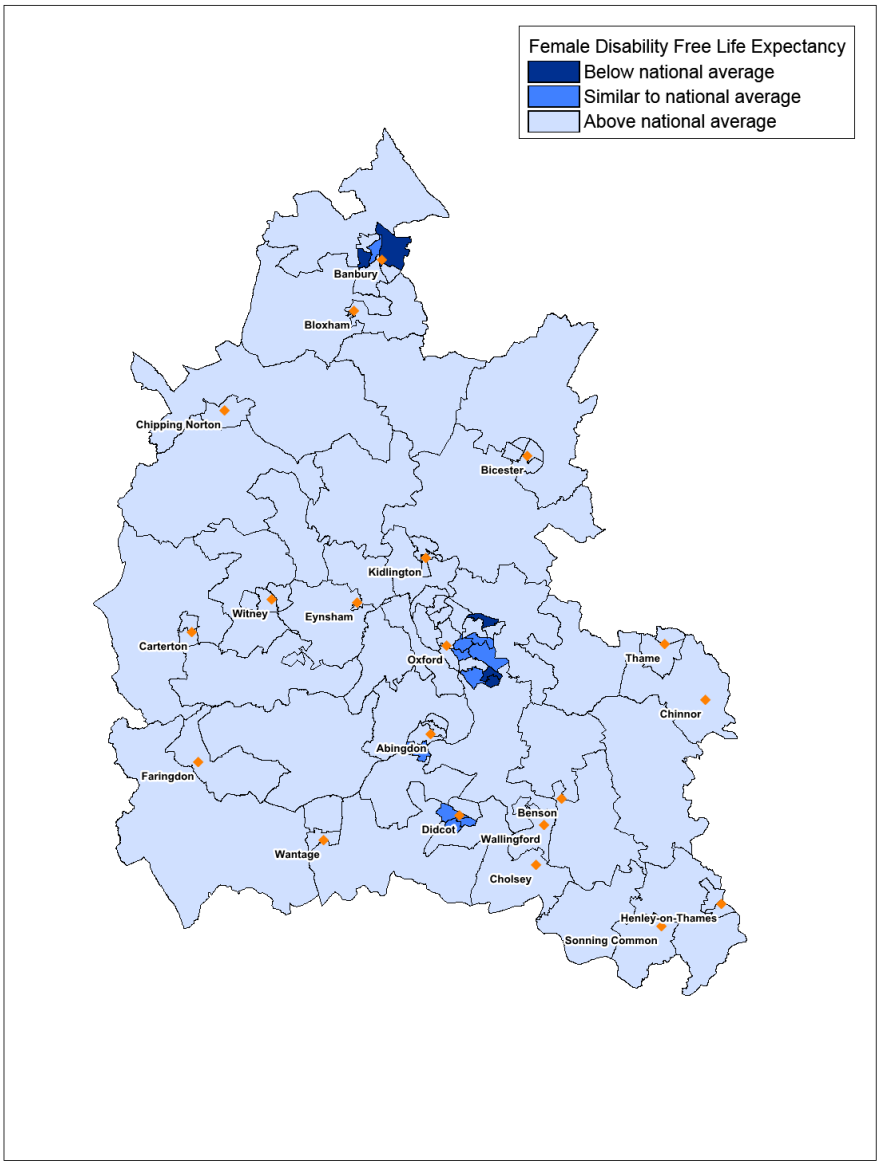
[21] ONS Health Expectancies at Birth for Middle Layer Super Output Areas (MSOAs), England, 2009-2013: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/2009-2013/index.html

Figure 14: Male disability free life expectancy at birth, mapped at Middle Layer Super Output Area (2009-2013)



Source: Office for National Statistics health expectancies statistics

Figure 15: Female disability free life expectancy at birth, mapped at Middle Layer Super Output Area (2009-2013)



Source: Office for National Statistics health expectancies statistics

In Oxfordshire, for the period 2009-2013, male DLE at birth was estimated to differ by 8.0 years between those living in the most and least deprived areas of the county.[22] The confidence level for this figure is 95% within the range 6.8-9.3 years. The level of inequality was significantly lower than in England overall.

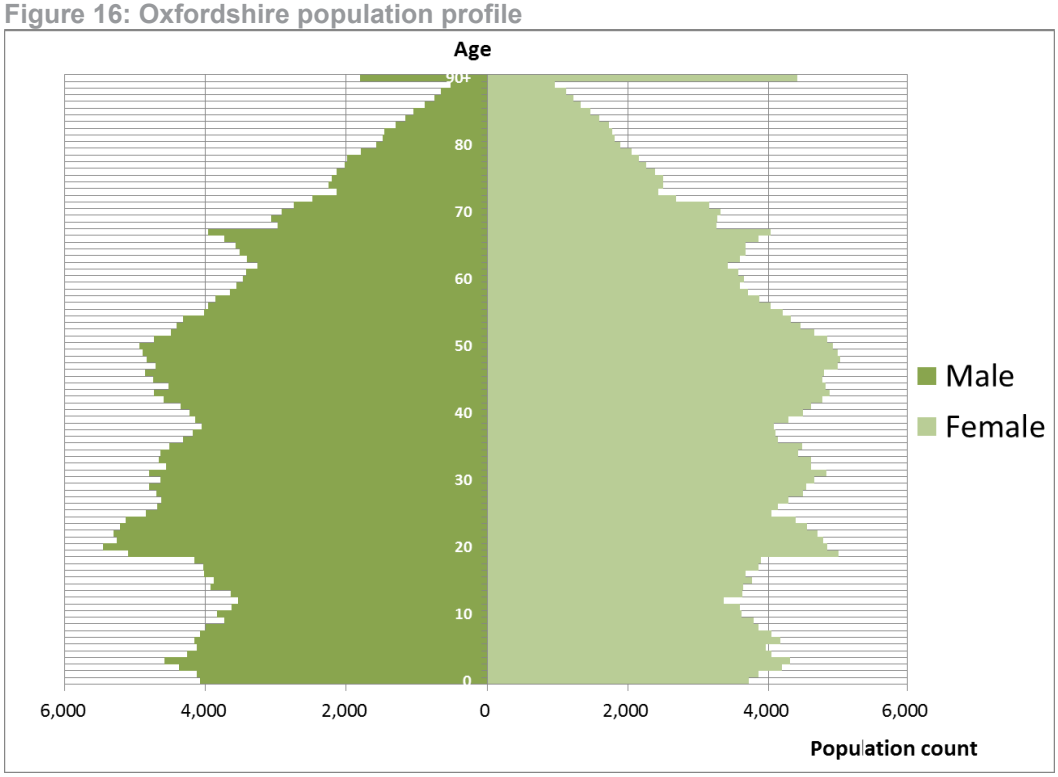
Meanwhile, the inequality in female DLE at birth was estimated at 7.3 years, with 95% confidence within the range 5.8-8.8 years. Again, this was significantly better than the national average.

[22] Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within upper Tier Local Authorities: 2009-2013 (ONS, November 2015): http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/inequality-in-health-expectancies-using-imd-2015-small-area-deprivation-scores--2009-13/stb-he.html#tab-Main-points-

2.3. Population by Sex and Age

The figure below shows the population profile of Oxfordshire, by sex and age, as of mid-2014.

Figure 16: Oxfordshire population profile



Source: Office for National Statistics population estimates for mid-2014

2.3.1. Sex

Whilst slightly more babies are recorded as male than female at birth, mortality rates (the number of deaths within a population during a given time period) are generally higher for men than for women.

In 2014 an estimated 49.6% of Oxfordshire's population was male and 50.4% was female.[23] The proportions were similar to those in the South East (49.2% male; 50.8% female) and England overall (49.3% male; 50.7% female). Across the county proportions were also similar, although Oxford was estimated to have a slightly higher proportion of male residents (50.4%). The relative proportions of men and women in the county have remained stable over time.

Several health and wellbeing outcomes are linked to a person's sex; these are mentioned throughout the report.

2.3.2. Age

A breakdown of Oxfordshire's population by age group is given in the table below. The number of people in each age group has grown between 2011 and 2014. The largest proportionate increase was among older people.[24] Ageing is a risk factor for many health

[23] ONS mid-year population estimates for 2013: http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2013/sty-population-estimates.html

[24] ONS mid-year population estimates for 2014: http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-

conditions, whereas wellbeing is thought to be 'U-shaped', tending to be higher among younger and older age groups. The relationship between age and health and wellbeing is discussed in more detail throughout the report.

Figure 17: Oxfordshire's population by age group

Age Group	Number in 2011 (Census)	Number in 2014 (ONS Mid-Year Estimate)	% change 2011-2014
0-3	33,000	33,200	+0.8%
4-17	105,000	107,900	+2.8%
18-64	412,000	415,800	+0.9%
65+	103,700	115,600	+11.4%
85+	14,700	*16,200*	+10.3%

Source: Office for National Statistics 2011 Census and mid-2014 Population Estimate

Older People

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).

The proportion of older people was higher in the more rural districts of the county. The lower number and proportion of older people in Oxford is due to the younger profile of the city, which is in turn partly attributable to the presence of two large universities in the city.

Figure 18: The number and proportion of older people in Oxfordshire and its districts

Area	People aged 65+ (number and % of population)	People aged 85+ (number and % population)
Cherwell	24,500 (17%)	3,200 (2.2%)
Oxford	17,800 (11.3%)	2,800 (1.8%)
South Oxfordshire	27,300 (19.9%)	3,800 (2.7%)
Vale of White Horse	24,400 (19.5%)	3,300 (2.7%)
West Oxfordshire	21,600 (19.9%)	3,100 (2.9%)
Oxfordshire	115,600 (17.2%)	16,200 (2.4%)

Source: Office for National Statistics Mid-2014 Population Estimate

The growing number of older people in the county is likely to affect health and wellbeing needs significantly. Older people are more likely than younger people to experience many health conditions.

Babies and Infants

In 2014 there were an estimated 33,200 infants aged 0-3 in Oxfordshire. The number of 0-3 year-olds was estimated to have grown by just under 1% since 2011, increasing the relative size of this age group slightly from 4.9% of the population to 5%. The proportion of 0-3 year-olds in Oxfordshire was similar to that in the South East (4.9%) and England overall (5.1%); it was also similar across each district (within half a percentage point either way).

2014/mid-year-population-estimates-for-the-uk-2014.html. Percentages are based on raw ONS figures rather than the rounded figures included in the JSNA.

Children and Young People

There were an estimated 107,900 children and young people aged 4-17 in Oxfordshire in 2014. Although the absolute number is estimated to have increased by 2.8% since 2011, the proportion of the population made up by 4-17 year olds fell slightly from 16.1% to 16% over the same period. The proportion of 4-17 year-olds in Oxfordshire was a little lower than in the South East (16.5%) and England overall (16.3%). Across the county, the proportion of 4-17 year olds was highest in Cherwell (24,700, making up 17.1% of the population).

Working Age Adults

There were an estimated 415,800 adults aged 18-64 in Oxfordshire in 2014, representing an increase of 0.9% since 2011. The proportion of the population made up by 18-64 year olds fell slightly, from 63% to 61.8%. There were proportionately slightly more people in this age group than in England (61.1%) and the South East (60%). Across the county there were estimated to be many more 18-64 year olds in Oxford than other districts (numbering 110,200 and making up 69.7% of the population).Again, this is likely to be linked to the presence of two large universities and a higher concentration of employment opportunities.

3. Population Groups

This section provides data on particular subsets of Oxfordshire's population, including those with legally protected characteristics[25] and those identified as being potentially vulnerable.[26] Further resources are available online, by visiting the JSNA – Population webpage.

3.1. Race and Ethnicity

3.1.1. White British and Irish

At the time of the 2011 Census, the majority of Oxfordshire's population came from White British or Irish backgrounds (553,100 people, or 84.6%).[27] This was a little lower than the proportion seen in the South East (86.1%) but above that of England overall (80.7%).

There were large differences between districts: just under two thirds of Oxford's population was White British or Irish (65.2%) compared with more than nine in ten for three districts: West Oxfordshire (93.3%), South Oxfordshire (91.8%) and Vale of White Horse (90.6%). Cherwell was closer to the county average with 87.1%.

You can explore ethnicity data using the interactive ethnicity dashboard on the Oxfordshire Insight website. For newer data on country of birth, see the September edition of the Oxfordshire Insight newsletter, and the interactive dashboard on mothers' countries of birth.

3.1.2. Other White

People from White backgrounds other than British or Irish numbered 40,900 people, or 6.3% of Oxfordshire's population (up from 4% in 2001). Much of the increase in the size of this group can be explained by movement of people from the countries which joined the EU in 2004 and 2007.[28] In 2011 13,200 people in Oxfordshire were born in these countries, representing 2% of the county's population. This figure was similar to the proportions in the South East and England (1.8% and 2% respectively).

Over a third of those coming from the EU accession countries lived in Oxford (38.2%) with around a quarter in Cherwell (25.6%). More than half of them were born in Poland (7,500 people in Oxfordshire, of whom 36% were in Oxford and 31% were in Cherwell).

Around 600 respondents to the 2011 Census identified their background as White Gypsy or Irish Traveller, representing 0.1% of the population. This was comparable with proportions across the South East (0.2%) and England (0.1%) as well as in the city and districts (all 0.1%, aside from West Oxfordshire, where 0.2% of the population classified themselves in this way).

[25] The Equality Act 2010 identifies nine protected characteristics: age (covered in the previous section of the JSNA), disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (covered in the previous chapter of the JSNA), and sexual orientation. Further information is available at the following link: http://www.equalityhumanrights.com/legal-and-policy/legislation/equality-act-2010.

[26] Other potentially vulnerable groups include those identified in Oxfordshire's equalities briefing: http://insight.oxfordshire.gov.uk/cms/equalities-briefing-october-2015.

[27] Census 2011, table QS201EW: https://www.nomisweb.co.uk

[28] Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Czech Republic, Slovakia, Slovenia, Romania and Bulgaria.

3.1.3. Black and Minority Ethnic

Oxfordshire's black and minority ethnic (BME) communities numbered 59,800 in 2011, comprising 9.2% of its population. This was nearly double the 2001 proportion of 4.9%, and resulted from growth across all of the county's BME communities.

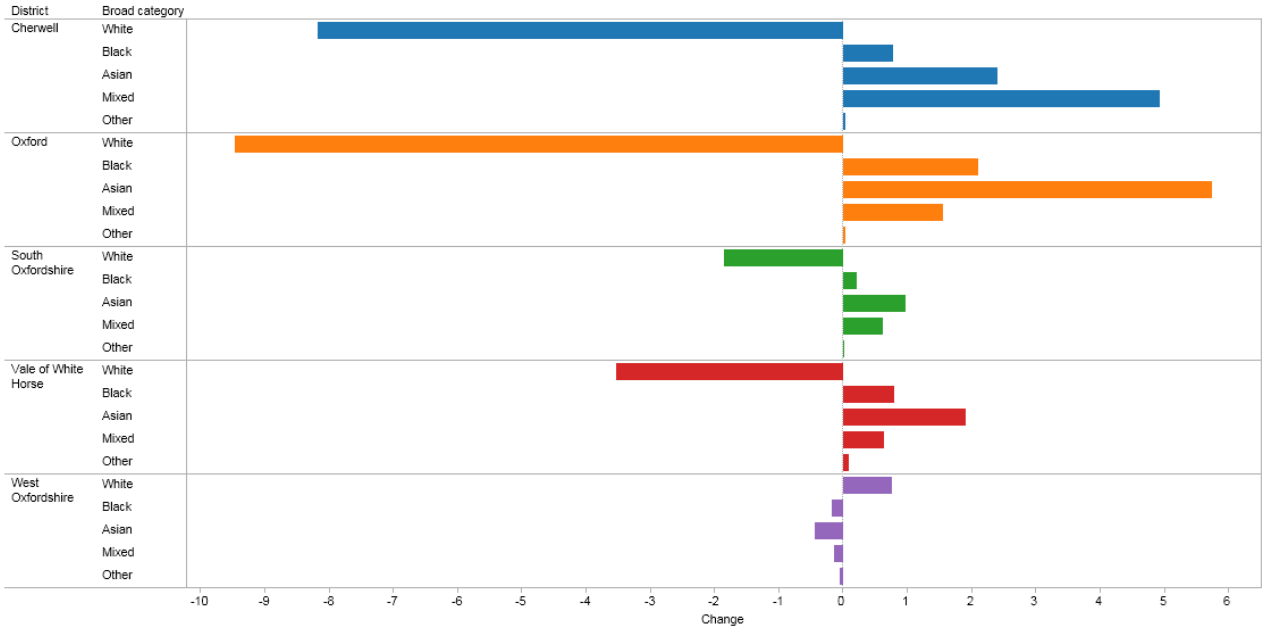
People from Asian backgrounds constituted the largest BME group, numbering 31,700, or 4.8% of the county's population (up from 2.4% in 2001). Most came from Indian backgrounds (1.3% of the population) or Pakistani backgrounds (1.2%).

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 backgrounds was 11,400, or 1.8% of the county's population (up from 0.8% in 2001).

Oxford and Cherwell saw the largest increases in BME communities between 2001 and 2011, as shown in the figure below. There was a 5.8% increase in the proportion of people from Asian backgrounds in Oxford, the largest increase of any of the broad categories. Meanwhile, Cherwell saw a 4.9% increase in the proportion of people of mixed ethnic backgrounds. West Oxfordshire was the only district where there was a reduction in the proportion of the population from BME backgrounds.

Figure 19: Change in the proportion of the population made up by ethnic groups



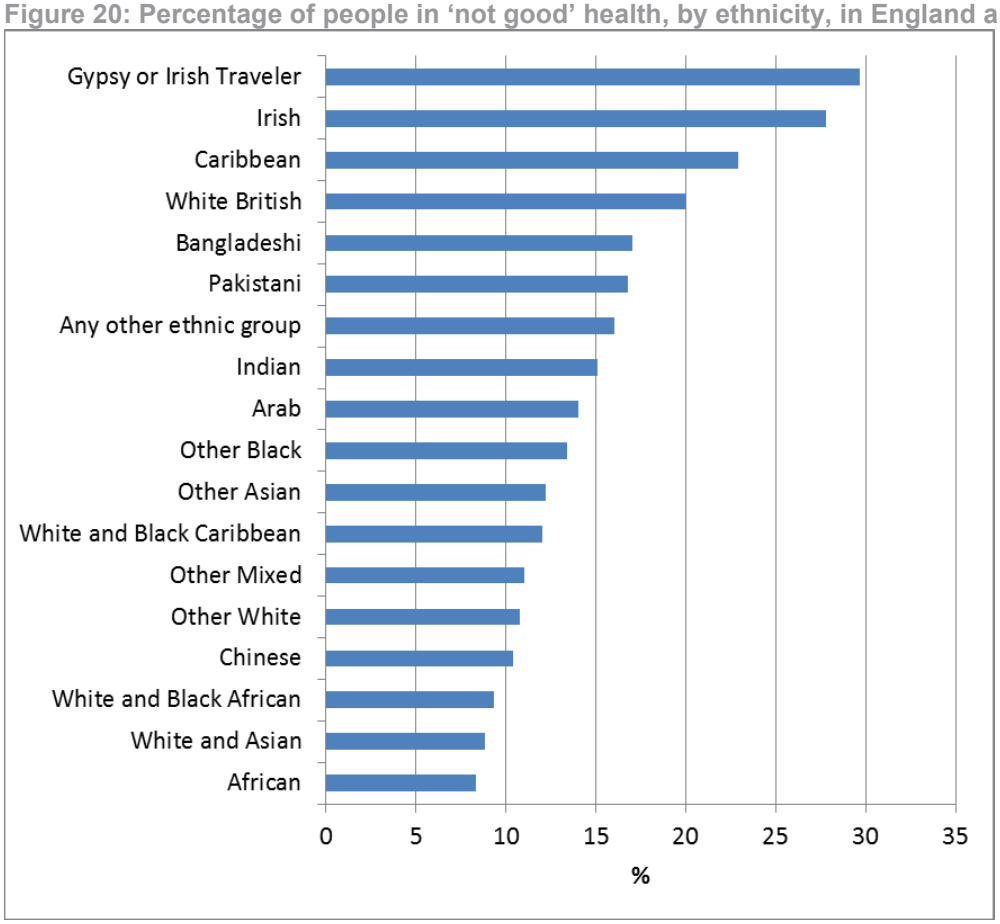
Source: Oxfordshire Insight, data taken from 2001 and 2011 ONS Census surveys

3.1.4. Ethnicity and Health

National analysis of data from the 2011 Census has found that Gypsy or Irish Travellers were in the poorest health, 29.8% of whom were in 'not good' health (i.e. reporting that their general health was fair, bad, or very bad).[29] These differences may reflect different age structures, different social conditions or cultural expectations.

[29] Office for National Statistics, 2011 Census analysis: http://visual.ons.gov.uk/health-census/

Figure 20: Percentage of people in 'not good' health, by ethnicity, in England and Wales, 2011



Source: Office for National Statistics

Ethnicity can also be a risk factor for some health conditions, for example Type 2 diabetes is more common in people of South Asian, African, and African-Caribbean origin.[30]

3.2. Language

National research has linked poor English language skills to worse health.[31] Not being proficient in English could also affect residents' access to health and social care services (which could perhaps explain the link with poorer health).

At the time of the 2011 Census, 93.1% of people aged three and over in Oxfordshire spoke English as their main language.[32] For 3.7%, the main language spoken was another European (EU) language. Polish was the most common of these, and was the main language of 1.1% of the county's population. The same proportion (1.1%) spoke a South Asian language as their main language. Meanwhile, for 0.9% the main language was an East Asian language. Less than 0.1% of people in Oxfordshire said sign language was their main language. Over half of them (58%) were using British Sign Language.

The proportions of main languages spoken were similar (within one or two percentage points) to those for the South East and England as a whole.

Across the county, smaller proportions spoke English as their main language in Oxford (83.8%) than in the other districts: 97.3% in West Oxfordshire, 96.5% in South Oxfordshire,

[30] Diabetes: Facts and Stats, version 4 June 2015 (Diabetes UK): https://www.diabetes.org.uk/About_us/What-we-say/Statistics/
[31] ONS Census 2011 analysis: http://visual.ons.gov.uk/language-census-2011/
[32] Census 2011, table QS204EW: https://www.nomisweb.co.uk

96.1% in Vale of White Horse and 94.4% in Cherwell. Proportionately more people in Oxford spoke EU languages (7.7%), South Asian languages (2.8%) and East Asian languages (2.5%).

Of the people in Oxfordshire who didn't speak English as their main language, nearly nine in ten spoke English well (87.2%).[33] This was higher than the proportions seen in the South East (84%) and England overall (79.3%). Meanwhile, it was found that around one in ten did not speak English well (11.1%, numbering 4,800). 1.7% did not speak English at all (numbering around 700 people, and representing 0.1% of the county's total population).

Across the county, proficiency in English among those who did not speak it as their main language was lower in Cherwell (80.3%) and West Oxfordshire (86.5%) than in other parts: 89.4% in Vale of White Horse, 88.8% in Oxford and 87.9% in South Oxfordshire.

3.3. Religion and Belief

At the time of the 2011 Census, six in ten people in Oxfordshire said they were Christian (60.2%, down from 72.5% in 2001).[34] Over a quarter said they did not have any religion (27.9%, up from 17.5% in 2001). Muslims made up 2.4% of the county's population (up from 1.3% in 2001). The proportion of Hindus in the population was 0.6%, whilst Buddhists comprised 0.5% (both religious communities stood at 0.3% in 2001). The county's Jewish population remained at 0.3%. 7.5% of people in Oxfordshire did not state their religion (similar to the proportion in 2001, of 7.3%).

Patterns of religion and belief across Oxfordshire's population were broadly reflective (within one percentage point) of those in the South East and England overall. The exceptions were that Oxfordshire had a smaller Muslim community than England overall (where it represented 5% of the population) and more people said they had no religion in Oxfordshire than in England overall (where the proportion was 24.7%).

Oxford had a proportionately smaller Christian community than the county overall, although this was still the largest religious group there, comprising 48% of the population. Meanwhile, Oxford had a relatively large proportion of people with no religion, with almost one in three saying this (33.1%). It also had proportionately larger communities of Muslims (6.8%), Hindus (1.3%), Buddhists (0.9%) and Jews (0.7%).

3.4. Sexual Orientation

It is still difficult to obtain reliable estimates of the number of people who identify themselves as heterosexual/ straight, gay/ lesbian, bisexual, or of another sexual orientation. The 2011 Census did not include questions on sexual orientation. Meanwhile, using the number of people in a civil partnership will not capture those who are in a relationship but are not registered, nor those who are single.

Survey data for 2014 show that 92.6% of people in the South East identified themselves as heterosexual/ straight, whilst 1% said they were gay/ lesbian, and 0.5% said they were bisexual.[35] 0.4% identified themselves as having another sexual orientation. The remainder (over 5%) did not identify their sexual orientation. Data at local levels are not currently available.

[33] Census 2011, table QS205EW: https://www.nomisweb.co.uk
[34] Census 2011, table KS209EW; Census 2001, table S103: https://www.nomisweb.co.uk
[35] ONS Integrated Household Survey (October 2015 release): http://www.ons.gov.uk/ons/rel/integrated-household-survey/integrated-household-survey/index.html

Sexual orientation can have important links with health and wellbeing. For example, self-harm and thoughts of suicide are more common among people who are lesbian, gay and bisexual.[36] Meanwhile, around one in 20 gay and bisexual men nationally is living with HIV.[37]

3.5. Gender Reassignment

It is also difficult to obtain reliable data on the number of people identifying their gender as different from the one assigned to them at birth. However, the Ministry of Justice publishes numbers of UK applications for gender recognition certificates.[38] These certificates enable people to change their gender legally and to gain the rights and responsibilities of their acquired gender.

During the 2014/15 financial year there were 343 applications for gender recognition certificates in the UK. This represents an increase of 10% on the 2013/14 number. The number of applications per quarter has ranged between 60 and 100 over the past six years and appears to be increasing gradually over time. Data at local levels are not currently available.

As for sexual orientation, gender identity can have important links with health and wellbeing, and being transgender is also linked to greater risk of self-harm and thoughts of suicide.[39]

3.6. Marriage and Civil Partnership

At the time of the 2011 Census, just under half of adults in Oxfordshire were married (48.8%) whilst around a third were single (34.7%).[40] The remainder were:

- divorced or formerly in a same-sex civil partnership which had been legally dissolved (8.1%)
- widowed or surviving partners from a same-sex civil partnership (6.1%)
- separated (2.1%)
- in a registered same-sex civil partnership (0.3%)

Patterns of marital status in Oxfordshire were similar (within one percentage point) to those for the South East and England, except that Oxfordshire had a higher proportion of single people than the South East (where 31.9% were single) and a higher proportion of married people than England overall (where 46.6% were married).

Across the county there were proportionately fewer married people in Oxford (32.9%) than in other districts: 54.8% in South Oxfordshire, 54.7% in Vale of White Horse, 54% in West Oxfordshire and 51.7% in Cherwell. This is likely to be related to Oxford's younger age profile. Conversely, over half of people in Oxford were single (53.8%) compared with smaller proportions in the other districts: 30.4% in Cherwell, 28.3% in Vale of White Horse, 28% in South Oxfordshire and 27.8% in West Oxfordshire. There were also proportionately fewer people in Oxford who had previously been married or in a same-sex civil partnership.

[36] The LGBT ASCOF Companion Document (LGBT Foundation, 2015): http://lgbt.foundation/get-support/downloads/detail/?downloadid=365
[37] The LGBT ASCOF Companion Document (LGBT Foundation, 2015): http://lgbt.foundation/get-support/downloads/detail/?downloadid=365
[38] Ministry of Justice data downloaded from UK Trans Info: http://uktrans.info/grc-stats
[39] The LGBT ASCOF Companion Document (LGBT Foundation, 2015): http://lgbt.foundation/get-support/downloads/detail/?downloadid=365
[40] Census 2011, table KS103EW: https://www.nomisweb.co.uk. Because same-sex marriage became possible in March 2014, marriage figures from the 2011 Census will only include married couples of the opposite sex.

3.7. Pregnancy and Maternity

3.7.1. Conceptions

In 2013 there were around 9,400 conceptions in Oxfordshire, reflecting a rate of 70.6 conceptions per 1,000 women aged 15-44.[41] This rate now appears to be declining, after hitting a peak of 74.3 in 2010. It remained below the rates seen in the South East (75.6) and England overall (78).

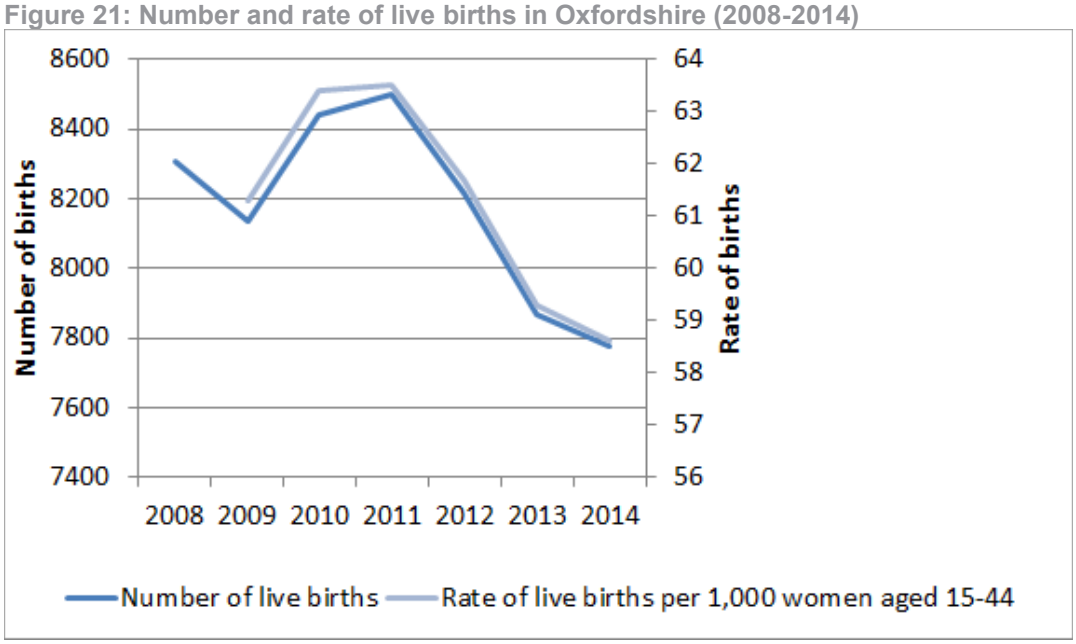
In Oxfordshire 17.6% of conceptions led to therapeutic abortion in 2012, a similar proportion as in the previous three years (within three percentage points).[42] The proportion of abortions was lower than in the South East (19.7%) and England overall (21.2%).

Teenage conceptions are discussed in chapter 6: Lifestyles.

3.7.2. Births

In 2014 there were 7,775 live births to Oxfordshire mothers, representing a rate of 58.6 babies being born per 1,000 women aged 15-44.[43] Both the number and rate of births have been declining over the past few years.

Figure 21: Number and rate of live births in Oxfordshire (2008-2014)



Source: Office for National Statistics Birth Statistics

Across the county, Oxford and Cherwell had higher numbers of births in 2014 than other districts, making up nearly half of the total (this is despite the relatively low birth rate in Oxford, due to the relatively large number of female residents in the 15-44 age group).

[41] ONS Conception Statistics: http://www.ons.gov.uk/ons/rel/vsob1/conception-statistics--england-and-wales/2013/index.html
[42] This figure includes legal abortions under the Abortion Act 1967. It does not include miscarriages or illegal abortions.
[43] ONS Live Births Statistics: http://www.ons.gov.uk/ons/rel/vsob1/births-by-area-of-usual-residence-of-mother--england-and-wales/index.html

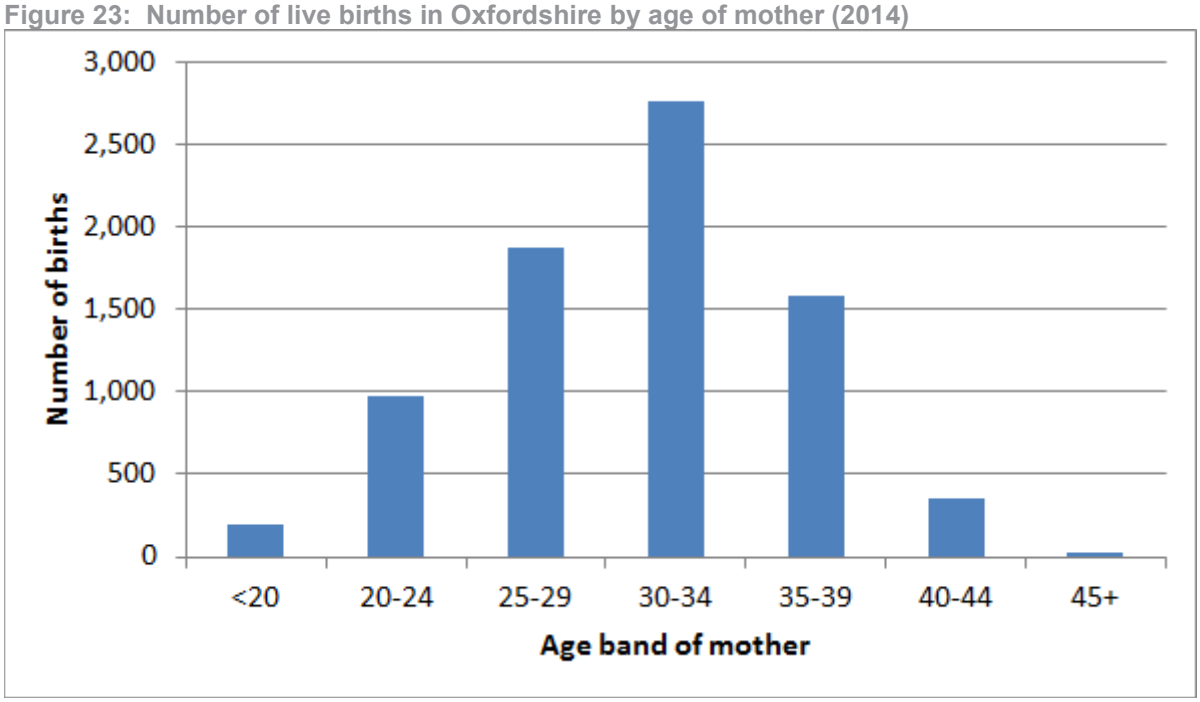
Figure 22: Number and rate of live births in Oxfordshire's Districts (2014)

Area	Number of live births	Rate of live births per 1,000 women aged 15-44
Cherwell	1,817	66.5
Oxford	1,845	44.3
South Oxfordshire	1,508	64.8
Vale of White Horse	1,416	65.1
West Oxfordshire	1,189	63.3

Source: Office for National Statistics Birth Statistics

Four fifths of live births in Oxfordshire in 2014 were to mothers aged 25-39.

Figure 23: Number of live births in Oxfordshire by age of mother (2014)



Source: Office for National Statistics Birth Statistics

In 2013 there were 36 still births in Oxfordshire.[44]

3.8. Disability

This section discusses indicators of the prevalence of disability, as defined under the Equality Act 2010 (as a physical or mental impairment that has a 'substantial' and 'long term' negative effect on the ability to do normal daily activities. Long term conditions are also covered in chapter 5: Morbidity and Mortality.

Further national data on disability is available from the Papworth Trust's disability statistics.

3.8.1. Census Data on Limitations to Daily Activities

At the time of the 2011 Census, 89,800 people in Oxfordshire said they were limited in their daily activities, representing nearly one in seven people in the county (13.7%).[45] 94.3% of these were living at home.

You can explore the data using the interactive health and disability dashboards on the Oxfordshire Insight website.

[44] Health & Social Care Information Centre still births data: https://indicators.ic.nhs.uk/webview/
[45] Census 2011, table QS303EW: https://www.nomisweb.co.uk.

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.

Proportions of people limited in their daily activities were broadly similar across the county. However, they were a little lower in Oxford (12.4%) than in the other districts: 14.5% in West Oxfordshire, 14.2% in Vale of White Horse, 14.1% in Cherwell and 13.8% in South Oxfordshire. Again, this may be because of the younger profile of Oxfordshire's population.

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%). There was little variation across the county, with the city and districts within half of one percent of the county average.

Limitations by Sex

Overall, more female than male residents of Oxfordshire said they were limited in their daily activities: female residents made up 55.3% of those who felt limited.

Limitations by Ethnicity

Proportionately more of those from White Irish backgrounds (20.6%) and White British backgrounds (14.9%) reported being limited in their daily activities than for Oxfordshire overall. Meanwhile, proportionately fewer of those from other ethnicities said this: 8.6% of those from all Black ethnicities; 7.2% of those from all Asian ethnicities; 6.8% of those from Mixed ethnicities; and 5.8% of those from other White backgrounds.

Limitations by Age

The proportion of people in the county saying they were limited in their daily activities increased with age. The following analysis applies just to those living in households, not in communal establishments.

More than four in ten people aged 65 and over living in households reported being limited in their daily activities (44.5%). This group accounted for more than half of all those living in households who experienced limitations (52.6%). Meanwhile, over four fifths of people aged 85 and over reported being limited (81.1%).

Applying these proportions to the population projections for Oxfordshire, we might expect that by 2030 between 69,700 and 75,700 household residents aged 65 and over will be limited in their daily activities (an increase of up to 70% from 44,500 in 2011). Meanwhile, we might expect between 20,000 and 26,500 aged 85 and over to be limited (an increase of up to 164% from 10,100 in 2011). However, these projections do not take into account potential improvements in disability free life expectancy (DLE), which might reduce the proportion of older people who feel limited in their daily activities.

Around two in ten of those aged 65 and over living at home in Oxfordshire said they were limited a lot in their daily activities (19.6%). This was similar to the proportion across the South East (20.4%) and below that across England (25%).

Applying these proportions to the population projections for Oxfordshire, we might expect that by 2030 between 30,700 and 33,400 household residents aged 65 and over will be very limited in their daily activities (an increase of up to 70% from 19,600 in 2011).

Almost half of those aged 85 and over in households in Oxfordshire reported that their daily activities were limited a lot (49.1%). This was slightly above the proportion seen in the South East (48%) but below that in England overall (52.3%).

Applying these proportions to the population projections for Oxfordshire, we might expect that by 2030 between 12,100 and 16,000 household residents aged 85 and over will be limited a lot (an increase of up to 164% from 6,000 in 2011).

Separate research found that in 2012-13 around 6.7% of people in England aged 65 and over and living at home experienced three or more difficulties with activities of daily living, such as dressing and bathing.[46] Over half of these were female (57%) and two in five lived alone (40%).

3.8.2. Family Resources Survey Disability Data (National Data)

The Family Resources Survey for 2013/14 estimated that around 19% of the UK's population was disabled, experiencing physical, mental, cognitive, learning, social, behavioural or other types of impairments.[47] The proportion in the South East was a little lower, at 17%.

A simple extrapolation of the rate for the South East to the 2014 population estimate for Oxfordshire suggests that there could be around **114,300** people with a disability in the county. However, this does not take account of differences in prevalence that may exist between the South East overall and Oxfordshire, specifically.

The proportion of disabled people in the UK population remained similar between 2002/3 and 2013/14. However, their number has increased due to population growth, from 10.8 million to 11.9 million. An estimated 7% of children (numbering 0.9 million) were disabled, compared with 16% of those of working age (numbering 6 million) and 42% of adults over State Pension Age (numbering 5 million).[48] A slightly higher proportion of women and girls were disabled (21%) than men and boys (18%). These proportions have remained broadly stable over time.

Impairment types among disabled people in the UK are shown in the figure below.[49] The total will sum to more than 100% as respondents can be affected (and can report) more than one impairment type; the denominator is the number of disabled people.

[46] The Bigger Picture: Understanding disability and care in England's older population: http://strategicsociety.org.uk/bigger-picture-understanding-disability-care-englands-older-population/

[47] Family Resources Survey (FRS): https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201314. This covers people with a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities. The means of identifying disabled people has changed over time. From 2012/13 disabled people are identified as those who report any physical or mental health condition(s) or illness(es) that last or are expected to last 12 months or more and which limit their ability to carry out day-to-day activities. The FRS does not cover residents of nursing or retirement homes, meaning that disability prevalence among older people is likely to be higher than estimated.

[48] Children are generally defined as being under 16 years old but could be aged 16-19 if they meet criteria for being defined as dependent children. The State Pension age is 65 for men born before 6 April 1959. For women born on or before 5 April 1950, State Pension age is 60. From 6 April 2010, the State Pension age for women born on or after 6 April 1950 will increase gradually between April 2010 and November 2018. From December 2018, the State Pension age for both men and women will start to increase to reach 66 in October 2020.

[49] Family Resources Survey: https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201314.

Figure 24: Disability prevalence disaggregated by impairment type in the United Kingdom (2013/14)

Impairment Type	Millions	Percentage of Disabled People
Mobility	6.5	55%
Stamina/ breathing/ fatigue	4.5	38%
Dexterity	3.4	28%
Mental health	2.1	18%
Memory	1.9	16%
Hearing	1.7	14%
Vision	1.5	13%
Learning	1.5	12%
Social/ behavioural	0.8	6%
Other	1.8	15%

Source: Family Resources Survey, 2013/14

Applying these rates to Oxfordshire (using the above estimate of 114,300 disabled people in the county) would provide the extrapolated numbers for impairment types displayed in the figure below. Again, these do not account for any differences in patterns of prevalence that may exist between Oxfordshire and the UK overall.

Figure 25: Extrapolated impairment type figures for Oxfordshire

Impairment type	Extrapolated number with impairment
Mobility	62,900
Stamina/ breathing/ fatigue	43,400
Dexterity	32,000
Mental health	20,600
Memory	18,300
Hearing	16,000
Vision	14,900
Learning	13,700
Social/ behavioural	6,900
Other	17,100

Source: Extrapolation from Family Resources Survey, 2013/14

At a national level, the FRS data show that disabled people of State Pension age were more likely than disabled people of working age to have certain impairments, such as mobility and hearing difficulties. In comparison, disabled people of working age were more likely to report mental health, learning, and social or behavioural impairments. The impairment types that were most likely to affect disabled children were learning impairments, stamina, breathing and fatigue impairments, and social and behavioural impairments.

3.8.3. Physical Disability

The number of people aged 18-64 in Oxfordshire with a moderate physical disability has been estimated at over 30,000.[50] The number with a serious physical disability has been estimated at over 9,000.

3.8.4. Sight Loss

Sight loss is associated with a range of factors, including[51];

[50] Projecting Adult Needs and Service Information, figures for 2014: http://www.pansi.org.uk/. These figures are based on responses to the 2001 Health Survey for England.

- Age – one in five people aged 75 and over and half of people aged 90 and over in the UK are living with sight loss
- Ethnicity – risk of developing types of glaucoma can be higher in African, African-Caribbean, South-East Asian, and Chinese populations; risk of developing cataracts is higher among the Asian population; and risk of developing diabetic eye disease is higher among African, African-Caribbean, and Asian populations
- Learning disability – nearly one in ten adults with learning disabilities in the UK is blind or partially sighted, making them 10 times more likely than the general population to be living with sight loss[52]
- Low income and deprivation – three quarters of blind or partially sighted people are living in low income
- Lifestyle factors such as smoking and obesity – those who smoke or are obese increase their risk of developing eye conditions such as age-related macular degeneration and cataracts
- Health conditions, such as stroke and high blood pressure

Sight loss can have wider implications for health and wellbeing. For example, an evidence review found that almost half (47%) of all falls sustained by blind and partially sighted people were directly attributable to their sight loss[53]

Research has also shown that blind and partially sighted people over 65 have a higher rate of physical and mental co-morbidities than sighted counterparts.[54] [55]

People Registered Blind or Partially Sighted

At the end of March 2014, there were 3,095 people in Oxfordshire who were registered as blind or partially sighted (1,675 and 1,410 respectively).[56] More than three quarters of these were aged 65 or over. Two thirds were also recorded as having an additional disability.

Sight Loss Prevalence

In comparison, modelled data produced by RNIB indicate that there could be nearly 19,000 people living with sight loss in Oxfordshire, of whom over 2,000 have severe sight loss (blindness).[57] RNIB projects that these figures could increase by almost 25 per cent to over

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[51] Eye health and sight loss; statistics and information for developing a Joint Strategic Needs Assessment (RNIB, January 2015): http://www.ukvisionstrategy.org.uk/get-involved-england-commissioning-eye-care-and-sight-loss-services-commissioning/health-and

[52] See also See Ability's May 2015 report on their London pilot study on learning disabilities and eye care: https://www.seeability.org/uploads/files/PDFs_Books_non_Easy_Read/LOCSU-tri-borough-report.pdf

[53] Boyce, T et al 2013. Projecting the number of falls related to visual impairment. *British Journal of Healthcare Management*. Vol 19, 226-229

[54] Court, H. et al. 2014. Visual impairment is associated with physical and mental co morbidities in older adults: a cross-sectional study. *BMC Medicine* 12:181: http://www.biomedcentral.com/1741-7015/12/181

[55] Further guidance for commissioners is available from the UK Vision Strategy: http://www.commissioningforeyecare.org.uk/commhome.asp?section=167&sectionTitle=The+eye+care+commissioning+cycle; and the RNIB report: *Sight Loss: A Public Health Priority*: http://www.rnib.org.uk/sites/default/files/Sight_loss_a%20public_health_priority.pdf;

[56] Health and Social Care Information Centre Registered Blind and Partially Sighted People - Year Ending 31 March 2014, England: http://www.hscic.gov.uk/catalogue/PUB14798

[57] RNIB Sight Loss Data Tool (Version 2.2): http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool. Prevalence rates have been estimated using a much wider definition than those who are registered blind or partially sighted, including: people who are having treatment, e.g. for cataracts; people whose sight is better than the eligibility criteria for registration but still have poor vision; people who are eligible for registration but who are not registered for whatever reason; and people whose sight could be improved by wearing correctly prescribed glasses. Further details about the methodology used to calculate this data can be found in

23,000 affected by sight loss by 2020, nearly 3,000 of whom will have severe sight loss (blindness).[58] The increase is attributed chiefly to an ageing population.

The four major causes of sight loss are age-related macular degeneration (AMD), Glaucoma, Cataract and Diabetic eye disease. Sight loss is linked to smoking: people who have been exposed to passive smoking over a period of five years almost double their risk of developing AMD.[59] It is also linked to obesity[60] and is influenced by health inequalities, including deprivation, ethnicity and age.[61]

Preventable Sight Loss

The Public Health Outcomes Framework includes indicators on preventable sight loss, given that 50% of sight loss is estimated to be avoidable if detected and treated early enough.[62]

These indicators show that in 2013/14 the rate of sight loss due to glaucoma in Oxfordshire was 8 per 100,000 people aged 40 and over. This was below the England average of 12.9. Oxfordshire also had a lower rate of sight loss certifications than the national average (36.2 per 100,000 people, compared with 42.5 in England overall). The rate of sight loss due to diabetic eye disease was 2.5 people aged 12 and over per 100,000 in the population. Meanwhile, the rate of sight loss due to age related macular degeneration was 122.7 per 100,000 people aged 65 and over. These rates were similar to those for England overall.

3.8.5. Hearing Loss

Hearing loss can be socially isolating and has been associated with increased risk of physical and mental health problems.[63] Nationally, around one in six people are thought to have some form of hearing loss.[64]

Data on people registered as deaf or hard of hearing were collected every three years up to 2010.[65] At this time an estimated 915 people in Oxfordshire were either deaf or hard of hearing. The bulk of these (550) were 75 years and over and were hard of hearing. Overall there were around 145 people in the county registered as deaf and a further 775 who were hard of hearing.

Access Economics 2009. Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population: https://www.rnib.org.uk/sites/default/files/FSUK_Summary_1.pdf

[58] This is calculated by applying the current estimated prevalence rate to ONS population projections.

[59] RNIB information on smoking and sight loss: http://www.rnib.org.uk/eye-health-looking-after-your-eyes/smoking-and-sight-loss. See also Khan, JC et al. (2006). Smoking and age related macular degeneration: the number of pack years of cigarette smoking is a major determinant of risk for both geographic atrophy and choroidal neovascularisation. British Journal of Ophthalmology, 90: 75–80.

[60] RNIB information on obesity and sight loss: http://www.rnib.org.uk/eye-health-looking-after-your-eyes/obesity-and-sight-loss

[61] Public Health Outcomes Framework: http://www.phoutcomes.info/

[62] Access Economics 2009. Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population: https://www.rnib.org.uk/sites/default/files/FSUK_Summary_1.pdf

[63] For further information, see the Action Plan on Hearing Loss (Department of Health/ NHS England, March 2015): http://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

[64] Action on hearing loss statistics (accessed November 2015): http://www.actiononhearingloss.org.uk/your-hearing/about-deafness-and-hearing-loss/statistics.aspx This figure is in line with data from the latest Health Survey for England (data for 2014, published December 2015): http://www.hscic.gov.uk/searchcatalogue?productid=19585&q=health+survey+for+england&sort=Relevance&size=10&page=1#top

[65] Health & Social Care Information Centre - People Registered Deaf or Hard of Hearing Year ending 31 March 2010, in England: http://www.hscic.gov.uk/pubs/regdeaf10

3.8.6. Learning Disability

In 2014/15 there were around **2,600 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area who were recorded as having learning disabilities.[66] This represents a prevalence rate of 0.4% of the patient population, similar to averages for England and the South (both 0.4%).

Datasets from other sources estimate that numbers of people living with a learning disability may be higher than this, as described below.

Adults with Learning Disability

In 2012 Public Health England estimated that there were 908,000 adults aged 18 and over with a learning disability.[67] This would have been around 2% of the total adult population of England in 2012. A direct extrapolation of that rate to the latest adult population estimate for Oxfordshire would give a figure of around **11,000** adults with a learning disability.[68] However, this does not take account of any differences in local prevalence rates that may exist, nor any change in prevalence rates since 2012. Therefore the figure should be treated with caution.

Separate estimates for 2015 put the number of 18-64 year olds in Oxfordshire with a learning disability at around **10,000**.[69] Just under a quarter of these are estimated to have a learning disability that is either moderate or severe.

3.8.7. Children with Statements of Educational Needs

As of January 2015 around 2,400 (2.2% of) pupils in Oxfordshire schools had statements of special educational needs (SEN).[70] This proportion has remained broadly similar in the years since 2007. Oxfordshire's rate of SEN-statemented pupils was a little lower than in the South East (2.9%) and England overall (2.8%).

In the same year around 13,600 (12.6% of) pupils in Oxfordshire schools were recorded as having SEN support but not having statements. This represented a fall from 2014 levels (16,700 pupils, representing 15.7% of the total), bringing the county into line with averages for the South East (12.3%) and England (12.6%).

3.8.8. Disability Benefits

The Department for Work and Pensions provides statistics on disability-related benefits.[71] Key data for Oxfordshire are set out below:

- Around 19,800 in Oxfordshire were claiming Disability Living Allowance in May 2015 (this has now been phased out for new claimants)[72]

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[66] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887

[67] People with Learning Disabilities in England 2012 (Public Health England's Improving Health and Lives Learning Disabilities Observatory): https://www.improvinghealthandlives.org.uk/securefiles/151009_1140//IHAL2013-10%20People%20with%20Learning%20Disabilities%20in%20England%202012v3.pdf

[68] Calculation based on ONS population estimates for mid-2014, and rounded to the nearest 1,000.

[69] Projecting Adult Needs and Service Information, figures for 2014: http://www.pansi.org.uk/. These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004.

[70] Special educational needs statistics: https://www.gov.uk/government/collections/statistics-special-educational-needs-sen. This will not be an accurate reflection of the number of children with SEN *resident* in Oxfordshire, due to some pupils travelling across county borders to attend school.

[71] Department for Work and Pensions tabulation tool: http://tabulation-tool.dwp.gov.uk/100pc/tabtool.html.

[72] Disability Living Allowance (DLA) provides a non-contributory, non means-tested and tax-free contribution towards the disability-related extra costs of severely disabled people who claim help with those costs before the age of 65. It replaced and extended Attendance Allowance and Mobility

- As of October 2015 around 3,000 Personal Independence Payment (PIP) claims were being paid.[73]
- Around 13,300 people were claiming Attendance Allowance in May 2014[74]
- Around 14,200 people were claiming Employment and Support Allowance in May 2014[75]
- Around 1,000 people were claiming Incapacity Benefit or Severe Disablement Allowance (both of which have now been phased out for new claimants)

Explore PIP data using the Department for Work and Pensions' interactive map.

These numbers will include people who claimed more than one type of benefit. Trends have not been shown, due to changes in the qualification criteria for benefits, which are likely to reduce the number of people eligible to claim.

3.9. Rural Population

Oxfordshire remains a relatively rural county. At the time of the 2011 Census, around two thirds of Oxfordshire's population lived in an urban area (66.6%) and a third lived in a rural area (33.4%).[76] This compares to proportionately larger urban populations in the South East (79.6% of the total population) and England overall (82.4%).

There was considerable variation across the different parts of the county, as shown in the figure below: whereas Oxford was 98.8% urban, a majority of residents in West Oxfordshire lived in rural areas (56.6%).

Allowance for people in this age group from April 1992. The figures include those who have had their payment suspended, for example if they are in hospital.

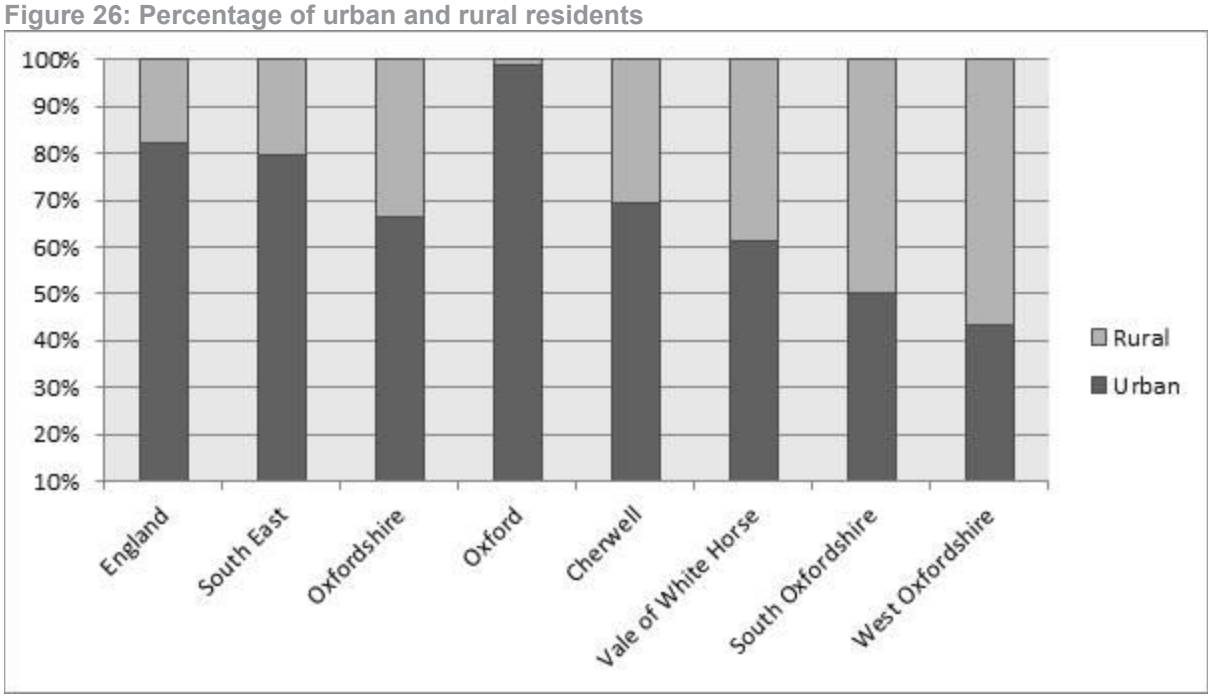
[73] Department for Work and Pensions StatXplore tool: https://stat-xplore.dwp.gov.uk/ Personal Independence Payment (PIP) helps with some of the extra costs caused by long-term ill-health or a disability if you're aged 16 to 64. PIP started to replace Disability Living Allowance (DLA) for people aged 16 to 64 from 8 April 2013.

[74] Attendance Allowance (AA) provides a non-contributory, non-means-tested and tax-free contribution towards the disability-related extra costs of severely disabled people who are aged 65 and over when they claim help with those costs. It can be awarded for a fixed or an indefinite period. To qualify, people must have needed help with personal care (i.e. attention in connection with their bodily functions and/or continual supervision to avoid substantial danger to themselves or others) for at least 6 months (the 'qualifying period'). The figures include those who have had their payment suspended, for example if they are in hospital.

[75] Employment and Support Allowance (ESA) replaced Incapacity Benefit and Income Support paid on the grounds of incapacity for new claims from October 2008.

[76] Census 2011, table QS102EW: https://www.nomisweb.co.uk. This analysis uses the ONS 2011 Rural-Urban Classification (England and Wales) which is based on output areas.

Figure 26: Percentage of urban and rural residents



Source: Office for National Statistics 2011 Census

In 2011 proportionately more of those aged 65 and over were living in rural areas (41.5%) than the county average (33.4%). Recent national research suggests that older people living in rural areas fare better than their urban counterparts on several determinants of health and wellbeing.[77] However, the study finds that older people in rural areas are likely to have some specific needs, including around transport and housing; these may present a growing challenge as the older population increases.

A small minority (3.9%) of Oxfordshire's population lived in a rural hamlet or isolated dwelling – a proportion broadly comparable with the South East (4.1%) and England overall (3.1%). Around four in ten of those people lived in South Oxfordshire (40.1%). Just over a quarter lived in West Oxfordshire (26.8%) whilst one in five were in Vale of White Horse (20.8%) and about one in ten were in Cherwell (11.5%).

3.10. Armed Forces Personnel

3.10.1. Regular Armed Forces Personnel

At the time of the 2011 Census Oxfordshire was home to 5,500 regular armed forces personnel, comprising 0.8% of the county's population.[78] (It should be noted, though, that an expansion of activities at RAF Brize Norton in West Oxfordshire, during 2011/12, saw an increase of several hundred resident personnel there.[79]) The proportion of regular armed forces personnel in Oxfordshire was higher than for the South East (0.4%) and England overall (0.3%).

[77] 2013 Rural Ageing Research, commissioned by the Department for Environment, Food and Rural Affairs: http://www.ilcuk.org.uk/images/uploads/publication-pdfs/11690_DEFRARuralAgeingReport.pdf

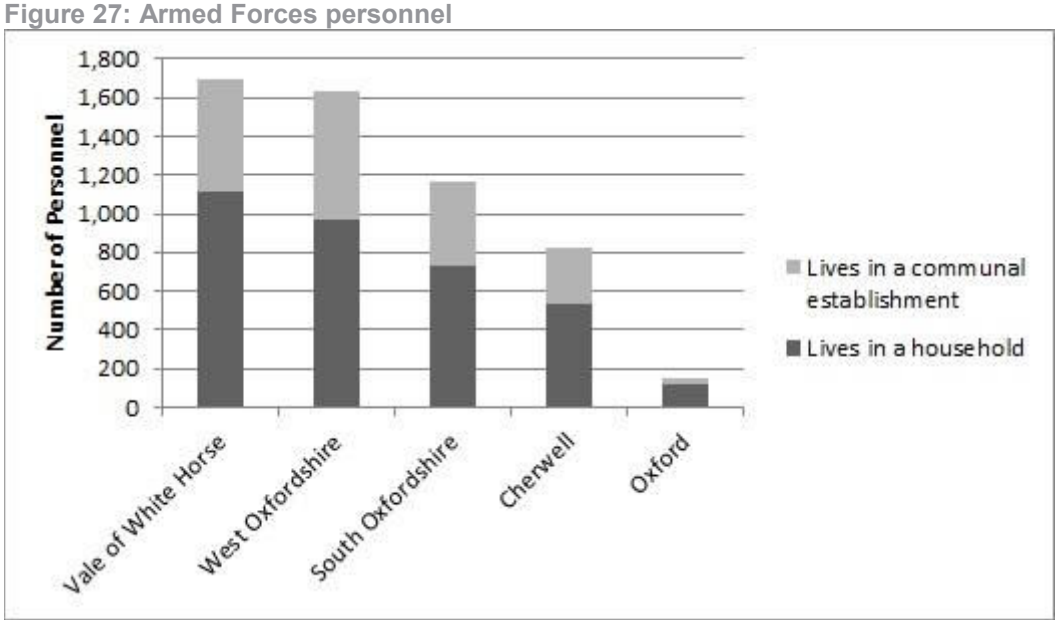
[78] Census 2011, table QS121EW: https://www.nomisweb.co.uk. Regular Armed Forces personnel receive all their primary care from Defence Medical Services (DMS) GPs, not the NHS, although secondary care is accessed via the NHS. DMS Medical Centres at RAF Brize Norton and RAF Benson also provide GP care for a number of families.

[79] District Data Service Armed Forces Briefing Note, March 2014: http://www.oxford.gov.uk/Library/District%20Data/Chart%20Mar14%20armed%20forces%20-%20JSNA.pdf

Nearly two thirds of Oxfordshire's armed forces personnel lived in households (63.5%) while a third lived in communal establishments (36.5%).

Around six in ten armed forces personnel lived in Vale of White Horse (31%) or West Oxfordshire (29.9%). Around two in ten lived in South Oxfordshire (21.3%) with the remainder in Cherwell (15%) and Oxford (2.8%).

Figure 27: Armed Forces personnel



Source: Office for National Statistics 2011 Census

As of 1st October 2015, around 9,500 regular armed forces personnel were stationed in Oxfordshire (although not all necessarily reside in the county).[80] This number has declined in recent years. The majority of armed forces personnel stationed in Oxfordshire at this time were military personnel (89%) with a minority being civilians (11%). Just under half were stationed in West Oxfordshire (48%) with slightly under a quarter in Vale of White Horse (23%). Around two in ten were in South Oxfordshire (19%), with the remainder in Cherwell (10% of the total) and Oxford (1% of the total).

3.10.2. Veterans

A number of local authorities and Clinical Commissioning Groups (CCGs), in conjunction with their Public Health departments, have undertaken military veterans' health needs assessments. In reviewing a cross-section of these health needs assessments in February 2014 Lord Ashcroft noted that the reports all highlighted significant limitations created by an absence of reliable quantitative national data about the veteran population, and an inability to accurately estimate the size of the local veteran population.[81] Delineating and quantifying the veterans in a community is a challenge, as are the extraction and validation of information about veteran health, the analysis of their associated needs and understanding how these may, or may not, differ from the rest of the local community.

Despite these barriers, the various needs assessments contain common findings and these match the evidence base of the King's Centre for Military Health Research, based at King's

[80] Ministry of Defence Quarterly Location Statistics (accessed December 2015): https://www.gov.uk/government/statistics/location-of-uk-regular-service-and-civilian-personnel-quarterly-statistics-2015

[81] The Veterans' Transition Review by Lord Ashcroft (February 2014): http://www.veteranstransition.co.uk/

College London. The findings indicate that veterans have similar health needs and experiences to the rest of the adult population, with the same implications for resources for both health and adult social care. For veterans over 65 years old (the largest veteran group at 60% of the total), mobility, independent living and social isolation were the main concerns. Most veterans questioned, irrespective of age, did not report adverse health effects as a result of their Service; for those that did, the common themes were musculoskeletal disorders and hearing loss.

A smaller than expected number of veterans reported some adverse mental health outcomes and these had frequently been compounded by other factors, such as financial and welfare problems. The common mental health problems presenting were depression and anxiety, matching the experiences of the general population. There was a reported increased risk of alcohol misuse and associated mental health problems, predominantly in younger male veterans – notably from lower ranks or those who left the Service early.

When analysed in context, the evidence suggests that the routine health needs of veterans are not appreciably different from the overall age-matched patient base. The numbers of veterans in any one location with specific Service-related conditions are small and, as a group, they are not demanding consumers of healthcare resources.

3.11. Carers

3.11.1. Number of Carers

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, representing 9.4% of the county's population (up from 8.8% in 2001).[82] This proportion was slightly lower than in the South East (10.2%) and England overall (9.8%).

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.

Of those providing informal care in Oxfordshire, 71.6% provided between 1 and 19 hours of care per week, 10.5% provided between 20 and 49 hours, and 17.9% provided more than 50 hours.

The group most likely to provide unpaid care was aged 50-64, with one in five providing some level of care (19.8%). Meanwhile, 13.8% of people aged 65 and over provided some unpaid care, compared with 8.5% of people aged 25 to 49, and 2.1% of people under 25. 1.1% of children aged 0-15 provided some unpaid care, numbering 1,300.

A larger proportion of unpaid care in Oxfordshire was provided by female residents (58.1%) than by male residents (41.9%). This was particularly the case for higher-intensity care, 60.2% of which was provided by female residents.

You can explore the data using the interactive health dashboards (Carers and Age tab) on the Oxfordshire Insight website.

As of the end of September 2015, around 17,200 carers were known to Oxfordshire County Council's social care team.[83] This figure has been increasing over time. It includes all carers whose needs have been assessed, some of whom will also have received a service from the council.

[82] Census 2011, table LC3304EW: https://www.nomisweb.co.uk
[83] Oxfordshire County Council data

3.11.2. Carers' Needs and Outcomes

The Personal Social Services Survey of Adult Carers in England is carried out every two years and took place for the second time in 2014-15.[84] The survey covers informal, unpaid carers aged 18 or over, caring for a person aged 18 or over, where the carer has been assessed or reviewed, either separately or jointly with the cared-for person, by social services during the 12 months prior to the sample being identified. (This sample is clearly more specific than for the Census, which may explain differences in, for example, reported numbers of hours spent caring. It does not include young carers, aged under 18.)

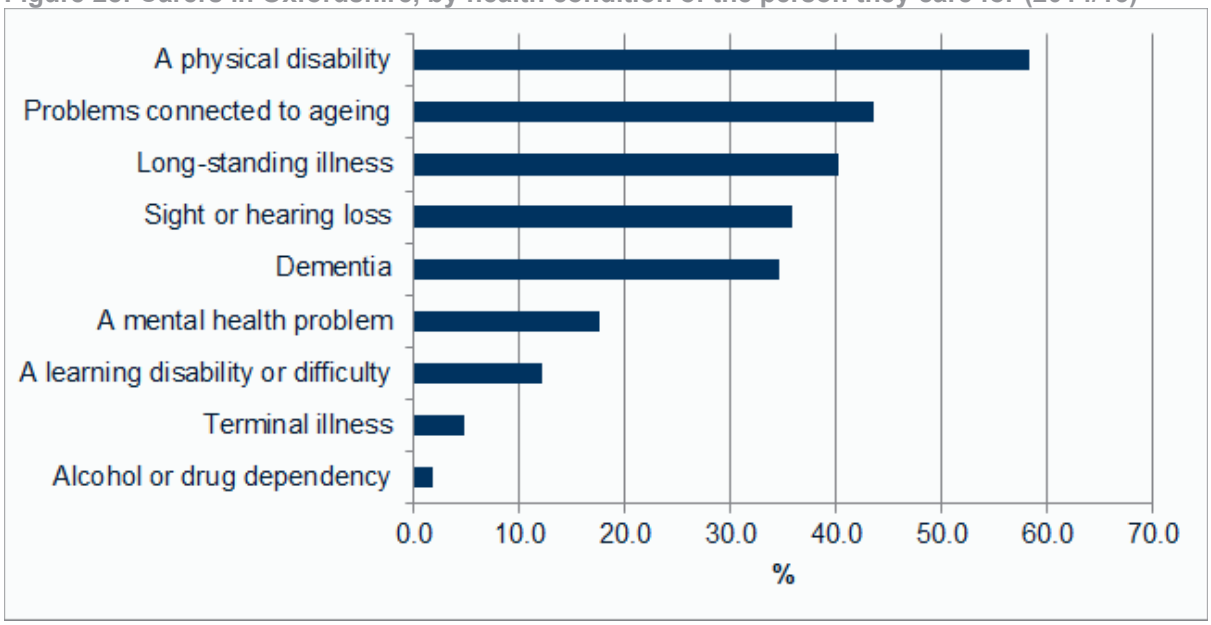
715 carers in Oxfordshire responded to the survey in 2014/15. The following analysis highlights where the survey results for Oxfordshire differed significantly from national averages; otherwise they can be assumed to be similar. Due to relatively wide confidence intervals around the local figures, it is not possible to identify any changes since the previous survey in 2012/13. It may be possible to get a better sense of trends in future years.

About three quarters were living with the person they cared for. Most (three fifths) had been caring for them for between one and ten years. However, more than one in three had been caring for more than ten years. Slightly under half of respondents (44.1%) reported providing 100 or more hours of care per week.

Nearly two thirds of the carers (65.3%) were retired. Whilst 12.0% were in paid work and felt supported by their employer, 4.1% did not feel supported. A further 16.4% of respondents said they were not in employment *because of* their caring responsibilities.

For over half of the carers in Oxfordshire who responded to the survey, the person they cared for had a physical disability.

Figure 28: Carers in Oxfordshire, by health condition of the person they care for (2014/15)



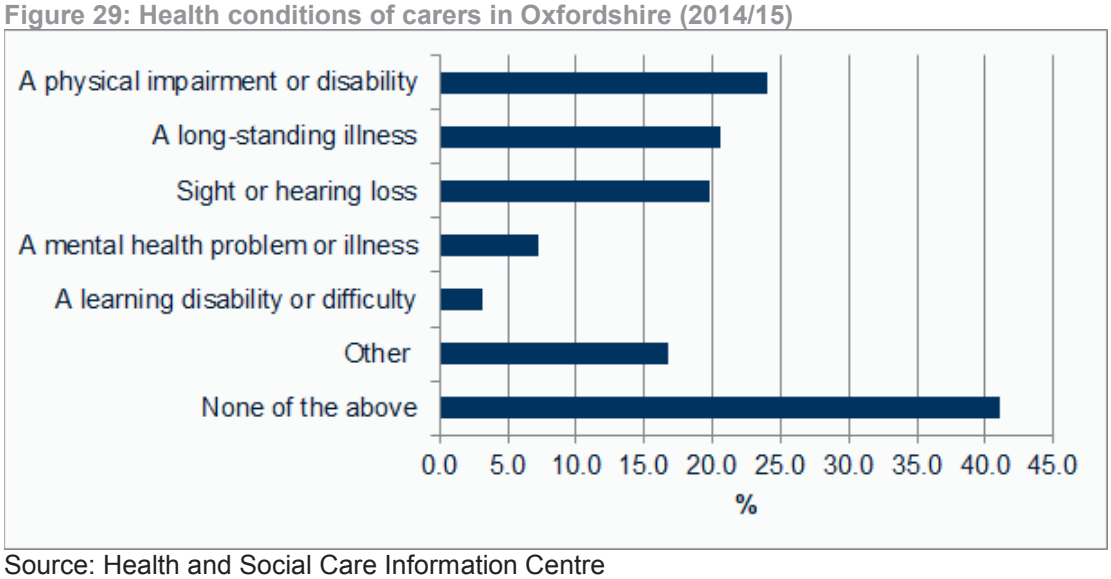
Source: Health and Social Care Information Centre

This pattern broadly reflected that at national and regional levels, although carers in Oxfordshire were more likely than nationally to be caring for someone with problems connected to ageing. This is likely to be linked to the fact that many care for a partner.

[84] Personal Social Services Survey of Adult Carers in England, 2014-15: http://www.hscic.gov.uk/searchcatalogue?productid=18781&q=carer+survey&sort=Relevance&size=10&page=1#top

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.

Figure 29: Health conditions of carers in Oxfordshire (2014/15)



Source: Health and Social Care Information Centre

Compared with the national picture, Oxfordshire carers were more likely to report having a physical impairment or disability, and loss of sight or hearing.

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. Most said they were able to do some of these things but not enough (65.8%). 14.3% said they didn't do anything they value or enjoy. The pattern of responses did not differ significantly from the national picture.

Likewise, over seven in ten respondents said they did not have as much control over their daily life as they want. Some of these said they had *no* control (making up 12.4% of all respondents). The pattern of responses did not differ significantly from the national picture.

Only a minority of carers in Oxfordshire felt they had as much social contact as they want (fewer than two fifths). 14.6% said they had little social contact and felt isolated. Again, this pattern of responses did not differ significantly from the national picture.

The majority of respondents reported being able to look after themselves, although 13.2% felt they were neglecting themselves. The pattern of responses did not differ significantly from the national picture.

Carers who had accessed support or services were most likely to say this was in the form of information or advice.

Figure 30: Proportions of carers in Oxfordshire accessing support or services (2014/15)

Source: Health and Social Care Information Centre

Most respondents said they had found it (very or fairly) easy to find information and advice about support, services and benefits. Nearly 90% had found the information and advice they had received (very or quite) 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, and to the results of the previous survey in Oxfordshire in 2012/13.

4. Wider Determinants of Health

This section considers wider economic, social and environmental factors affecting health and wellbeing.[85] Further resources are available online, by visiting the JSNA – Wider Determinants webpage.

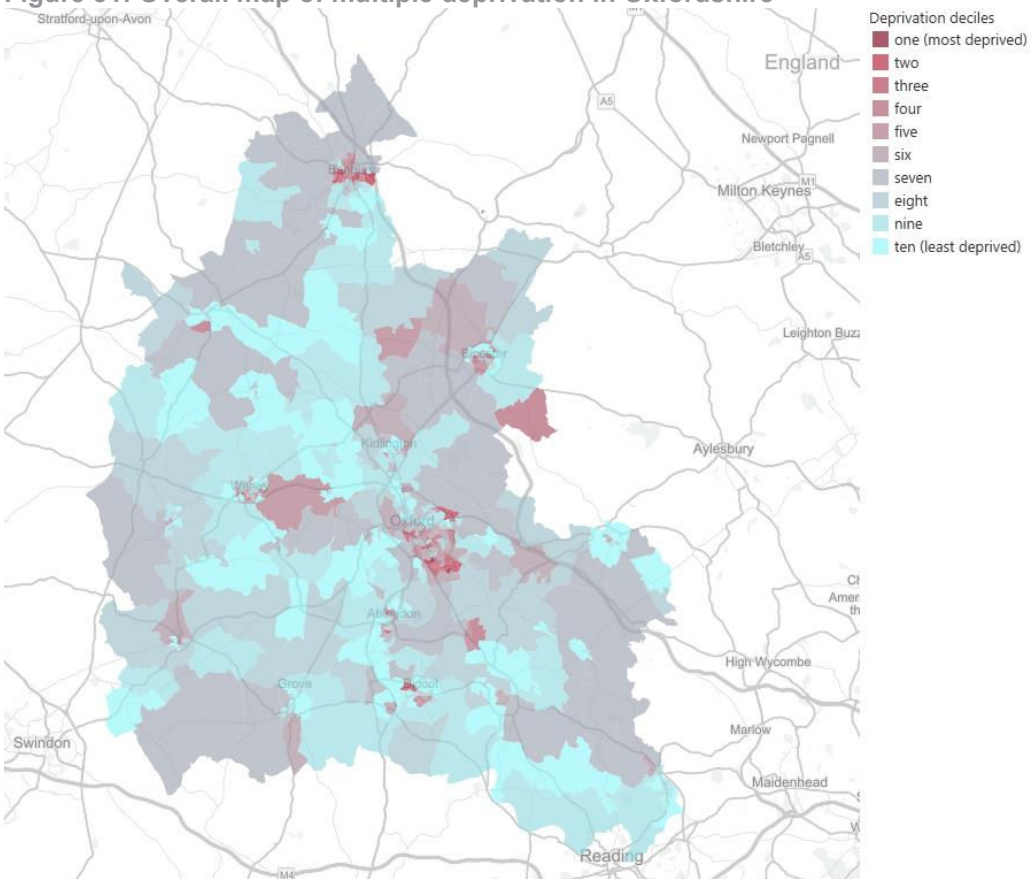
4.1. Affluence and Deprivation

4.1.1. Overall Index of Multiple Deprivation

The English Indices of Deprivation 2015 are based on 37 indicators spanning seven broad types of deprivation.[86] These indicators are used to calculate an overall Index of Multiple Deprivation (IMD). The IMD is a key single measure of multiple deprivation experienced by people living in English neighbourhoods.

Overall, Oxfordshire has relatively low levels of multiple deprivation. It is the 11th *least* deprived of 152 upper tier local authorities in England (up from 12th least deprived in 2010). However, there is significant variation across different parts of the county.

Figure 31: Overall map of multiple deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

[85] Wider determinants of health were looked at in detail in the 2010 report: *Fairer Society Healthy Lives* (The Marmot Review): http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[86] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

The IMD provides analysis of deprivation at the level of small areas (called Lower level Super Output Areas, or LSOAs). Each LSOA contains 1,000-3,000 residents, or 400-1,200 households. The IMD compares all 32,844 LSOAs in England and ranks them according to their level of deprivation. 407 of these LSOAs fall within Oxfordshire's boundaries.

As is evident from the map above, most of Oxfordshire's 407 LSOAs are less deprived than the national average. 110 are among the least deprived 10% nationally. A further 83 are among the 10-20% least deprived. Overall, nearly half (46%) of the county's population lives in areas that are among the least deprived 20% in England. More than four in five residents (82%) live in areas that are less deprived than the national average.

On the other hand, two LSOAs are among the 10% most deprived in England. These are in Oxford City, in parts of Rose Hill and Iffley ward, and Northfield Brook ward. In 2010 only the latter of these was among the 10% most deprived areas. 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.

Figure 32: Small areas in Oxfordshire among the 20% most deprived nationally

LSOA	Ward	District	Deprivation Decile
Oxford 016E	Rose Hill and Iffley	Oxford	10% most deprived
Oxford 018B	Northfield Brook	Oxford	10% most deprived
Cherwell 004A	Banbury Grimsbury and Castle	Cherwell	10-20% most deprived
Cherwell 004G	Banbury Grimsbury and Castle	Cherwell	10-20% most deprived
Cherwell 005B	Banbury Ruscote	Cherwell	10-20% most deprived
Cherwell 005F	Banbury Ruscote	Cherwell	10-20% most deprived
Oxford 005A	Barton and Sandhills	Oxford	10-20% most deprived
Oxford 005B	Barton and Sandhills	Oxford	10-20% most deprived
Oxford 016F	Rose Hill and Iffley	Oxford	10-20% most deprived
Oxford 017A	Blackbird Leys	Oxford	10-20% most deprived
Oxford 017B	Blackbird Leys	Oxford	10-20% most deprived
Oxford 017D	Northfield Brook	Oxford	10-20% most deprived
Oxford 018A	Blackbird Leys	Oxford	10-20% most deprived
Oxford 018C	Northfield Brook	Oxford	10-20% most deprived
Vale of White Horse 008C	Abingdon Caldecott	Vale of White Horse	10-20% most deprived

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 LSOA 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 LSOA in Ruscote ward has moved out of the 10-20% most deprived. Due to LSOA boundary changes, an LSOA in Grimsbury and Castle ward that was in the 10-20% most deprived in 2010 no longer appears in this decile. However, a new LSOA, covering much of the same area, is now within the 10-20% most deprived.

You can explore the data using the interactive deprivation tool published by Oxfordshire County Council's Research and Intelligence Team. Further analysis is also available in the District Data Service chart of the month for December 2015.

Deprivation has important implications for health: an important piece of national research has shown marked health inequalities between the least deprived and most deprived areas.[87] Analysis of 2011 Census data similarly shows that people living in deprived areas and working in routine occupations were more likely to experience greater limitations to their daily activities.[88]

4.1.2. Index of Income Deprivation

An index of income deprivation was published as part of the English Indices of Deprivation 2015.[89] This index measures the proportion of the population in an area experiencing deprivation relating to low income. The definition of low income used includes people who are out of work, and those who are in work but have low earnings, and satisfy means tests for claiming certain income-related benefits.

Oxfordshire has relatively low levels of income deprivation: it is the 10th *least* deprived of 152 upper tier local authorities in England. Most of the 407 small areas in Oxfordshire are *less* deprived than the national average. 104 are in the 10% *least* deprived nationally and a further 85 are in the 10-20% *least* deprived.

However, three small areas are in the 10% *most* deprived. These are all located in Oxford City, in parts of Rose Hill and Iffley ward, Northfield Brook ward, and Blackbird Leys ward. A further 11 areas are in the 10-20% *most* deprived and are located in parts of Oxford and Banbury.

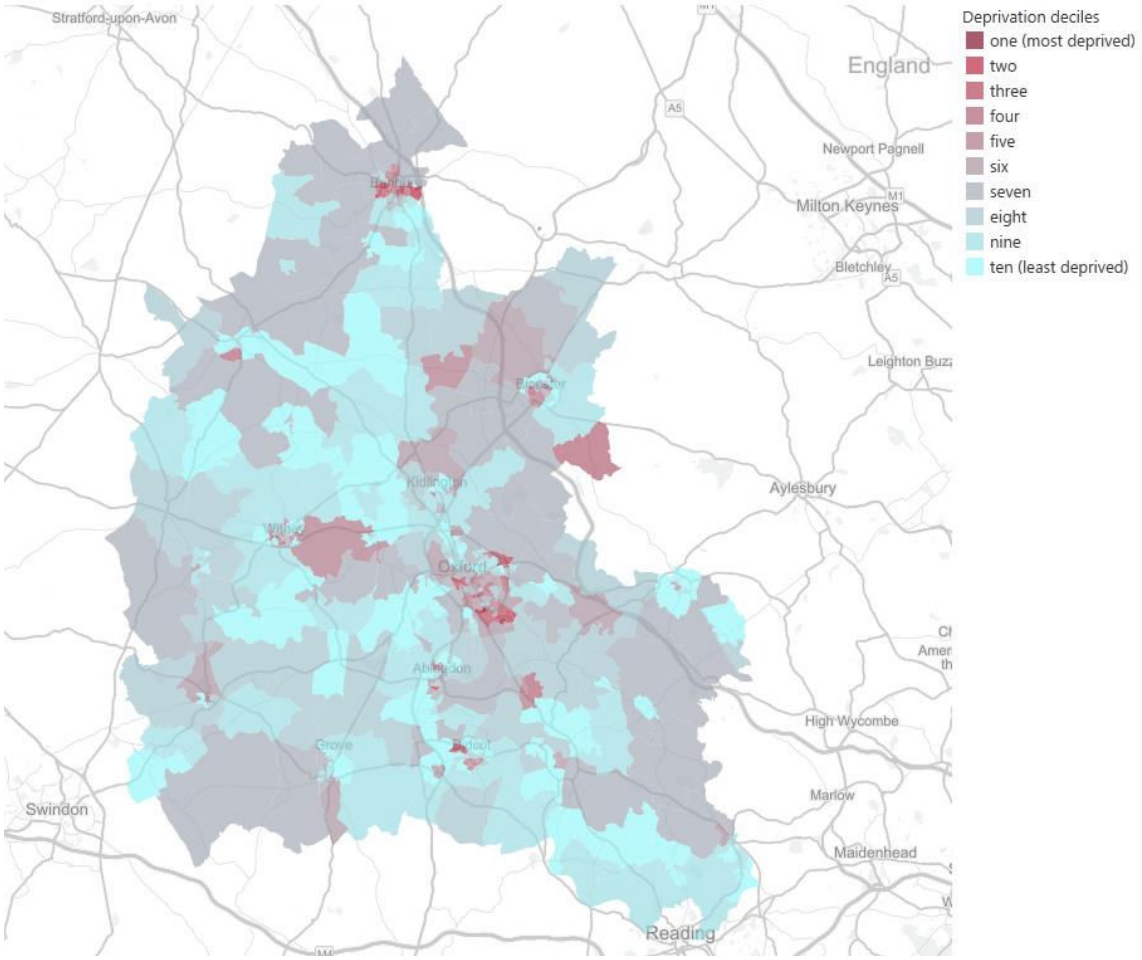
The map below shows the pattern of income deprivation across Oxfordshire.

[87] Newton, J. N. et al. (2015). Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet:* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2900195-6/abstract

[88] ONS Census 2011 analysis: http://visual.ons.gov.uk/disability-census/

[89] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015.

Figure 33: Map of income deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

Some of the other domain-specific data included in the English Indices of Multiple Deprivation 2015 are discussed elsewhere in the report.[90]

4.1.3. Levels of Income

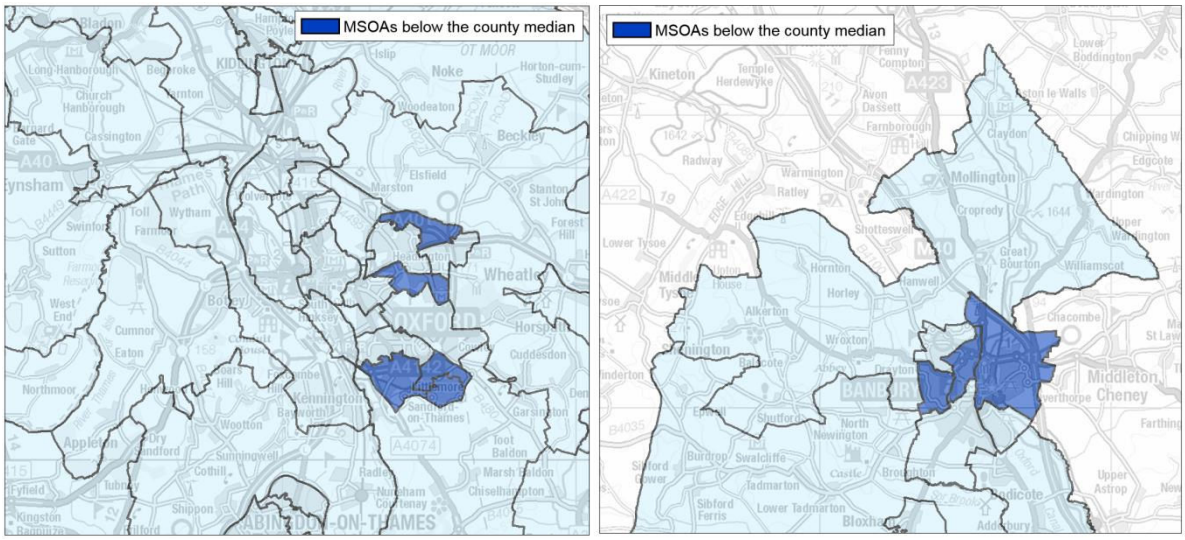
Estimates have been produced of the mean net weekly household income for each medium-sized area in England and Wales (technically known as middle-layer super output areas, or MSOAs).[91]

The 2011/12 estimates for Oxfordshire suggest that, across the county's 86 MSOAs, income ranges from around £411 to £921 per week (before housing costs) and from about £324 to £845 after housing costs are accounted for.

Eight areas in Oxfordshire had significantly lower income than the (median) average of all MSOAs in the county. These were all located in parts of Oxford and Banbury, as shown on the maps below.

[90] See sections: 4.2.3; 4.2.5; 4.3.5; 4.4.4; 4.5.1; 4.8.1; 4.9.3; and 5.1.
[91] Data from the ONS Small Area Model-Based Income Estimates, 2011/12: http://www.ons.gov.uk/ons/rel/ness/small-area-model-based-income-estimates/2011-12/index.html

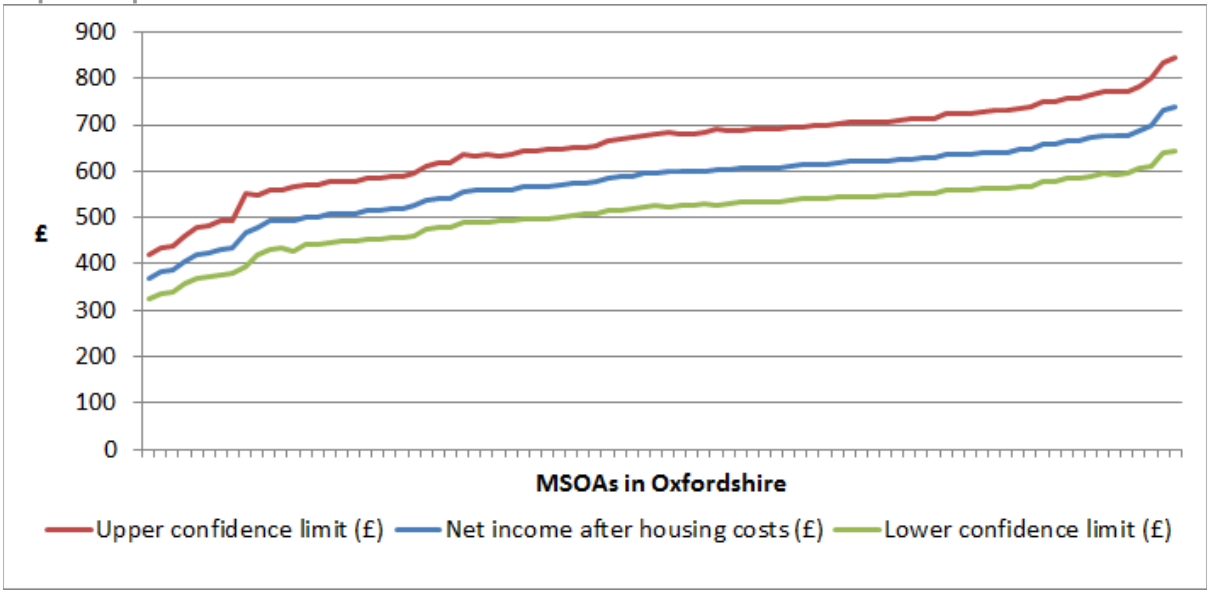
Figure 34: Map of areas in Oxford and Banbury with low mean net weekly household income



Source: Office for National Statistics

The chart below shows the distribution of income across all of Oxfordshire's 86 MSOAs. This is relatively shallow but with a marked upward tick among a few MSOAs with higher levels of income (although the differences from the county median level are not statistically significant) and a drop off among MSOAs at the lower levels of income.

Figure 35: Distribution of mean net weekly household income across the 86 Middle Layer Super Output Areas in Oxfordshire



Source: Office for National Statistics

4.2. Housing and Homelessness

This section brings together information about housing tenure, availability, affordability, and condition, as well as statutory homelessness and rough sleeping. Further detailed analysis of housing need is available from the 2014 Oxfordshire Strategic Housing Market Assessment (SHMA).

4.2.1. Tenure

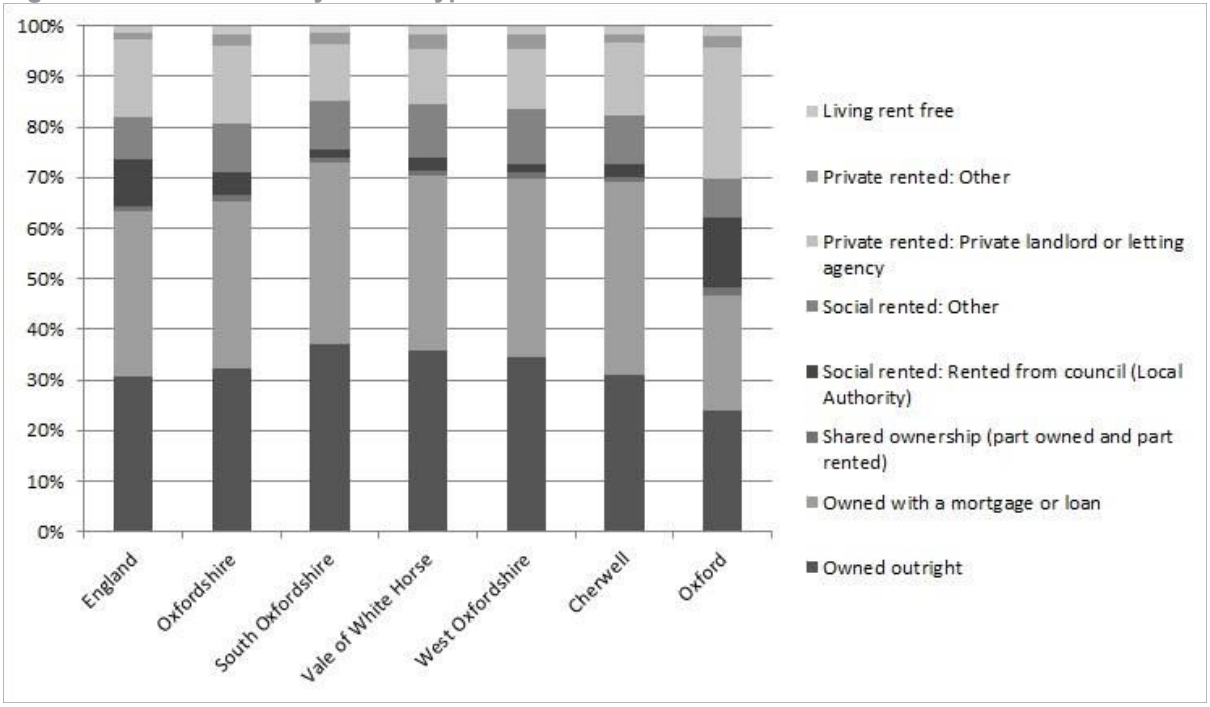
At the time of the 2011 Census, there were 258,900 households in Oxfordshire. Around two thirds lived in housing they owned, either outright (32.3%) or with a mortgage or loan

(33.2%).[92] These proportions had changed since 2001, when 29.8% of households owned their housing outright, and 40.2% with a mortgage or loan.

Around one in six households were in privately rented housing (17.5%, up from 12.6% in 2001). Around one in seven were in social housing, either rented from the council (4.6%, down from 6.5% in 2001) or from other providers (9.7%, up from 7.9% in 2001).

The proportions for each tenure type were broadly comparable with those of England, as can be seen in the figure below.

Figure 36: Households by tenure type



Source: Office for National Statistics 2011 Census

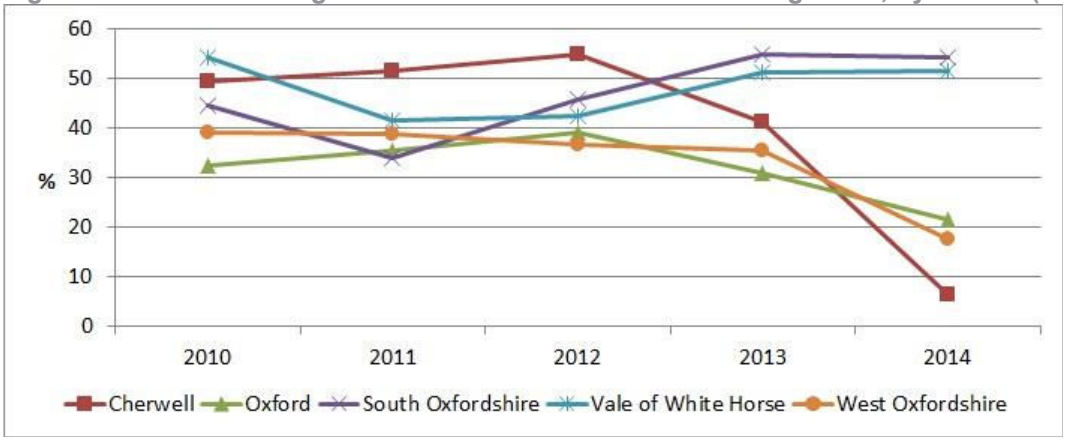
The figure above demonstrates considerable variation in tenure patterns across different parts of the county. Most notably, the proportion of Oxford's households in local authority social housing was about three times higher than for Oxfordshire overall (13.6%, compared with 4.6%).

4.2.2. Availability of Social Housing

The availability of social housing varies among districts. In South Oxfordshire and Vale of White Horse, the shortfall remains in excess of half of the existing social housing stock. In other districts the shortfall has declined to below a quarter of the current stock.

[92] Census 2011, table KS402UK; Census 2001, table S049: https://www.nomisweb.co.uk

Figure 37: Social housing shortfall as a % of the social housing stock, by district (2010-2014)



Source: Office for National Statistics Housing Statistics

4.2.3. Barriers to Housing

An index of barriers to housing and services was published as part of the English Indices of Deprivation 2015.[93] This index is composed of two subdomains: geographical barriers (see section 4.9.3: Geographical Barriers) and wider barriers to housing, including indicators of overcrowding, homelessness, and affordability.

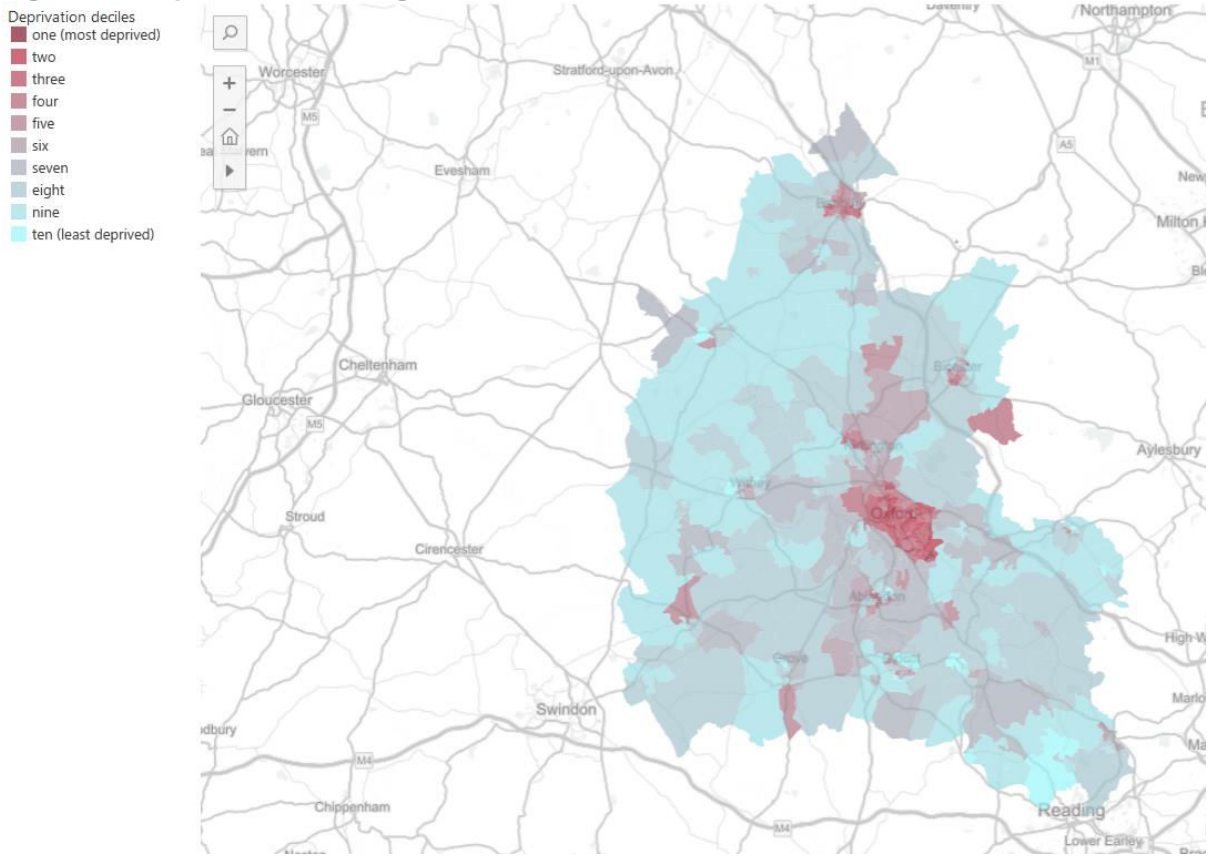
In terms of wider barriers to housing, most of Oxfordshire's 407 small areas (technically known as lower layer super output areas, or LSOAs) are *less* deprived than the national average. 93 are in the 20% *least* deprived of 32,844 small areas in England.

However, three of Oxfordshire's small areas (in parts of Northfield Brook and Blackbird Leys wards in Oxford) are in the 10% *most* deprived nationally. A further 36 small areas are in the 10-20% *most* deprived nationally. These are also concentrated in parts of Oxford City.

The map below shows where barriers to housing are more or less of a problem in Oxfordshire.

[93] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 38: Map of wider housing barriers in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

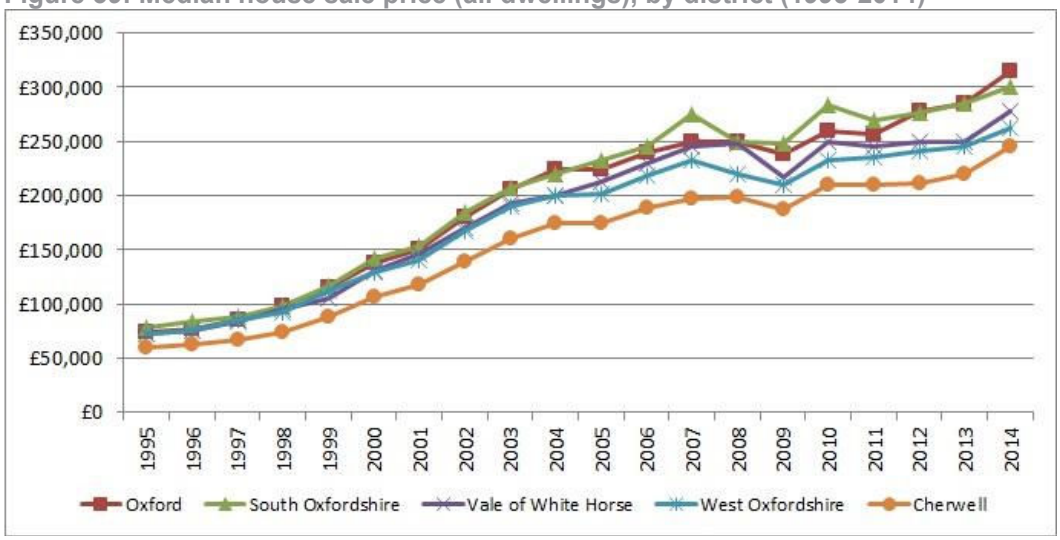
4.2.4. Housing Affordability

House Prices

Housing in Oxfordshire can be expensive. In all districts of the county, median house sale prices have been rising and remain higher than in the majority of local authorities in England and Wales.[94]

[94] Data from ONS House Price Statistics for Small Areas: http://www.ons.gov.uk/ons/rel/regional-analysis/house-price-statistics-for-small-areas/index.html

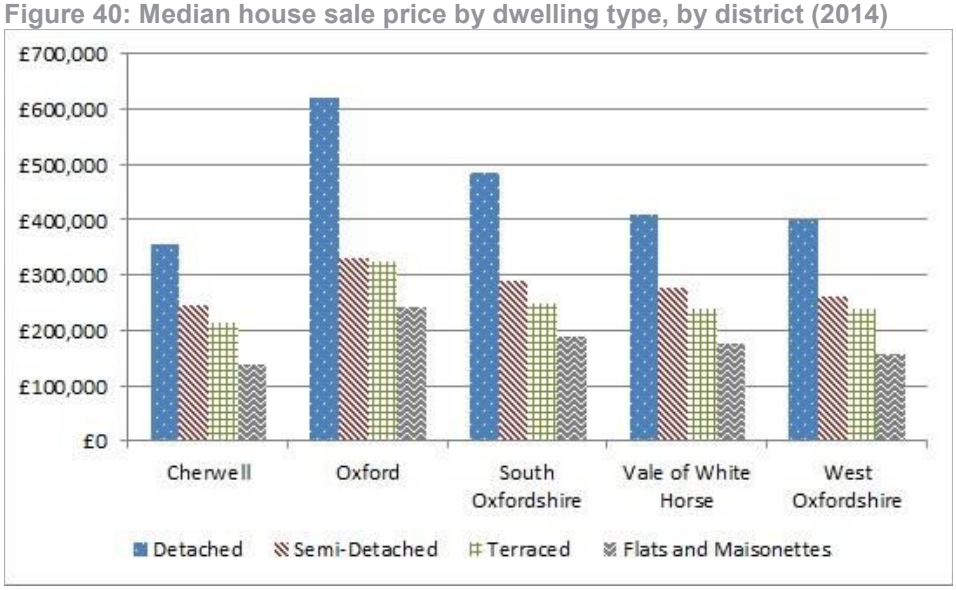
Figure 39: Median house sale price (all dwellings), by district (1995-2014)[95]



Source: Office for National Statistics House Price Statistics for Small Areas

Prices vary across different types of dwelling and across districts, as shown in the figure below.

Figure 40: Median house sale price by dwelling type, by district (2014)

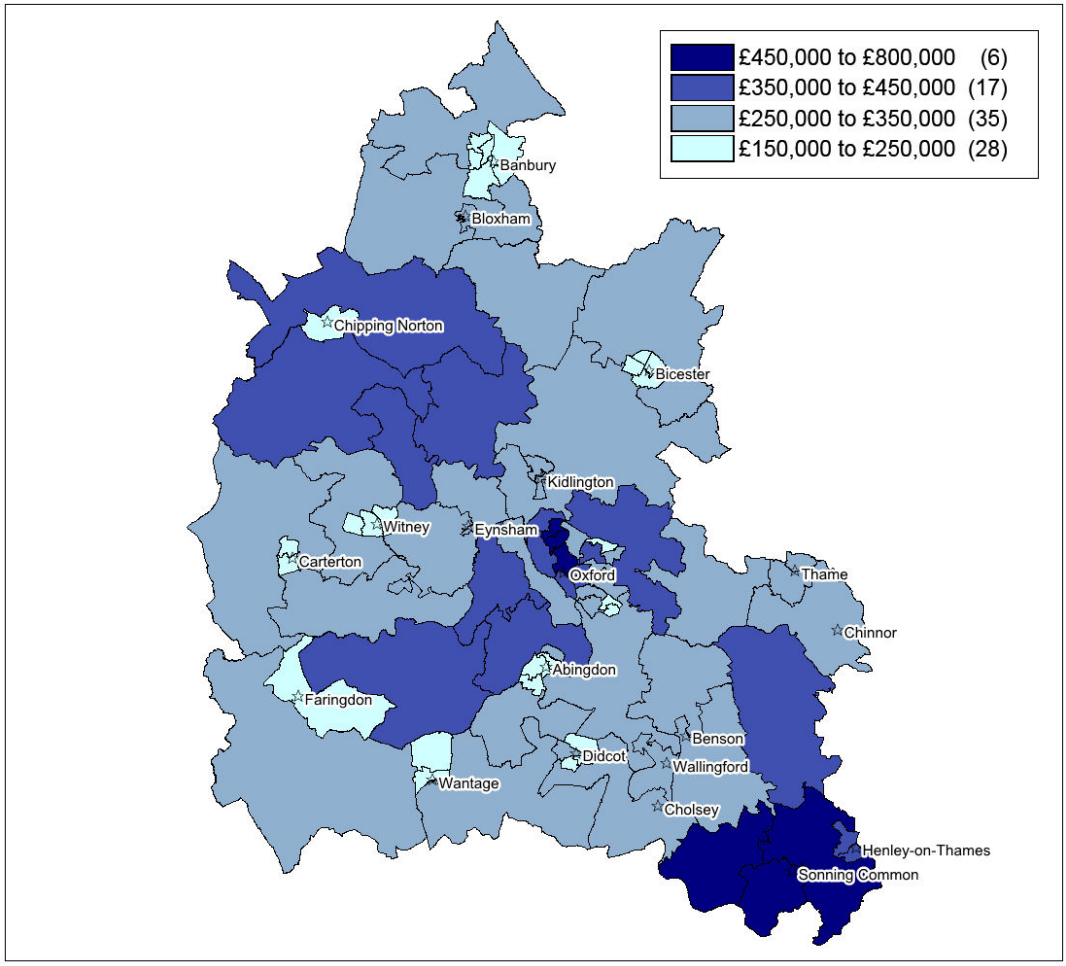


Source: Office for National Statistics House Price Statistics for Small Areas

The map below shows in more detail where house prices are highest in Oxfordshire.

[95] This trend chart does not take account of inflation: prices are shown in nominal not real terms.

Figure 41: Map of median house sale price (all dwellings, 2014)



Source: Office for National Statistics House Price Statistics for Small Areas

Although salaries in Oxfordshire are often higher than elsewhere ratios of house prices to salaries are also high and rising. In 2014 median house prices tended to be over ten times median gross annual salaries.[96] Again, the ratio is higher than in the majority of English and Welsh local authorities.

Figure 42: Ratio of median house price to median gross annual salary, by district (2014)

Area	Ratio of median house price to median gross annual salary
Cherwell	10.7
Oxford	12.1
South Oxfordshire	11.6
Vale of White Horse	10.3
West Oxfordshire	*Official data unavailable. However, Oxfordshire County Council has produced an estimate of 10.1*[97]

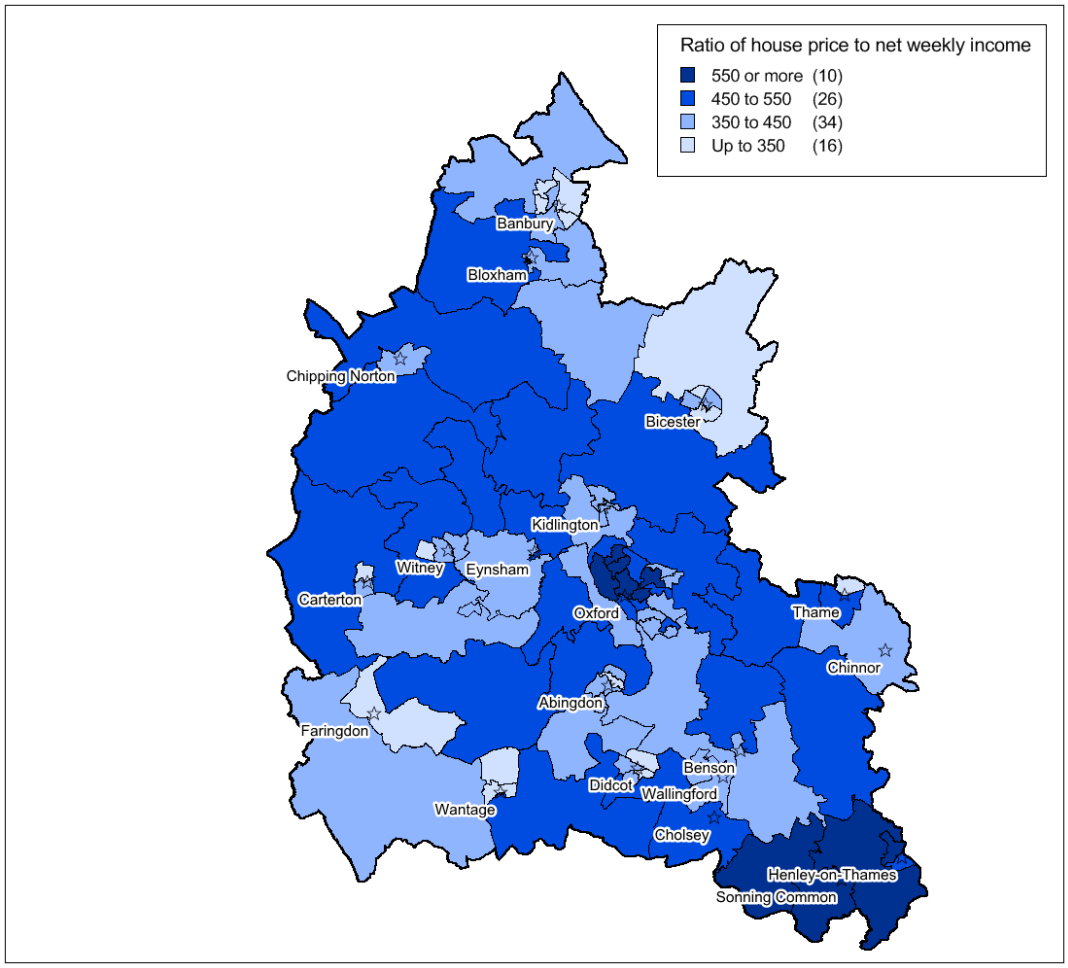
Source: Office for National Statistics House Price Statistics for Small Areas/ Annual Survey of Hours and Earnings

[96] Wendell Cox, in the *11th Annual Demographia International Housing Affordability Survey: 2015* (http://www.demographia.com/dhi.pdf) classes a multiple in excess of 5 as "extremely unaffordable". Anything above 3 is considered unaffordable to some extent.

[97] Salary data is not available for West Oxfordshire for 2014. Oxfordshire County Council's Research and Intelligence Team has applied the percentage increase in Oxfordshire salaries, from 2012 to 2014, to the 2012 salary figure provided for West Oxfordshire, to arrive at a best estimate.

The map below shows in more detail where the ratio of house prices to income is highest, i.e. in parts of Oxford and South East Oxfordshire.[98] *NB this map uses data on weekly income rather than annual salary, so the absolute ratios are larger than in the table above.*

Figure 43: Map showing the ratio of house prices to net weekly household income (2011/12)



Source: Office for National Statistics

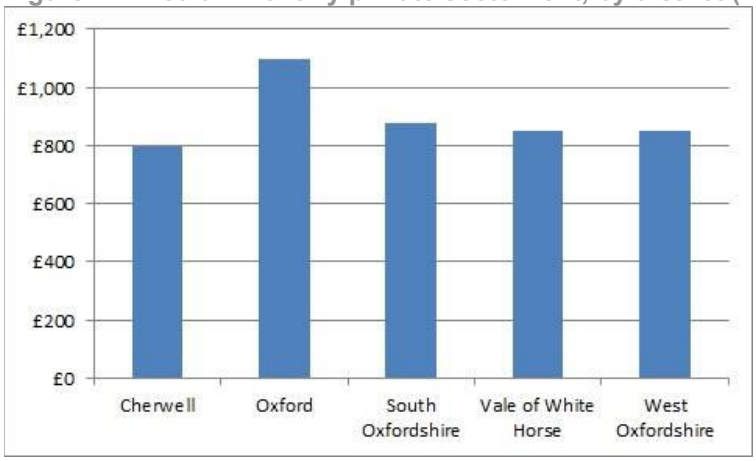
Private Sector Rents

Renting in Oxfordshire also tends to be expensive: in all districts median monthly private sector rent in 2014 was higher than in most local authorities in England.[99]

[98] Data from the ONS Small Area Model-Based Income Estimates, 2011/12: http://www.ons.gov.uk/ons/rel/ness/small-area-model-based-income-estimates/2011-12/index.html

[99] Data from the ONS Housing Statistics Portal: http://www.ons.gov.uk/ons/rel/regional-analysis/housing-statistics-portal/index.html

Figure 44: Median monthly private sector rent, by district (2014)[100]



Source: Office for National Statistics Housing Statistics

Private sector rents in Oxfordshire tend to account for between a third and a half of earnings, with particular pressures evident in Oxford.

Figure 45: Median monthly private sector rent as a % of median gross monthly salary, by district (2014)

Area	Median monthly private sector rent as % of median gross monthly salary
Cherwell	41.5%
Oxford	50.6%
South Oxfordshire	40.4%
Vale of White Horse	38.0%
West Oxfordshire	*Official data unavailable. However, Oxfordshire County Council has produced an estimate of 39.3%*[101]

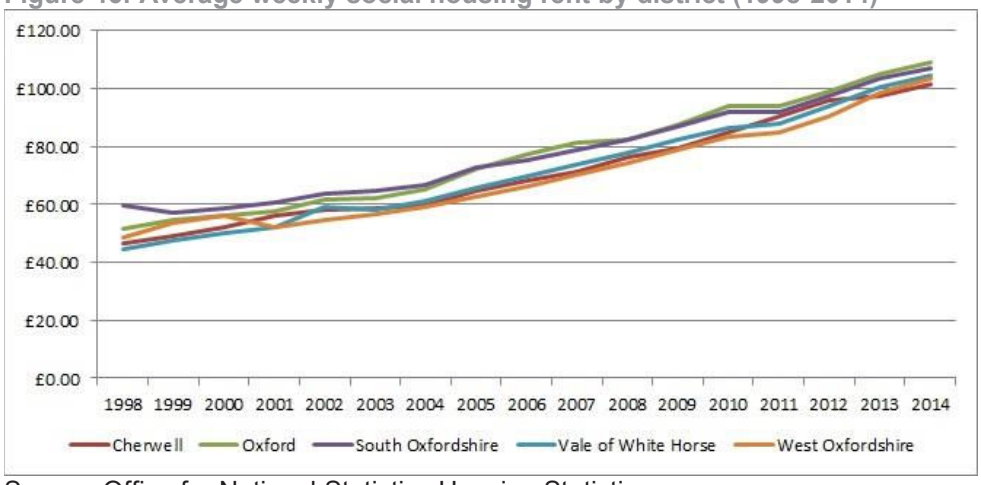
Source: Office for National Statistics Housing Statistics/ Annual Survey of Hours and Earnings

Social Housing Rents

Social housing rents in Oxfordshire have been rising in all districts and remain higher than in most local authorities in England and Wales.[102]

[100] This trend chart does not take account of inflation: prices are shown in nominal not real terms.
[101] Salary data is not available for West Oxfordshire for 2014. Oxfordshire County Council's Research and Intelligence Team has applied the percentage increase in Oxfordshire salaries, from 2012 to 2014, to the 2012 salary figure provided for West Oxfordshire, to arrive at a best estimate.
[102] Data from the ONS Housing Statistics Portal: http://www.ons.gov.uk/ons/rel/regional-analysis/housing-statistics-portal/index.html

Figure 46: Average weekly social housing rent by district (1998-2014)[103]



Source: Office for National Statistics Housing Statistics

For someone whose earnings are in the lowest 10% nationally, social rents could account for all (or more) of earnings, on average. These proportions have risen substantially in all districts since the early 2000s. However, the figures do not take account of other sources of income or financial support.

Figure 47: Average weekly social housing rent as a % of tenth percentile gross weekly salary, by district (2014)[104]

Area	Median monthly social housing rent as % of tenth percentile gross weekly salary
Cherwell	73.9%
Oxford	80.2%
South Oxfordshire	111.3%
Vale of White Horse	71.3%
West Oxfordshire	87.4%

Source: Office for National Statistics Housing Statistics

For more information about housing costs in Oxford City, see the Oxford City Council Chart of the Month for September 2015.

4.2.5. Housing Conditions

It has been found that bad housing conditions – including homelessness, temporary accommodation, overcrowding, insecurity, and housing in poor physical condition – can constitute a risk to physical and mental health.[105] This can include, for example, increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety.

Indoor Living Environment

An index of deprivation in relation to indoor living environments was published as a sub-domain of the English Indices of Deprivation 2015.[106] This index includes indicators on central heating and housing in poor condition.

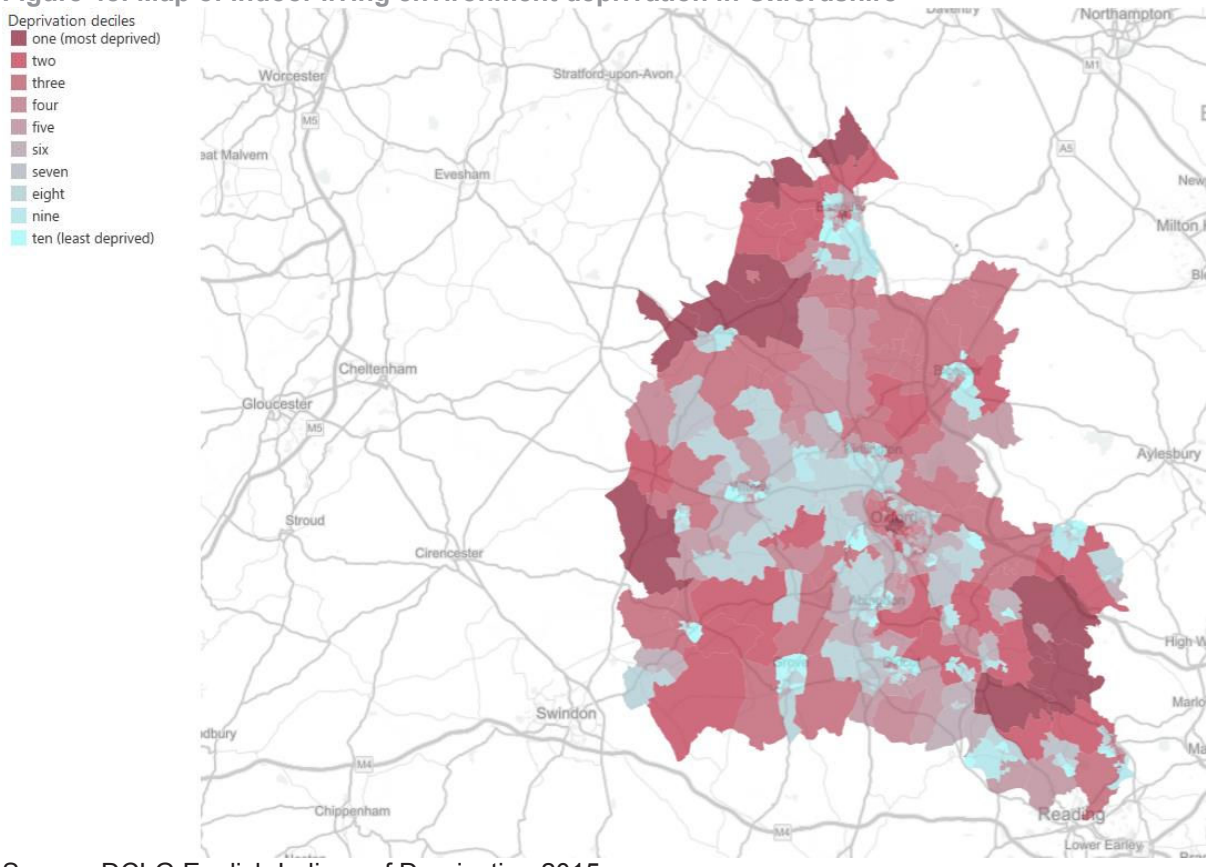
[103] The data cover larger private registered providers of social housing only
[104] The figures do not take account of other sources of income or financial support.
[105] The Marmot Review: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review; Chartered Institute of Environmental Health's Housing and Health Resource: http://www.cieh-housing-and-health-resource.co.uk/
[106] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

In terms of the indoor living environment, the majority of Oxfordshire's 407 small areas (technically known as lower layer super output areas, or LSOAs) are *less* deprived than the national average. 106 are in the 20% *least* deprived of 32,844 small areas in England.

However, 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.

The map below shows the pattern of living environment deprivation in Oxfordshire.

Figure 48: Map of indoor living environment deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

Separate national research has estimated that 15.3% of homes in England fall into the category of 'poor housing', having at least one major hazard. More than another 20% contain hazards considered significant.[107] The associated impact on health and health services is thought to be substantial, costing the NHS £2bn per year.

Overcrowding

At the time of the 2011 Census, a third of people in Oxfordshire lived in households with more than one person per bedroom (33.3%).[108] This was a slightly smaller proportion than was seen in the South East (34.9%) and England overall (36.8%).

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.

[107] *The cost of poor housing to the NHS* (BRE, 2015): http://www.bre.co.uk/page.jsp?id=3611
[108] Census 2011, table QS414EW**:** https://www.nomisweb.co.uk

National analysis of data from the 2011 Census shows that people living in overcrowded houses tended to be in worse health.[109]

Fuel Poverty

Tens of thousands of UK residents are made ill by living in a home that is too cold.[110] People at greatest risk include those who:

- have cardiovascular or respiratory conditions
- are under the age of five
- are over the age of 65
- have mental health conditions
- are pregnant
- have low incomes[111]

Under the 'Low Income High Cost' measure of fuel poverty, households are considered to be fuel poor when: (i) they have required fuel costs that are above average (the national median level) and (ii) were they to spend that amount, they would be left with a residual income below the official fuel poverty line.

In 2013 an estimated 21,800 people in Oxfordshire were living in fuel poverty, making up 8.2% of the population (broadly similar to the proportion in the previous two years). [112] This was also similar to the South East average (8.1%) and below that for England overall (10.4%).

Oxford had proportionately more people living in fuel poverty (11.9% or around one in ten people). For the other districts, fuel poverty affected around 7% of people (approximately one in fourteen).

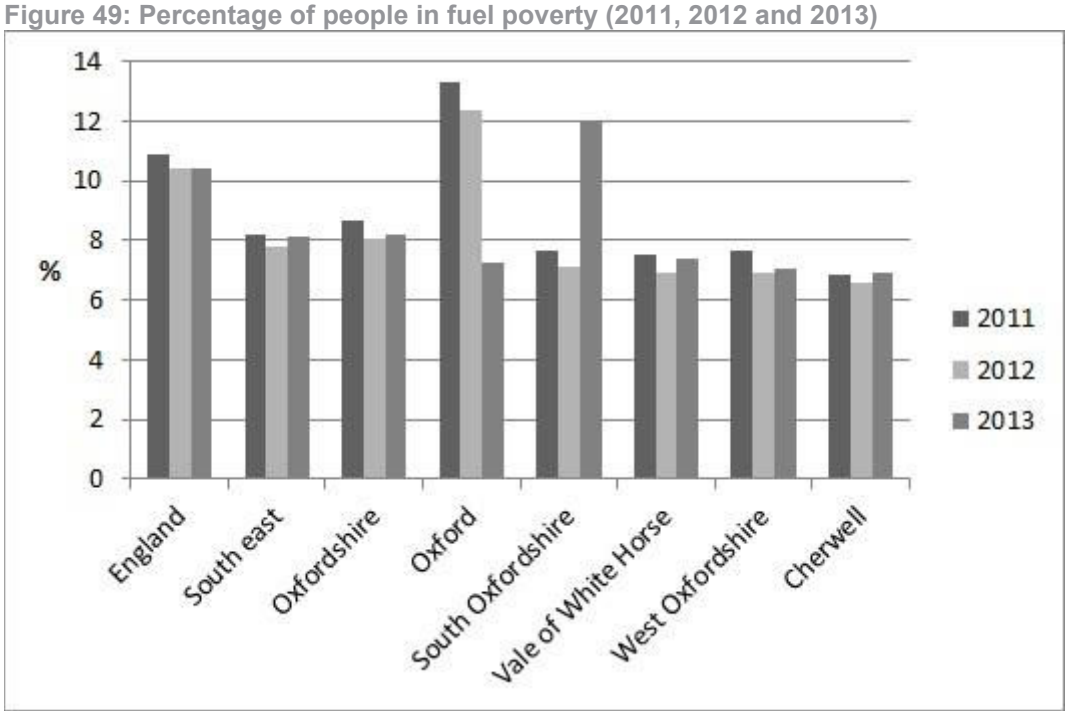
[109] ONS Census 2011 analysis of health in England and Wales (July 2015): http://visual.ons.gov.uk/health-census/

[110] National Institute for Health and Care Excellence feature on vulnerable people living in cold homes: http://www.nice.org.uk/news/article/vulnerable-people-living-in-cold-homes-need-greater-support

[111] National Institute for Health and Care Excellence feature on vulnerable people living in cold homes: http://www.nice.org.uk/news/article/vulnerable-people-living-in-cold-homes-need-greater-support

[112] Public Health Outcomes Framework, indicator 1.7: http://www.phoutcomes.info/ .

Figure 49: Percentage of people in fuel poverty (2011, 2012 and 2013)



Source: Public Health England/ Department of Energy and Climate Change

For more analysis of fuel poverty in Oxfordshire, see the District Data Service chart of the month for June 2015.

Households not connected to the gas network are reliant on fuels that could be more expensive, such as heating oils and solid fuels. To that extent, they may be more vulnerable to fuel poverty.

Estimates indicate that in 2013 around 42,500 households in Oxfordshire were not connected to the gas network.[113] Across the county, proportionately more households were unconnected in West Oxfordshire (23%), Cherwell (22%) and South Oxfordshire (18%) than in Vale of White Horse (15%) and Oxford (10%).

4.2.6. Homelessness

Homelessness is linked to a range of indicators of adverse health.[114] More information about the healthcare needs of homeless patients who present at Oxford's Luther Street Medical Centre is provided in section 5.3: Morbidity.

Statutory Homelessness

To be deemed statutorily homeless a household must have become homeless unintentionally and must be considered to be in priority need. The Public Health Outcomes Framework tracks the following two kinds of statutory homelessness:

i. Homelessness acceptances: households accepted as being owed a duty by their local authority under homelessness legislation, as a result of being eligible for assistance, unintentionally homeless and in priority need
ii. Households in temporary accommodation.

[113] Sub-national estimates of households not connected to the gas network: https://www.gov.uk/government/statistics/sub-national-estimates-of-households-not-connected-to-the-gas-network

[114] Public Health England Outcomes Framework: http://www.phoutcomes.info/

In 2014/15 the rate of homelessness acceptances in Oxfordshire was 1.2 households per 1,000.[115] This rate has remained at a similar level for the past five years and is still lower than the South East average (2.0 in 2014/15) and England average (2.4).

The rate of households in temporary accommodation in Oxfordshire in 2014/15 was 0.7 households per 1,000.[116] Again, this rate has not shown any significant change over the past five years and is lower than the averages for the South East (1.6 in 2014/15) and England (2.8).

Across the county, Oxford had higher rates of both kinds of statutory homelessness than the county average. This could in part be related to the presence of homeless facilities in the city. Conversely, South Oxfordshire and Vale of White Horse had rates of homelessness acceptances that were below the county average in 2014/15. Meanwhile, West Oxfordshire had a lower rate of households in temporary accommodation.

Rough sleeping

In 2014/15 there were estimated to be 70 people sleeping rough in Oxfordshire.[117] This figure combines the annual estimates produced by each district in the autumn, using the same approved and verified methodology. Oxford City also undertakes quarterly street counts (which are not practicable in other districts) and the alternative figure as of autumn 2014 is provided in the third column of the table below.

Figure 50: Estimates and counts of rough sleeping (2014/15)

Area	Number sleeping rough (estimate)	Number sleeping rough (count)
Cherwell	14	N/A
Oxford	43	26
South Oxfordshire	5	N/A
Vale of White Horse	5	N/A
West Oxfordshire	3	N/A

Source: Oxfordshire Health Improvement Board/ DCLG

4.3. Education and Qualifications

Differences in educational attainment have been found to correlate with health inequalities including, for example, being overweight, smoking and developing lung cancer and other limiting illnesses.[118] International research has found that the most consistent predictor of the likelihood of death in any given year is level of education.[119]

[115] Public Health England Outcomes Framework, indicator 1.15i: http://www.phoutcomes.info/
[116] Public Health England Outcomes Framework, indicator 1.15ii: http://www.phoutcomes.info/
[117] Estimates are taken from the annual report on housing and health indicators for 2014/15, presented to Oxfordshire's Health Improvement Board: http://mycouncil.oxfordshire.gov.uk/documents/s29207/Item%207c%20-%20Basket%20of%20Housing%20Indicators%20Annual%20Report%202014-15.pdf; Count data for Oxford City is taken from the Department for Communities and Local Government's rough sleeping statistics for autumn 2014: https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2014
[118] *Fair Society, Healthy Lives: The Marmot Review:* http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/Marmot/MarmotIndicators2014.aspx
[119] McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93. http://content.healthaffairs.org/content/21/2/78.long#ref-15

4.3.1. Early Years

In 2014/15 the proportion of children in Oxfordshire achieving a 'good' level of development at the end of reception (the early years foundation stage, or EYFS) was 66.2%.[120] This was up from 60.1% in 2013/14. Children are defined has having reached a good level of development if they achieve the expected level of development across a range of personal, social, emotional, physical, communication, language, mathematics, and literacy measures.

Oxfordshire has seen a significant improvement in EYFS levels of development since 2012/13, and is now in line with the national average of 66.3%. However, the 2013/14 figure remained below the regional average of 70.1%.

Girls in Oxfordshire continue to outperform boys at EYFS: 74.6% of girls achieved a good level of development against 58.4% of boys a gap of 16.2%. This gap is larger than both the national and the regional averages (15.6% and 15.5% respectively).

Children with free school meal status are less likely to be achieving a good level of development at the end of reception. In 2014/15, fewer than half of these children in Oxfordshire were achieving a good level of development (45%). Although this figure has been improving over the past two years, it remains below the national and regional averages (51% and 53%, respectively).

4.3.2. Pupil Attainment at Key Stage 2 (Year 6)

Pupils are assessed at the end of Key Stage 2, which runs from Year 3 to Year 6. The key performance measure is the percentage of pupils achieving level 4 or above in reading, writing and maths.

In 2015 over four in five pupils in Oxfordshire schools (81%) achieved level 4 or above in reading, writing and maths.[121] This compares with an England average of 80%.

Across the county two districts – Vale of White Horse and South Oxfordshire – were in the top 25% of districts nationally in 2015, for the proportion of pupils achieving level 4 or above in reading, writing and maths. This compares with one district (West Oxfordshire) in 2014, and four Oxfordshire districts in 2013. The performance of pupils in Oxford has increased by four percentage points in 2015 but Oxford continues to rank in the bottom 25% of districts nationally.

For all subjects, at least 90% of pupils in Oxfordshire made the expected progress (equivalent to two levels) between Key Stage 1 and Key Stage 2.

61% of pupils known to be eligible for free school meals in Oxfordshire achieved level 4 or above in reading, writing and maths. This was 22 percentage points lower than the figure for all other pupils (83%). The attainment gap remains larger than the national average (which was 17 percentage points in 2015).

4.3.3. Pupil Attainment at Key Stage 4 (GCSE)

The key performance measure at Key Stage 4 is the percentage of pupils achieving five or more A*-C grades at GCSE, including English and maths. The way in which performance is

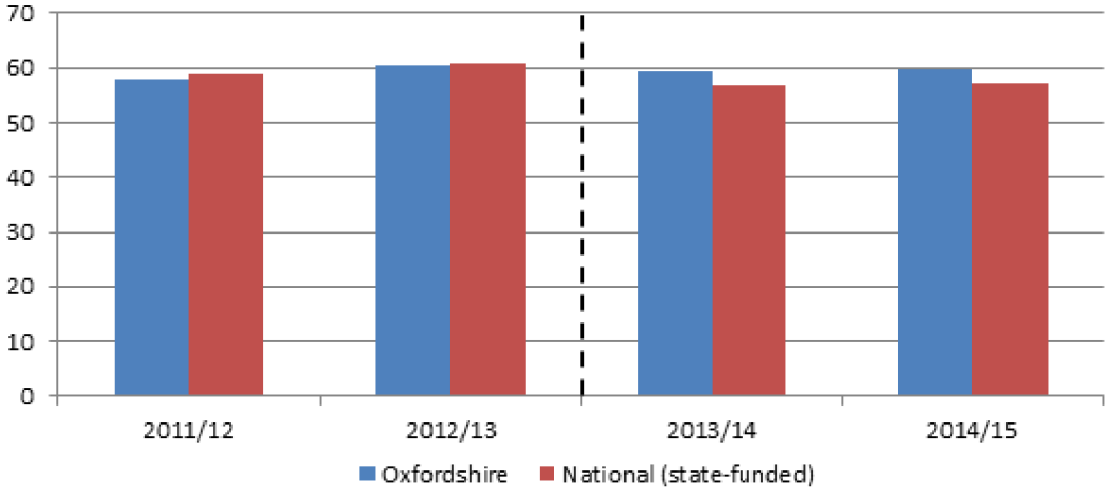
[120] Department for Education statistics on early years foundation stage profile assessments: https://www.gov.uk/government/collections/statistics-early-years-foundation-stage-profile; Public Health England Children and Young People's Health Benchmarking Tool: http://fingertips.phe.org.uk/profile/cyphof

[121] Department for Education National Curriculum Assessments Key Stage 2: 2015 (revised), published December 2015: https://www.gov.uk/government/statistics/national-curriculum-assessments-at-key-stage-2-2015-revised

reported changed in 2014 and is now based on First Entry (i.e. the first time a pupil sits an exam), rather than Best Entry (which can include resits).

In 2015 59.7% of pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE, including English and maths.[122] This was above the England average of 57.3%.

Figure 51: Percentage of pupils attaining five or more A*-C grades at GCSE, including English and maths



The way in which performance is reported changed in 2014 and is now based on First Entry rather than Best Entry. For this reason previous years' results cannot be directly compared.

Source: Department for Education

Two districts ranked in the top quartile nationally for their schools' GCSE results (Vale of White Horse and South Oxfordshire) whilst West Oxfordshire ranked in the second quartile. Cherwell and Oxford City ranked in the third quartile, meaning that Oxford City schools remained out of the bottom quartile for a second year. Oxford City recorded the greatest percentage point increase in pupils achieving 5 or more A*-C grades including English and maths out of all the county districts.

In 2015 the proportion of pupils at schools in Oxfordshire making the expected progress in English and maths (of three whole levels between Key Stages 2 and 4) was higher than the national average. NB Around 25% of maintained schools boycotted key stage 2 tests in 2010. Where pupils have missing test results due to the 2010 boycott, teacher assessments have been used as their prior attainment level to calculate progress.

Pupils known to be eligible for free school meals in Oxfordshire schools were 31 percentage points less likely to achieve five or more A*-C grades at GCSE, including English and maths, than those who were ineligible. This gap has narrowed by 3 percentage points compared to 2014 but remains wider than the national average (28 percentage points).

4.3.4. Qualifications

At the time of the 2011 Census, 35.7% of people over 16 in Oxfordshire had at least a bachelor's degree (census category level 4 and above). This was up from 27.7% in 2001. The proportion was higher than in the South East (29.9%) and England overall (27.4%). 16.7% of Oxfordshire's population lacked any qualification (down from 18.6% per cent in 2001). This was below the proportions seen in the South East (19.1%) and England (22.5%).

[122] Department for Education Statistical First Release - GCSE and equivalent results, including pupil characteristics 2014-2015 published Jan 2016: https://www.gov.uk/government/collections/statistics-gcses-key-stage-4

Across the county, Oxford contained the highest proportion of people with at least a bachelor's degree (42.6%) and the lowest proportion of people with no qualification (13.6%). There were proportionately more people in Cherwell with no qualification (19.7%) than the county average (16.7%). However, this was still below the proportion seen in England overall (22.5%).

You can explore the data using the interactive qualification dashboards on the Oxfordshire Insight website.

4.3.5. Education and Deprivation

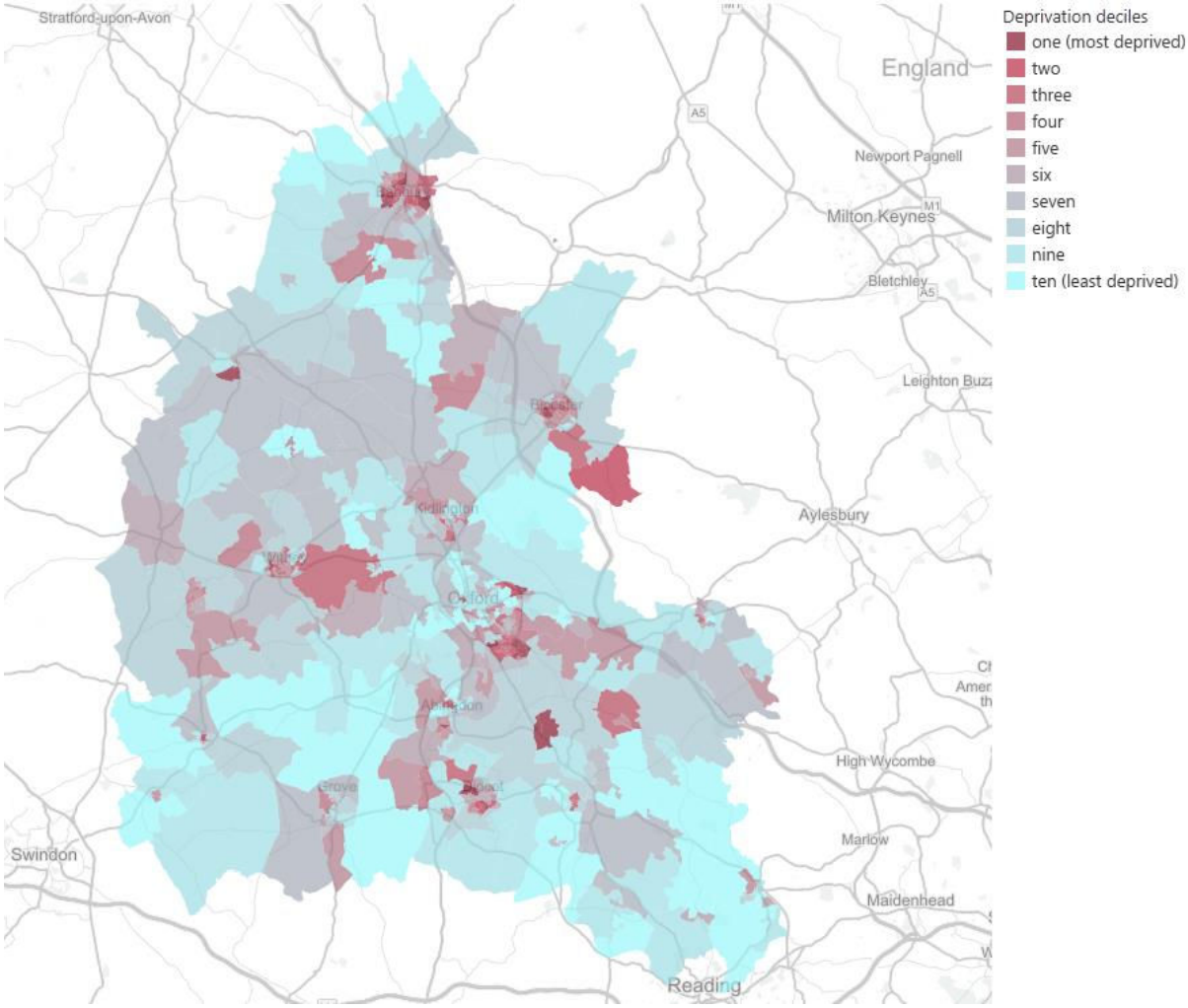
An index of deprivation relating to education, skills and training was published as part of the English Indices of Deprivation 2015.[123] This index covers two sub-domains relating to children's and young people's attainment, on one hand, and adult skills and qualifications on the other.

Oxfordshire has relatively low levels of education deprivation: it is the 34th *least* deprived of 152 upper tier local authorities in England. Most of the 407 small areas in Oxfordshire are *less* deprived than the national average. 69 are in the 20% *least* deprived nationally.

However, 25 small areas are in the 10% most deprived in terms of education and a further 15 are in the 10-20% most deprived. These areas are scattered around different parts of the county, as shown in the map below.

[123] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 52: Map of education, skills and training deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

Separate national research shows that children in care or in need, perform relatively poorly in terms of educational outcomes, with the gap widening through each key stage.[124]

4.3.6. Young People Not in Education, Employment or Training

As of the end of 2014 there were estimated to be just under 700 Oxfordshire residents aged 16-18 who were not in education, employment or training (and were therefore classified as 'NEET').[125] NEETs made up around 3.7% of all 16-18 year olds in the county. This figure has fallen from 4.8% at the end of 2013 and 6.6% at the end of 2012. The Oxfordshire rate remains below the average rate for England as a whole (4.7%).

4.4. Work and Earnings

Correlations have been found between being in good quality employment and better health; conversely, unemployment is linked to poorer health.[126]

[124] The Educational Progress of Looked After Children in England: Linking Care and Educational Data: http://reescentre.education.ox.ac.uk/wordpress/wp-content/uploads/2015/11/EducationalProgressLookedAfterChildrenOverviewReport_Nov2015.pdf

[125] Young people NEET: comparative data scorecard (Department for Education, July 2015 release): https://www.gov.uk/government/publications/young-people-neet-comparative-data-scorecard#history

[126] *Fair Society, Healthy Lives: The Marmot Review:* http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/Marmot/MarmotIndicators2014.aspx

4.4.1. Economic Activity

In the financial year 2014/15 there were an estimated 360,900 economically active people in Oxfordshire.[127] This was equivalent to 80.1% of people aged 16-64, a rate which has remained fairly stable over the last ten years. The economic activity rate in Oxfordshire was similar to that for the South East (80%) and England (77.6%). It was higher among men (84.6%) than women (75.8%).

4.4.2. Employment

In the financial year 2014/15 an estimated 77.4% of Oxfordshire residents aged 16-64 were in employment (67.3% were employees; 9.8% were self-employed).[128] This proportion has also remained fairly stable over the last ten years. The proportion employed was similar to the South East average (76.3%) but higher than that for England overall (72.9%).

Employment rates remain similar across different parts of the county.

4.4.3. Unemployment

Over the same period, an estimated 11,800 people in Oxfordshire were unemployed. This is equivalent to 3.5% of economically active residents aged 16-64, similar to the 2013/14 figure (3.4%), following a fall from a nine-year high of 6.8% in 2012/13.[129] As a proportion of the total economically active population aged 16 and over, the unemployment rate was 3.3%. Oxfordshire's unemployment rates were not statistically different from those for the South East but remained below those for England overall.

Unemployment rates are difficult to compare at district level, due to the small numbers of survey respondents from each area.

Experimental statistics show that in December 2015 there were 2,490 people aged 16 and over in Oxfordshire who were out of work and were either claiming Jobseeker's Allowance or were claiming Universal Credit.[130] (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.)

Fewer than one in one hundred (0.6% of) people aged 16-64 in Oxfordshire were out of work and claiming Jobseekers Allowance or Universal Credit. The rate among men was 0.7%; among women it was 0.4%.

The figure below shows trends in the claimant count (for both men and women combined) in Oxfordshire, compared with England, the South East, and individual districts. The time series begins in November 2013, as Universal Credit claimants were counted differently, or not at all, prior to that date. Over the past two years, both the number and proportion of claimants has fallen, and has remained stable at the current level since mid-2015.

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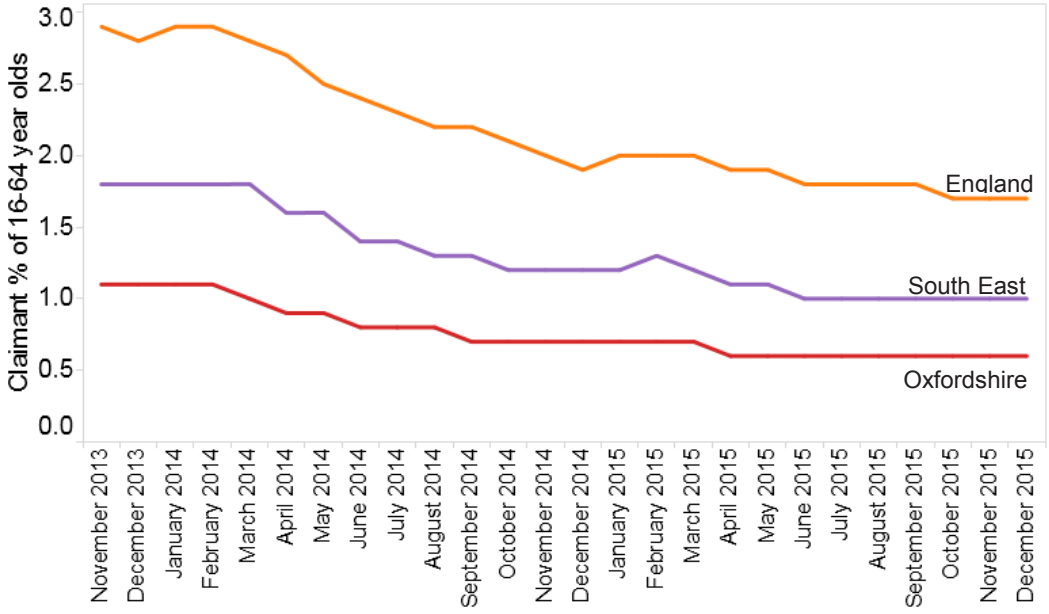
[127] Official labour market statistics: https://www.nomisweb.co.uk.

[128] Those counted as being in employment include people who did some paid work in the survey reference week (whether as an employee or self-employed); those who had a job that they were temporarily away from (e.g. on holiday); those on government-supported training and employment programmes; and those doing unpaid family work. Of the 19.9% of 16-64 year olds who were not economically active, over a third were studying (35.1%) and over a quarter were looking after the family or home (27.4%). Smaller numbers were retired (15%) and long-term sick (14.2%).

[129] Those counted as being unemployed include people without a job who were available to start work in the two weeks following their interview and who had either looked for work in the four weeks prior to interview or were waiting to start a job they had already obtained.

[130] Official Claimant Count data, downloaded from Nomis: https://www.nomisweb.co.uk/

Figure 53: Claimant count, 2013-2015



Source: Nomis

You can explore the data using the interactive unemployment dashboards on the Oxfordshire Insight website. More data on workless households is included in the November 2015 edition of the Oxfordshire Insight newsletter.

4.4.4. Employment Deprivation

An index of employment deprivation was published as part of the English Indices of Deprivation 2015.[131] This index measures the proportion of the working age population in an area who would like to work but are unable to do so.

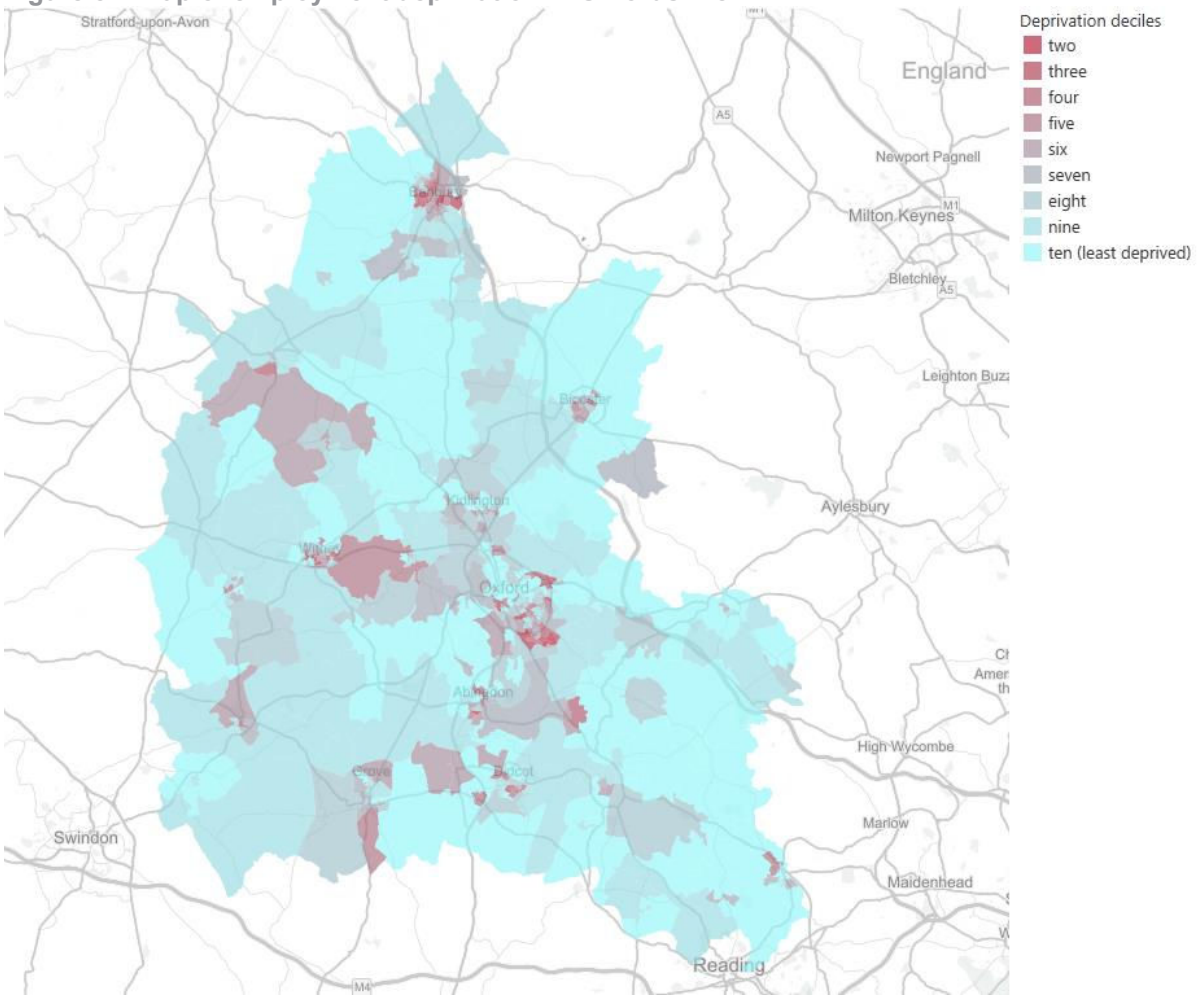
Oxfordshire has relatively low levels of employment deprivation: it is the 9th *least* deprived of 152 upper tier local authorities in England. Most of the 407 small areas in Oxfordshire are *less* deprived than the national average. 224 are in the 20% *least* deprived nationally.

However, 7 small areas in parts of Oxford City, Banbury, and Abingdon are in the 10% most deprived in terms of employment. A further 17 areas are in the 10-20% most deprived and are concentrated in parts of Oxford City, Banbury, and Witney.

The map below shows the pattern of employment deprivation across Oxfordshire.

[131] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 54: Map of employment deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

4.4.5. Earnings

The Annual Survey of Hours and Earnings (ASHE) is the most comprehensive source of data on earnings in the UK.[132] ASHE is based on a 1% sample of employee jobs taken from HM Revenue & Customs (HMRC) PAYE records. It does not cover the self-employed, nor does it cover employees not paid during the reference period.

The ONS's preferred measure of average earnings is median pay, representing the value below which 50% of people fall.[133] In 2014 the median gross full-time pay of Oxfordshire's residents was estimated at £579 per week (or £30,200 per year).[134] The provisional figure for 2015 was £578 per week (or £30,100 per year). Average earnings in the county have remained fairly stable over the past six years.[135]

[132] Annual Survey of Hours and Earnings: http://www.ons.gov.uk/ons/guide-method/method-quality/specific/labour-market/annual-survey-of-hours-and-earnings/index.html

[133] The median is preferred to the mean because it is less affected by a relatively small number of very high earners and the skewed distribution of earnings. It therefore gives a better indication of typical pay than the mean.

[134] ASHE data downloaded from NOMIS: https://www.nomisweb.co.uk/default.asp. Gross pay means pay before tax.

[135] Although there is a 3.6% difference between estimates of average earnings in 2013 and 2014, the confidence intervals either side of these figures mean that the difference is not statistically significant.

In 2014 a quarter of people working full time in Oxfordshire were estimated to be earning more than £796 per week, with the top 10% earning more than £1,105. In contrast, another quarter earned less than £422 per week, and the bottom 10% earned less than £329.

Comparing across sexes, male full time employees resident in Oxfordshire earned an average of £606 per week in 2014; female employees earned £514. This remains a statistically significant difference, in line with the national pattern.

Overall, average earnings of Oxfordshire residents are higher than the national average but similar to the rest of the South East. There are no significant differences at district-level.

You can explore the data using the interactive earnings dashboard on the Oxfordshire Insight website.

4.4.6. Workplace Health and Wellbeing

Between 2010 and 2012, an average of 1.7% of working days were lost due to sickness absence in Oxfordshire.[136] This was the same as the 2009-2011 level. The proportion was similar to that across England (1.6%) and the South East (1.5%) and did not vary significantly across the county.

At a UK level, nearly a third of sickness absence in 2013 was due to minor illnesses (30%) whilst a fifth was due to musculoskeletal problems (20%).[137] The next most significant reasons for sickness absence included stress, depression and anxiety (8%) and gastrointestinal problems (7%).

Working hours lost due to sickness absence were proportionately higher among women (2.6%) than men (1.6%). Relatively more working hours were lost among older than younger age groups: 2.8% of working hours were lost among the 50-64 age group; 2.3% among those aged 65 and over; and 2% among the 35-49 age group. This compares with 1.2% and 1.5% among the 16-24 and 25-34 age groups, respectively.

4.5. Crime

4.5.1. Crime Deprivation

An index of crime deprivation was published as part of the English Indices of Deprivation 2015.[138] This index measures the risk of violence, burglary, theft, and criminal damage.

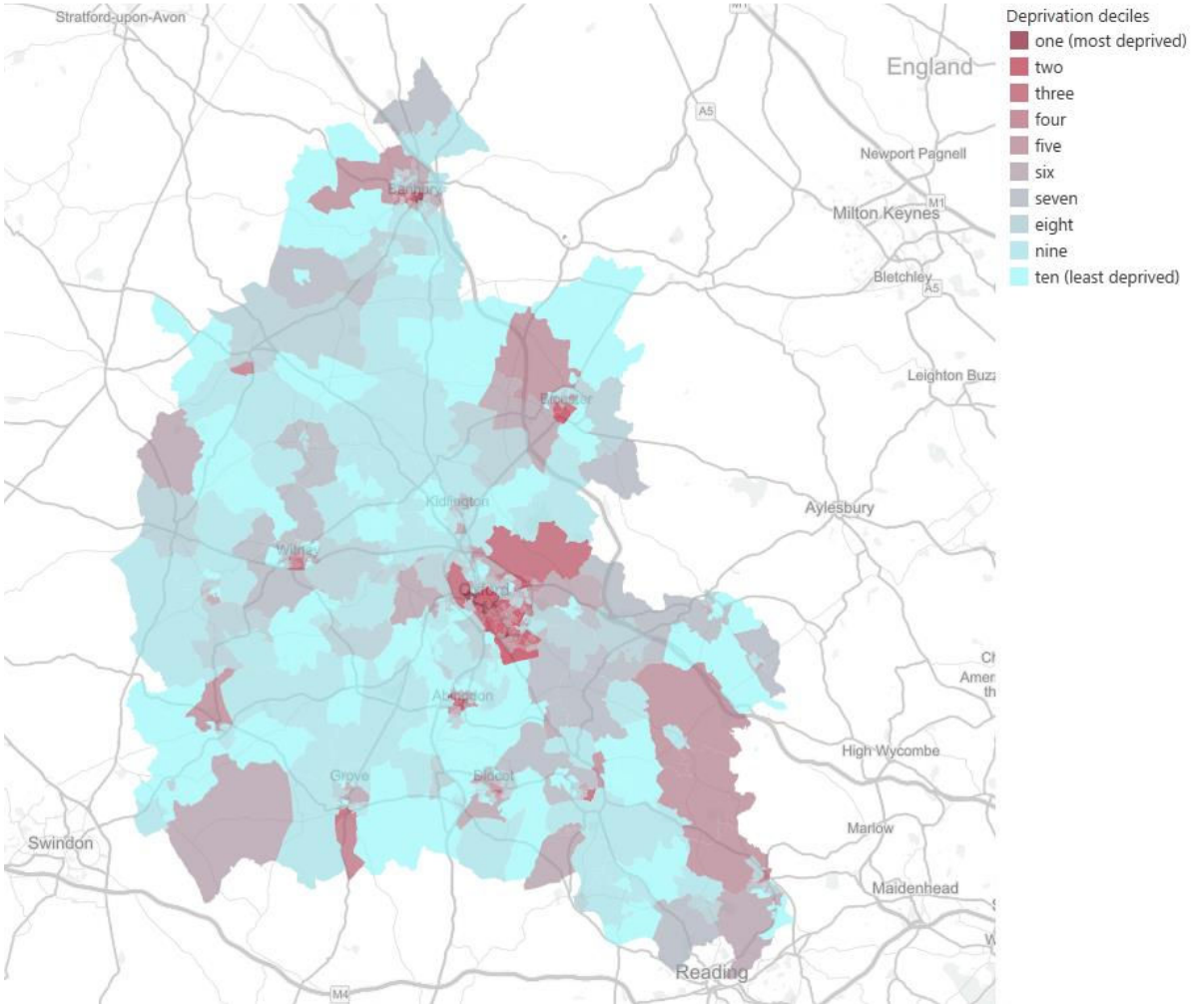
Oxfordshire has relatively low levels of crime deprivation: it is the 16th *least* deprived of 152 upper tier local authorities in England. Most of the 407 small areas in Oxfordshire are *less* deprived than the national average. 167 are in the 20% *least* deprived nationally.

However, 7 small areas in parts of Oxford City and Banbury are among the 10% most deprived in terms of crime. A further 19 areas are in the 10-20% most deprived and are located in parts of Oxford City, Banbury, Bicester, Abingdon, and Didcot.

The map below shows the pattern of crime deprivation across Oxfordshire.

[136] Public Health Outcomes Framework, indicator 1.09ii: http://www.phoutcomes.info/
[137] ONS Sickness Absence in the Labour Market data: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-351500
[138] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 55: Map of crime deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

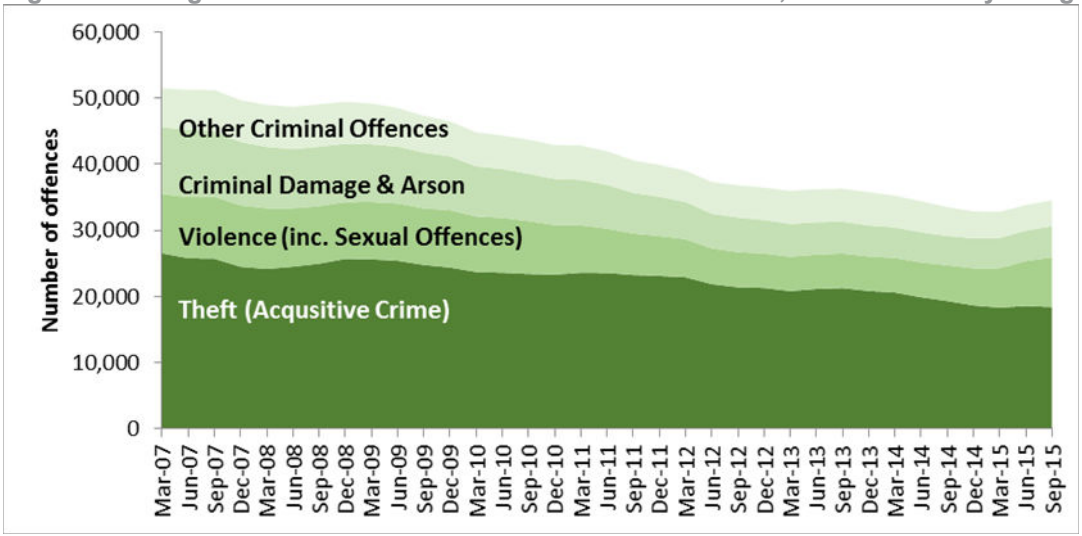
4.5.2. Crime Trends

In the 12 months to 30 September 2015 the police recorded 34,556 crimes in Oxfordshire.[139] This represents an increase of 3.1% (1,032 crimes) compared with the previous 12 months. This has been driven in large part by a nationwide improvement in police forces' compliance with national recording standards for violent and sexual offences.

Over the longer term, recorded crime in Oxfordshire has fallen by a third (33%) between (the 12 months to) September 2007 and (the 12 months to) September 2015. Over the last four years, it has fallen by 6%.

[139] ONS Police Recorded Crime Statistics (January 2016 release): http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime

Figure 56: Long-term trends in recorded crime in Oxfordshire, broken down by category



Source: Office for National Statistics Crime Statistics

More detailed crime data are available from the Oxfordshire Safer Communities Partnership's Strategic Intelligence Assessment.

4.6. Abuse and Exploitation

4.6.1. Domestic Violence and Abuse

The cross-government definition of domestic violence and abuse is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

This definition (which is not a legal definition) includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and it is clear that victims are not confined to one gender or ethnic group.

During the 2015 calendar year, Thames Valley Police recorded 3,161 domestic abuse crimes in Oxfordshire, although a minority of these crimes will involve individuals who are aged under 16 or are unknown to one another, and therefore fail to meet the national definition.[140] This number has increased in each of the last two years, which is likely to reflect improved reporting rates.

In the same year, the police recorded 8,516 domestic abuse incidents that were non crime occurrences, although again a minority of these incidents will involve individuals who are aged under 16 or are unknown to one another, and therefore fail to meet the national definition. Similarly to domestic abuse crimes, the number of non crime occurrences has increased in each of the two years since 2013.

[140] Data in this subsection are from the Thames Valley Police Summary of Notifiable Offences (downloaded in January 2016): http://www.thamesvalley.police.uk/aboutus/aboutus-operf/aboutus-operf-figs.htm. Due to recording issues, these data are thought to provide a better picture of domestic abuse than the data on incidents known to meet the national definition.

More detailed data on domestic violence and abuse in Oxfordshire are available from the Oxfordshire Safer Communities Partnership's Strategic Intelligence Assessment.

Research across the EU Member States shows that women in the UK are more likely than average to report experiencing physical and/ or sexual violence (44% of UK women compared with an EU average of 33%).[141] Women in the UK were also more likely to say they had experienced physical, sexual or psychological violence before the age of 15 (40% compared with and EU average of 35%). These data are only available at national level, so it is not possible to establish what the local picture looks like.

A recent report published by Public Health England highlights the heightened risk of domestic abuse among people with a disability, particularly women.[142]

4.6.2. Female Genital Mutilation

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Procedures are mostly carried out on young girls sometime between infancy and age 15, and occasionally on adult women. The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among some migrants from these areas.[143] FGM is illegal in the UK and violates treaty provisions in the Universal Declaration of Human Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination Against Women.

Research commissioned by the UK Home Office estimated that at the time of the 2011 Census up to 60,000 girls had been born in England and Wales to mothers who had undergone FGM. [144] The study estimated that approximately 103,000 women and girls aged between 15 and 49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales may already be living with the consequences of undergoing the practice. In addition, approximately 10,000 girls under 15 who have migrated to England and Wales are likely to have undergone FGM. However, the true extent is unknown due to the 'hidden' nature of FGM.

Experimental statistics published by the Health and Social Care Information Centre indicate that in the first quarter of the 2015/16 financial year there were over 1,000 newly recorded cases of FGM in England (note that these are not new *incidents* of FGM but newly recorded *observations*).[145] In the second quarter, there were a further 1,385 newly recorded cases (155 of which were in the South of England). However, no figure is available for the total number of people who may have been affected by FGM.

[141] European Agency for Fundamental Rights Violence against women survey (March 2014): http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-results-glance
[142] Disability and domestic abuse: Risk, impacts and response (Public Health England, November 2015): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf
[143] Health and Social Care Information Centre Female Genital Mutilation Dataset: http://www.hscic.gov.uk/fgm
[144] Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk; Interim report on provisional estimates, Equality Now and City University, July 2014: www.city.ac.uk/__data/assets/pdf_file/0009/226287/FGM-statistics-report-21.07.14-no-embargo. pdf
[145] Health and Social Care Information Centre Female Genital Mutilation Dataset: http://www.hscic.gov.uk/fgm

4.6.3. Forced Marriage

In 2014 the UK Forced Marriage Unit gave advice or support related to a possible forced marriage in 1,267 cases nationwide. [146] This was down from 1,302 in 2013 and 1,485 in 2012. 10.8% of the cases were in the South East, compared with 11% in 2012.

4.6.4. Child Sexual Exploitation

Child sexual exploitation (CSE) is when people use the power they have over children to groom, coerce and exploit them into participating in sexual activity.[147]

CSE is a form of child sexual abuse. Victims of CSE can experience severe and enduring consequences on their physical and mental health. The prevalence of CSE has been an emerging national issue of concern over recent years. As knowledge and understanding of the issue grows, there is increasing awareness of the different models of abuse and the growing risk to children through on-line grooming and abuse; this includes pressurising children to send indecent images, which are then used to threaten or blackmail the child or are sold on to paedophiles.

Both boys and girls are known to be victims of abuse through sexual exploitation and boys remain harder to identify, although there is growing understanding of the ways in which boys are groomed.

Perpetrators of CSE are mainly male but females are also known to be involved. Perpetrators include older adults and similar age peers, and they groom children on-line, on the streets, at 'parties', and in other face-to-face situations. Perpetrators act alone, in groups and in gangs. Like their victims, they come from all sectors of the community.

Since 2011, when Operation Bullfinch commenced, there have been a number of successful convictions across Oxfordshire and there are a number of active investigations into both recent and non-recent (historic) abuse.

Since its inception in November 2012 the multi-agency CSE specialist Kingfisher team has worked with 299 children at risk of sexual exploitation. The majority of these were aged between 13 and 17 years.

Risk factors linked to the risk of CSE include children going missing from home, from care and from school, children with a history of abuse and children in care. During the first half of 2015, there were 203 reports of missing children in Oxfordshire, with 29% of those going missing on more than two occasions. The numbers of children going missing have reduced significantly in the last twelve months but more of those children are missing more often.

The Oxfordshire Safeguarding Children Board (OSCB) has a CSE strategy and action plan which is managed through a dedicated CSE sub-group with wide partnership representation. The subgroup monitors missing children and the prevalence of CSE across the county.

In 2015 the OSCB undertook a CSE Stocktake and a Learning Review, both of which are published on the website (www.oscb.org.uk).

[146] Forced marriage Unit Statistics: https://www.gov.uk/forced-marriage

[147] A full definition is available in Safeguarding Children and Young People from Sexual Exploitation (Department for Children, Schools and Families, 2009): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278849/Safeguarding_Children_and_Young_People_from_Sexual_Exploitation.pdf

4.6.5. Human Trafficking

At national level, in 2014 the UK National Referral Mechanism received 2,340 referrals of potential victims of trafficking; this represented a 34% increase on 2013 referrals, which in turn was a 49% increase on 2012 referral totals.[148]

More detailed data on human trafficking and modern slavery are available from the Oxfordshire Safer Communities Partnership's Strategic Intelligence Assessment.

4.7. Troubled Families

Oxfordshire's Troubled Families programme supports families identified as being among the most in need of help. This is based on national and local criteria relating to:

- Poor school attendance and behaviour
- Anti-social and criminal behaviour
- Offending
- Domestic violence
- Children being subject to a child in need plan or a child protection plan
- A family member being in a treatment plan for drug or alcohol dependence
- Adults out of work
- Young people not being in education, employment or training

As of the end of January 2016, 424 troubled families had been identified in Oxfordshire, and were being worked with to improve outcomes across employment, education, offending and anti-social behaviour, children's social care, and public health.[149]

4.8. Environmental Quality

4.8.1. Outdoor Environment

An index of deprivation in relation to outdoor environments was published as a sub-domain of the English Indices of Deprivation 2015.[150] This index includes indicators on air quality and road traffic accidents.

In terms of the outdoor environment, the majority of Oxfordshire's 407 small areas (technically known as lower layer super output areas, or LSOAs) are *less* deprived than the national average. 178 are in the 20% *least* deprived of 32,844 small areas in England.

However, 8 of Oxfordshire's small areas are among the 10% *most* deprived nationally. A further 39 small areas are in the 10-20% *most* deprived nationally. These areas are concentrated in Oxford City.

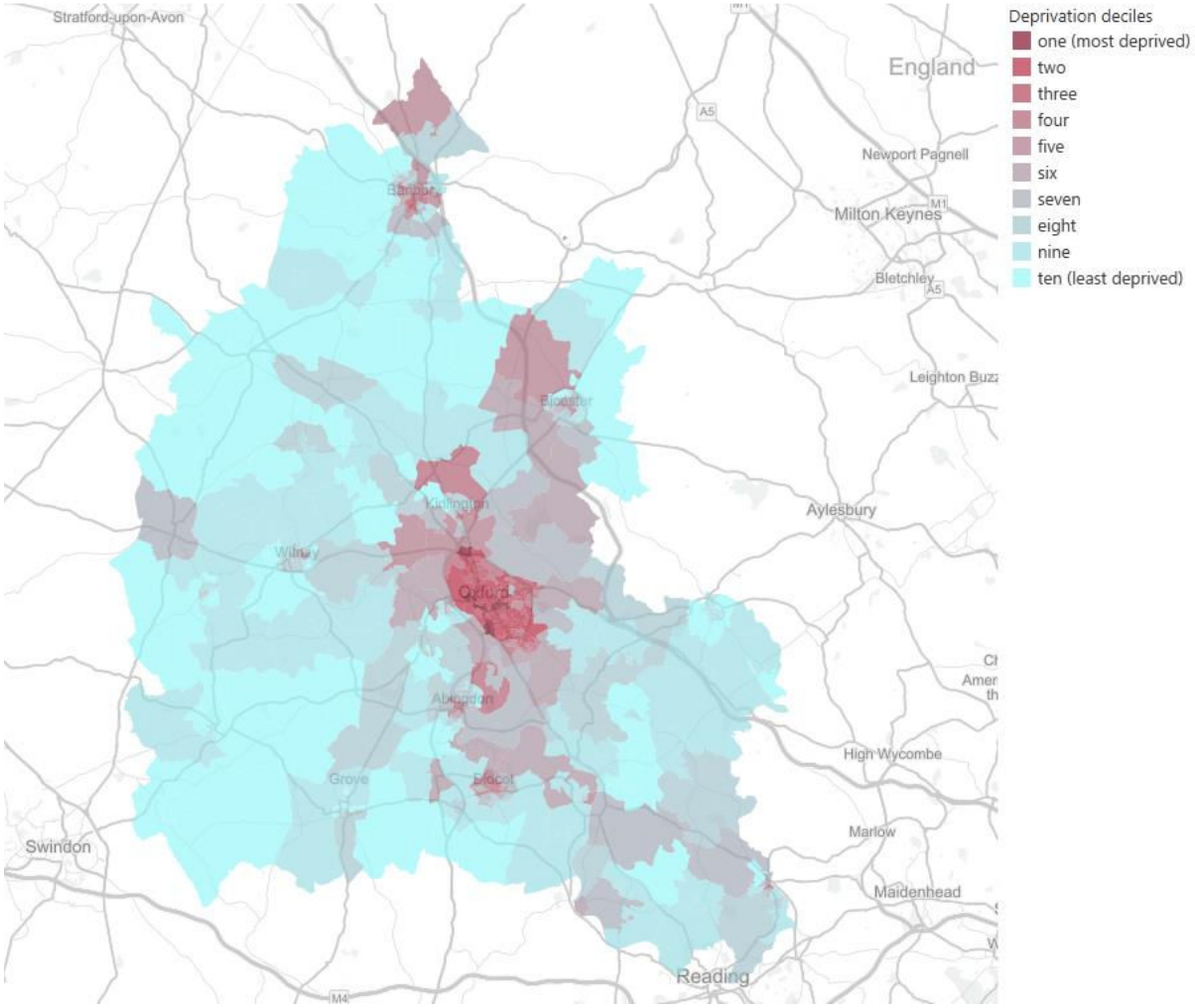
The map below shows the pattern of living environment deprivation in Oxfordshire.

[148] National referral mechanism statistics: http://www.nationalcrimeagency.gov.uk/publications/national-referral-mechanism-statistics

[149] Data provided by Oxfordshire County Council Joint Commissioning Team. As of the end of October 2015, 13 of these families had achieved 'Continuous Employment', based on their achievement of national employment, education, offending and anti-social behaviour outcomes.

[150] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 57: Map of outdoor environment deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

4.8.2. Air Quality

Poor air quality is known to have negative impacts on health.

Air Quality Monitoring and Management

Air quality across Oxfordshire is considered to be generally good as the county is largely rural in nature. In the more densely populated areas of the county, and those which experience high traffic flows, increased levels of air pollution are of concern. In these areas, road traffic is the most significant source of pollutant emissions.

Air quality is regularly monitored at many locations across Oxfordshire.[151] At some locations air quality is at levels where legal intervention is required by Local Authorities. Under the

[151] More information about monitoring is available through the Oxfordshire Air Quality website and District Council websites:

- Oxfordshire Air Quality http://www.oxfordshire.air-quality.info/
- Cherwell: http://www.cherwell.gov.uk/airqualitymanagement
- Oxford: http://www.oxford.gov.uk/PageRender/decEH/Air_Pollution_occw.htm
- South Oxfordshire: http://www.southoxon.gov.uk/services-and-advice/environment/air-quality
- Vale of White Horse: http://www.whitehorsedc.gov.uk/services-and-advice/environment/pollution/air-quality
- West Oxfordshire: https://www.westoxon.gov.uk/residents/environment/environmental-health/air-quality/

Environment Act 1995: where national air quality objectives are unlikely to be achieved, an Air Quality Management Area (AQMA) must be declared and an action plan produced. There are currently 13 AQMAs in Oxfordshire, where the annual mean objective for nitrogen dioxide is being exceeded (four in Cherwell, one covering the whole of Oxford, three in South Oxfordshire, three in Vale of White Horse and two in West Oxfordshire).[152]

Trends in air quality across some of Oxfordshire's long-standing AQMAs show signs of improvement, with reductions in concentrations of nitrogen dioxide over recent years. However, new AQMAs are still being identified.

Air Quality and Mortality Estimates

In 2010 the UK Committee on the Medical Effects of Air Pollutants estimated that removing all man-made, particulate matter air pollution could save the UK population approximately 36.5 million life years over the next 100 years, and would be associated with an increase in UK life expectancy from birth, of six months on average.[153]

In April 2014 Public Health England (PHE) produced a report estimating local mortality burdens associated with particulate air pollution which is helpful in raising awareness of air pollution on public health.[154] All-cause mortality data was used for the years 2008, 2009 and 2010. However there were uncertainties associated with the modelling process and this increased for local estimates of mortality. The calculated attributable proportion of deaths associated with air pollution, among those aged 25 and over in Oxfordshire, was 5.6% in 2010. However, given the uncertainties this could, in fact, be somewhere between 0.9% and 11%.

For 2013 it was estimated that 5.3% of all-cause mortality among people aged 30 and over in Oxfordshire was attributable to particulate air pollution from man-made sources.[155] This value has fluctuated between 5.1% and 5.6% over the years between 2010 and 2013 but it is not possible to tell whether or not changes are statistically significant. The national and regional averages in 2013 were 5.3% (England) and 5.2% (South East). Meanwhile, the proportion of mortality attributable to man-made air pollution in the districts ranged from 5% (in West Oxfordshire) to 5.6% (in Oxford) with the other three districts at 5.3%. Again, it should be noted that there remains considerable uncertainty around the figures.

The quantification of mortality burden associated with long term nitrogen dioxide concentration exposure is likely to be available during the first half of 2016.[156]

4.8.3. Use of Outdoor Space

For the period March 2013 – February 2014 it was estimated that 15.7% of people in Oxfordshire used outdoor space for exercise or health reasons.[157] This was down from

[152] Department for Environment, Food and Rural Affairs list of local authorities with AQMAs: http://uk-air.defra.gov.uk/aqma/list?view=W

[153] *The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom* (Committee on the Medical Effects of Air Pollutants, 2010): https://www.gov.uk/government/groups/committee-on-the-medical-effects-of-air-pollutants-comeap

[154] *Estimated Local Mortality Burdens associated with Particulate Air Pollution*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332854/PHE_CRCE_010.pdf

[155] Public Health Outcomes Framework, indicator 3.01: http://www.phoutcomes.info/.

[156] Committee on the Medical Effects of Air Pollutants (COMEAP) Interim Statement on Quantifying the Association of Long-Term Average Concentrations of Nitrogen Dioxide and Mortality (December 2015) https://www.gov.uk/government/publications/nitrogen-dioxide-interim-view-on-long-term-average-concentrations-and-mortality

[157] Public Health Outcomes Framework, indicator 1.16: http://www.phoutcomes.info/. Outdoor space is defined as open spaces in and around towns/ cities, including parks, canals and nature areas; the

19.4% in 2012/13 but similar to the 2011/12 level of 15.1%. Due to wide confidence levels, the proportion of people in Oxfordshire using outdoor space was not statistically different from that for the South East (18%) and England (17.1%).

Green spaces have been found to have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage.[158]

4.8.4. Noise

In 2011 Public Health England estimated that 3.4% of Oxfordshire's population was exposed to road, rail and air transport noise of 65 A-weighted decibels or more, during the daytime.[159]

At the same time, an estimated 5.4% of Oxfordshire's population was exposed to road, rail and air transport noise of 55 A-weighted decibels or more, during the nighttime.[160]

In 2013/14 the rate of complaints about noise in Oxfordshire was estimated at 5.3 per 1,000 people in the population.[161] This was similar to rates in the previous two years. It was also similar to the estimate for the South East (5.4) but lower than that for England overall (7.4). Across the county there were thought to be proportionately more complaints in Oxford (9 per 1,000 people in the population) than in other districts.

4.9. Isolation, and Loneliness

Various national and international research studies have linked social isolation and loneliness with adverse health outcomes, including higher mortality rates.[162] Meanwhile, social engagement has been found to be a driver of quality of life.[163]

A national survey of GPs in 2013 found that over a quarter saw one to five people per day who they thought had come in mainly because they were lonely.[164] One in ten reported seeing between six and ten lonely patients a day, and a small minority (4 per cent) said they saw more than 10 lonely people a day.

There is evidence to suggest that older people can be more susceptible to social isolation and loneliness and this is being covered in more detail in a forthcoming in-depth piece of analysis on the needs of older people in Oxfordshire.

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coast and beaches; and the countryside, including farmland, woodland, hills and rivers. This may be from a few minutes to all day. It does not include routine shopping trips or time spent in own garden.

[158] Public Health Outcomes Framework: http://www.phoutcomes.info/.

[159] Public Health Outcomes Framework, indicator 1.14ii: http://www.phoutcomes.info/.

[160] Public Health Outcomes Framework, indicator 1.14iii: http://www.phoutcomes.info/.

[161] Public Health Outcomes Framework, indicator 1.14i: http://www.phoutcomes.info/. This figure is a modelled or synthetic estimate.

[162] A useful summary of research is provided here: http://www.campaigntoendloneliness.org/threat-to-health/. See also: McGinnis JM, Williams-Russo P, Knickman JR. (2002). The case for more active policy attention to health promotion. Health Aff (Millwood): 21(2):78-93: http://content.healthaffairs.org/content/21/2/78.long#ref-15; Berkman, L.F., and Syme. S.L. (1979). "Social Networks, Host Resistance, and Mortality: A Nine-Year Follow-Up Study of Alameda County Residents." *American Journal of Epidemiology;* 109:186-204; Giles L. C., Glonek G. F. V., Luszcz M. A., Andrews G, R. (2005). Effect of social networks on 10 year survival in very old Australians: the Australian longitudinal study of aging. *J Epidemiol Community Health;* 59:574–579.

[163] See, for example: Bowling, A., Kennelly, C. (2003). Adding quality to quantity: older people's views on quality of life and its enhancement; and Helliwell, J. F. (Ed.) "Social Capital: Measurement and Consequences," in *The Contribution of Human and Social Capital to Sustained Economic Growth and Well-Being*.

[164] Lonely visits to GPs: http://www.campaigntoendloneliness.org/blog/lonely-visits-to-the-gp/

4.9.1. Social Contact

Social contact among carers and care users is discussed in sections 3.11: Carers and 7.7.1: Adult Social Care, respectively.

4.9.2. Living Alone

At the time of the 2011 Census over a quarter of households in Oxfordshire were one-person households (27.4%, numbering 70,800).[165] This was similar to the proportion in 2001 (27.1%).This was broadly similar to the proportions seen across the South East (28.8%) and England overall (30.2%). In Oxford around a third of households were composed of one person (33.1%) whereas the proportion was lower in other districts: 26.4% in Vale of White Horse and West Oxfordshire; 25.4% in South Oxfordshire; and 25.2% in Cherwell.

Based on current trends in people living alone, applied to Oxfordshire County Council's principal population projection, there could be around 91,500 people living alone in the county by 2024 (an increase of 29% on the 2011 number).[166]

In 2011 slightly more people aged 65 and over lived alone (28.8%, numbering 29,900). Again, this figure was broadly similar to proportions in the South East (30.4%) and England (31.5%). In Oxford proportionately more older people lived alone (36.4%) relative to the other districts: 27.6% in West Oxfordshire, 27.5% in Cherwell, 27.3% in Vale of White Horse and 26.9% in South Oxfordshire.

Based on current trends in people aged 65 and over living alone, applied to Oxfordshire County Council's principal population projection, there could be around 40,700 older people living alone in the county by 2024 (an increase of 36% on the 2011 number).

In 2011 a third of occupants of one-person households in Oxfordshire had a long-term health problem or disability (33.3%). This was slightly lower than the proportions seen in the South East (35.9%) and England overall (38.6%). The proportions were broadly similar across districts.

Among people aged 65 and over living alone in Oxfordshire, over half had a long-term health problem or disability (54.2%, numbering 16,200).[167] This was similar to the proportion seen in the South East (54.9%) and slightly below that for England overall (59.6%). Again, proportions were broadly similar across districts.

Although living alone does not necessarily imply loneliness, people who make the transition to living alone in later life (primarily due to the death of a cohabiting partner) have been found to be more vulnerable to psychological distress in the initial period thereafter.[168] Social support (discussed in the last subsection) has been shown to affect the extent to which people recover from the transition to living alone.

[165] Census 2011, table KS105EW and KS102EW; Census 2001, table T08: https://www.nomisweb.co.uk

[166] The projected figures are based on the 2011 Census ratio of numbers living alone to the number of households represented by a person who is single (never married, divorced, separated or widowed) but not necessarily living alone. The assumption is that this ratio stays constant over the projection period. Further details of Oxfordshire County Council's population projections are at Appendix A.

[167] Census 2011, table DC1301EW: https://www.nomisweb.co.uk

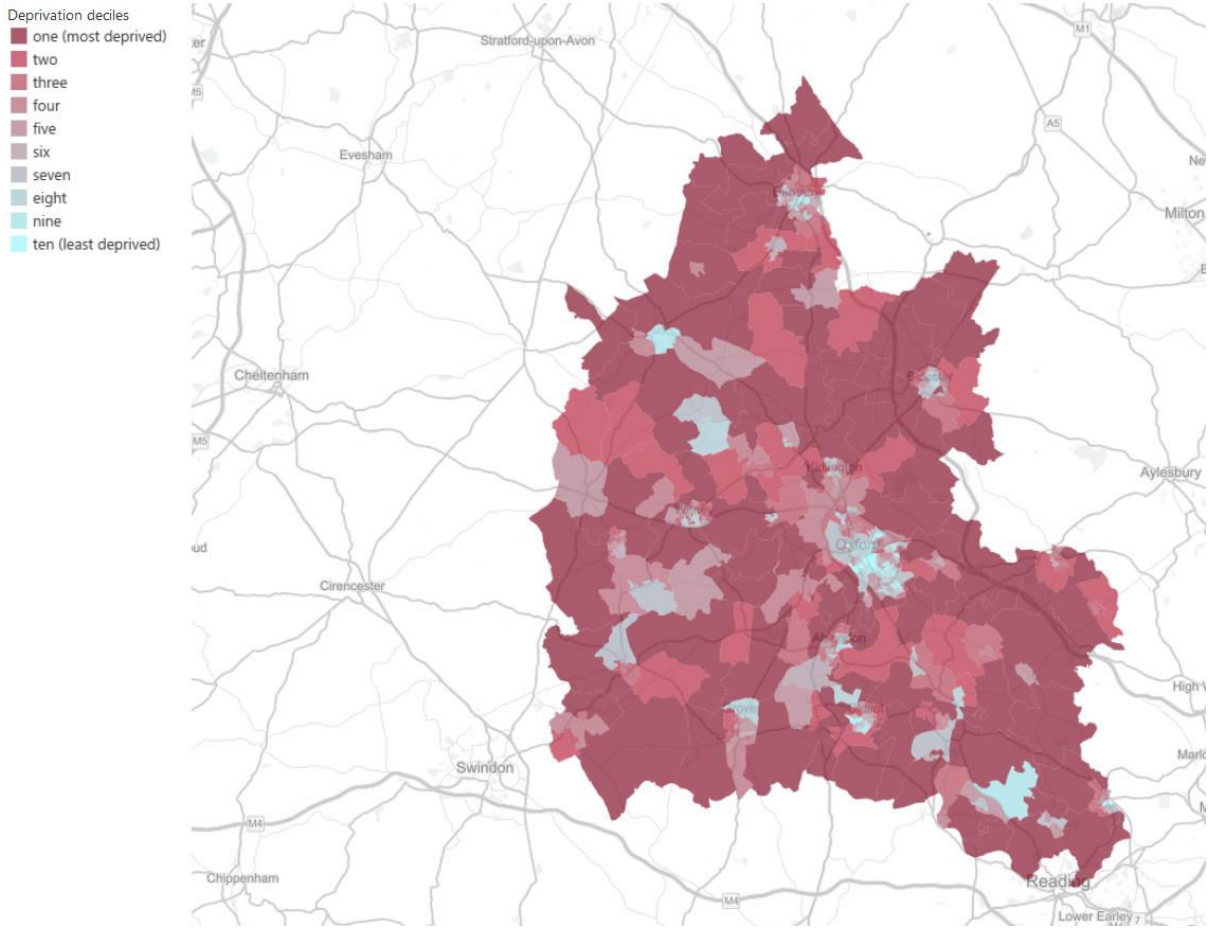
[168] Living alone in later life and its psychological impacts – the significance of the means of transition into living alone: http://ageing.oxfordjournals.org/content/42/3/366.full.pdf+html

4.9.3. Geographical Barriers

An index of geographical barriers was published as a sub-domain of the English Indices of Deprivation 2015.[169] This index is based on road distances to post offices, primary schools, GP surgeries, and general stores or supermarkets. It therefore relates to the degree of rurality, covered in section 3.9: Rural Population].

In terms of geographical barriers, the majority of Oxfordshire's 407 small areas (technically known as lower layer super output areas, or LSOAs) 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 map below shows the pattern of geographical barriers in Oxfordshire.

Figure 58: Map of Geographical Barriers in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

For more detailed analysis of geographical barriers, see the District Data Service chart of the month for December 2015.

[169] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

5. Morbidity and Mortality

This section covers the prevalence of illnesses and diseases in Oxfordshire (morbidity) and causes of deaths (mortality). Further resources are available online, by visiting the JSNA – Morbidity and Mortality webpage.

5.1. Health Deprivation and Disability

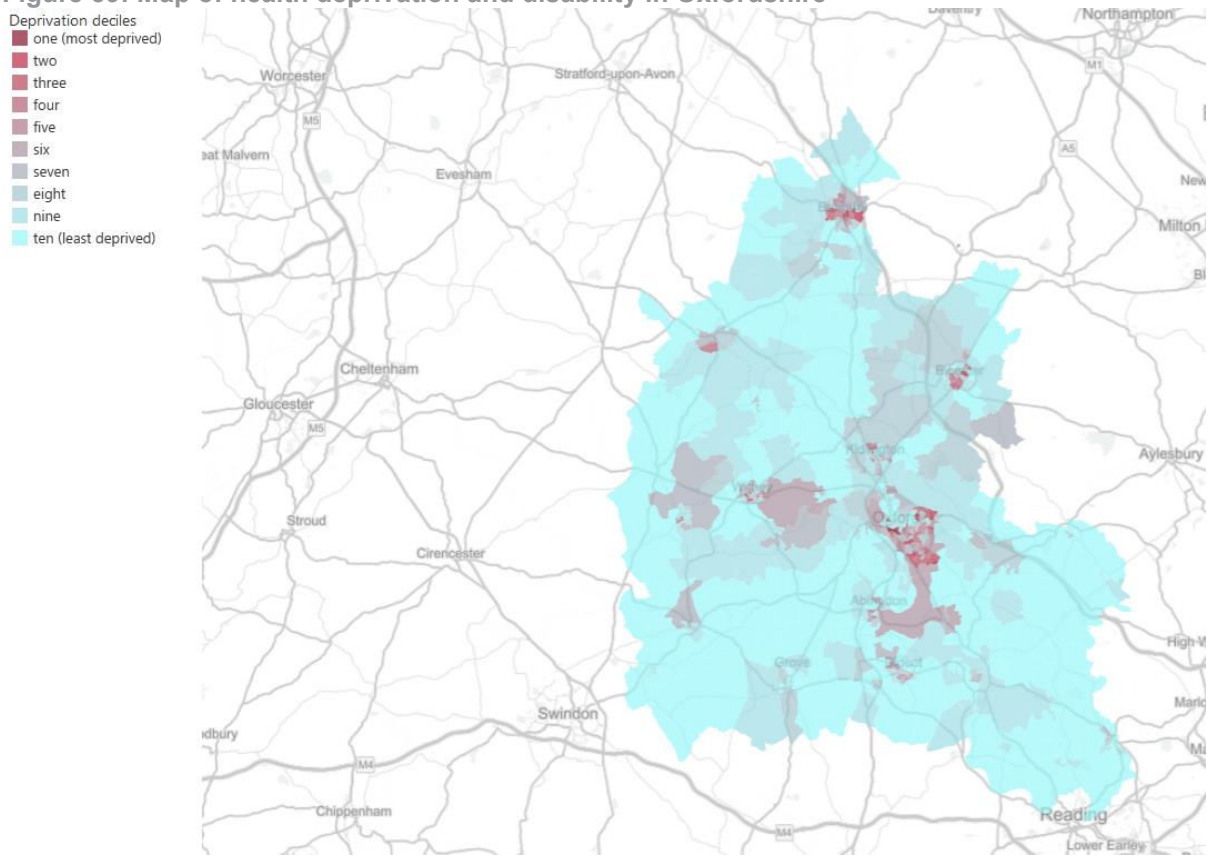
An index of health deprivation and disability was published as part of the English Indices of Deprivation 2015.[170] This combines indicators about premature death, illness, disability, and hospital use. Oxfordshire is the 16th *least* deprived upper tier local authority in terms of health and disability.

Most of Oxfordshire's 407 small areas (technically known as lower layer super output areas, or LSOAs) are *less* deprived in terms of health than the national average. 137 are in the 10% *least* deprived of 32,844 small areas in England. A further 88 are in the 10-20% *least* deprived.

However, two of Oxfordshire's small areas (in parts of Northfield Brook and Carfax wards in Oxford City) are in the 10% *most* deprived nationally. A further 12 small areas are in the 10-20% *most* deprived nationally. These are concentrated in parts of Banbury and Oxford City.

The map below shows the pattern of health deprivation in Oxfordshire.

Figure 59: Map of health deprivation and disability in Oxfordshire



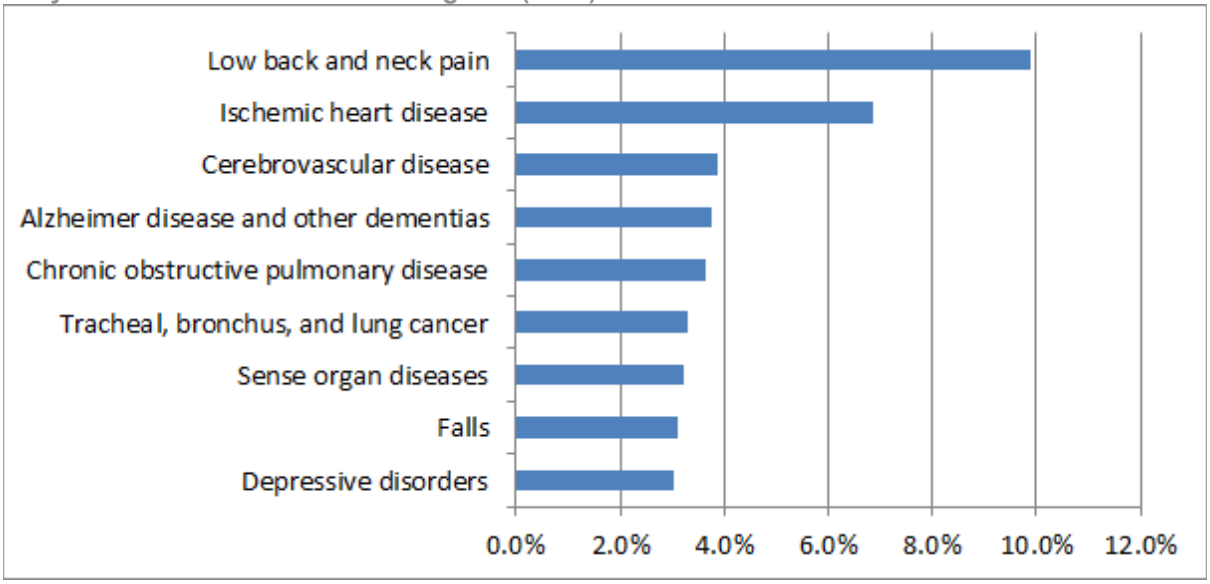
Source: DCLG English Indices of Deprivation 2015

[170] DCLG English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015. See section 4.1: Affluence and Deprivation for the overall map of deprivation in Oxfordshire.

5.2. Global Burden of Disease

Important new research into the 'global burden of disease' provides regional estimates of the contribution that individual health conditions make to the overall burden of ill health, disability, and early death.[171] The largest single contributory factors for the South East of England are shown in the figure below, with the estimated proportion of the burden they account for.

Figure 60: Largest single contributory factors to the overall burden of ill health, disability, and early death in the South East of England (2013)



Source: Institute for Health Metrics and Evaluation

Explore the global burden of disease data in more detail using the interactive tool produced by the Institute for Health Metrics and Evaluation.

5.3. Morbidity

This section includes estimates of the prevalence of several health conditions. These estimates are often based on the patient population of GP practices in the Oxfordshire Clinical Commissioning Group area. The quality of the data is dependent on diagnosis and recording within practices.

Where possible, prevalence rates are compared at GP practice level to give a snapshot of where in the county needs may be the greatest. It is important to remember that rates have not been standardised by age or sex, and will be affected by the underlying social and demographic characteristics of each practice's patient population. So, for example, prevalence of certain conditions may be higher among GP practices with high proportions of patients in older age groups.

[171] Newton, J. N. et al. (2015). Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet:* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2900195-6/abstract

Luther Street Medical Centre in Oxford is a specialist primary care health service for patients experiencing homelessness and vulnerable housing, serving 900 different patients per year since 1985. The service is provided in a building where patients can access a variety of healthcare services and professionals.

The health and care needs of patients include:

- Chronic alcohol use, often requiring detoxification services
- Substance abuse and misuse issues
- Mental health issues
- Healthcare needs relating to contraception, pregnancy, sexual health, and public health/ infectious disease
- Physical health needs

Over 70% of patients experience alcohol and drug abuse issues, as well as varying mental health diagnoses. The team often address complex healthcare needs within consultations, helping patients to access healthcare services.

More information is available on the Luther Street Medical Centre website.

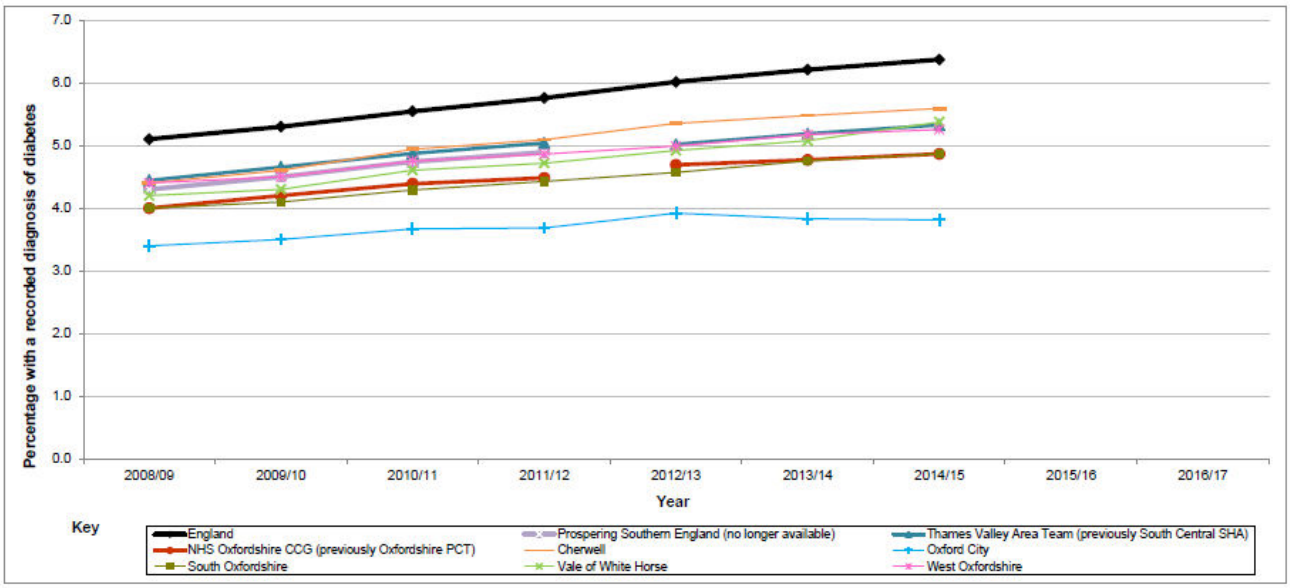
5.3.1. Diabetes

Diabetes mellitus is a lifelong condition that causes a person's blood sugar level to become too high. It is thought to affect 3.3 million people in the UK with a further 590,000 people likely to have the condition but not be aware of it.[172] The majority of these will have Type 2 diabetes, which occurs when the body doesn't produce enough insulin.

In 2014/15 there were around **28,100 GP-registered patients aged 17 and over** in the Oxfordshire Clinical Commissioning Group area who had a diabetes diagnosis.[173] This number has increased by 1,000 (or 3.7%) since 2013/14. The rate of diabetes prevalence has also increased slightly from 4.8% to 4.9% of patients aged 17 and over. However, it remains below the average rates for England (6.4%) and the South (5.8%).

[172] Diabetes UK: https://www.diabetes.org.uk/Guide-to-diabetes/What-is-diabetes/
[173] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887

Figure 61: Percentage of patients aged 17+ with a recorded diagnosis of diabetes in the GP registered population (2004/05-2014/15)[174]



Source: Quality and Outcomes Framework

The table below shows the 5 Oxfordshire GP practices with the highest rates of diabetes diagnosis.

Figure 62: Oxfordshire GP practices with the highest rates of diagnosed diabetes among patients aged 17 and over

Practice Name	Ward*	District*	Diagnosed diabetes rate
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	7.8%
Berinsfield Health Centre	Berinsfield	South Oxfordshire	7.8%
Windrush Surgery	Banbury Easington	Cherwell	7.1%
The Leys Health Centre	Northfield Brook	Oxford	6.8%
Gosford Hill Medical Centre	Yarnton, Gosford and Water Eaton	Cherwell	6.8%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

Raised blood glucose levels

There is a larger group of people who have raised blood glucose levels which, whilst not being in the diabetic range, increase the risk of developing Type 2 Diabetes. In 2015 it was estimated that around **58,300 people in Oxfordshire aged 16 and over** are in this situation, making up 10.7% of the adult population.[175] This compares with an average rate of 11.4% in England overall.

[174] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.

[175] NHS diabetes prevention programme: non-diabetic hyperglycaemia: https://www.gov.uk/government/publications/nhs-diabetes-prevention-programme-non-diabetic-hyperglycaemia

5.3.2. Cancer

Methodological Note
Cancer incidence rates are directly age-standardised using the European Standard Population (ESP). The ESP in use was introduced in 1976 and is an accepted methodological standard in health statistics in the UK and the rest of Europe. At the end of 2012 Eurostat decided to bring this population structure up to date. For both sexes, cancer incidence rates in 2012 were higher when calculated using the 2013 ESP compared with the 1976 ESP. The impact is smaller for female rates and the percentage increase varies by cancer site. The highest increases are found in bladder, stomach, colorectal, breast, and lung cancers. This methodological revision also affects some other age-standardised rates, such as mortality rates (see section 5.4: Mortality).

One in two people in the UK born after 1960 will be diagnosed with some form of cancer during their lifetime.[176] The risk of developing cancer up to the age of 50 years is 1 in 35 for men and 1 in 20 for women. National trends in cancer diagnosis and outcome show that the number of people diagnosed with cancer in England every year has more than doubled in the past 40 years.[177] This is likely to be due to population growth and ageing, as well as better diagnosis. Cancer survival rates have also been increasing over time.

The incidence of detected cancers has been increasing across all areas in people under the age of 75 but this now appears to be levelling off. The data shows that Oxfordshire has had a higher rate of incidence than the South East and England in both men and women, but more recent data shows that it is no longer significantly higher in men. The higher rate may in part be explained by better ascertainment (diagnosis of cancer) or the local population may be more aware of the signs and symptoms of cancer and seek medical advice early resulting in a prompt diagnosis.[178]

Together breast, lung, prostate and bowel cancers account for over half of all new cancers each year (both nationally and locally). Breast, lung and bowel cancer are covered in more detail in the next subsections.

In 2014/15 there were around **17,400 GP-registered patients** in the Oxfordshire Clinical Commissioning Group who had a cancer diagnosis.[179] This number has increased by around 1,400 (or 8%) since 2013/14. The rate of cancer prevalence also rose, from 2.3% to 2.5% of the patient population. This is slightly above the average rate for England (2.3%) but similar to that for the South (2.5%).

The table below shows the 5 Oxfordshire GP practices with the highest rates of cancer diagnosis.

[176] Cancer Research statistics: http://www.cancerresearchuk.org/health-professional/cancer-statistics
[177] ONS analysis of cancer data, July 2015: http://visual.ons.gov.uk/40-years-of-cancer/
[178] Health and Social Care Information Centre: http://www.hscic.gov.uk/
[179] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887

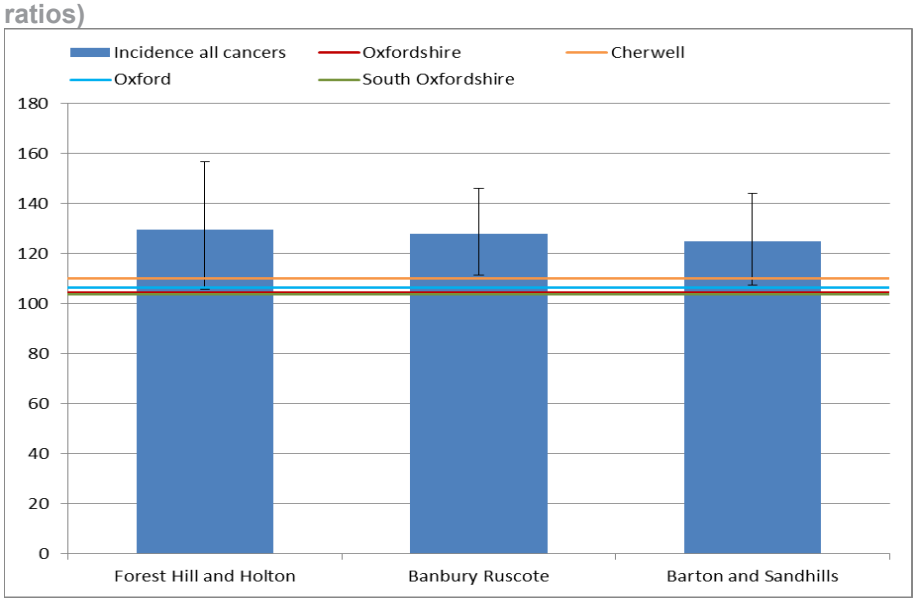
Figure 63: Oxfordshire GP practices with the highest rates of cancer diagnosis

Practice Name	Ward*	District*	Diagnosed Cancer rate
Nettlebed Surgery	Watlington	South Oxfordshire	4.0%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	3.9%
Eynsham Medical Group	Eynsham and Cassington	West Oxfordshire	3.8%
White House Surgery	Chipping Norton	West Oxfordshire	3.8%
Goring and Woodcote Medical Practice	Woodcote	South Oxfordshire	3.7%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

Pooled data for the years from 2007 to 2011 show that three wards in Oxfordshire had cancer incidence rates that are higher than their local district rate and the county average.[180] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 64: Oxfordshire wards with the highest cancer incidence (indirectly age-standardised ratios)



Source: Public Health England

Breast Cancer

For the three-year period 2010-12, the rate of new breast cancer diagnoses in Oxfordshire was 159.4 per 100,000 women aged under 75.[181] This was above the national and regional averages (139.1 and 142.5 respectively). Oxfordshire's higher incidence of breast cancer is not unexpected because the county is relatively affluent, and research indicates that women in the least deprived socioeconomic groups have higher breast cancer incidence. This is thought to be linked to their tending to have children at a later stage, to have fewer children,

[180] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at smaller geographies will be relatively low and confidence intervals will therefore be wide.
[181] Health & Social Care Information Centre Indicator Portal (Compendium of Population Health Indicators): https://indicators.ic.nhs.uk/webview/

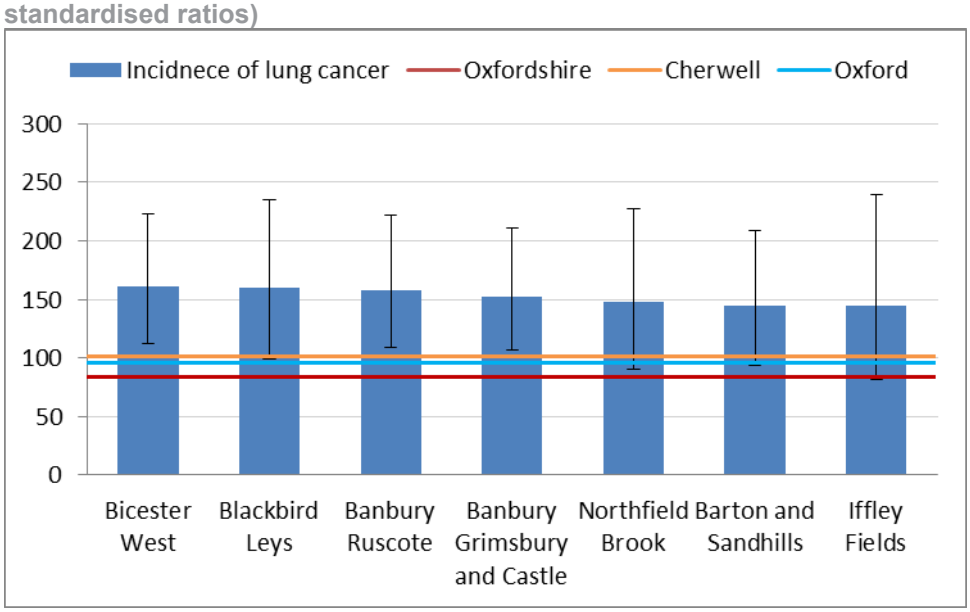
and to take hormone replacement therapy, all of which are associated with increased breast cancer incidence.[182]

Lung Cancer

Smoking is the main avoidable risk factor for lung cancer, linked to an estimated 86% of lung cancer cases in the UK.[183]

Pooled data for the years from 2007 to 2011 show that seven wards in Oxfordshire had lung cancer incidence rates above the national average.[184] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 65: Oxfordshire wards with the highest lung cancer incidence (indirectly age-standardised ratios)



Source: Public Health England

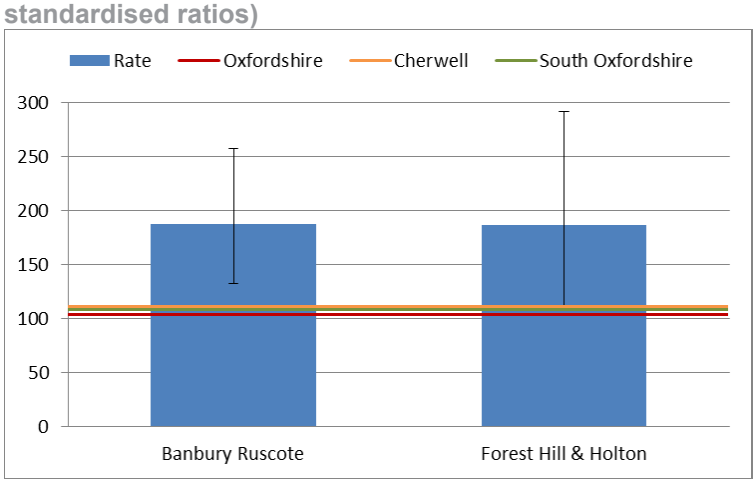
Bowel Cancer

A person's risk of developing bowel cancer depends on many factors, including age (95% of cases occur in people aged 50 and over), genetics, and exposure to risk factors.[185] An estimated 54% of bowel cancers (UK) are linked to lifestyle factors including meat consumption, overweight and obesity, alcohol and smoking. Fibre consumption and physical activity protect against bowel cancer.

Pooled data for the years from 2007 to 2011 show that two wards in Oxfordshire had bowel cancer incidence rates above the national average.[186] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

[182] Cancer Research UK statistics: http://www.cancerresearchuk.org/content/breast-cancer-incidence-statistics#heading-Seven
[183] Cancer Research UK: http://www.cancerresearchuk.org/
[184] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at smaller geographies will be relatively low and confidence intervals will therefore be wide.
[185] Cancer Research UK: http://www.cancerresearchuk.org/
[186] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at smaller geographies will be relatively low and confidence intervals will therefore be wide.

Figure 66: Oxfordshire wards with the highest bowel cancer incidence (indirectly age-standardised ratios)



Source: Public Health England

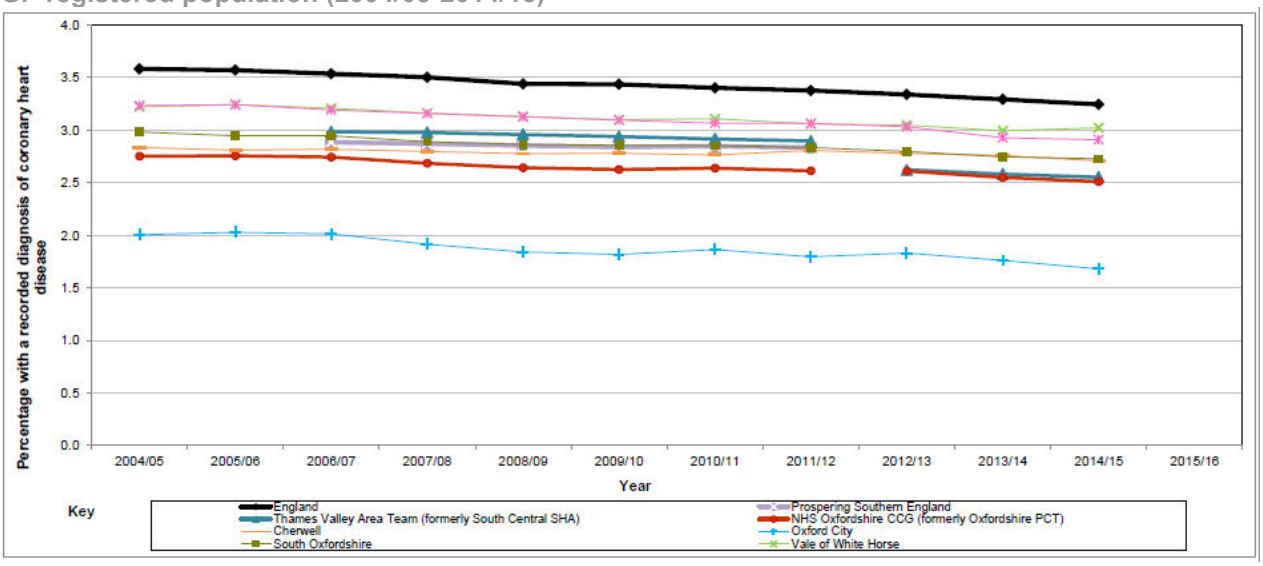
5.3.3. Circulatory Diseases

Coronary Heart Disease (CHD)

Coronary heart disease (CHD) involves the narrowing of the arteries providing blood to the heart, due to a gradual build-up of fatty material.

In 2014/15 there were around **17,900 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area who had CHD.[187] This is similar to the 2013/14 number. However, due to growth in the patient population over the same period, the rate of CHD prevalence has fallen slightly, from 2.6% to 2.5% of patients. This is in line with national trends. The Oxfordshire rate remains below that for England overall (3.3%) and the South region (3.2%).

Figure 67: Percentage of patients with a recorded diagnosis of coronary heart disease in the GP registered population (2004/05-2014/15)[188]



Source: Quality and Outcomes Framework

[187] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887

[188] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates for CHD.

Figure 68: Oxfordshire GP practices with the highest rates of coronary heart disease (CHD)

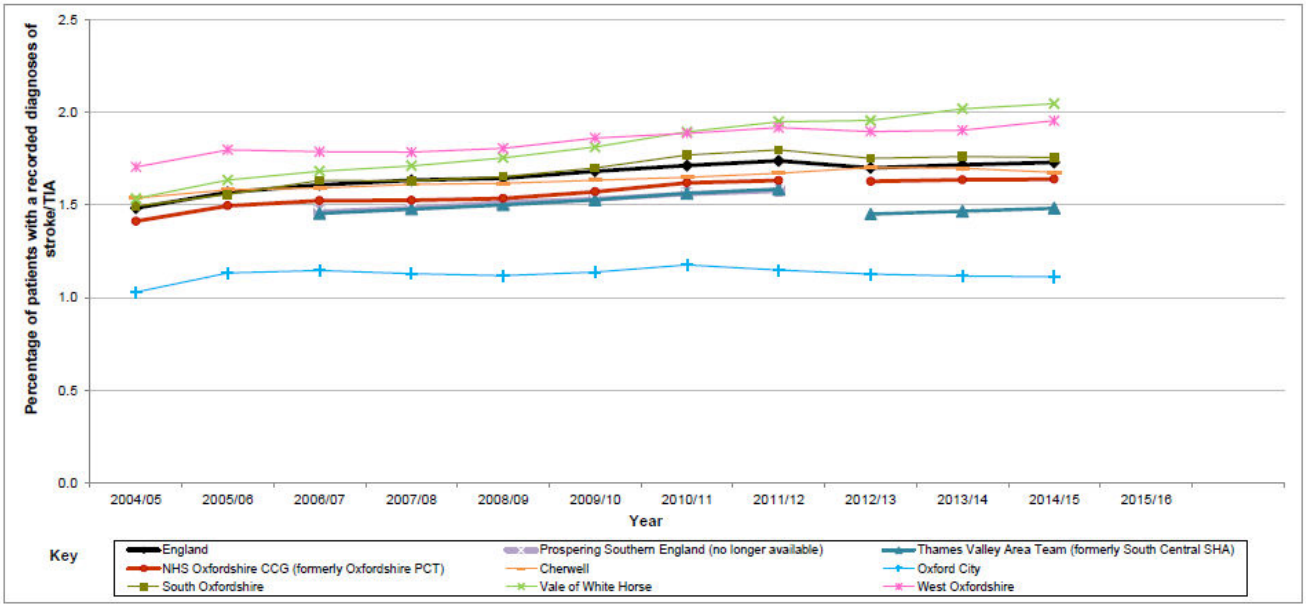
Practice Name	Ward*	District*	CHD prevalence
Bampton Surgery	Bampton and Clanfield	West Oxfordshire	3.9%
Sibford Surgery	Sibford	Cherwell	3.9%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	3.8%
Kennington Health Centre	Kennington and South Hinksey	Vale of White Horse	3.8%
Woodstock Surgery	Woodstock and Bladon	West Oxfordshire	3.8%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

Stroke or Transient Ischaemic Attack (TIA)
Stroke and Transient Ischaemic Attack occur when blood flow to an area of the brain is cut off, depriving brain cells of oxygen.

In 2014/15 there were around **11,600 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area who had a diagnosis of Stroke or TIA. This number has increased by around 200 (or 2.0%) since 2013/14. However, due to growth in the patient population over the same period, the rate of stroke or TIA has remained similar, at 1.6% of patients. It is slightly below average rates for England (1.7%) and the South (1.9%).

Figure 69: Percentage of patients with a recorded diagnosis of Stroke or TIA in the GP registered population (2004/05-2014/15)[189]



Source: Quality and Outcomes Framework

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates for stroke or TIA.

[189] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.

Figure 70: Oxfordshire GP practices with the highest rates of Stroke/ Transient Ischaemic Attack (TIA)

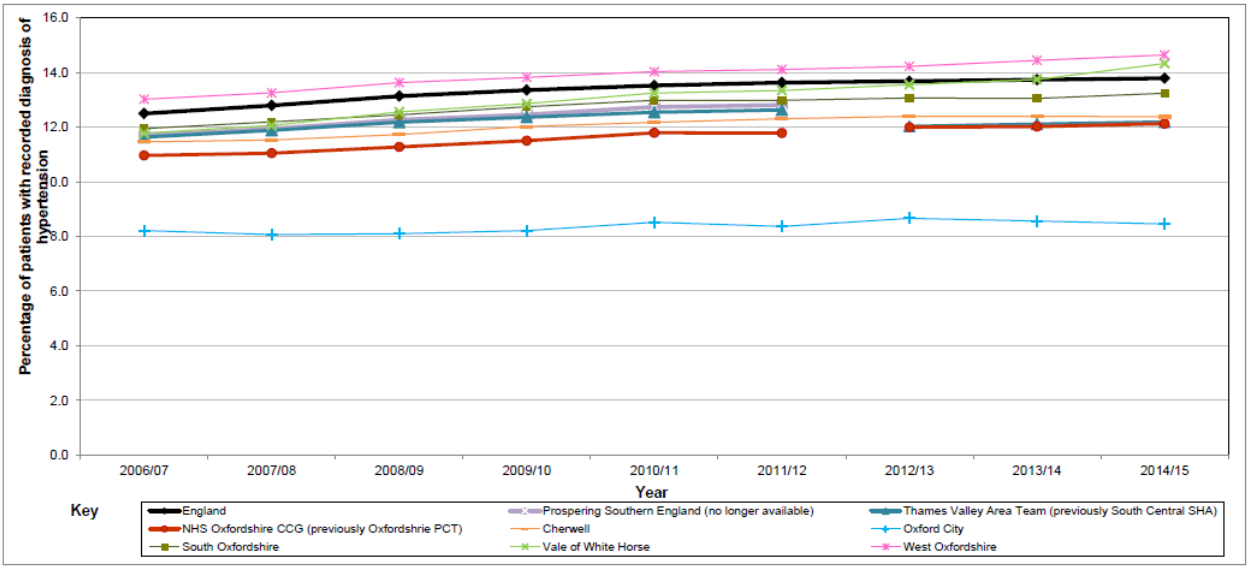
Practice Name	Ward*	District*	Stroke/ TIA prevalence
Berinsfield Health Centre	Berinsfield	South Oxfordshire	3.1%
The Malthouse Surgery	Abingdon Abbey and Barton	Vale of White Horse	2.7%
Exeter Surgery	Kidlington South	Cherwell	2.6%
Kennington Health Centre	Kennington and South Hinksey	Vale of White Horse	2.5%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	2.5%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

5.3.4. Hypertension (High Blood Pressure)

In 2014/15 there were around **86,200 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area who had hypertension (high blood pressure).[190] This number has increased by around 2,000 (or 2.4%) since 2013/14. The prevalence rate of hypertension also rose slightly, from 12.0% to 12.1% of patients. However, it remains below the average rates for England (13.8%) and the South (14.0%).

Figure 71: Percentage of patients with a recorded diagnosis of hypertension in the GP registered population (2006/07-2014/15)[191]



Source: Quality and Outcomes Framework

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates for hypertension.

[190] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887
[191] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.

Figure 72: Oxfordshire GP practices with the highest rates of Hypertension

Practice Name	Ward*	District*	Hypertension prevalence
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	19.8%
Nuffield Health Centre	Witney South	West Oxfordshire	19.2%
Cropredy Surgery	Cropredy	Cherwell	18.5%
Eynsham Medical Group	Eynsham and Cassington	West Oxfordshire	17.1%
Gosford Hill Medical Centre	Yarnton, Gosford and Water Eaton	Cherwell	16.6%

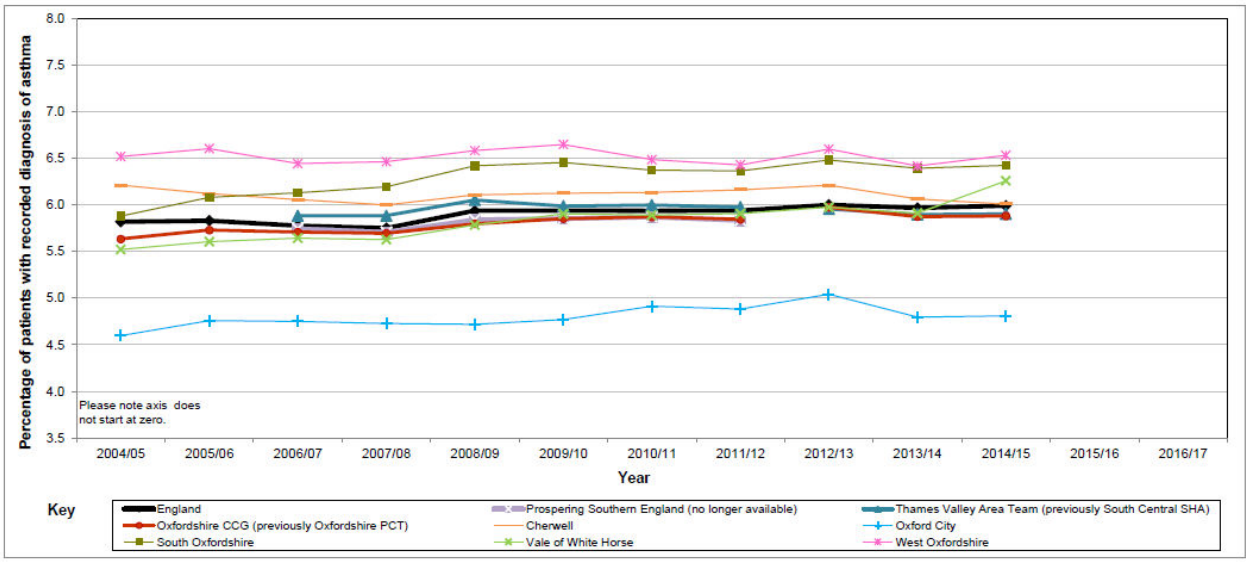
*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

5.3.5. Asthma

Asthma is a common long-term condition that can cause coughing, wheezing, chest tightness, and breathlessness.

In 2014/15 there were around **41,800 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area who had asthma.[192] This number has increased by around 1,100 (or 2.6%) since 2013/14. The rate of asthma prevalence also rose slightly, from 5.8% to 5.9% of patients. However, it was slightly below the average for England (6.0%) and the South (6.1%).

Figure 73: Percentage of patients with a recorded diagnosis of asthma in the GP registered population (2004/05-2014/15)[193]



Source: Quality and Outcomes Framework

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates for asthma.

[192] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887 This excludes patients with asthma who have not been prescribed any asthma-related drugs in the previous 12 months.
[193] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.

Figure 74: Oxfordshire GP practices with the highest rates of asthma

Practice Name	Ward*	District*	Asthma prevalence
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	8.9%
Berinsfield Health Centre	Berinsfield	South Oxfordshire	8.0%
Nettlebed Surgery	Watlington	South Oxfordshire	8.0%
Woodlands Surgery	Banbury Grimsbury and Castle	Cherwell	7.6%
Burford Surgery	Burford	West Oxfordshire	7.6%

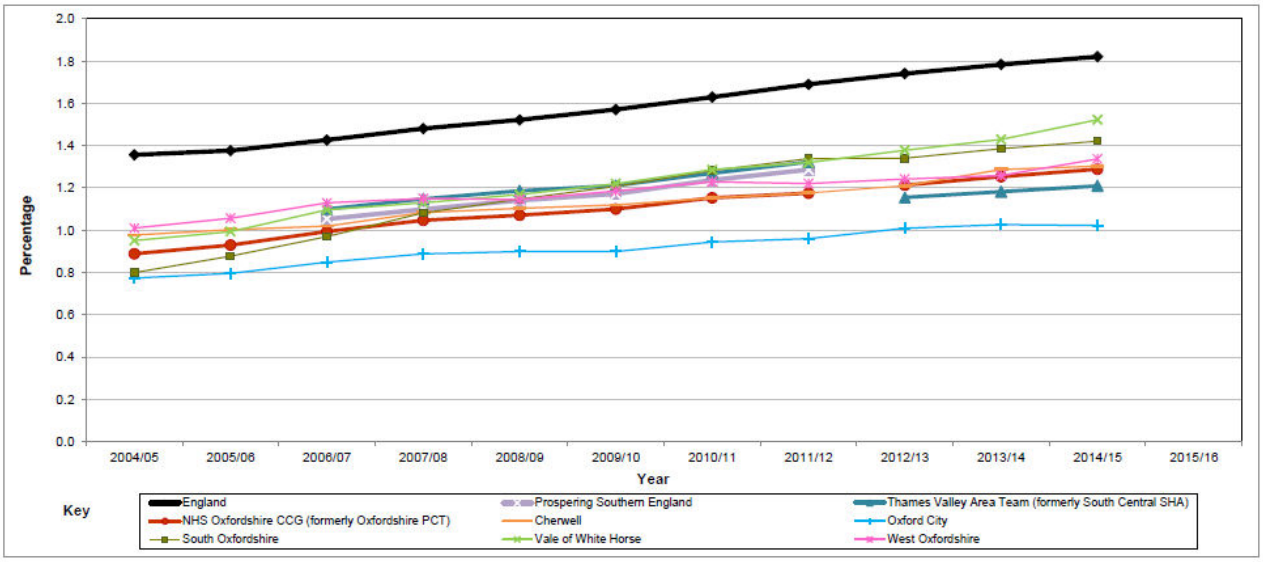
*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

5.3.6. Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) refers to a collection of lung diseases that lead to difficulties with breathing. The main risk factor for COPD is smoking and the risk increases the longer a person has smoked.

In 2014/15 there were around **9,200 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area who had COPD.[194] This number has increased by around 400 (or 4.3%) since 2013/14. However, due to growth in the patient population, prevalence of COPD remained at 1.3% of patients. This rate is a little lower than the England average (1.8%) and the average for the South region (1.7%).

Figure 75: Percentage of patients with a recorded diagnosis of chronic obstructive pulmonary disease in the GP registered population 2004/5-2014/15[195]



Source: Quality and Outcomes Framework

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates for COPD.

[194] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887
[195] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.

Figure 76: Oxfordshire GP practices with the highest rates of Chronic Obstructive Pulmonary Disease (COPD)

Practice Name	Ward*	District*	COPD prevalence
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	2.6%
Berinsfield Health Centre	Berinsfield	South Oxfordshire	2.3%
The Malthouse Surgery	Abingdon Abbey and Barton	Vale of White Horse	2.3%
Montgomery House Surgery	Bicester Town	Cherwell	2.2%
Kennington Health Centre	Kennington and South Hinksey	Vale of White Horse	2.0%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

5.3.7. Dementia

Dementia results from damage to the brain from disease or strokes, and can lead to symptoms such as memory loss and difficulties with thinking, problem-solving, and language.

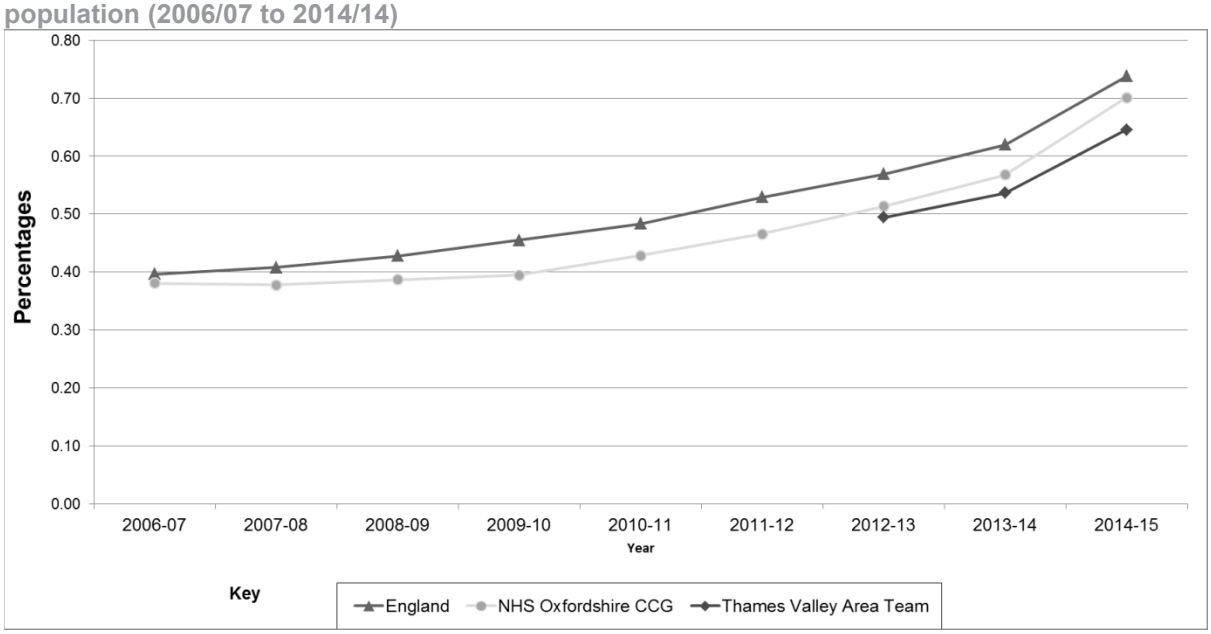
In 2015/16 the estimated number of people aged 65 and over in the Oxfordshire Clinical Commissioning Group area who have dementia is 7,641.[196] It is thought that nearly 3,000 of these are as yet undiagnosed.

Data are collected from Quality and Outcomes Framework (QOF) on a monthly basis to support the Dementia Strategy and the Prime Minister's Dementia Challenge, one aim of which is to improve the national diagnosis rate of dementia.

In 2014/15 there were around **5,000 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area who had a diagnosis of dementia.[197] This number has increased by around 1,000 (or 25.3%) since 2013/14. The rate of dementia prevalence also rose slightly from 0.6% to 0.7% of patients. This is just below the England and South East averages but above that for the Thames Valley area. The figure below shows a steady increase across all geographies.

[196] Data provided by Oxfordshire Clinical Commissioning Group, January 2016
[197] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887

Figure 77: Percentage of patients with a recorded diagnosis of dementia in the GP registered population (2006/07 to 2014/14)



Source: Health & Social Care Information Centre - Quality and Outcomes Framework (QOF)

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates for dementia.

Figure 78: 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%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere

Source: Quality and Outcomes Framework

5.3.8. Epilepsy

Epilepsy is a condition that affects the brain and causes repeated seizures.

In 2014/15 there were around **4,000 GP-registered patients** aged 18 and over in the Oxfordshire Clinical Commissioning Group area who were receiving drug treatment for Epilepsy.[198] This number has increased by about 100 (or 4.0%) since 2013/14. However, due to small numbers of Epilepsy sufferers, and growth in the patient population, prevalence remains at 0.7% of patients. This is slightly lower than the averages for England and the South (both 0.8%).

The table below shows the 5 Oxfordshire GP practices with the highest rates of epilepsy; these are still low, at around 1%.

[198] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887

Figure 79: Oxfordshire GP practices with the highest rates of patients aged 18 and over receiving drug treatment for epilepsy

Practice Name	Ward*	District*	Rate of epilepsy
West Bar Surgery	Banbury Easington	Cherwell	1.2%
Berinsfield Health Centre	Berinsfield	South Oxfordshire	1.1%
Nuffield Health Centre	Witney South	West Oxfordshire	1.0%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	1.0%
Hollow Way Medical Centre	Lye Valley	Oxford	1.0%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

5.3.9. Autistic Spectrum Disorder

Autism (or Autistic Spectrum Disorder, ASD) is a lifelong developmental and neurological disability. People with autism can experience difficulty with social communication, social interaction, social imagination, sensory issues, and other difficulties.[199]

In 2013, Oxfordshire County Council estimated that there could be in the region of **6,850** people in Oxfordshire who are on the autistic spectrum.[200]

In January 2015, there were **1,140 pupils** in Oxfordshire schools with special educational needs (SEN) whose primary type of need was ASD.[201] Of these, 429 were in state funded primary schools (making up 6.6% of all pupils in these schools). Meanwhile, 471 were in state-funded secondary schools (making up 10.8% of all pupils in these schools). The remaining 240 were in special schools (making up 23.3% of all pupils in these schools).

The latest estimates of the prevalence of ASD in Oxfordshire (from 2013) suggest that there could be[202]:

- **40-60 pre-school children** with autistic spectrum disorder
- **2,000-3,000 adults with both autistic spectrum disorder and learning disabilities** (defined as having an IQ below 70)
- **Well over 2,000 adults with autistic spectrum disorder but no learning disabilities** (many of whom will have Asperger's syndrome)

Nationally, a diagnosis of autism is three to four times more common in men than women, although the condition may be particularly under-diagnosed in women.[203] Autism is also associated with learning disability in around half of cases. Meanwhile, mental health problems, including depression and anxiety, are thought to be more common among people with autism than in the general population.

[199] More information is available from The National Autistic Society: http://www.autism.org.uk/
[200] Oxfordshire Autism Joint Commissioning Strategy 2013-2017: https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/business/providers/OxfordshireAutismStrategy.pdf
[201] Department for Education SEN Statistics (January 2015): https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
[202] Data from the Oxfordshire Autism Joint Commissioning Strategy 2013-2017: https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/business/providers/OxfordshireAutismStrategy.pdf
[203] Data in this paragraph are from the Oxfordshire Autism Joint Commissioning Strategy 2013-2017: https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/business/providers/OxfordshireAutismStrategy.pdf

For more information about Autistic Spectrum Disorder in Oxfordshire, including about support needs, see the Oxfordshire Autism Joint Commissioning Strategy 2013-2017

5.3.10. Mental Health

This section considers the prevalence of mental health problems and self-harm among adults and children. Suicide is discussed in section 5.4.9. Use of mental health services is discussed in section 7.5.

Nationally, people with serious mental illness have higher mortality and morbidity rates and die on average 10 to 20 years younger than the general population.[204]

To explore the relationship between mental health and life expectancy in more detail, take a look at the web tool produced by the RSA, supported by partners including Healthwatch, Mind, Open Public Services and the Cabinet Office.

Adult Wellbeing

The Office for National Statistics (ONS) began measuring personal wellbeing in April 2011, through the Annual Population Survey (APS). [205] Since then, the APS has included four questions which are used to monitor personal wellbeing in the UK:

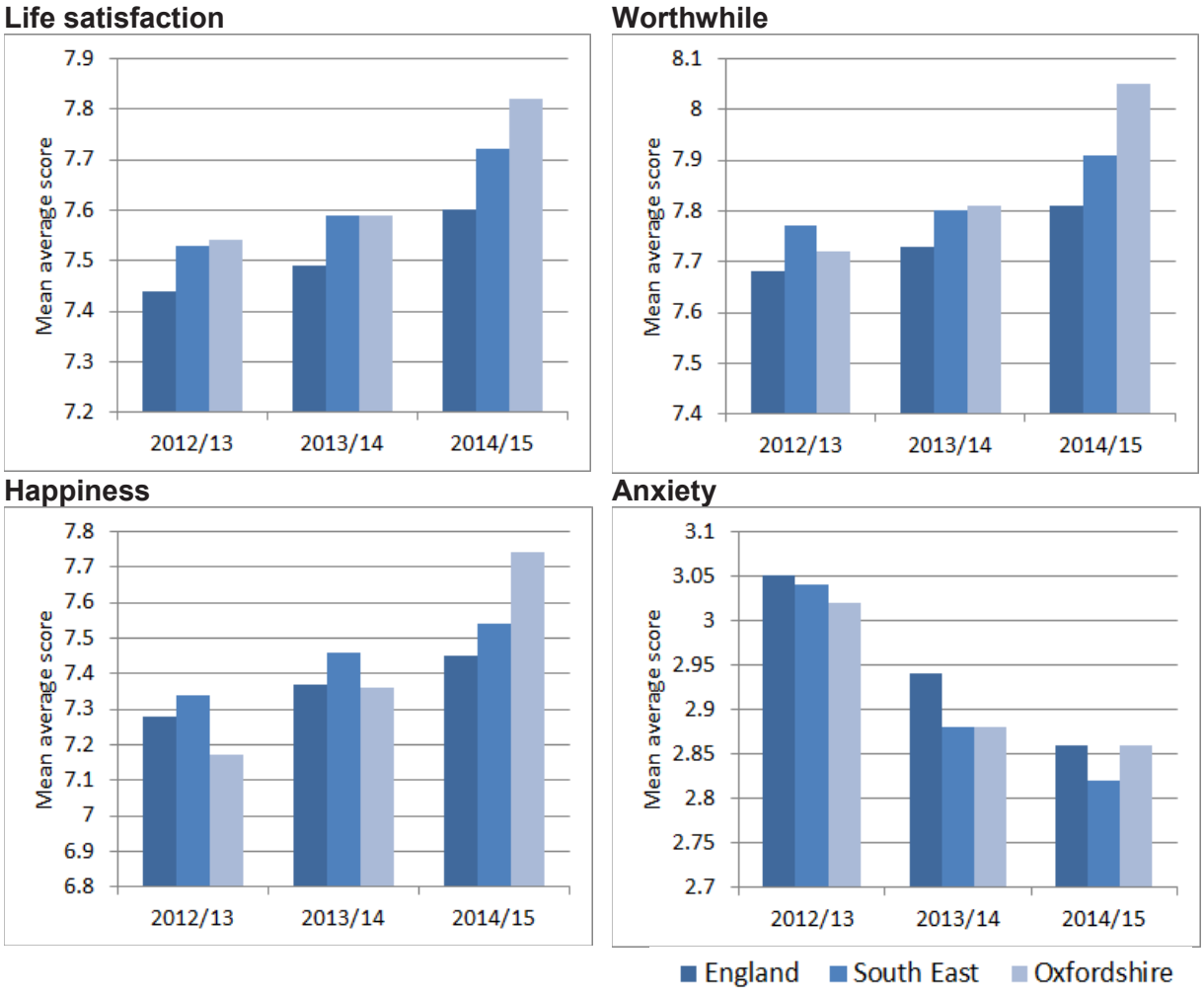
- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

Adults surveyed are asked to give their answers on a scale of 0 to 10, where 0 is 'not at all' and 10 is 'completely'. Scores relating to life satisfaction, worthwhile activities and happiness were significantly higher in Oxfordshire than in England overall. Otherwise, scores were broadly similar to regional and national averages.

[204] No health without mental health: A cross-governmental Mental Health Outcomes Strategy for People of All Ages (Department of Health, 2011): https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-mental-health-outcomes-strategy-for-people-of-all-ages-a-call-to-action

[205] ONS Personal Wellbeing in the UK 2014/15: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/index.html

Figure 80: Average ratings of personal wellbeing (2012/13-2014/15)



Source: Office for National Statistics Personal Wellbeing Statistics

Pooled data for the period April 2011 to March 2014 show higher levels of anxiety in Oxford compared with two of the other districts (South Oxfordshire and Vale of White Horse).[206] Aside from this, there were no significant differences between districts.

To view wellbeing data at local authority district level, visit the interactive mapping tools produced by the Office for National Statistics:
http://www.neighbourhood.statistics.gov.uk/HTMLDocs/dvc238/index.html

National analysis has shown that levels of personal wellbeing are strongly linked to levels of household wealth: on average, levels of life satisfaction, sense of worth, and happiness are higher, and anxiety is lower, as the level of household wealth increases.[207] This tends to be truer of financial wealth than other kinds of wealth, such as property and pensions. Levels of household *income* were found to be less strongly linked to wellbeing than wealth, although they did relate to greater life satisfaction and greater sense of worth.

[206] Measuring National Well-being, Personal Well-being in the UK, Three Year Data 2011/2014 (ONS, March 2015): http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--three-year-data-2011-2014/index.html

[207] Relationship between Wealth, Income and Personal Wellbeing, July 2011 to June 2012 (ONS, September 2015): http://www.ons.gov.uk/ons/rel/was/wealth-in-great-britain-wave-3/wealth--income-and-personal-well-being/art-wealth--income-and-personal-well-being.html#tab-Main-points

A separate national study, based on a different dataset, found that mental and physical health were much more important indicators of life satisfaction than family income.[208] It also showed that the most powerful of the childhood predictors of adult life-satisfaction included in the analysis was the child's emotional health, followed by the child's conduct. The least important was the child's intellectual development.

Child Wellbeing (National Data)

National data gathered by the Children's Society in 2013 show that just over three quarters of children aged 10-15 had a medium/ high level of life satisfaction (rating this 7-10 out of 10).[209] This is up slightly from 74.5% in 2012. Similar proportions had a medium/ high level of happiness (74.1% in 2013, up from 72.1% in 2012) and a medium/ high level of worthwhileness (75.3% in 2013, up from 69.7% in 2012).

Mental Disorders

National data for 2012/13 find **indications of depression or anxiety** in 18.3% of adults in the UK.[210] The figure for England was 18.4%, and for the South East 17.4%. A direct extrapolation to Oxfordshire of the regional figure would give an estimate of **92,500 adults** in the county with signs of depression and anxiety. However, this does not take account of any local differences in prevalence that may exist.

Nationally, there has been no significant change in the proportion of people displaying signs of depression or anxiety over the past three years but it has got worse compared with 2009/10 (when it stood at 18%). These conditions are more evident among adults in younger age groups (16-54 years) than among older adults. Women are also more likely to present with signs of depression or anxiety: in 2012/13 over a fifth (21.5%) did so, compared with less than a sixth (14.8%) of men.

The Quality and Outcomes Framework provides GP data on **diagnosed depression**.[211] In 2014/15 there were around **42,600 GP-registered patients aged 18 and over** in the Oxfordshire Clinical Commissioning Group area with a new diagnosis of depression.[212] This number has increased by 5,600 (or 15%) since 2013/14. The rate of prevalence of diagnosed depression also increased from 6.6% to 7.5% of patients aged 18 and over. It remains slightly higher than the averages for England (7.3%) and the South (7.4%).

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates for depression.

[208] Layard, R. et al. (2014). What predicts a successful life? A life-course model of well-being. *The Economic Journal*: http://eprints.lse.ac.uk/57267/

[209] ONS Measuring National Wellbeing, Children's Wellbeing, 2014: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/children-s-well-being--2014/index.html

[210] ONS Measuring National Wellbeing, Domains and Measures (September 2015 release), using data from the Understanding Society survey: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/domains-and-measures---september-2015/index.html

[211] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887

[212] This includes patients diagnosed with depression in the preceding 12 months, who have been reviewed between 10-56 days following diagnosis.

Figure 81: Oxfordshire GP practices with the highest rates of diagnosed depression among patients aged 18 and over

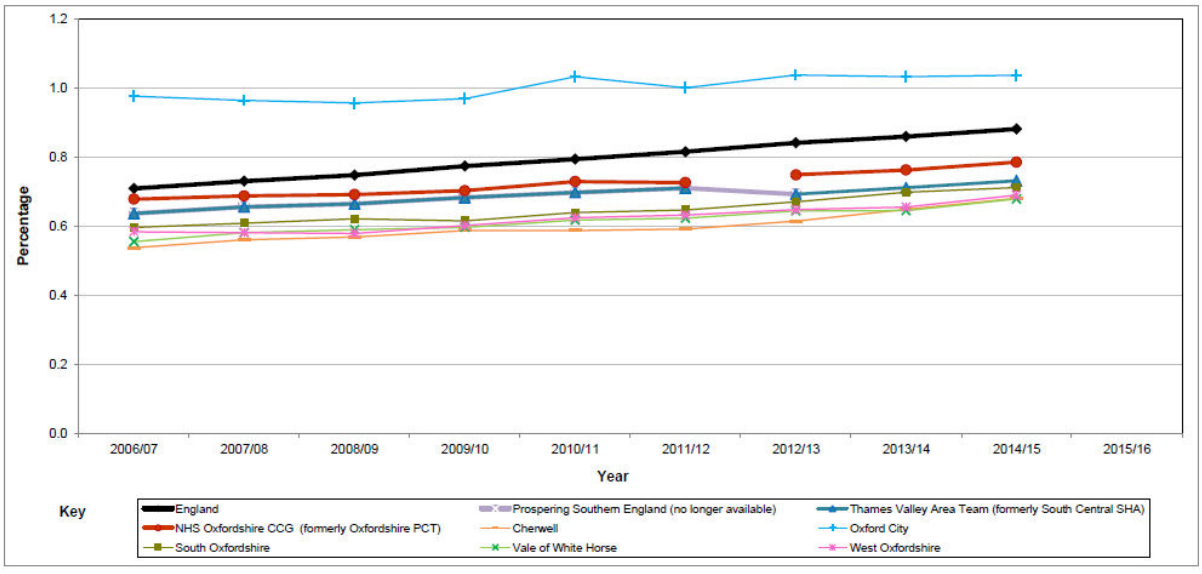
Practice Name	Ward*	District*	Rate of diagnosed depression
Oak Tree Health Centre	Didcot Ladygrove	South Oxfordshire	17.3%
Broadshires Health Centre	Carterton North East	West Oxfordshire	16.3%
Langford Medical Practice	Bicester South	Cherwell	13.7%
Didcot Health Centre Practice	Didcot All Saints	South Oxfordshire	13.2%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	13.1%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

More information about depression among homeless patients who present at Oxford's Luther Street Medical Centre is provided above, under section 5.3: Morbidity.

The Quality and Outcomes Framework also provides GP data on patients diagnosed with **schizophrenia, bipolar affective disorder, or other psychoses; or who were on lithium therapy**.[213] In 2014/15 there were around **5,600 GP-registered patients** in the Oxfordshire Clinical Commissioning Group area with these conditions. This number has increased by around 200 (or 5%) since 2013/14. However, due to the small numbers of people with these serious mental illnesses, and the growth in the patient population, prevalence remains at 0.8% of patients. This is broadly similar to the averages for England (0.9%) and the South (0.8%).

Figure 82: Percentage of patients with a recorded diagnosis of a severe mental health problem in the GP registered population (2006/07-2014/15)[214]



Source: Quality and Outcomes Framework

The table below shows the 5 Oxfordshire GP practices with the highest prevalence rates.

[213] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887
[214] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.

Figure 83: Oxfordshire GP practices with the highest rates of patients diagnosed with schizophrenia, bipolar affective disorder, or other psychoses; or who were on lithium therapy

Practice Name	Ward*	District*	Rate of mental illness
Temple Cowley Health Centre	Cowley Marsh	Oxford	1.9%
Bartlemas Surgery	St Clement's	Oxford	1.5%
Cowley Road Medical Practice	St Clement's	Oxford	1.5%
South Oxford Health Centre	Hinksey Park	Oxford	1.4%
St Clements Surgery	St Mary's	Oxford	1.3%

*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

The most recent **adult psychiatric morbidity** survey (conducted in 2007) indicated rates of mental disorder among all people in England aged 16 or over, as shown in the figure below.[215]

Figure 84: Rates of mental disorder in England

Disorder Category	Rate in 2007 (adults aged 16+)	Trends 2000-2007 (16-74 year olds)	Trends 1993-2000 (16-64 year olds)
Common mental disorders (including different types of depression and anxiety)	15.1% *(7.5% likely to warrant treatment)*	No change*	Increased*
Current posttraumatic stress disorder	3%	N/A	N/A
Suicidal thoughts	16.7%	Increase	N/A
Suicide attempts	5.6%	No change	N/A
Self-harm	4.9%	Increased	N/A
Psychosis	0.4%	No change	N/A
Antisocial and borderline personality disorders	0.3%	No change	N/A
Attention deficit hyperactivity disorder characteristics	8.2%	N/A	N/A
Eating disorder	6.4%	N/A	N/A
Alcohol misuse (hazardous drinking)**	24.2%	N/A	N/A
Alcohol dependence**	5.9%	Decrease	N/A
Drug use**	9.2%	No change*	Increased*
At risk of problem gambling	3.2%	N/A	N/A

Source: Adult psychiatric morbidity in England, 2007
* Differences calculated for 16-74 year olds
** Alcohol and drug misuse is discussed further in chapter 6: Lifestyles.

Just under a quarter of adults in England screened positive for at least one of the conditions included in the study. Of those with at least one condition 68.7% met the criteria for *only* one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions. Numbers of identified conditions were not significantly different for men and women.

[215] *Adult psychiatric morbidity in England, 2007:* http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

Detentions under Section 136

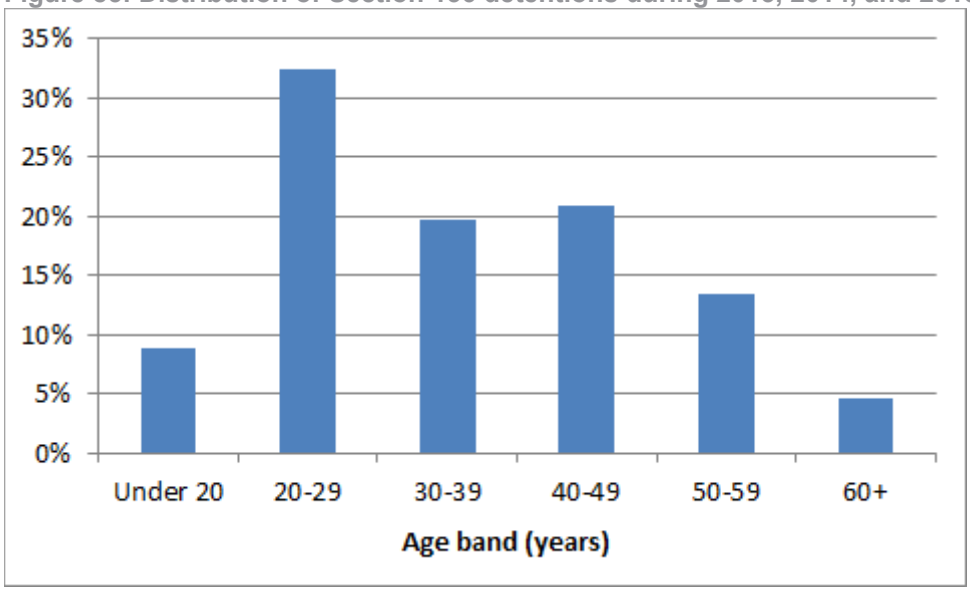
Section 136 of the Mental Health Act enables the police to act if they believe that someone is suffering from a mental illness and is in need of immediate treatment or care. The police may take that person from a public place to a place of safety, either for their own protection or for the protection of others. This is known as a Section 136 detention.

During the three calendar years 2013-2015, there were 891 Section 136 detentions in Oxfordshire.[216] Around 40% of these (358) were during 2013, with around 30% in each of 2014 and 2015 (266 and 267 detentions, respectively).

Over the full three-year period, around 45% of the detentions were made in Oxford, whilst around 35% were in Cherwell and West Oxfordshire, and around 21% were in South Oxfordshire and Vale of White Horse.

A majority of the detainees were male (around 59%). The chart below shows the age distribution, with those aged 20-29 making up the largest group of people detained.

Figure 85: Distribution of Section 136 detentions during 2013, 2014, and 2015, by age band



Source: Thames Valley Police

Mental Health in Children

It has been estimated that 50% of adult mental illness starts before the age of 15 and more than 75% by the age of 18.[217] However, there is limited information available on the prevalence of mental ill health in children.

There are relatively few data about prevalence rates for mental health disorders in pre-school age children.[218] A 2006 literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6%.[219]

[216] Data provided by Thames Valley Police, January 2016.
[217] Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Arch Gen Psychiatry*. 2003 Jul;60(7):709-17
[218] CAMHS Needs Assessment: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34
[219] Egger, H. L. and Angold, A. (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. Journal of Child Psychology and Psychiatry, 47 (3-4), 313–37.

General prevalence estimates for mental health disorders in children aged five to 16 years have been estimated in a report by Green et al (2004).[220] Prevalence was found to vary by age and sex, with boys more likely to have experienced or be experiencing a mental health problem than girls (11.4% compared with 7.8%). Children aged 11 to 16 years were also found to be more likely than 5 to 10 year olds to experience mental health problems (11.5% compared with 7.7%).

The more recent 'What About YOUth' survey showed that mental wellbeing among children aged 15 in England was better among those who were:[221]

- 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

The same study 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 deprived areas, who were in worse health, or who had experienced bullying.

Separate national-level research indicates higher incidence of mental health problems among children and young people with learning disabilities, looked after children, and children who are homeless or sleeping rough.[222]

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.[223]

Self-Harm (Hospitalisation)

Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves, irrespective of the purpose of the act. There is a significant and persistent risk of future suicide following an episode of self-harm.[224]

During 2013/14 the number of emergency hospital admissions for intentional self-harm in Oxfordshire was 1,421.[225] The rate of hospital admissions for intentional self-harm is rising in Oxfordshire, similarly to the regional and national picture.

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[220] Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004. Office for National Statistics. London, HMSO. Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life.

[221] Health and Wellbeing of 15 year olds in England: Findings from the What About YOUth? Survey 2014 (HSCIC/ Ipsos MORI, December 2015): http://www.hscic.gov.uk/catalogue/PUB19244/what-about-youth-eng-2014-rep.PDF

[222] CAHMS Needs Assessment: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34

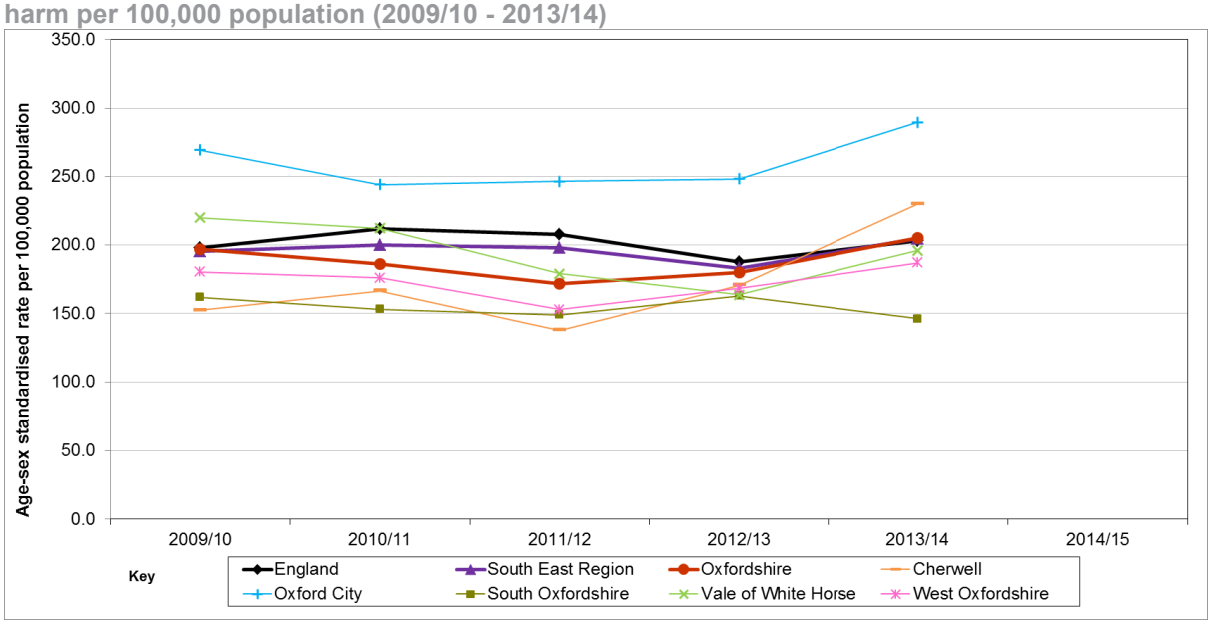
[223] Annual Report of the Chief Medical Officer 2013: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

[224] Public Health England Local Health tool: http://www.localhealth.org.uk/#v=map4;l=en

[225] Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

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

Figure 86: Age/ sex-standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population (2009/10 - 2013/14)



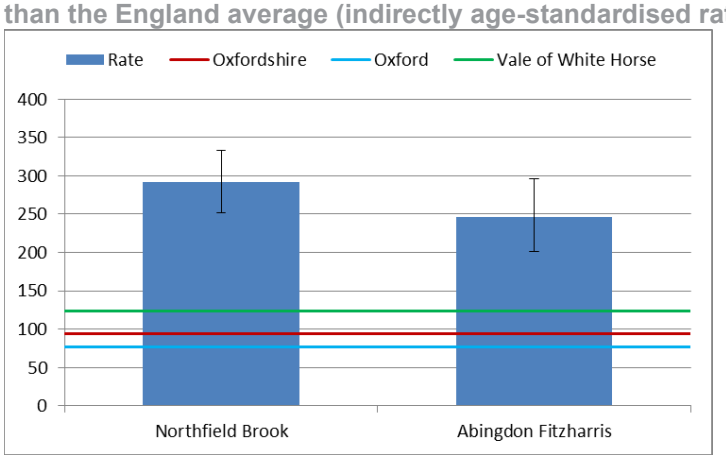
Source: Local Authority Health Profiles

Within the county, the rate of emergency hospital admissions for intentional self-harm is higher in Oxford than in other districts. Elsewhere in the county, South Oxfordshire shows a decline in rates of emergency admissions for self-harm.

Pooled data for the years 2008/09 to 2012/13 show that two wards in Oxfordshire had higher rates of hospital stays for self-harm than the district, county, and national averages.[226] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

[226] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at smaller geographies will be relatively low and confidence intervals will therefore be wide.

Figure 87: Oxfordshire wards with rates of hospital stays for self-harm significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

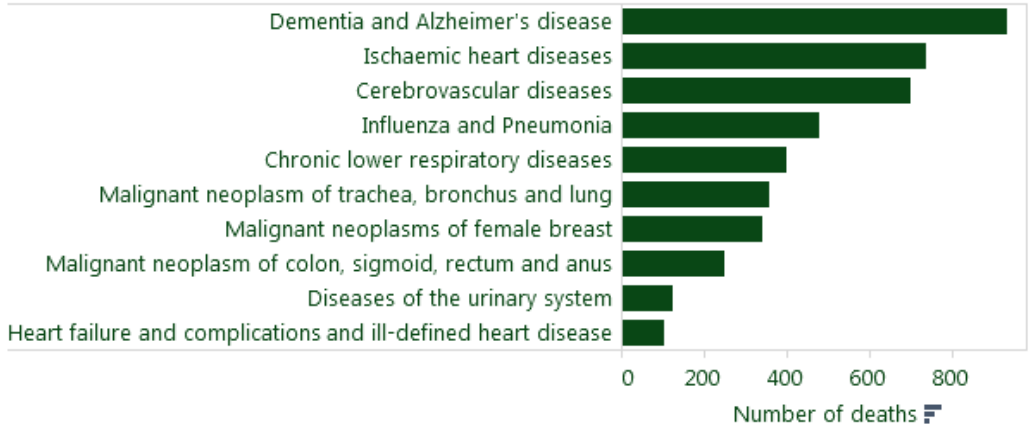
5.4. Mortality

This section covers some of the main causes of death in Oxfordshire.

5.4.1. Overview

Oxfordshire is similar to the national picture in terms of leading causes of death in males and females.[227] Analysis of male and female mortality data for the three-year period 2011-13 is presented in the charts below.[228] Where possible, mortality data in the rest of this section is for the period 2012-14. However, in some cases data for this time period is not yet available.

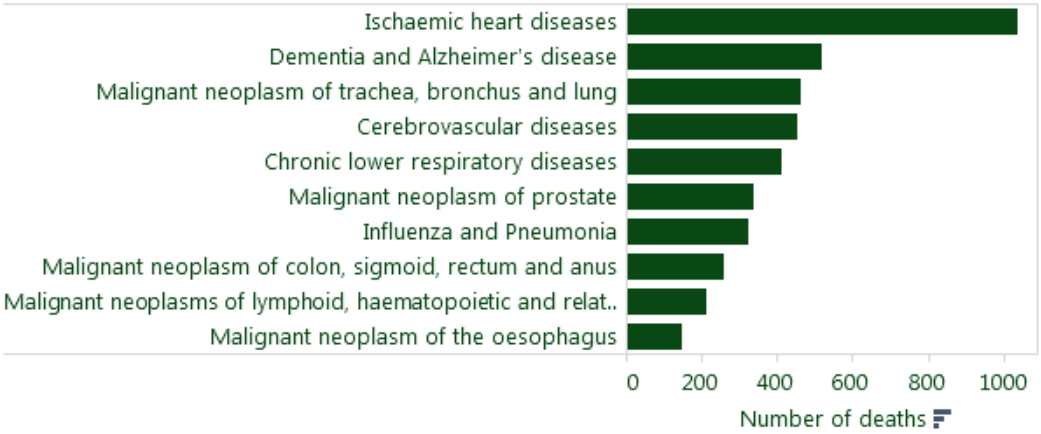
Figure 88: Leading causes of female mortality in Oxfordshire (2011-2013)



Source: Office for National Statistics/ Public Health England

[227] ONS mortality data: http://ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates
[228] Analysis provided by Public Health England

Figure 89: Leading causes of male mortality in Oxfordshire (2011-2013)



Source: Office for National Statistics/ Public Health England

Methodological Note

Mortality outputs are based on rates that are directly age-standardised using the European Standard Population (ESP). The ESP in use was introduced in 1976 and is an accepted methodological standard in health statistics in the UK and the rest of Europe.

At the end of 2012 Eurostat decided to bring this population structure up to date. For both sexes, mortality rates for all causes of death registered in 2012 were significantly higher when calculated using the 2013 ESP compared with the 1976 ESP. This is to be expected as deaths predominantly occur at older ages and the larger number of older people in the 2013 ESP wields more influence on these summary figures. This affects three year pooled data for 2010-12 onwards.[229]

This methodological revision will also affect some other age-standardised rates, such as cancer incidence rates.

The Office for National Statistics has produced an interactive map of age-standardised mortality rates in English and Welsh local authorities.

5.4.2. Cancer

Early mortality from cancer is a direct measure of health care need, as public health interventions for prevention, early diagnosis and effective treatment can all reduce the burden of cancer morbidity and mortality.

In 2012-14 there were less than 2,000 deaths in Oxfordshire from all types of cancer in people under the age of 75 years.[230] For male residents the cancer mortality rate was 133 deaths per 100,000 under the age of 75 years. This rate remains significantly lower than the England average (157.7). In female residents the mortality rate was 115.8, also significantly lower than the England average (126.6).

More than one in five of all cancer deaths in the UK are from lung cancer. Lung, bowel, breast and prostate cancers together accounted for almost half (46%) of all cancer deaths in

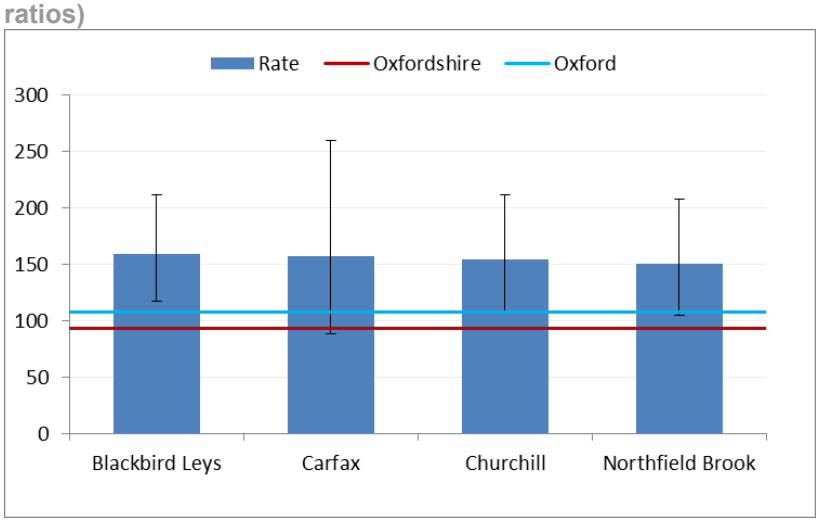
[229] For more information, see: http://www.ons.gov.uk/ons/rel/subnational-health2/european-standard-population/effect-on-uk-official-statistics/sty-revision-of-esp.html

[230] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/

the UK in 2012[231]. The proportion was slightly lower in Oxfordshire at 43% but these remain the major causes of cancer mortality in the county.[232]

Pooled data for the period from 2008 to 2012 show that the four Oxfordshire wards with the highest death rates from cancer were all in Oxford City, and two of these were significantly above the district and county averages.[233] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 90: Oxfordshire wards with the highest cancer mortality (indirectly age-standardised ratios)



Source: Public Health England

5.4.3. Circulatory Diseases

Pooled data for 2012-14 shows that the mortality rate from cardiovascular disease among male residents of Oxfordshire aged under 75 was 80.6 deaths per 100,000 population.[234] This rate was significantly lower than in England (106.2) and the South East region (90.7). The equivalent female mortality rate was 33.4 per 100,000 population (less than half that for men) and was also significantly lower than the rates for England (46.9) and the South East region (38.9).

5.4.4. Respiratory Diseases

Two of the main respiratory diseases are chronic obstructive pulmonary disease (COPD) and asthma.

The most common cause of COPD is smoking. Over the 2012-14 three-year period, the rate of mortality from COPD in male residents of Oxfordshire aged under 75 was 12.6 deaths per 100,000 population.[235] In female residents it was 11.4. Both rates were significantly lower than in England overall, which had a male mortality rate of 19.9 and a female mortality rate of 15.6. However, Oxford City had a significantly higher male mortality rate from COPD. As

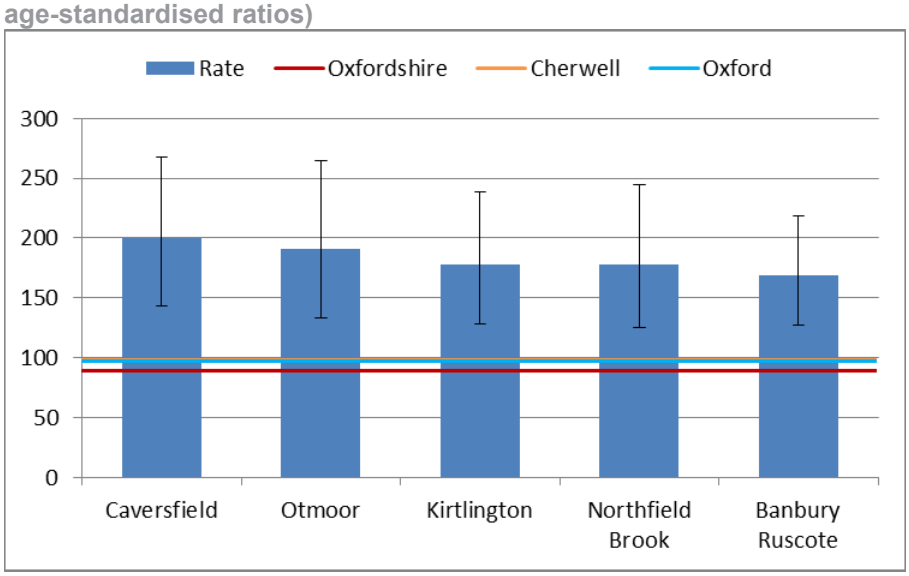
[231] Cancer mortality statistics: http://www.cancerresearchuk.org/content/cancer-mortality-statistics#heading-One
[232] Health and Social Care Information Centre: https://indicators.ic.nhs.uk/webview/
[233] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at smaller geographies will be relatively low and confidence intervals will therefore be wide.
[234] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/
[235] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/

there is a correlation between smoking prevalence and deprivation this may account for the higher rates in Oxford City.

Generally speaking Oxfordshire's mortality rates from asthma (for all ages and both genders) have decreased, and although there has been some variation over the last few years, the number of deaths from asthma remains fairly static.[236]

Pooled data for the period from 2008 to 2012 show that five Oxfordshire wards had higher death rates from respiratory diseases, compared with the county average.[237] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 91: Oxfordshire wards with the highest mortality from respiratory diseases (indirectly age-standardised ratios)



Source: Public Health England

5.4.5. Deaths Caused by Smoking

Smoking is the biggest single preventable cause of disease and premature death in the UK.[238] One in two regular smokers is killed by tobacco - half dying before the age of 70, losing an average of 21 years of life. Preventing people from starting smoking is key to reducing the health harms and inequalities associated with tobacco use.

The latest available figures (for the 2011-13 period) indicate that Oxfordshire had a significantly lower mortality rate than the national average, with a directly standardised rate of 230.7 per 100,000, compared to 288.7 for England. However the rate in Oxford was higher than the rest of Oxfordshire.

[236] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/

[237] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

[238] Action on Smoking and Health smoking statistics (November 2014): http://ash.org.uk/files/documents/ASH_107.pdf

5.4.6. Deaths Caused by Alcohol

The harmful use of alcohol results in 3.3 million deaths globally each year.[239] In England there were 18,100 deaths in the three-year period 2011-13 (12,325 males, 5,775 females) which were due to alcohol-specific conditions.[240] In Oxfordshire, alcohol-specific mortality accounted for 142 deaths in the same three-year period (85 male, 57 female).

For both men and women in Oxfordshire, alcohol-specific mortality has remained fairly steady. The mortality rate for males in 2011-13 was significantly lower than England. For females, although lower than England, it was not significantly so. Most Oxfordshire districts have low numbers of deaths among men caused directly by alcohol consumption and are significantly lower than for England.[241]

In 2012-14 Oxfordshire's overall mortality rate from liver disease in people under 75 years was significantly lower than England (7.4 and 10.8 per 100,000 population, respectively)[242]. Data split by gender shows that liver disease mortality in males is significantly better than England (17.4 and 23.4 per 100,000 male population, respectively) but in females it is similar to England (12.9 and 12.4 per 100,000 female population respectively).

5.4.7. Excess Winter Deaths

The number of excess winter deaths depends on the temperature and the level of disease in the population as well as other factors, such as how well equipped people are to cope with the drop in temperature.[243] Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population.

Three-year rolling data for the period August 2010-July 2013 shows that there were an estimated 1,034 excess winter deaths in Oxfordshire (around half of which were among those aged 85 and over). This represented a ratio of extra deaths to expected deaths (based on the average of the number of non-winter deaths) of 21.2.[244] This was similar to surrounding areas in the South East region and the national average.

A majority of the excess winter deaths between 2010 and 2013 were among women. In Oxfordshire, the ratio of extra female deaths to expected female deaths was worse than the national average (at 25.3 compared with 19.3). This appears to be driven by above average rates in Oxford and South Oxfordshire.

For more analysis of excess winter deaths in Oxfordshire, see the District Data Service chart of the month from August 2015.

[239] World Health Organisation (WHO) Facts and Figures: http://www.who.int/substance_abuse/facts/en/
[240] Conditions included are only those wholly attributable (100%) to alcohol (2014 version): http://www.cph.org.uk/publication/updating-england-specific-alcohol-attributable-fractions/
[241] Public Health England Local Alcohol Profiles for England: http://fingertips.phe.org.uk/profile/local-alcohol-profiles
[242] Health & Social Care, Compendium of Health Indicators: https://indicators.ic.nhs.uk/webview/
[243] Public Health Outcomes Framework, indicators 4.15i-iv : http://www.phoutcomes.info/
[244] Public Health Outcomes Framework, indicators 4.15i – 4.15iv: http://www.phoutcomes.info/: The Excess Winter Deaths (EWD) Index expresses the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths based on the average of the number of non-winter deaths.

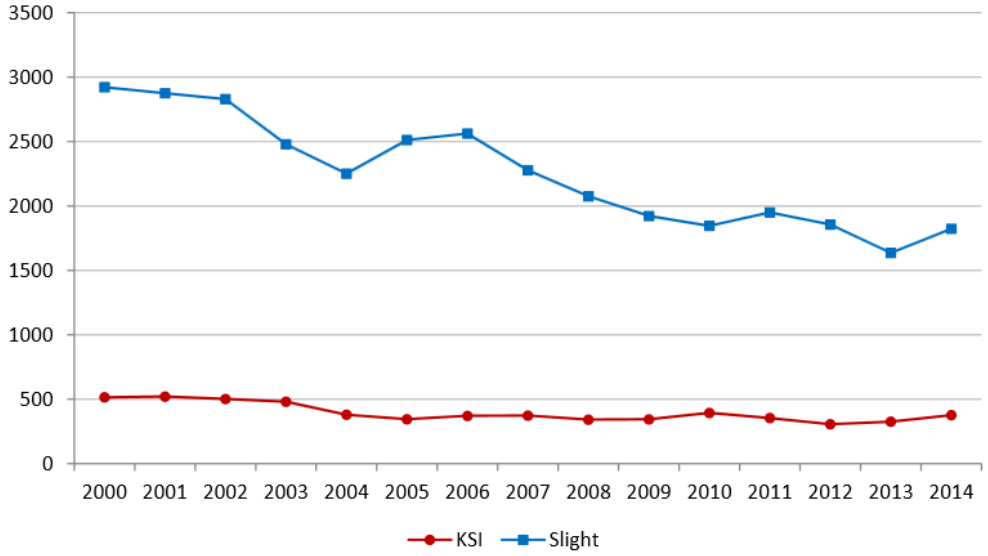
5.4.8. Road Casualties

378 people were reported to the police as killed and seriously injured (KSI) on Oxfordshire's roads in 2014.[245] Of these, 26 were killed (including three children) and 352 were seriously injured (including 19 children). A further 1,824 slight injuries were reported to the police.

Car drivers made up the largest group of road casualties in 2014 (accounting for two fifths of the total) followed by cyclists (who made up 16.4%) and car passengers (who made up 15.5%). Motorcyclists and pedestrians each made up just under 10% of the total casualties.

The charts below show key trends since the turn of the century. Most of the main road user groups have seen a fall in the number of casualties over this period. However, injuries among pedal cyclists have shown a rising trend (as has also been reported nationally) which appears to be due at least in part to increased levels of cycling.

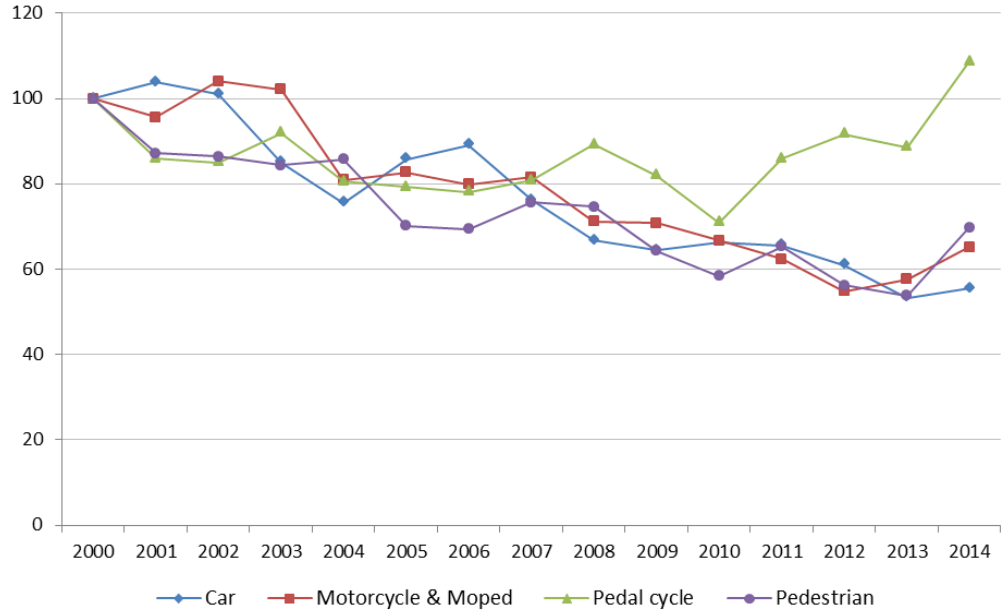
Figure 92: Number of police-reported road casualties in Oxfordshire (2000-2014)



Source: Oxfordshire County Council

[245] Oxfordshire County Council's road casualties statistics: https://www.oxfordshire.gov.uk/cms/content/road-casualties

Figure 93: Indexed comparison of police-reported road casualties in Oxfordshire (2000-2014) by specific road user-group (where casualty numbers in 2000 = 100)

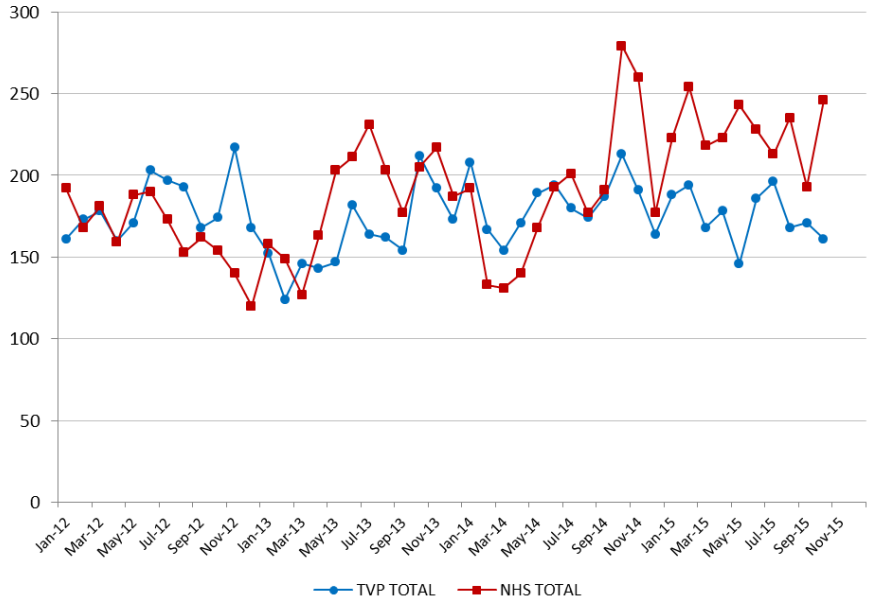


Source: Oxfordshire County Council

Men are slightly more likely than women to be killed or injured on the roads; they made up 57.7% of total casualties in 2014.

Police-reported casualty statistics are likely to underestimate the true number, as a substantial number of accidents – particularly those involving minor injuries – are not reported to the police. Some of these may, however, be reported to the health service, when casualties attend hospital Accident and Emergency (A&E) departments. The chart below compares the number of road casualties reported to police and recorded in Oxfordshire's A&E departments.

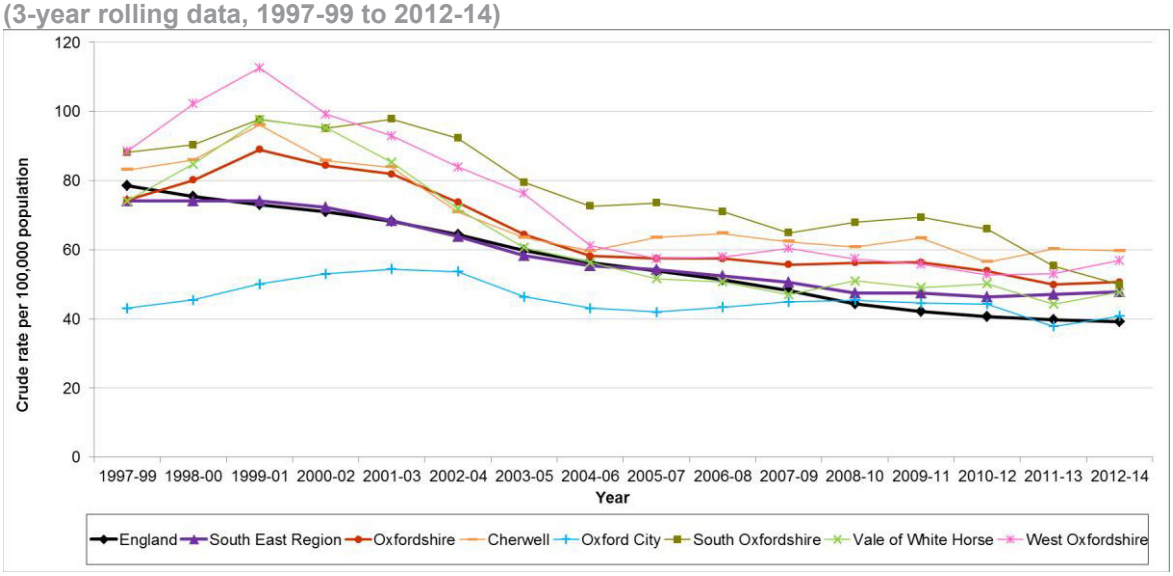
Figure 94: Number of police-reported and A&E admitted casualties in Oxfordshire (Jan 2012 - Oct 2015)



Sources: Oxfordshire County Council / Oxford University Hospitals NHS Foundation Trust

The latest 3-year rolling data for people reported to the police as killed and seriously injured (KSI) on the roads in Oxfordshire covers the period 2012-2014.[246] These statistics show a KSI rate of 50.6 people per 100,000 in the population. Since the turn of the century, there has been a general downward trend in the rate of people killed or seriously injured on Oxfordshire's roads.

Figure 95: Crude rate per 100,000 population of people killed or seriously injured on the roads (3-year rolling data, 1997-99 to 2012-14)



Sources: Department for Transport / Oxfordshire County Council

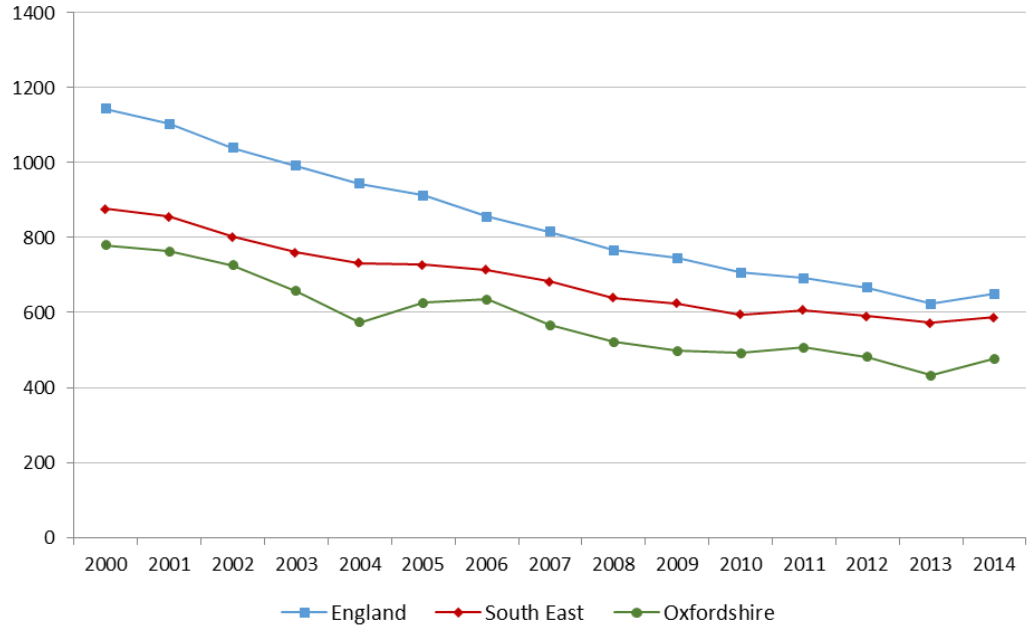
Oxfordshire continues to have a significantly higher rate of KSI per head of population (50.6 in 2012-14) than in the South East (47.9) and England overall (39.3). Across all districts except Oxford, rates exceeded the national average. Rates in Cherwell and South Oxfordshire also exceeded the regional average, whereas Oxford had a significantly lower rate than in the South East overall. When compared to its statistical neighbours on this measure, Oxfordshire's performance continues to be relatively poor.

However, a more detailed analysis of the casualty data, taking account of traffic flows by the main user groups, and the character of the roads where the casualties were sustained (whether higher speed rural environments or lower speed urban/ village settings), suggests that the actual risks faced by road users in Oxfordshire are very similar to, or lower than, those in other parts of the country. [247]

The chart below, comparing casualty rates per billion vehicle miles, shows that Oxfordshire's casualty rate has been consistently below the national and regional averages, and has fallen at a similar pace.

[246] Public Health Outcomes Framework, indicator 1.10: http://www.phoutcomes.info/
[247] Oxfordshire County Council analysis

Figure 96: Total casualty rate per billion vehicle miles (2000-2014)



Sources: Department for Transport/ Oxfordshire County Council

In summary, compared to other parts of the country, Oxfordshire has relatively more and busier rural roads but fewer residents so, whilst the population-based casualty rate is higher than average, the traffic-based rate is lower.

For more detailed information, including comparisons with Oxfordshire's statistical neighbours, see the Oxfordshire County Council Road Traffic Accident Casualty Data Summary 2014.

5.4.9. Suicide

In 2012-14 the rate of suicide and undetermined injury in Oxfordshire was 9.7 people per 100,000.[248] This was lower (although not significantly so) than rates seen across the South East (10.7) and England overall (10.6). The number of suicides in 2014 was 54, compared to 58 in 2013. In Oxfordshire, the suicide rate in men is around three times the rate in women, in line with the national picture.

Because of the small numbers involved, it is difficult to establish clear patterns in suicide rates over time or across different parts of the county.

[248] Health and Social Care Information Centre Compendium of Population Health Indicators: http://www.hscic.gov.uk/

6. Lifestyles

This section presents data on lifestyle factors that affect health and wellbeing, such as smoking, drinking, drugs, weight, and exercise. Further resources are available online, by visiting the JSNA – Lifestyles webpage.

6.1. Overview of Risk Factors

New national research estimates that dietary risks are the single largest risk factor for health, accounting for around one tenth of the total burden of ill health, disability, and early death in the South East of England in 2013.[249] These were closely followed by tobacco smoke and having a high body-mass index, which each account for around 9% of the burden. Other important behavioural risk factors included alcohol and drug use, accounting for 5.5% and low physical activity, accounting for 2.7%.

6.2. Excess Weight and Obesity

There is now a considerable amount of evidence linking obesity with a wide range of health issues.[250] Compared with a non-obese man, an obese man is five times more likely to develop Type 2 Diabetes, three times more likely to develop cancer of the colon and more than two and half times more likely to develop high blood pressure (a major risk of stroke and heart disease). An obese woman, compared with a non-obese woman, is almost thirteen times more likely to develop Type 2 diabetes, more than four times more likely to develop high blood pressure and more than three times likely to have a heart attack. Risks of other diseases, including angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke, are also increased.

A complex range of factors are linked to obesity, including poverty and deprivation, parental weight, and access to green spaces.[251]

6.2.1. Excess Weight in Adults

Excess weight in adults is recognised as a major determinant of premature mortality and avoidable ill health. The Active People Survey began including questions on height and weight for the first time from January 2012 to enable the monitoring of excess weight in adults at a local level.[252] An indicator measuring excess weight in adults is now calculated from three years of Active People Survey (APS) data combined, rather than a single year as previously used (i.e. for 2012). This means that trend data are not available.

The latest 3-year rolling data for Oxfordshire on excess weight in adults covers the period 2012-2014.[253] This estimates that 60.9% of those aged 16 and over are classified as overweight or obese. This is lower than both the average for England (64.6%) and the average for the South East (63.4%). Adults in Oxford were less likely to be overweight than in other districts; this may relate in part to its younger age profile.

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[249] Institute for Health Metrics and Evaluation (IHME). **GBD Compare - Public Health England**. Seattle, WA: IHME, University of Washington, 2015. Available from http://vizhub.healthdata.org/gbd-compare. (Accessed November 2015)

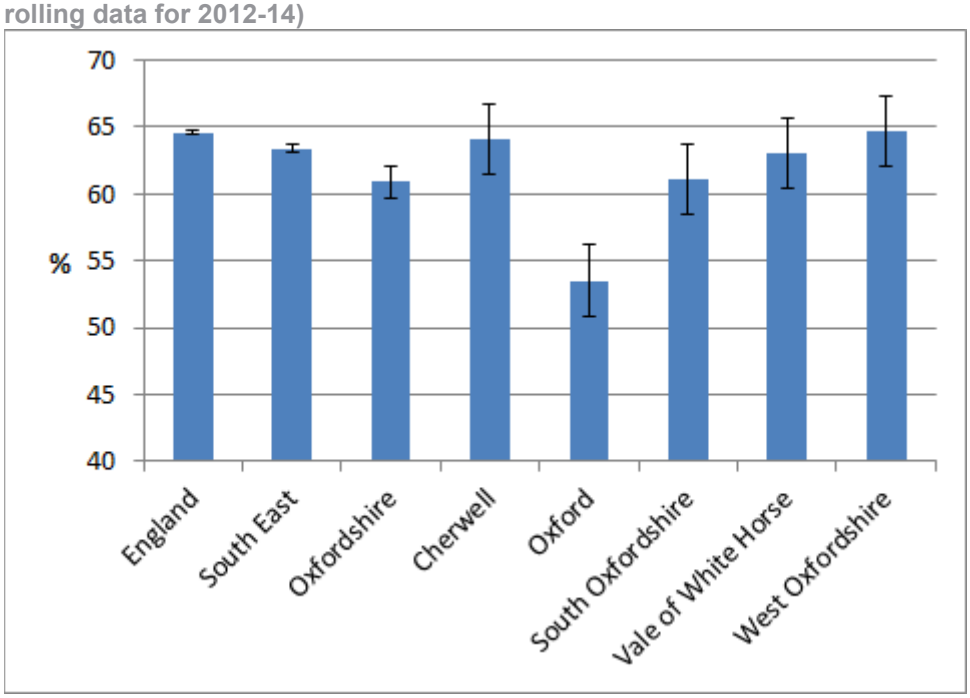
[250] Data in this paragraph are from Public Health England web resources on health risks (accessed November 2015): http://www.noo.org.uk/NOO_about_obesity/adult_obesity/Health_risks

[251] Parkhurst, A. (2014). Fat Chance? Exploring the evidence on who becomes obese: http://www.2020health.org/2020health/Publications/Publications-2015/Fat-chance.html

[252] Public Health Outcomes Framework, indicator 2.12: http://www.phoutcomes.info/. Adults are defined as overweight (including obese) if their body mass Index (BMI) is greater than or equal to 25kg/m^2. As this is the first year of recorded data it is not possible to examine trends.

[253] Public Health Outcomes Framework, indicator 2.12: http://www.phoutcomes.info/

Figure 97: Excess weight in adults in England, South East, Oxfordshire and its districts (3-year rolling data for 2012-14)



Source: Public Health Outcomes Framework/ Active People Survey, Sport England. *NB The vertical axis starts at 40% not 0%.*

GP practices maintain a register of patients aged 16 or over who have been recorded as having a body mass index (BMI) of 30 or above during the preceding 12 months. The quality of the data is dependent on recording within practices.

In 2014/15 there were around **43,000 GP-registered patients aged 16 and over** in the Oxfordshire Clinical Commissioning Group area who were recorded as being obese in the previous 12 months.[254] This number has fallen by around 1,500 since 2013/14. The prevalence rate of obesity likewise fell from 7.7% to 7.4% of patients aged 16 and over. This is in line with national trends. The rate for Oxfordshire remains below the averages for England (9.0%) and the South (8.2%).

The table below shows the 5 Oxfordshire GP practices with the highest recorded rates for obesity. It is important to remember that rates have not been standardised by age or sex, and will be affected by the underlying social and demographic characteristics of each practice's patient population. The quality of the data is also dependent on diagnosis and recording within practices. However, the figures give a snapshot of where health needs relating to excess weight may be the greatest.

[254] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887. Obesity is defined as having a body mass index (BMI) of 30 or above.

Figure 98: Oxfordshire GP practices with the highest recorded rates of obesity

Practice Name	Ward*	District*	Obesity rate
Nettlebed Surgery	Watlington	South Oxfordshire	16.2%
Broadshires Health Centre	Carterton North East	West Oxfordshire	13.6%
North Bicester Surgery	Bicester North	Cherwell	12.1%
Berinsfield Health Centre	Berinsfield	South Oxfordshire	12.0%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	11.9%

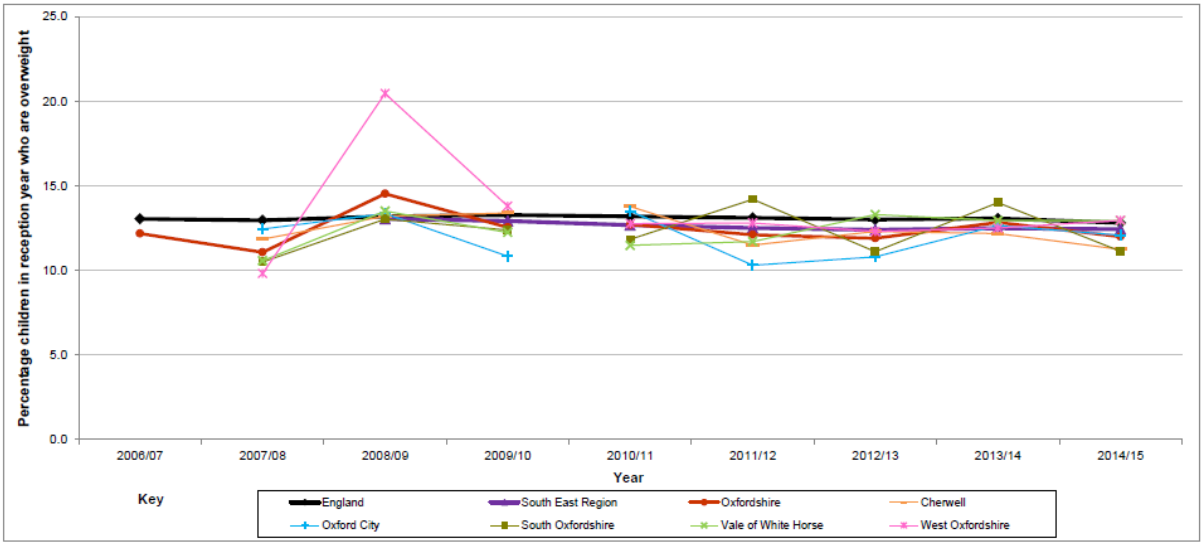
*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

6.2.2. Excess Weight in Children

Being obese or overweight can increase the risk of developing a range of serious diseases in later life. Children in Reception year and Year 6 have been measured in schools since 2006/7 under the National Child Measurement Programme (NCMP). The latest data available are for the school year 2014/15.[255]

Prevalence of excess weight among children has remained fairly stable, with some fluctuation at district level. The data for 2014/15 show that 11.9% of reception-age children were overweight and a further 6.6% were obese.

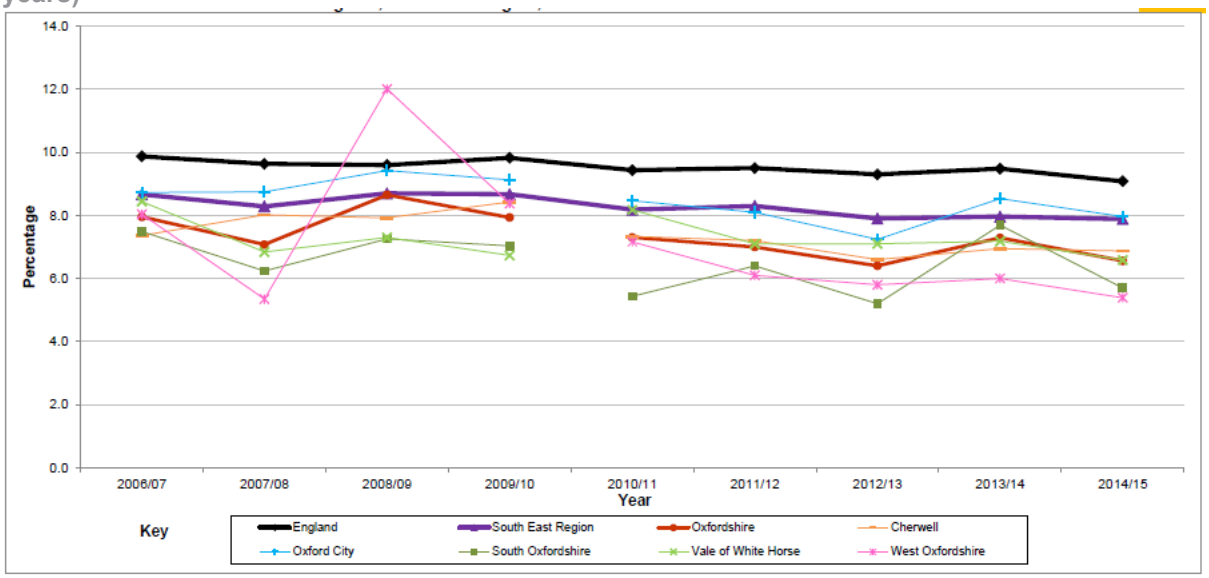
Figure 99: Percentage of Reception Year children who are overweight (2006/07-2014/15 academic years)[256]



Source: National Child Measurement Programme

[255] National Child Measurement Programme: http://www.hscic.gov.uk/ncmp
[256] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

Figure 100: Percentage of Reception Year children who are obese (2006/07-2014/15 academic years)[257]

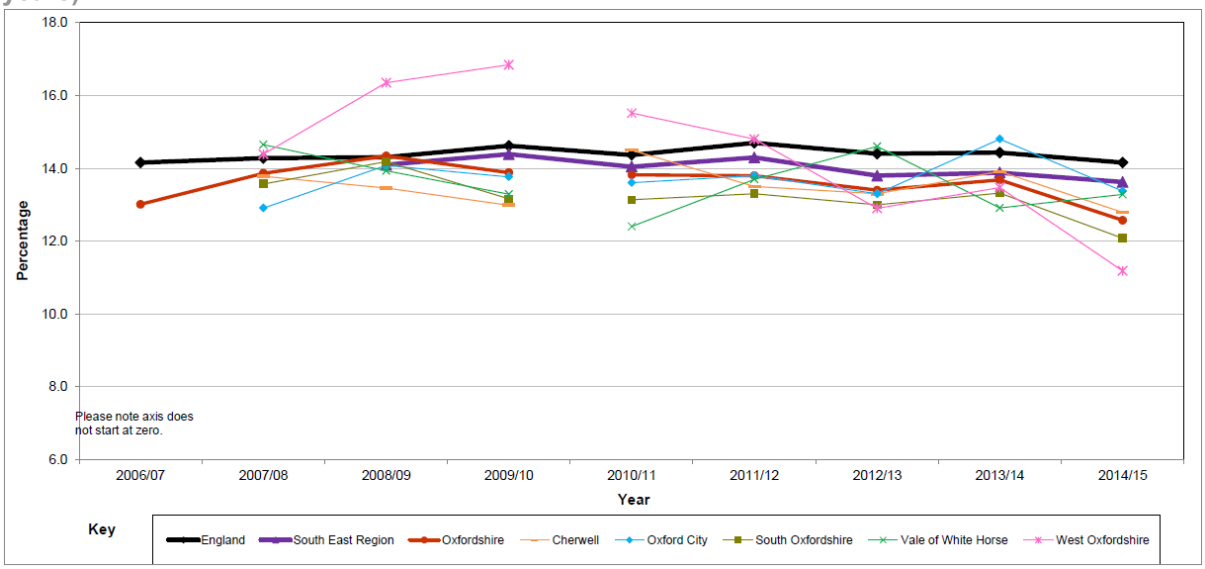


Source: National Child Measurement Programme

For Year 6 children, 12.6% were overweight and another 16.2% were obese. These rates were significantly lower than in England overall. Three of Oxfordshire's districts (West Oxfordshire, Vale of White Horse, and South Oxfordshire) continue to have lower levels of childhood excess weight than the national average. However, Cherwell has moved closer to the national average in 2014/15 and its Year 6 obesity rate is no longer better than the national average.

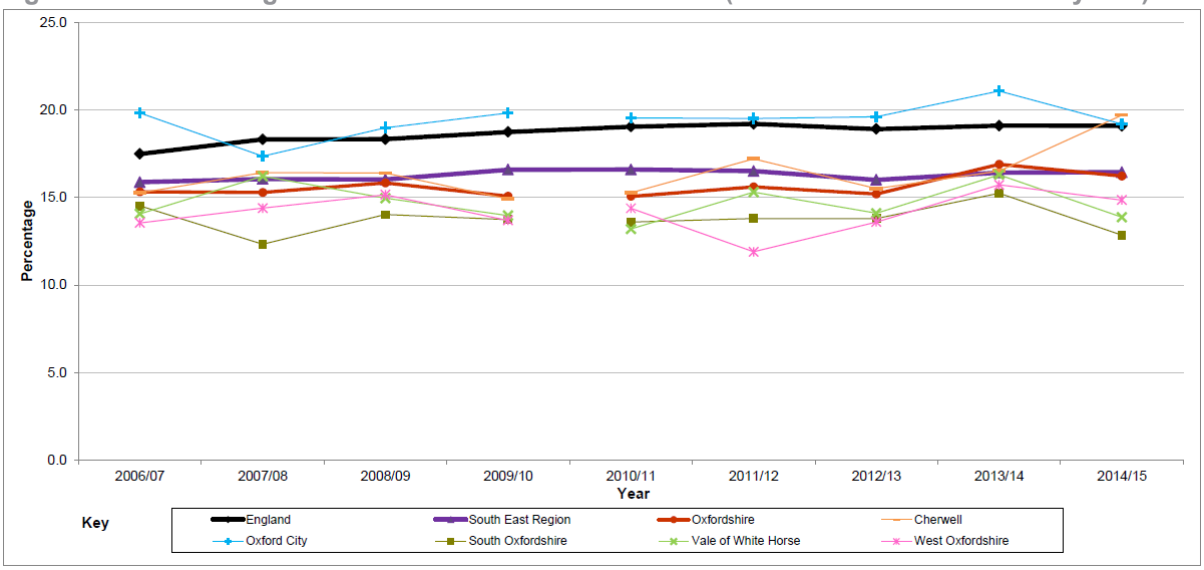
[257] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

Figure 101: Percentage of Year 6 children who are overweight (2006/07-2014/15 academic years)[258]



Source: National Child Measurement Programme

Figure 102: Percentage of Year 6 children who are obese (2006/07-2014/15 academic years)[259]



Source: National Child Measurement Programme

6.3. Physical Activity

People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared with those who have a sedentary lifestyle.[260] Meanwhile, physical inactivity has been linked to a range of other health

[258] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

[259] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

[260] Public Health Outcomes Framework: http://www.phoutcomes.info/.

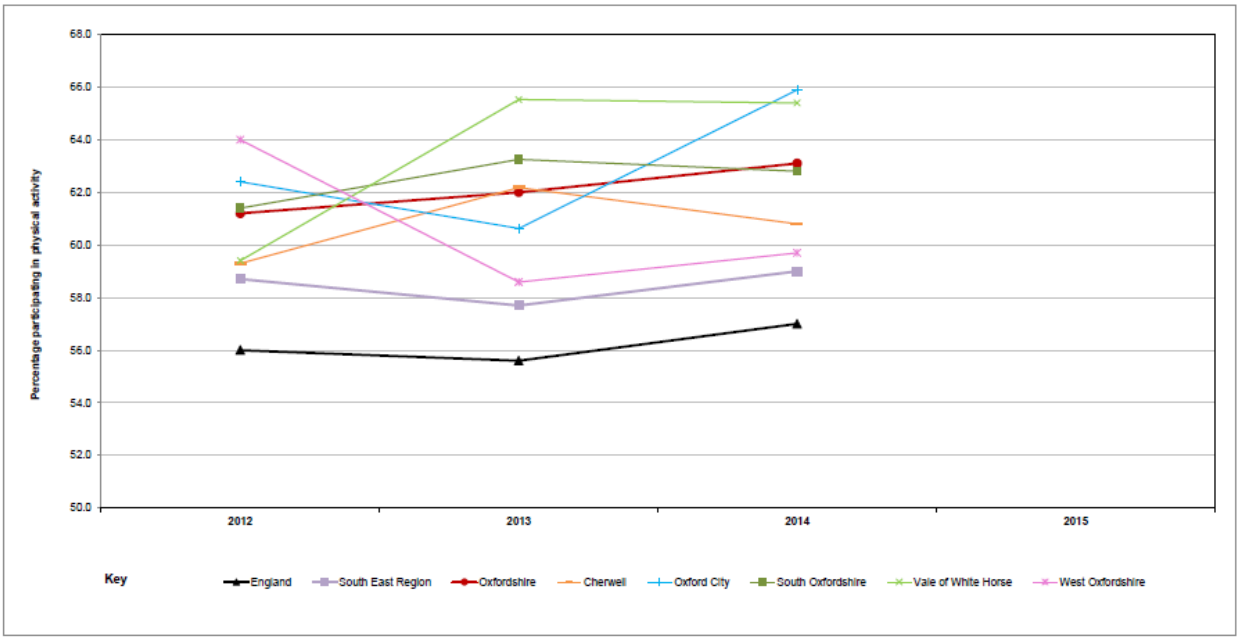
conditions, including diabetes and some cancers; it is estimated to be responsible for a significant proportion of premature all-cause mortality.[261]

The Chief Medical Officer currently recommends that adults undertake 150 minutes (2.5 hours) of moderate activity per week in stints of 10 minutes or more.

In 2014 an estimated 63.1% of those aged 16 years and over in Oxfordshire achieved at least 150 minutes of physical activity per week.[262] This was similar to the level for the previous two years year (60%) and higher than the averages in the South East (59%) and England overall (57%).

Across the county, estimates varied from 59.7% in West Oxfordshire to 65.9% in Oxford. However, these differences were not statistically significant, due to wide confidence levels.

Figure 103: Percentage of adults aged 16+ participating in sport and recreational activity (2012-2014)



Source: Sport England Active People Survey

Those who do less than 30 minutes of at least moderate intensity physical activity per week are classed as 'physically inactive'.[263] In 2014 an estimated 21.9% of people aged 16 years and over in Oxfordshire were physically inactive. This was similar to previous years (23% in 2013 and 22% in 2012). The proportion was significantly lower than in the South East (25.4%) and England overall (27.7%). According to the publication "Turning the Tide of Inactivity" Oxfordshire has the 9th lowest level of inactivity of 150 local authorities.[264]

[261] See, for example, Ekelund et al. (2015). Physical activity and all-cause mortality across levels of overall and abdominal adiposity in European men and women: the European Prospective Investigation into Cancer and Nutrition Study (EPIC). *American Journal of Clinical Nutrition:* http://ajcn.nutrition.org/content/early/2015/01/14/ajcn.114.100065.full.pdf+html; *Making the Case for Physical Activity:* (British Heart Foundation National Centre, 2013): http://www.bhfactive.org.uk/resources-and-publications-item/40/419/index.html

[262] Public Health Outcomes Framework, indicator 2.13i: http://www.phoutcomes.info/. Until more years of data become available it is not possible to say whether or not physical activity participation is increasing.

[263] Public Health Outcomes Framework, indicator 2.13ii: http://www.phoutcomes.info/

[264] Turning the Tide of Inactivity (2014): http://www.ukactive.com/turningthetide/

6.4. Smoking

Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease.

In 2014 an estimated 13.6% of adults in Oxfordshire were smokers.[265] This figure has fallen over the past five years, from 18.5% in 2010. It is now significantly lower than both the national and regional averages (18.0% and 16.6%, respectively). However among routine and manual workers there is no significant difference (29.3% in Oxfordshire, 28.0% in England).

Smoking prevalence in all of Oxfordshire's districts was either below, or similar to, national and regional averages. Modelled synthetic estimates of smoking prevalence at ward-level indicate that levels of smoking may be above the national average in five wards in Oxfordshire, all of which are concentrated in Oxford and Banbury: Blackbird Leys, Banbury Ruscote, Banbury Neithrop, Northfield Brook, and Banbury Grimsbury and Castle.[266]

6.4.1. Smoking among Children

In 2014/15 an estimated 10.4% of 15 year olds were smokers.[267] This figure was significantly worse than the national average (8.2% in England) and similar to the regional figure for the South East (9.0%).

6.4.2. Smoking in Pregnancy

Smoking in pregnancy increases the risk of miscarriage, complications during pregnancy, low birth weight, congenital defects, stillbirth, or death within the first week of life. The latest figures for Oxfordshire indicate that 8.6% of women were smoking at the time of delivery during 2014/15.[268] This was significantly lower than the national average (11.4%).

6.5. Alcohol Consumption

The health harms associated with alcohol consumption are widespread. Around 9 million adults in England drinking at levels that pose some risk to their health.[269] Drinking may also harm other people.[270] Statistics on people in alcohol treatment in Oxfordshire can be found in section 7.6 below. More information about chronic alcohol use among homeless patients who present at Oxford's Luther Street Medical Centre is provided above, under section 5.3: Morbidity.

6.5.1. Alcohol-Related Hospital Admissions

The acute or long term effects of excessive alcohol consumption are a major cause of avoidable hospital admissions.[271]

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[265] Integrated Household Survey, analysed by Public Health England for the Local Tobacco Profiles, 2015: http://www.tobaccoprofiles.info/

[266] Public Health England's Tobacco Control JSNA Support Pack for Oxfordshire: http://insight.oxfordshire.gov.uk/cms/system/files/documents/20151019%20South%20East%20-%20Oxfordshire%20-%20Tobacco%20Data%20-%20JSNA%20Support%20Pack%20V3.pdf

[267] What About YOUth (WAY) survey, data available through the Public Health England Local Tobacco Profiles, 2015: http://www.tobaccoprofiles.info/

[268] Calculated by Public Health England from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD), available from the Public Health Outcomes Framework, indicator 2.03: http://www.phoutcomes.info/

[269] Local Alcohol Profiles for England: http://www.lape.org.uk/

[270] See for example, *Alcohol's Harm to Others* (Institute of Alcohol Studies, July 2015): http://www.ias.org.uk/News/2015/13-July-2015-Majority-of-Brits-harmed-by-other-peoples-drinking.aspx

[271]

In 2013/14 the directly age-standardised rate of hospital admissions for alcohol-specific conditions in Oxfordshire was 284 per 100,000 people.[272] These conditions are a direct result of alcohol consumption and are often related to high consumption levels, defined as harmful drinking, including alcohol dependency ("alcoholism").

The rate of alcohol-specific hospital admissions in Oxfordshire has remained broadly stable over the last five years. In 2013/14 it was also similar to the South East average (295) but lower than the England rate (374). The rate was higher among male residents of the county (370) than female residents (203). In absolute numbers, 1,165 men in Oxfordshire were admitted to hospital with alcohol-specific conditions, compared with 670 women.

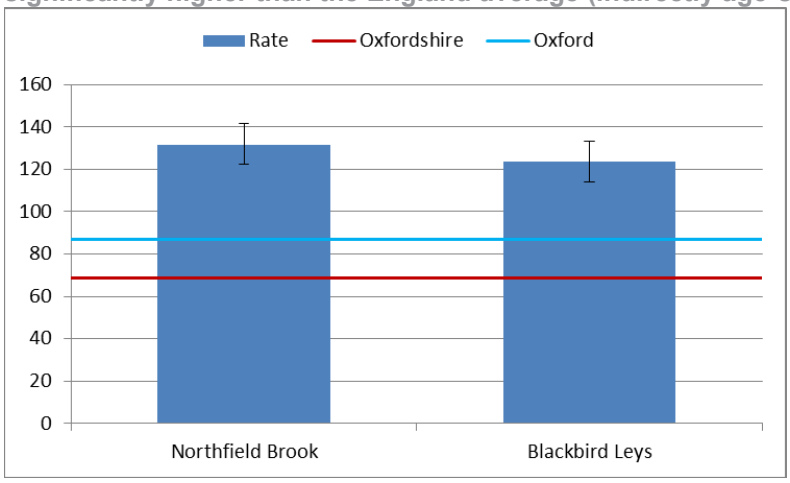
Rates of alcohol-specific admissions in Oxford were above county and national averages (estimated at 453 per 100,000 people). This was driven in particular by the high male rate in the city (estimated at 644). All other districts of the county had similar or, in many cases, significantly lower, rates relative to the regional and national averages.

Three-year rolling data for the period 2011/12-2013/14 shows that the rate of alcohol-specific hospital admissions among under 18 year olds in Oxfordshire was 41.9 per 100,000 in the population. This was statistically similar to proportions in the South East (35.6) and England overall (40.1). However, again it was higher in Oxford (72.8 per 100,000 under 18s) whilst other districts had rates similar to or lower than the national average.

Oxfordshire had relatively low rates of alcohol-*related* (as opposed to alcohol-*specific*) hospital admissions, as well as admissions for alcohol-related conditions.

Pooled data for the years 2008/09 to 2012/13 show that two wards in Oxfordshire had higher rates of hospital stays for alcohol-attributed conditions than the district, county, and national averages.[273] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 104: Oxfordshire wards with rates of hospital stays for alcohol-attributable conditions significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

[272] Public Health England Local Alcohol Profiles for England: http://fingertips.phe.org.uk/profile/local-alcohol-profiles

[273] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

6.6. Drugs

Drugs are known to have a variety of damaging effects on both physical and mental health and wellbeing.[274] Statistics on people in drug treatment in Oxfordshire can be found in section 7.6. More information about substance abuse among homeless patients who present at Oxford's Luther Street Medical Centre is provided above, under section 5.3: Morbidity.

A 2014 study indicates that the percentage of 15 year olds who have ever tried cannabis in Oxfordshire is approximately 13.8%, compared to an England average of 10.7%.[275] However the proportion who have taken drugs (excluding cannabis) in the last month is less than 1% (similar to England average).

6.6.1. New Psychoactive Substances ('Legal Highs')

The number of deaths involving new psychoactive substances (NPS) is low compared with the number of deaths involving heroin/ morphine, other opiates, or cocaine. However, over the past few years there has been a rise in NPS deaths in England, with 67 deaths registered in 2014 (up from 60 deaths in 2013).[276]

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol implemented an early warning system across Europe in 1997 to facilitate the sharing of information about new substances between EU countries. Since 2007 growing numbers of new psychoactive substances have been discovered and reported each year, from 15 in 2007 to 101 in 2014.[277]

The Psychoactive Substances Act received Royal Assent in January 2016 and is expected to come into force on 6 April 2016.

6.7. Oral Health

Poor oral health can have important physical and psychological effects for both children and adults, including pain, sleeplessness and poor dietary intake.[278] Population groups at high risk of oral diseases include:

- Older people
- People with mental illness
- Prisoners
- Homeless people
- People with drug and alcohol problems
- People with learning disabilities
- People who use tobacco

In 2011/12 the proportion of five year old children with some tooth decay experience in Oxfordshire was 32.9%.[279] This represented an increase from 25.7% in 2007/8. It was higher than the proportion for England overall (27.9%) but similar to that for the Thames Valley.

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[274] This includes, for example, links between injecting drugs and incidence of hepatitis C and bacterial infections, as evidenced in a 2014 report from Public Health England, *Shooting Up: infections among people who inject drugs in the UK* https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk

[275] What About YOUth? Survey (2014): http://www.hscic.gov.uk/article/3742/What-About-Youth-Study)

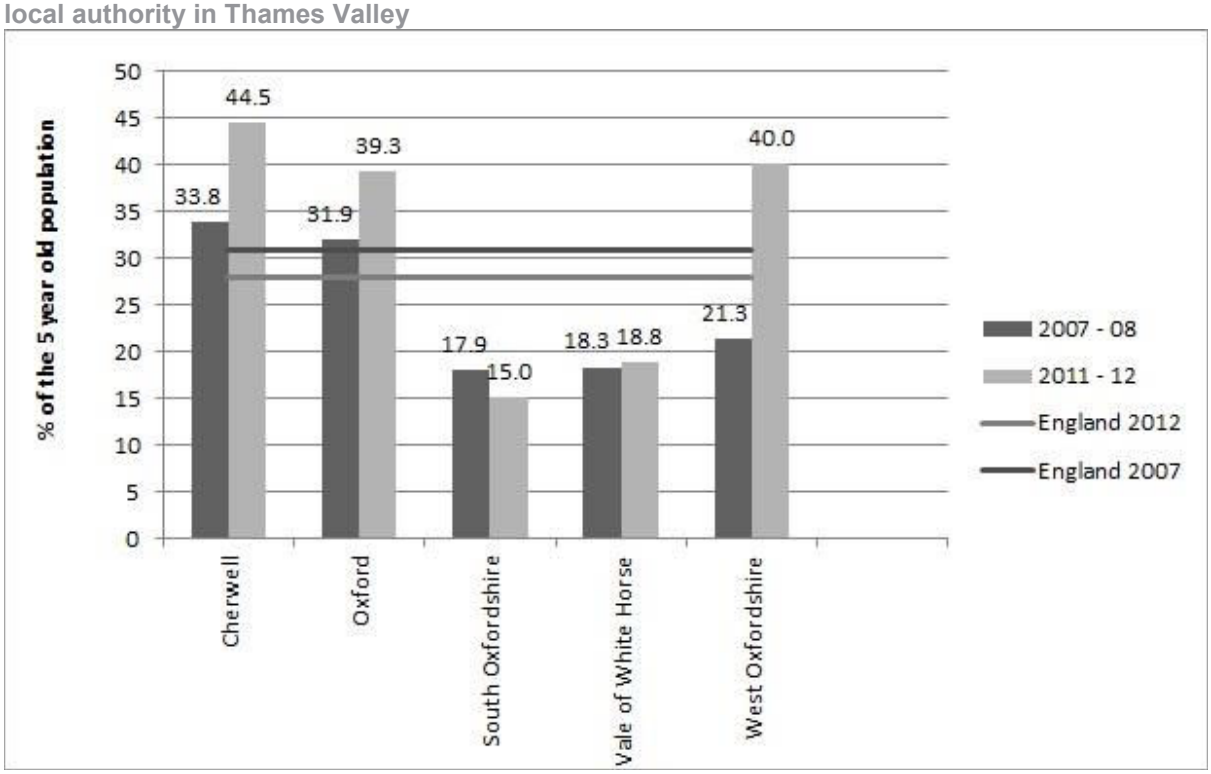
[276] Office for National Statistics: http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2014/deaths-related-to-drug-poisoning-in-england-and-wales--2014-registrations.html

[277] EMCDDA-Europol 2014 Annual Report on the implementation of Council Decision 2005/387/JHA: http://www.emcdda.europa.eu/publications/implementation-reports/2014

[278] All data and analysis on oral health included in this section have been provided by Public Health England.

Across the county fewer than two in ten five year olds in South Oxfordshire and Vale of White Horse had some tooth decay experience in 2011/12 (15% and 19% respectively). However, the proportions in other districts were above the county average: 39% in Oxford, 40% in West Oxfordshire (which saw a significant increase between 2007/8 and 2011/12) and 45% in Cherwell.

Figure 105: Proportion of 5 year olds with some tooth decay experience (d3mft>0) by lower tier local authority in Thames Valley



Source: Public Health England National Dental Epidemiology Oral Health Surveys

Children from routine and manual family backgrounds experience higher levels of decay than those from managerial and professional family backgrounds.

Nationally, rates of tooth decay among adults have fallen from 46% in 1998 to 30% in 2009. However, some adults remain at greater risk of oral disease, including those who are:

- living in deprived conditions
- reliant on others for support/care
- not attending the dentist regularly
- smoking or drinking heavily

More people are keeping their own teeth into old age: the proportion of 65-75 year olds in England with their own teeth increased from 26% in 1979 to 84% in 2009. However, as the older population increases so will the number living with long-term conditions, which can increase their risk of oral diseases. People retaining their own teeth into old age require more complex care to maintain their teeth and oral health.

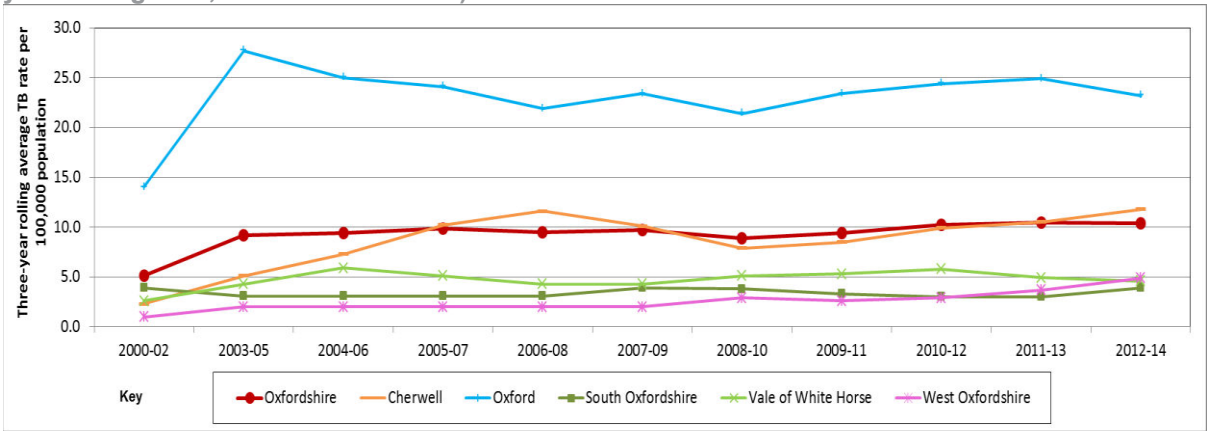
[279] Public Health England National Dental Epidemiology Oral Health Survey, 2012. Since 2007/08 the sample size has been smaller due to a change in the consent method: under positive consent parents are now required to give consent for their child to take part in the survey. If no consent is given the child is not examined.

6.8. Tuberculosis (TB)

In the past three years there has been a year on year decline in the number of tuberculosis (TB) cases in England.[280] The recent reduction is mainly due to a decline in cases in the non-UK born population, which make up nearly three-quarters of all TB cases in England.

The latest three-year rolling data for Oxfordshire, covering the period 2012-14 shows that the incidence rate of TB was 10.4 cases per 100,000 people.[281] This rate has remained stable for the last three years. It is below the national average (13.5 per 100,000 people in England) but above the regional average (8.4 cases per 100,000 people in the South East). Across Oxfordshire's districts, the highest rate is in Oxford (23.2) and this remains above the national average. However, the Oxford rate has fallen slightly in the latest three-year period.

Figure 106: Tuberculosis (TB) rates in Oxfordshire and its districts, per 100,000 population (3-year rolling data, 2000-02 to 2012-14)



Source: Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

6.9. Sexually Transmitted Infections (STIs)

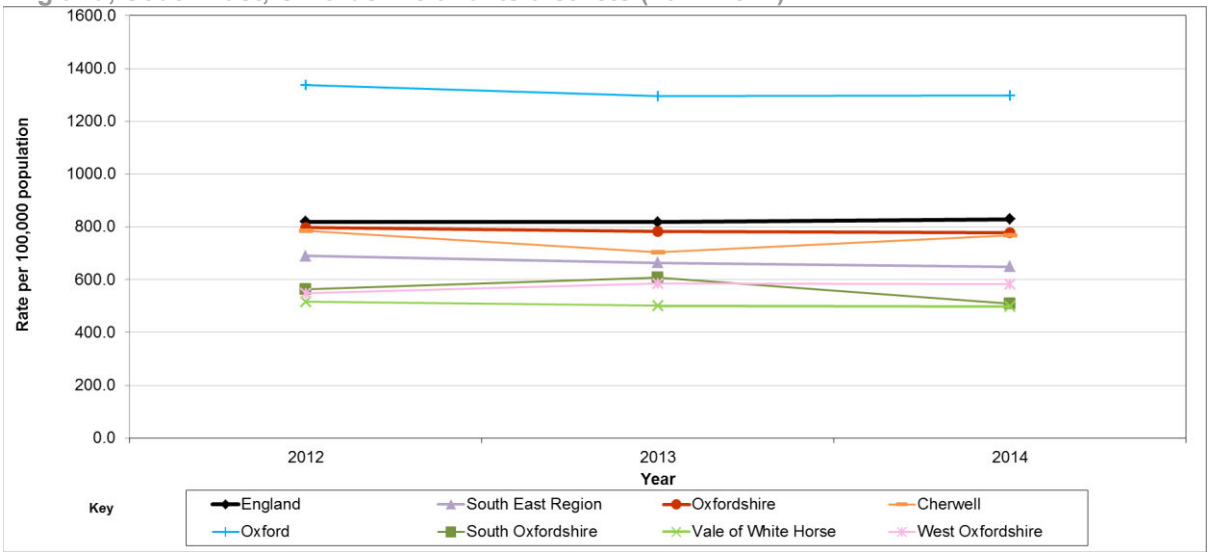
In 2014 the rate of new STI diagnoses in Oxfordshire was 777 per 100,000 people aged 15-64.[282] This was significantly lower than the national average (829). However, in Oxford City the rate (1,298) was significantly higher than the national average.

[280] Tuberculosis in England (Public Health England, 2015): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464914/TB_Annual_Report_2015.pdf

[281] Public Health Outcomes Framework, indicator 3.05ii: http://www.phoutcomes.info/

[282] Data in this section are taken from Public Health England's Sexual and Reproductive Health Profiles: http://fingertips.phe.org.uk/profile/sexualhealth

Figure 107: Rates of new sexually transmitted infections per 100,000 people aged 15-64, in England, South East, Oxfordshire and its districts (2012-2014)



Source: Public Health England

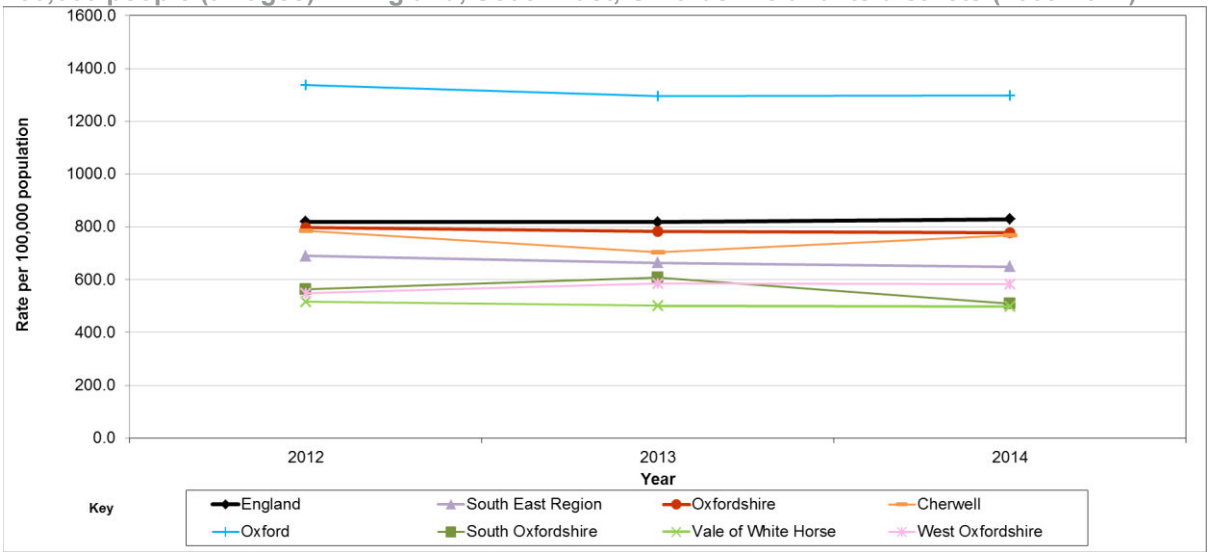
From these data it is not possible to state which STIs or age groups may be causing the rate to be high. However, nationally, the impact of STIs remains greatest in young heterosexuals under the age of 25 years and in men who have sex with men (MSM).

More information about sexual health issues among homeless patients who present at Oxford's Luther Street Medical Centre is provided above, under section 5.3: Morbidity.

6.9.1. Gonorrhoea

Gonorrhoea diagnoses have increased, which may be due in part to the introduction of the new test for gonorrhoea in August 2012. This has greatly improved sensitivity for extra-genital gonococcal infections (throat and rectum) so has increased case finding in MSM.

Figure 108: Rate of diagnoses of gonorrhoea in Genito-urinary Medicine (GUM) clinics per 100,000 people (all ages) in England, South East, Oxfordshire and its districts (2009-2014)

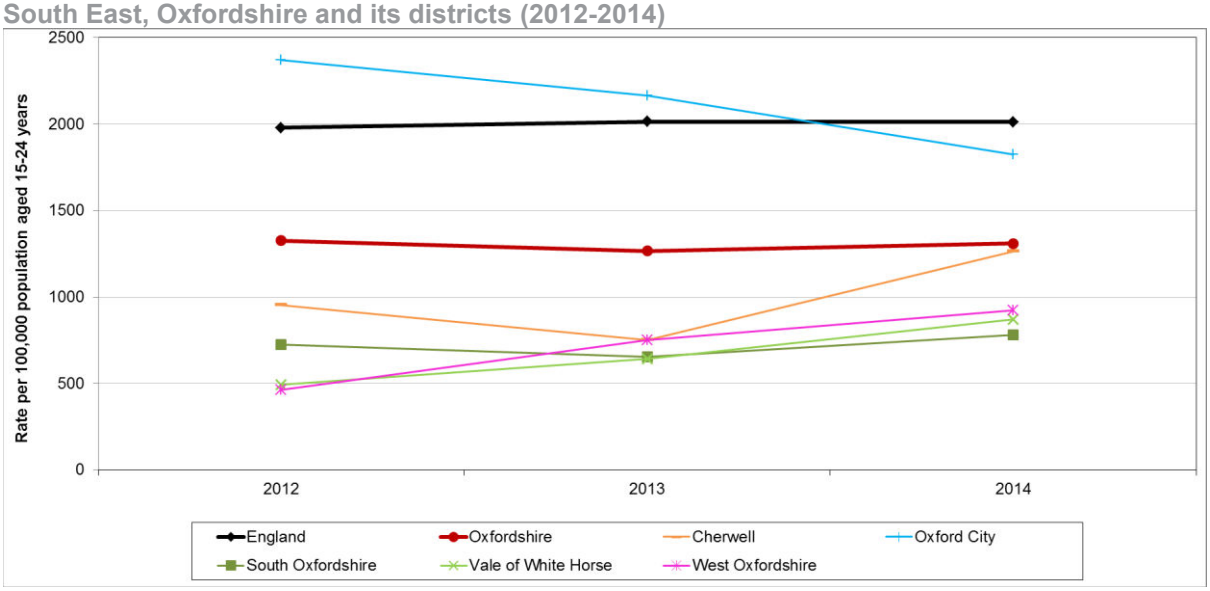


Source: Public Health England

6.9.2. Chlamydia

Chlamydia was the most commonly diagnosed STI in 2014. The detection rate for Chlamydia was set by the Department of Health as a level that would encourage high volume screening in young people under 25 years old.

Figure 109: Rate of diagnoses of chlamydia per 100,000 people aged 15-24 years, in England, South East, Oxfordshire and its districts (2012-2014)



Source: Public Health England

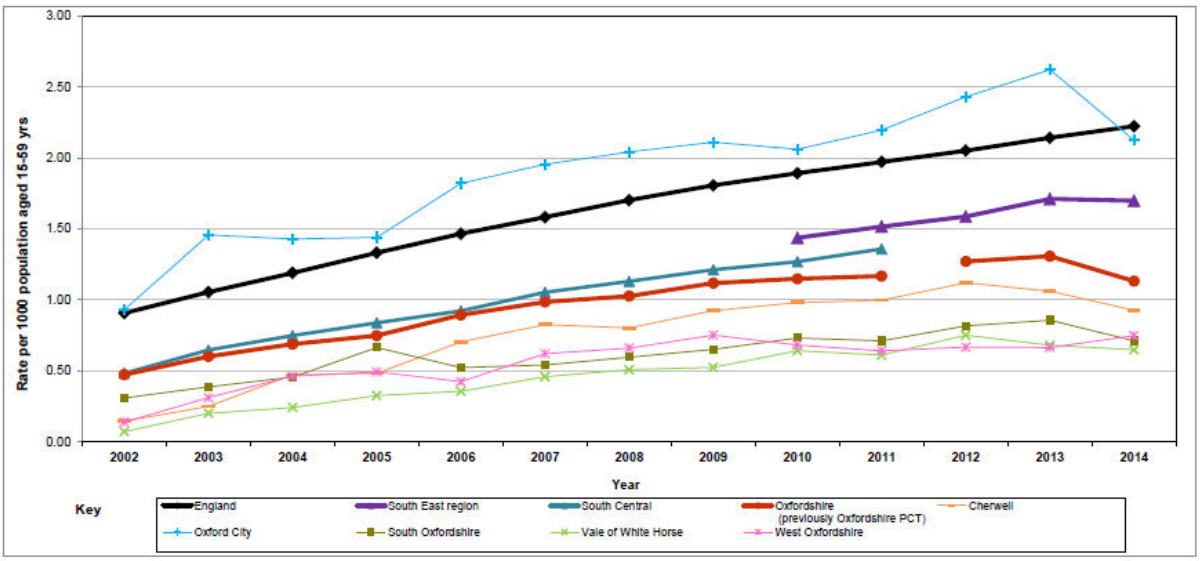
6.9.3. HIV

Human Immunodeficiency Virus (HIV) continues to be one of the most important communicable diseases in the UK. It attacks the immune system, and weakens the ability to fight infections and disease. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost. HIV is most commonly caught by having unprotected sex. It can also be passed on by sharing infected needles and other injecting equipment, and from an HIV-positive mother to her child during pregnancy, birth and breastfeeding.

Individuals who are diagnosed with HIV at early stages in their infections respond well to antiretroviral treatment, have improved health outcomes and are less likely to transmit the virus to others. Because treatment is now provided at an earlier stage in the disease, people who are HIV positive will continue to live longer so the prevalence rate will gradually increase over time i.e. the number of people living with HIV will "accumulate". As a result of this, the prevalence of people living with a diagnosis of HIV has been increasing across all geographical areas over the past 12 years.

Overall in Oxfordshire the prevalence rate of HIV is significantly lower than the national average. However more than half of the people with HIV live in Oxford City which, until recently, has had a significantly higher prevalence rate than England.

Figure 110: Prevalence of diagnosed HIV per 1,000 population aged 15-59 (2002-2014)[283]



Source: Public Health England

6.10. Teenage Conceptions

The latest 3-year rolling data for 2011-2013 indicates that in Oxfordshire there were 19.9 conceptions per 1,000 girls aged 15-17 years.[284] Teenage conceptions have fallen in Oxfordshire, as they have nationally. The current rate for Oxfordshire is lower than that of the South East (23.3) and England (27.6). Across the county, higher rates in Oxford have continued to fall and now remain lower than the national average.

There are some wards in Oxfordshire that continue to have high rates or high numbers of teenage conceptions. These are predominantly in parts of Oxford (including in Iffley Fields, Holywell and St Mary's, Northfield Brook, Rose Hill & Iffley, Barton & Sandhills and Blackbird Leys) and parts of Cherwell (including in Banbury Grimsbury & Castle, Banbury Ruscote and Bicester East).

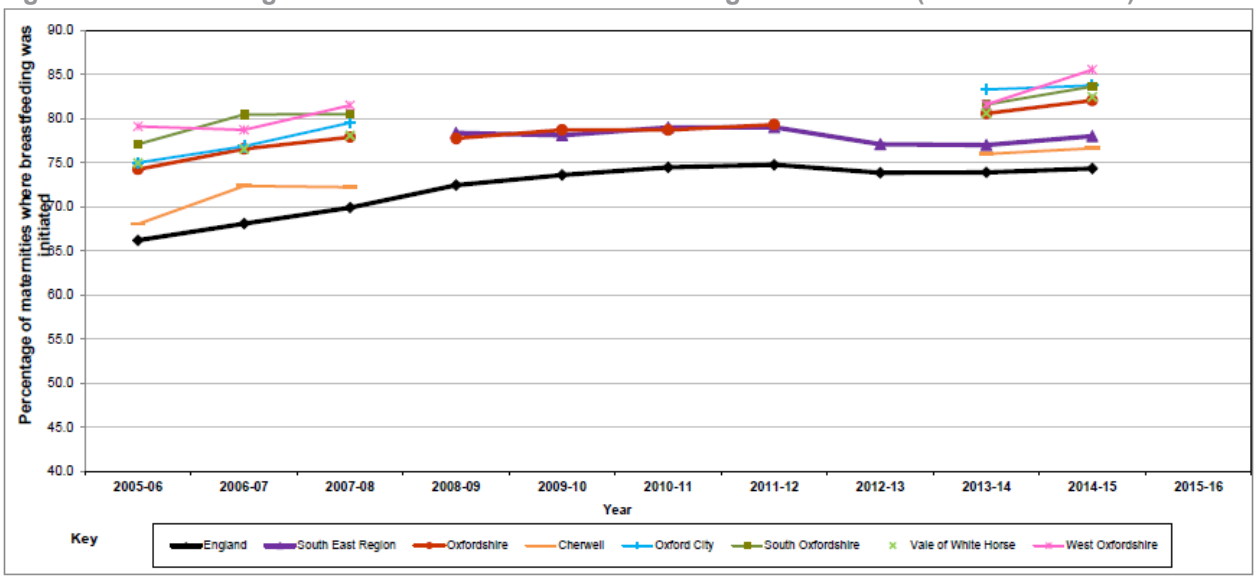
6.11. Breastfeeding

Breastfeeding has been found to give a baby the best possible nutrition, and protect against disease and future obesity, as well as encouraging a strong bond between mother and baby.

[283] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.
[284] ONS Conceptions Statistics: http://www.ons.gov.uk/ons/rel/vsob1/conception-statistics--england-and-wales/2013/index.html

Breastfeeding initiation measures the very first stages of breastfeeding. A mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast or the baby is given any of the mother's breast milk. This is useful but is no guarantee of continued breastfeeding. In 2014/15, 82.1% of mothers in Oxfordshire initiated breastfeeding.[285] This rate is similar to the previous year and is significantly higher than the England average (74.3%) and that for the South East (78.0%).

Figure 111: Percentage of maternities where breastfeeding was initiated (2005/06-2014/15)[286]



Source: Public Health England

The proportion of babies who were being breastfed at 6-8 weeks in 2014/15 was a little lower than initiation, at 62.6%.[287] This rate has been increasing in recent years and it remains significantly higher than in England overall (43.8%).

Rates vary among Oxfordshire districts but all are significantly higher than national averages, both for breastfeeding initiation and at 6-8 weeks.

[285] NHS England data, available through the Public Health Outcomes Framework, indicator 2.02i: http://www.phoutcomes.info/

[286] The gap in trend data between 2007-08 to 2008-09 reflects a methodological change in the way local data were gathered and analysed.

[287] NHS England data, available through the Public Health Outcomes Framework, indicator 2.02ii: http://www.phoutcomes.info/

7. Service Use

This section sets out the changing demand for health and social care services across Oxfordshire. A small amount of summary information is included on the quality of services. Further resources are available online, by visiting the JSNA – Service Use webpage.

The Oxfordshire Clinical Commissioning Group (OCCG) is responsible for commissioning the vast majority of the healthcare provided to patients registered at Oxfordshire-based General Practitioners (GP) practices.

Reports published by Healthwatch Oxfordshire provide more information about the quality of services, from a patient perspective.

7.1. Primary Health Care

7.1.1. GP Practice Population

As of 1st January 2016, there were 77 General Practitioners (GP) practices in the Oxfordshire Clinical Commissioning Group (OCCG) area, with 720,029 registered patients.[288] Across England, demand for general practice is increasing as the population grows in size and ages.[289]

The latest data on GP rates show that in September 2014 there were 75.6 GPs per 100,000 people in the Oxfordshire CCG area.[290] This rate has remained reasonably similar over the past few years. It was above the England average of 66.5.

Nationally, 92% of people live within 2 kilometres of a GP surgery, but there are stark differences between urban and rural areas: only 1% of people in urban areas do not have a GP surgery within 2 kilometres, compared with 37% in rural areas.[291] Deprived areas have also been found to have a lower ration of GPs and nurses to patients.[292]

7.1.2. Contact with GPs

Survey data for 2015 shows that just over half of patients registered with GPs in the Oxfordshire Clinical Commissioning Group area reported having seen or spoken to a GP within the last three months (51%).[293] This compares with 54% in 2014 (although it is not clear whether the difference is statistically significant). Just under seven in ten said they had done so in the last six months (68%). This compares with 71% in 2014, although the difference is not statistically significant. There is also no statistically significant difference from the England average of 70%.

Nationally, patient satisfaction with access to GP appointments is declining and was found to be worse among younger patients and people from Black, Asian and minority ethnic groups.[294]

[288] Health & Social Care Information Centre: http://www.hscic.gov.uk/
[289] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/
[290] Health and Social Care Information Centre LBOI Indicator 8.1: https://indicators.ic.nhs.uk/webview/
[291] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/
[292] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/
[293] GP Patient Survey (January 2016 release): https://gp-patient.co.uk/surveys-and-reports
[294] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/

7.1.3. Out of Hours GP Services

In the 12 months leading to end of September 2015 OCCG commissioned 106,849 Out-of-Hours contacts. This is a similar level of activity to the previous 12 months. 59,680 of the contacts involved patients attending primary care centres, 34,749 concluded on telephone advice, with the remaining 12,420 involving a patient receiving a visit at their home.

7.1.4. GP Patient Survey

The GP Patient Survey takes place twice a year and asks patients about experiences of their local GP surgery and other local NHS services.[295]

In 2015 just under nine in ten (88% of) patients registered with GPs in the Oxfordshire Clinical Commissioning Group area rated their overall experience of their GP surgery as (very or fairly) good. 82% said they would (definitely or probably) recommend the surgery to someone who has just moved into the local area. These statistics are broadly in line with findings from the previous two years.

Satisfaction and advocacy rates in Oxfordshire were significantly higher than for England overall, where 85% rated their GP surgery as good and 78% said they would recommend it.

In March 2015 Healthwatch published research into people's most common problems with primary care: http://www.healthwatch.co.uk/primarycare

7.2. Secondary Health Care

Nationally, hospital admissions in 2014/15 were up 2.8% on 2013/14 levels, and 31.3% on the levels of ten years ago.[296] The rise in the number of hospital admissions has outpaced population growth, which is likely to be partly to do with the ageing population. However, the length of stay in hospital has been gradually falling over the same period. The Thames Valley has the lowest rate of admissions per head of population of any NHS area team in England.

7.3. Planned Secondary Health Care

The OCCG expects demand to rise at a faster rate than average population growth across the range of planned secondary health care services which they commission, due principally to the changing (ageing) profile of their population.[297]

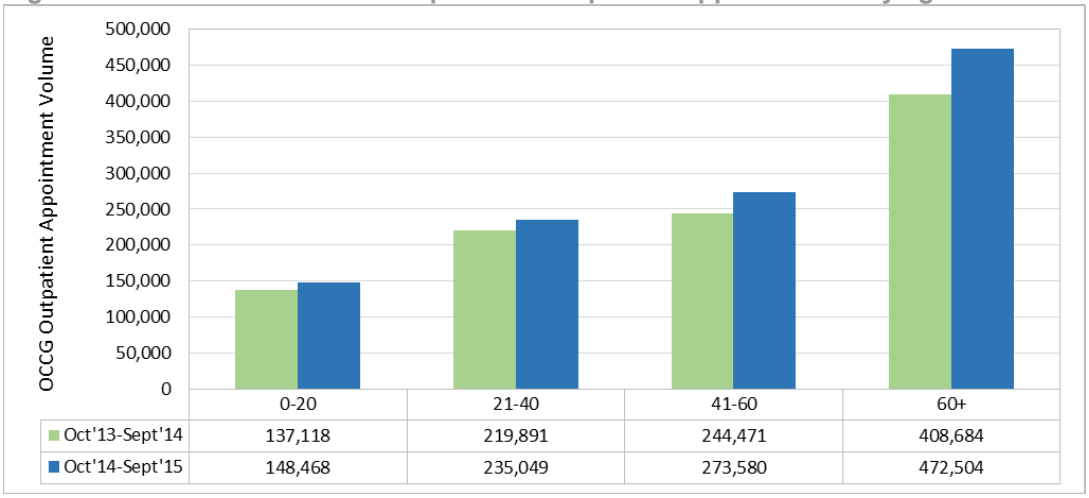
7.3.1. Outpatient Appointments

'Outpatients' are people referred to attend short appointments in hospital.

In the 12 months to the end of September 2015, patients registered with GP practices in the OCCG area scheduled 1,129,601 outpatient appointments. This represents a rise of 10.6% on the previous 12 months' volume of 1,010,164 appointments. 5.1% of scheduled outpatient appointments in this period did not go ahead due to the patient not attending.

[295] GP Patient Survey (January 2016 release): https://gp-patient.co.uk/surveys-and-reports
[296] Hospital Episode Statistics, Admitted Patient Care, England – 2014-15 (Health and Social Care Information Centre, November 2015): http://www.hscic.gov.uk/catalogue/PUB19124
[297] Data in this section, including information about expected changes in service demand, has been provided by the Oxfordshire Clinical Commissioning Group.

Figure 112: Distribution of OCCG patients' outpatient appointments by age



	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

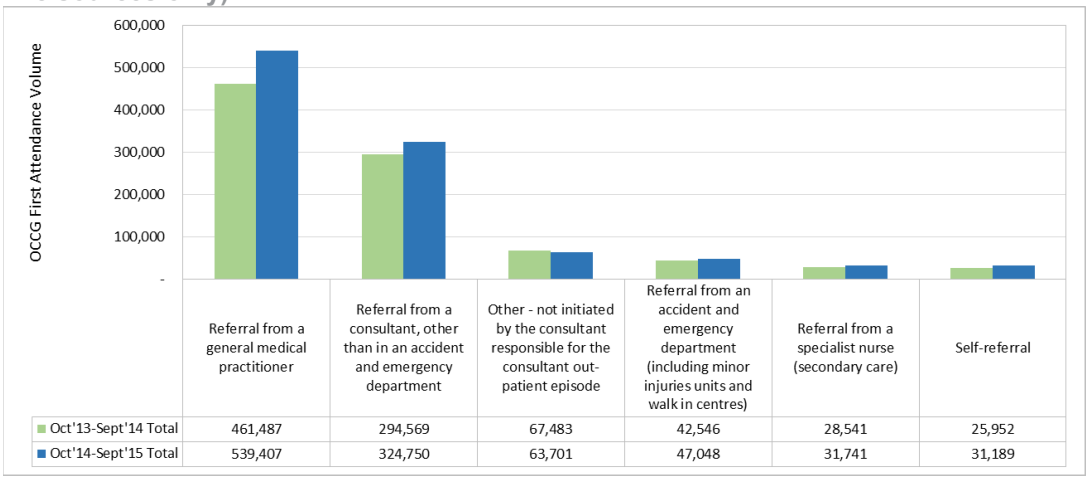
Source: Oxfordshire Clinical Commissioning Group

Around 90% of outpatient appointments can be categorised as 'first attendances' or 'follow-up appointments'. These are discussed in more detail in the next two subsections.

First Attendances

In the 12 months to the end of September 2015, patients registered with GP practices in the OCCG area scheduled 336,180 outpatient first attendances, of which 190,858 (56.8%) resulted from GP referrals. This represents an overall decrease on the previous 12 months, which saw 344,129 attendances, but an increase in GP referrals from 174,414.

Figure 113: Distribution of OCCG patients' first outpatient appointments by referral source (top five sources only)



	Referral from a general medical practitioner	Referral from a consultant, other than in an accident and emergency department	Other - not initiated by the consultant responsible for the consultant out-patient episode	Referral from an accident and emergency department (including minor injuries units and walk in centres)	Referral from a specialist nurse (secondary care)	Self-referral
Oct'13-Sept'14 Total	461,487	294,569	67,483	42,546	28,541	25,952
Oct'14-Sept'15 Total	539,407	324,750	63,701	47,048	31,741	31,189

Source: Oxfordshire Clinical Commissioning Group

Follow-Up Appointments

In the 12 months to the end of September 2015 the number of follow-up outpatient appointments among patients registered with GP practices in the OCCG area was 650,624. This represents an increase on the previous 12 months' figure of 568,559 appointments.

Community Hospital Admissions

During the 12 months to the end of September 2015, OCCG commissioned 2,222 community hospital admissions in Oxford Health Foundation Trust, the OCCG's largest community hospital provider. This is a reduction of 17.4% on the previous 12 months which saw 2,690 admissions.

7.3.2. Elective Admissions

Elective admissions are planned admissions to hospital, for stays of one or more nights.

Elective admissions accounted for 15,423 hospital encounters by patients registered with GPs in the OCCG area in the 12 months to the end of September 2015. This is a 1.0% increase on the previous 12 months, which saw 15,266 admissions. It is likely that some patients experienced multiple admissions, so this figure is not representative of the patient count.

7.3.3. Day Case Admissions

Day case admissions are planned admissions to hospital, where patients do not need to stay overnight. This includes patients who are undertaking a series of planned regular admissions to administer broadly similar treatments (for example, dialysis or chemotherapy).

In the 12 months to the end of September 2015, there were 73,146 day case attendances made by patients registered with GP practices in the OCCG area. This is an increase of 0.2% on the previous 12 months, which saw 73,015 attendances. It is likely that some patients experienced multiple admissions, so this figure is not representative of the patient count.

7.3.4. District Nursing

In the 12 months to the end of September 2015 OCCG commissioned 260,153 district nurse contacts for patients registered with GP practices in the OCCG area. This represents a 3.0% reduction on the previous 12 months' activity of 268,059 contacts.

7.4. Emergency and Unplanned Health Care

Across the range of emergency care services commissioned by Oxfordshire Clinical Commissioning Group (OCCG), the OCCG expects demand to rise at a faster rate than average population growth, due principally to the changing (ageing) profile of the population.[298] For the same reason, it expects admissions to involve longer average stays in hospital.

7.4.1. Accident and Emergency (A&E)

A&E Attendance

Nationally, A&E attendances have been rising every year since 2001/02.[299]

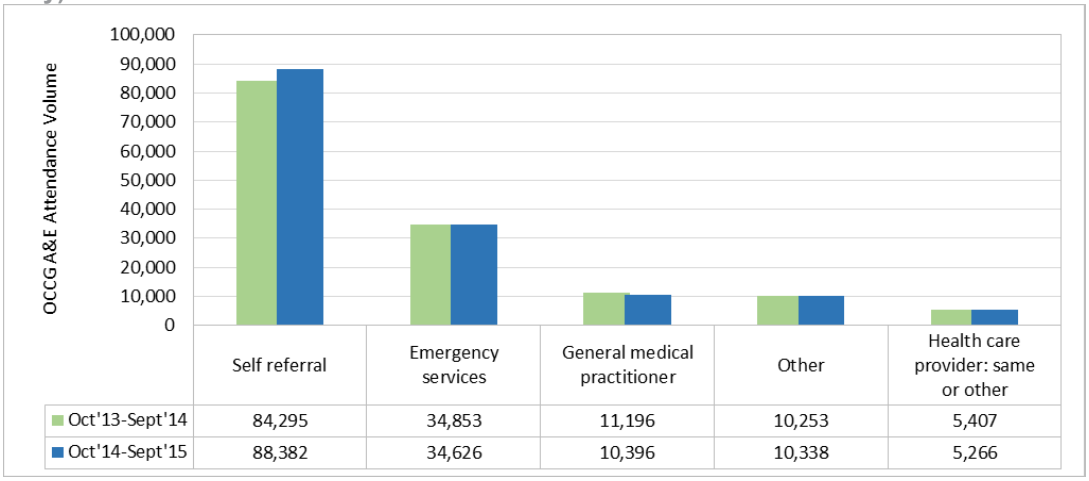
In the 12 months to the end of September 2015, patients registered with GP practices in the OCCG area attended A&E 152,725 times. This represents an increase of 1.4% on the previous 12 months, when attendances totalled 150,661. Attendances among OCCG patients occurred across the country at over 200 providers and hospitals. However, the majority were treated by Oxford University Hospitals NHS Foundation Trust (101,938), Oxford Health NHS Foundation Trust (31,321), and the Royal Berkshire Foundation NHS Trust (5,760).

Of attendances where the referral source was recorded (99.9% of the total) a marginal reduction of 0.5% was observed in the total number of emergency service referrals. However, self-referrals increased by 4.8%.

[298] Data in this section, including information about expected changes in service demand, has been provided by the Oxfordshire Clinical Commissioning Group.

[299] Key facts and trends in acute care (NHS Confederation, November 2015): http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/NHSC%20factsheet%20Nov%20WEB.pdf

Figure 114: Distribution of OCCG patient A&E attendances by referral source (top five sources only)

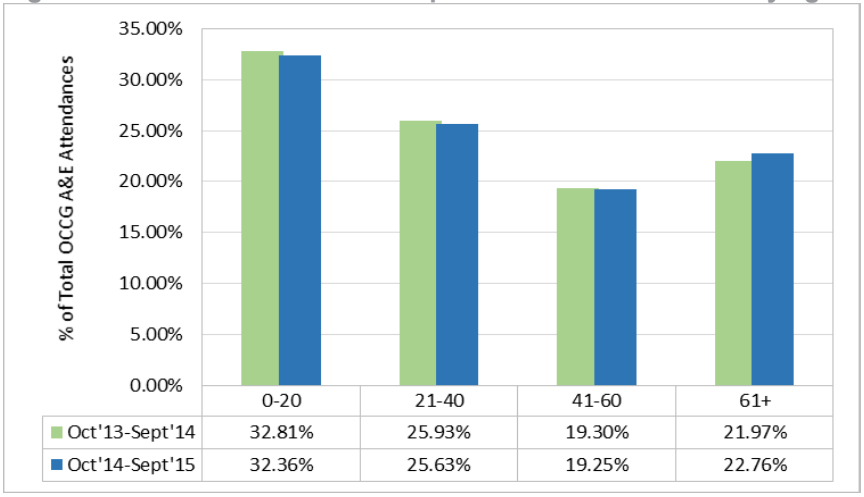


	Self referral	Emergency services	General medical practitioner	Other	Health care provider: same or other
Oct'13-Sept'14	84,295	34,853	11,196	10,253	5,407
Oct'14-Sept'15	88,382	34,626	10,396	10,338	5,266

Source: Oxfordshire Clinical Commissioning Group

The chart below shows the year on year percentage distribution of OCCG patient A&E attendances across age categories.

Figure 115: Distribution of OCCG patient A&E attendances by age

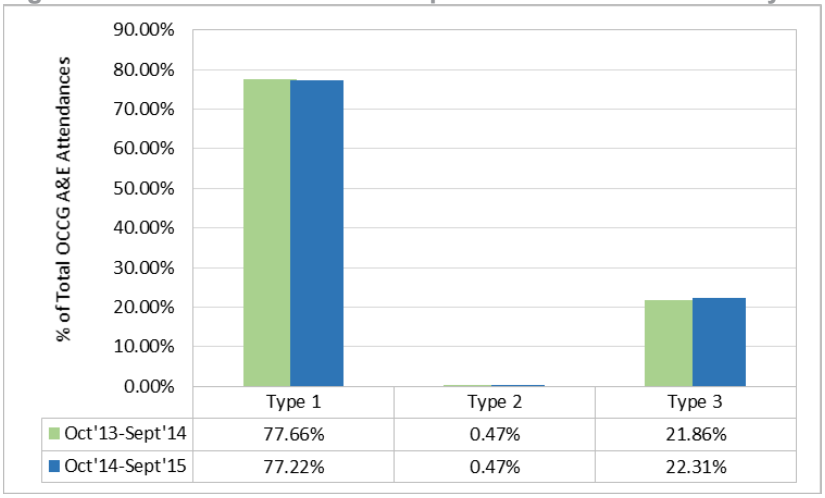


	0-20	21-40	41-60	61+
Oct'13-Sept'14	32.81%	25.93%	19.30%	21.97%
Oct'14-Sept'15	32.36%	25.63%	19.25%	22.76%

Source: Oxfordshire Clinical Commissioning Group

A&E attendance has seen growth across all three department types this year, with the greatest growth seen in Type 3 (Minor Injury Units/Other A&E) which saw an increase of 3.5% from 32,940 attendances to 34,075. Type 1 departments (a consultant-led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients) saw year on year growth of 0.8% (117,009 to 117,928 attendances). Type 2 departments (a consultant-led single speciality accident and emergency service, e.g. ophthalmology, dental, with designated accommodation for the reception of patients) saw year on year growth of 1.4% (712 to 722 attendances).

Figure 116: Distribution of OCCG patient A&E attendances by A&E department type



	Type 1	Type 2	Type 3
Oct'13-Sept'14	77.66%	0.47%	21.86%
Oct'14-Sept'15	77.22%	0.47%	22.31%

Source: Oxfordshire Clinical Commissioning Group

Emergency Department Attendances for Alcohol and Violence

Data gathered from Emergency Departments at the John Radcliffe and Horton General hospitals show that, in the first nine months of the 2015/16 financial year (1st April to 31st December) around 2,000 attendances were recorded as being alcohol-related.[300] They made up around 2.1% of all emergency department attendances. As might be expected, alcohol-related attendances were more likely to occur at the weekend, and also in the early hours of the morning.

The age group experiencing the most alcohol-related attendances were those aged 20-24, making up over one in six of the total number. 63% of attendances were for men or boys, compared with 37% for women or girls. Over 90% of attendances were among people of White ethnicities, broadly in line with the overall make-up of the population.

Meanwhile, slightly over 800 emergency department attendances were recorded as involving assault. Again, they were more likely to occur at the weekend (particularly Sunday) and during the evening/ night.

Again, the age group experiencing the most alcohol-related attendances was those aged 20-24, making up almost a quarter of the total number. Over three quarters of attendances (77%) were for men or boys, compared with 23% for women or girls. Slightly below 90% of attendances were among people of White ethnicities, suggesting that people from Black and Minority Ethnic could be slightly overrepresented in the assault-related attendances figures, compared with the proportion of the overall population they make up.

A little under 200 emergency department attendances were recorded as involving both alcohol *and* assault. These made up around 9% of all alcohol-related attendances, and around 23% of all attendances for assault. However, it is thought that the figures are likely to understate the true extent of alcohol-related violence presenting in A&E.

A&E Waiting Times

The two major A&E departments used by Oxfordshire residents are Oxford University Hospitals NHS Trust (OUHT) and Royal Berkshire Foundation NHS Trust (RBFT).

Of the 139,557 visits made to Oxford University Hospitals Foundation NHS Trust's A&E by the OCCG population in the 12 months to September 2015, 13,442 (9.6%) breached the 4

[300] Data provided by Emergency Department Community Safety Practitioner.

hour waiting time. This is an increase on the previous 12 months which saw 10,016 (7.5%) breaches out of 133,815 visits.

National research by Monitor found that the main reason for more trusts failing to meet the 4-hour emergency standard over the winter of 2014/15 was a reduction in the capacity of inpatient wards to receive admissions from emergency departments.[301]

Emergency Services

The number of 999 calls made for patients registered with GPs in the OCCG area in the 12 months to end of September 2015 totalled 96,368. Around 8,636 came from healthcare professionals, and 38,862 resulted in a patient being conveyed to hospital.

7.4.2. Emergency Hospital Admissions

National analysis suggests that people presenting at A&E increasingly have more serious health issues, which require them to be admitted to hospital.[302] The proportion of A&E attendees admitted into hospital rose from 20.8% in 2004/05 to 27.3% in 2014/15. This is largely driven by the ageing population.

Emergency inpatient admissions, including those of less than 24 hours, for patients registered with GP practices in the OCCG area accounted for 57,474 admissions in the 12 months to the end of September 2015. This was an increase of 2.2% on the previous 12 months' activity level of 56,220 admissions. It is likely that some patients experienced multiple admissions, so this figure is not representative of the patient count

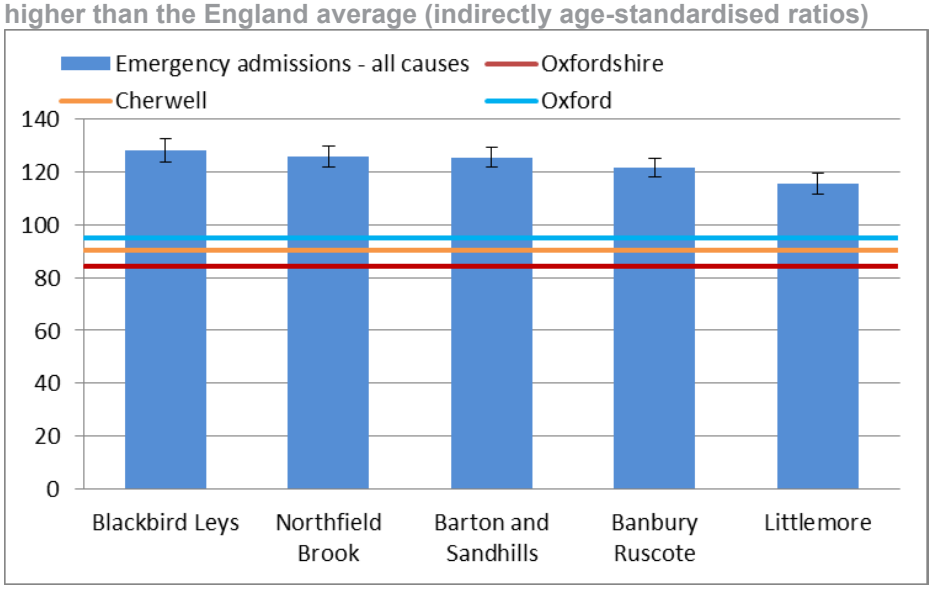
Pooled data for the years 2008/09 to 2012/13 show that Oxfordshire and its five districts had proportionately fewer emergency hospital admissions than nationally.[303] However five wards in Oxford and Banbury have higher rates of emergency hospital admissions for all causes - Blackbird Leys, Northfield Brook, Barton & Sandhills, Littlemore and Banbury Ruscote. This is shown in the chart below, where the England average ratio is standardised to a value of 100.

[301] Improving patient flow: evidence to help local decision-makers (Department of Health, September 2015): https://www.gov.uk/government/publications/improving-patient-flow-evidence-to-help-local-decision-makers/improving-patient-flow-evidence-to-help-local-decision-makers

[302] Key facts and trends in acute care (NHS Confederation, November 2015): http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/NHSC%20factsheet%20Nov%20WEB.pdf

[303] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

Figure 117: Oxfordshire wards with rates of emergency hospital admissions significantly higher than the England average (indirectly age-standardised ratios)

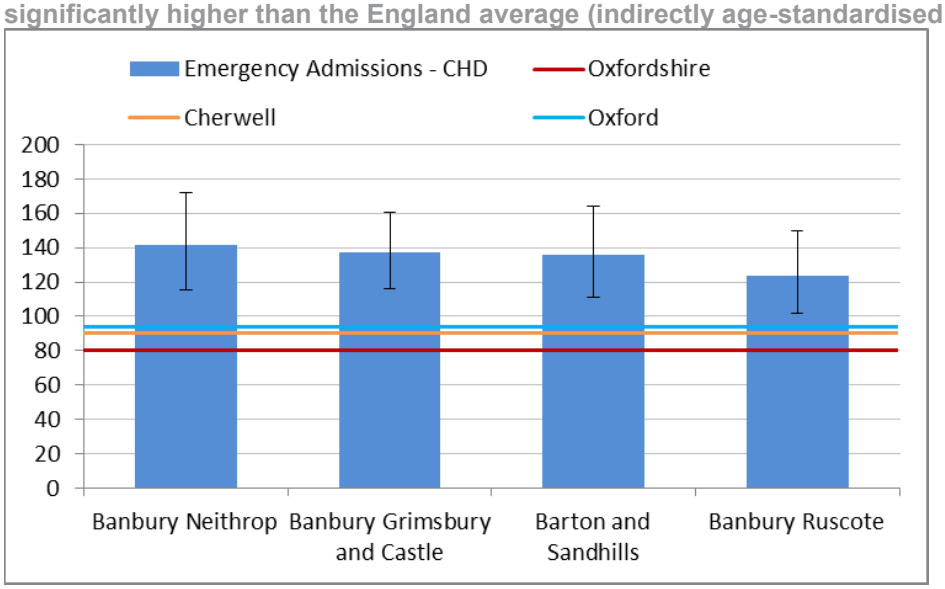


Source: Public Health England

Emergency Hospital Admissions for Coronary Heart Disease

Pooled data for the years 2008/09 to 2012/13 show that Oxfordshire and its five districts had proportionately fewer emergency hospital admissions for coronary heart disease (CHD) than nationally.[304] However, there are four wards within Oxford and Cherwell that have significantly higher rates. This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 118: Oxfordshire wards with rates of emergency hospital admissions for CHD significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

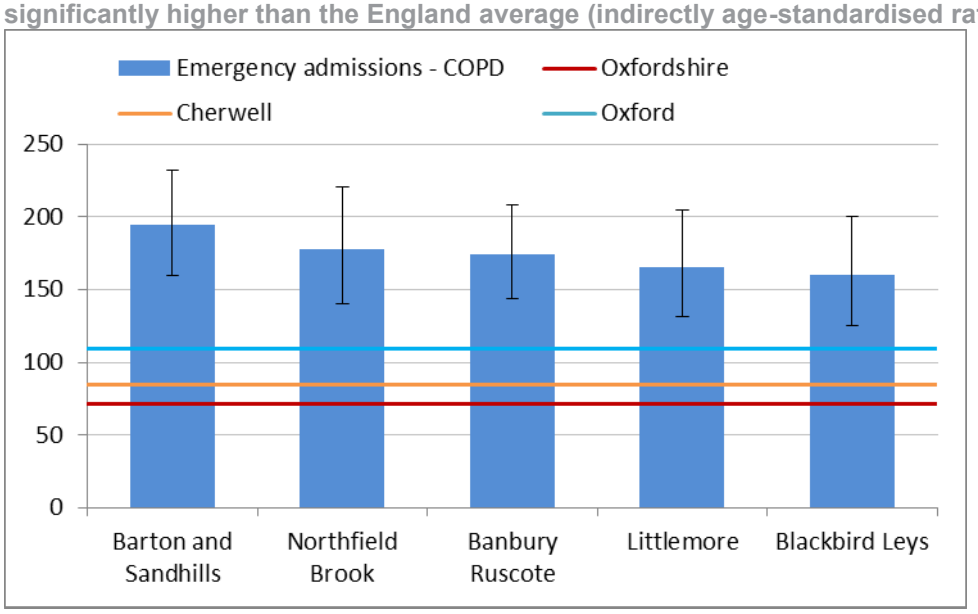
Emergency Hospital Admissions for chronic obstructive pulmonary disease

Pooled data for the years 2008/09 to 2012/13 show that Oxford City was the only district in Oxfordshire that had a higher rate of emergency hospital admissions for chronic obstructive

[304] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

pulmonary disease (COPD) than the national average.[305] However, there were five wards in Oxford and Cherwell that have high rates. This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 119: Oxfordshire wards with rates of emergency hospital admissions for COPD significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

Emergency Hospital Admissions for Dementia

Nationally, there are growing numbers of emergency hospital admissions for people with dementia.[306] This is likely to be due in part to greater awareness and recording of dementia symptoms.

Emergency Hospital Admissions for Head and Brain Injury

Nationally, the rate of hospital admissions for head injury was around 264 per 100,000 people in 2013/14.[307] Applied to Oxfordshire this would give a figure of around 1,800 admissions.[308] However, this figure does not take into account any local differences that may exist in brain injury admission rates

The rate of hospital admissions for acquired brain injury in the UK was 566 per 100,000 people in 2013/14. Applied to Oxfordshire this would give a figure of around 3,800 admissions. Again, this figure does not take into account any local differences that may exist in brain injury admission rates.

7.4.3. Hospital Discharge and Delayed Transfers of Care

A delayed transfer of care occurs when a patient is deemed medically fit to depart from their current care, but is unable to do so because of non-clinical reasons, for example because the patient is awaiting a care package in their own home, or further non-acute care.

[305] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

[306] *Reasons why people with dementia are admitted to a general hospital in an emergency* (National Mental Health Dementia and Neurology Intelligence Network, March 2015): http://www.yhpho.org.uk/resource/view.aspx?RID=207311

[307] Data in this section comes from Headway statistics (accessed December 2015): https://www.headway.org.uk/about-brain-injury/further-information/statistics/

[308] Calculation based on ONS population estimates for mid-2014.

In 2014/15 the average daily rate of delayed transfers of care within Oxfordshire was 27.5 people aged 18 and over per 100,000.[309] This was similar to the figure for the previous two years; it was down from 30.6 in 2011/12. It was significantly higher than the reported average rate for England, of 11.2 per 100,000 people.

In July 2015 Healthwatch published research into people's experiences of being discharged from hospital, focusing on older people, homeless people, and people with mental health conditions: http://www.healthwatch.co.uk/safely-home

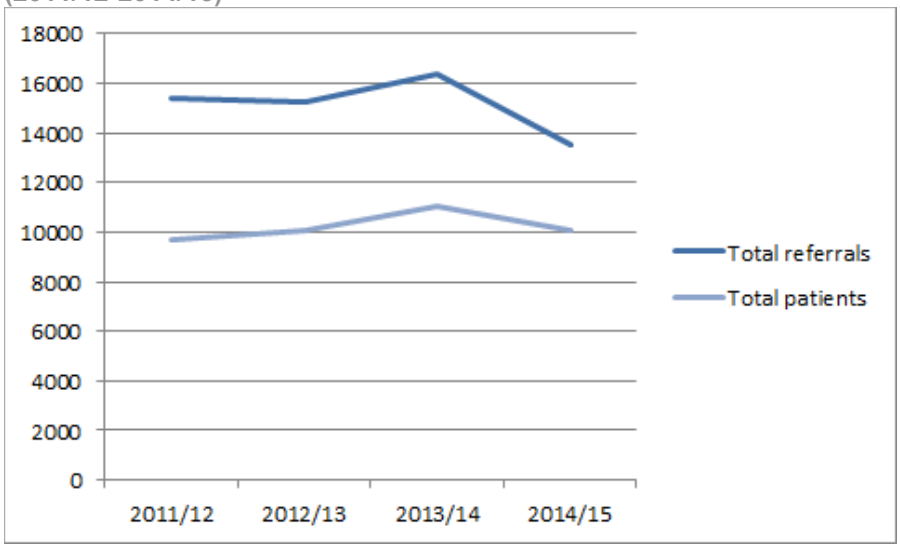
7.5. Mental Health Services

7.5.1. Oxford Health Mental Health Referrals

In 2014/15 slightly over 10,000 Oxfordshire residents were referred to Oxford Health mental health services and seen at least once.[310] 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.

Figure 120: Number of Oxfordshire residents referred to Oxford Health mental health services (2011/12-2014/15)



Source: Oxford Health

More female than male residents were referred, making up around 58% of the service users, compared with 42% male. This ratio has remained fairly stable over the last three years.

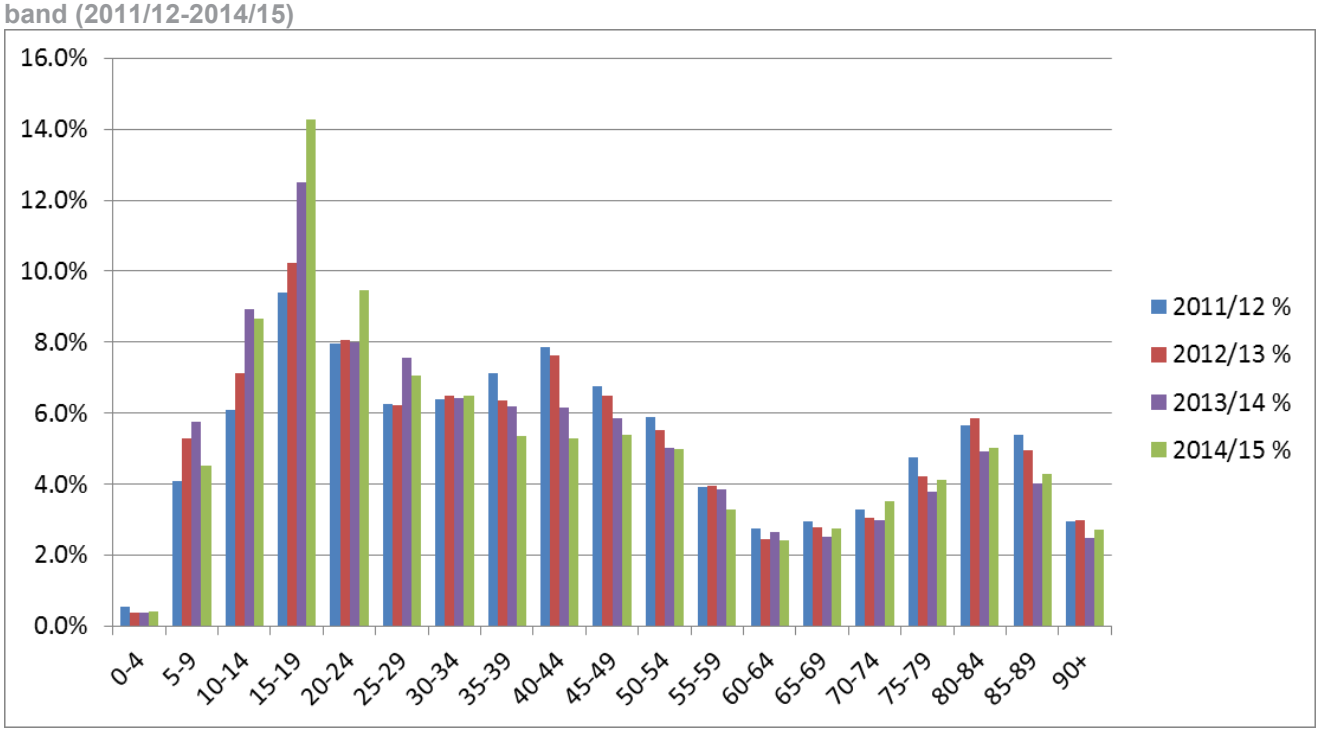
Nine in ten Oxfordshire service users for whom ethnicity data have been recorded were from White British or Irish Backgrounds (90%). Around 4% were from other White backgrounds, 2% were from Mixed ethnic backgrounds, 1% were from Asian or Asian British backgrounds, and 1% were from Black or Black British backgrounds.[311] Again, these proportions have remained fairly stable over the last three years.

[309] NHS Delayed Transfers of Care Statistics: http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
[310] Data in this section has been provided by Oxford Health
[311] NB in this dataset the figure for Asian or Asian British service users does not include people from Chinese backgrounds.

Using population data from the 2011 census, it can be seen that there were higher rates of service use among people from White British and Mixed backgrounds (11-12 service users per 1,000 people from these backgrounds in the population). There were lower rates of service use among people from other White backgrounds (7-8 service users per 1,000 population), Black or Black British backgrounds (6-7 service users per 1,000 population), and Asian or Asian British backgrounds (3-4 service users per 1,000 population).

The 15-19 age group continued to make up the largest proportion of referrals to Oxford Health mental health services in 2014/15. This proportion has been growing in recent years. In general, there has been a shift from older to younger service users, as shown in the chart below.

Figure 121: Oxford Health mental health referrals for Oxfordshire residents, % in each age band (2011/12-2014/15)



Source: Oxford Health

Almost half of the referrals were for Oxfordshire Adult Mental Health Services (47%). Just under a quarter were for Oxfordshire Children and Adolescent Mental Health Services (23%) and 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. As would be expected from the changing age profile of service users, the proportion of referrals to the Children and Adolescent Mental Health Services has grown slightly in recent years.

7.5.2. Oxfordshire Mind Wellbeing Service

The Wellbeing Service delivered by Oxfordshire Mind supports the residents of Oxfordshire presenting with a broad range of common mental health and emotional problems.[312]

The Wellbeing Service is open to any one aged 16 or older and acts as a portal for information about mental health services in Oxfordshire. It provides advice, options, signposting, supported onward referrals and appropriate evidence based wellbeing interventions.

[312] More information on the service is available http://www.oxfordshiremind.org.uk/about-us/

In 2014/15 the Wellbeing Service supported 1,914 unique (existing and new) individuals with a range of interventions, including information services and options; educational courses and open peer support groups.[313]

Through its activities the Wellbeing Service reached:[314]

- 8,000 residents through county wider Public Wellbeing events and activities
- 2,000 residents through provision of mental health information and options
- 1,914 residents in educational and coping skills courses, peer support groups and one-to-one support

Of the total individuals accessing the Wellbeing Service in 2014/15, a third (33%) were from Cherwell and West Oxfordshire, whilst 31% were from South Oxfordshire and 31% were from Oxford City. (For 5% the area of residence was unknown).

Within the Wellbeing Service, 58% of service users in 2014/15 were women and 42% were men.

Between April 2014 and March 2015, of those individuals supported, 135 (7%) were in age range 16-24, 1,416 (74%) were in age range 25-59, and 363 (19%) were aged 60 and over.

The ethnicity of individuals using the Wellbeing Service in 2014/15 was predominantly White British (72%). 20% were from non-white British, European, mixed, Chinese, and other ethnic backgrounds , with 8% of individuals preferring not to say.

In addition in 2014/15:

- 200 residents took up a sport or a physical activity as part of joint work between Oxfordshire Mind and the Oxfordshire Sports Partnership
- 688 residents were supported by the 'Benefits for Better Mental Health' project,
- 300 residents were reached through workshops for employers and other community groups
- 120 new volunteers were trained, including 28 'peer support' volunteers who completed our specialist 25-hour training programme

7.5.3. TalkingSpace Oxfordshire

TalkingSpace is a service co-delivered by Oxfordshire Mind and Oxford Health NHS Foundation Trust, which offers a range of psychological (talking) therapies for the treatment of common mental health depression and anxiety. It follows a stepped care approach according to the need of the patient.

TalkingSpace offers evidence-based treatments at Step 2, including short courses, groups to treat insomnia, computerised Cognitive Behavioural Therapy and self-help with guidance from a member of the team. Treatments at Step 3 include group CBT, mindfulness groups and individual therapy.[315]

In 2014/15 the service received 9,000 referrals.[316] It helped support 4,800 patients within Step 2 services, achieving 55% recovery rates, which is above the national average.

[313] Data provided by Oxfordshire Mind.
[314] Oxfordshire Mind Annual Review, 2014/15 http://www.oxfordshiremind.org.uk/about-us/annual-review/
[315] More information is available: http://www.talkingspaceoxfordshire.org/contact-us/
[316] Data provided by Oxfordshire Mind.

7.5.4. Psychological Therapies

In 2014/15 there were 12,045 referrals for psychological therapy services commissioned by the Oxfordshire Clinical Commissioning Group.[317] 8,140 referrals entered treatment, meaning that they had a first treatment appointment in the year (but may have been referred in the previous year). 5,125 referrals finished a course of treatment in the year (following at least two treatment appointments. Again, the referral and appointments may have happened in previous time periods). 60.1% of these showed a reliable improvement, similar to the national average of 60.8%.

Women were over twice as likely as men to use psychological therapy services. Around 2.5% were gay/ lesbian (1.5%) or bisexual (1%).

7.5.5. Child Hospital Admissions for Mental Health

In 2013/14 there were 67 children aged 0-17 in Oxfordshire who were admitted to hospital for mental health conditions.[318] This represents a rate of 47.8 per 100,000 children aged 0-17. The rate has remained broadly similar over the four years from 2010/11, and remains significantly lower than the averages for England (87.2) and the South East (96.1).

7.6. Drug and Alcohol Treatment Services

In 2014/15 there were around 1,800 adults (aged 18 and over) in drug and/ or alcohol treatment in Oxfordshire.[319] The number in treatment for alcohol only was 433, most of whom are considered to be high risk drinkers.

In 2014/15 the number of young people (aged under 18 years) in specialist substance misuse services in Oxfordshire was 58. Most of these (48) started specialist treatment on or after 1 April 2015. Of these:

- 42 began using their main substance before they reached 15 years of age
- 34 were using more than one substance
- 14 reported being affected by others' substance misuse.

Referrals were predominantly from education services, children and family services, or self-referred (including referrals by family and friends).

7.7. Social Care

7.7.1. Adult Social Care

Short-Term Adult Social Care

Older people are the primary users of short-term adult social care services. The figure below shows their use of short-term services in Oxfordshire during 2014/15. The numbers relate to episodes, or contacts, rather than unique individuals: individuals may have accessed multiple services, and may have accessed them more than once. [320]

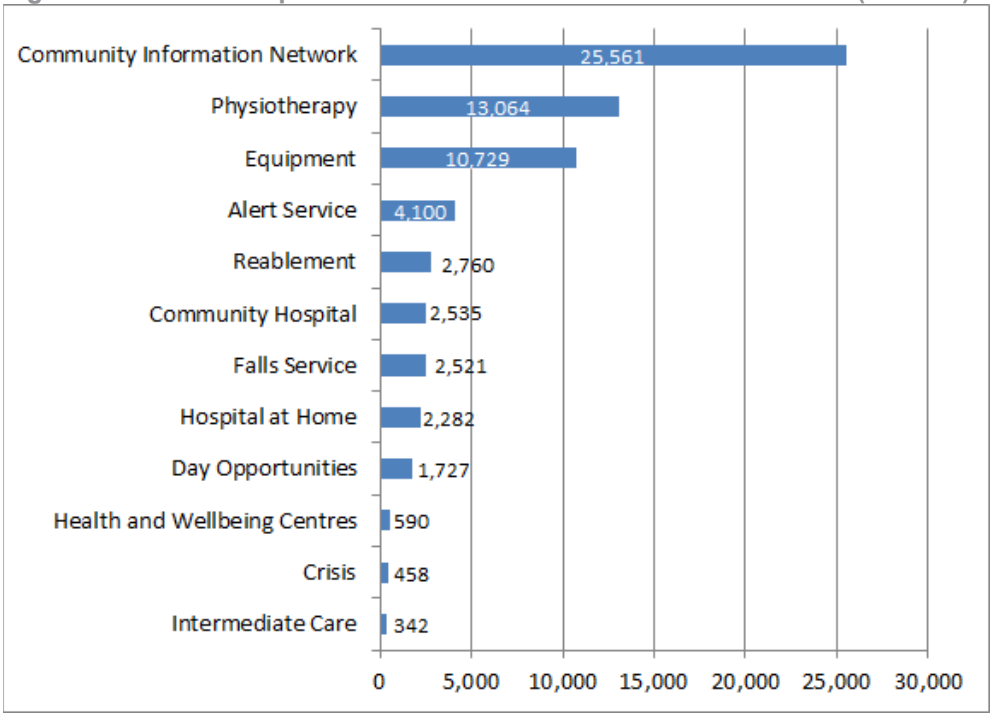
[317] Psychological Therapies, Annual Report on the use of IAPT services – England, 2014-15: http://www.hscic.gov.uk/catalogue/PUB19098

[318] Public Health England's Children and Young People's Health Benchmarking Tool: http://fingertips.phe.org.uk/profile/cyphof

[319] Data in this section come from the National Drug Treatment Monitoring System, and have been provided to Oxfordshire County Council by Public Health England.

[320] Oxfordshire County Council data

Figure 122: Older People's Use of Short-Term Social Care Services (2014/15)



Source: Oxfordshire County Council

'Reablement' is a social care service aimed at supporting people to regain independence that may have been reduced or lost through illness or disability. Guidance from the Department of Health states that a medium-performing reablement service would see between 2-5% of its older population in reablement, and a high performing service over 5%. It is expected that 50% of these would come from hospital and 50% from their own home.

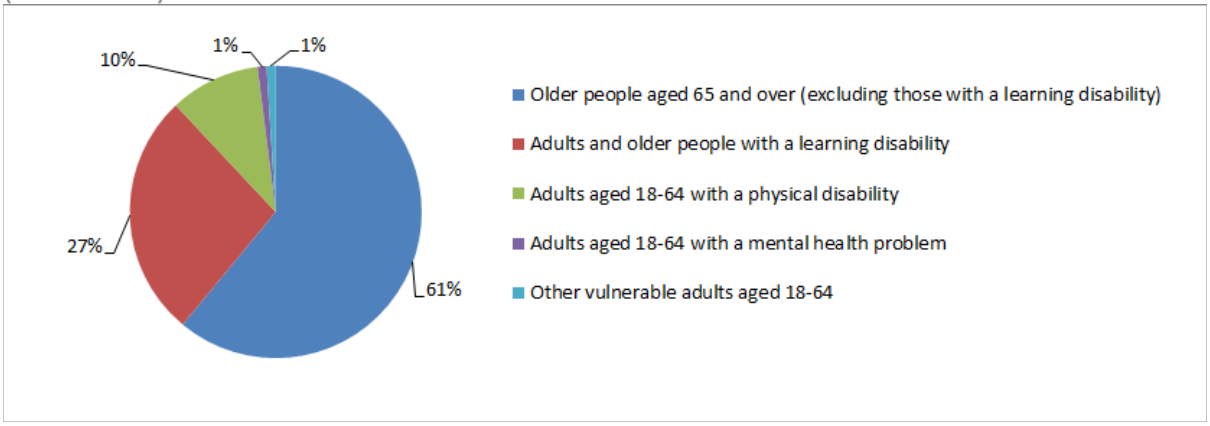
On this basis, a medium-performing reablement service in Oxfordshire could be expected to support just over 4,000 people aged 65 and over, and a high-performing service would support around 6,000 people. As can be seen from the chart above, Oxfordshire's reablement service supports fewer older people than this. However, the number of older people offered reablement services following discharge from *hospital* is similar to what would be expected for a medium-performing service, and reflects national rates. Therefore, the difference relates primarily to older people being offered reablement services from *home*.

Long-Term 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.[321] 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.

[321] Oxfordshire County Council data

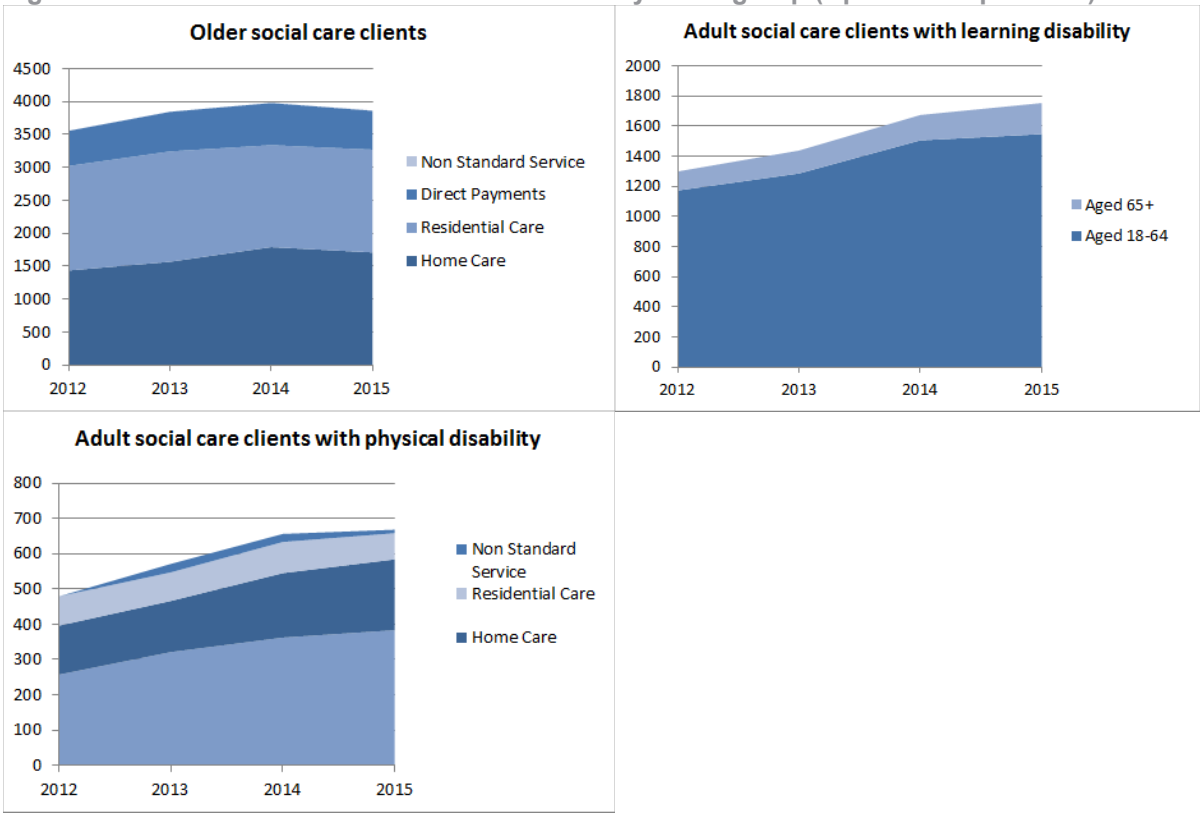
Figure 123: Recipients of local authority funded, long-term, adult social care in Oxfordshire (March 2015)



Source: Oxfordshire County Council

The figures below show trends in the number of social care clients being supported by Oxfordshire County Council as of 1st April in each of the past four years.

Figure 124: Oxfordshire adult social care trends by client group (April 2012-April 2015)



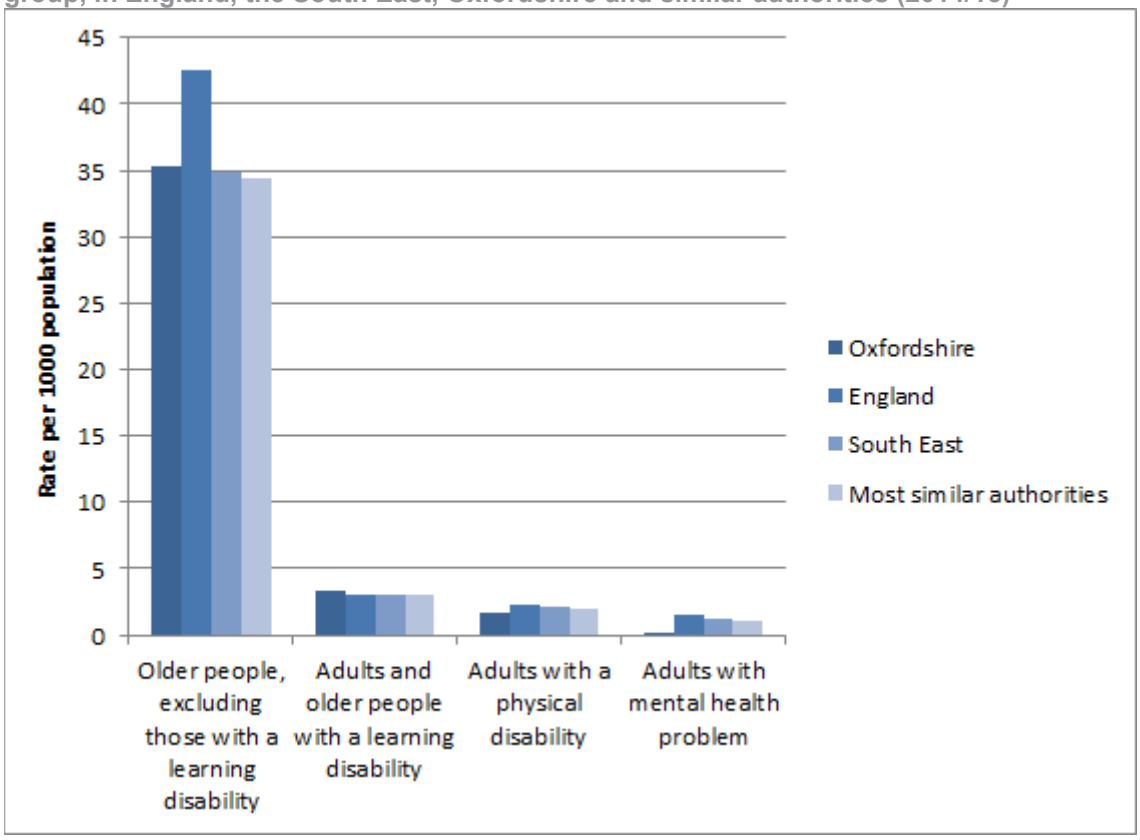
Source: Oxfordshire County Council

The chart below compares rates of local authority funded, long-term adult social care provision in Oxfordshire with the national and regional averages, and a group of the most similar local authorities (our 'statistical neighbours')[322]

[322] The set of local authorities that are Oxfordshire's statistical neighbour authorities for adult social care are: Buckinghamshire, Cambridgeshire, Essex, Gloucestershire, Hampshire, Hertfordshire, Leicestershire, North Yorkshire, Northamptonshire, Somerset, Suffolk, Surrey, Warwickshire, West Sussex, and Worcestershire.

It is important to keep in mind that the way long-term versus short-term support is defined may vary by local authority: support that is considered short-term in Oxfordshire may be classed as long-term elsewhere.

Figure 125: Rates of local authority funded, long-term, adult social care provision, by client group, in England, the South East, Oxfordshire and similar authorities (2014/15)

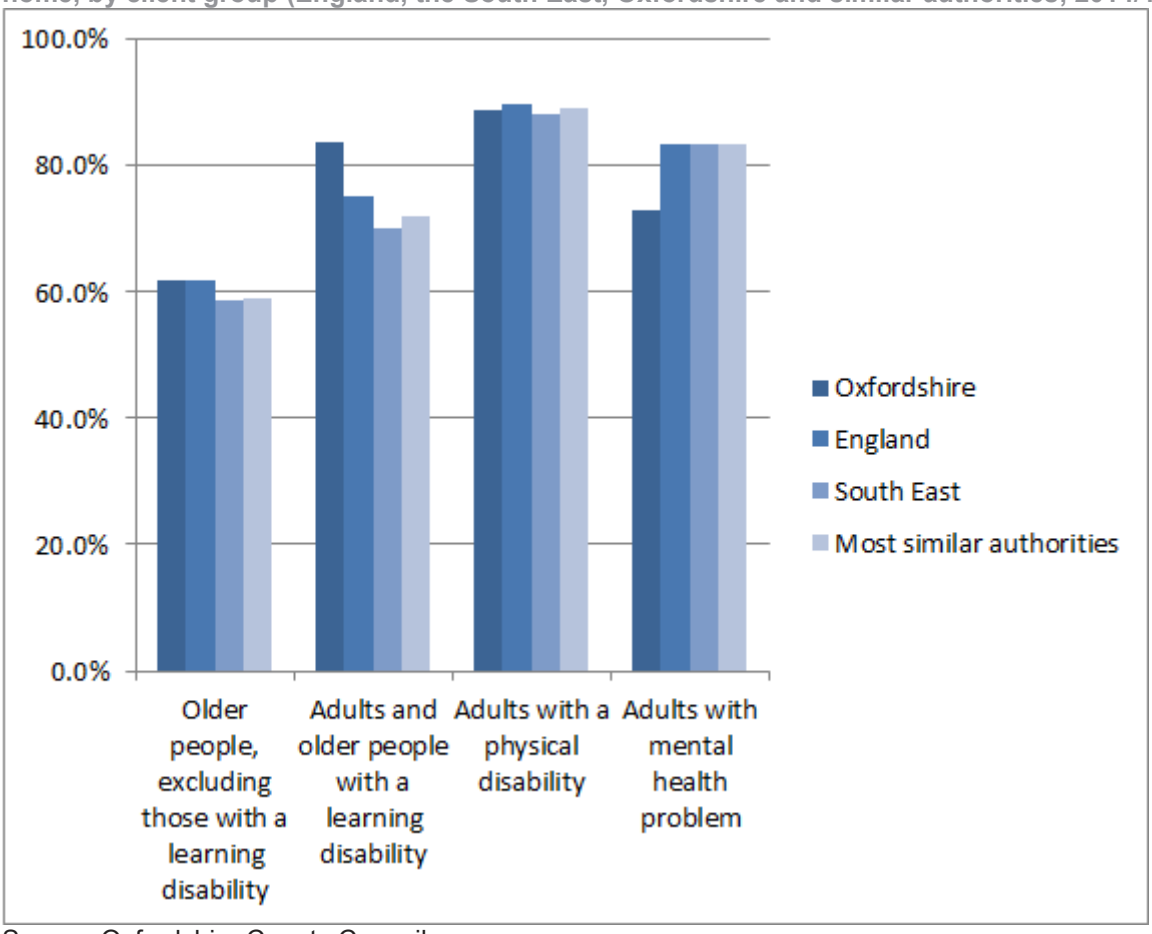


Source: Oxfordshire County Council

The majority of adult social care users are supported at home rather than in a care home. The chart below compares the proportion of adult social care clients in Oxfordshire who are supported at home against national and regional averages, and our statistical neighbours.

Again, it is important to keep in mind that the way long-term versus short-term support is defined may vary by local authority: at-home support that is considered short-term in Oxfordshire may be classed as long-term elsewhere. This may particularly affect the data for clients with physical disabilities and mental health conditions.

Figure 126: Proportion of local authority funded, long-term, adult social care that is provided at home, by client group (England, the South East, Oxfordshire and similar authorities, 2014/15)



Source: Oxfordshire County Council

Adult Social Care Outcomes

For the last five years councils have surveyed users of social care aged 18 and over as part of a national survey.[323] The survey is run each February for people receiving social care funded wholly or in part by councils in the previous September. Its purpose is to learn more about whether or not the services are helping them to live safely and independently in their own home, and to understand the impact on their quality of life. In the 2014/15 survey, 513 adult social care users in Oxfordshire responded.

The headline measure produced by the survey is an overarching view of the 'quality of life for users of social care'. This is a composite measure of eight questions in the survey. The measure identifies whether, after care has been provided, people still have needs in any of the following areas: control over their daily life; being clean and presentable; having enough food and drink; having a clean and comfortable home; feeling safe; having adequate social contact; spending time as they wish and being treated with dignity. In 2014/15, social care-related quality of life in Oxfordshire remained at a similar level to the previous four years. It also remained above the national average, with Oxfordshire ranking 57th of 152 local authorities in England on this measure.

Further analysis of survey responses suggests that Oxfordshire's relatively high quality of life score may be driven by social care users feeling they have control over their lives, feeling safe, and feeling that they have enough social contact.

[323] Adult Social Care User Survey: http://www.hscic.gov.uk/socialcare/usersurveys

In 2014/15, the proportion of care users who were very satisfied with their care and support was 60.6% (although, overall, 90% reported being satisfied). This was down slightly on previous years' results (64.5% in 2013/14 and 62.7% in the two years before that). It was also below the national average, with Oxfordshire ranking 118th of 152 local authorities in England.

The national outcome framework for adult social care brings together data from the adult social care survey and other sources to measure the overall performance of the adult social care system.[324] Oxfordshire performs above average on 74% of the measures in the framework.

To explore the data on adult social care outcomes, visit the interactive health story on Oxfordshire Insight.

Adult Social Care, Sexual Orientation and Gender Identity

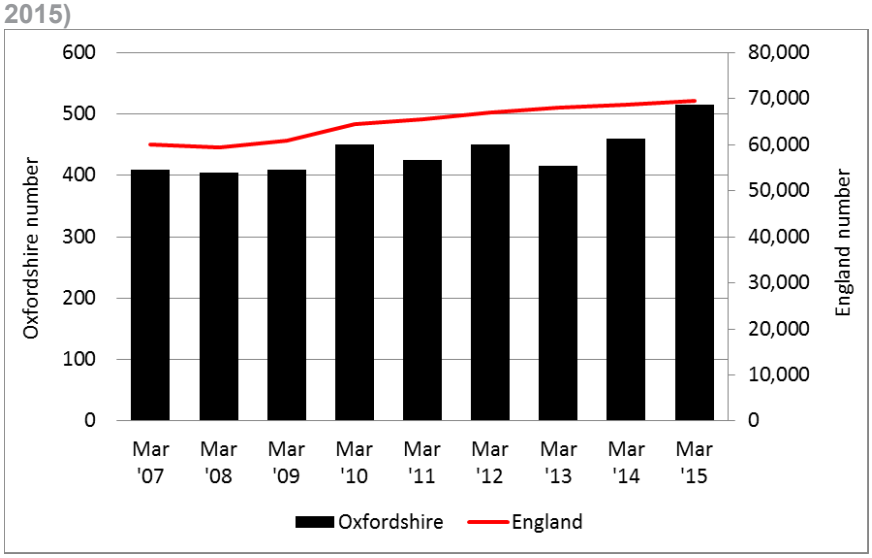
National research has been conducted with adult social care users who are lesbian, gay, bisexual and trans (LGB&T), and their carers.[325] This suggests that these groups may have distinct needs, for example they may be more at risk of social isolation and loneliness; and they may face distinct issues, including discrimination. However, the data on sexual orientation and gender identity of the social care community is currently limited.

7.7.2. Children's Social Care

Looked After Children

As of the end of March 2015 there were 515 children in Oxfordshire who were in care (also known as 'looked after children').[326] The rate of looked after children in Oxfordshire remains below the national average and our statistical neighbours but the number of cases has generally been rising over recent years.

Figure 127: Numbers of looked after children in England and Oxfordshire (March 2007 – March 2015)



Source: Department for Education

[324] Adult Social Care Outcomes Framework: http://www.hscic.gov.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF

[325] The LGBT ASCOF Companion Document (LGBT Foundation, 2015): http://lgbt.foundation/get-support/downloads/detail/?downloadid=365

[326] Department for Education statistics on looked after children (accessed November 2015): https://www.gov.uk/government/collections/statistics-looked-after-children; supporting data provided by Oxfordshire County Council

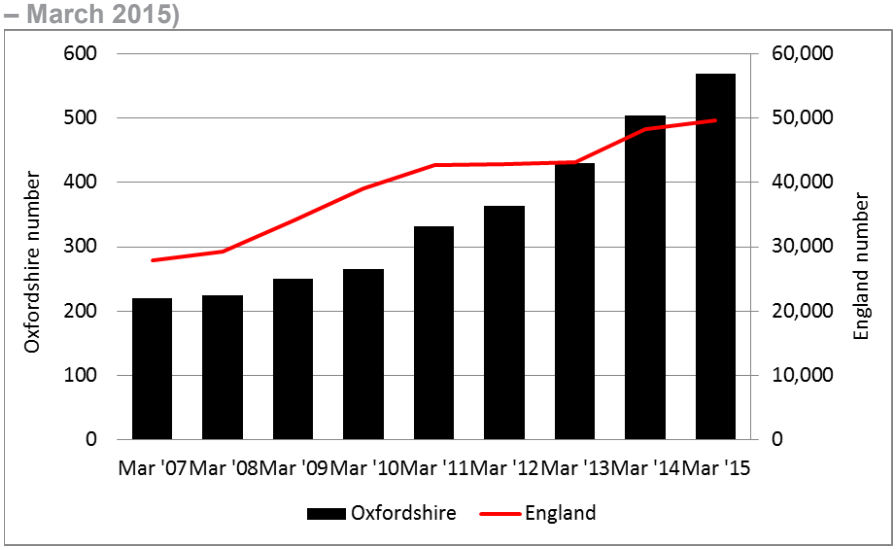
In a Survey of Looked After Children in December 2013, 85% stated that they were happy with their social workers.[327] Further feedback from children and young people has suggested that transition planning and management at key transition points is not always smooth, particularly between children and adult social care and health services, at admission or discharge from hospital, and from primary to secondary school. It was emphasised that communication between professionals and across organisations at transition points is key.

Child Protection Plans

As of the end of March 2015 there were 569 children in Oxfordshire who were the subject of a child protection plan.[328] In slightly over half of cases (56%) this was because of neglect.

Overall, the rate of children on protection plans has tended to be lower locally than nationally but above most of our statistical neighbours. However, the number of children on protection plans in Oxfordshire has been rising in recent years, and it has been rising at a faster rate than in England overall. The biggest increase in the number of protection plans has been among older girls.

Figure 128: Numbers of children on protection plans in England and Oxfordshire (March 2007 – March 2015)



Source: Department for Education

The increase in the number of children on protection plans in Oxfordshire is in line with other areas that have experienced high profile cases of child sexual exploitation. Likewise, other authorities judged 'good' by Ofsted have tended to see a bigger rise in children on protection plans than the national average.

Factors such as parental mental health, drug abuse or domestic violence increase the risk of children becoming subject to a child protection plan.

Care Leavers

Young people leaving care tend to be particularly vulnerable to poor health and wellbeing. For example, national research shows that they are at greater risk of social exclusion, unemployment, health problems, and offending.[329]

[327] Data provided by Oxfordshire County Council's Joint Commissioning Team

[328] Department for Education statistics on children in need and child protection (accessed November 2015): https://www.gov.uk/government/collections/statistics-children-in-need; supporting data provided by Oxfordshire County Council

[329] See, for example, Care leavers' transitions to adulthood: https://www.nao.org.uk/report/care-leavers-transitions-to-adulthood/; *Finding Their Feet: Equipping care leavers to reach their potential*

7.8. Transport Services

Patients with eligible medical needs may access NHS-funded Non-Emergency Patient Transport Service (NEPTS) for non-emergency journeys to and from hospital or acute community healthcare.

During the 2014/15 financial year 102,991 NHS-funded journeys were booked for patients registered with a GP in the Oxfordshire Clinical Commissioning Group area. This represents a reduction from 110,260 in 2013/14. Locally agreed criteria for eligibility have been applied since November 2014.

Patients who are ineligible for NEPTS are signposted to community transport services, provided by voluntary and community organisations. (Alternatively, patients may be able to have their travel costs reimbursed under the NHS Healthcare Travel Cost Scheme; informal lift sharing is also thought to be very common.)
Community transport plays an ever increasing role in transporting people to and from hospitals and other health-related appointments. There has been a slight increase in the number of volunteer car schemes in the county over the past year, from 47 to 49 schemes. They vary in size dramatically, some with 4 volunteer drivers, to others with 50 or more volunteer drivers. There are around 1,100 volunteer car drivers in total and they carry out 59,000 single journeys per year, most of which are health-related. The number of journeys to hospitals has increased, and transport for regular 'wellbeing' appointments has also increased.

Community First Oxfordshire (CFO) provide OCTA badges (hospital parking permits agreed with Oxford University Hospitals NHS Foundation Trust - OUH), which allow volunteers to park in delegated spaces at OUH sites. To evidence the need for OCTA badge spaces, CFO found that the seven main car schemes, between them, carry out 52 return journeys a week to the John Radcliffe hospital alone.

As Oxfordshire is relatively rural, and the subsidies for some bus routes are likely to be withdrawn,[330] it is expected that there will be greater need for community transport in the near future.

Demand for transport services may also be affected by the rural nature of Oxfordshire (see section 3.9: Rural Population and 4.9.3: Geographical Barriers) and the ageing population (see section 2.3.2: Age).

(The Centre for Social Justice, January 2015):
http://www.centreforsocialjustice.org.uk/publications/finding-their-feet

[330] See Oxfordshire County Council Cabinet decision of 10th November 2015:
https://consultations.oxfordshire.gov.uk/consult.ti/stconsultation/consultationHome?utm_source=FURL-1&utm_medium=stconsultation&utm_term=nil&utm_content=&utm_campaign=stconsultation

8. Conclusion

This report summarises key trends affecting the health and wellbeing needs of Oxfordshire's population. It is not intended to be exhaustive. The JSNA webpages on Oxfordshire Insight point users to further data and tools available. Meanwhile, the JSNA Publications Directory contains a number of related documents.

The JSNA summary report is expected to be refreshed annually each spring. However, data and publications will be added to the webpages on an on-going basis.

For any enquiries, suggestions or information about how to get involved with the JSNA development, please email the Research and Intelligence Team: JSNA@Oxfordshire.gov.uk.

Index of Figures

NHS
Oxfordshire
Clinical Commissioning Group

Briefing: Oxfordshire Health Inequalities Commission 'Calls for Evidence'

The Health Inequalities Commission in Oxfordshire has now convened to review health inequalities in Oxfordshire and make recommendations on what actions are needed to address them.

Members of the Commission include:

- Independent Chair, Professor Sian Griffiths
- Professor Trish Greenhalgh, Professor of Primary Care Health Sciences and Fellow of Green Templeton College at the University of Oxford
- Cllr Ed Turner, Deputy Leader of Oxford City Council
- Patrick Taylor, Chief Executive of Mind
- Paul Cann, Chief Executive of Age UK
- Richard Lohman, Director on the board of Healthwatch Oxfordshire
- Dr Joe McManners, Local GP and Clinical Chair of Oxfordshire Clinical Commissioning Group
- Andrew Stevens, Director of Planning & Information at Oxford University Hospitals NHS Foundation Trust
- County Councillor Representative to be confirmed

Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives. The causes of health inequalities are complex, and include lifestyle factors—smoking, nutrition, exercise to name only a few—as well as wider determinants such as poverty, housing and education.

The Health Inequalities Commission will make recommendations for actions which could be taken to achieve sustainable reductions in health inequalities in the county. It will focus on how we can improve the delivery of health and social care functions to reduce health inequalities at all ages across the life-course. This will involve considering aspects of urban and rural living, the experiences of ethnic minority groups and of those populations living in situations of particular disadvantage such as homelessness and poor housing.

As part of the process of the Commission, evidence sessions will be held in public over the next few months providing opportunities to explore certain issues in greater depth through oral evidence.

In addition, the Commission is calling for written responses, particularly from the public.

The findings and recommendations will be reported to the Oxfordshire Health & Well Being Board in the autumn. The report will then be published for organisations to use as a basis for ongoing actions.

The Evidence Sessions will be held:

26 February, 9.30 to 12.30pm at Exeter Hall in Kidlington. The theme is 'beginning well'; submissions are invited on maternity, children, young people's health, early intervention: early communication and nurturing, education: schools, education and health literacy, lifestyle interventions and prevention, e.g. smoking and promoting physical activity. Deadline for submissions is 15 February.

7 March, 9.30 to 12.30pm at John Paul II Centre in Bicester. The theme is 'living well'; submissions are invited on the working age population, living with diabetes, living with mental health challenges, living with learning disabilities, healthy workplaces and challenges associated with living on low incomes/income support. Deadline for submissions is 27 February.

11 April, 9.30 to 12.30pm at the Rose Hill Centre in Oxford. The theme is 'ageing well'; submissions are invited on older people's health and inequalities issues and living with dementia. Deadline for submissions is 29 March.

23 May, 9.30 to 12.30pm in the Council Chamber at Oxford Town Hall in Oxford. The session will be based on cross cutting themes and challenges including housing, education, rural living, poverty etc. Deadline for submissions is 6 May.

For information about how to submit evidence call 07919 346547, send an email to cscsu.talkinghealth@nhs.net or visit http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/health-inequalities-commission/

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Health and Wellbeing Board: Thursday 3rd March 2016

Personal Health Budget Local Offer and Roll-out Plan

Purpose of report

1. The purpose of this paper is to inform the Oxfordshire Health and Wellbeing Board on NHS England Guidance requiring CCGs to develop and publish a Local Offer for a major expansion of Personal Health Budgets (PHBs), and seek approval of the Oxfordshire Local Offer for PHBs, which must be included within the Health and Wellbeing Strategy.

2. The Health and Wellbeing Board is asked to:
   a. Note NHS England Guidance on the roll out of PHB beyond Continuing Healthcare and work to date undertaken in Oxfordshire
   b. Approve a Local Offer outlining groups who could potentially benefit from PHBs and could receive them from April 2016, to be published and included in the Health and Wellbeing Strategy.
   c. Note that the next steps and governance process going forward

What is a Personal Health Budget (PHB)?

3. A PHB is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. It is not new money, but is money that would normally have been spent by the NHS on a person's care being spent more flexibly to meet their identified needs. The vision for PHBs is to enable people with long-term conditions and disabilities to have greater choice, flexibility and control over the healthcare and support they receive.

4. PHB's aim to increase people's choice and control over the care and support they receive. Nonetheless, the NHS retains a duty of care to individuals who opt to have a PHB and a direct payment and consideration must be given to implementing this mandate in conjunction with other policies and frameworks such as; Guidance on Direct Payments for Healthcare: Understanding the Regulations (2014).

5. PHBs do not abdicate clinicians from their duty of care to ensure the individual's care is safe and effective in meeting their assessed needs and specified outcomes. In the current arrangements for Continuing Healthcare the approval of care plans has been subject to review by a risk panel.

6. PHB funding should not be used as a mechanism to fund services / items for which there are other available grants and funding available i.e. Disabled Facilities Grant for

housing adaptations, Motability and attendance allowance, disability living allowance etc.

7. PHBs can be delivered in three ways:
    - Notional Budget: where the commissioner holds the budget and utilises it to secure services based on the outcomes of the personal support plan.
    - Third Party Budget: where an organisation independent of the individual and NHS manages the budget on the individual's behalf.
    - Direct Payment: where the money is transferred to a person or his or her representative or nominee who contracts for the necessary services.

8. Use of PHB's must be lawful, affordable for the individual within their budget allocation, and effective. There are a small number of services for which PHBs cannot be used. These are set out in the Guidance for Direct Payments for Healthcare and summarised below:

Services* agreed in a care plan which will meet health and wellbeing outcomes.

Services which are appropriate for the state to provide.

Primary medical services provided by a GP.
Acute unplanned care (including A&E).
Surgical procedures.
Medication.
NHS charges e.g. prescription charges, dental charges, vaccinations, immunisation, screening, NHS health checks.
Gambling, debt repayment, alcohol, tobacco.

*'Services' refers to anything which can be bought and which will meet someone's health or wellbeing needs.

Background

9. Oxfordshire was a national pilot site for the designing and testing of the delivery of PHBs, 2009 - 2012. During that time, Oxfordshire Primary Care Trust worked collaboratively with Oxford Health NHS Foundation Trust and Oxfordshire County Council to design and implement a sustainable system for PHBs in NHS continuing healthcare and for integrated health and social care budgets in anticipation of a roll-out to other groups / individuals. The project team continued with support from NHS England until March 2015, being both a Going Further Faster site and a regional peer support site.

10. The 'right to have' a PHB in NHS continuing healthcare came into force in England in October 2014 for both Adults and Children - Oxfordshire is fully compliant with this. PHB processes, including care and support planning, are integral to the case management offered to every adult eligible for NHS continuing healthcare.

Current NHS England Guidance

11. The publication of NHS Forward View Into Action: Planning for 2015/16, outlined that:

> "To give patients more direct control, we expect CCGs to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit. As part of this, we expect that personal health budgets or integrated personal budgets across health and social care should be an option for people with learning disabilities, in line with the Sir Stephen Bubb's review. To improve the lives of children with special educational needs, CCGs will need to continue to work alongside local authorities and schools on the implementation of integrated education, health and care plans, and the offer of personal budgets. CCGs should engage widely and fully with their local communities and patients, including with their local Healthwatch, and include clear goals on expanding personal health budgets within their published local Joint Health and Wellbeing Strategy."

12. There is an expectation that PHBs will be offered to individuals who could benefit from them, this is based on level of need rather than a particular diagnosis – such as:

- people receiving NHS Continuing Healthcare or children's continuing care, who already have a right to have a personal health budget;
- people who have high levels of need but are not NHS Continuing Healthcare, but who have health needs which would be suitable-this might include people who currently use high levels of healthcare but in a way that is not meeting their needs;
- children with education, health and care plans, who could benefit from a joint budget including money from the NHS;
- people with learning disabilities or autism and high support needs (in line with Sir Stephen Bubb's report)-specifically where use of a PHB might enable someone to stay out of hospital, and/or might help him step down from hospital;
- people who make ongoing use of mental health services-for people falling within the scope of the outcome based contract for mental health, this has been written into the contract;
- people with long-term conditions for whom current services don't work, so end up accessing acute services more; and
- people who need high cost, longer term rehabilitation e.g. people with an acquired brain injury, or spinal injury, or with severe mental health conditions.

13. Although NHS England have stated that CCGs have the flexibility to set their own plans for expansion of PHBs, informed by local demographics and current understanding of groups which may benefit from PHB, they have indicated that this could equate to around 0.1 – 0.2 % of the population, or at least 660 PHBs if applied to Oxfordshire.

14. By March 2017 it is expected that CCGs develop a longer term vision and plan for 3-5 years which will include "large scale contracting and commissioning changes" taking place by March 2019. This will require relevant commissioners across the

CCG to "unbundle" contracts to offer individuals' access to PHBs without double payment.

Requirement to publish a Local Offer

15. Whilst guidance states that CCG's will have the flexibility to plan to introduce PHBs at a pace and scale that meets their local circumstances, by March 2016, it is expected that CCG's should consider client groups who could benefit from PHBs and publish a Local Offer as part of the Health and Wellbeing Strategy which must include:

    - Those eligible for adult CHC and Children's Continuing Care
    - Children with special educational needs and disabilities
    - Adults and children with learning difficulties

16. NHS England has clarified that the Local Offer does not have to be a lengthy detailed document but could include a statement of intent (including client groups which the CCG are considering rolling out PHBs to subject to further work), as well as giving details of client group who the CCG is obliged to offer PHBs, such as Continuing Healthcare. The Local Offer should be included within the Health and Wellbeing Strategy and include details of:
    - Who can get a PHB (including any eligibility criteria)
    - Which organisations are involved in PHBs
    - Where can professionals and the public find out more information
    - How patients can apply for PHBs

17. The development of an Oxfordshire Policy for PHBs is required to underpin any future PHB offer and address implications raised including clinical governance and financial risks. The policy will need to provide consistency, equity, clear and transparent governance arrangements, outline support services required for people with PHBs (and commission them as appropriate) and agree a Resource Allocation System. This policy will be developed in line with national guidance during 2016-17.

Proposed Oxfordshire Local Offer

18. The CCG held a workshop in January with NHS England and key stakeholders, (including PHB users) to identify potential groups which could benefit from PHBs and Integrated Budgets and form part of our published Local Offer.

19. As a result of this workshop and ongoing work within the CCG, it is envisaged that by 1st April the Oxfordshire Local Offer will include offering a PHB to the following client groups:
    - Patients receiving NHS Continuing Healthcare or children's continuing care, who already have a right to have a personal health budget.
    - People with an Acquired Brain Injury (ABI) who would benefit from PHB and which will help them achieve their outcomes.
    - People with learning disabilities who will benefit from one, in particular:
    - Those with acute needs (e.g co-morbid mental and physical disability)
    - Those at risk of admission to hospital owing to behaviours that challenge
    - Those people who remain in hospital where there is a block to discharge

- Children who are part of the Special Educational Needs and Disability (SEND) reforms.
- The CCG will also consider including other client groups whose needs are currently not being met by existing services.

20. In addition, during 2016/17 it is the intention to explore the expansion of PHBs to the following groups:

    - Those with mental health issues, who would benefit from them in particular:
        - very complicated, often chaotic clients (for example with comorbidity of mental health and Learning Disability or with Acquired Brain Injury) whose needs are not being met within existing contracts and services.
        - those benefiting from recovery to support them move on from services.
        - high cost "frequent flyers" where offering a PHB would help achieve their outcomes.
    - Renal dialysis patients who use Patient Transport who may have improved outcomes from a PHB to procure alternative transport.
    - In conjunction with Primary Care, identify people with Long Term Conditions for whom current services do not work.

Next Steps and governance process

21. Subject to Oxfordshire Health and Wellbeing Board approval a Local Offer for PHBs will be published by 1st April and included within the Oxfordshire Health and Wellbeing Strategy.
22. A multi-agency Project Board has been established to oversee the implementation of this work, including agreement of a countywide policy, and is meeting on 22nd February.
23. During 2016/17 further scoping work will continue to enhance the Oxfordshire Local Offer and report into the Project Board.

Author: Angela Strange, Commissioning Manager, OCCG

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Oxfordshire
Clinical Commissioning Group

Oxfordshire Health and Wellbeing Board

Date of Meeting: Thursday, 3rd March 2016

Title of Presentation: Oxfordshire's Sustainability and Transformation plan, 2016/17 Better Care Fund and OCCG's 2016/17 Operational Plan

Purpose: To provide Oxfordshire Health and Wellbeing Board with an update on the development of a system wide 5 Year Sustainability and Transformation plan by June 2016, the CCG's 2016/17 Operational Plan and emerging plans for BCF in 2016/17

Author: Libby Furness, Head of Planning and Transformation	**Executive Lead :** John Jackson, Director of Strategy & Transformation

1. Background

Over the past year the Transformation Board has made good progress in developing the scope and vision for change needed across Oxfordshire to address current issues and future demand against a backdrop of achieving significant savings and financial constraint in future years.

The storyboard was presented at your last meeting and provides a clear rationale for change. The Care Closer to Home Strategy, which is on the agenda, for this meeting provides a means of scoping the transformational change needed.

The Transformation Board is starting to develop a financial plan showing how resources will be allocated, how the annual NHS savings of £271m will be achieved and where and when they will be re-invested. It will also need to consider the implications of the County Council's financial position.

The 2016/17 NHS Planning Guidance asks all local systems to develop a place-based 5 year Sustainability and Transformation Plan (STP). This central requirement dovetails with our local direction of travel at an ideal time. It means the service changes we have been working on for system transformation can be drawn together in a single document that we can use for both local stakeholder consultation and to meet the STP requirement.

2. The Five Year Sustainability and Transformation Plan (STP)

Oxfordshire's STP will describe how we take forward, at scale and pace, our ambition for transforming the system and evidence the ways in which we will be working together to close the health and wellbeing gap, drive transformation to close the care and quality gap and close the finance and efficiency gap (£271m), whilst still delivering on the first two.

Because we had begun our work on transformation, work is already underway to scope the gaps and challenges affecting our readiness for change and identify the 'big ticket' projects that will contribute to system savings.

Developing the STP is going to require a step change in how system partners work together in communication, having a single version of numbers, a common understanding of the service models and identifying a level of collective savings over 5 years that is far higher than the NHS has ever delivered.

Working on the STP and delivering the transformation plans is going to have to become a large part of the day job for lead clinicians and managers across all organisations.

It will be challenging for governance because normal structure are designed to take an organisational perspective. Consideration of how the structure will work and how it will be managed and resourced is being considered by the Transformation Board.

3. Transformation Footprints

In developing our local STP we need to agree our planning and/or transformation footprints. Having a footprint signed off by NHS England is the mechanism to secure NHS transformation funds

We are working on an Oxfordshire footprint:

- As a Health and Wellbeing Board,
- For Pooled Budget arrangements,
- To manage Systems Resilience and Transformation
- To develop plans for devolution

Members of the Transformation Board discussed and agreed at their January 2016 meeting that our footprint would be Oxfordshire, accepting that there is a wider footprint of Thames Valley and beyond for specialised services and some mental health and learning disability services.

We are still in discussion with other CCG's and NHS England about what our natural footprint should be. The latest position will be reported to the meeting.

5. 2016/17 Operational Plans

The priority for Oxfordshire Clinical Commissioning Group (OCCG) and its partners in 2016/17 and over the next 5 years will be to deliver the NHS Mandate goals and our system transformation plans. The one-year OCCG Operational Plan includes details of how the CCG will meets its budget, delivers efficiency savings, maintains quality and safety, manages risk and links to the emerging STP. It also articulates how the following 'must do's' will be delivered by every local system in 2016/17:

1. Develop a high quality and agreed **STP** to achieve the aims of the **Five Year Forward View.**
2. Return the system to **aggregate financial balance.**
3. Plan to address the **sustainability and quality of general practice.**
4. Back on track with **access standards for A&E and ambulance waits.**
5. Improve and maintain **referral to treatment** wait times.
6. Deliver **62 day cancer waiting standard** and improve **one-year survival rates.**
7. Achieve and maintain **two new mental health access standards** and continue to meet **dementia diagnosis** rate.
8. Transform care for people with **learning disabilities.**
9. Improvements in **quality.**

The Individual operational plans for OCCG and partner organisations have been developed through a shared and open book process and together will show how individually and collectively we intend to deliver the first year of the STP.

First drafts of the operational plans have been submitted and will include elements of Oxfordshire's 2016/17 Better Care Fund Plans.

6. 2016/17 Better Care Fund Plans (BCF)

The Better Care Fund was announced as part of the 2013 spending round to create a local single local pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The Oxfordshire system invested circa £37.5m in 2015/16 in schemes to improve outcomes, including a commitment to protect adult social care with an additional investment of £8m, and a further allocation of £1.35m to support the implementation of the Care Act 2014.

The system has make good progress across the health and social care economy in line with the national BCF requirements, including progress against the 6 national conditions.

Of particular note are:

- Our success in developing and measuring Ambulatory Emergency Care Pathways, which have contributed to the reduction in our overall non-elective admissions. Difficulties with national coding have meant that the 0.3% reduction in non-elective is not reflected within SUS*, however NHS England are aware of this and accept this is a national issue that needs to be resolved. This reduction places us in a very favourable position when benchmarked against other areas.
- The work undertaken to develop a robust data gathering and performance dashboard recognised by NHS England as good practice who would like to use it in other areas and potentially at a regional level.
- Oxfordshire's innovative approach to locality nursing which is also getting recognised nationally. We were successful in a bid for funding to develop it further.
- Adult social care successfully implementing the Care Act requirements from April 2015, including online self-assessment for carers as part of a redesigned process to identify and meet eligible needs for support.
- Continuing to meet increased demand for services, including an increased number and complexity of care packages for people remaining in their own home.

**The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.*

Local Health and Wellbeing Areas were informed that BCF will continue for at least another financial year. However, the technical guidance/templates due to be released in early 2016 still remain outstanding at the time of writing this report. Nonetheless, we

have now received the 2016/17 financial allocation for BCF which has been increased to a mandated minimum of £3.9 billion nationally. This for Oxfordshire equates to **£40.607m,** which is made up of a mixture of the existing OCCG allocations, social care formula and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund**.**

The absence of the technical guidance/templates makes the BCF 2016/17 planning challenging, however we know that the plan requires local areas to demonstrate how we:

- Plan to fully integrate health and social care by 2020;
- Plan to meet the national conditions, including the 2 new conditions which are:
    i. Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
    ii. Agreement on local action plan to reduce delayed transfers of care.

Oxfordshire is in a very good position to demonstrate how it plans to achieve full integration across health and social care which is a large part of the local devolution work. Further, our Care Closer to Home Strategy and the Delayed Transfers of Care Plan will provide the necessary detail of what is required for the new national conditions.

7. Recommendations

The Health and Wellbeing Board is asked to:

- Note the need for and plans to develop a system wide Sustainability and Transformation Plan By end of June 2016 through the Transformation Board
- Note progress with Oxfordshire CCG's 2016/17 Operational plan
- Agree delegated authority for sign off of Oxfordshire's 2016/17 BCF Plans in light of the fact that the BCF Plan is likely to be submitted before the Board next meets in July 2016.

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Closer to Home Health & Care Strategy

Bringing care closer to home


North


North East


Oxford City


South East


South West


West

What is the problem?

A challenged health and care system:

- Increasing demand
- Increasing complexity
- Increasing cost
- Workforce under pressure
- Current models of care under pressure
- Slow progress in delivering more anticipatory care and managing local population health

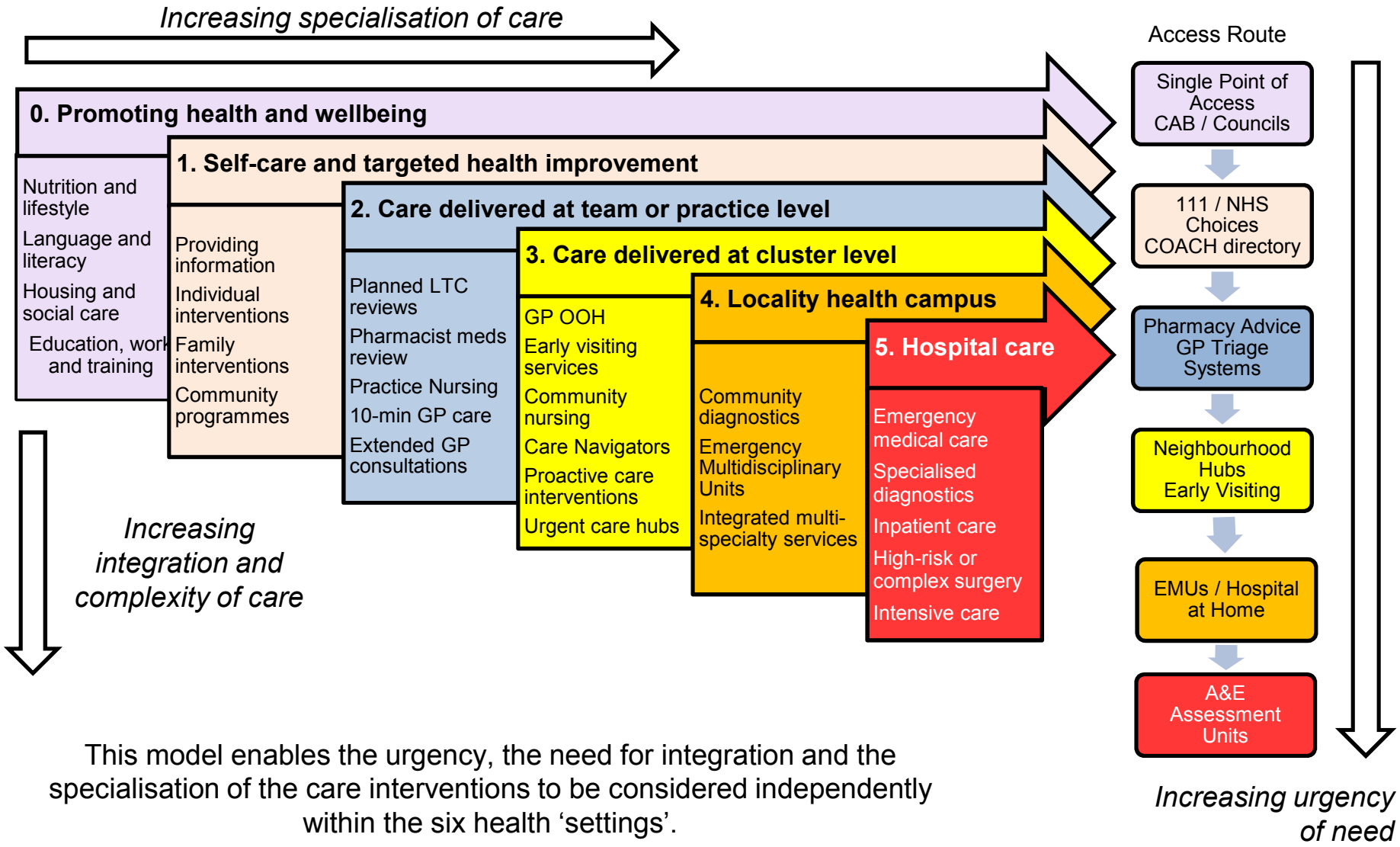
Closer to Home Health & Care Strategy

Our Vision:

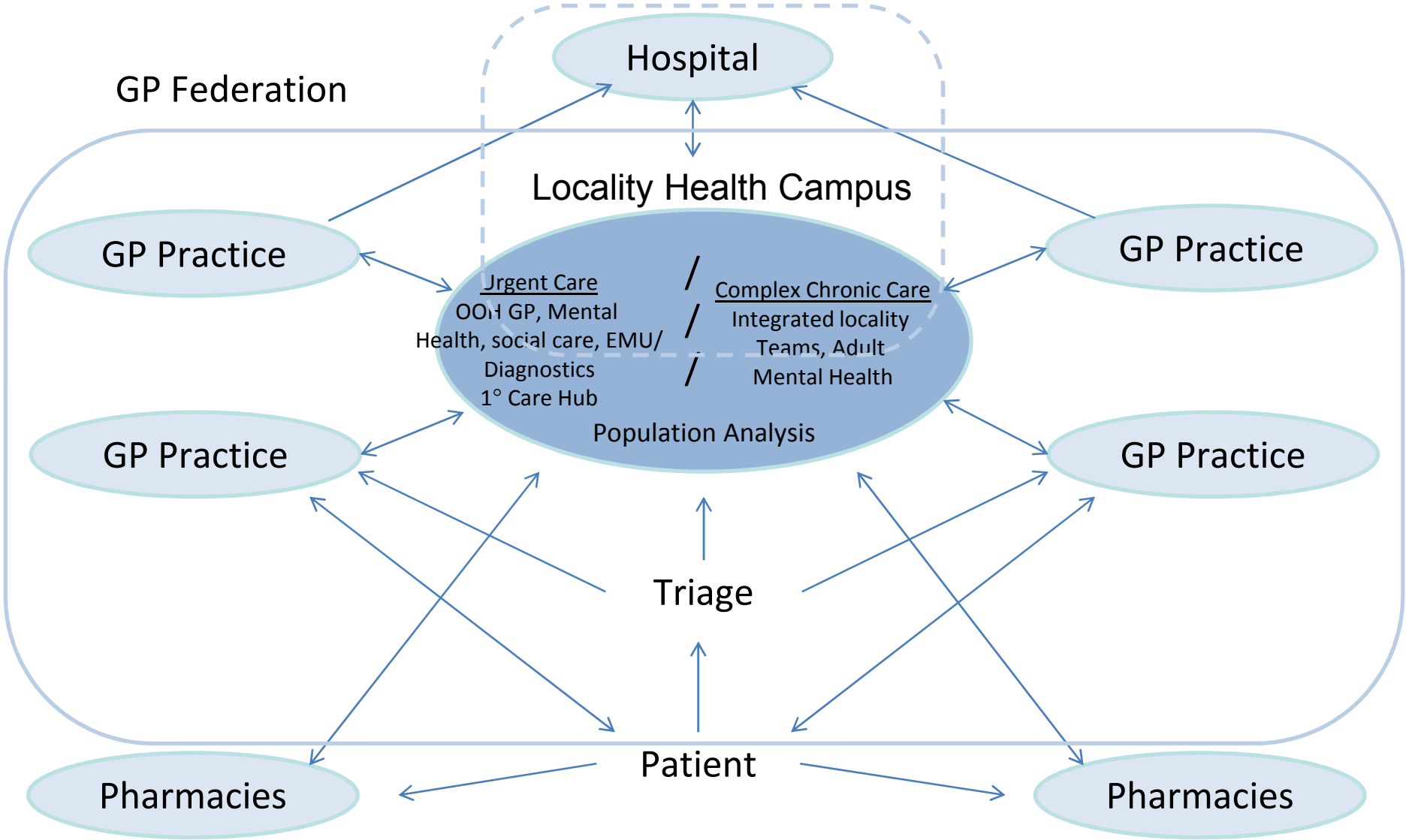
To enable people in Oxfordshire to access more care at /or closer to home, achieving a step change in developing community services by:

- increasing their ability for self-care
- building on the successful UK General Practice model
- delivering more integrated primary, community, acute and social care
- managing population health to improve outcomes
- increasing the capacity of the out of hospital care workforce to provide more care.
- bringing together organisations to develop a ‘whole Oxfordshire’ approach
- delivering outcomes based commissioning

Oxfordshire 'Closer-to-Home' Health and Care Model



This model enables the urgency, the need for integration and the specialisation of the care interventions to be considered independently within the six health 'settings'.


GP Federation
Hospital
Locality Health Campus
GP Practice
GP Practice
Urgent Care
OOH GP, Mental Health, social care, EMU/ Diagnostics
1° Care Hub
Complex Chronic Care
Integrated locality Teams, Adult Mental Health
Population Analysis
GP Practice
GP Practice
Triage
Patient
Pharmacies
Pharmacies

Development of the Care closer to Home Health & Care Strategy

1. The overall strategic framework has been agreed by the Transformation Board
2. OCCG's locality commissioning groups have been consulted and have broadly agreed the strategy
3. The strategy is being further refined, working with partners in OCC, OUHT and OHFT and GP Federations
4. Further work is needed to agree how we will measure success.
5. Public engagement to develop the strategy is ongoing.

What changes will this mean for 16/17 ?

1. The overarching Care Closer to Home strategy will be implemented across the localities – co-designing and testing new pathways of care with patients and providers
2. The impact of the Prime Ministers Challenge Fund pilots will be evaluated and the findings will feed into the development of new models of care
3. We will increase the use of ambulatory sub acute/acute pathways for when people become acutely unwell.
4. We will increase patient education and support, including the use of technology, to enable increased ‘self-care’, and enhanced promotion of health and wellbeing
5. OCCG is to set up a Quality and Innovation Support Team to support practices to work more efficiently and to introduce innovations that will increase their sustainability.
6. We need to test new workforce roles, behaviours and competencies that can deliver new care pathways and identify the scale of changes to the workforce required to increase more care in the community.
8. We need to increase inter-operability of IT to support new models of care.

Testing new care pathways in the localities

Each locality is currently identifying its priority areas for implementing the Care Closer to Home strategy:

- North East: developing new care pathways to increase local access to specialist advice for patients with diabetes, those with ear, nose and throat problems and for frail older people
- City: increasing integration between GP practices and community health and social care teams
- South east: developing the RACU (Rapid Access Care Unit)
- South West: planning to meet the population growth around Didcot
- North: remodelling its urgent care pathway
- West: increasing support for frail older people in the community

Engagement and Consultation

December 2015/January 2016/early February 2016

- Testing ideas with primary care, social care, community care
- Developing with colleagues from other providers and the voluntary sector
- Bringing our early thinking to the HOSC
- Talking to the Care Closer to Home Patient Advisory Group
- Discussing ideas in localities

February to June 2016

Feeding this work into the development of and engagement in the Oxfordshire's Sustainability and Transformation Plan

- How can we close the health and wellbeing gap?
- How can we drive transformation to close the care and quality gap?
- How can we close the finance and efficiency gap?

June 2016

- Final STP setting out plans for the next five years, describing the service changes required and areas of public consultation

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Healthwatch Oxfordshire

Healthwatch Oxfordshire Paper – Health and Wellbeing Board – February 2016

1 Introduction

1.1 The main focus of this report is on providing a summary of the actions taken by commissioners and providers in Oxfordshire to recommendations made by Healthwatch Oxfordshire and its grant aided partners since April 2015. (Sections 2 and 3)

1.2 Full details on all recommendations, responses and actions taken can be found on the Healthwatch Oxfordshire Website on: http://healthwatchoxfordshire.co.uk/sites/default/files/appendix_to_update_to_hosc_february_4th_2016.pdf

2 Tracking delivery of HWO recommendations

2.1 During the course of 2015/16 Healthwatch Oxfordshire with our partners have made a number of recommendations about how local services may be improved.

2.2 Some of these recommendations have been made directly by Healthwatch (for example those relating to the annual Hearsay event, or our Discharge and Dignity reports. Others have been made by organisations to whom Healthwatch has given grant funding and project support. Healthwatch has then undertaken to bring the issues raised by these organisations to the attention of commissioners and providers.

2.3 HWO wrote to all commissioners and providers in Oxfordshire before Christmas, re-iterating the various recommendations we have made to each organisation this year, reminding them about the commitments they had made to address issues raised at the point of publication of the relevant reports, and asking for an update on delivery of those commitments.

2.4 We are delighted that all providers and commissioners responded and a report detailing their responses can be found on the Healthwatch Oxfordshire website, www.healthwatchoxfordshire.co.uk . Section 3 below summarises the key changes being delivered on behalf of local service users as a result of recommendations made by HWO and its partners this year.

3 Summary of action taken

3.1 **Oxfordshire County Council.** A number of our recommendations were already addressed by OCC's work to be compliant with new legislation, and they have addressed other issues brought to their attention:

a. Introducing a thorough carers assessment, assessing 4,000 carers since 1 April 2015 – 1,152 of which were found to be eligible for a direct payment
b. Introducing Dementia Oxfordshire, which provides a range of support services to people living with dementia and their carers.
c. Increasing the befriending service and face to face support through the council's contract with Carers Oxfordshire
d. Developing an e-marketplace for to help people choose good quality care (to be implanted April 2016)
e. Introducing Age UK as a partner in the Integrated Teams, having care navigators, dementia support workers and carers outreach workers working in the locality integrated teams.
f. A commitment to co-producing documents and films to inform the public on – eligibility criteria, care assessment, financial assessment and benefits information.
g. Implementing new ways of working: senior practitioner and social workers working as part of community health teams; a Nursing Triage Hub in the West of the county; and weekly cross health and social care complex case meetings.
h. Working towards an Oxfordshire Care Summary.
i. Working with carers and clients in developing new home care contracts.

3.2 **Oxfordshire Clinical Commissioning Group** has:

a. Developed and released a guideline to GPs on a wide range of treatments and therapies to help patients with migraine.
b. Are working on a new headache pathway.
c. Scheduled a conference for 23rd February to discuss the possibility of a service-user lead organisation to support service users in service redesign.
d. Monitoring that the providers it commissions delivers care within the 6 C's which are care, compassion, courage, communication, competence and commitment.
e. Monitoring performance and facilitating improvements in cancer treatment wait time targets.

3.3 **Oxford Health Foundation Trust.** In response to HWO and its partners' recommendations, OHFT have:

a. Established a service-user working group to take the lead of developing an organisation across the mental health partnership, including a conference on service-user involvement in April 2016.
b. Ensured that all health visitors in the trust receive baby-friendly training within 6 months of joining the trust.

c. Developing an Alliance programme with the OUH to transform urgent healthcare services for older people.
d. Active participants in 'breaking the cycle' quality improvement initiative to test ways of working to resolve delayed transfers of care.
e. Consulting widely with patients and stakeholders on a new Patient Involvement and Experience Strategy
f. Introducing the recovery star model, which identifies join goals and monitoring with adult mental health teams.
g. Sharing the 10 dignity dos with all members of staff in their monthly update on patient experience and committed to use them in training courses going forward.
h. Reviewing the questions used in ongoing patient surveys to ensure dignity is monitored.
i. Employing locum staff to support waiting list management on PCAMHS, given an increase in referrals of 49% in the last 3 years.

3.4 **Oxford University Hospitals Foundation Trust.** In response to HWO and its partners' recommendations, OUHFT have:

a. Co-produced a new privacy and dignity polity
b. Delivers a trust-wide weekly compassionate care training, (536 members of staff have attended).
c. Working to review advocacy arrangements at the trust including raising the profile of Independent mental capacity Advocates.
d. Implementing a means by which it can understand exactly how much 'direct' and 'indirect' time (i.e. managing a complex discharge process) Nurses and Nursing Assistants spend with patients.
e. Piloting and evaluating a carer's surgery.

3.5 **Southern Health Foundation Trust.** In response to HWO and its partners' recommendations, SHFT have:

a. Ensured specialist needs are identified within their core assessment process.
b. Regularly provided deaf awareness training run by a member of staff and but the speech language therapy team.

3.6 **South Central Ambulance Service.** In response to HWO and its partners' recommendations, SCAS have:

a. Introduced a strategy to integrate their services with other providers and ensuring best use of front-line ambulances and referring others to appropriate advice or services as appropriate.
b. Introduced a quality assurance coach into the 111 and 999 services.
c. Rolled out values based recruitment to ensure SCAS recruits to NHS and trust values.
d. Worked to identify areas for quality improvement, including in streamlining processes.

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Protocol outlining the relationship between the Oxfordshire Health and Wellbeing Board, the Oxfordshire Safeguarding Children Board, the Oxfordshire Safeguarding Adults Board, Oxfordshire's Community Safety Partnerships and the Oxfordshire Safer Communities Partnership

1. Purpose

1.1 This protocol relates to the multi-agency Boards/Partnerships in Oxfordshire that are working to improve the health and wellbeing of Oxfordshire residents and safeguard children, young people and adults with care and support needs who are vulnerable to abuse and neglect. Specifically these are:

i. Oxfordshire Health and Wellbeing Board (HWB) and its associated partnership boards and joint management groups
ii. Oxfordshire Safeguarding Children Board (OSCB)
iii. Oxfordshire Safeguarding Adults Board (OSAB)
iv. Oxfordshire Community Safety Partnerships (CSPs)
v. Oxfordshire Safer Communities Partnership (OxSCP)

1.2 The protocol sets out the framework within which these Boards/Partnerships will work together to safeguard and promote the welfare of people living in Oxfordshire, including the distinct roles, responsibilities and governance arrangements for each of them. It also refers to the relationship between the Boards/Partnerships and other partnership forums in Oxfordshire.

1.3 The opportunities presented by formal working relationships between the Boards/Partnerships include:

- An integrated approach to tackling key issues and commissioning services by sharing information and intelligence; for example, each Board/Partnership contributes to the Joint Strategic Needs Assessment which is drawn to inform strategic plans.
- Aligning annual plans with shared strategic priorities, including safeguarding children, young people and adults with care and support needs.
- Evaluating the impact of the key business strategies on safeguarding outcomes, community safety and wider determinants of health.
- A coordinated approach to performance and risk management, quality assurance and transformational change.

1.4 Whilst some of the Boards/Partnerships have a broader focus, safeguarding is still 'everyone's business'. This protocol will clarify the means by which accountability, co-ordination and coherence is achieved for thematic areas that are relevant to more than one of the Boards/Partnerships. It will ensure that there is effective challenge and scrutiny of safeguarding arrangements across Oxfordshire and there is a strong interface with community safety work. The protocol aims to reduce duplication of effort, ensure there are no gaps in

thinking or service provision, and that the work of the Boards/Partnerships has a positive impact on outcomes for Oxfordshire residents.

1.5 Where the word safeguarding is used in this protocol it refers to:

- Protecting people from abuse, maltreatment or neglect;
- Preventing impairment of health or development;
- Ensuring that children and adults have safe and effective care;
- Taking action to enable people to have the best life chances.

2. Role of the Boards/Partnerships

2.1 The Boards/Partnerships have distinct, but complementary roles which are outlined below. The key functions of each Board/Partnership and their respective areas of responsibility are detailed in Appendix A.

Oxfordshire Health and Wellbeing Board

2.2 The Oxfordshire Health and Wellbeing Board (HWB) is a forum where key leaders from the health and care system work together to improve the health and wellbeing of the local population and reduce health inequalities. Each local authority is required to have a Health and Wellbeing Board under the Health and Social Care Act 2012.

2.3 Board members are expected to collaborate to gain an understanding their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils and a more effective and responsive local health and care system.

2.4 There are two partnership boards and four joint management groups that report directly to the HWB specifically on the priorities of the Health and Wellbeing Strategy they are responsible for. These are:

- *Children's Trust* - a multi-agency board that oversees joint strategic planning for children's services in Oxfordshire and monitors improvement of these services.

- *Health Improvement Partnership Board (HIB)* – a partnership board that oversees the coordination of a joint approach to influencing a broad range of health determinants to bring about health improvement and reduce health inequalities

- *Joint Management Groups (JMGs)* – a collection of groups that provide oversight and management of spending and activity to improve outcomes and meet the needs of older people, people with a physical disability, learning disability or mental illness.

Oxfordshire Safeguarding Children Board

2.5 The Oxfordshire Safeguarding Children Board (OSCB) is the means by which key local agencies responsible for child protection in Oxfordshire come together to agree how they will cooperate with one another to safeguard and promote the welfare of children and young people. Board members are expected to agree strategic safeguarding priorities and jointly monitor and evaluate the effectiveness of arrangements made by individual agencies and the wider partnership to achieve these.

2.6 Each local authority is required to have a Local Safeguarding Children Board under the Children Act 2004. The Act defines Board's core objectives and its functions are set out in 'Working together to safeguard children 2015'. They cover communication, quality assurance, learning from serious case reviews, reviewing child deaths and ensuring sound safeguarding policies and procedures are in place.

2.7 There are a number of themed sub-groups that report to the Board on specific areas of work, namely learning and improvement; training; communication; and multi-agency working.

2.8 In particular, the Performance, Audit and Quality Assurance sub-group (PAQA) is tasked with measuring the effectiveness of how partner agencies of the OSCB and the Children's Trust fulfil their legal responsibilities to safeguard and promote the welfare of Oxfordshire's children and young people. It oversees and reports to the OSCB and the Trust on the performance indicators in the Children and Young People's Plan, which includes safeguarding data.

Oxfordshire Safeguarding Adults Board

2.9 The Oxfordshire Safeguarding Adults Board (OSAB) brings together key partners involved in protection of vulnerable adults across Oxfordshire to ensure that effective adult safeguarding arrangements are in place in both the commissioning and delivery of services. Board members are expected agree strategic safeguarding priorities and jointly monitor and evaluate the effectiveness of arrangements made by individual agencies and the wider partnership to achieve these.

2.10 Each local authority is required to have a Safeguarding Adults Board under the Care Act 2014. The Act sets out the objectives of the Board which include the coordination of effective and proportionate multi-agency safeguarding work; learning from safeguarding adult reviews, holding partners to account; and using data and intelligence to identify risks and act on them.

2.11 There are a number of themed sub-groups that report to the Board on specific areas of work, namely training; safeguarding reviews; procedures; and performance and quality assurance.

2.12 In particular, the Performance, Information and Quality Assurance sub-group (PIQA) leads on auditing and monitoring the effectiveness of work to safeguard and promote the welfare of adults in need of care and support across Oxfordshire. It reports to the Board on performance against multi-agency indicators that include national comparison and benchmarking measures, and ensures that learning from quality assurance processes are disseminated across the workforce.

Oxfordshire Safer Communities Partnership

2.13 The Oxfordshire Safer Communities Partnership (OxSCP) provides strategic oversight for the prevention of crime and anti-social behaviour across Oxfordshire. The Partnership consists of an officer/member-led Board and an officer-led Business Group. It supports collaboration on community safety issues between the four district-led Community Safety Partnerships, Health, the Police, the County Council, Probation services, the Prison service and the voluntary sector and provides challenge to member organisations on their engagement with any common risk or priority.

2.14 Each local authority is required to have a county-wide strategy group under the Crime and Disorder (Formulation and Implementation of Strategy) Regulations 2007.Under these regulations the officer-led Business Group of the Partnership prepares an annual community safety agreement and work programme for the county area based on the shared annual strategic assessment of the responsible authorities in the area. This identifies ways in which responsible authorities might more effectively implement identified priorities and otherwise reduce crime and disorder through coordinated or joint working. The Agreement is approved by each Community Safety Partnership and reviewed by the officer/member-led Board before it is finalised.

Community Safety Partnerships

2.15 The four district-led Community Safety Partnerships (CSPs) are multi-agency forums where relevant partners work together to assess local crime priorities and agree how to deal with these issues. The Partnerships develop local plans for their respective areas to ensure delivery of community safety priorities that address local risks. They have direct lines of communication with the Safeguarding Boards for relevant issues or concerns to be escalated as necessary. CSPs are also represented on each Safeguarding Board through district council representatives.

2.16 Community Safety Partnerships were established under the Crime and Disorder Act 1998 to reduce reoffending, tackle crime and disorder, anti-social behaviour, substance misuse and any other behaviour that has a negative effect on the local environment. They are required to develop and implement a strategy for tackling crime and disorder in their local area jointly with the Police and to take account of the Police and Crime Commissioner priorities in developing their plans.

3. Principles of Joint working

3.1 The following principles of joint working underpin the work of the Boards/Partnerships, ensuring that resources are used effectively across Oxfordshire to safeguard the health and wellbeing of vulnerable people and the organisations responsible for their protection are held to account.

Think partnerships

3.2 All of the Boards/Partnerships will adopt a mind-set where they consider the wider partnerships context in relation to the work they are doing. Where there is mutual benefit in informing or working together with another partnership board they will do this.

Understanding accountability

3.3 The Boards/Partnerships will have an understanding of their remit and responsibilities in respect of the areas of work they oversee and the agencies they hold to account. Each Board/Partnership is also responsible for identifying themes that overlap with the work of other Boards/Partnerships and require a joint approach. They will have clear and effective processes in place for the escalation of issues and information sharing as appropriate.

3.4 Each Board/Partnership member will also have an understanding of their individual accountability as the appropriate representative for their organisation in each forum.

3.5 Where there is cross-over in membership of the Boards/Partnerships in respect of either an individual or partner organisation, members will be responsible for communicating and sharing relevant information or concerns that will facilitate effective joint working or a joint response to an issue.

Work together on themes of common interest

3.6 Some themes have relevance across a number of partnerships and in these cases the Boards/Partnerships will work together and take a pragmatic approach to achieve the best outcomes for people and ensure that there is no duplication of effort. In practice this means that each Board/Partnership has the opportunity to input into an area of work where it carries a responsibility and/or has relevant knowledge, expertise and experience.

3.7 Where a piece of work with a cross-cutting theme is identified, the other Boards will initially be contacted to ascertain the relevance of the theme / area of work for them. The relevant Boards will agree the following:

- The approach that will be taken,
- Which Board will lead on the area of work and how other partnerships will contribute,
- Responsibility and accountability for the area of work,
- Communication and reporting arrangements.

Sharing information about risk

3.8 The Boards/Partnerships will share all relevant information with each other on key risk or concerns. This will help partner organisations maintain a good awareness and understanding of emerging risks that are relevant to their area of work and will enable the Boards/Partnerships to consider strategic actions that can manage and reduce these risks. Sharing information also supports the principle of mutual challenge and support.

Mutual challenge and support

3.9 In addition to the specific scrutiny roles of the OSCB and OSAB, all the Boards/Partnerships will mutually challenge and support one another's activities to optimise safeguarding arrangements in Oxfordshire and ensure the best outcomes are achieved for vulnerable people in the county.

3.10 The OSCB and OSAB have a specific remit to ensure that effective safeguarding arrangements are in place across partner organisations. Within this remit, these Safeguarding Boards will work with, and offer challenge to, the OxSCP, the CSPs and the HWB, including the Children's Trust, the Health Improvement Board and the Joint Management Groups.

Share good practice and resources

3.11 To ensure the Boards/Partnerships continue to develop and increase their effectiveness, relevant good practice and resources will be shared. This includes sharing policies and practices, learning from other authorities and opening up training and development opportunities to the wider partnerships, e.g. Children's Trust members will benefit from attending the OSCB annual conference, usually themed around a current issue.

Openness and honesty

3.12 The Boards/Partnerships will work together in a way that is open and honest in recognition of their common aim to achieve the best outcomes for Oxfordshire residents. In practice this means sharing all relevant information, holding each other to account and maintaining open channels of communication.

4. Interfaces between Boards

4.1 Joint working is important for developing integrated arrangements that ensure priorities for change are delivered in practice. All the Boards/Partnerships will work together to develop effective joint approaches and to understand the impact of services on outcomes for vulnerable children, young people and adults with care and support needs. Where appropriate this understanding will be used to challenge delays in progress and drive further improvements.

4.2 To ensure effective joint working across the Boards/Partnerships the following arrangements will be put in place to facilitate a co-ordinated and coherent approach. The formal relationships set out in this protocol reflect the respective roles of HWB, OSCB, OSAB, CSPs and OxSCP in relation to one another.

Reporting

4.3 In respect of shared priorities the Boards/Partnerships will share information through regular or thematic reports that also include the response and/or action required from the receiving Board/Partnership. This includes regular performance reports from PAQA and PIQA that highlight pressure points and related actions.

4.4 Key annual reports will be shared between Boards/Partnerships to inform priority setting. Where it is appropriate to do so, Boards/Partnerships may be asked to have input into the development and finalisation of each other's key reports. Appendix B outlines a timetable for these reports to shared and for what purpose.

4.5 If issues or reports need to be shared outside of this timetable the Chairman of a Board/Partnership may:

- Request information from another Board/Partnership and its consideration of an issue or concern,
- Request that an item be placed on another Board's/Partnership's agenda for discussion,
- Hold a meeting with one or more of the other Boards'/Partnerships' Chairmen to consider a particular issue and agree a way forward.

4.6 Where an issue cannot be resolved within the above framework, a resolution meeting will be held between the Board/Partnership Chairman/Chairmen and the appropriate senior officer(s) from the organisation(s) concerned.

4.7 Annual reports will include an honest evaluation of performance against annual plans and provide an opportunity for reciprocal scrutiny and challenge that will inform the development of future years' strategies and action plans. These reports may set out key findings from performance monitoring throughout the year and include recommendations for improvement.

4.8 Needs analyses that drive the formulation of the Health and Wellbeing Strategy and the county-wide Community Safety Agreement (e.g. the Joint Strategic Needs Analysis and the Strategic Intelligence Assessment) will be shared with Boards/Partnerships at key points in the development of their annual plans.

4.9 Annual plans will be shared between Boards/Partnerships in the formulation stages to avoid duplication, identify gaps, and enable co-ordination and shared business priorities where areas of work overlap - for example, work on domestic abuse is a priority for all the Boards/Partnerships.

Liaison and consultation

4.10 The key officers for each Board/Partnership will meet regularly, to ensure that key issues are identified and respective roles and responsibilities are clear in emerging areas of concern. The lead officers will also review current work to safeguard vulnerable people and discuss the Boards' annual reports and plans to reduce duplication of effort and identify opportunities for joint working.

4.11 Board/Partnership membership will include cross-partnership representation to enable on-going communication and provide opportunities for cross-cutting issues to be raised directly in meetings by lead members.

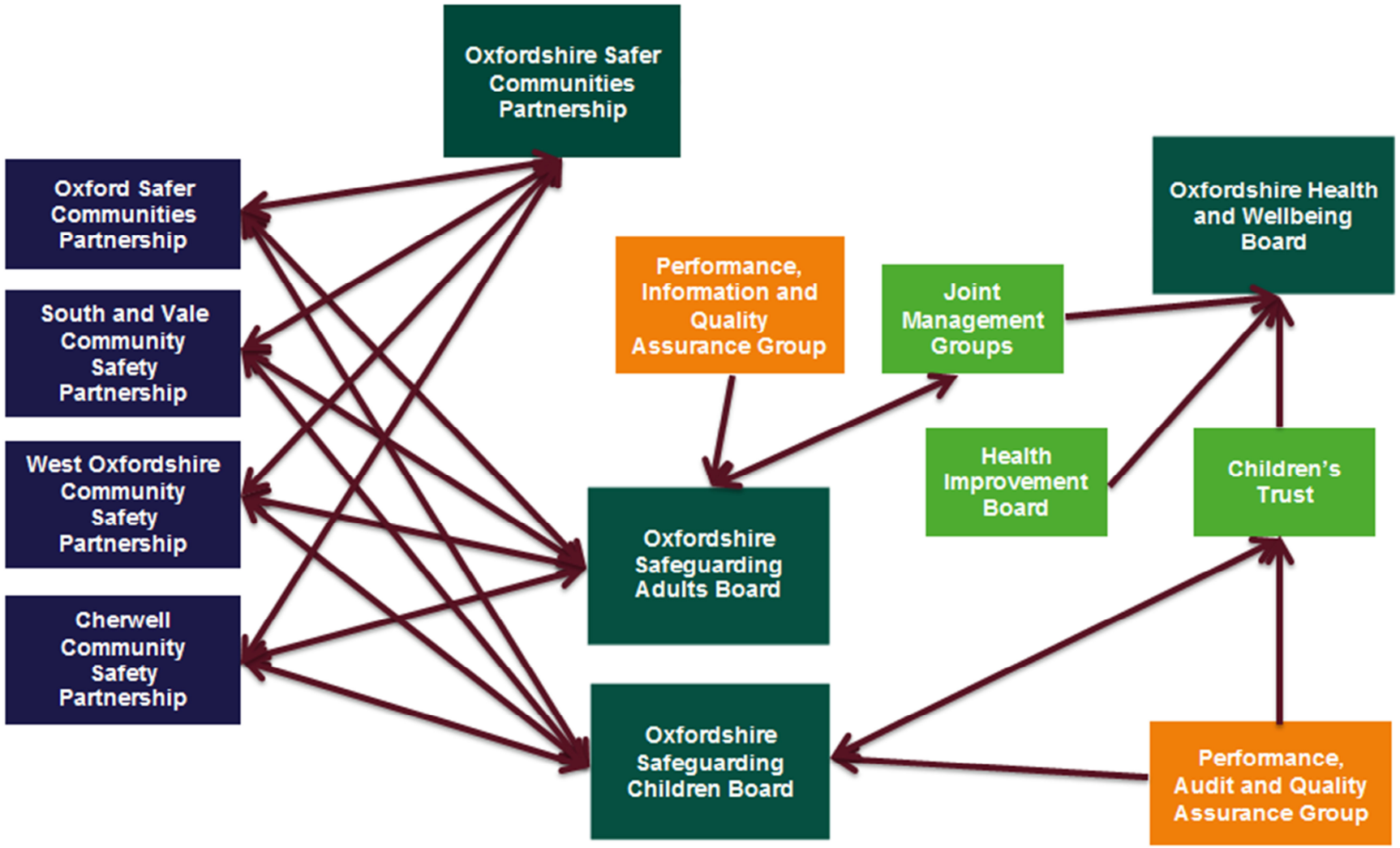
Escalation of safeguarding concerns

4.12 Any issues that relate to the abuse or potential abuse of children and/or adults with care and support needs and have not been resolved within a single-agency or multi-agency context will be escalated via the appropriate safeguarding route.

4.13 As a multi-agency issue, a concern will be raised at the respective Board/Partnership meeting and members will agree which partner will escalate the concern with the OSCB and/or OSAB Chairman.

4.14 The appropriate information sharing protocols will be followed to resolve the issue in a timely manner.

5. Governance Structure / Map



6. Review and monitoring

6.1 The effectiveness of this protocol will be reviewed and evaluated at least annually by the key officers and amended at any time by agreement between all the Boards/Partnerships or in response to any changes in legal responsibilities.

6.2 The protocol will be effective if:

- There are identifiable improvements attributable to multi-agency work on themes of common interest/concern.
- Areas of emerging concern are identified in a timely manner and reflected in business priorities as a result of effective risk management quality assurance, and issue escalation processes.
- Board/Partnership members have a clear understanding of the remit and responsibility of the Board/Partnership(s) of which they are a member.
- Each Board/Partnership is informed and aware of the work of other Boards/Partnerships and its interface with and effect on the areas of work it oversees.
- The intelligence gathered through needs analyses is evident in the shared priorities of the Boards/Partnerships.

6.3 Where an individual agency has a concern that this protocol is not being adhered to or is not effective, the agency will refer their concerns in the first instance to the Chairman of the Board/Partnership(s) of which they are a member. The Chairman will seek to resolve their concerns informally with the Chairmen of the other Boards/Partnerships. Where one or more of the Boards/Partnerships has a concern about the protocol the Chairmen will refer the matter to the relevant senior officer(s) in the appropriate organisation(s), who will identify a resolution in consultation with the relevant lead member as appropriate.

7. Supporting documents

7.1 The annual plans, supporting policies and protocols, and terms of reference for each Board/Partnership can be found on the following websites:

Partnership Board	Website
HWB	www.oxfordshire.gov.uk/healthandwellbeingboard
OSAB	www.osab.co.uk
OSCB	www.oscb.org.uk
OxSCP	www.oxfordshire.gov.uk
Oxford CSP	www.oxford.gov.uk
South and Vale CSP	www.whitehorsedc.gov.uk
West Oxfordshire CSP	www.westoxon.gov.uk
Cherwell CSP	www.cherwell.gov.uk

7.2 Relevant statutes and statutory guidance to be aware of are:

Health and Social Care Act 2012

Children Act 1989

Children Act 2004

Working Together to Safeguard Children, March 2015

Care Act 2014

Care and Support Statutory Guidance, October 2014

Crime and Disorder Act 1998

Crime and Disorder (Formulation and Implementation of Strategy) Regulations 2007

7.3 Schedule of circulation for the draft protocol for discussion, comment and agreement in principle:

Board/Partnership meeting	**Provisional meeting date**
Oxfordshire Safeguarding Children Board	27 January 2016
Older People's JMG	27 January 2016 (tbc)
Physical Disability JMG	28 January 2016 (tbc)
Learning Disability JMG	28 January 2016 (tbc)
South and Vale CSP	28 January 2016
West Oxfordshire CSP	2 February 2016
Health Improvement Board	18 February 2016
Oxford CSP	1 March 2016
Cherwell CSP	1 March 2016
Oxfordshire Health and Wellbeing Board	3 March 2016
Oxfordshire Safer Communities Partnership	10 March 2016
Oxfordshire Safeguarding Adults Board	24 March 2016
Mental Health JMG	24 March 2016 (tbc)
Children's Trust	31 March 2016

Appendix A | Functions of the Boards

Oxfordshire Health and Wellbeing Board (HWB)

Key functions

- Prepare a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy to determine priorities and objectives for health and social care services and drive the development and delivery of these services.
- Provide advice, assistance or other support to encourage integrated working between health and social care commissioners that meets the health and social care needs of Oxfordshire and uses resources effectively.
- Produce a pharmaceutical needs assessment (PNA).
- Agree how the Better Care Fund (formerly the Integrated Transformation Fund) is used in Oxfordshire and oversee its implementation.
- Use its power of influence to encourage closer working between commissioners of health-related services and the Board itself.
- Use its power of influence to encourage closer working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
- Undertake any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012.

Terms of reference and membership of the Health and Wellbeing Board can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

Health Improvement Partnership Board (HIB)

Key functions

- Bring a coordinated and coherent approach to influencing a broad range of determinants of health to bring about health improvement and reduce health inequalities.
- Work together to recommend priority areas to improve health to the Health and Wellbeing Board in order to make a real and measurable difference to outcomes.
- Recommend actions and responsibilities to make that improvement a reality.
- Hold each other to account for making the agreed change and for reporting progress.

Terms of reference and membership of the Health Improvement Partnership Board can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

The Children's Trust

Key functions

- Agree and recommend to the Health and Wellbeing Board, a Children and Young People's Plan for Oxfordshire and where resources should be focused to deliver the Plan
- Report on multi-agency performance for delivering the Plan to the Health and Wellbeing Board.
- Make specific recommendations on key outcomes for children and young people in Oxfordshire and as they move into adulthood, to include in the Joint Health and Wellbeing Strategy.
- Collaboratively solve issues and find solutions, jointly plan services and align and/or pool resources as appropriate to deliver improvements.
- Work in close partnership with the Oxfordshire Safeguarding Children Board to ensure that safeguarding concerns are fully considered in promoting the health and wellbeing of children and young people
- Work in partnership with other strategic boards, such as the Health Improvement Board, Joint Management Groups and the Oxfordshire Safer Communities Partnership to ensure that their plans and performances targets are in synergy with those of the Children's Trust.

Terms of reference and membership of the Children's Trust can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

Joint Management Groups (JMGs)

Key functions

- Oversee and manage spending and activity to improve outcomes and meet the needs of older people and people with a physical disability, learning disability or mental illness.
- Agree pooled resources and deliver shared objectives under a single agreement between the County Council and the Oxfordshire Clinical Commissioning Group (under section 75 of the National Health Services Act 2006)
- Monitor strategy and governance, finance, performance and risk in their respective areas of commissioning against key outcomes in the Joint Health and Wellbeing Strategy.

Terms of reference and membership of the Joint Management Groups can be found at: www.oxfordshire.gov.uk/healthandwellbeingboard

Oxfordshire Safeguarding Children Board (OSCB)

Key functions

- Prepare an annual Business Plan that identifies shared priorities for the safeguarding of children and young people in Oxfordshire, based on local issues and demands.
- Produce and publish an annual report on the effectiveness of safeguarding arrangements within Oxfordshire, which is reported to the Children's Trust and the Health and Wellbeing Board.
- Develop policies and procedures for safeguarding and promoting the welfare of children, including those in relation to thresholds, training, recruitment, investigations and allegations, privately fostered children and cooperation with other children's services.
- Monitor and scrutinise multi-agency activity in relation to safeguarding, highlighting underperformance and advising on ways to improve. This is done via case files audits, reviews and inspections.
- Communicate and raise awareness with professionals and within local communities about the need to safeguard and promote the welfare of children and young people.
- Undertake independent serious case reviews where abuse or neglect is known or suspected to be factor in a child's death or serious injury and advise on lessons learnt.
- Take responsibility for checking that the recommendations from an independent serious case review are delivered.
- Monitor and evaluate the effectiveness of training, including multi-agency training for all professionals in Oxfordshire.
- Lead on or contribute to specific safeguarding initiatives and be responsible for cascading information about national guidance and how this is implemented in Oxfordshire.

The OSCB has an Independent Chair who holds all agencies to account by scrutinising and monitoring their work with children and young people. The Chair is directly accountable to the County Council's Head of Paid Service, but works closely with all OSCB partners, in particular the Director of Children's Services for Oxfordshire.

Terms of reference and membership of the Oxfordshire Safeguarding Children Board can be found at: www.oscb.gov.uk

Oxfordshire Safeguarding Adults Board (OSAB)

Key functions

- Prepare an annual Business Plan that identifies shared priorities for the safeguarding of vulnerable adults in Oxfordshire, based on local issues and demands.
- Produce and publish an annual report on the effectiveness of safeguarding arrangements within Oxfordshire, which is reported to the Health and Wellbeing Board.
- Develop, agree and oversee local policies and procedures for inter-agency work to protect vulnerable adults, within the national framework provided by No Secrets (Department of Health, 2000).
- Ensure there is agreement and understanding across agencies about operational definitions and thresholds for intervention.
- Support the provision of multi-agency training and workforce development on safeguarding of vulnerable adults and consider any scope to jointly commission training with other partnerships, such as Community Safety Partnerships.
- Ensure mechanisms are in place to coordinate effective safeguarding activities between agencies based on national and local evidence and experience, and ensure that lessons learned are shared, understood and acted upon.
- Undertake independent serious case reviews where abuse or neglect is known or suspected to be factor in an adult's death or serious injury and advise on lessons learnt.
- Monitor and evaluate the effectiveness of safeguarding arrangements in Oxfordshire and the impact of the Board.
- Ensure compliance with formal governance requirements.

The OSAB has an Independent Chair who holds all agencies to account by scrutinising and monitoring their work with adults who have care and support needs. The Chair is directly accountable to the County Council's Head of Paid Service, but works closely with all OSAB partners, in particular the Director of Adult Social Services for Oxfordshire.

Terms of reference and membership of the Oxfordshire Safeguarding Adults Board can be found at: www.osab.co.uk

Oxfordshire Safer Communities Partnership (OxSCP)

Key functions

- Agree the community safety risks, opportunities and priorities that partners will address on a county-wide basis.
- Oversee and agree a Strategic Intelligence Assessment, Community Safety Agreement and work programme for the county to inform partners of the current community safety risks, using a combination of data and environmental scanning.
- Provide strategic direction and challenge member organisations on their engagement with any common risk or priority in the Community Safety Agreement and work programme
- Ensure the community safety work programme supports the local Community Safety Partnerships' strategies and links with cross-cutting priorities in Oxfordshire 2030.
- Ensure that partners are meeting their statutory responsibilities to identify how they might more effectively implement the identified priorities and otherwise reduce crime and disorder through coordinated or joint working.
- Provide a focal point for dialogue with the Police and Crime Commissioner.

The broad membership of OxSCP ensures strong linkages with other strategic partnerships, with several OxSCP Board members representing community safety on the partnership boards of the Health and Wellbeing Board as well as sub-groups of OSCB and OSAB.

Terms of reference and membership of the Oxfordshire Safer Communities Partnership can be found at:
https://www.oxfordshire.gov.uk/cms/content/oxfordshire-safer-communities-partnership

Community Safety Partnerships

Key functions

- Produce and monitor an annual Community Safety Plan and Strategy for the local area based on priorities identified through the Strategic Intelligence Assessment and send this to the Thames Valley Police and Crime Commissioner.
- Publish an annual report on progress towards delivering the plan.
- Liaise with the Thames Valley Police and Crime Commissioner to discuss local crime priorities.
- Provide guidance for local communities to promote active citizenship and build their capacity to play a role in reducing crime and the fear of crime locally.
- Provide strategic direction for community safety action groups, such as Joint Agency Tasking and Coordination and scrutinise the progress of these groups.
- Act as a channel for communication with local communities on community safety and safeguarding matters, reporting any concerns back to the Safeguarding Boards.

The four district/city–led partnerships are:

- Oxford Safer Communities Partnership
- South and Vale Community Safety Partnership
- West Oxfordshire Community Safety Partnership
- Cherwell Community Safety Partnership

Terms of reference and membership of the Oxfordshire Community Safety Partnerships can be found on the district / city council websites:
www.oxford.gov.uk
www.whitehorsedc.gov.uk
www.westoxon.gov.uk
www.cherwell.gov.uk

Appendix B | Reporting timetable

	HWB	Children's Trust	HIB	JMGs	OSCB	OSAB	OxSCP	CSPs
Joint Strategic Needs Assessment	Agree (Spring)	Inform (Spring)	Inform (Spring)	Inform (Spring)	Inform (Spring)	Inform (Spring)	Inform (Spring)	
Health and Wellbeing Strategy	Agree (Summer)	Consult (Summer)	Consult (Summer)	Consult (Summer)				
Children and Young People's Plan	Agree (Summer)	Agree (Spring)			Inform (Summer)			
OSCB Annual Report	Inform (Autumn)	Inform (Autumn)			Agree (Autumn)			
OSCB Business Plan					Agree (Autumn)			
OSAB Annual Report	Inform (Autumn)					Agree (Autumn)	Inform (Autumn)	
OSAB Business Plan						Agree (Autumn)		
OxSCP Annual Report					Inform (Summer)	Inform (Summer)	Agree (Summer)	
OxSCP Community Safety Agreement							Agree (Spring)	Inform (Spring)
Strategic Intelligence Assessment							Agree (Spring)	Inform (Spring)
CSP Community Safety Plans							Inform (Spring)	Agree (Spring)

Agree = Sign-off Inform = Use to inform work Consult = Board has input into

Appendix C | Good practice examples of joint working in Oxfordshire

In particular the following areas of work represent themes of common interest where there is already an integrated approach to delivering change. These are good practice examples from 2015-16.

Theme	Lead	Joint working arrangements
Child Sexual Exploitation (CSE)	**OSCB**	The OSCB's CSE sub-group provides oversight of the CSE Strategy which describes the strategic and operational arrangements for tackling CSE, including a multi-agency action plan. The OSCB and OxSCP provide mutual challenge and support to one another, with a particular focus on a prevention, disruption and enforcement. This will be facilitated by: • Community safety managers sitting on the CSE sub-group and contributing to the development of the CSE sub-group work plan, • The OSCB providing regular updates on CSE to the OxSCP, • Community Safety Partnerships developing local action plans to raise public awareness of CSE. The Children's Trust supports the work of the OSCB and the OxSCP by having representatives from both Boards as members and receiving reports on the progress of the OSCB's work on CSE as required. Work in this area will be fed up to the HWB via the regular reporting mechanisms of the Trust. The OSAB has a role in ensuring that appropriate provision is in place for children who continue to be exploited as they transition into adulthood, and for adults who disclose CSE in their past. CSE is also a priority for the Police and Crime Commissioner (PCC) and just over £50,000 of PCC funding has been provided through OxSCP to the OSCB sub-group to support CSE activity across Oxfordshire. The HWB will ensure that the JSNA includes robust and up-to-date profiling of CSE and the factors linked to the risk of CSE to inform commissioning decisions.

Female Genital Mutilation (FGM)	**OSCB**	Due to the impact that FGM has on the health, safety and wellbeing of women and girls it has been identified as a priority by the Thames Valley Police and Crime Commissioner. The OSCB's FGM Strategy ensures a coordinated approach to tackling FGM across Oxfordshire in consultation with community groups, the Police and Crime Commissioner and the other Boards. The OxSCP has a role in raising awareness of FGM through the allocation of Police and Crime Commissioner funding to support of victims of domestic abuse and exploitation and train professionals across Oxfordshire. The Children's Trust supports the work of the OSCB and the OxSCP and will receive reports on the progress of the OSCB's work on FGM as required. Work in this area will be fed up to the HWB via the regular reporting mechanisms of the Trust. The HWB will ensure that the JSNA includes robust and up-to-date profiling of the FGM to inform health and wellbeing priorities and future commissioning decisions.
Human trafficking and modern slavery	**CSPs**	The CSPs lead on Oxfordshire's multi-agency response to human trafficking and modern day slavery, including awareness raising activities and building an evidence base to develop an county-wide strategic plan and district level plans to tackle adult and child exploitation. The links between human trafficking, modern slavery and CSE are recognised by means of CSPs representation on the CSE sub-group of the OSCB, which enables relevant information to be cascaded and escalated to the OSCB where necessary. The OSAB, OSCB and the CSE sub-group have a role in offering support and challenge to CSPs on work being undertaken to tackle modern slavery and the outcomes this is achieving for vulnerable children, young people and adults. The CSPs will update the other Boards/Partnerships on progress in this area when necessary.
Preventing extremism	**OxSCP**	The OxSCP has strategic oversight of the Prevent duty to stop people becoming involved in or supporting terrorism. This includes: • Overseeing the Channel Panel - the multi-agency forum for sharing the assessment of risk where individuals are vulnerable to becoming radicalised, • Providing support and challenge to ensure the

		effective co-ordination of prevent through the district level Prevent action plans, • Providing regular updates on the volume of referrals to Prevent • Advising agencies on training frontline staff on the Prevent duty and developing training materials, • Liaising with other agencies and organisations subject to the Prevent duty, such as schools, to share learning and gather best practice to disseminate to partners, • Providing a single point of contact for information on the Prevent duty for the other Boards. The County Council has a Prevent strategy and the CSPs have developed action plans to deliver this agenda locally. Preventing extremism will be identified as a priority the county-wide Community Safety Agreement and the OxSCP business group will support and challenge CSPs on how they are managing the risk of extremism through their local action plans. The proportionate arrangements for the assessment of risk are agreed at the Channel Panel, which is chaired by the County Council. The CSPs have a duty to cooperate with the Panel and the OxSCP business group supports the co-ordinated approach to Prevent as appropriate. The OSCB has a focus on the radicalisation of children and young people as part of its work to raise awareness of serious safeguarding issues through its practitioner and training subgroups, and through increased engagement with the voluntary, community and faith sector. The Board aims to work in partnership with the OxSCP and the CSPs to promote key messages about preventing extremism. Safeguarding concerns relating to extremism are directly addressed through the appropriate Safeguarding Board via the CSP representative or County Council community safety representative, depending on the nature of the concern.
Domestic Abuse	**OxSCP & Children's Trust**	The OxSCP is the strategic lead for domestic abuse and oversees the Oxfordshire Domestic Abuse Strategy Group, receiving regular reports on the implementation of the Domestic Abuse Strategy. There are multi-agency referral risk assessment processes in place that the OxSCP monitors. The Children's Trust oversees the Children's Domestic Abuse Strategy Group and receives regular reports on the progress of work in this area.

		The OSCB works closely with the OSAB and Domestic Abuse Strategy Group on domestic abuse as a shared priority, given that it often underpins child abuse and neglect. Safeguarding of adolescents is also an OSCB priority as domestic abuse in peer relationships is reflected in the high numbers of young people subject to child protection plans and in the care system. The links between domestic abuse, honour based violence, forced marriage and FGM are recognised by means of CSPs representation on the CSE sub-group of the OSCB, which enables relevant information to be cascaded from the OxSCP and escalated to the OSCB where necessary.

Comments and Feedback

On the draft protocol outlining the relationship between the Oxfordshire Health and Wellbeing Board, the Oxfordshire Safeguarding Children Board, the Oxfordshire Safeguarding Adults Board, Oxfordshire's Community Safety Partnerships and the Oxfordshire Safer Communities Partnership

The draft protocol has been presented for discussion, comment and agreement in principle at the following meetings:

Board/Partnership meeting	Meeting date	Presented by	Protocol agreed in principle?	Comments / Feedback
Oxfordshire Safeguarding Children Board	27 Jan 2016	Richard Webb	Yes	No comments / suggested changes
Older People's JMG	27 Jan 2016	Ben Threadgold	Yes	No comments / suggested changes
Physical Disability JMG	28 Jan 2016 *cancelled*			
Learning Disability JMG	28 Jan 2016	Tan Lea	Yes	• Delegated authority to Chairman to sign-off final version. • Governance diagram needs a two-way link between the OSCB and the JMGs, as some of the JMGs cover children's issues. • Appendix A is particularly useful. • Individual members' internal accountability and responsibility to feedback safeguarding issues within their organisation should be emphasised. *Suggested amendment:* *3.4 Each Board/Partnership member will also have an understanding of their individual accountability as the appropriate representative for their organisation in each forum. They are responsible for ensuring that they put in place such arrangements that are necessary to share information within their organisation and with their organisation's representatives on other groups and partnerships.* *3.5 Where an individual represents their organisation at more than one Board/Partnership they will be responsible for communicating and sharing*

				relevant information or concerns across those Boards/Partnerships to facilitate effective joint working or a joint response to an issue.
South and Vale CSP	28 Jan 2016	Carys Alty-Smith	Yes	No comments / suggested changes
West Oxfordshire CSP	2 Feb 2016	Carys Alty-Smith	Yes	No comments / suggested changes
Oxford CSP	17 Feb 2016	Richard Adams	Yes	• Concurred with the comments from the Learning Disability JMG regarding individual members' internal accountability and responsibility to feedback safeguarding issues within their organisation. • Supported the JMG's suggested amendment to the draft protocol.
Health Improvement Board	18 Feb 2016	Tan Lea	Yes	No comments / suggested changes
Cherwell CSP	1 Mar 2016	Mike Grant		
Oxfordshire Health and Wellbeing Board	3 Mar 2016	Tbc		
Oxfordshire Safer Communities Partnership	10 Mar 2016	Richard Webb		
Oxfordshire Safeguarding Adults Board	24 Mar 2016	Richard Webb		
Mental Health JMG	24 Mar 2016	Ben Threadgold		
Children's Trust	31 Mar 2016	Tan Lea		

N.B. *Comments and feedback from all Boards/Partnerships will be collated in this document and attached with the original draft protocol for each meeting. After all Boards/Partnerships have had the opportunity to consider the protocol, appropriate amendments will be made to incorporate feedback and a final version will be circulated for agreement and sign-off.*

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Oxfordshire Health and Wellbeing Board
3 March 2016
Children's Trust Briefing

This paper outlines the activity of the Children's Trust since the last update which was provided to the Health and Wellbeing Board in November 2015. The Trust has met twice since the last update.

Members of the Trust have discussed and fed into issues including:

1. The **Domestic Abuse Review**. The Trust was informed about the multi-agency strategic review of domestic abuse services, aimed at aligning strands of work already going on across agencies. It was agreed that the Trust would have oversight of the work of the Oxfordshire Children's Domestic Abuse Strategy Group (OCDASG) to support robust governance arrangements and enable the Safeguarding Children Board to fulfil its role of challenge and effective scrutiny.

2. The **Education Strategy and Equity and Excellence in Education Strategy**. The Trust endorsed the Education Strategy's ambition to make all schools and settings in Oxfordshire at least 'good' by 2018, but recognised the changing role of the local authority in education. Members were concerned about high numbers of permanent exclusions in the county, but reassured that a county-wide protocol exists to ensure no children in care are excluded. The Equity and Excellence in Education Strategy for improving the educational attainment of vulnerable learners was also supported. The Trust will continue to receive updates on the implementation of these strategies.

3. The **Youth Justice Service Review**. The Trust recognised interdependencies between the review and the transformation of Children's Social Care and Early Intervention Services. Members discussed the importance of the Trust's links with Community Safety Partnerships (CSPs), as a proportion of funding for Youth Justice Services is allocated through these Partnerships. The Trust agreed to consider ways to strengthen its relationship with CSPs and to receive updates on the work they do with children and young people.

4. **Children in Care and Care Leavers.** The Trust considered the main barriers to achieving aspirational targets in the Education, Employment and Training Strategy for Looked After Children and Care Leavers and discussed where it could influence work in these areas. Members agreed to raise the profile of Looked After Children and Care Leavers by briefing the Local Enterprise Partnership and ensuring they become an area of focus for the Oxfordshire Skills Board.

   Members were also updated on the Placement Strategy and achievements/ activities of the Children in Care Council (CiCC) from 2015. Whilst the Trust was concerned about the cost of placements, members were pleased to note the high rates of adoption in Oxfordshire and the influential role of the CiCC. The Trust will continue to receive updates on the Strategy and the council's work with children and young people in the care system.

   Katie Read / Ben Threadgold
   February 2016

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Oxfordshire Health and Wellbeing Board
3 March 2016
Older People's Joint Management Group Briefing

This paper outlines the activity of the Older People's Joint Management Group since the last update provided to the Health and Wellbeing Board in November 2015.

The Group has met once since the last update, on 27th January 2016, and had discussions on performance, finance and activity for older people from April to December 2015 in addition to matters arising from the previous meetings.

The Older People's Joint Management Group monitors activity, performance and spending from the pooled budget to meet the six priorities of the **Older People's Joint Commissioning Strategy**, which are:

- I can take part in a range of activities and services that help me stay well and be part of a supportive community.
- I get the care and support I need in the most appropriate way and at the right time.
- When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.
- As a carer, I am supported in my caring role.
- Living with dementia, I and my carers receive good advice and support early on and I get the right help at the right time to live well.
- I see health and social care services working well together.

The Group discussed how to respond to the increasing demand for services within a diminishing budget. The broad savings agenda was discussed and concerns from the Clinical Commissioning Group about some of the savings proposals were noted, together with a commitment to work jointly on the future savings challenge.

The group discussed issues in relation to delayed transfers of care, and the Clinical Commissioning Group £2m project (including the purchase of up to 150 additional intermediate care beds in nursing homes). This spend is outside the older persons pooled budget but there are significant overlaps. The potential implications and risks of this project on the pooled budget were discussed, and in particular the risks of market destabilisation. On the positive side, the project will create capacity in the system by supporting people in moving to a setting suitable for their needs quickly. This is however a short term solution and the underlying problem for the delayed transfers of care in Oxfordshire still need to be addressed. The group noted the risks of the project and underlined that learning from this exercise should help to understand and address the challenges that Oxfordshire has been facing.

The group approved the actual pooled budget to date as £99.231m which equals a year-end overspend forecast of £2.494m.

The overspend figure includes an overspend of £1.024m on Non-Emergency Patient Transport. This currently sits with the Clinical Commissioning Group who have been working on how to manage this pressure with the provider.

Fulya Markham, 16 February 2016, ext 8079

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An update of the work of the Health Improvement Board
Report to the Oxfordshire Health and Wellbeing Board
March 2016

The Health Improvement Board has met twice since the last report to the Health and Wellbeing Board. There are also plans to run a workshop on the Oxfordshire Healthy Weight Strategy in March / April 2016.

1. Health Improvement Board workshop on Housing Related Support.

A workshop was held on January 14th 2016. This meeting was not held in public. The workshop was attended by members of the Health Improvement Board and the Executive / Cabinet members for Housing from each of the District Councils, with their supporting officers.

The workshop gave an opportunity for discussion about the future need for commissioning housing related support services. A further workshop will be arranged so that discussion can continue in April / May.

2. Health Improvement Board meeting, February 23rd, 2016

A meeting of the Board in February covered the following items on the agenda

- Performance reporting, with in-depth analysis of the immunisation figures for the county. There was also a report on the changing attitudes to smoking and the increased use of e-cigarettes which may be affecting how Stop Smoking services report smoking quit rates. There is a growing differentiation between people who are "tobacco-free" and those who are "nicotine-free".
- The work of the Affordable Warmth Network who have recently won a bid to British Gas and were awarded over £410,000 for work across Oxfordshire and Buckinghamshire to improve fuel poverty. A feature of the work is a reduction in the health harms of cold homes, so referrals from health services and social care are being encouraged.
- The extensive role of District Councils in delivering Health Improvement was outlined and discussed. This role, in providing housing and leisure services and in enabling planning, community development and economic development is very pertinent to ongoing discussions on devolution.
- An overview of Air Quality issues and the role of partners was also presented and led to discussion on the role of the Board in this work.

3. Healthy Weight Strategy Workshop – March / April 2016

A workshop is being set up to further the discussion on how all partners can work to prevent and reduce obesity in Oxfordshire. A national Childhood Obesity Strategy is awaited which should inform local work.

Jackie Wilderspin, February 2016

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Communications received by the Chairman November 2015 – February 2016
Report to the Health and Wellbeing Board, March 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 November 2015 to February 2016

Date received	Communication topic	Action taken
17.10.15	Children Heard and Seen – promoting group work among children who have a parent in prison	The promotional material was forwarded to Early Intervention Managers and Thriving Families team workers across the County.
30.10.15	Thames Valley Children's palliative care network, requesting Oxfordshire participation in the Network.	The request was forwarded to the Head of Commissioning for Children's Services who gave assurance that participation by commissioners and provider organisations (OUHT and Oxford Health) in this network is already well established.
11.11.15	Dental health promotion in Oxford – a request for support for Dental Health trainees to set up a health Promotion initiative.	The Public Health team put the trainee Dentists in contact with a local shopping centre and they arranged a dental health promotion event there in November 2015
9.12.15	Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020.	Receipt of the framework was acknowledged
1.2.16	Freedom of Information Request on palliative care, from Hospice UK	Response sent within the guidelines and timescales set out in the FOI policy.
10.2.16	Volunteer Cancer Campaign Ambassadors for Cancer Research UK sent an email asking for details of current smoking cessation services in Oxfordshire.	Public Health response, forwarding details of a paper on Smoking Cessation that has been published with papers for the Health Improvement Board meeting on 18th February.

Any questions on this report can be directed to jackie.wilderspin@oxfordshire.gov.uk

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