

Public Document Pack

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 22 March 2018 at 2.00 pm
Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND



Peter G. Clark
Chief Executive

March 2018

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

Membership

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

Board Members:

Councillor Anna Badcock	Chairman, Health Improvement Partnership Board
Lucy Butler	Director for Children's Services
Dr Matthew Gaw	Vice-Chairman, Children's Trust
Cllr Steve Harrod	Chairman, Children's Trust
Councillor Hilary Hibbert-Biles	Cabinet Member for Public Health & Education
Dr Jonathan McWilliam	Strategic Director for People & Director of Public Health
Dr Paul Park	Vice-Chairman, Older People's Joint Management Group
David Radbourne	NHS England, Director of Commissioning Operations (South Central)
Prof George Smith	Chairman, Healthwatch Oxfordshire
Councillor Lawrie Stratford	Chairman, Older People's Joint Management Group
Kate Terroni	Director for Adult Services
Councillor Marie Tidball	Vice Chairman, Health Improvement Partnership Board

In Attendance: Peter Clark, Chief Executive, OCC
Louise Patten, Chief Executive, OCCG

Notes: • - **Date of next meeting: 19 July 2018**
- **Please note a special meeting has been arranged for 2pm, 10 May 2018**

Declarations of Interest

The duty to declare.....

Under the Localism Act 2011 it is a criminal offence to

- (a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
- (b) provide false or misleading information on registration, or
- (c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?

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

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

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

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?

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

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

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

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

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

List of Disclosable Pecuniary Interests:

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

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

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

AGENDA

1. **Welcome by Vice Chair, Dr Kiren Collison**
2. **Apologies for Absence and Temporary Appointments**
3. **Declarations of Interest - see guidance note opposite**
4. **Petitions and Public Address**
5. **Note of Decisions of Last Meeting (Pages 1 - 18)**

To approve the Note of Decisions of the meeting held on 9 November 2017 (HBW5) and to receive information arising from them.

6. **Performance Report (Pages 19 - 34)**

2:05
20 minutes

Progress against Joint Health and Wellbeing Strategy Outcome Measures agreed for 2017-2018

Persons responsible: Strategic Director for People & Director of Public Health, Director for Adult Services, Director for Children's Services, Oxfordshire County Council (OCC); Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG)

Person giving report: Strategic Director for People & Director of Public Health

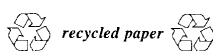
To receive an update on performance against the outcomes agreed for 2017-2018 in the Joint Health & Wellbeing Strategy (HWB6).

The Board is RECOMMENDED to hold members to account for performance against key indicators.

7. **Joint Strategic Needs Assessment (JSNA) (Pages 35 - 244)**

2:25
10 minutes

Persons responsible: Strategic Director for People & Director of Public Health, Chief Executive, OCCG; Chief Executive



Person giving report: Strategic Director for People & Director of Public Health;
Chief Executive, OCCG

The annual Joint Strategic Needs Assessment is attached for consideration and acceptance (**HWB7**).

Please note that the Annex containing the Health Inequalities basket of Indicators are available on the website under this item but have not been printed. A printed copy will be available at County Hall Reception and in the meeting itself.

The Board is asked to consider, comment on and approve the Joint Needs Assessment for 2018 -19.

8. Pharmaceutical Needs Assessment (Pages 245 - 328)

2:35
10 minutes

Person responsible: Director of Public Health
Person giving report: As above

The updated Oxfordshire Pharmaceutical Needs Assessment is before the Board for review and approval (**HWB8**).

Please note that Appendices A – E and the Maps are available on the website under this item but have not been printed. A printed copy will be available at reception and at the meeting itself.

The Board is RECOMMENDED to review and approve the updated Pharmaceutical Needs Assessment.

9. Special Educational Needs & Disability (SEND) Policy Review (Pages 329 - 368)

2:45
10 minutes

Person responsible: Director for Children's Services, OCC
Person giving report: As above

The report and Local Area Written Statement of Action is attached at (**HWB9**) for consideration.

The Board is RECOMMENDED to consider the outcomes of Oxfordshire's inspection and its responsibilities in relation to the joint area accountability for the delivery of the Written Statement of Action.

10. Healthwatch Oxfordshire (HWO) - Update (Pages 369 - 370)

2:55

10 minutes

Persons responsible: Chief Executive Officer and Chairman of HWO

Person giving report: Chairman of HWO

There will be an update on HWO activities given by the Chairman of HWO, Professor George Smith (**HWB10**).

The Board is RECOMMENDED to note the report.

11. Reports from Children's Trust, Joint Management Groups for Adults and Health Improvement Partnership Board (Pages 371 - 390)

3:05

10 minutes

Attached are the written reports on activities to deliver the priorities set out in the Joint Health & Wellbeing Strategy since the last Board meeting in November (**HWB11**) from:

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

The Board is RECOMMENDED to:

- (a) receive the above reports and assess progress in delivering the Joint Health & Wellbeing Strategy priorities; and***
- (b) approve the amended draft Terms of Reference for the Health Improvement Partnership Board and the Children's Trust.***

12. Care Quality Commission (CQC) Inspection Report and Required Actions (Pages 391 - 468)

3:15

30 minutes

Persons responsible: Director for Adult Services, OCC; Chief Executive, OCCG; Chief Executive, OH; Chief Executive, OUH; Chief Executive, OCC

People giving report: As above

A report on the CQC inspection carried out in November 2017, together with the Action Plan is attached at **HWB12**.

The Board is RECOMMENDED to note and discuss the report and Action Plan and approve the governance arrangements.

13. Older People Strategy (Pages 469 - 474)

3:45

10 minutes

Persons responsible: Director for Adult Services, OCC; Chief Executive, OCCG
Person giving report: As above

To consider a report which sets out the process whereby the new Older People Strategy will be co-produced. This will include the timetables for this in the light of the CQC report and the refreshed JSNA **(HWB13)**.

14. Health & Wellbeing Board Governance Review (Pages 475 - 490)

3:55

10 minutes

Person responsible: Strategic Director for People, OCC
Person giving report: As above

To discuss and seek the Board's agreement to the prospective review of the Health & Wellbeing Board's governance **(HWB14)**.

The Board is RECOMMENDED to note and discuss the emerging findings and approve the proposed next steps.

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 9 November 2017 commencing at 2.00 pm and finishing at 6.10 pm

Present:

Board Members: Councillor Ian Hudspeth – in the Chair

Dr Joe McManners (Vice-Chairman)
District Councillor Anna Badcock
Lucy Butler
Councillor Hilary Hibbert-Biles
Dr Jonathan McWilliam
Councillor Lawrie Stratford
Prof George Smith
Kate Terroni
Cllr Marie Tidball

Other Persons in Attendance: Dr Tony Berendt, (OUH); Stuart Bell (Oxford Health Foundation Trust & Oxfordshire Transformation Board; Peter Clark, OCC and David Smith, OCCG

Officers:

Whole of meeting Julie Dean, OCC

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

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

	ACTION
1 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
The Chairman welcomed all to the meeting. He took this opportunity to thank David Smith and Dr Joe McManners, this being their last meeting, for all their hard and very valuable work in support of the Board in their roles as Chief Executive and Chair of Oxfordshire Clinical Commissioning Group, respectively.	

2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
An apology had been received from Cllr Steve Harrod, Dr Barbara Batty (OCCG) attended in place of Dr Paul Park and Dr Tony Berendt (Oxford University Hospitals NHS Foundation Trust (OUH) and Stuart Bell CBE (Oxford Health Foundation Trust and Oxfordshire Transformation Board) were in attendance. NHS England's representation has not yet been confirmed.	Julie Dean
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)	
No requests to present a petition or address the meeting had been received.	Andrea Newman
5 Note of Decisions of Last Meeting (Agenda No. 5)	
The note of the last meeting, which took place on 13 July 2017, was approved and signed as a correct record. <u>Matters Arising</u> <u>In relation to 6/17 – Update on Delayed Transfers of Care and Better Care Fund Planning</u> – in response to a question, Kate Terroni confirmed that, as far as possible, the rise in the hourly care worker rate had been passed on to those frontline workers where Adult Social Care had commissioned the service, given the fact that under contractual rules this could not be insisted on. However, there were a variety of means to ensure that the money had been paid to frontline workers through audit and informal channels. However it was not possible to enforce it and there was no means of control over the 'self - funder' market.	Julie Dean
6 Performance Reports (Agenda No. 6)	
The Board received an update on performance against the outcomes agreed for 2017-2018, quarter 2, in the Joint Health &	

Wellbeing Strategy, in the following categories:

- (a) progress against the Outcome Measures agreed for 2017-18;
- (b) accident and Emergency Delivery Board Targets; and
- (c) Adult Social Care Outcomes Framework Published Results for 2016-17.

(a) Progress against the Outcome Measures agreed for 2017 – 18

Target indicator 1(1:1) – Priority 1 – ‘Ensuring children have a healthy start in life and stay healthy into adulthood’ – ‘Waiting Times for first appointment with Child & Adolescent Health Services (CAMHS)’

In response to a challenge regarding performance in this area, Stuart Bell, Oxford Health Foundation Trust (OH), reported that a new model of working with a consortium had just commenced based on work with Buckinghamshire. Barnado’s had also given significant assistance with the planning of this. He added that demand for this service had risen significantly for a variety of reasons and users should see a difference over the next few months in terms of access.

Target indicator 2(2:3) – Priority 2 – ‘Ensure that the attainment of pupils with SEN & Disability (SEND) but no Statement of Education Health & Care Plan is in line with the national average’

In relation to the challenge posed by a Board member relating to the extent that school exclusion and home school schooling could be a factor in non-attainment, Lucy Butler commented that this area was a major focus and the Children’s Services Directorate had key plans and initiatives for this area which she outlined.

Target indicator 3(3:5) – Priority 3: ‘Keeping children and young people safe’ – ‘Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 0-14 to the national level’ -

In response to a challenge that the Board understand the reasons behind the sharp rise in children self-harming, non-accidental or deliberate injuries, the Board requested that a more detailed analysis be submitted to a future meeting.

Target indicator 3(3:6) – Priority 3: ‘Keeping children & young people safe – maintain the current number of looked after children’

In response to a challenge by the Board about the rise in the

number of Looked After Children (LAC) which was above the national average, Lucy Butler stated that the past four years had seen a rise in child protection statistics. However this year was the first in which the trend was moving downwards. She voiced her uncertainty as to when this trend would affect the LAC statistics, but more work was taking place in this trajectory to ensure all that was possible was being carried out to keep them out of care.

Target Indicator 5(5:3) – Priority 5 – ‘Working together to improve quality and value for money in the Health and Social Care system’- ‘Reduce the average length of ‘days delay’ for people discharged from hospital to care homes’

A Board member challenged whether the recent reduction shown was sustainable. Kate Terroni responded that it was a challenge, but the collaborative working in Oxfordshire was helping it to move in the right direction, adding that there was a need to keep up all efforts. It was pointed out that the average length of stay per treatment was also better than most areas.

Target Indicator 6(6:9) – 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’ - ‘Reduce the number of people with Learning Disability and/or autism placed/living out of county’

The Board **AGREED** that it needed to keep track on those people choosing to stay out of county and to request Kate Terroni to report back to the Board.

(b) Accident and Emergency Delivery Board (AEDB)Targets

The Board considered the Accident & Emergency Board Targets performance report (October 2017) and reviewed the areas where performance was below target.

David Smith informed the Board of the following:

- AEDB was chaired by the Chief Executive of the Oxford University Hospitals NHS Foundation Trust (OUH) , Dr Bruno Holthof;
- All agencies were represented on it;
- It was tasked with ensuring the whole of emergency and the urgent care systems, which were under significant pressure, were working well;
- Actions to date from the team had included the introduction of GP streaming into A & E; an investigation into demand for A&E services and tracking patient users of the service;
- Emergency admissions were benchmarked very well to

accord with their peer group; • A paramount issue for the team was how not to admit people into hospital who did not need to be admitted. Finance and staffing factors were critical to this; • The Team was trying to do as well as it could in relation to these targets. Currently it was not achieving the 4 hour wait target but expected it to reach 95% by March 2018. Dr Tony Berendt (OUH) stated his support for the inclusion of these targets within this report in order alongside the other partners in order to show the overall shape of the system. He believed the process was not yet configured properly, for example, in relation to the difficulties experienced with patient discharge. He reassured the Board that the OUH Trust Board took it very seriously and was in discussion with their Regulator on the matter. Dr Berendt further stated that the 'breaking the cycle' meetings had proved to be very useful and illuminating, adding that work was still in progress to beat the DTOC problem. He highlighted the following problems current in the system: - DTOC; - The closure of a number of beds due to staffing issues, significantly the inability to recruit as highlighted may times. However, a constant for the Trust was a paramount commitment by the Trust to patient safety; - Staffing pressures encountered by Social Care; - Problems admitting patients as quickly as the Trust would like. He stated the strong commitment of the Trust to a hospital protocol with all systems working as one. David Smith cited the problems encountered with high numbers of people attending Accident & Emergency at the Horton Hospital and John Radcliffe Hospital, which was currently being addressed by the OCCG via the 'Admission Avoidance Workshop'. Positive and concrete actions being considered to help all across the system were: - How to improve access to GPs - More flexible use of community nurses - How to support care homes better. Dr Berendt added to this by stating that the acute ambulatory Unit which assisted with scans had increased its activity over the last 2 years and it was proving to be very successful. The Trust was also working closely with community nursing. In brief the Trust was looking at both internal and external processes to make improvements in acute patient care. All were looking at changing	

systems and looking to different ways of prioritising. He added that combined working looking at the dynamics of patient flow in different situations in order to understand better ways of understanding it, leading to better means of intervening, would assist enormously.

Professor Smith stated that HWO, who had a seat on the A & E Delivery Board, had looked at peaks of demand for A & E services and had concluded that, in order to mitigate this, the following was required:

- Meal breaks for ambulance staff needed to be staggered to take account of peaks and surges;
- Many patients could be dealt with in the primary sector – thus later opening hours in GP surgeries would assist;
- Hour by hour data changes in arrivals need to be tracked to ascertain what proportion could be dealt with in the primary sector, particularly in the early evening from 7pm onwards.

The A & E Delivery Board was endeavouring to understand a combination of factors, such as those below, which could serve to improve the current system.

- Many GP surgeries did work on past 7pm as part of the GP Out of Hours services, to which attendance statistics was rising;
- The CCG considered it of the utmost importance for people to access the 111 services and for more clinicians to be present to deal with these calls. People could then be signed to other more appropriate services rather than to A & E;
- Part of the work to be done in the community was to look again at good examples in the use of EMU'S in Abingdon and Witney, for example for them to provide the necessary clinical advice. In addition to this, clinical advice could be made available to care homes to avoid A & E visits;
- Currently there was no continual access to MIU's in the county. There was a need to hold discussions on how to do this with a view to gaining agreement across all parties and an overall picture of what was to be done;

Views and challenges expressed by the Board were as follows:

- Comparable data was required and it was important for components to be separated within it rather than looking at global figures;
- Traffic flows to the new, larger Health centres would need to be looked at, together with the numbers of

people with no access to transport; - Tracking the additional numbers of people who would be attending the JR Hospital for treatment was vital; - Tracking the numbers of people attending A & E who were making use of facilities such as Out of Hours and MIU's was vital. Also it was important to track how many GPs were liaising with the hospital to measure activity; - To ensure that there were targets measuring numbers of older people attending A & E and their pathway, including their waiting times. Dr Berendt pointed out that OUH was in the process of developing Frailty Units at the JR. He warned, however, that every new service needed to be sustainable, safe and resilient and this brought with it a cost. Dr Batty also added that the CCG was doing more work around how to better manage frailty. Part of this was to quickly identify patients from care homes. The Board AGREED to include the above performance data on all Agendas. Work on changes in the system could then be kept abreast of and critiqued in the same manner as the other performance data. <u>(c) Adult Social Care Outcomes Framework Published Results for 2016/17</u> The framework was presented and Kate Terroni, Karen Fuller and Benedict Leigh, Adult Social Care made themselves available for questions. In response to a challenge about what action was being taken to ensure social interaction and support for older people in light of the decrease in the number of day centre places, Karen Fuller responded that Age UK were continuing to track all who had been offered an assessment. In addition, Age UK was working with 40 individuals who had not settled in their placements. Further assessment was also undertaken in 3 months to ensure that they were settled. A review was then to be completed after 6 months to assess the impact of this action. In addition, two social workers had been allocated to each of the remaining day centres. Very positive stories, indicating good engagement had emerged, including the successful mixing of people with Learning and Physical Disability. Benedict Leigh also highlighted the usefulness of the forthcoming round of Daytime Support Grants for older people. Kate Terroni added also that feedback regarding the new service at Abingdon Hospital had been very positive and encouraging.	

In response to a comment on the success at Torbay of the integration of care works and qualified nurses into a Team which had led to a higher level of home support and a challenge for Oxfordshire to produce similar results, Kate Terroni stated that a Homecare Board, using Health, Domiciliary and Voluntary services had been set up in recognition of the importance of integrating the Health profession into Home Care. However, recruitment was a challenge, particularly in Oxfordshire, and the importance of encouraging people to value this work was of the utmost importance. She reminded the Board also that Social Care and Healthcare were already integrated in various localities. Dr McManners stressed the need to be very clear about what was meant by integration in a context of fragmented and duplicated services. He added that all aspired to tight integration and for those Teams to work in smaller, more local areas. Following a request, Kate Terroni undertook to come back to the Board with information regarding an Adult Social care Outcome Framework (ASCOF) measure for mental health. The Board was reminded that many of the issues discussed in relation to more general health and wellbeing performance had been considered at meetings of the Health Improvement Board.	Strategic Director for People/Director for Adult Services/Director for Children's Services/ Chief Executive and Chair, OCCG/Chief Executive, OUH/ Chief Executive OHFT
7 Care Quality Commission (CQC) Inspection (Agenda No. 7)	
Kate Terroni gave a presentation on the context, issues and plans for the forthcoming CQC inspection on behalf of the Chief Executives of OCCG, OH, OUH and OCC. She requested feedback from the Board on what it felt was missing, how the information given reflected Oxfordshire and the role of the Board in relation to the implementation of improved plans. Feedback from Members of the Board included: - To highlight two studies to illustrate how it looked from the patients point of view. This could be used to describe innovative services but also where there was a need to do better; - More information could be given in relation to the workforce situation in Oxfordshire; - More emphasis on what was prevention-led provision; - Slides could be distilled taking a SWOT analysis as there was a need to unpick the gap between assessment and delivery of a service and any problems	

encountered; - The importance of ensuring that staff were told they must be frank in giving evidence; - The importance of showing that there was a consistent vision and to explain that Oxfordshire had a plethora of plans; and - To ensure that any new technical facilities introduced were highlighted as a means of cutting down numbers going to Accident & Emergency.	Strategic Director for People/Director for Adult Services/Director for Children's Services/ Chief Executive and Chair, OCCG/Chief Executive, OUH/ Chief Executive OHFT
8 Early Lessons from the CQC reviews of Health and Social Care Systems (Agenda No. 8)	
The Board considered a report (HWB8) which set out the outcomes of the two completed CQC reviews of Health & Social Care systems and what lessons might be learned from the Oxfordshire system in general and the review of Health & Wellbeing Governance in particular. These were considered to be both useful and helpful. The comments on the functioning of Health and Wellbeing Boards were apposite and would help the debate on the review of Health & Wellbeing governance further down the Agenda. The Board emphasised that the Health & Wellbeing Board should be seen as a composite of the main board plus its sub-groups to get the whole picture of its activities.	All to note
9 Improved Better Care Fund and Delayed Transfers of Care (Agenda No. 9)	
Dr Barbara Batty, OCCG and Benedict Leigh, OCC gave an update (HWB9) on the development of the improved Better Care Fund (BCF) implementation and delayed Delayed Transfers of Care (DTOC) measurements. The Board was asked to review and endorse the Improved Better Care Fund Plan. Dr Batty reported that all agencies had worked together and plans had now been finalised for delivery. Professor Smith challenged that, in HWO's view, the best conceivable value for money was to provide more help and support for carers in a climate where the availability of respite had	

(f) request the Director of Adult Social Care to ensure where possible that any extra payments of care to agencies are passed down to care workers.	) Director for Adult Services
10 The Oxfordshire Transformation Board (Agenda No. 10)	
Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust, gave an update on the work of Oxfordshire's Transformation Board (TB). The Board had been in existence for 3 years. It has no statutory responsibility. To date it has looked at changes in demography and the effect on Health and Social Care services across Oxfordshire, and what changes are necessary to address the sets of demands, resource availability and the shape of future services. Numbers had increased on the Board over time from organisations such as the South Central Ambulance Trust and it had grown in its range and depth of coverage. There had been very good representation from OCC at member/officer level, the Local Medical Council, and clinical and GP representatives. For the last 18 months there had been a focus on the following areas of work: - Work on the case for change and the message for change for services such as Mental Health services; - The need to manage better care out of hospitals. This was all aligned with work with Older People's services; - More recently there had been much focus on the first phase of the Oxfordshire Transformation Plan in areas such as workforce pressures etc. This has not yet been resolved due to referral to the Secretary of State by HOSC; - Use of the TB to bring together all organisations regarding the CQC inspection; - The TB was looking at updates from ambulatory services; - The TB was currently doing a stock-take on how it was working and there would be discussions taking place with others with regard to this; - The Board was looking at STP issues in the Oxfordshire context and is a sub-group of the BOB STP was serving as a forum for this. Stuart Bell was also a member of the STP Executive Group. It was envisaged that the role of the TB may become more important in light of David Smith's imminent retirement as leader of the STP Executive Group; - An important task for the TB would be to contribute to	

the development of an ACS within the County. Stuart Bell was thanked for his update and for the useful information it gave the Health & Wellbeing Board in considering the next agenda items on accountable care systems and its own governance review.	All to note
11 Accountable Care Systems - Update (Agenda No. 11)	
The Board considered an update report on the development of Accountable Care Systems (ACS) including how this Board should be involved in its development. David Smith and Dr Joe McManners, who were leading on this issue, presented the report. They raised the following points: • At present there was no agreed line signed off from all organisations involved; • The work was about getting organisations properly aligned and working together as an organisation. It was important to be very focused on the purposes of each particular system before taking the system as a whole, and then for this Board to make the final decisions on systems to be included; • Key pieces of work would be required, for example, to ensure Health Inequalities work was aligned and all systems were pushing in a particular way; • In relation to the endeavour to work out what was best for Oxfordshire, the following questions were put to aid discussion; - What are the best outcomes for the residents of Oxfordshire? - What is the pool of money available? - What are the risks for each organisation? Suggestions, views and comments during the discussion included the following: • To take a number of patient studies to discuss the patient flow and to look at the strengths/weaknesses of the flow and if it could improve; • There was a need to have one accountable body; • Experience from Buckinghamshire was that there was a need to test the values of an ACS via individual care histories. However, this was not sufficient in itself and much could be built upon what had already taken place. Factors that Buckinghamshire found that made a	

difference was: - Proper co-ordination of primary care and community services helped to progress the ACS; - Integration with Social Care was also required not necessarily organisationally, but via the effective co-ordination of patient resources; - Thought would be required on how resources were used via a shared control function and a move away from contractual resources – development of a means of allocation to elected, urgent, mental health care etc; and - Preparedness for the alignment of Local Government and Health and to see through the change. The Board AGREED that it was willing, in principle, to move in the direction of an accountable care system as described, pending a future report.	Action for all as above
12 Health & Wellbeing Governance Review Proposal (Agenda No. 12)	
The Board was asked to discuss and agree to review the governance of this Board, taking into account the emerging findings of the CQC reviews, current measures, the report on the Better Care Fund, the work of the Transformation Board and the emergence of Accountable Care Systems, as set out in the preceding papers. Dr McWilliam suggested that it was timely for a review of governance to be done by March 2018, and that travel towards Accountable Care Systems should be an explicit part of that process. Views expressed by the Board members included: • The future report should be informed by the Health Inequalities work, including more reflection on inequalities and the raising of standards; • Representation should be from the following groups: the older people's population, the voluntary sector, care groups, the older age and the working age social care user groups, plus some of the key service users that are monitored via this Board; • Some Board members felt that a discussion needed to take place about representation on the Board. It was feared that the Board would become too unwieldy if there was a significant rise in membership. They were assured that this was the point of the governance review.	

Peter Clark, OCC, stated that if the Board agreed that it was timely to conduct a review on governance, then some proposed terms of reference could be considered at the next meeting. If agreement was reached, then some fully formed proposals could then be brought back to the following meeting. This would also allow time for discussion of the proposals with the Chairman and Vice Chairman of the Board. The Board AGREED to conduct a governance review and would consider terms of reference at its next meeting.	Strategic Director for People/Julie Dean
13 Development of a new Older People's Strategy (Agenda No. 13)	
The Board considered a proposed approach to developing an Older People's Strategy (HWB13) as a refreshed version of the existing strategy. This is timely in light of the focus on older people's issues arising in the rest of the agenda. The Board AGREED to the proposed approach to developing the Older People's Strategy, including the broader focus as set out in the report.	All for Action as above
14 Healthwatch Oxfordshire (HWO) - Update (Agenda No. 14)	
Professor Smith, Chairman of Healthwatch Oxfordshire (HWO) presented the regular update report on activities (HWB14). In relation to paragraph 6.2 of the report - Schools – Drug and alcohol sessions, Professor Smith undertook to follow up whether the school health nurses could have a useful role in delivering drug and alcohol sessions in schools, with an emphasis on harm reduction, as preferred by HWO. Professor Smith was thanked for his report. The Board AGREED to receive the report.	Chairman of Healthwatch Oxfordshire All to note
15 Annual Reports from Adult and Children Safeguarding Boards (Agenda No. 15)	
Pamela Marsden and Paul Burnett, Chairs of the Adult Safeguarding Board the Children Safeguarding Board attended	

the meeting to present a synopsis of their reports and the main issues arising from them. Pamela Marsden, who was accompanied by Karen Fuller, Deputy Director, Adult Social Care, was asked whether the Team anticipated a rise in vulnerable adult referrals as a result of the rise in the numbers of people suffering from dementia. She responded that Oxfordshire had not seen much of a rise to date. Karen Fuller added that 2 or 3 people had come to the Team's attention but these were already known to the Children's Safeguarding Team and had received the right support. Paul Burnett, when presenting the synopsis, paid tribute to the partner agencies in Oxfordshire for their good support and input, which had made for the best decisions which could then be disseminated into agencies in a better way.. He pointed out that the recent Section 11 Audit had found that all organisations were fully compliant, or close to compliance (via a peer challenge). He believed that this was a robust compliment for the organisation. He also paid tribute to the training pool which had been short-listed for a training award. When asked about which age ranges gave the highest levels of safeguarding cases, Paul Burnett stated that the first was babies/infants in respect of physical abuse and neglect, and the other was teenagers. This latter age range was more complex and it was particularly important to focus on neglect in the early years as it had a profound effect later in the teenage years. Paul Burnett was also asked if there was any one factor, or factors affecting teenagers in the safeguarding arena. He responded that there were links to parenting skills and economic well-being, but neglect in early years was the most important element in the story. Pamela Marsden and Paul Burnett were thanked for their attendance. The Board AGREED to receive the reports.	All to note
16 Director of Public Health Annual Report 2016-2017 (Agenda No. 16)	
The Director of Public Health's annual independent report for 2016/17 was before the Board (HWB16). The comments of the Oxfordshire Joint Health Overview & Scrutiny Committee on 14 September 2017 and Oxfordshire County Council's Cabinet were also before the Board.	

The Board AGREED to receive the report and to advise the appropriate bodies of their responsibilities in considering its recommendations.	Strategic Director of People
17 Development of the Joint Strategic Needs Assessment (JSNA) for 2018-19 (Agenda No. 17)	
Dr McWilliam (OCC) gave a presentation on the proposals for the further development of the JSNA and its direction for 2018-19. David Smith (OCCG) spoke of the importance of the OCCG Locality Plans in its development given the good work that had been done throughout the year using the JSNA to inform these plans and asked that this information be included in further iterations of the JSNA. Members of the Board congratulated the officers on the JSNA and its use by the system and on a very good report. The Board appreciated the fact that, although it was an aspiration, in reality it would prove too expensive to give wholly accurate locality – based predictions on housing growth area by area collecting real-time data. However, current projections and housing growth statistics would continue to be used to give the best summary data for planning purposes. The Board AGREED to accept the proposals for further development of the JSNA and its direction for 2018-19.	Strategic Director for People
18 Health Inequalities Commission - Implementation Plan (Agenda No. 18)	
The Board had before them a report (HWB18) which set out updated action to implement the recommendations from the Commission. An Annex setting out the Health Inequalities indicators was also available on the County Council website. Dr McWilliam reported that a further report would be brought back to the Board on further developments. He added that the Board's sub-groups were keeping abreast of ongoing work in relation to the implementation of the Commission's report on a regular basis. The Board noted the report HWB18.	Strategic Director for People/Chair, OCCG

19 Reports from Children's Trust, Joint Management Group for Adults and Health Improvement Partnership Board (Agenda No. 19)	
The Board received the reports.	All to note
20 PAPERS FOR INFORMATION ONLY (Agenda No. 20)	
Noted.	

..... in the Chair

Date of signing

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Health & Wellbeing Board Performance Report 2017/18 Quarter 3

Introduction

- Annex 1 shows performance for the priorities within the Health & Wellbeing strategy for 2017/18. Priorities 1-4 are managed through the Children's Trust; priorities 5-7 is managed through the Joint Management Groups for the Pooled Budgets for adult health and care services and priorities 8-11 is managed through the Health Improvement Board.

Summary

- The table below summarises performance on each priority. 63 measures are reported with 31 currently rated:
 - 11 (17%) are currently green,
 - 10 (16%) rated amber - not on target, but close to target
 - 10 (16%) rated red.

	Red	Amber	Green	Not Rated	Total
1. Ensuring children have a healthy start in life and stay healthy into adulthood	1	0	0	0	1
2. Narrowing the gap for our most disadvantaged and vulnerable groups	2	1	1	2	6
3. Keeping children and young people safe	3	1	0	2	6
4. Raising achievements for all children and young people	0	1	1	0	2
5. Working together to improve quality and value for money in the Health and Social Care System	2	0	3	2	7
6 Adults with long term conditions living independently and achieving their full potential	0	4	3	4	11
7. Support older people to live independently with dignity whilst reducing the need for care & support	1	1	1	7	10
8 Preventing early death and improving quality of life in later years	0	1	2	4	7
9. Preventing chronic disease through tackling obesity	0	1	0	2	3
10. Tackling the broader determinants of health through better housing and preventing homelessness	1	0	0	5	6
11. Preventing infectious disease through immunisation	0	0	0	4	4
Total	10	10	11	32	63

- Recommendation:** The Health and Wellbeing Board is recommended to hold members to account for performance against key indicators. Those indicators that are currently rated Red are listed in detail below.

- The individual indicators rated as red are:
 - Ensuring children have a healthy start in life and stay healthy into adulthood
 - 1.1 Waiting times for first appointment with Child and Adolescent Health Services (CAMHS). 75% of children will receive their first appointment within 12 weeks of referral by the end 2017/18.

- b. Narrowing the gap for our most disadvantaged and vulnerable groups
 - i. 2.3 Ensure that the attainment of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average.
 - ii. 2.6 Reduce the number of children and young people placed out of county and not in neighbouring authorities
- c. Keeping children and young people safe
 - i. 3.4 Reduce the number of children subject of a child protection plan
 - ii. 3.5 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 0-14 (Public Health measure number 2.07i) to the national level
 - iii. 3.6 Reduce the current number of looked after children
- d. Raising achievement for all children and young people
 - i. none
- e. Working together to improve quality and value for money in the Health and Social Care System
 - i. 5.2 Increase the percentage of people waiting a total time of less than 4 hours in A&E.
 - ii. 5.4 Reduce the number of people placed out of county into care homes by social care
- f. Adults with long term conditions living independently and achieving their full potential
 - i. none
- g. Support older people to live independently with dignity whilst reducing the need for care and support
 - i. 7.2 Reduce the number of older people placed in a care home from 11.25 per week in 2016/17 to 11 per week for 2017/18
- h. Preventing early death and improving quality of life in later years
 - i. none
- i. Preventing chronic disease through tackling obesity
 - i. none
- j. Tackling the broader determinants of health through better housing and preventing homelessness
 - i. 10.4 Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2016-17 (baseline 79)
- k. Preventing infectious disease through immunisation
 - i. none

Steve Thomas
Performance & Information Manager (Social Care)
March 2017

Oxfordshire Health and Wellbeing Board
Performance Report

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

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
1.1 Waiting times for first appointment with Child and Adolescent Health Services (CAMHS). 75% of children will receive their first appointment within 12 weeks of referral by the end 2017/18.	75%	68% (16/17)	53 %	R	45%	R	66%	R			The service continues to face high levels of demand. An action plan has been put in place by the provider (Oxford Health) which is routinely reviewed in contract meetings with the commissioned (CCG). Detailed updates have been provided to both the Children's Trust and its Performance and Quality Assurance sub group.

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

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
2.1 Reduce the proportion of children with Special Educational Needs and Disability (SEND) with at least one fixed term exclusion in the academic year.	<6.7%	7.1% 15/16	8.3% (terms 1-6 16/17 ac yr)	R			3.9%	A			Rag Q1 updated. Terms 1&2 (17-18 academic year) showing under Q3 – fig expected to increase.
2.2 Increase the proportion of children with a disability who are eligible for free school meals who are accessing short breaks services.	>42%	57% 16/17	53%	G	55%	G	53%	G			
Page 22 2.3 Ensure that the attainment of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average. * Key Stage 2 * Key Stage 4	16% 36.2	No baseline	9% KS2 32.8 KS4 (15/16)	R			17% KS2 28.5 KS4 (16/17)	R			KS2 fig (% SEN support pupils reaching at least the expected standard in reading writing and maths 16/17 academic year) - Oxon =17%, - National - 21%. 7th of our 12 statistical neighbours KS4 fig (Average point score of SEN support pupils 16/17 academic year) - Oxon = 28.5, - National = 31.9. Oxfordshire is ranked bottom out of statistical neighbours
2.4 Reduce the persistent absence of children subject to a Child In Need plan.	<28%	30.4% 16/17									
2.5 Reduce the persistent absence of children subject to a Child Protection plan.	<29%	30.3% 16/17									

2.6 Reduce the number placed out of county and not in a neighbouring authority from 77 to 60	60 (9.8%)	118 17.5%	132 19%	R	139 20%	R	146 20.6 %	R		as at 31/12/17 figure includes: 8 children placed for adoption 1 child in a secure unit 39 children placed in Children's Homes 2 placed with own parents 5 children placed in independent living 13 children placed in a kinship placement 76 children placed with other foster carer 1 child in residential school 1 mother and baby placements
2.7 Increase the % of care leavers who are in employment, education and training (17-21)	50%	48%					64%	G		

Priority Three: Keeping children and young people safe (select measures from the OSCB dataset)

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
3.1 Monitor the number of child victims of crime	Monitoring only	2189 16/17	604		1138		1658				Last year the figure was 1680 in quarter 3. A child victim of crime is anyone aged 17 and under who has reported to the police that they have been a victim of any crime.
3.2 Number of children missing from home	Monitoring only	2105	304		1052		1599				Last year the figure was 1022 in quarter 2
3.3 Reduce the number of social care referrals to the level of our statistical neighbours	6852	7066	1679	R	3151	G	4812	G			(Target amended to reflect publication of latest figures for statistical neighbours)
3.4 Reduce the number of children subject of a child protection plan	595	607	585	G	657	R	651	R			Child protection numbers are 7% more than the start of the year. Target amended to reflect latest comparative figures
3.5 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 0-14 (Public Health measure number 2.07i) to the national level	109.6	108	123.7	R	116.3	R	101.8	R			
3.6 Safely reduce the number of looked after children	700	667	691	R	701	R	710	A			Target amended based on latest comparative figures and realigned budget At the end of quarter 3 the number of looked after children was rising, but by March 1 had dropped to 671 0 virtually where it was at the start of the year. 52% of children becoming looked after in Q3 had been previously looked after or subject of a child protection plan within 12 months of becoming looked after

Priority Four: Raising achievement for all children and young people

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
4.1 Improve the disadvantaged attainment gap at all key stages and aim to be in line with the national average by 2018 and in the top 25% of local authorities. * Key Stage 2 * Key Stage 4	To be top quartile	31% KS2 15pts KS4					26%- KS2 14.9 pts – KS4	A			KS2 Oxfordshire gap 26% pts compared National gap 20% pts. Oxfordshire is in the 3 rd quartile nationally. KS4 disadvantage average point score gap in Oxfordshire is 14.9pts. This places the County 5 th out of statistical neighbours and in the 3 rd quartile nationally.
4.2 69% of children in early years & foundation stage reaching a good level of development, Early Years Foundation Stage Profile placing Oxfordshire in the top quartile of local authorities. Baseline is 66% from 2015.	69%	70%					73%	G			Annual Figure - available in public domain in November

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

	Target	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	R A G	Fig	R A G	Fig	R A G	Fig	R A G	
5.1 Reduce the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages	< baseline	524	511	G							Q2 and Q3 not yet available
5.2 Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95 %.	95%	86%	87.5	R	84.8	R	83.4 %	R			
5.3 Reduce the average length of “days delay” for people discharged from hospital to care homes	310	762	632	A	529	G	430	G			Agreed trajectory (BCF plan 31/7): Aug 558, Sep 480; Oct 434; Nov 434, Dec 434, Jan 403, Feb 336, Mar 310. Actual July: 622; Aug: 529 Sep data not yet available. Marked as on target as latest figures (August) are on target. Note measure amended to align with revised BCF
5.3a Validated local position of CCG on average length of days delay for locally registered people discharged from hospital to care homes											New indicator
5.4 Reduce the number of people placed out of county into care homes by social care	<306	306	302	G	299	G	307	R			
5.6 Ensure the proportion of (all) providers described as outstanding or good by CQC remains above the national average	> 81%	84%	87.5	G	89.4	G	90%	G			See table below for breakdown by provider
5.7 Ensure the proportion of people who use services who feel safe remains above the national average	> 69%	73.3		G		G		G			

CQC ratings by Provider Type as at 1-1-18

CQC rating as at 1-1-18	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	6	5%	2%	6	7%	2%	1	17%	12%	1	14%	6%	3	4%	5%
Good	93	78%	77%	81	88%	82%	5	83%	70%	3	43%	45%	66	94%	91%
Requires Improvement	16	13%	19%	4	4%	15%	0	0%	17%	3	43%	45%	0	0%	4%
Inadequate	4	3%	2%	1	1%	1%	0	0%	1%	0	0%	4%	1	1%	1%

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	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	R A G	Fig	R A G	Fig	R A G	Fig	R A G	
6.1 Increase the number of people with mild to moderate mental illness accessing psychological therapies, with a focus on people with long-term physical health conditions	17%	16.5	16.5	A	16%	A	17% (Oct)	A			Latest data is available for October 2017
6.2 Reduce the number of people with severe mental illness accessing Emergency Departments in acute hospital for treatment for their mental illness	tbc	tbc									This is a measure that is provided in the outcomes based contract: we do not have the baseline confirmed yet: performance will be measured from 1/10/17 annual review of contract.
6.3 Reduce the use of s136 Mental Health Act 1983 so that fewer people are detained in police cells when they are unwell: 6.3.1 Reduction in the use of s136 (number for 10/17)	tbc	266	76		130		185				This measure is in 3 parts: Adults JMG will confirm the trajectory in Dec.
6.3.2 People on s135/6 detained in police cells is a never event (number of people detained in police cell)		4	0		0		0				
6.3.3. Person is in health based place of safety (HBPOS) for no longer than 24hours (number of people in HBPOS for >24 hours)		5	0		3		5				
6.4 Reduce the number of deaths by suicides	< baseline	9.4					8.7 (2014-16)	G			Baseline is 2013-15 3 year average rate per 100k. The target tbc at Adult JMG Dec. It will be an annual measure-Q1 and Q2 is N/A.
6.5 Increase the number of people with severe mental illness in employment	16.5%	16.5%	18%	G	18%	G	18%	G			
6.6 Increase the number of people with severe mental illness in settled accommodation	70%	70%	80%	G	79%	G	71%	A			
6.7 Increase the number of people with learning disability having annual health checks in primary	75%	n/a	n/a		n/a		63%	A			This is a locally derived number which cannot routinely be produced.

care to 75% of all registered patients by 2019										
6.8 Reduce the number of people with learning disabilities and/or autism admitted to specialist in-patient beds to 11 by Q4 17/18 and 9 by Q4 18/19	11	16	12	G	16	R	15	A		This measure has been extended to monitor the NHSE Transforming Care Plan target in relation to people with learning disability and/or autism. The current performance is skewed as it includes 4 patients who are on s17 leave from their in-patient bed but who have to be counted for these purposes. There are a number of discharges planned for Q3.
6.9 Reduce the number of people with learning disability and/or autism placed/living out of county	< 182	182	179	G	181	G	179	G		

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

	Target	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	R A G	Fig	R A G	Fig	R A G	Fig	R A G	
Page 10 7.2 The number of home care hours purchased per week	Monitoring only	22,284	22,368		22,163		21,813				
7.3 Reduce the number of older people placed in a care home from 11.25 per week in 2016/17 to 11 per week for 2017/18	11	11.25	13	R	12.8	R	14.1	R			
7.3 Reduce the number of permanent admissions to care homes per 100k of population	469	480	554		546		636				
7.4 70% of people who receive reablement need no ongoing support (defined as no Council-funded long term service excluding low level preventative service).	70%	68%	56%	R	51%		51%				We are reviewing this target as we have a discharge to assess pathway and all people returning home are expected to go through this service. The 70% target is based on national benchmarks including people without a discharge to assess model. We will look to move to target which identifies how much we reduce the amount of care needed as people are supported to become more independent.
7.5 Increase in the number of people still at home 90 days post reablement	83%	80%									Figure available annually only
7.6 Reduce the beds days lost to delays in Oxfordshire from an average of 181 in March 2017	87	181	214	R	118	G	105	A			

to an average of 97 in November and 83 by March 2018										
7.7 Reduce the average number of weekly delays attributable to the HART service from 65 in March 2017 to 41 in November and 35 in March 2018	35	65	n/a		41	G	34	G		
7.8 Reduce the average overall length of stay in health funded beds from hospital admission to final destination										OCCG seeking to measure monitor patients length of stay through the bed-based pathway: if this cannot be resolved by Dec JMG will propose alternative measure or will use the acute and community hospital
7.9 Increase the number of carers receiving a social care assessment	6000	5609	865	R	1834		2659			We are reviewing this target in the light of feedback from carers. The assessment is not the most important thing for carers. IN the recent carers survey older carers were more likely to have accessed information and advice and more likely to rate advice as helpful
7.10 100% of patients with dementia are registered with GPs and live in Oxfordshire are known to the Dementia Support Service										We are working with GPs and Age UK (who run the dementia support service) to find a way to monitor this. If this cannot be resolved by Dec JMG will propose alternative measure.

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

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
8.1	At least 60% of those sent bowel screening packs will complete and return them (aged 60-74 years) - and adequately screened	60%	58.3%		0%		0%		0%		Data at least six months in arrears.
8.2	At least 95% of the eligible population 40-74 will have been invited for a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 80%	95% over 5-year period Q1 84%, Q2 88%, Q3 92%, Q4 95%	85.2%	G	90.7%	G	95.1%	G	0%		All CCG localities are above 80% (Oxford City has lowest proportion offered at 89.8%)
8.3	At least 45% of the eligible population 40-74 will have received a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 40%.	45% over 5-year period Q1 42%, Q2 43%, Q3 44%, Q4 45%	42.3%	A	44.7%	G	47.3%	G	0.0%		CCG localities are above 40%. Ranges from Oxford City 40.1% to North Oxfordshire 51.6%
8.4	Rate of successful quitters per 100,000 smokers aged 18+ should exceed the baseline set in 2017-18	>2315	2432	G	2159	A	2219	A	0		
8.5	The number of women smoking in pregnancy should remain below 8% recorded at time of delivery	<8%	8.0%	G	7.5%	G	0.0%		0.0%		-
8.6	Oxfordshire performance for the proportion of opiate users who successfully complete treatment.	>6.8%	7.3%	G	8.4%	G	0.0%		0.0%		
8.7	Oxfordshire performance for the proportion of non-opiate users who successfully complete treatment	>37.3%	44.6%	G	45.6%	G	0.0%		0.0%		-

Priority 9: Preventing chronic disease through tackling obesity

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
9.1	Ensure that obesity level in Year 6 children is held at below 16% (in 2016 this was 16.0%) No district population should record more than 19% (NCMP)	<=16%					16.9%	A			Cherwell 18.8%; Oxford 21.3%; South Oxfordshire 12.9%; Vale of White Horse 16%; West Oxfordshire 14.7%
9.2	Reduce by 0.5% the percentage of adults classified as "inactive" (Oxfordshire baseline Nov 2016 of 17%).	Reduce by 0.5% from baseline (17%)					0.0%				Nov. 18 next release (note change of definition from 16+ to 19+)
9.3	63% of babies are breastfed at 6-8 weeks of age (county). KEEP UNDER SURVEILLANCE IN 2017/18	63%	60.1%		62.3%		59.8%		0.0%		There has been a slight decline in breastfeeding at 6-8 weeks in the recent Quarter (Q3)

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

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
10.1	The number of households in temporary accommodation on 31 March 2018 should be no greater than level reported in March 2017 (baseline 161 households in Oxfordshire 2016-17).	≥161			180	R			0		Please see breakdown of housing data
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.3% in 2016-17)	≥75%	85.6%	G	83.1%	G	0.0%		0.0%		
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 80% in 2016-17).	80%			80.0%	G			0%		
10.4	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2016-17 (baseline 79)	≥79					117	R			Please see exception report by HSAG
10.5	At least 70% of young people leaving supported housing services will have positive outcomes in 2017-18	≤70% Aspire 95%			63.1%	A	0.0%		0.0%		Q1+Q2 combined
10.6	At least 1430 residents are helped per year over the next 4 years where building based measures account for 25% of those interventions by the final year. KEEP UNDER SURVEILLANCE in 2017/18	NO TARGET							0		

Priority 11: Preventing infectious disease through immunisation

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
11.1	1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 94.6%) No CCG locality should perform below 94%	95%	95.0%	G	94.6%	A	0.0%		0.0%		North Oxfordshire 92% in Q1
11.2	2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 5 (currently 93.1%) No CCG locality should perform below 94%	95%	93.6%	A	93.6%	A	0.0%		0.0%		Oxford City 91.5% & South West 93.9% in Q1
11.3	At least 55% of people aged under 65 in "risk groups" receive flu vaccination	≥ 55%							0.0%		
11.4	At least 90% of young women to receive both doses of HPV vaccination. KEEP UNDER SURVEILLANCE in 2017/18	≥ 90%							0%		Data available annually for school year Sept-Aug so published after September.

Joint Strategic Needs Assessment Annual Report 2018

Introduction

The Oxfordshire Joint Strategic Needs Assessment is produced to help inform the work of Oxfordshire's Health and Wellbeing Board. It underpins the Oxfordshire Health and Wellbeing Strategy¹.

Information, data and intelligence is included from a wide range of sources that cover the health and wellbeing of the population in its broadest terms.

When added to local knowledge of services, the JSNA gives Oxfordshire a common and consistent evidence-base which allows the NHS, Local Authorities and partners to pinpoint gaps and target improvements.

This annual report update 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
- Predicting future growth in population

The report is organised under the following broad JSNA theme headings:

- **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 and how this is expected to change.

- **Wider determinants of health (chapter 4)**

Factors with known links with health and wellbeing, such as deprivation, education, employment and the physical and social environment.

- **Health conditions and causes of death (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 plus positive factors such as volunteering.

¹ Oxfordshire's Joint Health and Wellbeing Strategy 2015 to 2019 (July 2017)

- **Service use (chapter 7)**

The number of people receiving health, social care and other services

Changes since the 2017 version of the JSNA include:

- Datasets
 - Updates to the majority of public health indicators and local datasets
 - Overview of housing growth
 - Updated Oxfordshire County Council population forecasts based on predicted housing growth
 - NEW - Survey of carers in Oxfordshire (2016-17)
 - NEW - Hospital inpatient data at local level
 - NEW - Use of Ambulance services
 - NEW - Social care data at local level
 - NEW – prevalence of severe obesity in children
 - NEW – air quality diffusion tube trend data from district councils
- New presentation of data
 - Addition of major new health inequalities basket of indicators annex with data by small areas (wards and middle layer super output areas)

This report has been made possible through invaluable contributions, advice and guidance of the JSNA Steering Group and the many experts and data analysts in Oxfordshire's local authorities, health services, police and voluntary organisations.

March 2018



Data has been updated in this version



Data has been reviewed and is unchanged

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Data has been reviewed and is unchanged

1 Executive Summary

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

Please note that more detailed and additional findings are in the main body of the report.

Population and population groups (chapters 2 and 3)

A growing and aging population

- As of mid-2016, the estimated total population of Oxfordshire was 683,200.
- Over the ten-year period, 2006 and 2016, there was an overall growth in the population of Oxfordshire of 52,100 people (+8.3%), similar to the increase across England (+8.4%).
- The five-year age band with the greatest increase over this period was the newly retired age group 65 to 69 (+41%). There was a decline in the population aged 35 to 44.
- District Councils' plans for new housing in existing (adopted) and draft local plans set out an ambition for new housing in Oxfordshire of 34,300 by the end of March 2022 and a further 47,200 homes by end March 2031, a total of 81,500 new homes in the next 15 years.
- Oxfordshire County Council population forecasts, based on these plans for housing growth, predict an increase in the number of Oxfordshire residents of +187,000 people (+27%) between 2016 and 2031, taking the total population of the county from 687,900 to 874,900.
- By 2031, the number of people aged 85 and over is expected to have increased by 55% in Oxfordshire overall, with the highest growth predicted in South Oxfordshire (+61%) and Vale of White Horse (+66%).

Increasing life expectancy. Inequalities remain

- Life expectancy is increasing. Between 2001-03 and 2014-16, the gap between male and female Life Expectancy in Oxfordshire decreased from 4.1 years to 3.2 years.
- Life expectancy by ward data for Oxford shows the gap in male life expectancy between the more affluent North ward and the relatively deprived ward of Northfield Brook has increased from 4 years in 2003-07 to 15 years in 2011-15. Female life expectancy in these wards has remained at similar levels with a gap of just over 10 years.

Health of carers affected by caring role

- The latest survey of carers shows that around a third (34%) of Oxfordshire carer respondents have had to see their own GP in the past 12 months because of their caring role. This was a similar proportion in carers of all ages.
- It is possible that this action – to see their GP as a result of their caring role – is an early indication that their caring role is at risk, potentially affecting around 6,200 people in Oxfordshire currently being supported by an informal carer.



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Wider determinants of health (chapter 4)

An affluent county with areas of deprivation

- Earnings remain relatively high for Oxfordshire residents.
- Despite relative affluence, income deprivation is an issue in urban and rural areas.
 - 14,000 children and 13,500 older people in Oxfordshire were affected by income deprivation.
 - Snapshot HMRC data (Aug14) shows almost 1 in 5 children aged 0-15 in Oxford were living in low income families.
- The increase in claimants of employment-related benefits in the older age group in Oxfordshire was above average.

Housing remains unaffordable

- House prices in Oxfordshire continue to increase at a higher rate than earnings and Centre for Cities has again ranked Oxford as the least affordable UK city for housing. In Oxford City, social rents charged by private registered providers in 2017 were 18% above the national average.

Homelessness remains an issue and benefit changes are affecting more households

- Over the past 6 years there has been an increase in people presenting as homeless and of people accepted as homeless and in priority need in Oxfordshire, although the latest data for 2016-17 shows a decline.
- Loss of private rented accommodation is an increasing cause of homelessness.
- The latest data shows a significant increase in the number of people rough-sleeping in Oxford.
- The number of households affected by the benefit cap across Oxfordshire has increased.
- There has been an increase in the proportion of households defined as “fuel poor” in each district of Oxfordshire.
- Oxfordshire’s Citizens Advice agencies have seen significantly more people needing help in relation to benefits, especially housing, employment and personal independence payments. Universal Credit has just been introduced in Oxfordshire, so it is too early to assess any impact.

Well qualified residents. Disadvantaged children doing less well than national average

- Oxfordshire has an above-average proportion of people with high level qualifications and a low proportion of people with no qualifications.
- Between 2016 and 2017 there was an increase in the proportion of children achieving a good level of development in all Early Learning Goals in each district in Oxfordshire, except for Cherwell where the rate declined. Girls continue to outperform boys.



Data has been updated in this version



Data has been reviewed and is unchanged

- Early Years attainment for 5 year olds with Asian or Black ethnic backgrounds in Oxfordshire was below the South East average.
- The proportion of Oxfordshire's disadvantaged pupils aged 10-11 achieving the expected standard at Key Stage 2 was below the England average in 2017
 - For pupils with SEN support, the proportion was 17% in Oxfordshire compared with 21% nationally.
 - For pupils with a first language other than English, the proportion was 55% in Oxfordshire compared with 61% nationally.
 - For pupils eligible for Free School Meals, the proportion was 38% in Oxfordshire compared with 43% nationally.
- Oxfordshire has a relatively high rate of unauthorised absences from school.

Environmental pressures

- Public Health England analysis found 423 fast food outlets in Oxfordshire of which 56% were in Cherwell and Oxford. The ward with the highest number of fast food outlets was Banbury Grimsbury & Castle (39 outlets).
- Oxfordshire continues to have 13 Air Quality Management Areas where the annual mean objective for nitrogen dioxide is being exceeded including the whole of Oxford city.
- The UK Health Alliance has identified opportunities from climate change including the co-benefits of emission reduction activities leading to healthier lifestyles (more walking/cycling, insulating homes and others).
- Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services. Areas rated as "high risk" for isolation and loneliness in Oxfordshire are mainly in urban centres.
- The British Social Attitudes Survey (national) shows an increasing willingness to walk short journeys of less than 2 miles, rather than go by car.
- A walking to school initiative, taken up by 18 schools in Oxfordshire so far, is showing an increase in active travel rates since September 2017 from 65% to 84% (+19pp).

Health conditions and causes of death (chapter 5)

A relatively healthy county overall

- The Public Health England health profile for Oxfordshire shows that, for the majority of health indicators, Oxfordshire is statistically better than the national average.
- Indicators at county level where Oxfordshire is worse than average are: hospital admission episodes for alcohol-specific conditions in under 18s; killed and seriously injured on roads.
- For the 3-year period, 2014 to 2016, total deaths of people aged under 75 from the four causes of: cardiovascular diseases, cancer, liver disease and respiratory disease in Oxfordshire was 3,396.
- Of these **1,959** (58%) were considered preventable.



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Data has been reviewed and is unchanged

Increase in rates of anxiety and depression, above-average self-harm and suicides of young people

- In Oxfordshire, the average wellbeing scores for: life satisfaction, “things you do are worthwhile” and happiness, are slightly lower in 2016-17 compared with 2015-16 and the anxiety mean is higher.
- The number and rate of GP-registered patients in Oxfordshire with depression or anxiety has increased significantly each year for the past 4 years.
- The percentage of GP-registered patients with a recorded diagnosis of a severe and enduring mental health problem has increased in all districts. The rate in Oxford City remains well above the average for NHS Oxfordshire CCG.
- Rates of intentional self-harm in Oxfordshire are now statistically above the England average.
- There were 15 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England.
- There were 23 suicides of people aged under 25 in the Oxfordshire Clinical Commissioning Group area in 2014-16. The OCCG rate was statistically above the England average.

Above average cancer diagnosis and lower (preventable) cancer mortality rate

- The proportion of GP-registered patients with a cancer diagnosis in Oxfordshire has remained above the national average.
- Preventable deaths (preventable mortality) from cancer in Oxfordshire remains better than the England and South East averages.
- The cancer mortality rate for females in Cherwell increased to just above the national average.
- Rates of bowel cancer deaths were above average in Oxfordshire in 2016 for both males and females.

Stroke and Dementia

- Stroke in females in Oxford and males in Vale of White Horse each above average in 2016.
- In West Oxfordshire, the age-standardised mortality rate for females due to Dementia and Alzheimer’s disease increased in 2014, 2015 and again in 2016 to well above the national and regional averages.
- The mortality rate for females due to Dementia and Alzheimer’s disease was above the national average in Cherwell in 2015 and 2016.

Knee and back pain affecting health and social care workers

- Work-related musculoskeletal disorders account for 35% of all working days lost due to work-related ill health (national survey).
- Human health and social work activities is one of the four industries with significantly higher rates of WRMSDs when compared with the rates for all industries.



Data has been updated in this version



Data has been reviewed and is unchanged

Lifestyles (chapter 6)

Over half of adults overweight or obese. Slight increase in obesity of children

- An estimated 55% of people aged 16 or over in Oxfordshire are classified as overweight or obese. This is below the national average.
- Data from the National Child Measurement Programme shows a similar level of obesity in younger children (aged 4-5 years) in Oxfordshire and a slight increase in obesity of children aged 10-11.
- In the 2016/17 academic year, a measure of prevalence of severe obesity was introduced. In Oxfordshire, around 110 (1.4%) reception year children were severely obese. In year 6, around 220 (3.4%) children were severely obese. Levels were highest in Oxford City.

Overall decline in smoking and consumption of alcohol, with exception of some groups

- Smoking prevalence in adults in routine and manual occupations was estimated at 24.5% in Oxfordshire, over double the rate of all adults and similar to the national average.
- Admissions for alcohol-related conditions were better than the England average in Oxfordshire overall and in rural districts. Oxford City had a similar rate to the national average.
- The rate of hospital admissions for alcohol-specific conditions in females under 18 in Oxfordshire has remained statistically above the national average in the latest data. The rate for males in Oxfordshire was similar to average.

Increasing number of recorded victims of abuse

- Police data shows an increase in recorded victims of most categories of abuse and exploitation in Oxfordshire (other than Child Sexual Exploitation which declined). There were over 100 recorded victims of modern slavery in Oxfordshire, almost three times in the number in 2016.

Service use (chapter 7)

High levels of health staff vacancies and health staff turnover

- In September 2017, there was a total of 644 advertised NHS vacancies (full time equivalents), 44% were for nurses/midwives and 22% were administrative and clerical.
- Turnover of Oxfordshire NHS Acute nursing & midwifery staff, other clinical and non-clinical staff in 2016-17 was well above the England average.

Increasing use of health services and increasing complexity of conditions

- Use of health services is increasing overall and per person. The number of times people visit their doctor or are treated in hospital has increased significantly in Oxfordshire (and nationally), especially in the older age group.



Data has been updated in this version



Data has been reviewed and is unchanged

- After contacting an NHS service outside of GP surgery hours, 30% of Oxfordshire respondents attended A&E (34% nationally).
- The proportion of hospital inpatients with complicating comorbidities is increasing.

Falls causing highest use of ambulance services and above-average rate of injuries

- Ambulance data show the top condition requiring an ambulance for Oxfordshire residents was falls.
- Oxfordshire's comparative rates of injuries due to falls in people aged 65+ and for people aged 80+ has recently improved, from statistically worse than average to similar to the South East average.

Delayed transfers of care have fallen, remaining above average

- The rate of delayed transfers of care (DTOC) within Oxfordshire has fallen but remains significantly higher than the England average.

Increase in referrals of children and young people to mental health services

- In the past year, there has (again) been an increase in the number of people referred for treatment to Oxford Health mental health services, particularly children and young people.
- As of December 2017, two thirds (66%) of young people, in the Oxfordshire Clinical Commissioning Group area referred to CAMHS, were seen within 12 weeks. In the previous 3 months (Sept-Nov17), less than half of referrals were seen within 12 weeks.

Increase in older clients supported at home, decline in number provided with social care reablement.

- There has been an increase in the proportion of older social care clients supported at home, from 44% of older clients in 2012 to 59% in 2017.
- Between 2015-16 and 2016-17 there was a 9% drop in the number of adults provided with short-term reablement services.
- Oxfordshire County Council estimates that: of the total number of older people receiving care in Oxfordshire, 40% (4,200) are being supported by the County Council or NHS funding and 60% (6,300) are self-funding their care.

Increase in children referred for social care services and children who are looked after

- Oxfordshire has seen increases in the number of children referred to social care, children on protection plans and children who are looked after.
- Care leavers in Oxfordshire are less likely than average to be in employment, education or training.



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Data has been reviewed and is unchanged

Expected growth in the oldest population is likely to increase demand for local health and social care services

- Assuming the use of health and social care services remains at current levels for the oldest age group (85+) would mean the forecast population growth in Oxfordshire leading to an increase in demand of:
 - +6,400 additional hospital inpatient spells for people aged 85+: from 12,600 in 2016-17 to 18,400 in 2031-32.
 - +1,000 additional clients supported by long term social care services aged 85+: from 1,900 in 2016-17 to 2,900 in 2031-32.



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Data has been reviewed and is unchanged

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 – key findings

This section highlights the key messages from the review of data on population (data sources and research references are provided with the detailed data in the remainder of this chapter).

- As of mid-2016, the estimated total population of Oxfordshire was 683,200.
- Over the ten-year period, 2006 and 2016, there was an overall growth in the population of Oxfordshire of 52,100 people (+8.3%), similar to the increase across England (+8.4%).
- The five-year age band with the greatest increase over this period was the newly retired age group 65 to 69 (+41%). There was a decline in the population aged 35 to 44.
- District Councils' plans for new housing in existing (adopted) and draft local plans set out an ambition for new housing in Oxfordshire of 34,300 by the end of March 2022 and a further 47,200 homes by end March 2031, a total of 81,500 new homes in the next 15 years.
- Oxfordshire County Council population forecasts, based on these plans for housing growth, predict an increase in the number of Oxfordshire residents of +187,000 people (+27%) between 2016 and 2031, taking the total population of the county from 687,900 to 874,900.
- By 2031, the number of people aged 85 and over is expected to have increased by 55% in Oxfordshire overall, with the highest growth predicted in South Oxfordshire (+61%) and Vale of White Horse (+66%).
- Life expectancy is increasing. Between 2001-03 and 2014-16, the gap between male and female Life Expectancy in Oxfordshire decreased from 4.1 years to 3.2 years.
- Life expectancy by ward data for Oxford City shows the gap in male life expectancy between the more affluent North ward and the relatively deprived ward of Northfield Brook has increased from 4 years in 2003-07 to 15 years in 2011-15. Female life expectancy in these wards has remained at similar levels with a gap of just over 10 years.
- Data for the combined years 2009 to 2013 shows that for males there was a 10-year gap in Disability Free Life Expectancy between the most and least deprived areas of Oxfordshire. For females, the gap was just under 10 years.



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Data has been reviewed and is unchanged

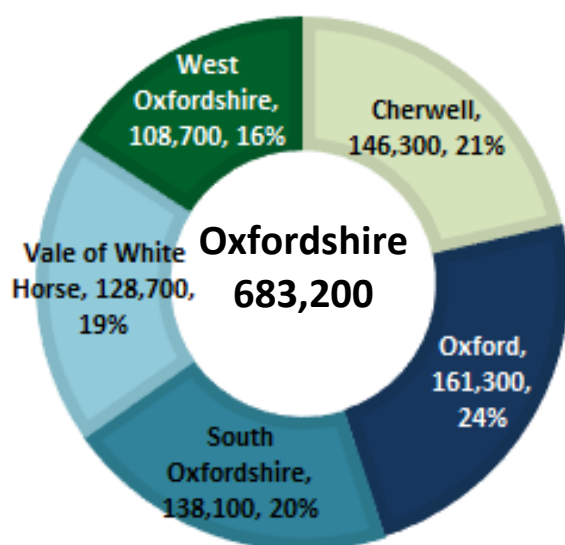
2.2 Population

Mid-2016 population estimate

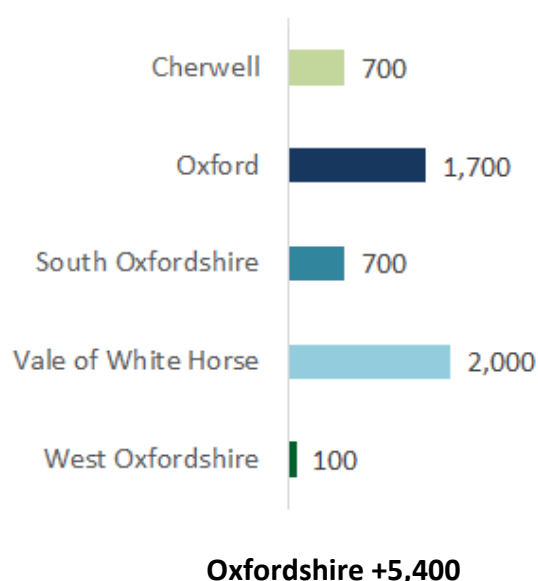
 As of mid-2016, the ONS estimated total population of Oxfordshire was **683,200** residents (including students and armed forces). This was an increase of 5,400 (+0.8%) compared with the previous year (mid-2015).

Figure 1 Population of Oxfordshire and districts, mid-2016 and change 2015 to 2016

Mid-2016 population (ONS)



mid-2015 to mid-2016 change in population



Source: ONS mid-year population estimates

Note that investigation by Oxfordshire County Council's Research and Intelligence team into the ONS mid-year estimates for Oxford city has highlighted concerns about ONS modelling of the student-age population and (to a lesser extent) young working age and child populations.



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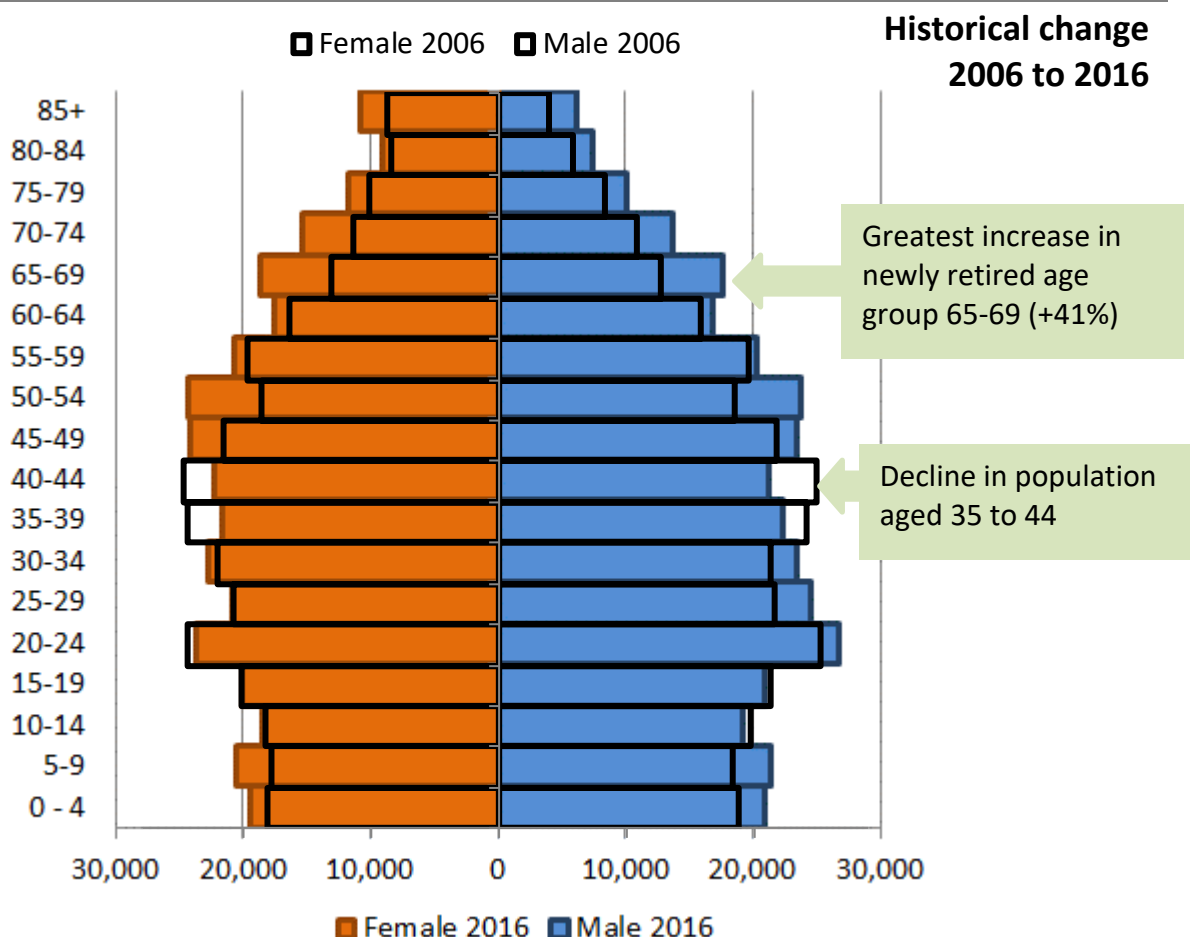
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➔ Historical change in population by age

Over the ten-year period, 2006 and 2016, there was an overall growth in the population of Oxfordshire of 52,100 people (+8.3%), similar to the increase across England (+8.4%).

The five-year age band with the greatest increase over this period was the newly retired age group 65 to 69 (+41%). There was a decline in the population aged 35 to 44.

Figure 2 Oxfordshire's population by age 2006 and 2016



Source: ONS mid-year population estimates

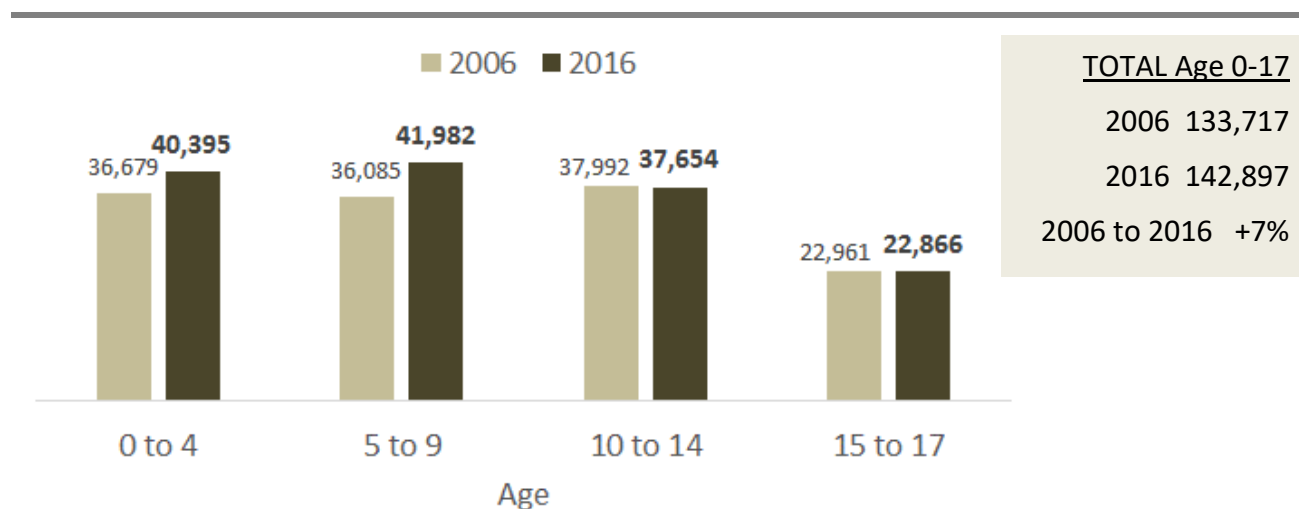
➔ **Children and young people** aged 0 to 17 made up 21% of Oxfordshire's population as of mid-2016, a similar proportion to that in 2006. As shown in the population pyramid above and the chart below, the greatest increases were in the age groups 0-4 and 5-9.



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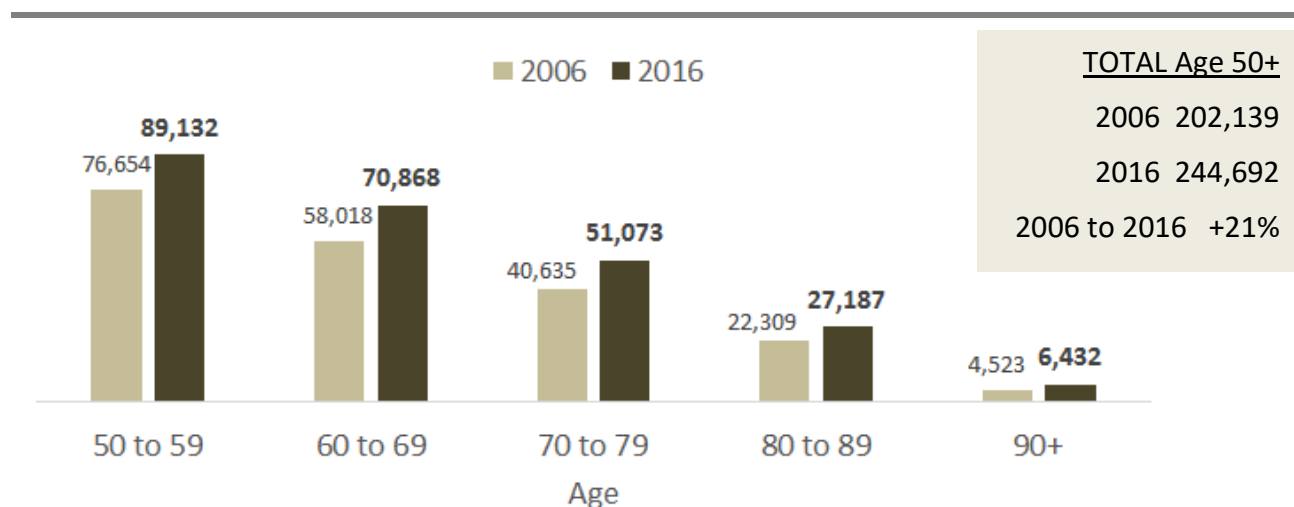


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Figure 3 Number of children and young people in Oxfordshire, 2006 and 2016

Source: ONS mid-year population estimates

Older people aged 50 and over, made up 36% of Oxfordshire's population as of mid-2016, up from 32% in 2006. The greatest increase over this time was in the number of people aged 60-69.

Figure 4 Number of older people in Oxfordshire, 2006 and 2016

Source: ONS mid-year population estimates

The change in population by age varies by district in Oxfordshire with rural districts seeing an increase in the retirement aged population and Oxford seeing a growth in the younger age groups.



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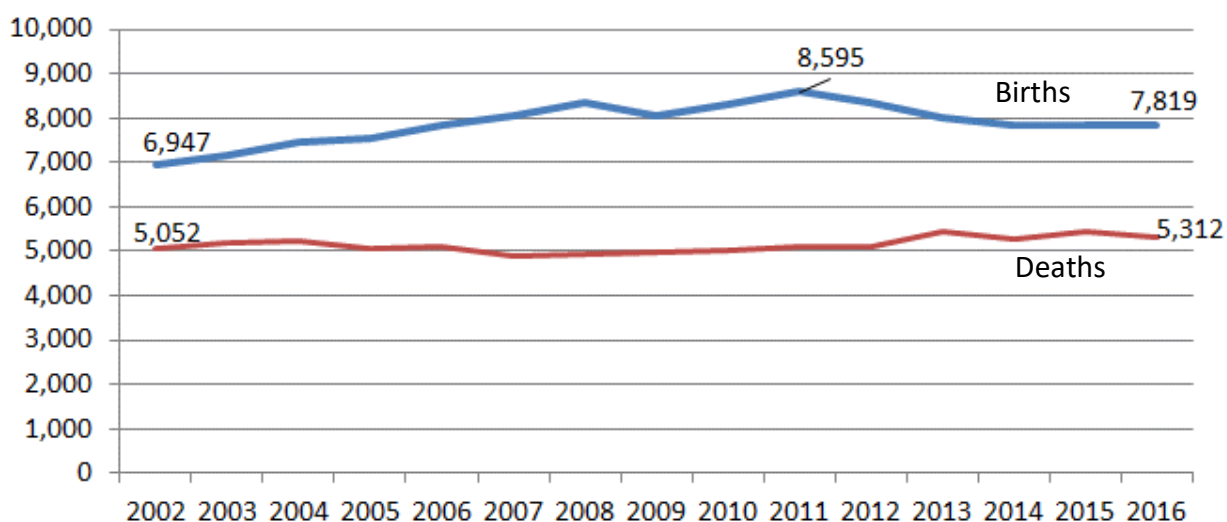
Natural change vs migration



The number of births in Oxfordshire reached a peak in mid-2011 and has since declined. In mid-2016 there were **7,819** births in Oxfordshire, very close to the number as of mid-2015 (7,828).

The number of deaths in Oxfordshire fell slightly to **5,312** by mid-2016, down from 5,462 in mid-2015 (-3%).

Figure 5 Oxfordshire: total number of births and deaths (mid-year estimates)



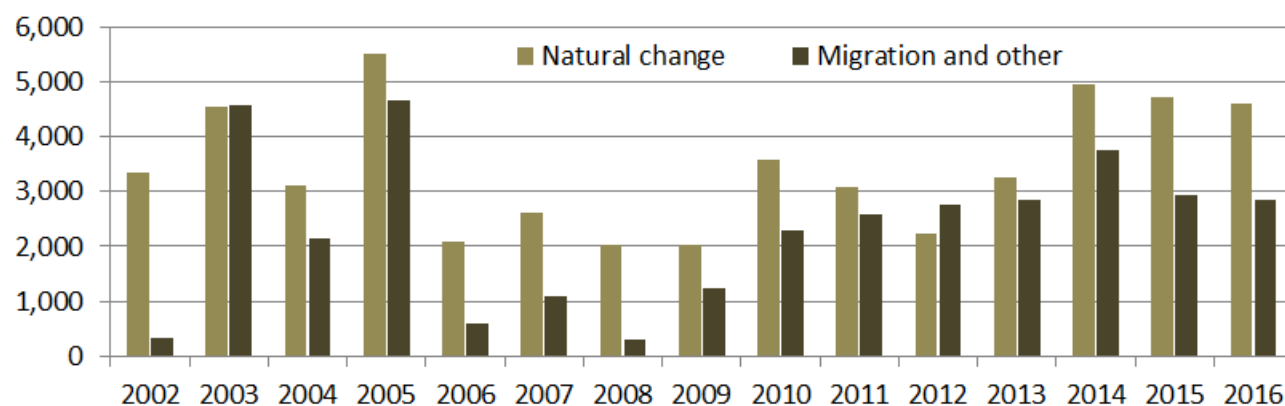
Source: ONS mid-year population estimates; NOTE: this data mid-year to mid-year (1 July to 30 June) in each year and not the calendar year



Natural change (rather than migration) has been the main driver of historical population growth in Oxfordshire.

- Natural change (births minus deaths) has been above net migration (internal and international, in-migration minus out-migration) for each year since mid-2002 with the two exceptions of 2003 and 2012.

Figure 6 Oxfordshire: Natural change and Net Migration



Source: ONS mid-year population estimates



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Data has been reviewed and is unchanged

Forecast growth in population

District Councils' local plans setting out planned housing development are at various stages of development.

- Cherwell has an existing (adopted) plan for Bicester, Banbury and Upper Heyford. An additional plan for Woodstock, A44 corridor, south and south east Kidlington and north Oxford sites will be examined in 2018.
- Oxford has development in progress in Barton and Northern Gateway and a new local plan is in early stages of development.
- South Oxfordshire has an existing plan covering housing in Didcot and Wallingford and a plan for new housing in Culham, Berinsfield, Chalgrove and Wheatley will be examined in 2018.
- Vale of White Horse has an existing plan for housing outside Didcot, in Wantage-Grove and north Abingdon. A plan with development at Harwell, Dalton Barracks and other sites will be examined in 2018.
- West Oxfordshire's local plan is in the later stages of the public examination and covers housing growth at Witney, Carterton, Eynsham and other sites.

The adopted and draft plans together set out housing growth in Oxfordshire of 34,300 by the end of March 2022 and a further 47,200 homes by end March 2031, a total of 81,500 new homes in the next 15 years.

Table 1 Total homes planned (adopted and draft local plans) for Oxfordshire to March 2031

	Apr17 to Mar22	Apr22 to Mar31
Cherwell	10,082	13,214
Oxford City	3,156	3,849
South Oxfordshire	7,021	10,628
Vale of White Horse	9,357	10,455
West Oxfordshire	4,687	9,037
Oxfordshire total	34,302	47,183

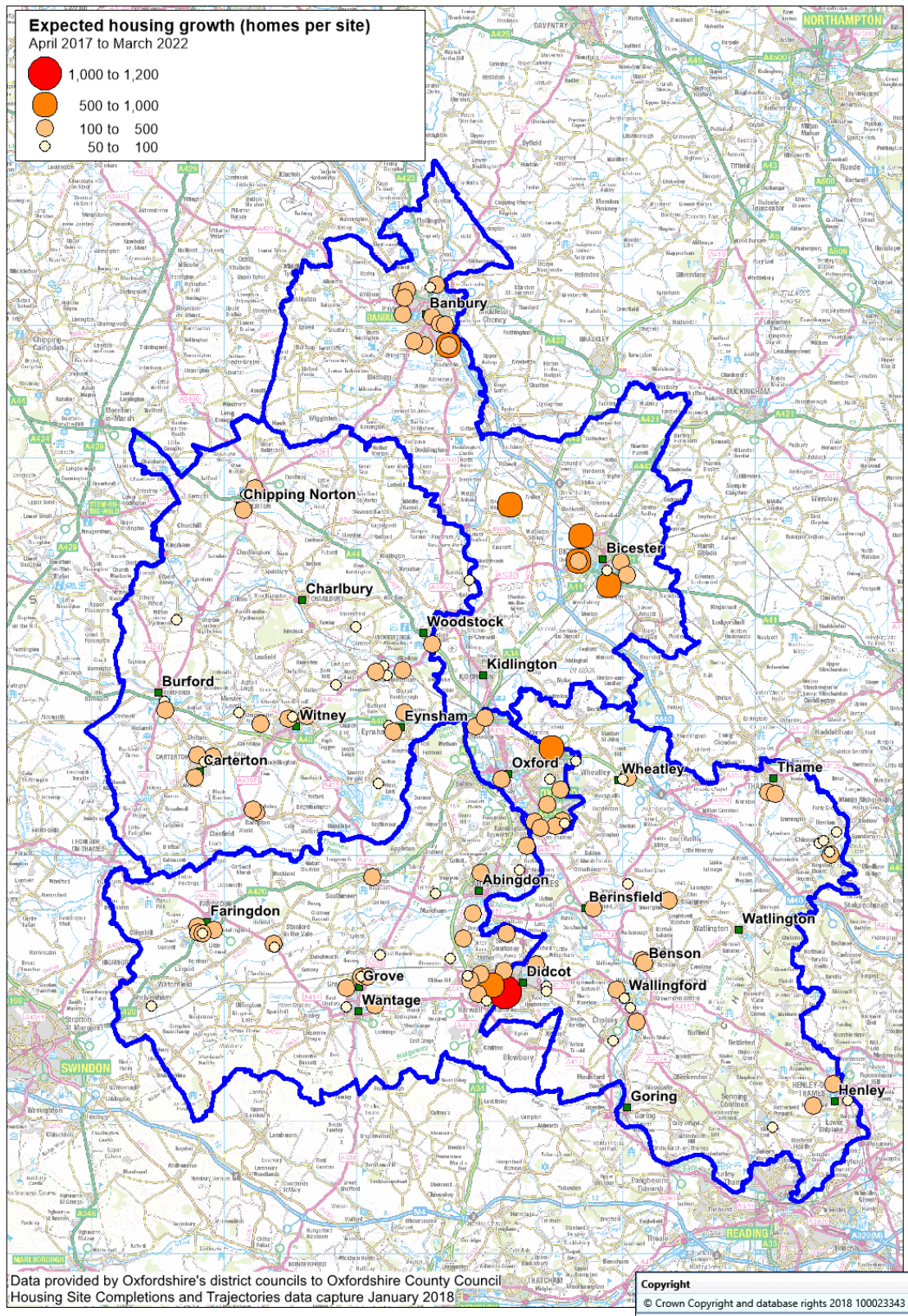
Based on Oxfordshire Infrastructure Strategy housing site completions and trajectories reviewed January 2018



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Data has been reviewed and is unchanged



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Data has been reviewed and is unchanged

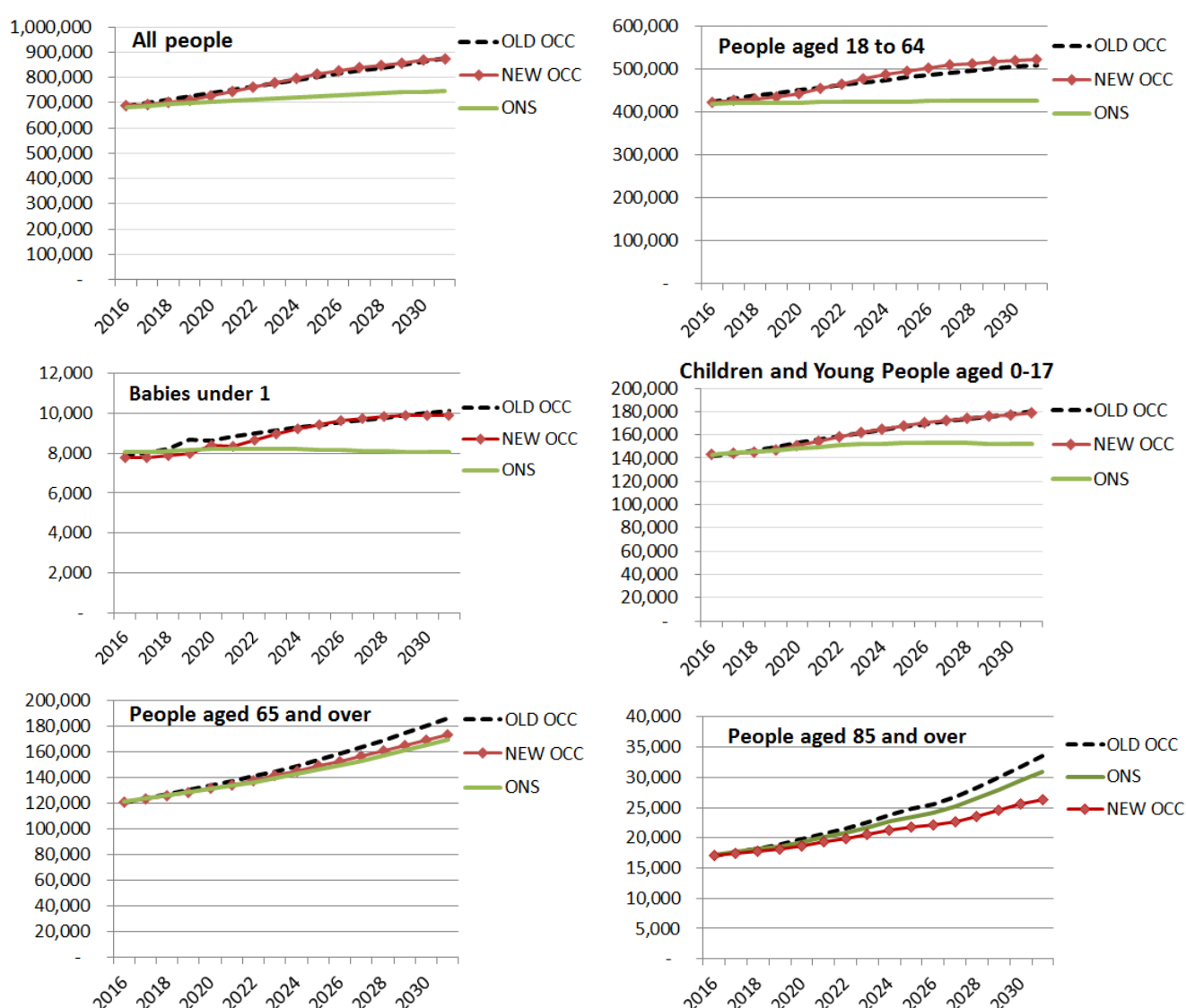
Oxfordshire County Council's updated local population forecasts include the expected housing growth in adopted and draft district local plans.

The new forecasts are also based on an improved set of assumptions from ONS, especially in the upper age bands where deaths data is now available by single year of age.

The following charts show the differences by age group between the new County Council forecasts (Mar18), the old County Council forecasts (Nov 2016) as reported in the previous JSNA and the trend-based Office for National Statistics 2014-based sub national population projections.

The comparisons show a similar trend in the total population and younger age groups and a lower predicted growth in the number of older people than the previous set of forecasts.

 **Figure 7 Comparison of Oxfordshire County Council population forecasts based on housing growth (Nov16 and Feb18) and ONS projections based on past trends**



Sources: Oxfordshire County Council population forecasts (Nov16 and Feb 2018) and ONS 2014-based subnational population projections



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Data has been reviewed and is unchanged

The latest Oxfordshire County Council population forecasts, predict an increase in the number of Oxfordshire residents of +187,000 people (+27%) between 2016 and 2031.



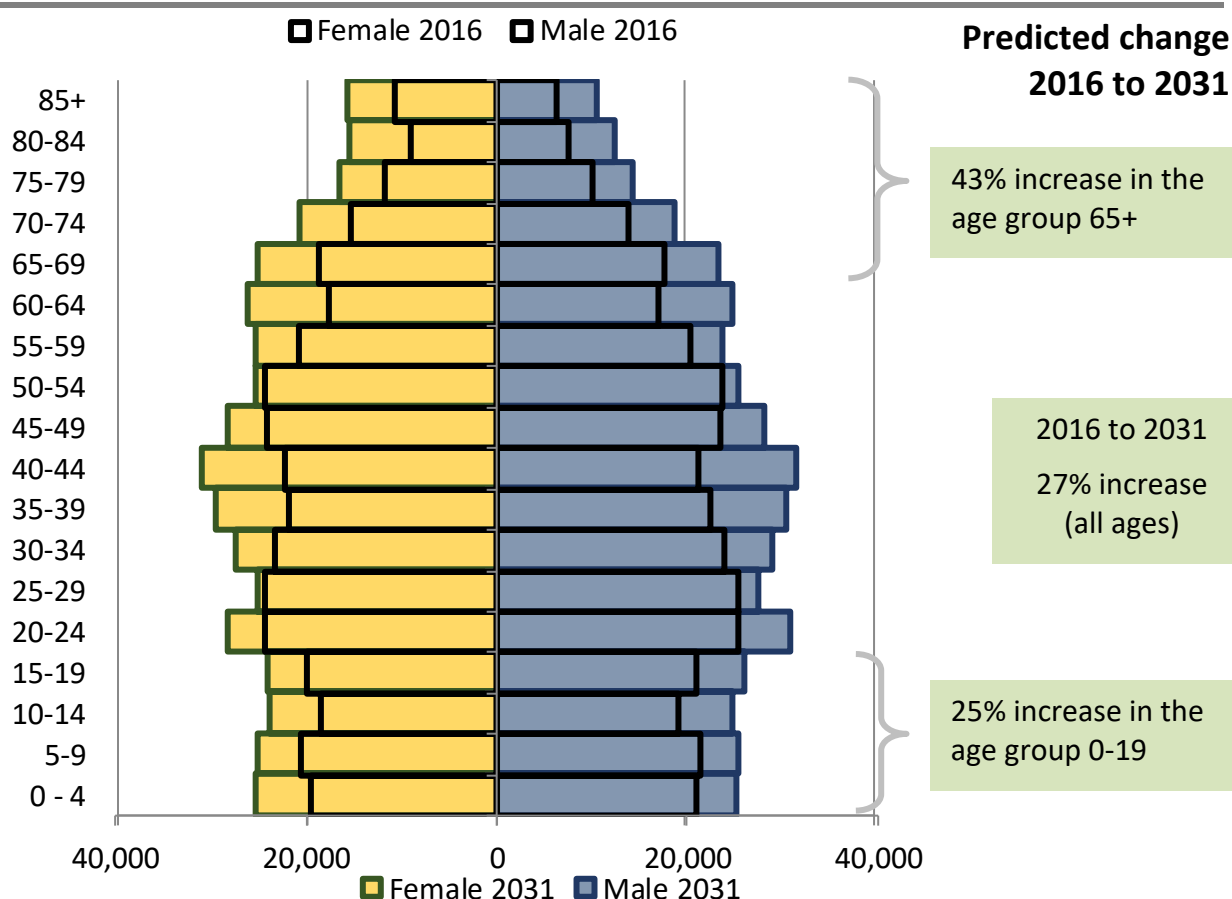
Table 2 Projected growth in total resident population 2016 to 2031

	2016	2031	Change 2016 to 2031	
Cherwell	148,200	205,000	56,800	38%
Oxford	161,400	170,500	9,000	6%
South	139,600	180,800	41,200	30%
Vale	129,400	179,900	50,600	39%
West	109,300	138,800	29,400	27%
OXFORDSHIRE	687,900	874,900	187,000	27%

Source: Oxfordshire County Council population forecasts (Mar18)

The older age group 65+ in Oxfordshire is expected to increase by +43%, well above the predicted growth in the number of children and young people aged 0-19 (25%).

Figure 8 Oxfordshire population by age 2016 and 2031



Source: Oxfordshire County Council population forecasts (Mar18)



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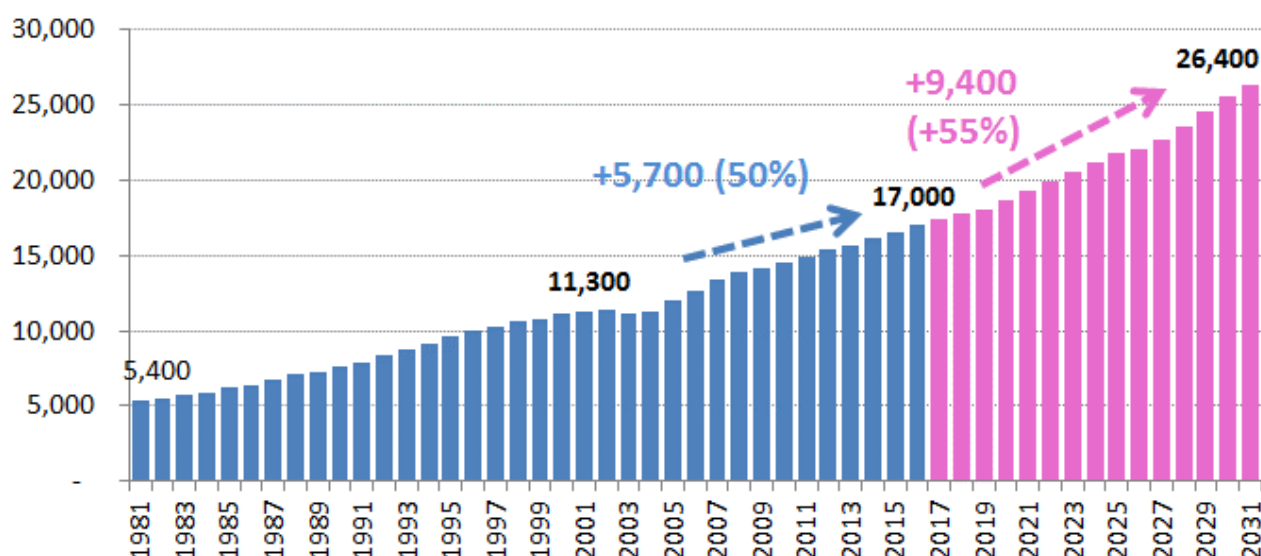
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Predicted growth of the oldest age group (85+)

 Between 2001 and 2016 the number of people aged 85 and over, living in Oxfordshire, increased from 11,300 to 17,000, a growth of 50%.

Between 2016 and 2031, Oxfordshire County Council predicts this age group will increase by a further 9,400 people to 26,400 (+55%).

Figure 9 Historical and forecast number of people aged 85 and over living in Oxfordshire



Sources: ONS mid-year population estimates; Oxfordshire County Council population forecasts (Mar18)

Each district in Oxfordshire is predicted an increase in the number of people aged 85 and over. The district expected to see the greatest increase in number and percentage change is Vale of White Horse.

Table 3 Historical and projected number of people aged 85 and over, Oxfordshire districts (2001 to 2016 and 2016 to 2031)

	ONS mid-year estimates			OCC projection		
	2001	2016	2001 to 2016	2031	2016 to 2031	
Cherwell	2,200	3,400	1,300	5,400	1,900	56%
Oxford	2,500	2,900	400	3,600	700	26%
South Oxfordshire	2,600	3,900	1,300	6,200	2,400	61%
Vale of White Horse	2,100	3,600	1,500	6,000	2,400	66%
West Oxfordshire	2,000	3,300	1,200	5,200	1,900	59%
Oxfordshire	11,300	17,100	5,800	26,400	9,300	55%

Sources: ONS mid-year population estimates; Oxfordshire County Council population forecasts (Mar18)



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Data has been reviewed and is unchanged

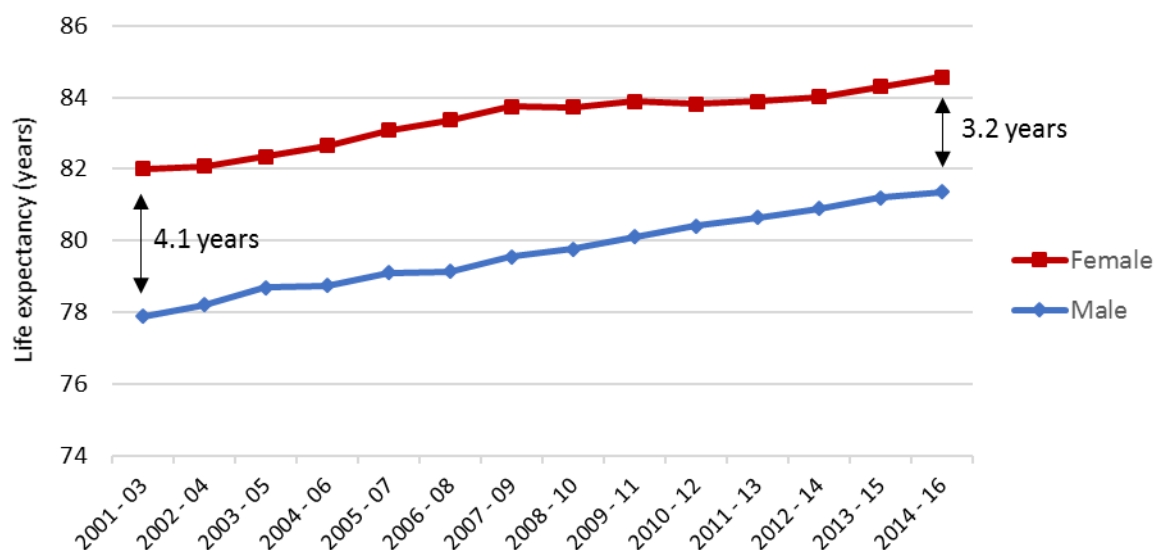
2.3 Life Expectancy

 The most recent set of 3-year Life Expectancy data shows that, between 2013-15 and 2014-16, Life Expectancy for males and females in Oxfordshire each increased.

- Male Life Expectancy increased from 81.2 to 81.4 (+0.2 years)
- Female Life Expectancy increased from 84.3 to 84.6 (+0.3 years)

Between 2001-03 and 2014-16, the gap between male and female Life Expectancy decreased from 4.1 years to 3.2 years.

Figure 10 Change in Life Expectancy in Oxfordshire – males and females to 2014-16



Source: ONS Figures are based on the number of deaths registered and mid-year population estimates, aggregated over 3 consecutive years. Note that scale does not start at 0

ONS data on changes in life expectancy by socio-economic group² (national data) shows a significant increase in life expectancy of professional males – above the gains for all groups of females and most of the other male socio-economic groups.

Life expectancy by ward data for Oxford shows a significant increase in **male life expectancy** in the more affluent North ward and no change in male life expectancy in the more deprived ward of Northfield Brook. The gap in male life expectancy between these two wards has increased from 4 years in 2003-07 to 15 years in 2011-15.

Female life expectancy in these wards has remained at similar levels with a gap of just over 10 years.

²

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/trendinlifeexpectancyatbirthandage65bysocioeconomicpositionbasedonthenationalstatistics socioeconomic classification england and wales/2015-10-21>

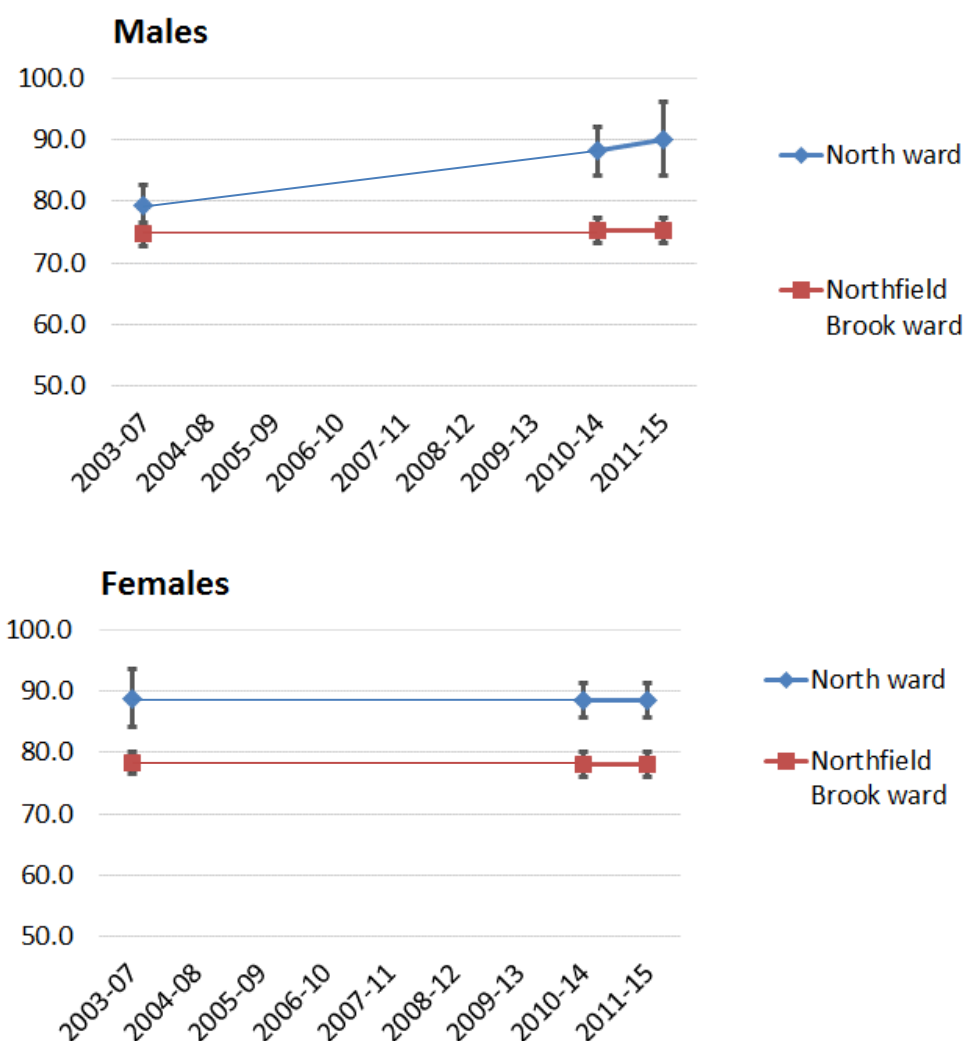


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 11 Trend in life expectancy by ward (showing confidence intervals), 5 year rolling average



Source: 2011-15 life expectancy by ward data available from Local Health; LE data for previous years from Oxfordshire County Council archive. Note that trend data is not available for wards outside Oxford City as a result of changes in ward boundaries in 2015 and 2016. Note scale does not start at 0.



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Data has been reviewed and is unchanged



2.4 Inequality in Disability Free Life Expectancy

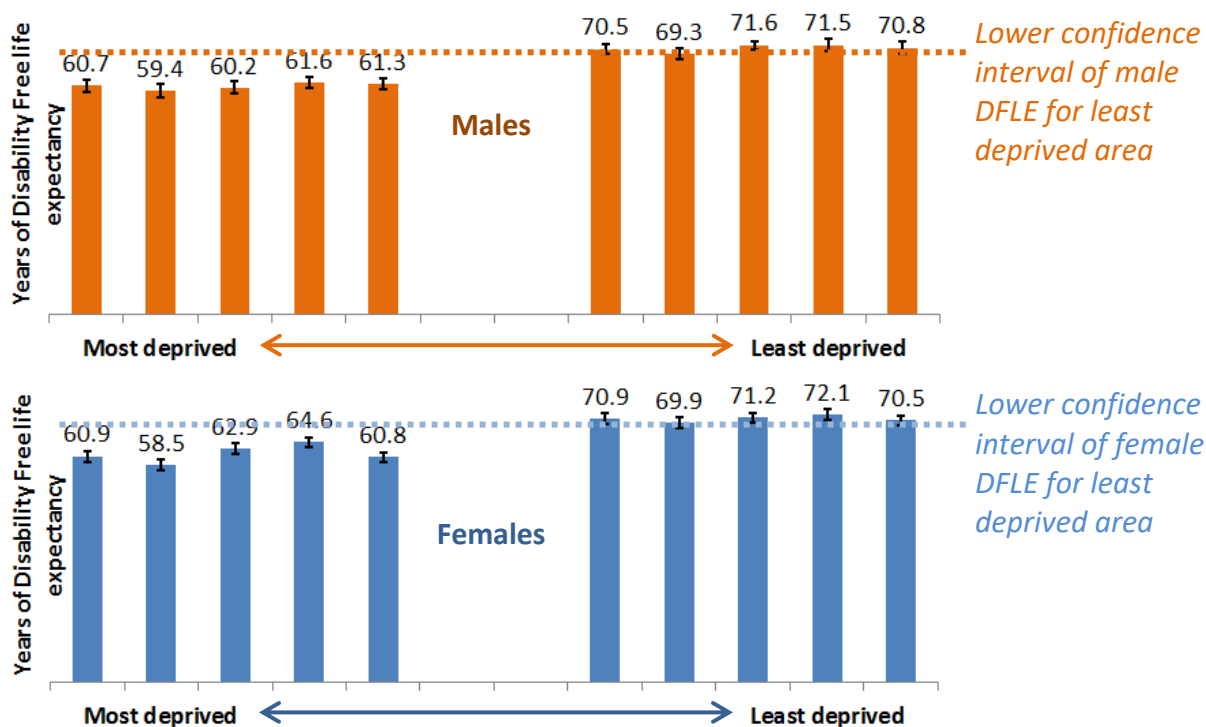
Disability Free Life Expectancy (DFLE) is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply.

There are clear inequalities in DFLE across Oxfordshire, with people in the most deprived areas having significantly lower Disability Free Life Expectancy compared with the least deprived.

- Data for the combined years 2009 to 2013 shows that for males there was a 10-year gap between the most and least deprived areas. For females, the gap was just under 10 years.

The following charts shows DFLE in years for the 5 most deprived Middle Layer Super Output areas in Oxfordshire compared with the 5 least deprived MSOAs.

Figure 12 Disability Free Life Expectancy: most deprived vs least deprived MSOAs in Oxfordshire, 2009-2013



Sources: ONS Disability Free Life Expectancy at birth by MSOA. IMD 2015 ranks and average scores for English Middle Layer Super Output Areas created by Public Health England from population weighted averages of their constituent Lower Super Output Area scores.

Next update to this data will be following the 2021 Census



Data has been updated in this version



Data has been reviewed and is unchanged

3 Population groups and equalities

This section provides data on people within the nine protected characteristics as defined by the 2010 Equalities Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation) and other groups: urban/rural populations, the Armed Forces population and people providing unpaid care.

Further resources are available online, by visiting the [JSNA – Population](#) web page.

3.1 Population groups – key findings

This section highlights the key messages from the review of data on Population Groups (data sources and research references are provided with the detailed data in the remainder of this chapter).

Race, ethnicity and language

- The age profile of Oxfordshire's population differs significantly by ethnic group (Census 2011). The ethnic minority group with the largest number of people in the older population in Oxfordshire was 'other white' (including people with European backgrounds).
- Over the past 5 years, there has been an increase in the number and proportion of primary school pupils in Oxfordshire with first language other than English.

Religion and belief

- Residents in older age groups were significantly more likely to identify themselves as Christian than people in other age groups (Census 2011).

Sexual orientation and gender reassignment

- Local data on sexual orientation and gender reassignment remains unavailable. Using national data implies a total of 11,100 people in Oxfordshire identifying as lesbian, gay or bisexual in 2016.

Marriage and civil partnership

- Rates of marriage and civil partnership in Oxfordshire were above average (Census 2011).

Pregnancy and maternity

- Long term ONS birth statistics for England and Wales (1941 to 2016) show a change in fertility by age group with declining rates in the under 20s and 20-24 age groups and increasing fertility rates for women in their 30s.
- In 2016 (as in 2015) Oxfordshire had a higher proportion of births to older mothers than the national average.
- Half of births in Oxford in 2016 were to mothers born outside the UK, the highest proportion of which was to mothers born in Europe.

Disability

- Rates of disability vary significantly by age and by district.



Data has been updated in this version



Data has been reviewed and is unchanged

- Oxfordshire had a slightly higher proportion of people aged 85 and over with a disability than the South East and the district with the highest rate of disability in this oldest age group was Cherwell followed by Vale of White Horse (Census 2011).
- As of May 2017, there was a total of 11,833 residents of Oxfordshire receiving Attendance Allowance. This was 9% below the total in May 2012 (13,056).
- The number of recipients of Attendance Allowance in Oxfordshire has declined in all age groups over the past 5 years, other than for those aged 65 to 69. This is similar to the national trend.
- Of the districts in Oxfordshire, Cherwell had the greatest number of Attendance Allowance claimants in each age group.

Rural population

- As at mid-2016, a third of the total population of Oxfordshire lived in areas defined as “rural” by the Office for National Statistics.
- Older people are more likely to live in rural areas than younger age groups.
- West Oxfordshire had the highest proportion living in rural areas and the highest proportion of older rural residents.

Armed forces

- As of 1 October 2017, around 9,200 regular armed forces (military and civilian) personnel were stationed in Oxfordshire (although not all necessarily reside in the county). This was a slight reduction on the number as of 1 October 2016 (9,400).
- The district with the largest number residents of Oxfordshire in receipt of Armed Forces Pension, War pension and Armed forces compensation scheme was West Oxfordshire.

Carers

- Census 2011 data gives a total of:
 - 61,100 residents of Oxfordshire providing any amount of unpaid care.
 - 17,400 residents of Oxfordshire providing 20 or more hours per week of unpaid care.
- The latest survey of Carers (2016-17) found that around a third (34%) of Oxfordshire carer respondents have had to see their own GP in the past 12 months because of their caring role. This was similar in all broad age categories.
- In addition, the survey found that 1 in 5 (21%) carers in Oxfordshire reported having developed “my own health condition” as a result of caring; 1 in 5 (21%) carers reported caring had made an existing condition worse.
- It is possible that this action – to see their GP as a result of their caring role – is an early indication that their caring role is at risk, potentially affecting around 6,200 people in Oxfordshire currently being supported by an informal carer.
- By the end of March 2017, the Oxfordshire Young Carers Service had identified and supported a total of 2,684 children and young adults (aged up to 25 years) who provide unpaid care to a family member. This is an increase from the number as of March 2016 (2,281).



Data has been updated in this version



Data has been reviewed and is unchanged

3.2 Race, ethnicity and language

The Census 2011 survey remains the most detailed source of data on the age profile and health of the population by ethnic group.

There was a total of **107,000** residents of Oxfordshire from an ethnic minority background (other than white British) in 2011, equivalent to 16% of the population. This was lower than the national average of 20%.

Oxford City had a significantly higher proportion of ethnic minority residents (36%) than Oxfordshire's rural districts and the second highest ethnic minority population in the South East region after Slough

Ethnic groups by age

The proportion of people with an ethnic minority background varies by age. In Oxfordshire, the highest rate was in the age group 25 to 49 (22%) well above the proportion of ethnic minority residents in the older population (6% of people aged 65+).

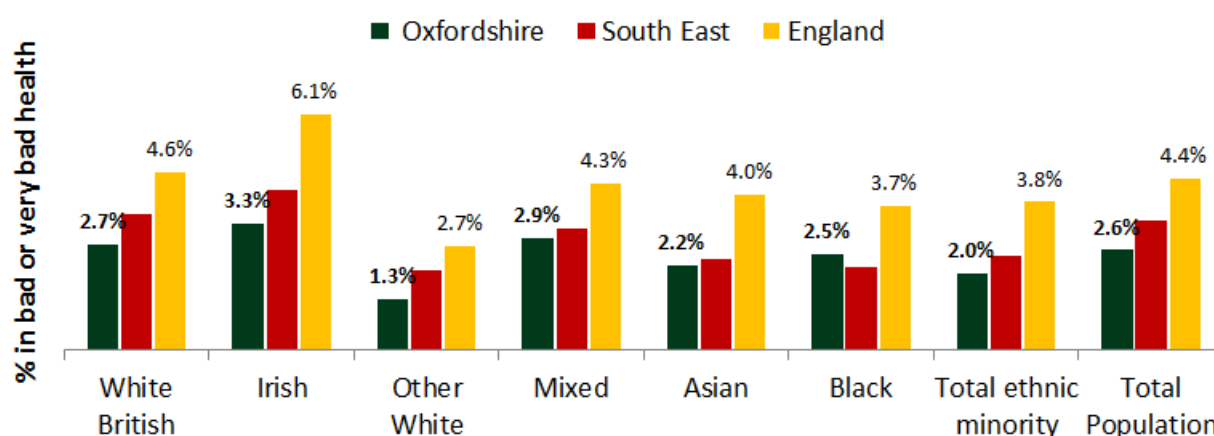
The age profile of individual ethnic groups differs significantly:

- The Irish population is relatively elderly with the highest rate of people with an Irish background in the older population.
- The mixed/multiple ethnic group is relatively young – a far higher proportion of this group are aged 0-24.
- The “other white” population, including recent migrants from Europe, is the largest group within the working age category 25-49.
- The Asian/Asian British and Black ethnic minority groups each have a similar proportion of those aged 0-24 and 25-49 implying families.

Ethnicity and health

1,500 or 2% of the working age population (between the ages of 16 and 64) in an ethnic minority group in Oxfordshire were in bad health, this was below the South East and England averages.

Figure 13 People aged 16 to 64 in bad or very bad health (2011, self-reported)



Source: ONS Census 2011 table LC3206



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Data has been reviewed and is unchanged

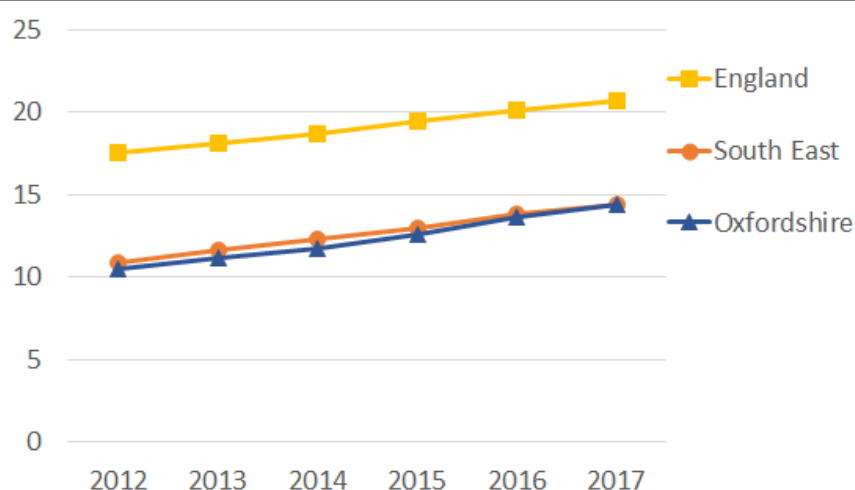
Language skills

Not being proficient in English can affect a person's ability to access health and other services.

 At the time of the Census 2011 survey there was a total of **5,500** people in Oxfordshire who could not speak English or speak English well. Of these the largest numbers were in the working age groups 25 to 34 and 35 to 49.

 Data published as part of the annual school census in January each year shows an increasing proportion of pupils at primary schools in Oxfordshire with first language other than English. The % of pupils with first language other than English in Oxfordshire in January 2017 was slightly higher than the regional South East average (14.4% in Oxfordshire compared with 14.3% in SE).

 **Figure 14 Percentage of pupils in primary schools whose first language is known or believed to be other than English**



Source: Department for Education; Includes primary academies, including free schools.

Lack of language skills is associated with lower performance of pupils in Oxfordshire schools.

 The gap between the performance of Oxfordshire and England pupils with first language other than English is greater at the end of primary school (KS2) than early years.

- In 2017³ 64% of pupils with English as a second language in state funded schools in Oxfordshire reached a good level of development at Early Years Foundation Stage, compared with 65% of this group in England.
- In 2017⁴ 55% of pupils with English as a second language in state funded schools in Oxfordshire reached the expected standard at KS2 in reading, writing and maths compared with 61% of this group in England.

³ <https://www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-2016-to-2017>

⁴ Department for Education: SFR69/2017: National curriculum assessments at key stage 2, 2017 (revised)



Data has been updated in this version



Data has been reviewed and is unchanged

3.3 Religion and belief

As with ethnicity data, the Census 2011 survey remains the most detailed source of data on religion.

 The Census showed that in Oxfordshire (as nationally) the older age groups were significantly more likely to identify themselves as Christian (83% Christian for those aged 75+ compared with 60% overall).

3.4 Sexual orientation

There remains very limited data on sexual orientation - those who identify themselves as heterosexual/straight, gay/lesbian, bisexual or another sexual orientation.

 One indicator is the number of people in a same-sex registered partnership which for Oxfordshire in 2011 was around **1,400** people. This will be, however, a significant undercount of the total lesbian, gay or bisexual (LGB) population.

 Experimental statistics on sexual identity released by the ONS in October 2017⁵ found that:

- In 2016, 2% of the UK population identified themselves as lesbian, gay or bisexual (LGB), up from 1.7% in 2015. In the South East region this was slightly higher, at 2.1% of the population.
- The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%, up from 3.3% in 2015).
- More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.
- The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%.

Using the proportion of LGB population by age from this research, it is estimated that there was a total of **11,100** people in Oxfordshire identifying as lesbian, gay or bisexual in 2016, up from 9,900 in 2015.

 **Table 4 Sexual orientation by age and estimate of total LGB population in Oxfordshire (using 2016 population estimates)**

Age	Heterosexual or straight		Gay or lesbian		Bisexual		Other		Don't know or refuse	
	%	Oxon est	%	Oxon est	%	Oxon est	%	Oxon est	%	Oxon est
16-24	90.6	76,097	1.7	1,428	2.4	2,016	0.8	672	4.6	3,864
25-34	92.3	84,694	2	1,835	0.9	826	0.4	367	4.4	4,037
35-49	93.5	126,528	1.3	1,759	0.5	677	0.5	677	4.2	5,684
50-64	94.4	116,793	1	1,237	0.4	495	0.4	495	3.8	4,701
65+	94.8	114,681	0.4	484	0.3	363	0.5	605	4.1	4,960
TOTAL		518,792		6,743		4,376		2,815		23,246

Sources: ONS Sexual identity experimental estimates and ONS 2016 mid-year population estimate for Oxfordshire

⁵ <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016>



Data has been updated in this version



Data has been reviewed and is unchanged

3.5 Gender reassignment

As reported in the 2016 JSNA, it is difficult to obtain reliable data on the number of people identifying their gender as different from the one assigned to them at birth. The Ministry of Justice publishes numbers of UK applications for gender recognition certificates.⁶ These certificates enable people to change their gender legally and to gain the rights and responsibilities of their acquired gender.

 During the 2016-17 financial year, there were 364 applications for gender recognition certificates in the UK, down from 374 in 2015-16. Data at local levels are not currently available.

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.⁷

3.6 Marriage and civil partnership

 At the time of the Census 2011 survey there were 128,400 married households in Oxfordshire and 682 households in a registered same-sex civil partnership.

The proportion of households married or in a same-sex civil partnership in Oxfordshire was above the rate for England in each age group.

⁶ Ministry of Justice data from <https://www.gov.uk/government/statistics/tribunals-and-gender-recognition-certificate-statistics-quarterly-july-to-september-2017>

⁷ The LGBT ASCOF Companion Document (LGBT Foundation, 2015): <http://lgbt.foundation/get-support/downloads/detail/?downloadid=365>



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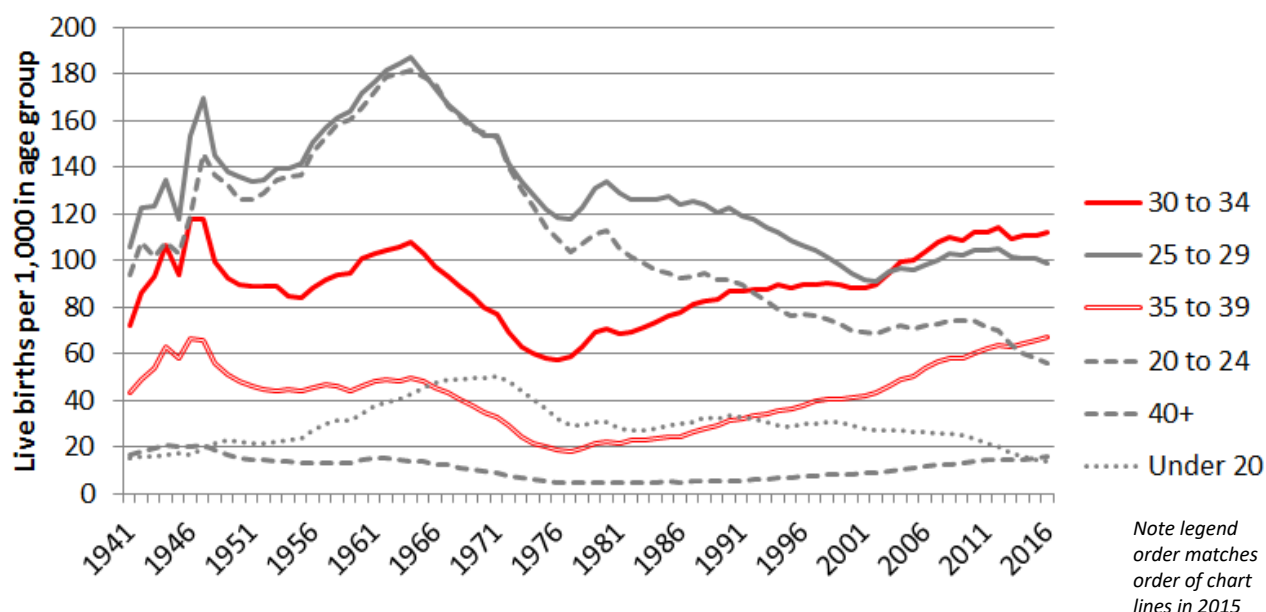
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3.7 Pregnancy and maternity

The national picture

Long term ONS birth statistics for England and Wales show a change in fertility by age group with declining rates in the under 20s and 20-24 age groups and increasing fertility rates for women in their 30s. The latest data (2016) shows these trends continuing.

Figure 15 Long term changes in fertility by age of mother, England and Wales



Source: Office for National Statistics licensed under the Open Government Licence.

Conceptions in Oxfordshire

There was a slight decline in conceptions in Oxfordshire in 2015 compared with the previous year and the rate of conceptions declined to 70.7 per 1,000 women aged 15-44 compared with 76.1 in the South East.

In Oxfordshire 17.6% of conceptions led to therapeutic abortion in 2015, similar to the proportion in 2013 (17.7%) and below the average for the South East (20.0%).

Table 5 Conceptions in Oxfordshire

	2013	2014	2015
Conceptions in Oxfordshire	9,400	9,500	9,344
Rate of conceptions per 1,000 women aged 15-44 in the area			
Oxfordshire	70.6	71.3	70.7
South East	75.6	75.4	76.1

Source: ONS Conception statistics; data not available for local authority district areas



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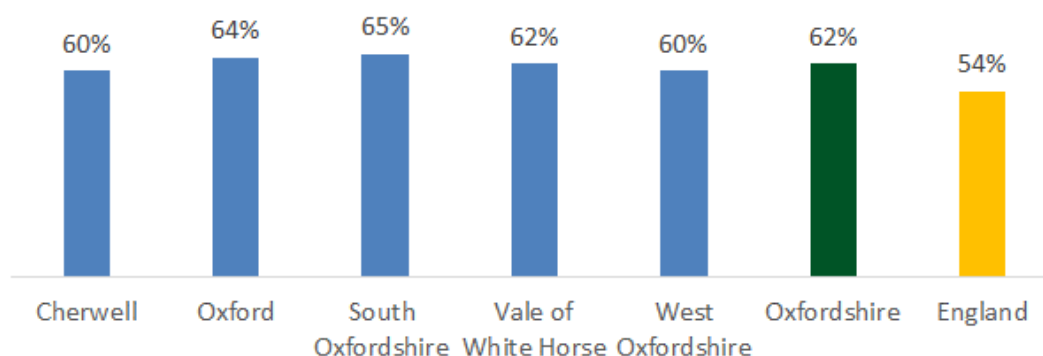
Births by age of mother



In 2016 (calendar year) there were **7,757** live births to mothers living in Oxfordshire, slightly below 2015 (7,893). Oxfordshire had a higher proportion of births to older mothers than the national average.

- 62% of births in Oxfordshire in 2016 were to mothers aged 30 and over (61% in 2015). The proportion of births to mothers aged 30+ in England was 54%.
- The proportion of births to mothers aged 30+ was highest in South Oxfordshire district (65%) and lowest in Cherwell and West Oxfordshire districts (60%).

Figure 16 % of births in area to mothers aged 30 and over (2016)



Source: ONS births by mother's usual residence

Births by mother's country of birth



In 2016, 71% of births to residents of Oxfordshire were to mothers born within the UK, the same as the national average (71%).

In Oxford this proportion was 49% with 20% of births in the city from mothers born in Europe (EU and non EU), followed by 18% to mothers born in Middle East and Asia.

Table 6 Births by mother's country of birth (2016)

	within UK		EU incl. 'New EU'*		New EU*		Rest of Europe (non EU)		Middle East and Asia		Africa		Rest of World	
Cherwell	1,328	72%	249	14%	179	10%	28	2%	114	6%	56	3%	61	3%
Oxford	894	49%	315	17%	165	9%	57	3%	325	18%	102	6%	118	7%
South Oxon	1,229	80%	159	10%	105	7%	14	1%	51	3%	43	3%	44	3%
Vale of WH	1,098	76%	139	10%	77	5%	9	1%	86	6%	56	4%	48	3%
West Oxon	959	85%	102	9%	66	6%	7	1%	24	2%	20	2%	22	2%
Oxfordshire	5,508	71%	964	12%	592	8%	115	1%	600	8%	277	4%	293	4%
<i>England</i>		<i>71%</i>		<i>11%</i>		<i>8%</i>		<i>1%</i>		<i>10%</i>		<i>5%</i>		<i>2%</i>

Source: ONS live births by parent's country of birth; *The 'New EU' constitutes the countries which joined the European Union (EU) between 2004 and 2016.



Data has been updated in this version



Data has been reviewed and is unchanged

3.8 Disability

Family resources survey (national data)

 The Family Resources Survey (FRS) for the UK in 2015-16 estimated that around 21% of the UK's population was disabled, experiencing physical, mental, cognitive, learning, social, behavioural or other types of impairment⁸. This was an increase of 1 percentage point on the previous year (2015-16).

The South East was slightly below the UK average at 19%. Applying this regional rate to Oxfordshire implies a total of **129,800** with a disability living in the county including **8,900** children aged 0-15.

This is well above the **89,800** people in Oxfordshire reported by the Census 2011 survey as having activities limited by health or disability⁹. The difference may be due to the definition (some impairments in the Family resources survey may not have been seen as “limiting” by people responding to the Census) or as a result of applying a UK prevalence rate or both.

The types of impairment reported in the FRS varied by age. Compared with other age groups:

- working age adults with disabilities reported the highest proportion of mental health impairments,
- children reported the highest proportion of learning and social/behavioural impairment and
- pension age adults reported the highest proportion of physical impairments, especially mobility and stamina/breathing/fatigue.

 **Figure 17 Impairment types reported by disabled people, by age group, 2015-16, United Kingdom, percentage of disabled people**

Impairment type	All disabled people	Working age adults	State Pension age adults	Children
Vision	13	11	18	8
Hearing	14	8	23	6
Mobility	52	44	68	21
Dexterity	27	24	34	12
Learning	13	14	8	36
Memory	16	16	17	11
Mental health	22	32	9	17
Stamina/ breathing/ fatigue	38	35	44	26
Social/behavioural	8	8	1	42
Other	15	16	13	14

Source: Family Resources Survey 2015-16. Totals will sum to over 100 per cent as respondents can report more than one impairment type. From 6 April 2010, the State Pension age for women has been gradually increasing. FRS data contained in this report was

⁸ <https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201516>

⁹ ONS Census 2011 table KS301



Data has been updated in this version



Data has been reviewed and is unchanged

collected throughout the financial year 2015/16, during which the State Pension age for women increased from 62 years and 6 months to 63 years 0 months. The changes do not affect the State Pension age for men, currently 65 years.

Applying the FRS UK survey data to the population of Oxfordshire by age, gives the following estimate of the number of people by age and impairment in Oxfordshire.

 **Table 7 Estimate of number of people in Oxfordshire by impairment type and age from UK prevalence data (2015-16)**

Impairment type	Children (0-15)	Working age adults (16-64)	State Pension age adults (65+)	TOTAL
Vision	700	8,600	9,600	18,900
Hearing	500	6,300	12,200	19,000
Mobility	1,900	34,400	36,200	72,500
Dexterity	1,100	18,800	18,100	38,000
Learning	3,200	11,000	4,300	18,500
Memory	1,000	12,500	9,100	22,600
Mental health	1,500	25,000	4,800	31,300
Stamina/ breathing/ fatigue	2,300	27,400	23,400	53,100
Social/behavioural	3,700	6,300	500	10,500
Other	1,200	12,500	6,900	20,600

Source: Extrapolation from Family Resources Survey 2014-15 and 2015 mid-year population estimate for Oxfordshire

 Note that for the mental health category this method implies 31,300 people with this impairment which appears to be a significant underestimate. The number of people in the Oxfordshire Clinical Commissioning Group with diagnosed depression (alone – without including other mental health conditions) was around 56,800 in 2016-17.

People registered for a disabled parking badge (blue badge)

 Oxfordshire County Council data on Blue Badge holders, as of January 2018, shows a total of 30,900 holders of blue badges for disabled parking, up from 23,800 in January 2017.

By district the greatest number of holders was in Cherwell and the greatest rate (per population aged 17+) was West Oxfordshire.



Data has been updated in this version



Data has been reviewed and is unchanged

Blue badges holders (for disabled parking) in Oxfordshire by district (as of Jan18)

	Blue Badge holders (Jan17)	Blue Badge holders (Jan18)	Jan 18 holders as % population aged 17+
Cherwell	5,445	7,046	6.1%
Oxford	4,105	5,233	3.9%
South Oxfordshire	5,069	6,627	6.0%
Vale of White Horse	4,762	6,229	6.1%
West Oxfordshire	4,429	5,784	6.6%
Total	23,810	30,919	5.6%

Sources: Oxfordshire County Council, ONS 2016 mid-year estimates; not including postcodes not mapped to districts (115 in Jan 2018); including applications from Jan 2014 to end Jan 2018

Concessionary Bus Passes and Disabled and Companion Bus Passes

As of January 2018, there were 22,400 people in Oxfordshire holding Concessionary Bus Passes and 2,900 holding Disabled and Companion Passes.

Figure 18 Concessionary Bus Passes and Disabled & Companion Passes (January 2018)

	Concessionary Passes	per 1,000 pop	Disabled & Companion Passes	per 1,000 pop
Cherwell	3,441	29.77	558	4.83
Oxford	3,543	26.73	343	2.59
South Oxfordshire	3,326	30.23	468	4.25
Vale of White Horse	2,399	23.38	935	9.11
West Oxfordshire	9,674	110.77	598	6.85
Oxfordshire	22,383	40.84	2,902	5.30

Sources: Oxfordshire County Council, ONS 2016 mid-year estimates, population aged 17+



Data has been updated in this version



Data has been reviewed and is unchanged

Census 2011 data on disability

The Census 2011 survey remains the most in-depth assessment of (self-assessed) rates of ill health and disability at a local level.

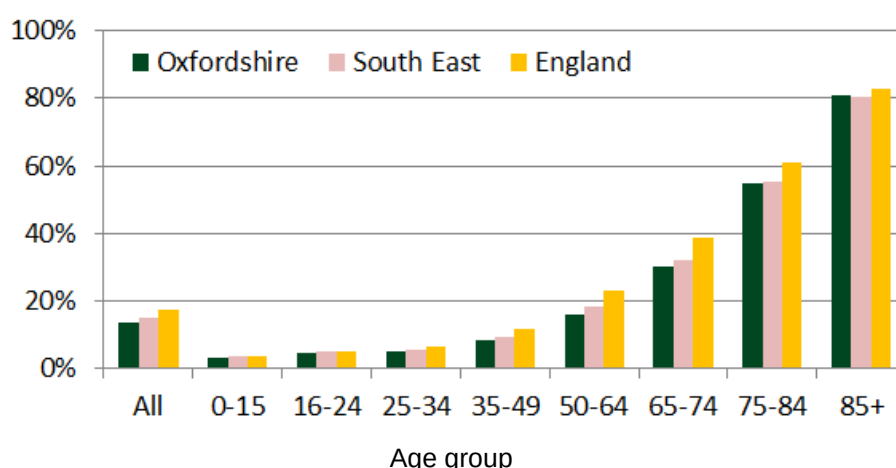
At the time of the 2011 Census, 84,860 people living in households in Oxfordshire (not including communal establishment residents) said they were limited in their daily activities, representing nearly one in seven people in the county (13.6%).

- By district the rates of people in households with daily activities limited by ill health varied slightly: Cherwell 13.8%; Oxford 13.0%; South Oxfordshire 13.3%; Vale of White Horse 13.9%; West Oxfordshire 13.9%.

Data shows that rates of disability vary significantly by age.

- In the younger age groups, rates of disability (daily activities limited by ill health or disability “a little” or “a lot”) in Oxfordshire were similar to or below the regional and national averages.
- Oxfordshire had a slightly higher proportion of people aged 85 and over with a disability than the South East (81.1% vs 80.6%). The district with the highest rate of disability in this oldest age group was Cherwell (83%), followed by Vale of White Horse (82%).

Figure 19 Percentage of residents in households* by age with daily activities limited by ill health or disability (a little or a lot) 2011, Oxfordshire vs South East and England



Source: ONS Census 2011 from nomis, table DC3302 *excludes people living in communal establishments such as care homes

Wards in Oxfordshire with higher rates of disability overall were also those with a higher proportion of older residents.

Wards with the higher rates of residents aged 85 and over (living in households) with disabilities were distributed throughout Oxfordshire’s rural districts. The ward with the highest rate was Carterton North East in West Oxfordshire; the ward with the highest rate and number was Kidlington North in Cherwell.



Data has been updated in this version



Data has been reviewed and is unchanged

People claiming Attendance Allowance

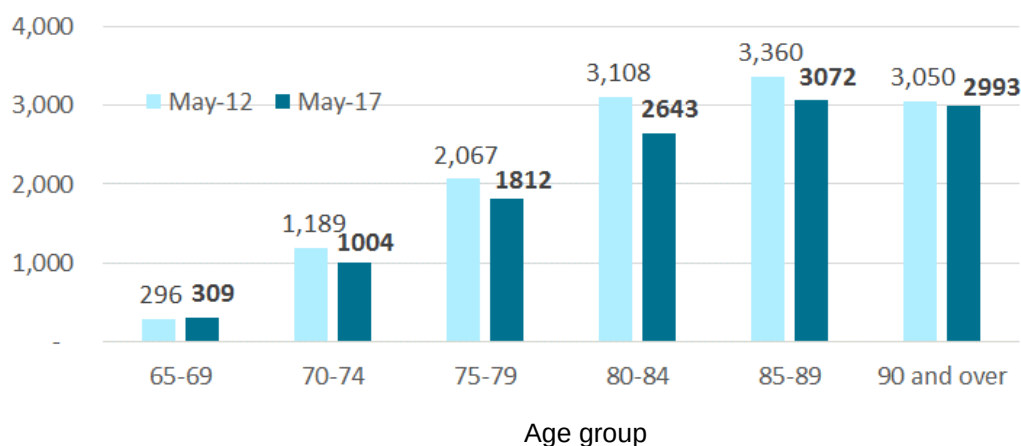
Attendance Allowance is not means tested and is available to anyone over 65 who meets the eligibility criteria. It is intended for:

- People who have a physical disability (including a sensory disability, such as blindness), a mental disability (including dementia and learning difficulties), or both.
- People with a disability severe enough to need help caring for themselves, or need someone to supervise them, for their own or someone else's safety.

As of May 2017, there was a total of **11,833** residents of Oxfordshire receiving Attendance Allowance. This was 9% below the total in May 2012 (13,056).

The number of recipients of Attendance Allowance in Oxfordshire has declined in all age groups over the past 5 years, other than for those aged 65 to 69. This is similar to the national trend.

Figure 20 Attendance Allowance cases in payment (000s), Oxfordshire May 2012 vs May 2017



Source: DWP tabulation tool

Of the districts in Oxfordshire, Cherwell had the greatest number of Attendance Allowance claimants in each age group. 38% of Cherwell residents aged 85 and over were receiving Attendance Allowance, above the average for the county (36%).



Data has been updated in this version



Data has been reviewed and is unchanged

 **Table 8 Attendance Allowance recipients, count and percentage of population, by age and district (May 2017)**

	Aged 65 - 69		Aged 70 - 74		Aged 75 - 79		Aged 80 - 84		Aged 85 and over		TOTAL
	count	%	count	%	count	%	count	%	count	%	count
Cherwell	72	0.9%	252	4.1%	466	9.9%	632	18.1%	1,297	38.1%	2,727
Oxford	58	1.1%	158	3.7%	314	9.8%	449	17.3%	1,018	35.1%	2,003
South Oxfordshire	54	0.7%	214	3.1%	366	6.9%	581	14.9%	1,303	33.4%	2,518
Vale of White Horse	74	1.0%	195	3.2%	355	7.7%	542	15.5%	1,281	35.6%	2,441
West Oxfordshire	51	0.8%	185	3.3%	311	7.8%	439	14.2%	1,166	35.3%	2,153
Oxfordshire	309	0.9%	1,004	3.4%	1,812	8.3%	2,643	15.9%	6,065	35.7%	11,842

Source: DWP tabulation tool

3.9 Armed forces

Regular armed forces personnel

 As of 1 October 2017, around **9,200** regular armed forces (military and civilian) personnel were stationed in Oxfordshire (although not all necessarily reside in the county). This was a slight reduction on the number as of 1 October 2016 (9,400).

Table 9 Armed Forces personnel stationed in Oxfordshire, Oct 2015 to Oct 2017

	01-Oct-15	01-Oct-16	01-Oct-17	Oct16 to Oct17
Military Total	8,430	8,340	8,230	-110
Officers	1,780	1,780	1,770	-10
Other Ranks	6,650	6,550	6,460	-90
Civilians Total	1,050	1,040	1,010	-30
Non Industrial	810	810	810	-
Industrial	250	220	200	-20

Source: Ministry of Defence Quarterly Location Statistics updated 16 Nov 2017

 As part of the November 2016 report on the review of Ministry of Defence land, it has been announced that three MoD sites in Oxfordshire will be sold for housing development, affecting a total of 1,744 Military personnel (not including families):

- St David's Barracks in Bicester (534 Military personnel)
- Vauxhall Barracks in Didcot (260 Military personnel)
- Dalton Barracks in Abingdon (950 Military personnel)

The closures are expected to take place before 2028-29.



Data has been updated in this version

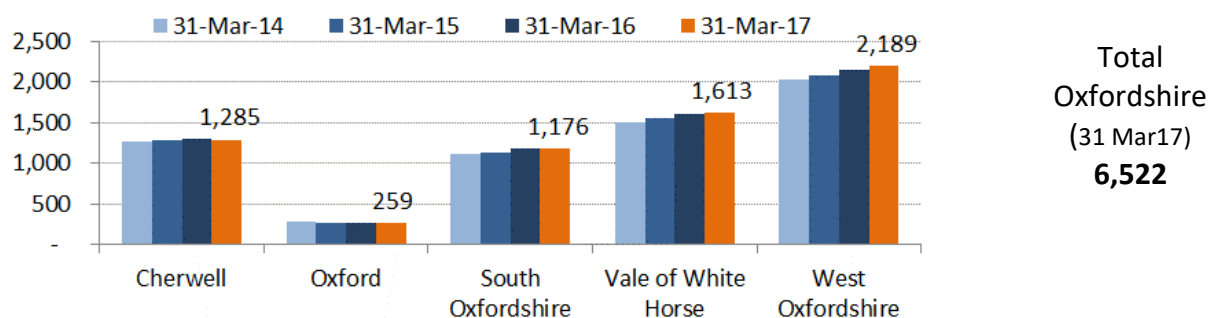


Data has been reviewed and is unchanged

Veterans

As at 31 March 2016, there was just over **6,500** residents of Oxfordshire in receipt of Armed Forces Pension, War pension and Armed forces compensation scheme. The district with the largest number was West Oxfordshire with around 2,200.

Figure 21 Number of residents in receipt of Armed Forces Pension, War pension and Armed Forces Compensation Scheme, Mar14 to Mar17



Source: Ministry of Defence, Location of armed forces pension and compensation recipients

3.10 Carers

Census 2011 data gives a total of:

- **61,100** residents of Oxfordshire providing any amount of unpaid care¹⁰.
- **17,400** residents of Oxfordshire providing 20 or more hours per week of unpaid care.

Analysis by age of carers as a proportion of the “out of term time” population¹¹ (i.e. excluding students with a main address elsewhere), shows that:

- Oxford had double the national average of young carers (aged under 16). The number of carers in this age group in Oxford was 90, of which half (45) were residents in the wards of Cowley Marsh, Northfield Brook, Lye Valley, Blackbird Leys and Hinksey Park.
- Oxford was above the regional South East average on the proportion of working age carers aged 35 to 49.
- Cherwell was above the regional South East average on the proportion of carers aged 65 and over. The number of carers in this older age group in Cherwell was 1,346, distributed across the district.

Compared with all people aged 65 and over, older people providing significant amounts of care (50 or more hours per week) were more likely to be in “bad” health.¹²

¹⁰ ONS Census 2011 table LC3304

¹¹ ONS Census 2011 table OT1101

¹² ONS Census 2011 table LC3301



Data has been updated in this version



Data has been reviewed and is unchanged

- 13% of people aged 65+ in Oxfordshire in 2011 providing significant amounts of care were in bad health compared with 10% overall.
- The proportion of older people providing care and in bad health was highest in Cherwell district (16%).

At the time of the 2011 Census there was a total of **4,200** people in Oxfordshire combining full time work (including employees and self-employed) with providing 20 or more hours a week of unpaid care.¹³

- Cherwell district had the highest rate of people combining full time work and caring with 1.84% of the employed population also carers, compared with 1.75% across Oxfordshire and 2.34% in England.



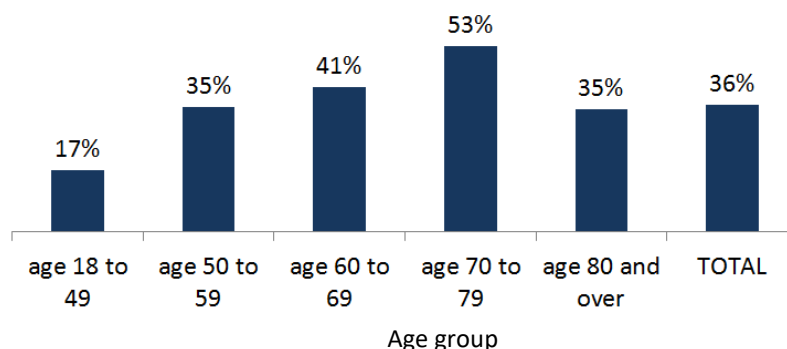
Survey of carers

The Carers survey is a national survey run every other year, the latest survey was sent November 2016.

- *Note that there has been a change to the methodology since the carers survey in 2014-15. The previous “eligible population” was limited to carers who had had a carer’s assessment or review within the previous 12 months. The latest survey included all carers, whether or not they have had a recent review.*

2,000 Carers known to Oxfordshire County Council¹⁴ were sent a survey with around 400 in each of the 5 broad age bands. There were 721 responses from Oxfordshire carers in total (36%) with the highest response rate in the age group 70-79.

Figure 22 Carers in Oxfordshire survey 2016-17: % respondents by age group



Source: 2016-17 Carers survey; Oxfordshire County Council

Older carers more likely to have accessed information and advice and more likely to rate advice as helpful.

¹³ ONS Census 2011 table LC6301

¹⁴ Carers with assessment or review AND with record of cared for person and minimum data on carer including age



Data has been updated in this version



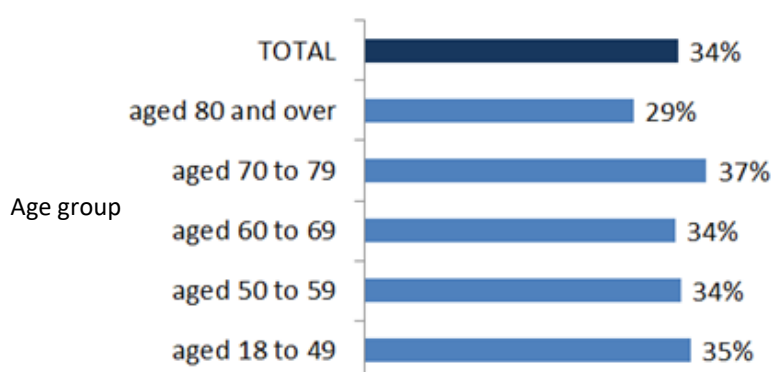
Data has been reviewed and is unchanged

Carers commented on..

- The challenges of caring;
- Lack of available care, support for day care, poor quality home care, praise for Age UK, dealing with bureaucracy.

Around a third (34%) of Oxfordshire carer respondents have had to see their own GP in the past 12 months because of their caring role. This was similar in all broad age categories.

Figure 23 % of Oxfordshire carer respondents who had to see their own GP because of their caring role, by broad age of carer



Source: 2016-17 Carers survey; Oxfordshire County Council

In addition:

- 1 in 5 (21%) carers reported having developed “my own health condition” as a result of caring;
- 1 in 5 (21%) carers reported caring had made an existing condition worse.

If the Oxfordshire Carers sample is representative then, of the group providing care 20 or more hours per week, an estimated total of 6,200¹⁵ carers in Oxfordshire will have had to see their GP as a result of their caring role in the past 12 months¹⁶;

It is possible that this action – to see their GP as a result of their caring role – is an early indication that their caring role is at risk, potentially affecting around 6,200 people currently being supported by an informal carer.

Over half of carer respondents in Oxfordshire would be prepared to take part in further research.

- 387 carers (over 50% of respondents) said they were happy to take part in future research.
- This “happy to take part in future research” group gave similar responses to the total.

¹⁵ Assumptions: 17,200 people providing 20+ hours unpaid care per week in Oxfordshire (ONS Census 2011 survey); 35% of 2016-17 Carer respondents providing 20+ hours unpaid care went to see their GP as a result of their caring role

¹⁶ This is likely to be a conservative estimate as the base data on total number of carers is from 2011 (6 years ago)

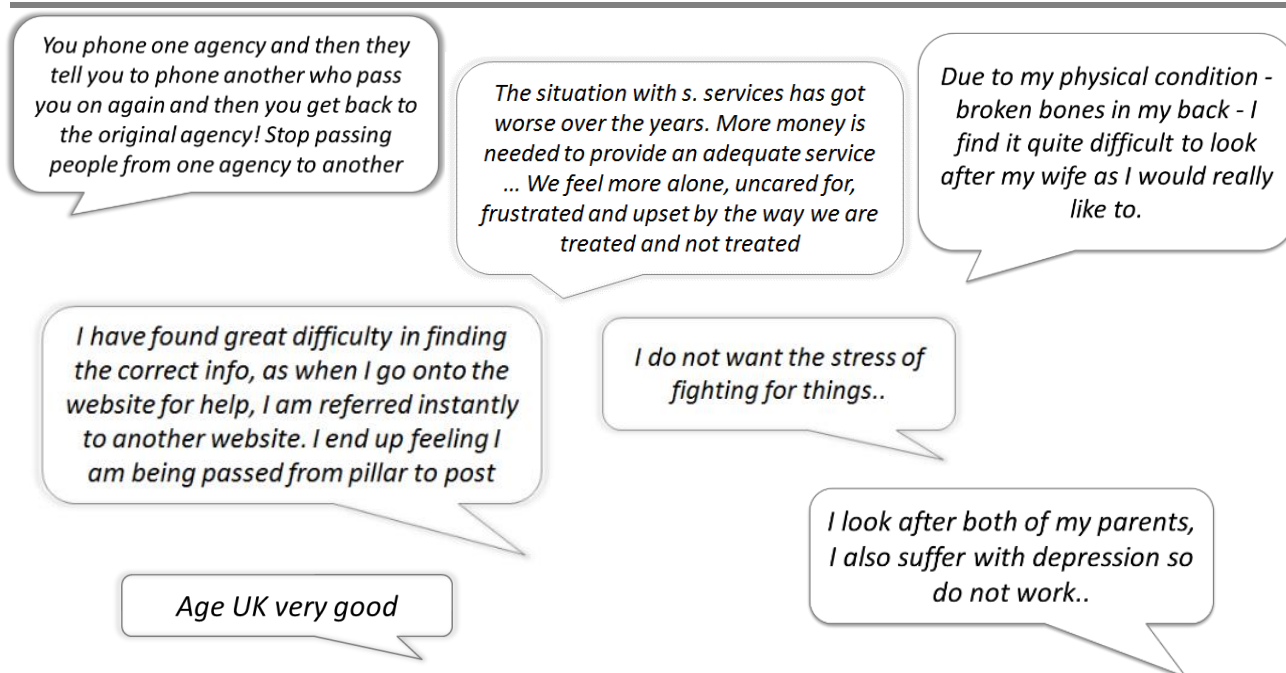


Data has been updated in this version



Data has been reviewed and is unchanged

Comments from Carers in Oxfordshire



Source: 2016-17 Carers survey; Oxfordshire County Council

Further data and analysis of the results of the 2016-17 carers survey is available from Oxfordshire Insight <http://insight.oxfordshire.gov.uk/cms/carers-survey-2016-17-jsna-briefing>

Young carers

Caring is well known as a cause of stress for young people.

 By the end of March 2017, the Oxfordshire Young Carers Service had identified and supported a total of **2,684** children and young adults (aged up to 25 years) who provide unpaid care to a family member¹⁷. This is an increase from the number as of March 2016 (2,281).

This included 456 new young carers identified in the year 2016-17 (480 in 2015-16).

Carers from ethnic minority groups

 The proportion of people providing care by ethnic minority group appears to be lower in Oxfordshire than nationally. This is very likely to be influenced by the age profile of each ethnic group.

¹⁷ Oxfordshire County Council



Data has been updated in this version



Data has been reviewed and is unchanged

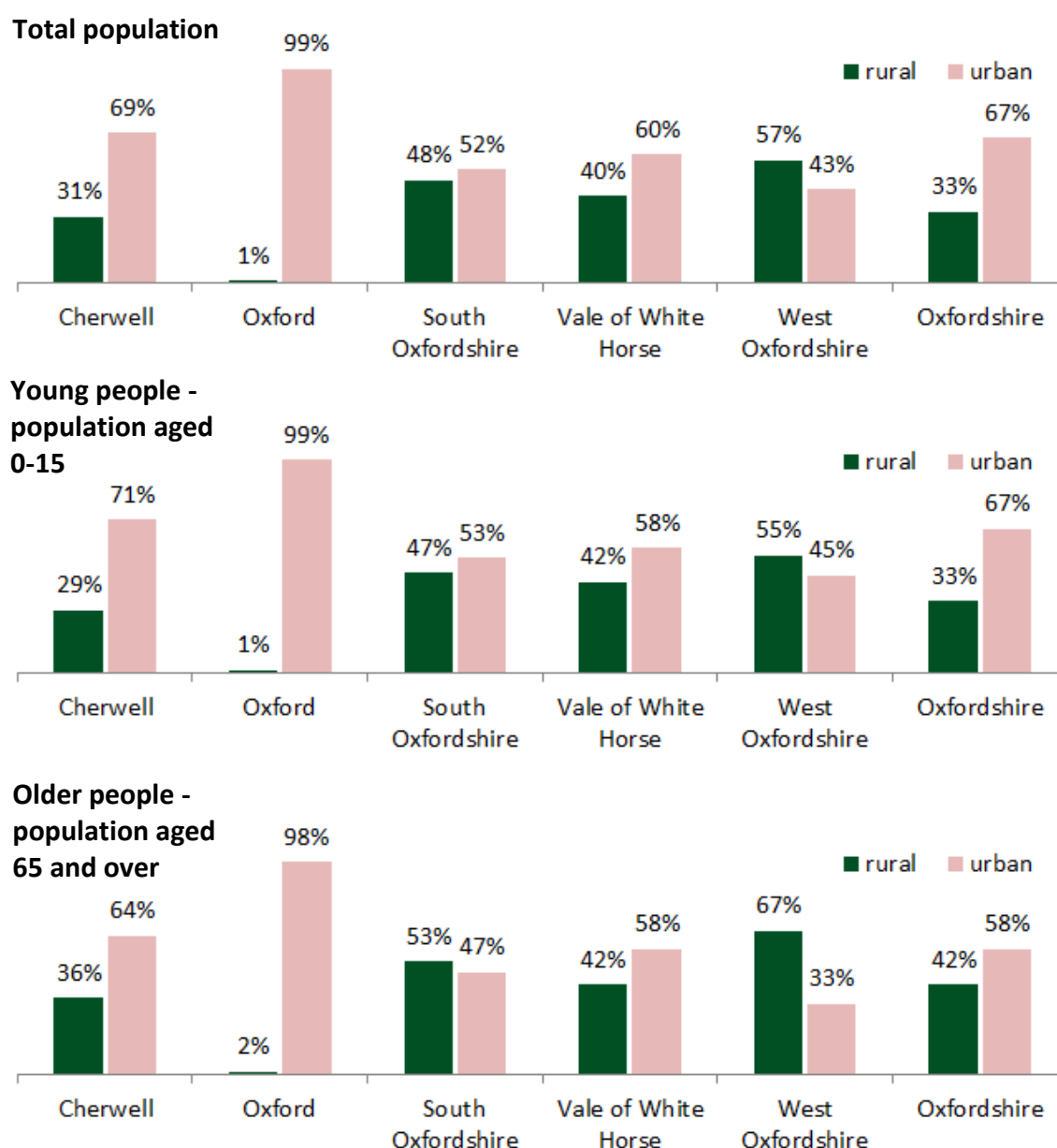
3.11 Rural population

 As at mid-2016, a third of the total population of Oxfordshire (225,600, 33%) lived in areas defined as “rural” by the Office for National Statistics.

Older people are more likely to live in rural areas than younger age groups. 42% of the population of the county aged 65+ lived in rural Oxfordshire.

West Oxfordshire had the highest proportion living in rural areas (57%) and the highest proportion of older rural residents (67%).

Figure 24 Population in rural and urban areas by district (2016 ONS population estimate and rural/urban classification based on lower super output areas)



Source: ONS population estimate 2016 by LSOA, ONS rural urban classification of Lower Layer Super Output Areas



Data has been updated in this version



Data has been reviewed and is unchanged

4 Wider determinants of health

This chapter on the wider determinants of health reports on:

1. Socioeconomic Status

Including work, affluence and deprivation.

ONS analysis¹⁸ has demonstrated higher life expectancies and greater life expectancy gains for people in the higher socio-economic groups.

2. Education and qualifications

A report on behalf of the OCED¹⁹ found that:

- *“there are substantial and important causal effects of education on health.”*
- *“empirical investigations often find that the effect of education on health is at least as great as the effect of income.”*

3. Physical Environment

Including built and natural environment.

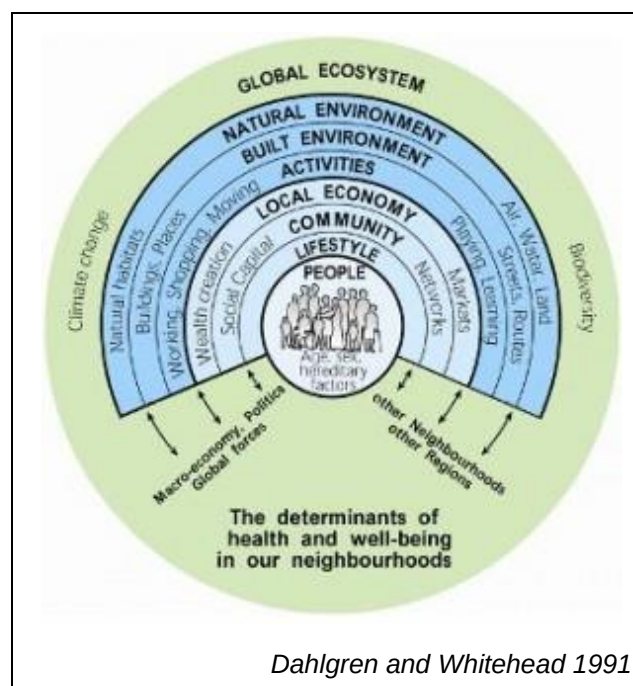
According to the World Health Organisation²⁰ the environment is a major determinant of health, estimated to account for almost 20% of all deaths in the WHO European Region.

4. Social Environment

Including social support networks within communities and between individuals, family and friends.

Research has found that being socially connected is influential for psychological and emotional well-being²¹ and has a significant and positive influence on physical well-being²² and overall longevity²³.

Further resources are available online, by visiting the [JSNA – Wider Determinants webpage](#).



¹⁸ Trend in life expectancy at birth and at age 65 by socio-economic position based on the National Statistics Socio-economic Classification, England and Wales: 1982—1986 to 2007—2011

¹⁹ The Effects of Education on Health: Concepts, evidence and policy implications. L Feinstein, R Sabates, TM Anderson, A Sorhaindo... - A review for the OECD, 2006

²⁰ <http://www.euro.who.int/en/health-topics/environment-and-health>

²¹ J Holt-Lunstad, TB Smith, M Baker 2015, Loneliness and social isolation as risk factors for mortality a meta-analytic review

²² Uchino BN, 2006: Social support and health: a review of physiological processes potentially underlying links to disease outcomes.

²³ Shor, Eran, Roelfs, David and Yogev, Tamar (2013): The strength of family ties: A meta-analysis and meta-regression of self-reported social support and mortality.



Data has been updated in this version



Data has been reviewed and is unchanged

4.1 Wider determinants – key findings

This section highlights the key messages from the review of data on Wider Determinants (data sources and research references are provided with the detailed data in the remainder of this chapter).

Work, affluence and deprivation

- National statistics show that, over a 30-year period, improvements in life expectancy have been greatest for those in higher socio-economic groups.
- Unemployment remains relatively low in Oxfordshire.
- The increase in claimants of employment-related benefits in the older age group in Oxfordshire was above average.
- Earnings remain relatively high for Oxfordshire residents.
- Despite relative affluence, income deprivation is an issue in urban and rural areas.
 - 14,000 children in Oxfordshire were affected by income deprivation (IMD 2015), 81% living in urban areas and 19% in rural Oxfordshire.
 - Snapshot HMRC data (Aug14) shows almost 1 in 5 children aged 0-15 in Oxford were living in low income families.
 - 13,500 older people in Oxfordshire were affected by income deprivation (IMD 2015), 68% living in urban areas and 32% in rural Oxfordshire.
- Just under half of people claiming Employment and Support Allowance (for people where illness and disability affects ability to work) in Oxfordshire were aged 50 and over. The number of ESA claimants has remained a similar level in Oxfordshire and nationally since early 2015.

Housing and homelessness

- House prices in Oxfordshire continue to increase at a higher rate than earnings.
- The Centre for Cities report 2018 again ranks Oxford as the least affordable UK city for housing. In Oxford City, social rents charged by private registered providers in 2017 were 18% above the national average.
- Over the past 6 years there has been an increase in people presenting as homeless and of people accepted as homeless and in priority need in Oxfordshire, although the latest data for 2016-17 shows a decline.
- Loss of private rented accommodation is an increasing cause of homelessness.
- There was a reduction in the number of households in temporary accommodation in Oxfordshire compared with the previous year.
- The latest data shows a significant increase in the number of people rough-sleeping in Oxford.
- As a result of the reduction of benefit cap levels in November 2016, the number of households affected by the benefit cap across Oxfordshire increased significantly, from 125 in 2015-16 to 618 households in 2016-17.



Data has been updated in this version



Data has been reviewed and is unchanged

- Between 2014 and 2015, an additional 1,600 households in Oxfordshire were classed as being “fuel poor” taking the total to 25,915 households in fuel poverty in the county. There was an increase in the proportion of households defined as “fuel poor” in each district of Oxfordshire.

Education and qualifications

- Oxfordshire has above the England average of pupils in state-funded primary and secondary schools with learning difficulties, most significantly for pupils with moderate learning difficulties.
- Between 2016 and 2017 there was an increase in the proportion of children achieving a good level of development in all Early Learning Goals in each district in Oxfordshire, except for Cherwell where the rate declined. Girls continue to outperform boys.
- Early Years attainment for 5 year olds with Asian or Black ethnic backgrounds in Oxfordshire was below the South East average.
- The proportion of Oxfordshire’s disadvantaged pupils aged 10-11 achieving the expected standard at Key Stage 2 was below the England average in 2017.
 - For pupils with SEN support, the proportion was 17% in Oxfordshire compared with 21% nationally.
 - For pupils with a first language other than English, the proportion was 55% in Oxfordshire compared with 61% nationally.
 - For pupils eligible for Free School Meals, the proportion was 38% in Oxfordshire compared with 43% nationally.
- The latest secondary school attainment data (replacing GCSE results) shows Oxfordshire just above the national average and 6th out of 11 in its statistical neighbour group.
- Oxfordshire has a relatively high rate of unauthorised absences from school.
- Provisional apprenticeship data for 2016-17 shows a 7% fall in number of apprenticeships started by Oxfordshire residents. The number of young people not in education, employment or training has continued to fall.
- Oxfordshire has an above-average proportion of people with high level qualifications and a low proportion of people with no qualifications.
- There are 25 areas in the county (including 10 in Oxford) which are ranked in the top 10% most deprived nationally on the Education and Skills domain of the IMD 2015.

Physical and social environment

- The British Social Attitudes Survey (national) shows an increasing willingness to walk short journeys of less than 2 miles, rather than go by car.
- A walking to school initiative, taken up by 18 schools in Oxfordshire so far, is showing an increase in active travel rates since September 2017 from 65% to 84% (+19pp).
- The number of people injured using cycles on roads in Oxfordshire has declined for a second year in a row.



Data has been updated in this version



Data has been reviewed and is unchanged

- Public Health England analysis found 423 fast food outlets in Oxfordshire of which 56% were in Cherwell and Oxford. The ward with the highest number of fast food outlets was Banbury Grimsbury & Castle (39 outlets).
- Oxfordshire continues to have 13 Air Quality Management Areas where the annual mean objective for nitrogen dioxide is being exceeded including the whole of Oxford city.
- It is likely that the weather patterns in Oxfordshire will change in coming decades with more heavy rainfall and more frequent heatwaves.
- As the elderly are more vulnerable to extreme heat and cold, the UK Health Protection Agency predicts that future health burdens from climate change are likely to be amplified by an ageing population.
- The UK Health Alliance has identified opportunities from climate change including the co-benefits of emission reduction activities leading to healthier lifestyles (more walking/cycling, insulating homes and others).
- Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services. Areas rated as “high risk” for isolation and loneliness in Oxfordshire are mainly in urban centres.

4.2 Work, affluence and deprivation

Employment and life expectancy

 Analysis by the ONS found that, over a 30-year period, improvements in life expectancy have been greatest for those in higher socio-economic groups²⁴. The ONS summary²⁵ reports that:

- *Since the 1970s, men have been catching women up in terms of survival. The decline of the mining industry and the move away from physical labour and manufacturing industries towards the service sector is a likely cause, along with a reduction in the proportion of men smoking.*
- *Over the past 30 years, inequalities in life expectancy by socioeconomic position have widened for both men and women **with improvements in life expectancy being greater for the most advantaged.***

The working age population in Oxfordshire (and nationally) is ageing.

- 
- Between 2006 and 2016, the total working age population (aged 16 to 64) in Oxfordshire increased by +4%. The growth in older working age residents (aged 50 to 64) of Oxfordshire was almost a third (+33%).

²⁴ Source: ONS Trend in life expectancy at birth and at age 65 by socio-economic position based on the National Statistics Socio-economic Classification, England and Wales: 1982—1986 to 2007—2011 (Oct 2015)

²⁵ <http://visual.ons.gov.uk/most-affluent-man-now-outlives-the-average-woman-for-the-first-time/>



Data has been updated in this version



Data has been reviewed and is unchanged

Unemployment



Unemployment remains relatively low in Oxfordshire.

- The official measure of unemployment is from the ONS Annual Population Survey and not directly available at local authority level due to small survey numbers.
- For local authorities, ONS provides model-based estimates of unemployment²⁶ which, for the period Jul16 to Jun17, gives an estimate of **12,500** people unemployed in Oxfordshire (+/- 4,900).
- The estimated rate of unemployment (as a percentage of the economically active population) was **3.4% in Oxfordshire** (+/-1.3). The value was just below the regional average (**3.5%** +/-0.3) and England average (**4.6%** +/-0.1).

There has been an above-average increase in the number of claimants of benefits related to unemployment in the past year in Oxfordshire.

- The experimental claimant count indicator provided by DWP provides the number of people claiming Jobseeker's Allowance plus those who claim Universal Credit and are required to seek work and be available for work.
- This shows of a total of **2,880 claimants in Oxfordshire** in November 2017, up from 2,700 in November 2016 (+180, +7%). Oxfordshire's increase was just above the average increase for England over this period (+6%).
- Each district saw an increase in claimants except for Cherwell where there was a slight decline.

 **Table 10 Claimant count (JSA and Universal Credit seeking work) Nov 16 and Nov 17**

	Nov 2016	Nov 2017	Nov 16 to Nov 17		Nov 2017 count as % of Oxfordshire
Cherwell	520	515	- 5	-1%	18%
Oxford	1,005	1,020	15	1%	35%
South Oxfordshire	410	445	35	9%	15%
Vale of White Horse	420	500	80	19%	17%
West Oxfordshire	345	400	55	16%	14%
Oxfordshire	2,700	2,880	180	7%	100%

Source: DWP from nomis. This experimental series counts the number of people claiming Jobseeker's Allowance plus those who claim Universal Credit and are required to seek work and be available for work and replaces the number of people claiming Jobseeker's Allowance as the headline indicator of the number of people claiming benefits principally for the reason of being unemployed.

Of the 2,660 claimants in Oxfordshire in November 2017:

- 61% were male and 39% female
- 465 (16%) were aged 18 to 24 and 875 (30%) were aged 50 and over

²⁶ Downloaded from www.nomisweb.co.uk from the Annual Population Survey datasets.



Data has been updated in this version



Data has been reviewed and is unchanged

The increase in claimants in the older age group was above the average for all age groups in Oxfordshire.

- Between November 2016 and November 2017, claimants aged 50 and over increased in Oxfordshire from 750 to 875 (+125, +17%). This was above the average for all ages in Oxfordshire (+7%) and above the increase in the older age group in England (+13%).

The wards in Oxfordshire with the highest number of claimants in November 2017 were Barton & Sandhills, Blackbird Leys and Banbury Grimsbury & Castle.



Data has been updated in this version



Data has been reviewed and is unchanged

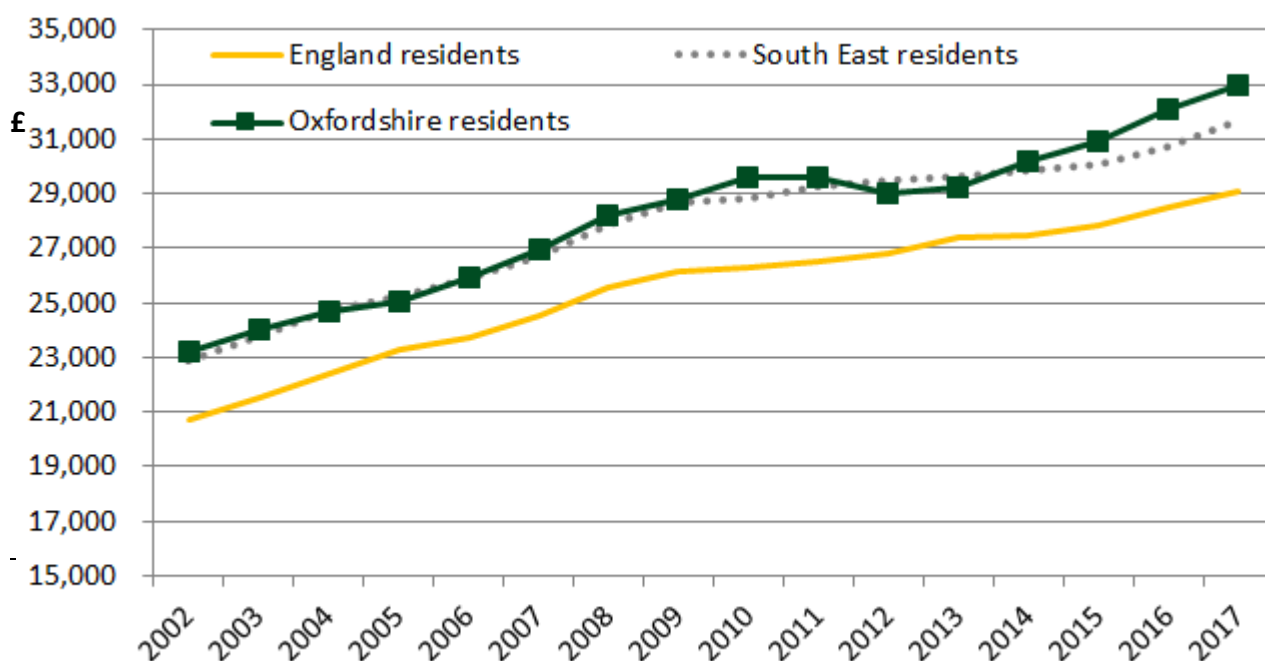
Earnings

Earnings remain relatively high for Oxfordshire residents and median earnings for residents was above the South East average (but not statistically above).



- In 2017, the median wage for Oxfordshire residents was £33,000 compared with £31,700 in the South East.
- Earnings will be strongly influenced by the mix of employment in the area.

Figure 25 Median gross full time annual pay of residents 2002 to 2017



Source: ONS Annual Survey of Hours and Earnings from nomis; NOTES: chart does not show confidence intervals. Median is the mid-point of the range. Scale does not start at 0



Income deprivation

The income deprivation domain of the 2015 Indices of Multiple Deprivation (IMD) shows Oxfordshire as a relatively affluent county.

- Out of the 407 lower super output areas in Oxfordshire, the clear majority (80%) were ranked within the least deprived 50% in England on the income deprivation domain.
- The most deprived areas of Oxfordshire on income deprivation were 3 areas within Oxford (parts of Rose Hill & Iffley, Blackbird Leys and Northfield Brook wards).



Data has been updated in this version



Data has been reviewed and is unchanged

Income Deprivation Affecting Children

According to the Income Deprivation Affecting Children supplementary index²⁷, **14,000** children in Oxfordshire were affected by income deprivation, 81% of whom were living in urban areas and 19% in rural Oxfordshire.

Oxford City had the highest rate, with 20% of the population aged 0-15 counted as income deprived.

Table 11 Income deprivation affecting children aged 0-15 (from IMD 2015) – rural vs urban by district

	Rural		Urban		Total	
	count	% of population	count	% of population	count	% of population
Cherwell	475	5.9%	2,775	13.5%	3,250	11.4%
Oxford	15	4.6%	5,110	19.8%	5,125	19.7%
South Oxfordshire	715	5.7%	1,220	9.0%	1,935	7.4%
Vale of White Horse	680	7.1%	1,365	9.9%	2,045	8.8%
West Oxfordshire	735	6.8%	915	10.0%	1,650	8.3%
Oxfordshire	2,620	6.4%	11,385	13.7%	14,005	11.3%
<i>% of Oxfordshire</i>	<i>19%</i>		<i>81%</i>		<i>100%</i>	

Source: CLG IMD 2015, underlying indicators, analysis by Oxfordshire County Council; indicators as of 2012

²⁷ The Income Deprivation Affecting Children Index is the proportion of all children aged 0 to 15 living in income deprived families. Income deprived families are defined as families that either receive Income Support or income-based Jobseekers Allowance or income-based Employment and Support Allowance or Pension Credit (Guarantee) or families not in receipt of these benefits but in receipt of Working Tax Credit or Child Tax Credit with an equivalised income (excluding housing benefit) below 60 per cent of the national median before housing costs.



Data has been updated in this version



Data has been reviewed and is unchanged

Child Poverty

 According to HM Revenue and Customs data on children in low income (local measure), between 2014 and 2015, the proportion of children in poverty in Oxfordshire decreased (from 11.3% to 9.8%), remaining below the national average (16.6%).

The Oxfordshire district with the highest rate of children in poverty was Oxford (16.4%) and the lowest was South Oxfordshire (7.2%).

Table 12 Children in low income families (local measure) 2013, 2014, 2015 (snapshot as of 31 August)

	31 Aug 2013	31 Aug 2014	31 Aug 2015	2014 to 2015 Percentage point change
Cherwell	10.4%	11.3%	9.9%	-1.4
Oxford	18.9%	19.2%	16.4%	-2.8
South Oxfordshire	7.4%	8.1%	7.2%	-0.9
Vale of White Horse	8.4%	9.1%	7.6%	-1.5
West Oxfordshire	7.6%	8.6%	7.4%	-1.2
Oxfordshire	10.7%	11.3%	9.8%	-1.5
England	18.0%	19.9%	16.6%	-3.3

Source: HM Revenue and Customs (released Feb 2018); all dependent children under the age of 20

Children in Poverty HMRC data

Children in "Poverty" is defined as the number of children living in families in receipt of Child Tax Credit whose reported income is less than 60 per cent of the median income or in receipt of Income Support or (Income-Based) Job Seeker Allowance, divided by the total number of children in the area (determined by Child Benefit data)

For more information and definitions refer to the technical note available at:

<https://www.gov.uk/government/statistics/personal-tax-credits-children-in-low-income-families-local-measure>

Latest release:

<https://www.gov.uk/government/statistics/personal-tax-credits-children-in-low-income-families-local-measure-2015-snapshot-as-at-31-august-2015>



Data has been updated in this version



Data has been reviewed and is unchanged

 Analysis by the End Child Poverty (ECP) Coalition²⁸ indicates that HMRC data under-counts children in poverty in working households.

ECP has produced a different set of local estimates of child poverty (before and after housing costs). These are more closely aligned to the national measure of low income households (based on the family resources survey) and make use of Labour Force Survey trend data to give more recent estimates than the HMRC data.

After housing costs, ECP estimates 26% of children in Oxford City are living in poverty.

Table 13 Comparison of Children Poverty estimates: HMRC (end Aug14) vs End Child Poverty (July-Sept 2017)

	HMRC 31 Aug 2015	ECP: Before Housing Costs (July-Sept 2017)		ECP: After Housing Costs (July-Sept 2017)	
		Number of children	%	Number of children	%
Cherwell	9.9%	3,371	10.5%	5,452	17.0%
Oxford	16.4%	4,669	16.8%	7,351	26.4%
South Oxfordshire	7.2%	2,211	7.6%	3,622	12.5%
Vale of White Horse	7.6%	2,293	8.8%	3,737	14.4%
West Oxfordshire	7.4%	1,862	8.2%	3,043	13.4%

Source: HM Revenue and Customs (latest estimate for Aug14 released Sept 2016) and ECP (released January 2018)

The End Child Poverty local indicators

The ECP figures are based on tax credit data, used to estimate the percentage of children on low incomes. They also use national trends in worklessness to estimate recent changes in the number of children who are in poverty because their parents have lost their jobs, to update the local tax credit data which is more than two years old.

This is not a direct measure of exactly how many children are in poverty on the official definition, but is based on the closest to an equivalent measure we have of local levels of child poverty. The data have been adjusted to produce figures compatible with the measures derived from the national survey of income, showing how many children live in households with below 60 per cent of median income. Specifically, the adjustments ensure that the total reported level of child poverty, before and after housing costs, is similar when adding up all the local figures as the official national totals. Thus, the local data gives an idea of the relative poverty levels in different areas, but are adjusted to estimate what these actual levels would be if they could be measured on the same basis as the national household income survey.

The local data starts by classifying children in poverty if they live in families in receipt of out of work benefits or in receipt of in-work tax credits where their reported family income is less than 60 per cent of median income. This indicator, compiled officially as a local estimate of child poverty, has been reported for August 2014 by HMRC. However, on its own it provides an inaccurate picture of actual child poverty,

²⁸ <http://www.endchildpoverty.org.uk/>



Data has been updated in this version



Data has been reviewed and is unchanged

considerably overstating the numbers in out-of-work poverty and understating the numbers in working poverty. While these factors may balance out overall, they can seriously misrepresent the overall trend where working and non-working poverty change in different ways, as well as misrepresenting local differences where working poverty is relatively more important in some areas than others. Therefore, the figures include an upward adjustment in the in-work figure and a downward adjustment in the out-of-work figure. The adjustments are made separately for AHC and BHC estimates, in each case according to how the total of the local estimates compare to the actual national measure. Figures are then updated, taking into account Labour Force Survey data on the number of children in non-working households for the third quarter of 2017.

<http://www.endchildpoverty.org.uk/poverty-in-your-area-2018/>

Income Deprivation Affecting Older People

According to the Income Deprivation Affecting Older People supplementary index²⁹, **13,500** older people in Oxfordshire were affected by income deprivation, 68% of whom were living in urban areas and 32% in rural Oxfordshire.

The districts with the highest number and rate of older people in poverty were Oxford and Cherwell.

In West Oxfordshire 1,440 older people in poverty were living in rural areas, 65% of the total in poverty in the district.

Table 14 Income deprived older people – rural vs urban by district (from IMD 2015)

	Rural		Urban		Total	
	count	% of population	count	% of population	count	% of population
Cherwell	765	6.9%	2,350	11.7%	3,115	10.0%
Oxford	30	8.5%	3,240	14.4%	3,270	14.3%
South Oxfordshire	1,160	6.5%	1,375	8.6%	2,535	7.5%
Vale of White Horse	945	7.5%	1,405	7.8%	2,350	7.7%
West Oxfordshire	1,440	8.0%	790	9.0%	2,230	8.3%
Oxfordshire	4,340	7.2%	9,160	10.7%	13,500	9.3%
<i>% of Oxfordshire</i>	<i>32%</i>		<i>68%</i>		<i>100%</i>	

Source: CLG IMD 2015, underlying indicators, analysis by Oxfordshire County Council; indicators as of 2012

²⁹ The Income Deprivation Affecting Older People Index is the proportion of all those aged 60 or over who experience income deprivation. This includes adults aged 60 or over receiving Income Support or income-based Jobseekers Allowance or income-based Employment and Support Allowance or Pension Credit (Guarantee).



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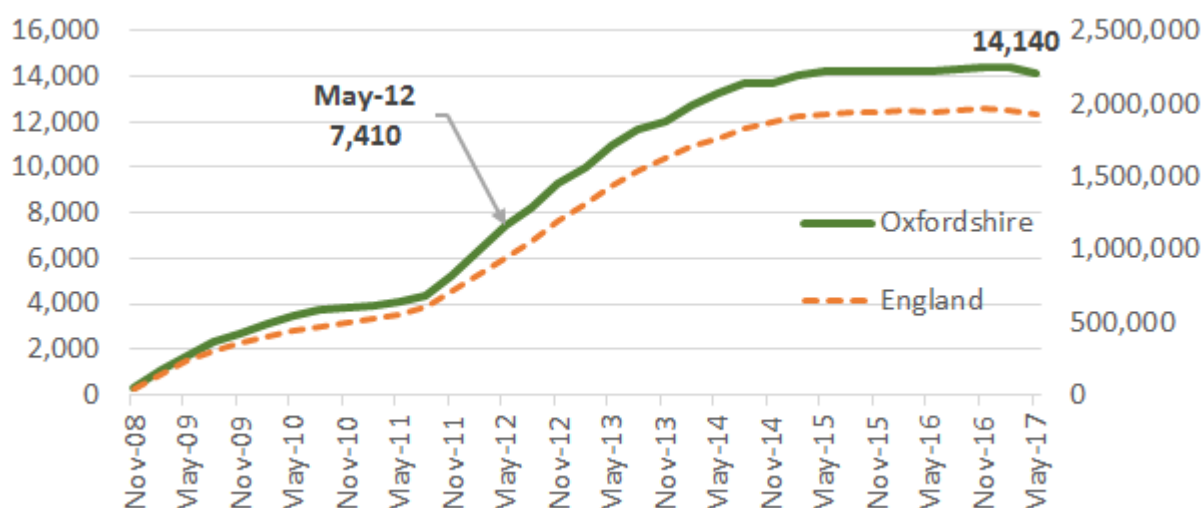


Employment and Support Allowance claimants

As of May 2017, there was a total of **14,140** people claiming Employment and Support Allowance (for people where illness and disability affects ability to work) in Oxfordshire of which just under half (6,270, 44%) were people aged 50 and over.

The number of ESA claimants has remained a similar level in Oxfordshire and nationally since early 2015.

Figure 26 Count of claimants of Employment and Support Allowance in Oxfordshire



Source: DWP from nomis; claimants aged 16-64

Just over half (51%) of claimants in Oxfordshire were as a result of mental and behavioural disorders, slightly higher than in England (49%).

The next highest condition was *Diseases of the musculoskeletal system and connective tissue* with 11% of claimants.

Employment and Support Allowance (ESA) is an income-related benefit for people where illness or disability affects ability to work. Claimants must be: under State Pension age; not getting Statutory Sick Pay or Statutory Maternity Pay and haven't gone back to work; not getting Jobseeker's Allowance.

There are 3 types of ESA:

- contribution-based ESA - if enough National Insurance contributions have been paid
- 'new style' ESA for people entitled to claim Universal Credit
- income-related ESA - on its own or on top of contribution-based ESA, for people on a low income



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Data has been reviewed and is unchanged

4.3 Housing and homelessness

+ House prices

House prices in Oxfordshire continue to increase at a higher rate than earnings.

- As of 2016 the ratio of the cheapest market housing (lower quartile) to lower quartile earnings was above 10X in each district in Oxfordshire.

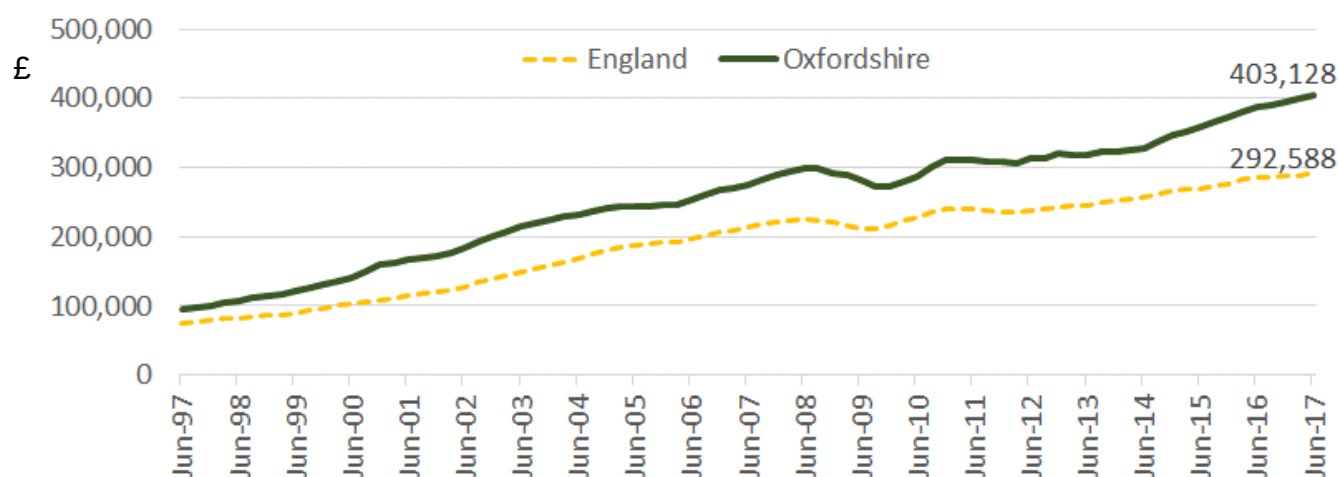
Table 15 Ratio of lower quartile house prices to lower quartile earnings

	2013	2014	2015	2016
Cherwell	8.71	9.45	10.21	10.85
Oxford	10.72	10.43	11.40	12.22
South Oxfordshire	11.09	10.97	11.00	11.84
Vale of White Horse	8.18	8.83	9.45	10.08
West Oxfordshire	9.71	9.97	10.15	12.32

Source: ONS Ratio of house price to workplace-based earnings (lower quartile) released March 2017

The average (mean) price paid for a dwelling in Oxfordshire to year ending June 2017 was £403,128, over a third more expensive than the England average.

Figure 27 Mean price paid (all dwellings) to year ending June 2017



Source: ONS Mean price paid for administrative geographies - HPSSA Dataset 12, released December 2017



Data has been updated in this version



Data has been reviewed and is unchanged

 The Centre for Cities report 2018³⁰ has again ranked Oxford as the least affordable UK city for housing. The analysis uses average house prices and average earnings and found that:

- In 2017, the average house price in Britain was 9.9 times the average annual salary.
- Oxford, London and Cambridge were the 3 least affordable cities.
- In Oxford, the least affordable city, house prices were 17.3 times annual salaries (up from 16.7 in 2016). In Burnley, the most affordable city, this figure was 4.2.

Social rented housing

 The proportion of social housing stock varies by district from between 11% and 13% in Oxfordshire's rural districts to 22% in Oxford. Since 2010 the proportion of social housing has declined in all districts in Oxfordshire other than Cherwell.

Table 16 Social housing stock as a percentage of total housing stock, 2010 to 2016

	2010	2015	2016
Cherwell	12.8	12.92	12.91
Oxford	23.9	23.28	21.97
South Oxfordshire	12.5	11.31	11.31
Vale of White Horse	15.3	12.70	12.95
West Oxfordshire	14.1	14.06	12.07

Source: ONS Housing Summary Measures 2017

Between 2016 and 2017, social rents charged by private registered providers in Oxfordshire fell by 1% in each district in Oxfordshire, by around £1 per week (similar to the national trend).

In Oxford City, social rents charged by private registered providers (such as A2Dominion, Catalyst Housing and SoHa housing) in 2016 were 18% above the national average.

Table 17 Average social rents charged by Private Registered Providers all sizes of dwellings, £ per week (as at 31st March each year)

	2016	2017	2016 to 2017		2017 social rents vs national average
Cherwell	£107.7	£106.7	-£0.97	-0.9%	10%
Oxford	£114.5	£113.6	-£0.91	-0.8%	18%
South Oxfordshire	£113.4	£112.3	-£1.03	-0.9%	16%
Vale of White Horse	£111.0	£109.3	-£1.67	-1.5%	13%
West Oxfordshire	£111.9	£110.5	-£1.44	-1.3%	14%
ENGLAND	£97.8	£96.6	-£1.23	-1.3%	0%

Source: DCLG Live tables on rents, lettings and tenancies, table 704, Figures are based on general needs stock available for social rent only and are only taken from the larger Private Registered Providers excl Council owned properties

³⁰ <http://www.centreforcities.org/publication/cities-outlook-2018/>



Data has been updated in this version



Data has been reviewed and is unchanged

Multi-person households



At the time of the Census 2011 survey, there was a total of 10,200 multi-person households in Oxfordshire, over half (56%) of which were in Oxford City.

Just over 1,000 multi-person households in Oxford City were occupied by an average of more than 1 person per bedroom, potentially indicating occupation by families.

Table 18 Persons per bedroom in multi-person households, all tenures (2011)

	TOTAL multi-person households	up to 1 person per bedroom	Over 1 person per bedroom	Over 1 person per bedroom percent of total
Cherwell	1,394	1,180	214	15%
Oxford	5,724	4,649	1,075	19%
South Oxfordshire	1,164	993	171	15%
Vale of White Horse	1,068	952	116	11%
West Oxfordshire	891	775	116	13%
Oxfordshire	10,241	8,549	1,692	17%
ENGLAND	787,684	608,329	179,355	23%

Source: ONS Census 2011 table LC4408

Homelessness



Indicators on homelessness are reported annually to the Oxfordshire Health Improvement Board. This section is from the 2016-17 report³¹.

Homeless households in priority need



There has been an upward trend in people presenting as homeless³², over the whole County, in the past six years, rising from 457 in 2011/12 to 482 in 2016/17, although the figure has fallen from last year's figure (2015/16) of 505. The situation differs across Districts, with some experiencing greater volumes of presentations and some less, over this six-year period.

The reasons for homelessness presentations are changing. The loss of private rented accommodation is becoming an increasing cause of homelessness and, in some Districts, has overtaken exclusion by family or friends as the main reason for homelessness.

There has been an increase in people who are accepted as statutorily homeless and are in priority need in the County since 2011/12 to 2016/17 (279 to 304 households). There was however a reduction in acceptances from 324 in 2015/16. There are differences between Districts however. Over the past year, all Authorities have seen reductions apart from West Oxfordshire.

³¹ <http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=899&MId=5211&Ver=4>

³² It should be noted that the indicators reported here exclude homeless applicants with a 'not homeless' or a 'not eligible' decision, so the total figure is not entirely the full number of all homeless presentations



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Data has been reviewed and is unchanged

The numbers of people found to be intentionally homeless has fallen for four years in a row; from a total of 141 in 2013/14 to 94 in 2016/17.

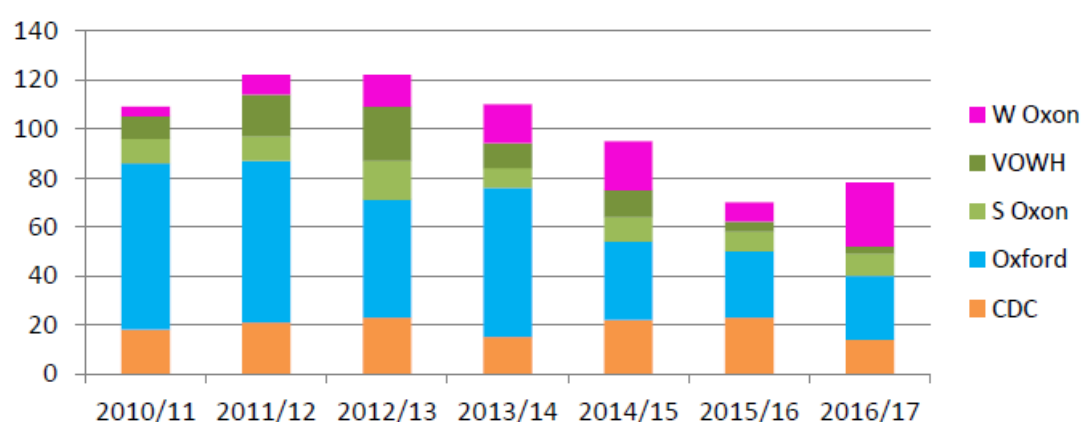
Young people accepted as homeless

➔ In 2015/16, 70 people aged 18 -24 were accepted as homeless in Oxfordshire. There was no-one aged 16 or 17. In 2016/17 the 18-24 figure rose slightly to **78**; however, this is still significantly lower than 2011/12, 2012/13 & 2013/14 figures (respectively: 122, 122 & 110).

Priority need because of physical or mental illness

➔ The number of households who are in priority need because of physical or mental illness remains moderately low. In 2016/17, there were 11 homeless households where a member had a physical disability and 23 because of mental health. In 2016/17 just 13 households accepted as homeless with the main reason being rent arrears (same figure as 2015/16).

Figure 28 Homeless applicants (unintentionally homeless in priority need) aged 18-24 years



Source: Health Improvement Board, Basket of Indicators for Housing and Health, Annual Report 2016-17

Households in Temporary Accommodation

➔ There were **161** households in temporary accommodation at the end of the financial year 2016/17, a reduction of 29 from the previous year.

Rough-Sleeping

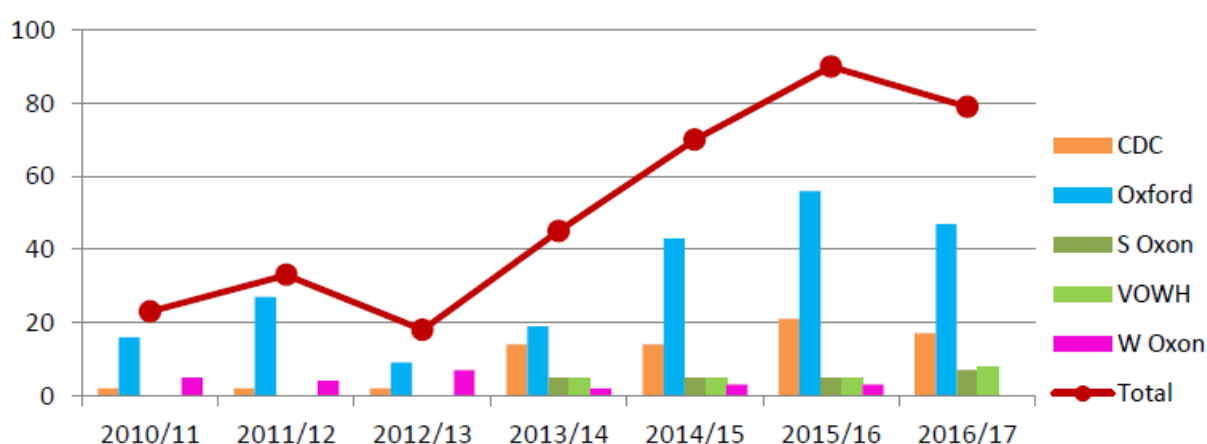
➔ The estimated number of people rough sleeping in 2016/17 was **79**. This was below the number in 2015/16 (90 people).



Data has been updated in this version



Data has been reviewed and is unchanged

Figure 29 Estimate of number of people sleeping rough

Source: Health Improvement Board, Basket of Indicators for Housing and Health, Annual Report 2016-17

➔ The latest data, reported February 2018, shows an increase in rough sleeping.

- Between November 2016 and November 2017, the number of people estimated to be rough sleeping in Oxfordshire rose by from 79 to 117 (+38 people, 48%).
- The numbers fell in two district council areas (Cherwell and South Oxfordshire), but rose in the other three (Oxford City, Vale of White Horse and West Oxfordshire).
- The increase was most significant in Oxford City, which saw an 89% increase (42 people) based on the estimate figures.
- West Oxfordshire also shows a significant change from zero to seven people in their estimate.

➔ **Table 19 People estimated to be sleeping rough in Oxfordshire, November 2016 to November 2017**

Description/ District	CDC	City	South	Vale	West	Total
Number of people estimated to be sleeping rough (Nov 16)	17	47	7	8	0	79
Number of people estimated to be sleeping rough (Nov 17)	9	89	2	10	7	117
Percentage change (Nov 16 to Nov 17)	-47%	+89%	-71%	+25%	-	+48%

Source: Exception Report by Housing Support Advisory Group, report on the number of people rough sleeping in the City of Oxford to Health Improvement Board 8th February 2018

Oxford City Council also conducts a street count of people observed as rough sleeping, and bedded down at the time of the count. In November 2016 the count recorded 33 people and in November 2017 the count had increased to 61 (+85%). This is the highest number ever recorded in Oxford.



Data has been updated in this version



Data has been reviewed and is unchanged

Figures just published by the Ministry for Housing, Communities and Local Government show that the number of people sleeping rough increased nationally by 15% (with an 18% rise in London and 14% in the rest of England) for the same period (Nov 16 to Nov 17).

The report notes that just under half of this increase was due to increases reported by eight local authorities, including Oxford. When considered per 1,000 households of population, Oxford is the 7th highest local authority listed, after City of London, Westminster, Brighton & Hove, Camden, Bedford & Luton.

Households affected by removal of Spare Room Subsidy and Benefit Cap

In 2016/17, the number of households who found that their housing benefit has been reduced because of the Social Sector size criteria³³ was 2,053. This is a reduction from 2,154 households in 2015/16.

Benefit Cap

The benefit cap is a limit on the total amount of income from certain benefits a household can receive. If people receive more than the benefit cap allows then their Housing Benefit or Universal Credit is reduced until within the cap.

In November 2016, the benefit cap was changed.

- The maximum level for single adults who don't have children or whose children don't live with them fell from £350.00 per week to £257.69 per week, and
- The maximum level for couples (with or without children living with them) and single parents whose children live with them fell from £500.00 per week to £384.62 per week.

As a result of the reduction of benefit cap levels, the number of households affected by the benefit cap across Oxfordshire increased significantly from 125 in 2015-16 to 618 households in 2016-17.

Condition of housing stock

 The latest house condition surveys in Oxfordshire show that overall housing conditions (all hazards) in Cherwell, Oxford City and West Oxfordshire are each better than the national average.

Exceptions are:

- Disrepair in Oxford City, particularly in the private rented sector, which is believed to be due in part to the older housing stock (50% of Oxford's housing stock was built before 1944)

³³ This affects households where the tenants are of working age and do not fall within one of the exception categories and they are assessed as having one or more bedrooms than they require according to the following formula of one bedroom for

- each adult couple
- any other person aged 16 or over
- two children of the same sex under the age of 16
- two children under the age of 10 regardless of their sex
- any other child
- a carer (who does not normally live with the tenant) if the tenant or their partner needs overnight care.

Tenants who are under occupying by one bedroom, have their benefit reduced by 14% of eligible rent, and tenants who are under occupying by two or more bedrooms have their benefit reduced by 25% of eligible rent.



Data has been updated in this version



Data has been reviewed and is unchanged

- Excess Cold hazards, where Cherwell District Council and West Oxfordshire each have a higher rate than the national average.
- Simple SAP energy efficiency rating, which suggests that the energy performance of buildings in Cherwell, Oxford and West Oxfordshire is lower than the national average. Rural areas tend to have higher rates of energy inefficient dwellings.

Table 20 Number and % of dwellings with a Housing Health and Safety Rating System (HHSRS) Category 1 hazard

	Dwellings	All hazards	Excess Cold	Falls	Disrepair	Simple SAP
EHS* 2009 (all Stock)		21%	8%	12%	6%	53
Cherwell (2013)	58,946	10,190 (17%)	5,903 (10%)	4,052 (7%)	2,449 (4%)	52
Oxford (2014)	52,704	9,204 (17%)	2,753 (5%)	5,979 (11%)	4,110 (8%)	51
West (2013)	41,219	8,289 (20%)	4,997 (12%)	3,120 (8%)	2,174 (5%)	51

Source: Oxford City Council, Cherwell and West Oxfordshire District Councils, collated by Oxfordshire County Council.

*English Housing Survey 2009

Table shows number of dwellings with a Housing Health and Safety Rating System (HHSRS) Category 1 hazard, which means there is one of 29 potential hazards that need action to be taken to make the property safe. The surveys, commissioned by District Councils, include the amount of disrepair, defined in the Governments former Decent Homes Standard criterion for disrepair.

Simple SAP is an estimate of the Governments energy efficiency rating - the higher the score the lower the running costs, with 100 representing zero energy cost.

Housing condition surveys for South Oxfordshire and Vale of White Horse have not been carried out in the past 5 years.

Fuel poverty

 Between 2014 and 2015, an additional 1,600 households in Oxfordshire were classed as being “fuel poor” taking the total to 25,915 households in fuel poverty in the county.

There was an increase in the proportion of households defined as “fuel poor” in each district of Oxfordshire.

Oxford is one of 9 (out of 67) local authority districts in the South East to be significantly worse than the national average on fuel poverty (2015). Cherwell, South Oxfordshire, Vale of White Horse and West Oxfordshire were each significantly better than the national average.

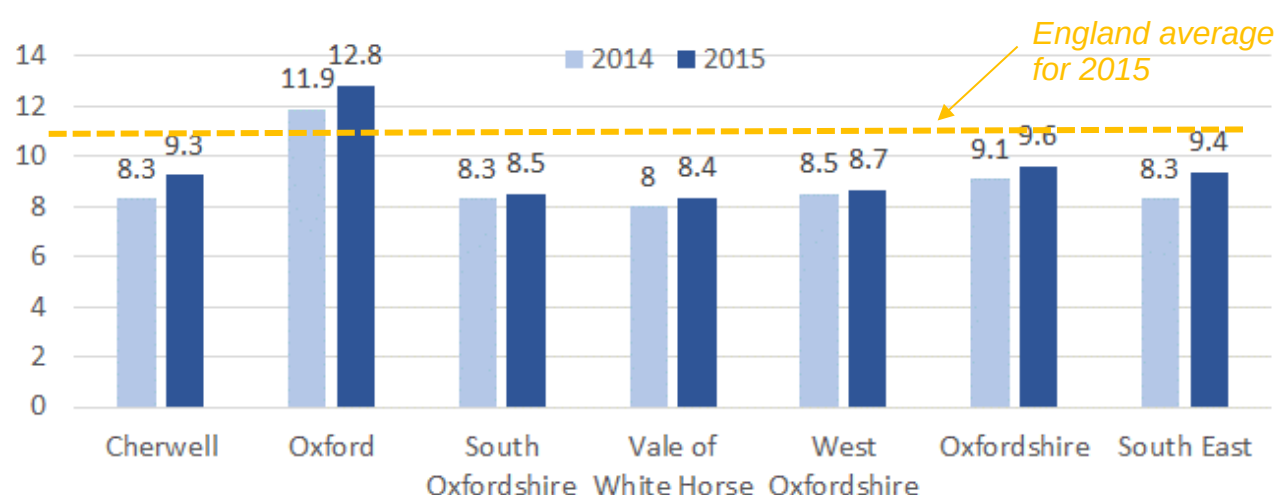


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Figure 30 Percentage of households in fuel poverty 2014 and 2015



Department for Business, Energy and Industrial Strategy published June 2017

Low Income High Costs (LIHC) definition: a fuel poor household is one in which (1) A household has required fuel costs that are above the median level; and (2) were the household to spend that amount, they would be left with a residual income below the official poverty line.

The greatest increase in the estimated number of fuel poor households was in Cherwell (+13%), similar to the regional average (13%).



Table 21 Estimated number of Fuel Poor Households

	2014	2015	2014 to 2015		% fuel poor 2015
Cherwell	4,870	5,481	611	13%	9.3
Oxford	6,840	7,406	566	8%	12.8
South Oxfordshire	4,670	4,809	139	3%	8.5
Vale of White Horse	4,099	4,306	207	5%	8.4
West Oxfordshire	3,798	3,913	115	3%	8.7
Oxfordshire	24,277	25,915	1,638	7%	9.6
South East	305,289	346,392	41,103	13%	9.4
England					11.0

Source: Department for Business, Energy and Industrial Strategy published June 2017

Fuel poverty in England is measured using the Low Income High Costs (LIHC) indicator. Under the LIHC indicator, a household is considered to be fuel poor if:

- they have required fuel costs that are above average (the national median level).
- were they to spend that amount, they would be left with a residual income below the official poverty line.



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Data has been reviewed and is unchanged

4.4 Education and qualifications

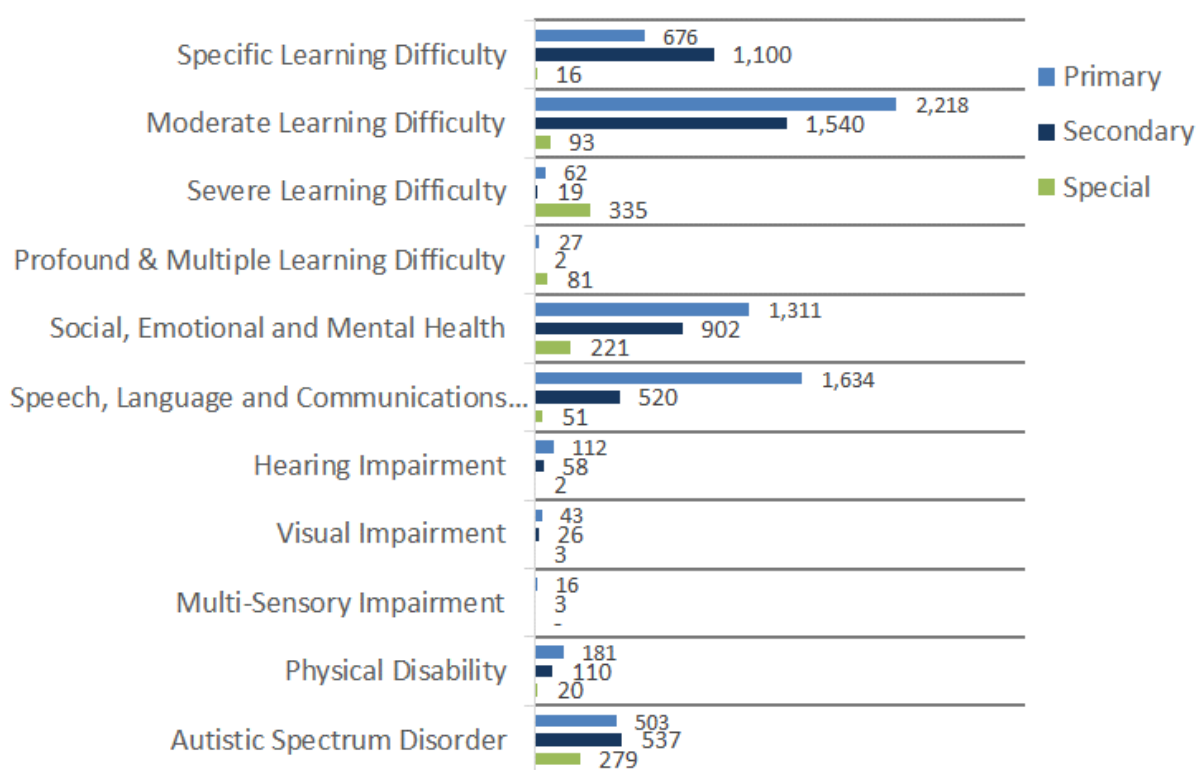
Special Educational Needs



In January 2017, there was a total of 13,000 pupils in Oxfordshire's primary, secondary and special schools with special educational needs (SEN). Of these:

- 47% (6,169) had a primary need of specific, moderate, severe or profound learning difficulty.
- 19% (2,434) had social, emotional or mental health needs.
- 17% (2,205) had speech, language and communications needs.
- 10% (1,319) had a primary need of Autistic Spectrum Disorder

Figure 31 Count of pupils in Oxfordshire in state-funded primary, secondary and special schools with Special Educational Needs by primary type of need (January 2017)



Source: Special educational needs January 2017, SFR 27/2017



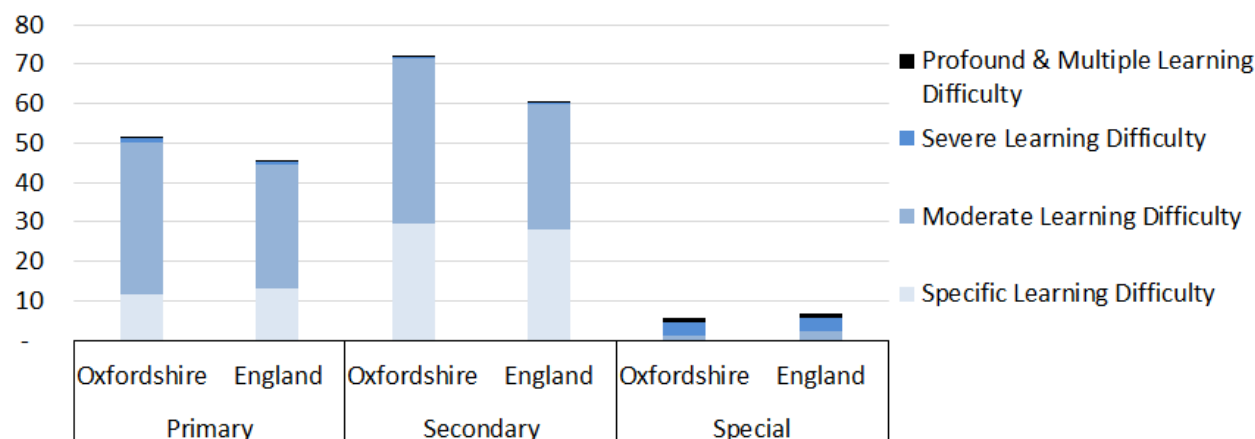
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Data has been reviewed and is unchanged

Oxfordshire has above the England average of pupils in state-funded primary and secondary schools with learning difficulties, most significantly for pupils with moderate learning difficulties.

Figure 32 Rate per 1,000 population of primary, secondary and special school pupils with learning difficulties, Oxfordshire vs England (Jan17)



Source: Special educational needs January 2017, SFR 27/2017; Denominator is ONS population estimate 2016 (primary = age 5-11; secondary = age 12-16; special = age 5-16)



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Early years

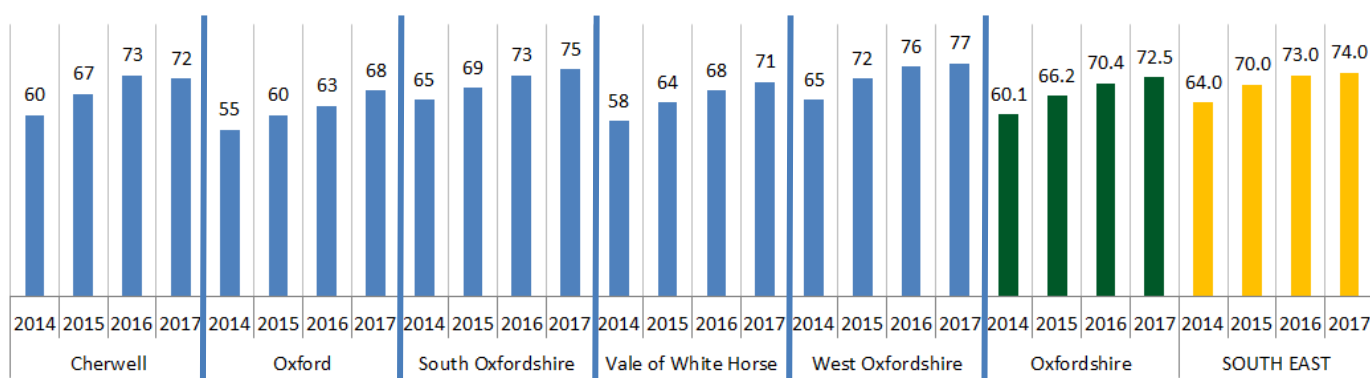
The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of children's development at the end of the academic year in which the child turns five.



The latest release of data³⁴ shows that between 2016 and 2017 there was an increase in the proportion of children achieving a good level of development in all Early Learning Goals in each district in Oxfordshire, except for Cherwell where the rate declined.

In 2017, South and West Oxfordshire was each above the average for the South East and Cherwell, Oxford and Vale of White Horse were below average.

Figure 33 % achieving a good level of development in all Early Learning Goals* 2014-2017



Source: Department for Education (released Oct2017), based on area of pupil residency

*There are 17 **Early Learning Goals**:

1. Listening and attention	2. Understanding
3. Speaking	4. Moving and handling
5. Health and self-care	6. Self-confidence and self-awareness
7. Managing feelings and behaviour	8. Making relationships
9. Reading	10. Writing
11. Numbers	12. Shape, space and measures
13. People and communities	14. The World
15. Technology	16. Exploring and using media and materials
17. Being imaginative	

³⁴ <https://www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-2016-to-2017>



Data has been updated in this version



Data has been reviewed and is unchanged



Figure 34 % achieving a good level of development in all Early Learning Goals by GENDER, Oxfordshire (2013 to 2017)

Girls continue to outperform boys in achieving the Early Learning Goals at aged 5 in Oxfordshire (and nationally).

The gap between girls and boys in Oxfordshire was 14.8 in 2013 and 14.4 in 2017.

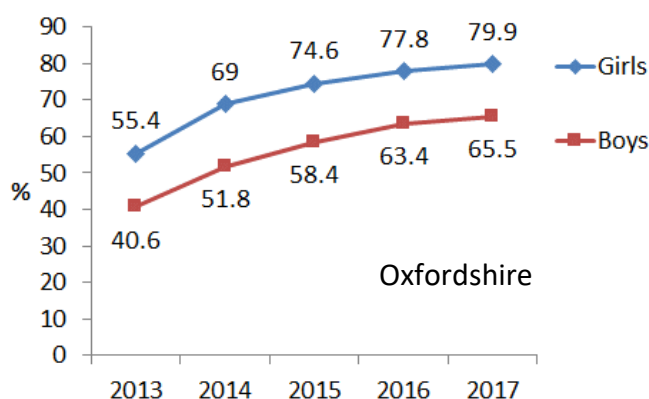


Figure 35 % achieving a good level of development in all Early Learning Goals by ETHNICITY, Oxfordshire vs South East (2017)

The ethnic groups with the lowest % of pupils achieving a good level of development in 2017 in Oxfordshire were Asian and Black, each 5 percentage points (ppts) below the average for the county.

5 year olds with an Asian or Black ethnic backgrounds in Oxfordshire were 4 ppts below the average for these ethnic groups in the South East.

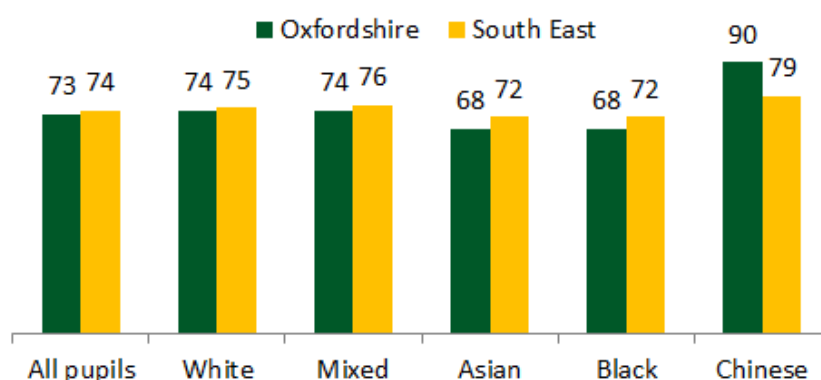
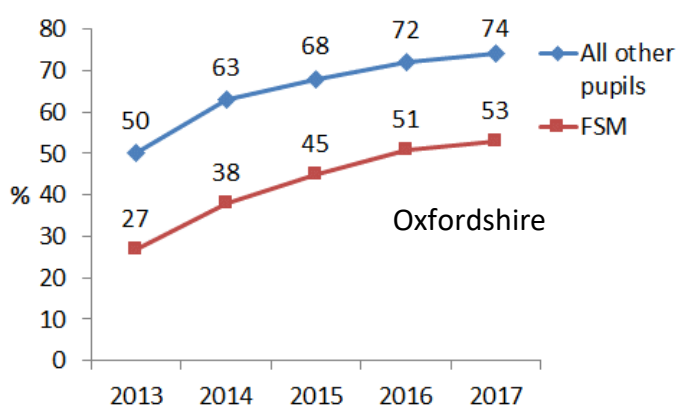


Figure 36 % achieving a good level of development in all Early Learning Goals by FSM, Oxfordshire (2013 to 2017)

The % of pupils known to be eligible for Free School Meals (FSM) in Oxfordshire and achieving a good level of development in ELGs remains significantly below other (non-FSM) pupils.

The gap has reduced slightly from 23 percentage points in 2013 to 21ppts in 2017.



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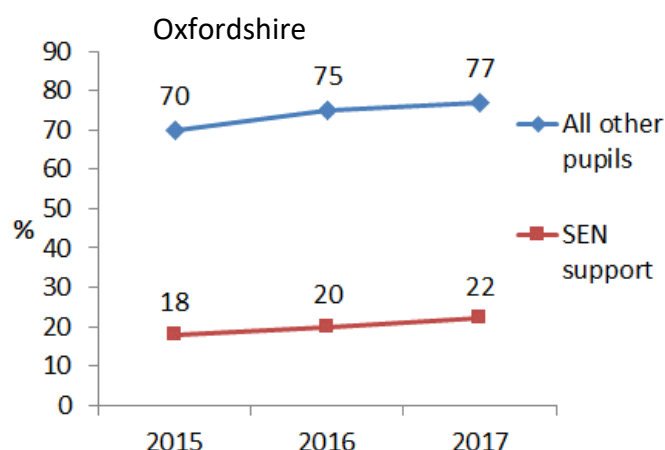


Data has been reviewed and is unchanged

Figure 37 % achieving a good level of development in all Early Learning Goals with and without Special Educational Needs Support Oxfordshire (2015 to 2017)

The % of pupils registered for Special Educational Needs in Oxfordshire and achieving a good level of development in ELGs remains significantly below other (non-SEN support) pupils.

The gap has increased from 52 percentage points in 2015 to 55pp in 2017.



Source: Department for Education (released Oct2017)

Pupil attainment at Key Stage 2 (aged 10-11)

In 2017 the proportion of pupils in Oxfordshire attaining at least the expected standard at Key Stage 2 in reading writing and mathematics was 61% just below the national average (62% in England).

The proportion of girls in Oxfordshire achieving the standard was similar to the national average. For boys, the proportion was slightly below average.

Table 22 Pupils achieving at least the expected standard at Key Stage 2 (pupils aged 10-11) in reading, writing and mathematics (2016 and 2017)

	2016			2017		
	All	Boys	Girls	All	Boys	Girls
Oxfordshire	52%	47%	56%	61%	57%	66%
ENGLAND (state-funded schools)	54%	50%	58%	62%	58%	66%

Source: ONS National curriculum assessments: key stage 2, 2016 (revised) Dec 2017;

<https://www.gov.uk/government/statistics/national-curriculum-assessments-key-stage-2-2017-revised>

The proportion of Oxfordshire's disadvantaged pupils aged 10-11 achieving the expected standard was below the England average at Key Stage 2 in 2017.

- For pupils with SEN support, the proportion was 17% in Oxfordshire compared with 21% nationally.
- For pupils with a first language other than English, the proportion was 55% in Oxfordshire compared with 61% nationally.
- For pupils eligible for Free School Meals, the proportion was 38% in Oxfordshire compared with 43% nationally.



Data has been updated in this version



Data has been reviewed and is unchanged

Pupil attainment at Key Stage 4 (GCSE)

A new secondary school accountability system was implemented in 2016. The headline accountability measures for schools from 2016 are: Attainment 8, Progress 8, Attainment in English and Maths (A*-C), and English Baccalaureate (EBacc) entry and achievement.

Although this is the second year of reporting against new measures, the data is not fully comparable. The Department for Education advises that..

Users should be cautious when comparing Attainment 8 scores between 2017 and 2016. In 2017, Attainment 8 scores were calculated using slightly different point score scales in comparison to 2016, in order to minimise change following the introduction of 9-1 reformed GCSEs. This means that Attainment 8 scores are likely to look different in 2017, as a result of changes to the methodology.

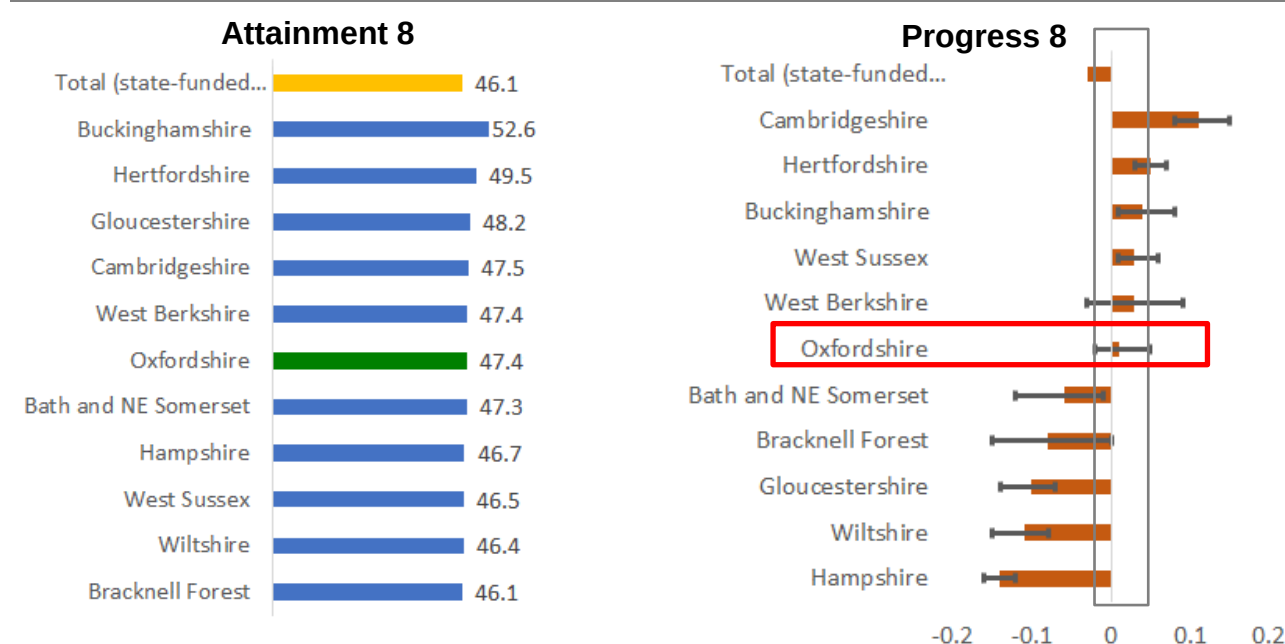
➔ The Attainment 8 score for Oxfordshire in 2016-17 was **47.4**. This was above the average for the state funded sector of 46.1.

The Progress 8 score for Oxfordshire was **0.01** which means that, on average, pupils in the county are making slightly more progress than pupils with the same prior attainment nationally.

Compared with Oxfordshire's statistical neighbour group³⁵, the county was ranked 6 out of 11 on Attainment 8 and 6 out of 11 on Progress 8.

Taking into account the confidence intervals on the Progress 8 measure, Oxfordshire was statistically better than the national average and better than Gloucestershire, Wiltshire and Hampshire. Oxfordshire was statistically worse than Cambridgeshire.

➔ **Figure 38 Attainment 8 and Progress 8 Oxfordshire and Statistical Neighbours (2016-17)**



Source: DfE GCSE and equivalent results: 2016 to 2017 (provisional) last updated 6 Dec 2017

³⁵ Statistical neighbour group – a set of local authorities designated by National Foundation for Educational Research (NFER) on behalf of the DfE as having the most similar socio-economic characteristics.



Data has been updated in this version



Data has been reviewed and is unchanged

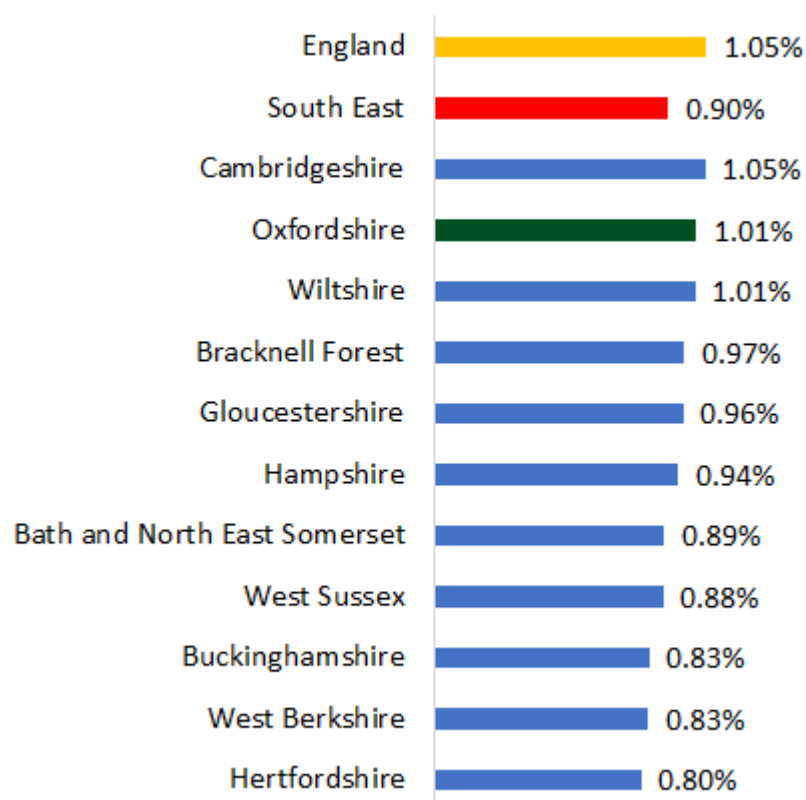
Pupil Absence



Oxfordshire has a relatively high rate of unauthorised absences from school.

- Department for Education data on pupil absence (Autumn 2016 to Spring 2017) shows Oxfordshire as second highest in its group of statistical neighbours on the percentage of unauthorised sessions in primary and secondary state-funded schools.

Figure 39 Unauthorised absence sessions as % of total sessions possible (Autumn 2016 to Spring 2017) state-funded primary and secondary schools



Source: Department for Education published Oct17, SFR55



Data has been updated in this version



Data has been reviewed and is unchanged

16-19 bursary

In 2010 the Education Maintenance Allowance (EMA), for transport and other costs of accessing education (not university), was closed in England and replaced by a 16-19 bursary scheme.

This discretionary bursary is allocated to education institutions which then assess and award varying amounts to any eligible student.

Responding to a data enquiry from Oxfordshire County Council in November 2016, the Education Funding Agency said that it cannot provide the number of students accessing the 16-19 bursary.

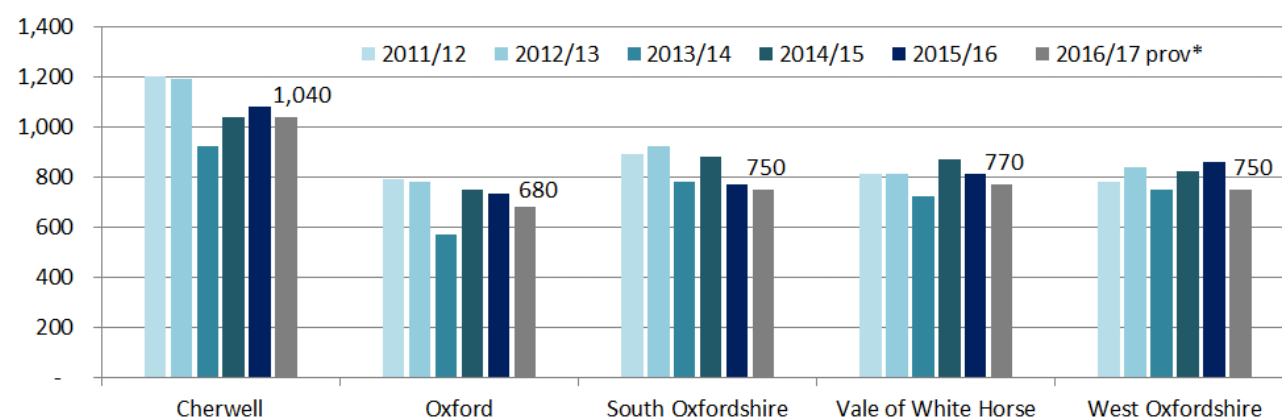
Because of how the scheme is administered it cannot be assumed how many students have been supported by the bursary allocation. We therefore rely on institutions to report numbers accessing support on the ILR. This is not always done and the data is therefore is not reliable.

Apprenticeships

In 2015-16 there was a total of **4,250** apprenticeships started by Oxfordshire residents, the greatest number of which were from Cherwell district (1,040).

Provisional data for 2016-17 appears to show there were **3,970** Oxfordshire resident starts, a decrease of 6.6%. It is thought that this decrease is as a result of the introduction of the employer levy for apprenticeships.

Figure 40 Apprenticeship starts, Oxfordshire and districts, 2011-12 to 2016-17



Source: Oxfordshire Local Enterprise Partnership; All figures are rounded to the nearest 10. *2016/17 data is provisional and may change

The industry sectors with the highest numbers of Oxfordshire resident apprenticeship starts in 2015-16 were Health/Public Services/Care, Retail & Commercial, Business/Admin/Law and Engineering & Manufacturing Technologies. These together accounted for 84% of the total.



Data has been updated in this version



Data has been reviewed and is unchanged

Young people Not in Education, Employment or Training

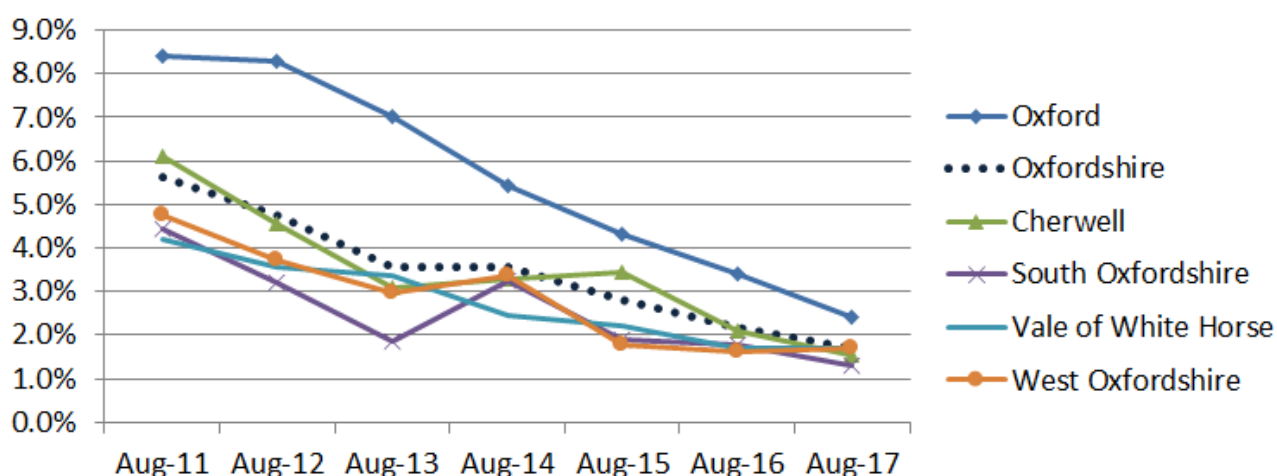
In September 2013, the education leaving age was raised to 17, and from September 2015 it was raised to 18.

It is now compulsory for young people in England between the ages of 16 and 18 to either:

- stay in full-time education, for example at a college;
- start an apprenticeship or traineeship;
- spend 20 hours or more a week working or volunteering, while in part-time education or training.

➔ As of August 2017, in the age range 16 to 19, there was a total of **210** young people in Oxfordshire who were classified as Not in Education, Employment or Training (NEET). This was equivalent to 1.7% of the population of that age group. The district with the highest rate was Oxford with 2.4% young people NEET.

Figure 41 Proportion of young people aged 16-19 who are Not in Education, Employment or Training, districts and county (consistent age range used in each year)



Source: Oxfordshire County Council



Data has been updated in this version



Data has been reviewed and is unchanged

Qualifications

As reported in the previous JSNA (2016)³⁶, Oxfordshire had an above-average proportion of people with higher qualifications and a below-average proportion of people with no qualifications.

- At the time of the 2011 Census survey, 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%).

The **Education and Skills domain** of the Indices of Multiple Deprivation 2015 had **25 areas** within Oxfordshire ranked in the top 10% most deprived nationally.

Table 23 Number of lower super output areas* within the 10% most deprived in England by domain

	Index of Multiple Deprivation (IMD)	Income	Employment	Education Skills and Training	Health and Disability	Crime	Barriers to Housing and Services	Living Environment
Cherwell	0	0	0	8	0	1	16	1
Oxford	2	3	0	10	2	6	3	6
South Oxfordshire	0	0	0	4	0	0	10	0
Vale of White Horse	0	0	0	1	0	0	8	0
West Oxfordshire	0	0	0	2	0	0	2	0
Oxfordshire	2	3	0	25	2	7	39	7

Source: Department for Communities and Local Government IMD2015; *lower super output areas are a statistical geography and have an average of around 1,500 residents and 650 households, LSOAs are the main geography used for the IMD.

³⁶ <http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment>



Data has been updated in this version



Data has been reviewed and is unchanged

4.5 Physical and social environment

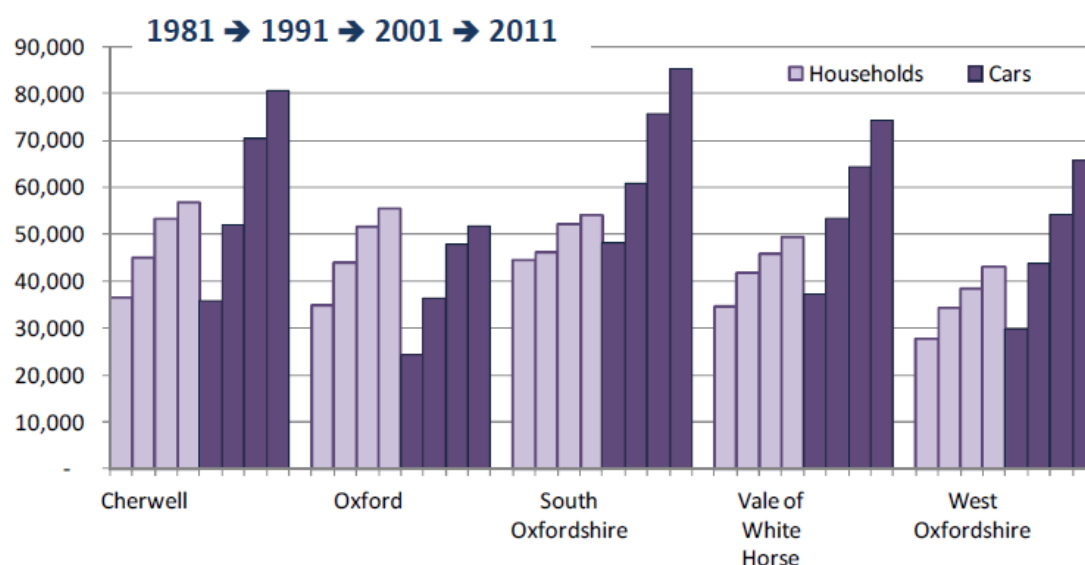
The environment is a major determinant of health. A well-designed physical environment can provide opportunities for:

- **people to be more active** e.g. encouraging walking and cycling as modes of transport, open spaces/green spaces for play and recreation, sports and leisure.
- **healthier food choices** e.g. restricting proximity of hot food takeaways to schools and encouraging healthy food provision in public spaces such as community centres, leisure centres and park kiosks.
- **social interaction** e.g. encouraging social community infrastructure and opportunities for social interaction, reducing social isolation and loneliness.

Car ownership

Between 1981 and 2011 the growth in the number of cars in each of Oxfordshire's districts was well above the growth in households.

Figure 42 Number of households and number of cars by district 1981 to 2011



Source: ONS Census 2011, table KS404, 1981 to 2001 original analysis carried out by Oxfordshire County Council transport planning team, chart from District Data Analysis service www.oxford.gov.uk/districtdata

As of 2011, the number of cars per household in Oxfordshire was 1.38, above the average for the South East (1.35) and England (1.16).

The number of cars per household in Oxfordshire districts was highest in South Oxfordshire (1.58), West Oxfordshire (1.52), Vale of White Horse (1.50) and Cherwell (1.48) and lowest in Oxford (0.93).



Data has been updated in this version



Data has been reviewed and is unchanged

Holders of driving licences

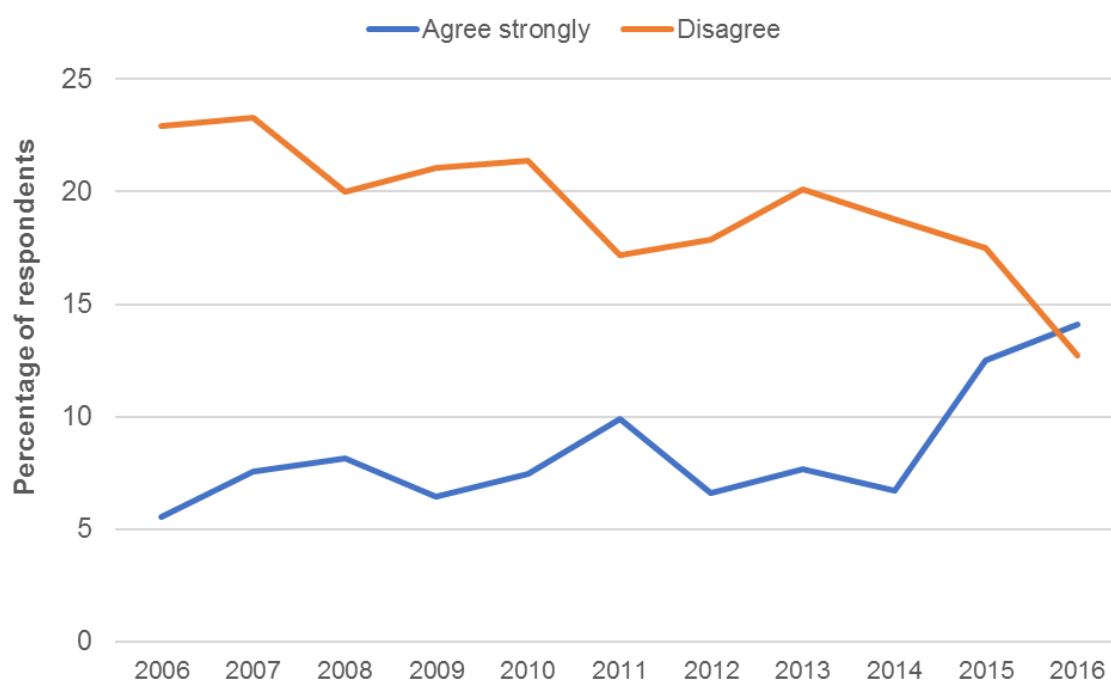
The increasing access to cars is reflected by trends in driving licence holding. 73% of all adults aged 17+ in England held a full car driving licence in 2016³⁷. This was an increase from 48% in the mid-1970s, and represented over 32 million licence holders.

While over the long-term licence holding among both men and women has increased, the rate of increase has been much greater for women. The proportion of males holding a licence has been flat since the early-1990s. For women it has continued to increase, reaching 67% in 2016, compared with 80% of men.

Active travel

 The British Social Attitudes Survey³⁸ measures public attitudes towards transport and has been doing so since 1996. Recent data (2016) shows that there is a strong willingness to walk short journeys less than 2 miles, rather than go by car. This has increased, from 6% in 2006 to 14% in 2016, whilst the proportion disagreeing has fallen from 23% to 13% in the same period.

Figure 43 “Many of the journeys of less than 2 miles that I now make by car I could just as easily walk” - Proportions agreeing and disagreeing



Source: Department for Transport, British Social Attitudes Survey

³⁷ Department for Transport: Driving licence holding and vehicle availability (NTS02)

³⁸ <https://www.gov.uk/government/statistical-data-sets/att03-attitudes-and-behaviour-towards-roads-and-road-travel#table-att0315>



Data has been updated in this version



Data has been reviewed and is unchanged

The same survey looks at perception of cycling danger. In 2016, 59% agreed that “It is too dangerous for me to cycle on the roads”, which is significantly lower than the 64% who agreed in 2015. The perception that roads are too dangerous for cyclists is at its lowest since the question was first asked in 2011.

Walking

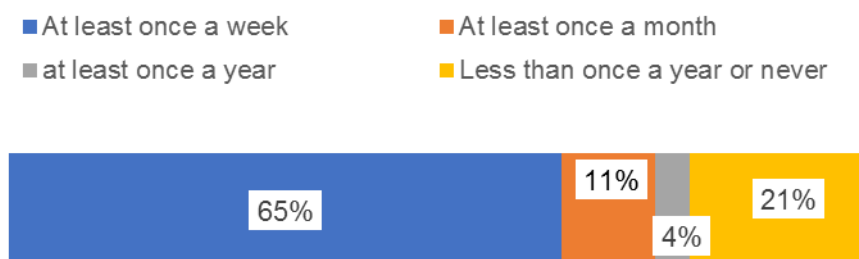


The National Travel Survey (NTS)³⁹ is a household survey of personal travel by residents of England travelling within Great Britain, from data collected via interviews and a one week travel diary. The NTS is part of a continuous survey that began in 1988, following ad-hoc surveys from the 1960s, which enables analysis of patterns and trends. Latest data is for 2016.

The NTS asks people to estimate how often they did a walk of more than 20 minutes. Around 65% of respondents said at least once a week.

Around 21% said less than once a year or never, but this varied by age. For age groups up to 50- 59, less than 20% of respondents gave this answer, compared to 45% of people aged 70 and over.

Figure 44 Walking frequency (walks of 20 minutes or more) 2016



Source: National Travel Survey 2016

The UK Time Use survey⁴⁰ provides an insight into the amount of time children in the UK (aged 8 to 15) spend engaging with the outdoors or participating in sports activities.

On any given day, 46% of children engaged in active travel – walking or cycling. 12% were active in an outdoor location.

³⁹ <https://www.gov.uk/government/statistical-data-sets/nts03-modal-comparisons#table-nts0312>

⁴⁰ United Kingdom Time Use Survey, 2014-2015; <https://www.timeuse.org/node/10833>



Data has been updated in this version



Data has been reviewed and is unchanged

Table 24 Participation rates of children engaging with the outdoors and sports activities in the UK, April 2014 to December 2015

Activity	Daily participation rate (%)	Lower 95% Confidence Interval	Upper 95% Confidence Interval
Sport	32.74	29.60	36.06
Entertainment and culture	9.54	7.69	11.78
Pet care and gardening	12.48	10.60	14.64
All activities	47.19	43.7	50.71
Active travel	46.16	42.93	49.43
All activities including active travel	68.75	65.35	71.97
Outdoor location	12.22	10.05	14.79

Participation rates refer to the proportion of children who took part in an activity as a percentage of all children aged 8 to 15 surveyed on any given day

Notes:

1. Children in this analysis are defined as those aged 8 to 15 years old.
2. Sports and exercise activities (physical or productive exercise) includes outdoor sports activities such as walking, jogging, biking, ball games, swimming, water sports, hunting and fishing, picking berries etc. and other unspecified sports related activities as well as indoor activities such as gymnastics, dance and fitness.
3. Entertainment and culture includes visiting historical, wildlife and botanical sites, leisure parks urban park playgrounds or designated play areas.
4. Pet care and gardening includes gardening, tending domestic animals, caring for pets, walking the dog, and other specified gardening and pet care and gardening/pet care to help other households.
5. Active travel includes travelling on foot and travelling by bicycle.
6. Outdoor location includes parks, countryside, seaside, beach or coast.
7. All activities includes sports and exercise, entertainment and culture and pets and gardening

Walking to school in Oxfordshire

Living Streets, the UK charity for everyday walking, has the ambition “*Every child that can, walks to school*”.

The challenge is a behavioural change programme that incentivises primary school children, their parents and teachers to travel actively all or part of the way to school.

Every day pupils record how they get to school on the WOW Travel Tracker. Children who walk at least once per week for a month are rewarded with themed badges.

In Oxfordshire 18 schools are signed up to take part in the challenge, with good results so far and an increase in active travel rates since September 2017 from 65% to 84% (+19pp).

As of February 2018, there were 4,755 pupils in 18 Oxfordshire schools taking part in the challenge. Between mid-October 2017 and February 2018, trips to school..

- By car reduced by 3%.
- By walking increased over 7%
- By Park & Stride increased by 3%

<https://www.livingstreets.org.uk/>



Data has been updated in this version



Data has been reviewed and is unchanged

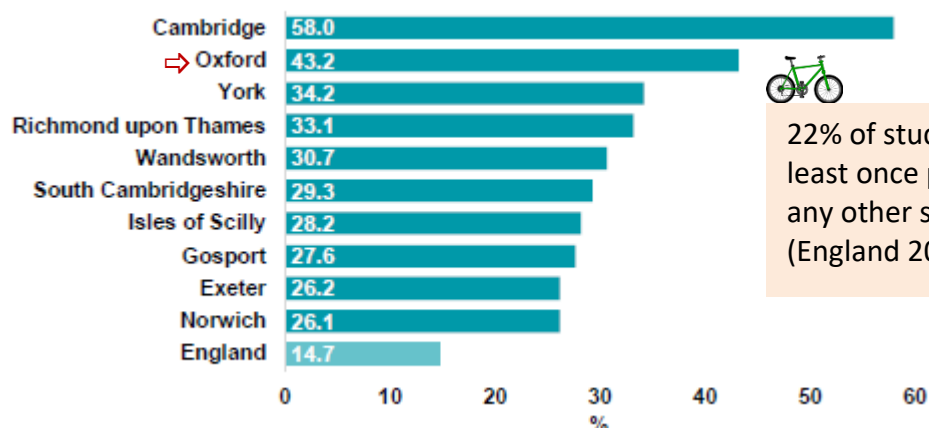
Cycling

Oxford continues to have relatively high rates of cycling, influenced by the higher rate of cycling amongst students.



- In England, the proportion of the adult population who cycled at least once per month has remained at around 15%. In Oxford, the proportion was over double this national rate (43%).

Figure 45 Percentage of adults cycling at least once a month: top 10 local authorities, England, 2014-15



22% of students report cycling at least once per month, more than any other socio-economic group (England 2014-15)

Source: Walking and cycling statistics Dept for Transport from Active People Survey (published July 2016, latest as of Jan18)

Comparing rates of walking and cycling between 2013-14 and 2014-15 shows little change in Oxfordshire's districts.

The exception was West Oxfordshire where there was a statistically significant increase in cycling between 2013-14 and 2014-15. The increase in West Oxfordshire was in people using a cycle for "utility" reasons (anything other than recreational, i.e. including cycling to work) at least once per month.

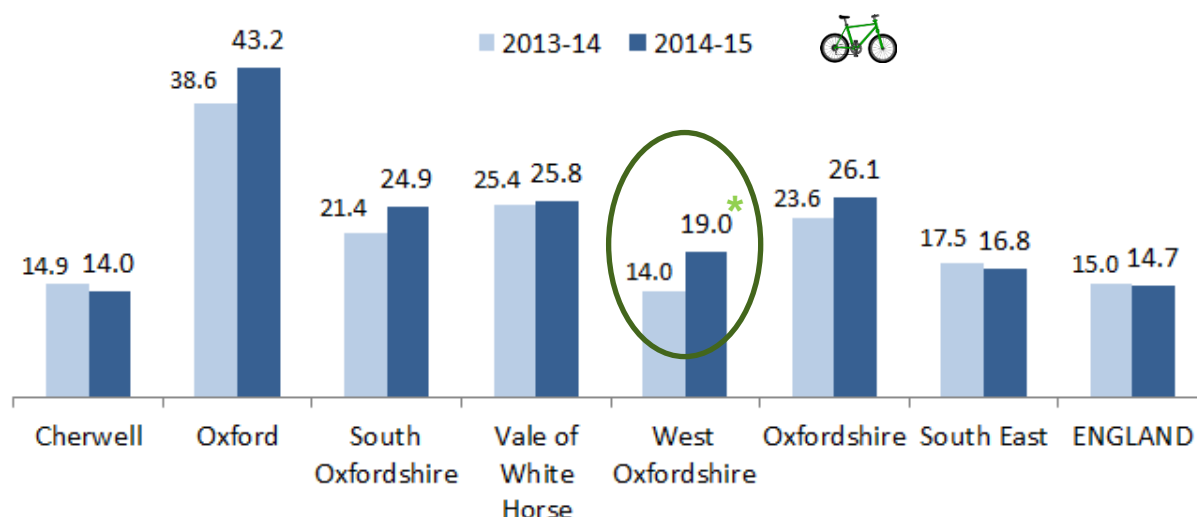


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 46 Any cycling in the last 4 weeks (% of survey respondents)



*statistically significant increase

Source: Walking and cycling statistics Dept for Transport from Active People Survey (published July 2016)

National analysis (England)⁴¹ shows differences between walking and cycling in urban vs rural local authorities:

- Walking and cycling for recreational purposes is more prevalent in rural areas,
- Walking and cycling for utility purposes is more prevalent in urban areas.
- Overall cycling prevalence levels are higher in rural authorities.

Oxfordshire County Council operates 28 automatic counters for monitoring cycling. According to transport monitoring data, between 2015 and 2016⁴², there was:

- A decline in cycle flows (counts) in Abingdon and Witney.
- An increase in cycle flows (counts) in Oxford (Barracks Lane, Parks cycle route) and A40 near Cassington.

⁴¹ Dept for Transport: Local area walking and cycling in England 2014-15
<https://www.gov.uk/government/statistics/local-area-walking-and-cycling-in-england-2014-to-2015>

⁴² <https://www.oxfordshire.gov.uk/cms/content/transport-monitoring>



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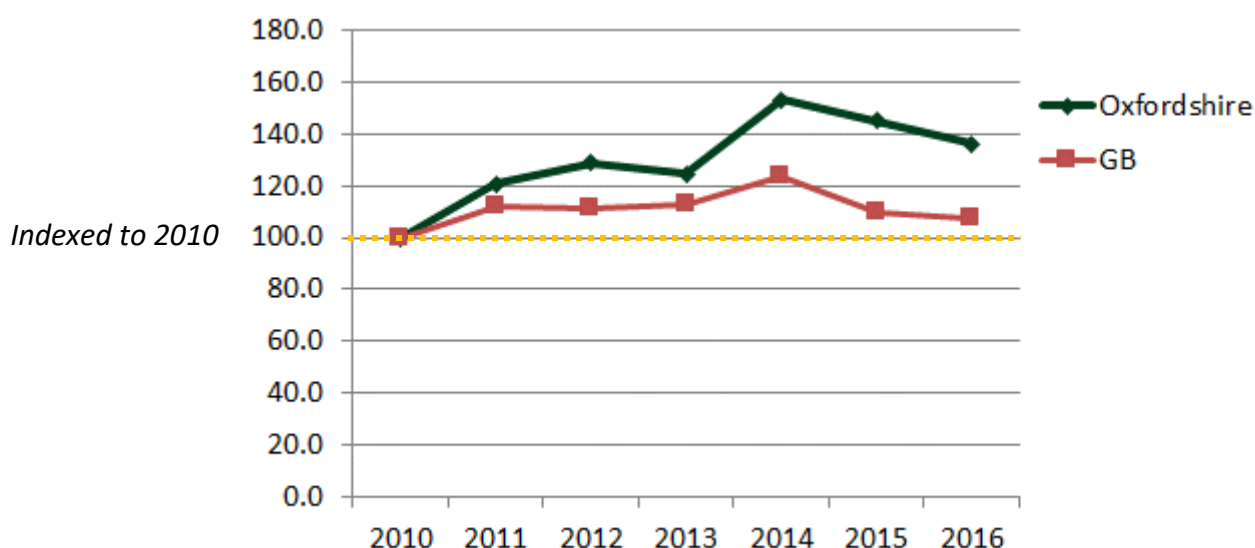
People injured on cycles

The number of people injured using cycles on roads in Oxfordshire has declined for the second year in a row.

In 2016 there was a total of **323** people injured on a pedal cycle (including killed, seriously injured or 'slight' casualties) in Oxfordshire down from 344 in 2015 (-6%).

Of the 323 injuries in 2016, 2 were fatal, 70 were serious and 251 were slight casualties.

Figure 47 Trend in casualties using a pedal cycle, Oxfordshire vs GB



Source: Oxfordshire County Council; GB data from Department for Transport statistics table RAS30004

Green spaces

An October 2016 Parliamentary Office of Science and Technology briefing on Green space and Health⁴³ found that:

- Areas with more accessible green space are associated with better mental and physical health.
- The risk of mortality caused by cardiovascular disease is lower in residential areas that have higher levels of 'greenness'.
- There is evidence that exposure to nature could be used as part of the treatment for some conditions.

⁴³ <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0538>



Data has been updated in this version



Data has been reviewed and is unchanged

Access to healthy food choices

There is limited data about the availability of healthy food choices at a local area. As part of work on obesity, Public Health England has published information on the number of fast food outlets by local authority and ward⁴⁴.

According to this analysis by Public Health England, there was a total of 423 fast food outlets in Oxfordshire of which 56% were in Cherwell and Oxford.

Table 25 Count and rate per 100,000 population of fast food outlets in Oxfordshire (2014)

	Count of outlets	Rate per 100,000 population	% of Oxfordshire outlets total
Cherwell	108	75	26%
Oxford	127	80	30%
South Oxfordshire	73	53	17%
Vale of White Horse	59	47	14%
West Oxfordshire	56	52	13%
Oxfordshire	423	63	100%

Source: Public Health England; rate uses ONS population estimate mid 2014

Banbury town centre (and surrounding retail areas) had more fast food outlets than Oxford city centre. Oxfordshire wards with the highest number of fast food outlets were:

- Banbury Grimsbury and Castle (39)
- Carfax (36)
- Bicester Town (20)
- Didcot South (19)
- Wantage Charlton (16)
- St Mary's, Oxford (15)
- Witney South (14)
- Didcot West (11)
- Henley-on-Thames (10)

Air quality

 Since the UK Clean Air Act's passage in the 1950s, there has been a steady stream of reports and epidemiologic studies that correlate human exposure to air pollutants with a variety of health impacts.

Most recently, such studies have increased significantly, mainly due to improvements of monitoring technology, coupled with scientific advances in modern chemistry and modelling.

In April 2016, the Committee on the Medical Effects of Air Pollutants⁴⁵, responsible for carrying out research into the link between air quality and human health stated that

⁴⁴ <http://www.noo.org.uk/visualisation>

⁴⁵ <https://www.gov.uk/government/collections/comeap-reports#history>



Data has been updated in this version



Data has been reviewed and is unchanged

considered epidemiological evidence was suggestive of an association between long term exposure to particulate pollution and chronic bronchitis. The committee's sensitivity analyses estimated that over 722,000 cases of chronic phlegm in 2010 could be attributable to exposure to particulate pollution (anthropogenic PM10) in the UK, and that a reduction of 1 $\mu\text{g}/\text{m}^3$ of this pollutant in 2010 could have led to over 65,000 fewer cases in 2010.

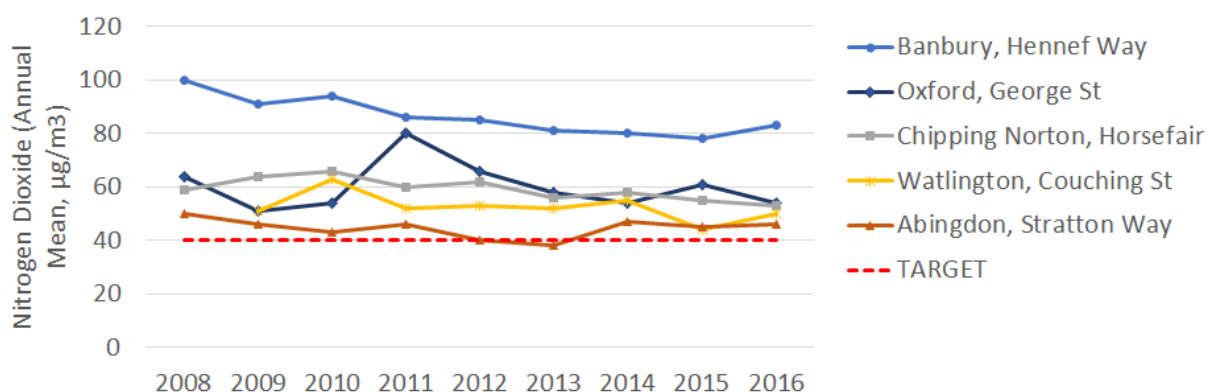
In February 2016, the Royal College of Paediatrics and Child Health published a study⁴⁶ estimating the amount of deaths in the UK attributable to exposure to outdoor air pollution of 40,000/year. In the same study, air pollution was linked to diseases such as cancer, asthma, stroke, heart disease, diabetes, obesity and dementia, and points out that neither the concentration limits set by the governments and the World Health Organization (WHO) define levels of exposure that are entirely safe for the population.

At a more regional level, in 2014 Public Health England estimated the mortality burden attributed to long term fine particulate air pollution exposure in Oxfordshire to be 5.6% of the population, equivalent to 276 deaths (Age 25+) and equivalent to 2,944 life years lost. However, given the uncertainties this could, in fact, be somewhere between 0.9% and 11%.

The Environment Act 1995 states that where national air quality objectives are unlikely to be achieved for a certain area, an **Air Quality Management Area (AQMA)** must be declared and an action plan produced. Oxfordshire has 13 Air Quality Management Areas, where the annual mean objective for nitrogen dioxide is being exceeded⁴⁷: four in Cherwell, one covering the whole of Oxford, three in South Oxfordshire, three in Vale of White Horse and two in West Oxfordshire. These are within the most populated areas of the county, where a direct link can be made between air pollution and emissions from road traffic.

According to diffusion tube data reported by the District Data Analysis Service⁴⁸, nitrogen dioxide levels have shown some improvement since 2008, although remain above the 40 $\mu\text{g}/\text{m}^3$ target, especially in Banbury.

Figure 48 Mean nitrogen dioxide at selected diffusion tubes in Oxfordshire



Source: District Data Analysis service December 2017 chart of the month; diffusion tube reading provided by District Council Environmental Officers. Tubes selected by districts as those with highest readings in 2016

⁴⁶ <https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution>

⁴⁷ Department for Environment, Food and Rural Affairs list of local authorities with AQMAs <https://uk-air.defra.gov.uk/aqma/list>

⁴⁸ http://www.oxford.gov.uk/districtdata/downloads/file/665/chart_of_the_month_-_nitrogen_dioxide



Data has been updated in this version



Data has been reviewed and is unchanged

with the exception of Oxford. The St Clement's tube had a higher reading than George St in 2016 but a long term trend for that location is not available

Noise Pollution

As reported by the 2016 JSNA, 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.

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 night-time.

In 2013/14 the rate of complaints about noise in Oxfordshire was estimated at 5.3 per 1,000 people in the population. 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.

Climate change

The UK Climate Change Risk Assessment 2017⁴⁹ by the Committee on Climate Change⁵⁰, (July 2016) summarises the greatest direct climate change-related threats for the UK as:

- large increases in flood risk
- exposure to high temperatures and heatwaves,
- shortages in water,
- substantial risks to UK wildlife and natural ecosystems,
- risks to domestic and international food production and trade, and
- risks from new and emerging pests and diseases.

A 2012 report from the Health Protection Agency⁵¹ on the health effects of climate change reported that:

- At present, the health burden due to low temperature exceeds that of high temperature. However, heat-related mortality, which is currently around 2,000 premature deaths per year, is projected to increase steeply in the UK throughout the 21st century.
- Southern, central and eastern England appear to be most vulnerable to current and future effects of hot weather compared with other UK regions. Cold is still likely to contribute to the majority of temperature related health effects over the coming decades, although the health burden due to the cold is projected to decline by the 2080s compared with the present-day levels.
- The elderly are more vulnerable to extreme heat and cold than younger people, so **future health burdens are likely to be amplified by an ageing population.**

⁴⁹ <https://www.theccc.org.uk/tackling-climate-change/preparing-for-climate-change/climate-change-risk-assessment-2017/>

⁵⁰ The Committee on Climate Change (CCC) is an independent statutory body established under the Climate Change Act 2008 to advise the UK and devolved administration governments on setting and meeting carbon budgets, and preparing for climate change.

⁵¹ Health effects of climate change in the UK 2012 <https://www.gov.uk/government/publications/climate-change-health-effects-in-the-uk>



Data has been updated in this version



Data has been reviewed and is unchanged

The Health Protection Agency report considered:

- ozone-related mortality, air pollution;
- aeroallergens associated with pollen grains and fungal spores;
- building overheating, indoor air pollution, flood damage and water and biological contamination of buildings;
- levels of Ultraviolet (UV) radiation;
- health implications of flooding, particularly impacts on mental health and impacts from disruption to critical supplies of utilities;
- range, activity and vector potential of ticks and mosquitoes (expected to increase across the UK by the 2080s). The potential for introduction of exotic species and pathogens;
- water and food-borne diseases;
- health co-benefits of measures to reduce greenhouse gas emissions (e.g. increased physical activity as a result of reduced car use in urban centres).

A recent report by the UK Health Alliance⁵² sets out the challenges and opportunities from climate change. Opportunities include the **co-benefits of emission reduction activities** leading to healthier lifestyles (more walking/ cycling, insulating homes and others).

It is likely that the weather patterns in Oxfordshire will change in coming decades. As reported in “Oxfordshire in a changing climate” (Oxfordshire County Council, updated January 2016):

- The widespread flooding in winter 2014 and winter 2012, show the county’s vulnerability to severe weather.
- Climate models indicate that severe weather events could become more frequent in Oxfordshire in the future with:
 - **More heavy rainfall** - more days with heavy rainfall of 25mm (1 inch) or more, particularly in winter.
 - **More frequent heatwaves** - average temperatures likely to increase by between 2.5 and 8.0 °C by the 2080s. Heat waves likely at least once in every three years by 2050s.

⁵² A Breath of Fresh Air: Addressing Climate Change and Air Pollution Together for Health 2016
<http://www.ukhealthalliance.org/new-report-breath-fresh-air-addressing-climate-change-air-pollution-together-health/>



Data has been updated in this version



Data has been reviewed and is unchanged

Isolation and loneliness

Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services.

- Loneliness can be as harmful for our health as smoking 15 cigarettes a day⁵³.
- Lonely individuals more likely to visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term health care⁵⁴.

In 2015, Age UK carried out a study to predict risk of loneliness at a local area level by applying findings from the English Longitudinal Study of Ageing (wave 5) to local demographic and social statistics.

The factors which were more associated with a higher prevalence of loneliness were:

- Health
 - The poorer the self-reported health, the more likely the respondent feels lonely.
 - Having difficulty with one or more activities of daily living is positively associated with the prevalence of loneliness
- Household type:
 - Being single, divorced or separated and widowhood are associated with a higher prevalence of loneliness compared to being married.
 - Household size is inversely related with prevalence of loneliness (the more people in the household the less like the respondent feels lonely).

Areas rated as “High risk” for isolation and loneliness in Oxfordshire were mainly found in Oxford and the urban centres of Banbury, Bicester, Kidlington, Didcot, Henley, Thame, Wallingford, Abingdon, Faringdon, Wantage and Grove, Chipping Norton and Witney.

⁵³ Social relationships and mortality risk: a meta-analytic review. Holt-Lunstad J, Smith TB, Layton JB. PLoS Med 2010;7(7)

⁵⁴ Cohen, G.D. et al. 2006 'The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults' The Gerontologist 46 (6)
<http://gerontologist.oxfordjournals.org/content/46/6/726>



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Data has been reviewed and is unchanged

5 Health Conditions and Causes of Death

This chapter 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 Key findings – Health Conditions and Causes of Death

This section highlights the key messages from the review of data on Health Conditions and Causes of Death (data sources and research references are provided with the detailed data in the remainder of this chapter).

Health profile - overall

- The Public Health England local health profile for Oxfordshire shows that, for the majority of indicators, Oxfordshire is statistically better than the national average.
- Indicators at county level where Oxfordshire is worse than average are: hospital admission episodes for alcohol-specific conditions in under 18s; killed and seriously injured on roads.

Leading causes of death

- Cancer was the leading cause of death in Oxfordshire (for the combined years 2014, 2015 and 2016), accounting for 28% of deaths of males and 23% of deaths of females.
- The second highest cause was:
 - Males: Heart diseases (affecting the supply of blood to the heart), 13% of deaths.
 - Females: Dementia and Alzheimer disease, 17% of deaths.
- For the 3-year period, 2014 to 2016, total deaths of people aged under 75 from the four causes of: cardiovascular diseases, cancer, liver disease and respiratory disease in Oxfordshire was 3,396.
- Of these **1,959** (58%) were considered preventable.

Health conditions

- From the Quality and Outcomes Framework data, the health conditions with the greatest number of GP-registered patients in Oxfordshire were:
 - Hypertension (high blood pressure): 89,900 patients
 - Depression: 56,800 patients
 - Asthma: 42,200 patients
 - Diabetes: 29,500 patients

Mental Health

- In Oxfordshire, the average wellbeing scores for: life satisfaction, “things you do are worthwhile” and happiness, are slightly lower in 2016-17 compared with 2015-16 and the anxiety mean is higher.
- The number and rate of GP-registered patients in Oxfordshire with depression or anxiety has increased significantly each year for the past 4 years.



Data has been updated in this version



Data has been reviewed and is unchanged

- Between 2015-16 and 2016-17, the number of GP-registered patients with diagnosed depression in the Oxfordshire CCG group area increased by around 7,100 or **+14%**.
- The percentage of GP-registered patients with a recorded diagnosis of a severe and enduring mental health problem has increased in all districts since 2006-07. The rate in Oxford City remains well above the average for NHS Oxfordshire CCG.
- Rates of intentional self-harm in Oxfordshire are now statistically above the England average.
- There were 15 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2011-12 to 2015-16), these included 7 in Oxford, 3 in Cherwell, 3 in Vale of White Horse, 1 in South Oxfordshire, and 1 in West Oxfordshire.
- The two wards with the highest rates were the relatively deprived areas of Northfield Brook and Blackbird Leys in Oxford.
- There were 23 suicides of people aged under 25 in the Oxfordshire Clinical Commissioning Group area in 2014-16. The OCCG rate of 5.7 (age standardised) was statistically above the England average (4.7).

Cancer

- The proportion of GP-registered patients with a cancer diagnosis in Oxfordshire has remained above the national average.
- Preventable deaths (preventable mortality) from cancer in Oxfordshire remains better than the England and South East averages.
- Between 2013 and 2016, age-standardised mortality rates for cancer in Oxfordshire remained at a broadly similar level.
- The cancer mortality rate for females in Cherwell increased to just above the national average.
- For both males and females, rates of lung cancer deaths in Oxfordshire in 2016 were well below the England average.
- Rates of bowel cancer deaths were above average in Oxfordshire in 2016 for both males and females.
- There were 4 wards in Oxfordshire with a significantly higher mortality ratio for cancers than England (2011-15). As in the previous dataset (2010-14), the ward with the highest rate was Banbury Ruscombe in Cherwell district.

Heart Disease

- The proportion of GP-registered patients in the Oxfordshire CCG with heart disease has remained below the regional and national averages.



Data has been updated in this version



Data has been reviewed and is unchanged

- There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for coronary heart disease than England (2011-12 to 2015-16): Banbury Ruscott in Cherwell and Northfield Brook in Oxford.
- Mortality due to heart disease has declined nationally and in every district in Oxfordshire except for South and West Oxfordshire where male mortality due to heart disease increased slightly between 2015 and 2016.

Stroke

- The proportion of GP-registered patients in the Oxfordshire CCG with stroke has remained below the regional and national averages.
- Between 2015 and 2016, the age-standardised mortality rate for cerebrovascular diseases (stroke) increased in males in Oxfordshire, against the declining national and regional trend.
- The rates by district show stroke in females in Oxford and males in Vale of White Horse each above average in 2016.

Dementia and Alzheimer's disease

- The proportion of GP-registered patients in the Oxfordshire CCG with Dementia and Alzheimer's disease has remained just below the national average (and well below the South of England average).
- In West Oxfordshire, the age-standardised mortality rate for females due to Dementia and Alzheimer's disease increased in 2014, 2015 and again in 2016 to well above the national and regional averages.
- The mortality rate for females due to Dementia and Alzheimer's disease was above the national average in Cherwell in 2015 and 2016.

Diabetes

- The number of GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of diabetes has increased slightly, the proportion remains well below the national and regional averages.
- National survey data (HSE 2015) shows the prevalence of diabetes is higher for men than women and significantly higher in those who are overweight or obese.

Hypertension (high blood pressure)

- The number and proportion of GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of Hypertension has increased slightly, remaining below the national and regional averages.
- National survey data (HSE 2015) shows the prevalence of Hypertension is higher for men than women and significantly higher in those who are overweight or obese.

Musculoskeletal disorders (Knee and Back pain)

- Using the Public Health England tool prevalence estimates and the most recent population data (ONS 2016) gives an estimate for Oxfordshire of:
 - 49,600 people aged 45 and over with lower back pain
 - 50,200 people aged 45 and over with chronic knee pain



Data has been updated in this version



Data has been reviewed and is unchanged

- Work-related musculoskeletal disorders account for 35% of all working days lost due to work-related ill health.
- *Human health and social work activities* is one of the four industries with significantly higher rates of WRMSDs when compared with the rates for all industries.



Data has been updated in this version



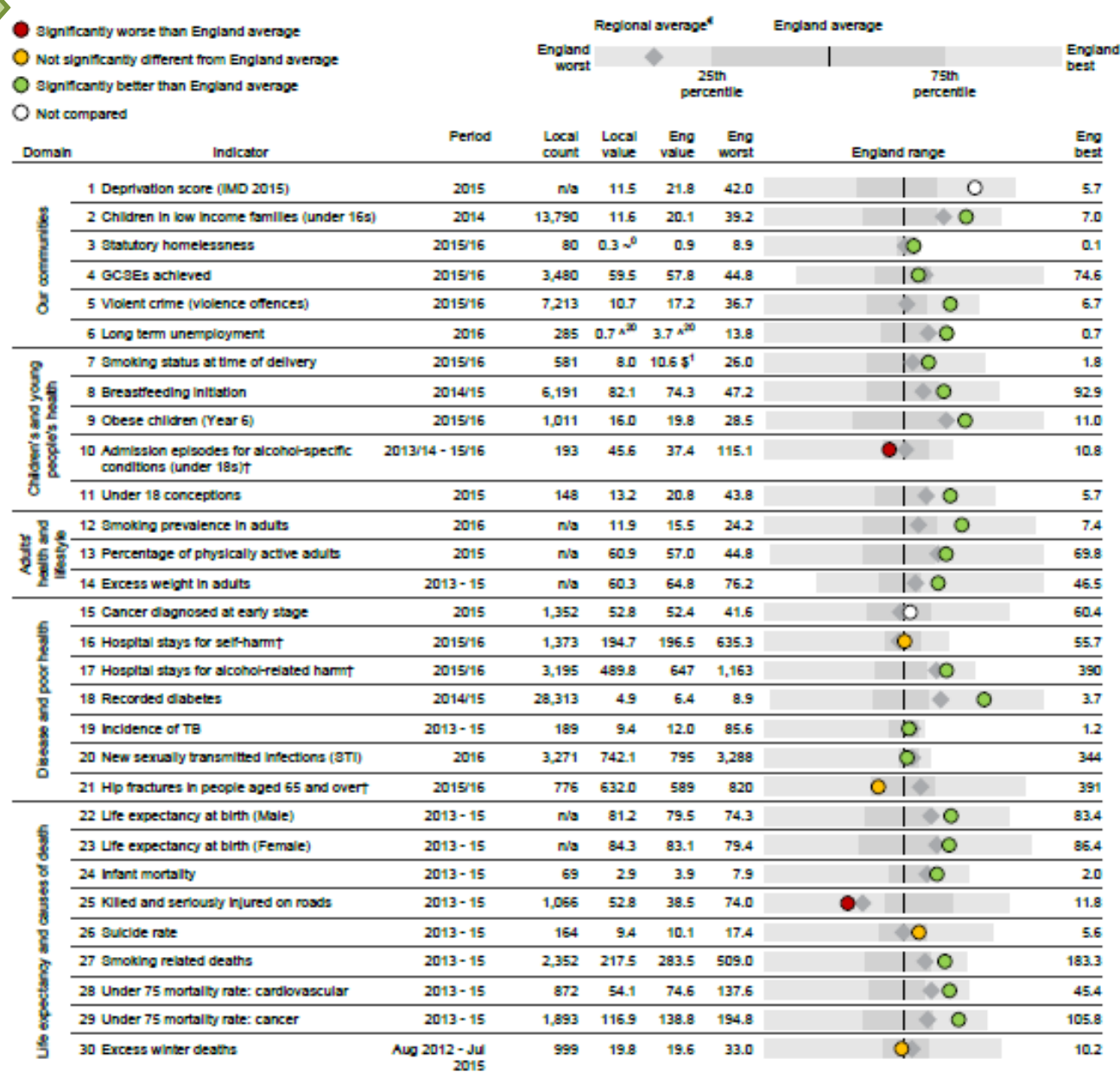
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5.2 Oxfordshire Health Profile

The Public Health England local health profile for Oxfordshire shows that, for the majority of indicators, Oxfordshire is statistically better than the national average.

Indicators at county level where Oxfordshire is worse than average are: hospital admission episodes for alcohol-specific conditions in under 18s; killed and seriously injured on roads.

Figure 49 Oxfordshire Public Health profile 2017



Source: Public Health England fingertips (profile last updated 2017)



Data has been updated in this version



Data has been reviewed and is unchanged

5.3 Causes of death

There were **5,435** deaths registered in Oxfordshire in 2016⁵⁵(calendar year), a slight increase on 2015 (5,299). There were slightly more deaths in females (2,797) than males (2,638).

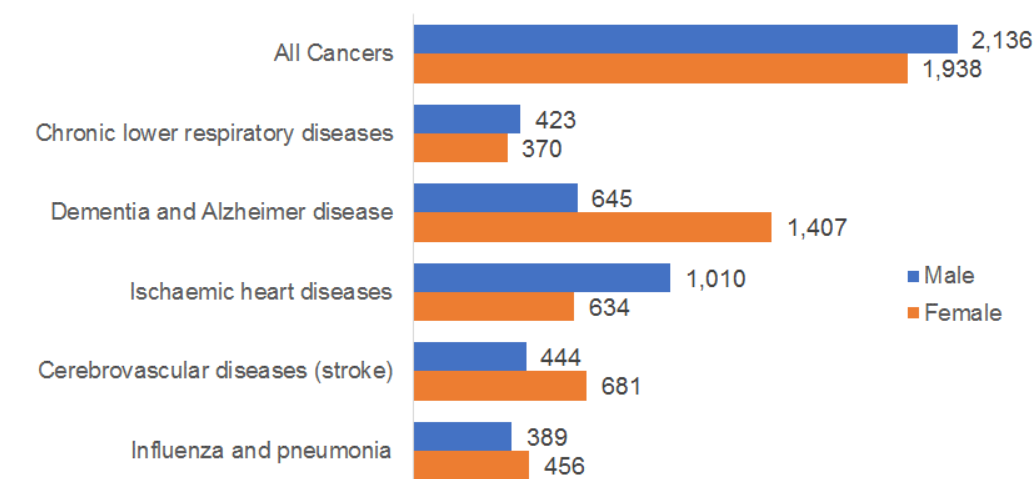
Leading causes of death

Cancer continues to be the leading cause of death in Oxfordshire (for the combined years 2014, 2015 and 2016), accounting for 28% of deaths in males and 23% of deaths in females.

The second highest cause was:

- Males: Heart disease (affecting the supply of blood to the heart), 13% of deaths.
- Females: Dementia and Alzheimer disease, 17% of deaths.

Figure 50 Leading causes of death in Oxfordshire by gender (2014-2016)



Source: ONS from nomis

Some wards in Oxfordshire had significantly higher standardised mortality ratios (SMRs) than the England average (see Annex: Health Inequalities Basket of Indicators).

⁵⁵ ONS (released July 2017)

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathregistrationssummarytablesenglandandwalesreferencetables>



Data has been updated in this version



Data has been reviewed and is unchanged

Preventable mortality

The basic concept of **preventable mortality** is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.

Preventable mortality overlaps with, but is not the same as 'amenable' mortality, which includes causes of deaths which could potentially be avoided through good quality healthcare.

Preventable mortality and amenable mortality are the two components of 'avoidable' mortality, as defined by the Office for National Statistics in April 2012.

The inclusion of this indicator (alongside an indicator on mortality from causes amenable to healthcare in the NHS Outcomes Framework) sends out a clear signal of the importance of prevention as well as treatment in reducing avoidable deaths.

Public Health

England

➔ For the 3-year period, 2014 to 2016, total deaths of people aged under 75 from the four causes of: cardiovascular diseases, cancer, liver disease and respiratory disease in Oxfordshire was 3,396 of which 1,959 (58%) were considered preventable.

There was a gender difference, with 59% of male deaths under 75 from these causes considered preventable and 56% of female deaths under 75.

The highest cause of preventable deaths for people aged under 75 was cancer in Oxfordshire with just over 1,000 deaths from 2014 to 2016.

➔ **Table 26 Deaths under the age of 75 from four causes considered preventable, Oxfordshire (3 years, 2014 to 2016)**

Deaths aged under 75 by cause	All deaths aged under 75			Considered preventable		
	Males	Females	Total	Males	Females	Total
Cardiovascular diseases	595	260	855	410	122	532
Cancer	1,005	899	1,904	514	506	1,020
Liver disease	150	82	232	127	63	190
Respiratory disease	243	162	405	122	95	217
Total of these four diseases	1,993	1,403	3,396	1,173	786	1,959
% of total considered preventable				59%	56%	58%

Source: Public Health England Outcomes Framework (Healthcare and Premature Mortality)

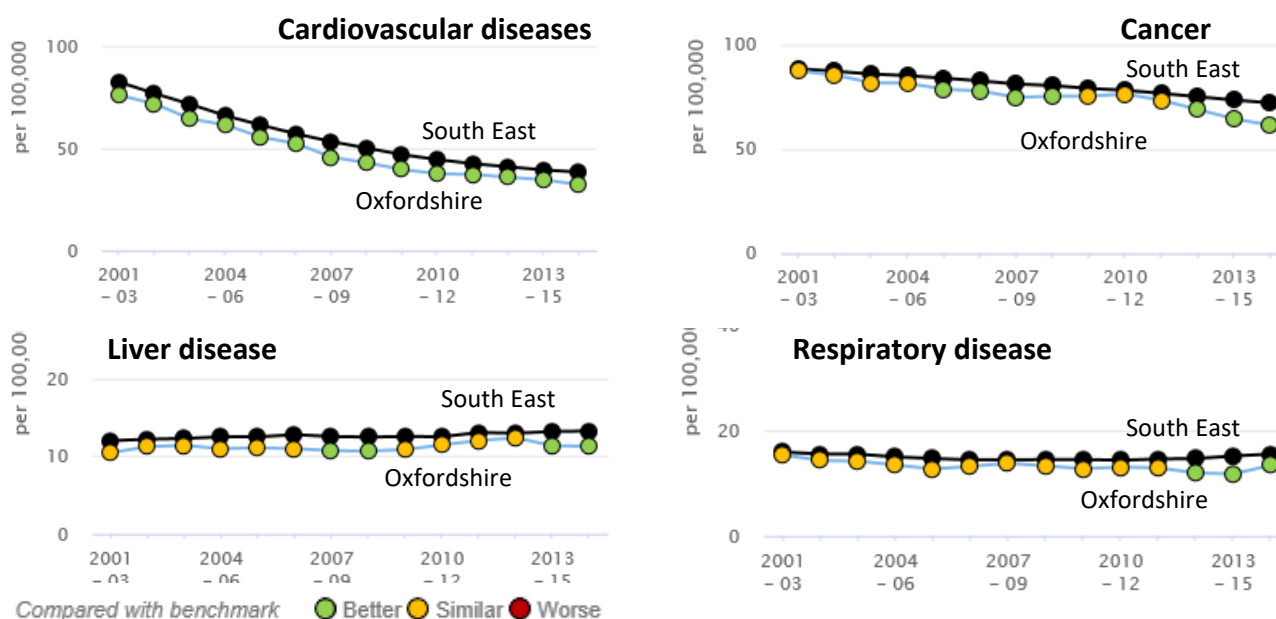


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 51 Trend in preventable mortality (aged under 75) by leading causes, Oxfordshire vs South East region; 2001-03 to 2014-16



Source: Public Health England Outcomes Framework, charts from fingertips.phe.org.uk

Excess winter deaths

About Excess winter deaths

The number of excess winter deaths is a statistical measure of the increase in mortality during winter and is not the number of people who died directly as a result of cold weather.

The ONS standard method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in 2 non-winter periods; the preceding August to November and the following April to July.

The EWM index is calculated so that comparisons can be made between sexes, age groups and regions, and is calculated as the number of excess winter deaths divided by the average non-winter deaths, expressed as a percentage.

ONS Excess winter mortality methodology

There has been a change in the number of Excess Winter Deaths in Oxfordshire from 1,034 in 2010-13 to 899 in 2013-16. The chart below shows the trend in the EWM Index since 2001-04 within upper and lower confidence limits. The latest data (2013-16) shows a similar EWM Index to England (17.8).

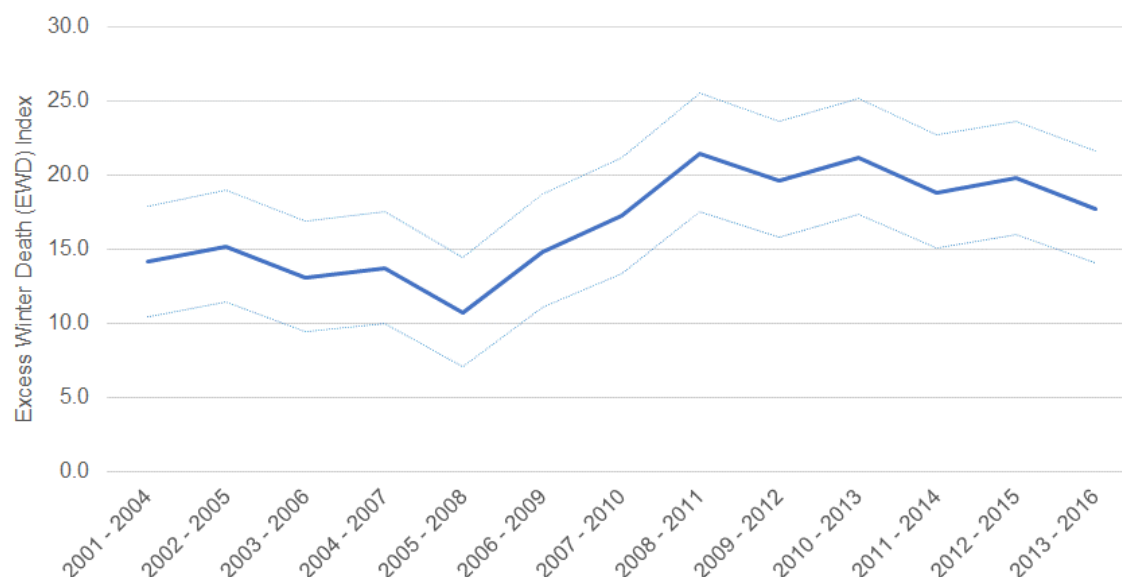


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Data has been reviewed and is unchanged

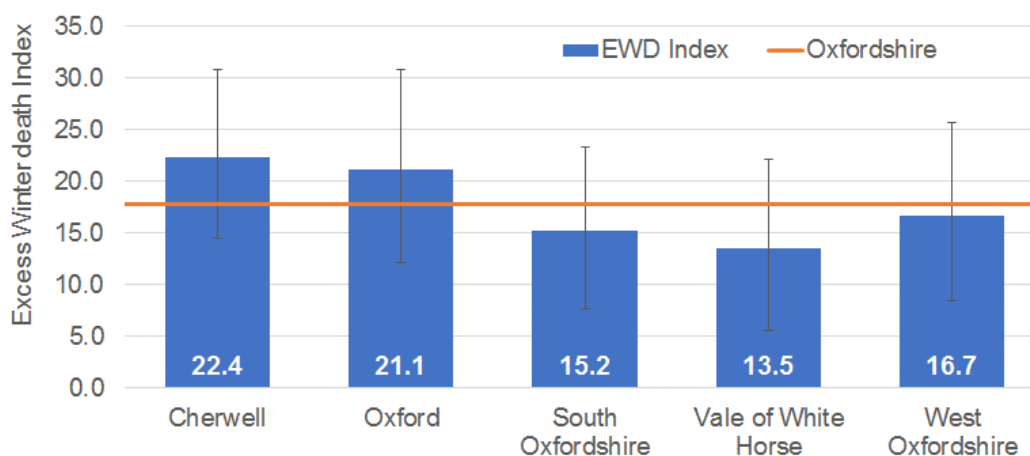
Figure 52 Excess Winter Mortality Index (3-years combined) – trended data for Oxfordshire 2001-2004 to 2013-2016



Source: Public Health Outcomes Framework

➔ At a district level data fluctuates more widely. Cherwell district had the highest number of excess winter deaths (255) and the highest EWM Index (22.4). Cherwell and Oxford City have a higher EWM Index than Oxfordshire overall, but neither are significantly higher. Similarly, other districts have a lower EWM Index than Oxfordshire overall but none are significantly lower.

Figure 53 Excess Winter Mortality Index – districts in Oxfordshire – 2013-2016 (3 years combined)



Source: Public Health Outcomes Framework



Data has been updated in this version



Data has been reviewed and is unchanged

Road casualties

➔ There was a total of 2,061 police-reported road casualties in Oxfordshire in 2016 of which 358 were more serious “killed or seriously injured” (KSI). This was a decline of 4% on the number in 2015 (2,146 in total including 361 KSI)⁵⁶.

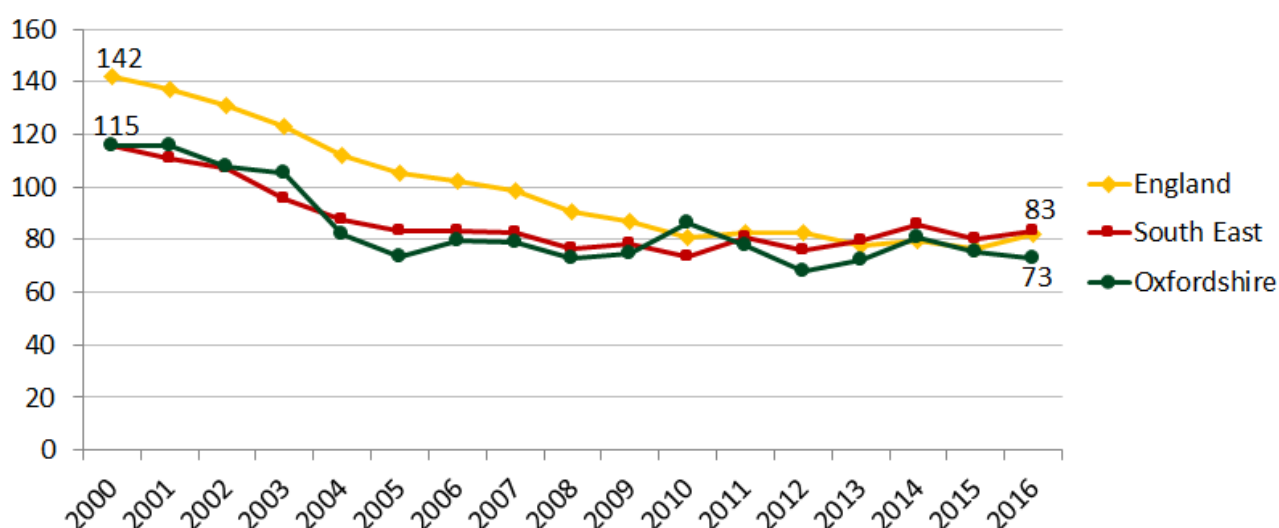
Per head of population

➔ According to the Public Health England road casualties indicator⁵⁷, Oxfordshire continues to have a significantly higher rate of people killed or seriously injured per head of population (53.9 in 2014-16) than in the South East (50.6) and England overall (39.7). All districts, except for Oxford, had rates exceeding the national average. The highest was Cherwell with 62.3.

Per billion vehicle miles

Between 2000 and 2009, the rate of people killed or seriously injured per billion vehicle miles in Oxfordshire was below the national average. Since 2010 it has been closer to the national average. As of 2016 the rate in Oxfordshire was 73 compared with 83 in the South East and 82 in England.

➔ **Figure 54 Rate of Killed and Seriously Injured per billion vehicle miles**



Source: Oxfordshire County Council (KSI=Killed or Seriously Injured)

In 2016 the split of all casualties by vehicle type in Oxfordshire was 65% car, 17% pedal cycle, 10% motorcycle and 8% pedestrian.

Indexing the number of casualties to the count in 2000 shows that pedal cycle casualties are now just below the number in 2000 but still above the low point in 2010.

⁵⁶ Source: Oxfordshire County Council

⁵⁷ Source: Public Health England Outcomes Framework, Killed and Seriously Injured Casualties on Roads, crude rate per 100,000



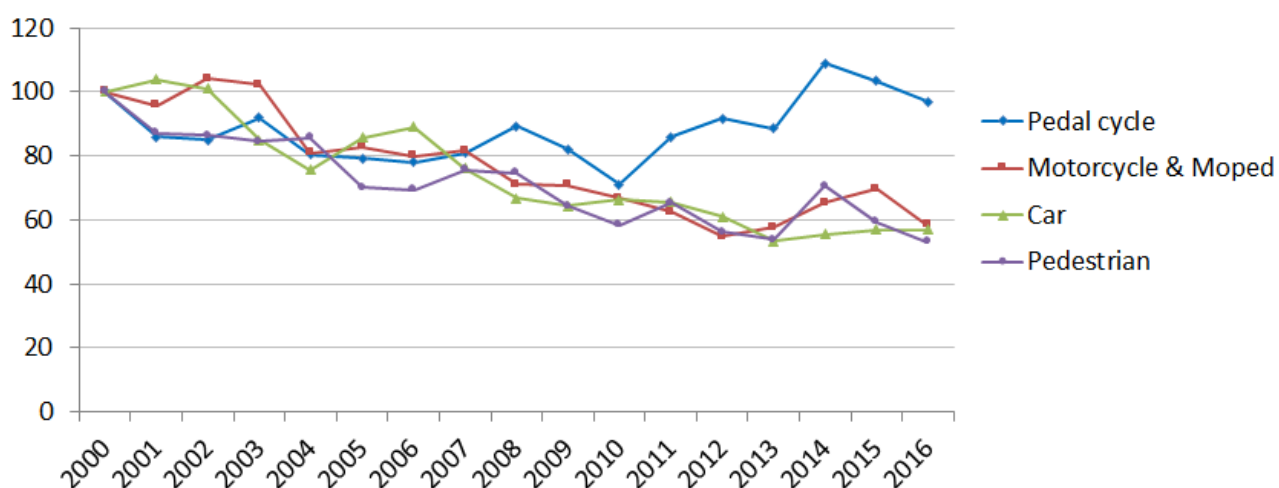
Data has been updated in this version



Data has been reviewed and is unchanged



Figure 55 Road casualties in Oxfordshire by vehicle type (indexed to yr 2000)



Source: Oxfordshire County Council

A full 2016 report on road accident statistics is available from
<https://www.oxfordshire.gov.uk/cms/content/road-casualties>



Data has been updated in this version



Data has been reviewed and is unchanged

5.4 Health conditions

The Quality and Outcomes framework provides a count of GP-registered patients by health condition.

 The following table shows the change between 2015-16 and 2016-17 for the NHS Oxfordshire Clinical Commissioning Group (CCG) area and **highlights** conditions that were above the England average in the most recent year of data - cardiovascular disease, cancer, depression and osteoporosis.

Table 27 Change in prevalence of health conditions recorded by GPs (Quality and Outcomes Framework) for Oxfordshire CCG, 2015-16 to 2016-17

	2015-16		2016-17			
	Count	Rate	Count	Rate	pp change	Eng average rate
Cardiovascular group						
Atrial fibrillation	11,615	1.66	13,237	1.81	+0.15	1.84
Cardiovascular disease	4,392	1.15	4,724	1.19	+0.03	1.17
Coronary heart disease	17,422	2.50	17,768	2.43	-0.06	3.15
Heart failure	4,468	0.64	4,767	0.65	+0.01	0.79
Hypertension	85,799	12.29	89,883	12.31	+0.02	13.83
Peripheral arterial disease	3,585	0.51	3,661	0.5	-0.01	0.6
Stroke and transient ischaemic attack	11,759	1.68	12,477	1.71	+0.02	1.75
Respiratory group						
Asthma	40,087	5.74	42,213	5.78	+0.04	5.94
Chronic obstructive pulmonary disease	9,381	1.34	9,897	1.36	+0.01	1.87
Lifestyle group						
Obesity	42,042	7.52	45,905	7.85	+0.33	9.65
High dependency and other long term conditions group						
Cancer	19,076	2.73	21,222	2.91	+0.17	2.58
Chronic kidney disease	19,512	3.49	19,906	3.4	-0.09	4.09
Diabetes mellitus	27,925	4.92	29,469	4.97	+0.04	6.67
Palliative care	1,828	0.26	1,851	0.25	-0.01	0.37



Data has been updated in this version



Data has been reviewed and is unchanged

	2015-16		2016-17			
	Count	Rate	Count	Rate	pp change	Eng average rate
Mental health and neurology group						
Dementia	5,176	0.74	5,461	0.75	+0.01	0.76
Depression	49,662	8.88	56,795	9.71	+0.83	9.09
Epilepsy	3,953	0.71	4,131	0.71	0.00	0.8
Learning disabilities	2,551	0.37	2,713	0.37	+0.01	0.47
Mental health	5,692	0.82	6,093	0.83	+0.02	0.92
Musculoskeletal group						
Osteoporosis	1,519	0.62	2,056	0.81	+0.18	0.47
Rheumatoid arthritis	3,580	0.62	3,790	0.63	+0.01	0.74

Source: NHS Digital Quality Outcomes Framework <http://digital.nhs.uk/catalogue/PUB30124>

 From the Quality and Outcomes Framework data, the health conditions with the greatest number of GP-registered patients in Oxfordshire were:

- Hypertension (high blood pressure): 89,900 patients
- Depression: 56,800 patients
- Asthma: 42,200 patients
- Diabetes: 29,500 patients

 The four health conditions in Oxfordshire that were above the England average in 2015-16 have remained above average in 2016-17 and are:

- Cardiovascular disease: 1.19% vs 1.17%
- Cancer: 2.91% vs 2.58%
- Depression: 9.71% vs 9.09%
- Osteoporosis: 0.81% vs 0.47%



Data has been updated in this version



Data has been reviewed and is unchanged

About the Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.

The three QOF domains are: Clinical; Public Health and Public Health – Additional Services. Each domain consists of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement. The 2015-16 QOF measured achievement against 77 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 559 points.

- clinical: the domain consists of 65 indicators across 19 clinical areas (e.g. chronic kidney disease, heart failure, hypertension) worth up to a maximum of 435 points.
- public health: the domain consists of seven indicators (worth up to 97 points) across four clinical areas – blood pressure, cardiovascular disease – primary prevention, obesity 18+ and smoking 15+.
- public health – additional services: the domain consists of five indicators (worth up to 27 points) across two service areas – cervical screening and contraception.

The QOF gives an indication of the overall achievement of a surgery through a points system. Practices aim to deliver high quality care across a range of areas for which they score points. The higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of surgery workload, local demographics and the prevalence of chronic conditions in the practice's local area.

Caveats (relating to QOF indicators for Oxfordshire used in this report)

GP practices were mapped to the districts based on the postcode of the practice. Data prior to 2012-13 relate to patients registered with a GP in Oxfordshire PCT and did not include patients living in Oxfordshire who were registered with a Thame or Shrivenham GP as these practices fell outside the PCT boundary. Whilst this may remain the case for some patients, one GP practice in Thame (Rycote practice) is now included for NHS Oxfordshire Clinical Commissioning Group.

Caution should be exercised when interpreting the data because the denominator includes people of all ages registered with the GP practices. Percentages are a crude proportion and not adjusted for factors such as age, sex and ethnicity. In addition, it does not include people who are awaiting a diagnosis or do not visit their GP.

There may be some variability between practices in the completeness and quality of recording as practices do not need to achieve 100% coverage to gain Quality Outcome Framework (QOF) points. Some large increases in prevalence may be due to better recording within practices rather than a true increase in prevalence.

Percentages presented here are not necessarily a true prevalence as the objective of QOF registers is to improve quality of care. Confidence intervals were calculated locally using numerators and denominators given.

Source of QOF charts and notes: Public Health, Oxfordshire County Council

<http://qof.digital.nhs.uk/>



Data has been updated in this version



Data has been reviewed and is unchanged

5.5 Mental health

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

As reported in the evidence-base report by the Mental Health Foundation and the Faculty of Public Health⁵⁸

Public mental health is fundamental to public health in general because mental health is a determinant and consequence of physical health as well as a resource for living.

As reported in **Better Mental Health For All** - A public health approach to mental health improvement⁵⁹..

The Sustainable Development Commission commented that **self-care is a more sustainable approach to health service delivery** and observed that as well as empowering people to be in charge of their own health care, it reduces health inequalities.

Adult wellbeing

The Office for National Statistics has been surveying general adult wellbeing since 2011-12.

About the ONS wellbeing indicators

Every year since 2011, the ONS has asked a sample of UK adults aged 16 to answer 4 personal wellbeing questions:

- 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?

People are asked to respond on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely”. From 2016, personal well-being data will be included within the main Annual Population Survey (APS) dataset available on www.nomisweb.co.uk rather than being released as a separate dataset.

<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/measuringnationalwellbeingdomainsandmeasures>

 Releasing the wellbeing data for April 2016 to March 2017⁶⁰, ONS commented..

It's worth noting that employment rates rose during the period covered by this report, and other ONS analysis showed people perceiving an improvement in their own

⁵⁸ <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

 ⁵⁹ Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

⁶⁰ ONS Personal well-being in the UK: April 2016 to March 2017



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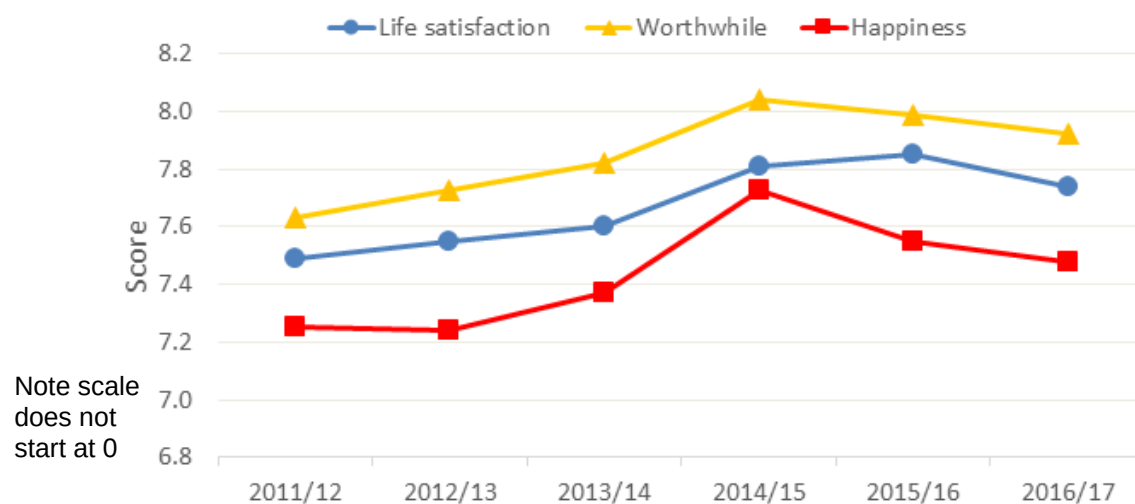


Data has been reviewed and is unchanged

financial situations and in the overall economy. These are factors we believe may account for some people's increased sense of personal well-being.

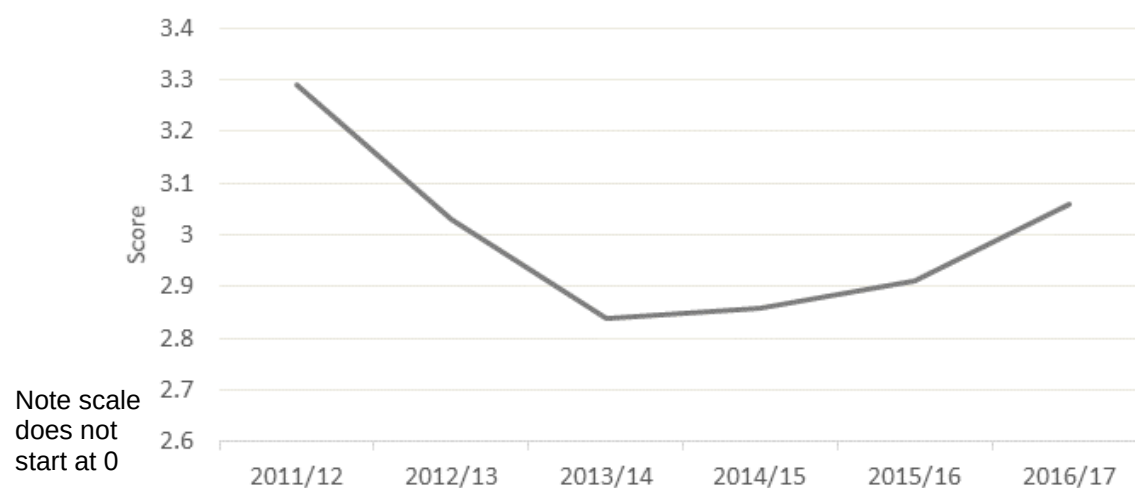
In Oxfordshire, the average wellbeing scores for: life satisfaction, “things you do are worthwhile” and happiness, are slightly lower in 2016-17 compared with 2015-16 and the anxiety mean is higher.

Figure 56 Trend in average wellbeing scores in Oxfordshire for (a) life satisfaction, (b) things you do that are worthwhile and (c) happiness



Source: Office for National Statistics Personal Wellbeing released Nov17

Figure 57 Trend in mean score for anxiety - Oxfordshire



Source: Office for National Statistics Personal Wellbeing released Nov17



Data has been updated in this version



Data has been reviewed and is unchanged

Child wellbeing

Over three quarters of all mental health problems have emerged by the age of twenty, making childhood determinants primary in future mental wellbeing.⁶¹

There remains limited data on mental health of children and young people.

According to the Public Health England report on Promoting children and young people's emotional health and wellbeing, in an average class of 30 15-year-old pupils⁶²:

- three could have a mental disorder
- ten are likely to have witnessed their parents separate
- one could have experienced the death of a parent
- seven are likely to have been bullied
- six may be self-harming

The 2015 Health Survey for England⁶³ was the latest health survey to report on child wellbeing and found that:

- The majority of 13 to 15 year olds had high or very high scores on the ONS measures of life satisfaction (81%), feeling that the things they did were worthwhile (78%) and feeling happy yesterday (74%). More than half, 61%, also reported low or very low ratings for feeling anxious yesterday.
- The ONS measures showed some variation by age and sex, but these were not consistent. In general, older children and girls recorded lower levels of well-being than younger children and boys.
- Well-being was associated with whether or not 13 to 15 year olds had ever smoked or ever drunk alcohol. Children who had never smoked reported higher levels of well-being than those who had ever done so. Similarly, children who had not drunk alcohol reported higher levels of well-being than those who had drunk alcohol.

Common mental disorders

Common mental disorders (CMDs) include different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMDs to society is great.⁶⁴

The 2014 Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing (a national survey, published Sept 2016) found that:

- **One adult in six had a common mental disorder (CMD):** about one woman in five and one man in eight. Since 2000, overall rates of CMD in England steadily increased in women and remained largely stable in men.

⁶¹ <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

⁶² Lavis, P. (2015). Promoting children and young people's emotional health and wellbeing: A whole school and college approach. London: Public Health England

⁶³ <http://www.content.digital.nhs.uk/catalogue/PUB22610>

⁶⁴ Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (Sept 2016) NHS Digital <http://content.digital.nhs.uk/catalogue/PUB21748>



Data has been updated in this version



Data has been reviewed and is unchanged

- Reported rates of self-harming increased in men and women and across age groups since 2007. However, much of this increase in reporting may have been due to greater awareness about the behaviour.
- Young women have emerged as a high-risk group, with high rates of CMD, self-harm, and positive screens for posttraumatic stress disorder (PTSD) and bipolar disorder.
- The gap between young women and young men increased.
 - In 1993, 16 to 24 year old women (19.2%) were twice as likely as 16 to 24 year old men (8.4%) to have symptoms of CMD. In 2014, CMD symptoms were about three times more common in women of that age (26.0%) than men (9.1%).
- Most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed.

About the Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing

- The Adult Psychiatric Morbidity Survey series provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over).
- The 2014 survey (published September 2016) is the fourth in a series and was conducted by NatCen Social Research, in collaboration with the University of Leicester, for NHS Digital.
- The previous surveys were conducted in 1993 (16-64 year olds) and 2000 (16-74 year olds) by the Office for National Statistics, which covered England, Scotland and Wales. The 2007 Survey included people aged over 16 and covered England only.
- The survey used a robust stratified, multi-stage probability sample of households and assesses psychiatric disorder to actual diagnostic criteria for several disorders.

<http://content.digital.nhs.uk/catalogue/PUB21748>

Depression



GP (QOF) data on the number of patients **diagnosed with depression** shows that in 2016-17 there were around **56,800** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with depression, 9.7% of patients.

Between 2015-16 and 2016-17 the number of patients with depression in Oxfordshire CCG increased by 14%.

The rate of patients with depression in Oxfordshire (9.7%) has been above average for the South of England commissioning region and the average for England in each of the past 5 years.



Data has been updated in this version



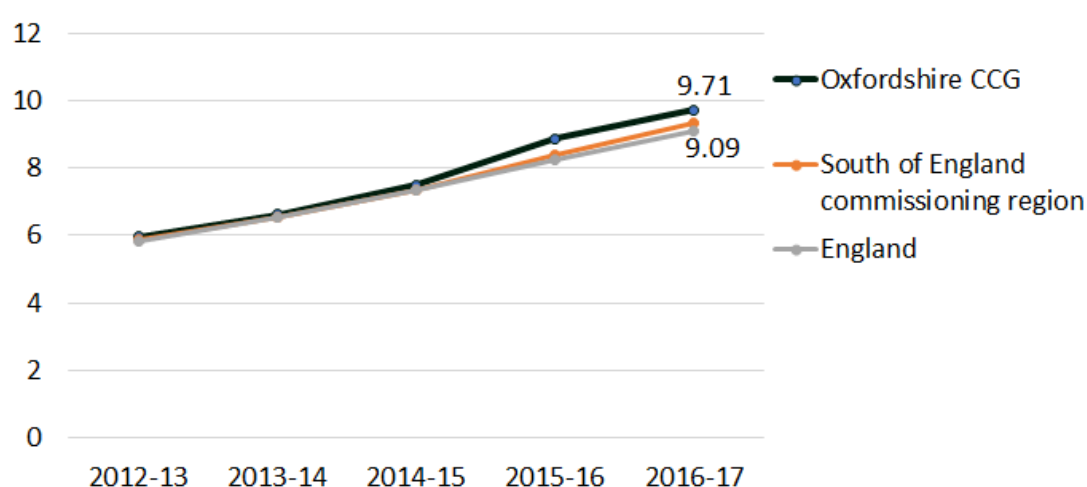
Data has been reviewed and is unchanged

Table 28 Patients registered with depression – count and percent

Count	2012-13	2013-14	2014-15	2015-16	2016-17
Oxfordshire CCG	32,634	37,002	42,594	49,662	56,795
<i>Change from previous year</i>		+4,368	+5,592	+7,068	+7,133
		+13%	+15%	+17%	+14%
Percent of patients aged 18+	2012-13	2013-14	2014-15	2015-16	2016-17
Oxfordshire CCG	5.97	6.62	7.5	8.88	9.71
South of England commissioning region	5.88	6.53	7.35	8.39	9.33
England	5.84	6.52	7.33	8.24	9.09

Source: NHS Digital Quality Outcomes Framework

Figure 58 Trend in prevalence of depression (percent of patients aged 18+), Oxfordshire CCG vs South of England and England



Source: NHS Digital Quality Outcomes Framework; indicators of depression at GP practice level are included in Annex

Severe and enduring mental disorders

People diagnosed with severe and enduring mental disorders are at increased risk of deprivation due to the challenges of maintaining employment, housing and social connections.

The Quality and Outcomes framework provides GP data on the number of patients diagnosed with schizophrenia, bipolar affective disorder or other psychoses; or who were on lithium therapy. In 2016/17 there were around 6,100 GP-registered patients in the Oxfordshire Clinical Commissioning Group area with these conditions. This number has increased by around 400 or 0.2% since 2015/16.



Data has been updated in this version

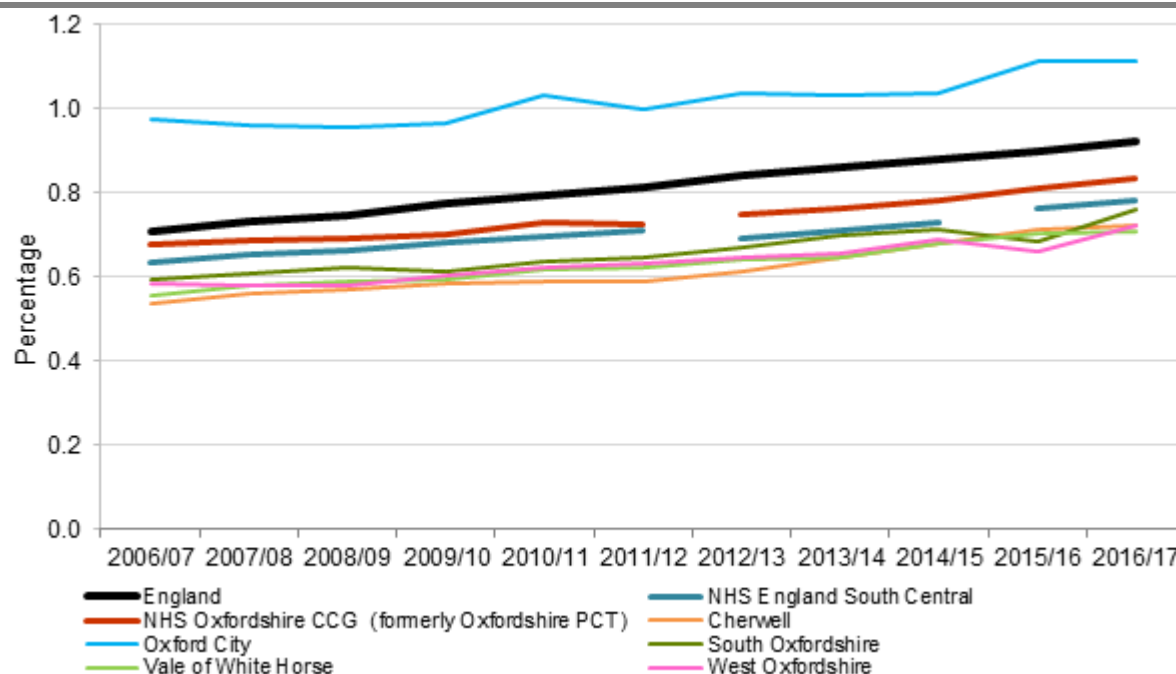


Data has been reviewed and is unchanged

The percentage of GP-registered patients with a recorded diagnosis of a severe and enduring mental health problem has increased in all districts since 2006-07. The rate in Oxford City remains well above the average for NHS Oxfordshire CCG.



Figure 59 Percentage of patients with a recorded diagnosis of a severe and enduring mental health problem in the GP registered population 2006-07 to 2016-17



Source: NHS Digital; quality and outcomes framework; indicator at GP practice level is included in Annex



Data has been updated in this version



Data has been reviewed and is unchanged

Intentional self-harm

Self-harm is a manifestation of emotional distress and a behavioural indication that something is wrong rather than a primary disorder. For each person, the contributing circumstances are unique.

An act of self-harm is not necessarily a suicide attempt or even an indicator of suicide but people who self-harm are statistically at a high and persistent risk of suicide.

Common reasons for self-harm are: difficult personal circumstances; past trauma and social/economic deprivation together with some level of mental disorder. Self-harm can be associated with the misuse of drugs or alcohol.

The available indicator of self-harm is the rate of emergency hospital admissions. This is likely to be an under-estimate of the true scale however as:

- The identification and coding of intent may be subject to recording bias.
- A variation in completeness of hospital records and quality of coding between hospital trusts (e.g. whether an injury is intentional).
- Data includes only those patients who were admitted to hospital therefore any patients attending A&E or Minor Injury Units (MIU) and NOT admitted are not included.
- Many will not attend hospital at all.

 During 2016-17 the number of emergency admissions for intentional self-harm in Oxfordshire was 1,465, this was greater than the number recorded in 2015-16 (1,373).

Oxfordshire's rates of hospital admissions for self-harm have been significantly lower than England, but the rate in 2016-17 has increased (unlike the decline across the South East region) and was significantly higher than England. There is insufficient data to know whether this is a trend or if self-harm is on the increase.

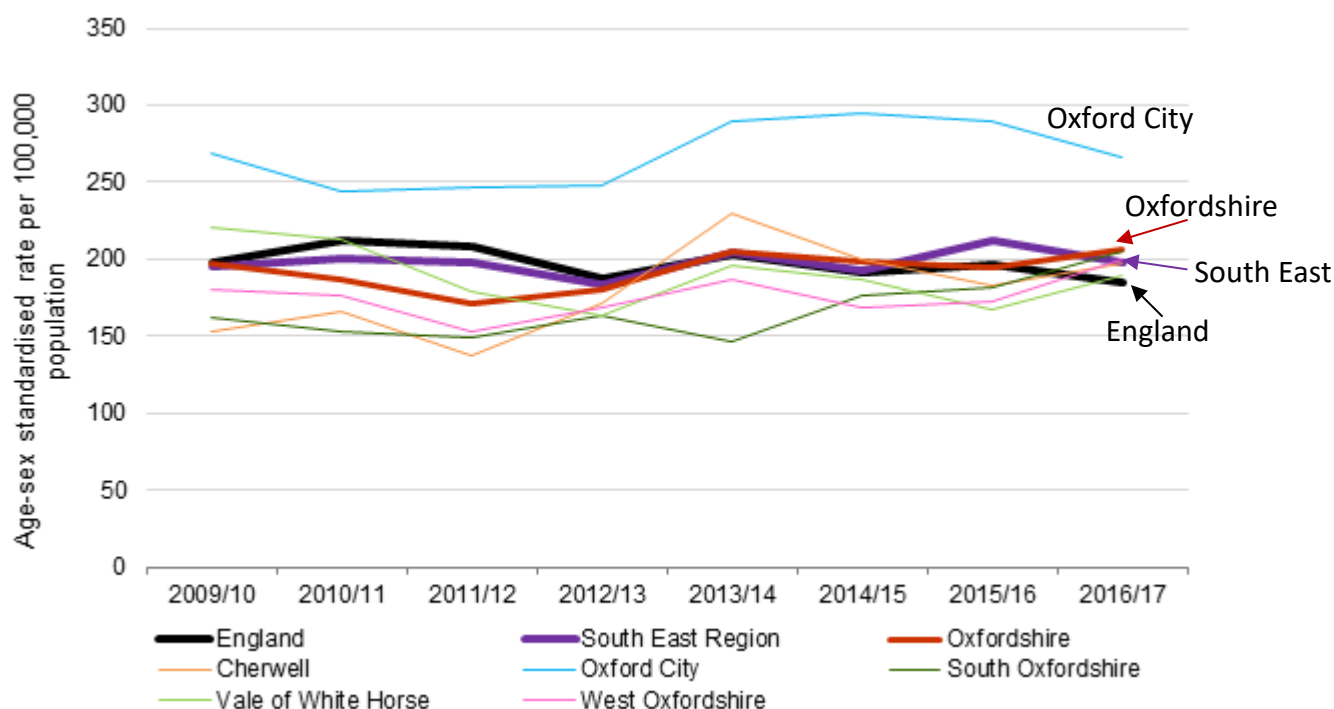


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 60 Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population (2009-10 to 2016-17)



Source: Hospital Episode Statistics (HES) published via Local Authority Health Profiles (Public Health Observatories). Office for National Statistics (ONS) mid-year population estimates

Rates of hospital admission in Oxford City are significantly higher than Oxfordshire as a whole. This may be due to the presence of areas of deprivation, the higher proportion of drug and alcohol and mental health service users who live in the city as well as more facilities for the homeless.

➔ There were 15 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2011-12 to 2015-16), these included 7 in Oxford, 3 in Cherwell, 3 in Vale of White Horse, 1 in South Oxfordshire, and 1 in West Oxfordshire.

The two wards with the highest rates were the relatively deprived areas of Northfield Brook and Blackbird Leys in Oxford.

See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in intentional self-harm across Oxfordshire

Suicide

➔ Between 2014 and 2016, there was a total of **156** deaths registered as suicides in Oxfordshire⁶⁵. The rate of suicides was not significantly different to England.

⁶⁵ ONS Suicides in England and Wales by Local Authority (released Sept17)



Data has been updated in this version



Data has been reviewed and is unchanged

There were 23 suicides of people aged under 25 in the Oxfordshire Clinical Commissioning Group area in 2014-16⁶⁶. The OCCG rate of 5.7 (age standardised) was statistically above the England average (4.7).

5.6 Autism

Autism is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them.⁶⁷

The common diagnostic term for autism is 'autism spectrum disorder' (ASD). Autism as a spectrum condition means that autistic people share certain difficulties, but being autistic will affect them in different ways.

Some autistic people also have learning disabilities, mental health issues or other conditions⁶⁸.

 In January 2017, there were **1,319 pupils** in Oxfordshire schools with special educational needs (SEN) whose primary type of need was ASD.⁶⁹ This is above the number in January 2016 (1,220). Of these, 503 were in state funded primary schools, 537 were in state-funded secondary schools and 279 were in special schools.

 As reported in the 2016 Oxfordshire JSNA, Oxfordshire County Council's 2013 estimate was that there could be in the region of **6,850** people in Oxfordshire who are on the autistic spectrum.⁷⁰

Estimates of the prevalence of autism in Oxfordshire (from 2013) suggest that there could be⁷¹:

- 40-60 pre-school autistic children
- 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)

⁶⁶ Number of suicides by sex, age and clinical commissioning groups in England, 2014 to 2016 death registrations (user request released 18 Dec17)

⁶⁷ The National Autistic Society <http://www.autism.org.uk/about/what-is.aspx>

⁶⁸ The National Autistic Society <http://www.autism.org.uk/about/diagnosis/criteria-changes.aspx>

⁶⁹ Department for Education SEN Statistics (January 2017, published July 2017): <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2017>

⁷⁰ Oxfordshire Autism Joint Commissioning Strategy 2013-2017: <https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/business/providers/OxfordshireAutismStrategy.pdf>

⁷¹ 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>



Data has been updated in this version



Data has been reviewed and is unchanged

 The Adult Psychiatric Morbidity Survey (2014)⁷² includes a chapter on Autism, although the survey was only able to include a very small sample (12 probable cases). This found that the estimated prevalence of autism in 2014 was 0.7% of the adult population in England. The estimated prevalence of autism in the 2007 data (1.0%) was similar to the 2014 estimate; with largely overlapping confidence intervals.

This finding is similar to a 2012 study of autism⁷³ which indicated that 1.1% of the population in the UK may have autism.

Gender difference

 In 2015, the ratio of men to women who used National Autistic Society (NAS) adult services was approximately 3:1, and in those that use NAS schools it was approximately 5:1.⁷⁴

The NAS references a wide range of studies on the gender difference in diagnosis of autism and possible reasons why women and girls with autism may have been missed by professionals.

⁷² Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 published Sept2016 <http://content.digital.nhs.uk/catalogue/PUB21748>

⁷³ Estimating the Prevalence of Autism Spectrum Conditions in Adults, 2012, Brugha T et al The Health and Social Care Information Centre

⁷⁴ <http://www.autism.org.uk/about/what-is/gender.aspx>



Data has been updated in this version



Data has been reviewed and is unchanged

5.7 Cancer

Prevalence

➔ In 2016-17 there were around **21,200** GP-registered patients in the Oxfordshire Clinical Commissioning Group who had a cancer diagnosis, up from 19,000 in 2015-16.

The prevalence increased from 2.73% of patients to 2.91% in 2016-17, this was above the national average of 2.58%.

Table 29 GP-registered patients with a cancer diagnosis (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	19,076	21,222	2,146
NHS Oxfordshire %	2.73%	2.91%	+0.17pp
South of England (health region) %	2.75%	2.94%	+0.2pp
England %	2.42%	2.58%	+0.16pp

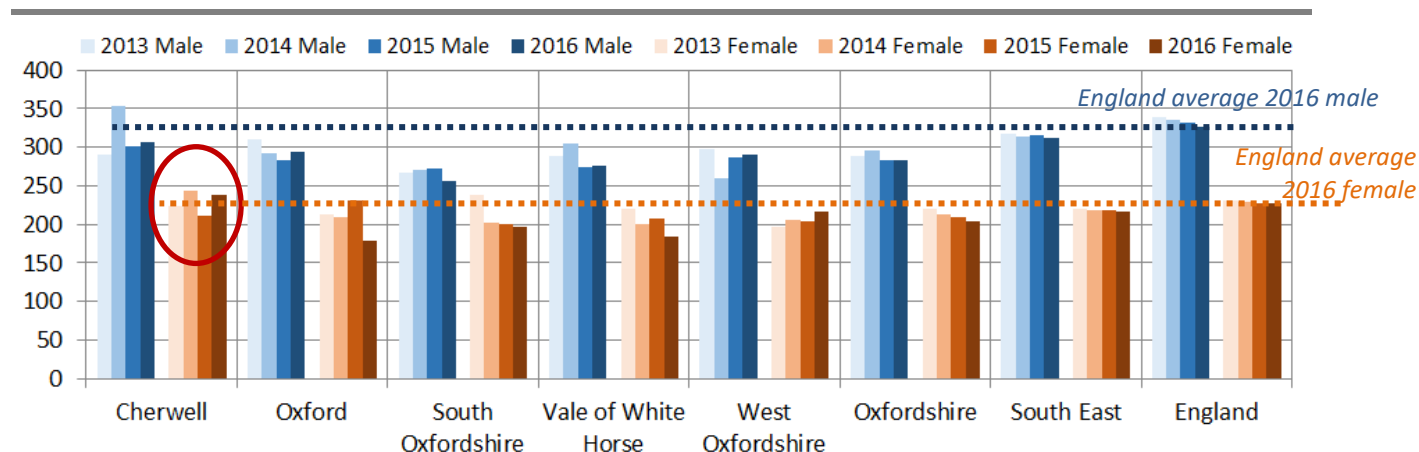
Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

Deaths

➔ In 2016, ONS statistics show 1,497 deaths from cancer in Oxfordshire.

Between 2013 and 2016, age-standardised mortality rates for cancer in Oxfordshire remained at a broadly similar level. The cancer mortality rate for females in Cherwell increased to just above the national average.

➔ **Figure 61 Age-standardised mortality rate, 2013 to 2016, Cancer**



Source: ONS mortality statistics (from nomis "life events")



Data has been updated in this version



Data has been reviewed and is unchanged

Age-standardised mortality rates (ASMRs) allow for differences in the age structure of populations and therefore allow valid comparisons to be made between geographic areas, over time and between sexes. Using the direct method, the age-standardised rate for a particular condition is that which would have occurred if the observed age-specific rates for the condition had applied in a given standard population.

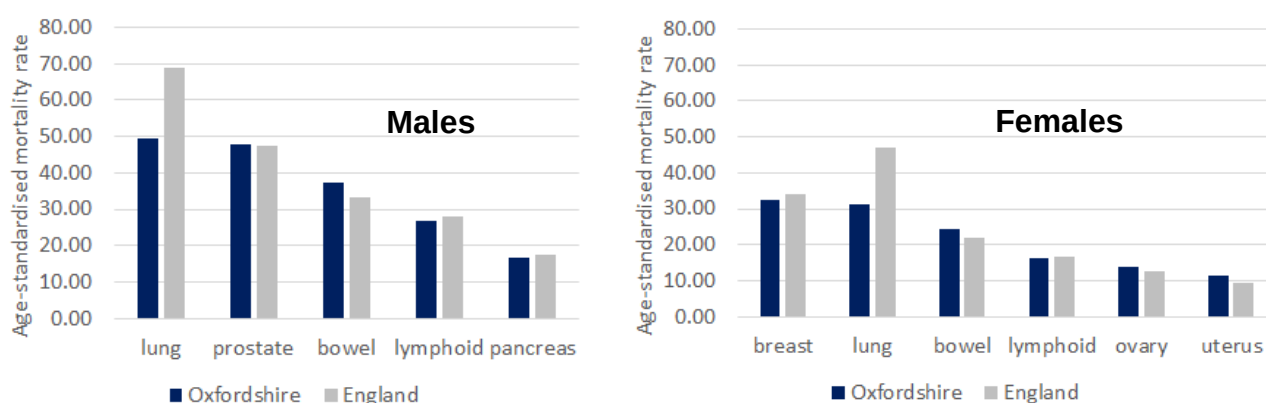
ONS User Guide to Mortality Statistics July 2016

In 2016, the causes of the greatest number of deaths from cancer in Oxfordshire were cancers of the lung, prostate, breast, bowel and lymphoid. Together these 5 causes accounted for just over half of all deaths from cancer (807 deaths, 54%).

For both males and females, rates of lung cancer deaths in Oxfordshire in 2016 were well below the England average.

Rates of bowel cancer deaths were above average in Oxfordshire in 2016 for both males and females.

Figure 62 Age-standardised mortality rate by cancer type, males and females, Oxfordshire vs England (2016)



Source: ONS mortality statistics (from nomis "life events")

Table 30 Count and age-standardised mortality rate by cancer type, males and females, Oxfordshire vs England (2016)

Males				Females			
	Oxfordshire count	Oxfordshire rate (SMR)	England rate (SMR)		Oxfordshire count	Oxfordshire rate (SMR)	England rate (SMR)
lung	137	49.36	68.95	breast	113	32.48	34.09
prostate	128	48.03	47.48	lung	107	31.42	47.07
bowel	103	37.32	33.24	bowel	87	24.2	22.1
lymphoid	75	26.81	28.04	lymphoid	57	16.39	16.88
pancreas	49	16.67	17.57	ovary	48	14	12.75
				uterus	39	11.46	9.48

Source: ONS mortality statistics (from nomis "life events")



Data has been updated in this version



Data has been reviewed and is unchanged



There were 4 wards in Oxfordshire with a significantly higher mortality ratio for cancers than England (2011-15). As in the previous dataset (2010-14), the ward with the highest rate was Banbury Ruscote in Cherwell district.

See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in cancer mortality across Oxfordshire

5.8 Heart disease

Prevalence



In 2016-17 there were just below **17,800** GP-registered patients in the Oxfordshire Clinical Commissioning Group with coronary heart disease, up from 17,400 in 2015-16. The prevalence decreased from 2.50% of patients to 2.43%, remaining below regional and national averages.

Table 31 GP-registered patients with Coronary Heart Disease (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	17,422	17,768	+346
NHS Oxfordshire %	2.50	2.43	-0.06
South of England (health region) %	3.15	3.14	-0.01
England %	3.19	3.15	-0.04

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for coronary heart disease than England (2011-12 to 2015-16): Banbury Ruscote in Cherwell and Northfield Brook in Oxford.

See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in admissions for heart disease across Oxfordshire



Data has been updated in this version

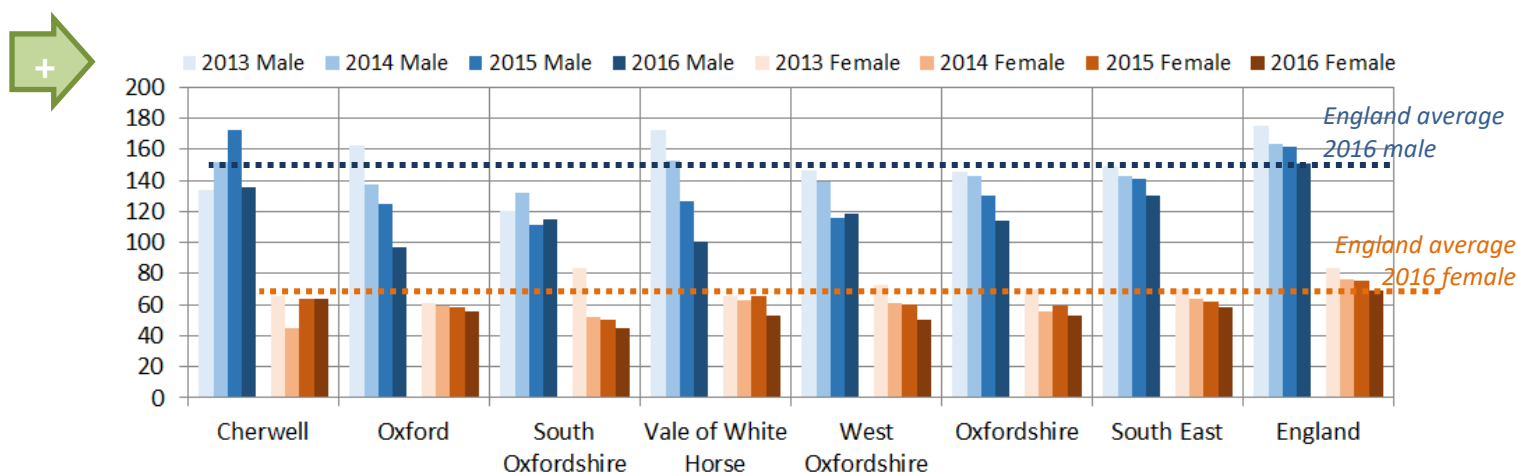


Data has been reviewed and is unchanged

Deaths

➔ Mortality due to heart disease has declined nationally and in every district in Oxfordshire except for South and West Oxfordshire where male mortality due to heart disease increased slightly between 2015 and 2016.

Figure 63 Age standardised mortality rate, 2013 to 2016, Ischaemic heart diseases



Source: ONS mortality statistics (from nomis "life events")

5.9 Stroke

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

Prevalence

➔ In 2016-17 there were around **12,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of stroke and transient ischaemic attack, up from 11,800 in 2015-16. The prevalence increased from 1.68% of patients to 1.71%, remaining below the regional and national averages.

Table 32 GP-registered patients with stroke and transient ischaemic attack

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	11,759	12,477	+718
NHS Oxfordshire %	1.68	1.71	+0.02pp
South of England (health region) %	1.87	1.89	+0.03pp
England %	1.74	1.75	+0.01pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



Data has been updated in this version



Data has been reviewed and is unchanged



There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for stroke than England (2011-12 to 2015-16): both in Banbury (Cherwell).

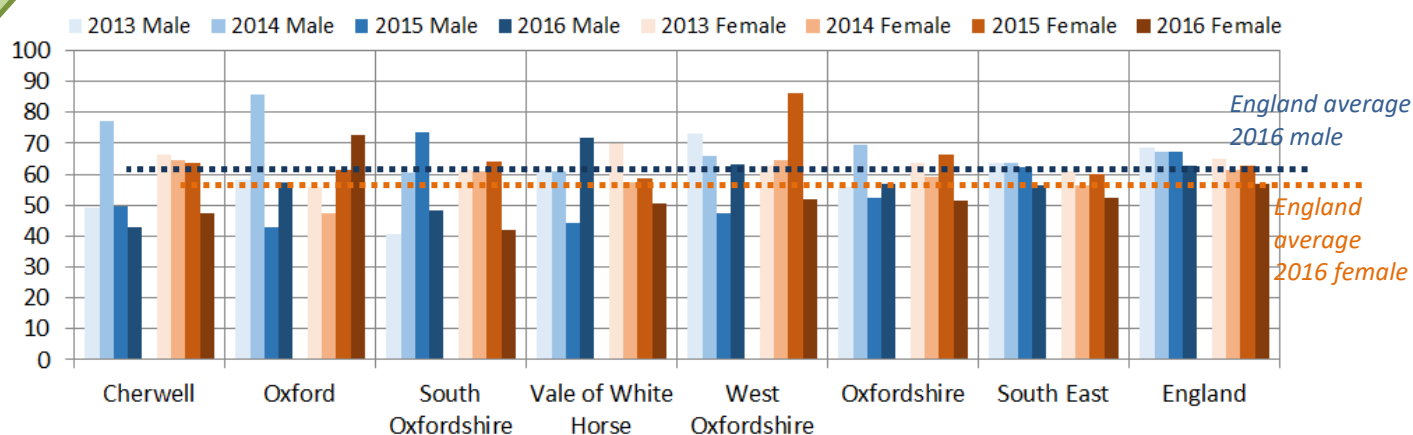
See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in admissions for stroke across Oxfordshire

Deaths

Between 2015 and 2016, the age-standardised mortality rate for cerebrovascular diseases (stroke) increased in males in Oxfordshire, against the declining national and regional trend.

The rates by district show females in Oxford and males in Vale of White Horse each above average in 2016.

Figure 64 Age standardised mortality rate, 2013 to 2016, Cerebrovascular diseases



Source: ONS mortality statistics (from nomis "life events")



Data has been updated in this version



Data has been reviewed and is unchanged

5.10 Dementia and Alzheimer's disease

Prevalence

 In 2016-17 there were almost **5,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of Dementia and Alzheimer's disease, up from 5,200 in 2015-16. The prevalence increased from 0.74% of patients to 0.75%, just below the national average and below the regional average.

Table 33 GP-registered patients with Dementia and Alzheimer's disease (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	5,176	5,461	+285
NHS Oxfordshire %	0.74	0.75	+0.01pp
South of England (health region) %	0.84	0.84	0pp
England %	0.76	0.76	+0.01pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

The estimated total number of people living with dementia in Oxfordshire (diagnosed and undiagnosed) is around 8,000⁷⁵.

Deaths

 In West Oxfordshire, the age-standardised mortality rate for females due to Dementia and Alzheimer's disease increased in 2014, 2015 and again in 2016 to well above the national and regional averages.

The mortality rate for females due to Dementia and Alzheimer's disease was above the national average in Cherwell in 2015 and 2016.

⁷⁵ Oxfordshire Clinical Commissioning Group

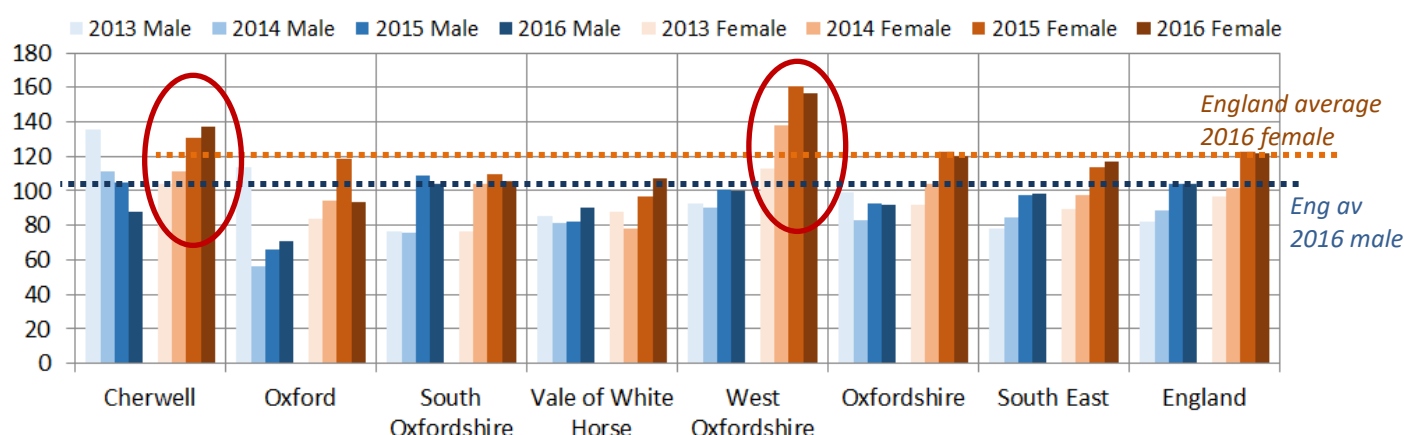


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 65 Age standardised mortality rate, 2013 to 2016, Dementia and Alzheimer's disease



Source: ONS (from nomis "life events")

5.11 Diabetes

Diabetes mellitus is a condition that causes a person's blood sugar level to become too high. There are two types of diabetes⁷⁶:

- Type 1 diabetes is an autoimmune condition where the body attacks and destroys insulin-producing cells, meaning no insulin is produced. This causes glucose to quickly rise in the blood.
- In Type 2 diabetes, the body doesn't make enough insulin, or the insulin it makes doesn't work properly, meaning glucose builds up in the blood. Type 2 diabetes is caused by a complex interplay of genetic and environmental factors. Up to 58 per cent of Type 2 diabetes cases can be delayed or prevented through a healthy lifestyle.
- About 90 per cent of people with diabetes have Type 2.

In 2016-17 there were around **29,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of diabetes, up from 27,900 in 2015-16.

The prevalence increased from 4.92% of patients to 4.97% in Oxfordshire, remaining below the national and regional averages.

⁷⁶ <https://www.diabetes.org.uk/Diabetes-the-basics/>



Data has been updated in this version



Data has been reviewed and is unchanged

Table 34 GP-registered patients with a recorded diagnosis of diabetes (count and % of list)

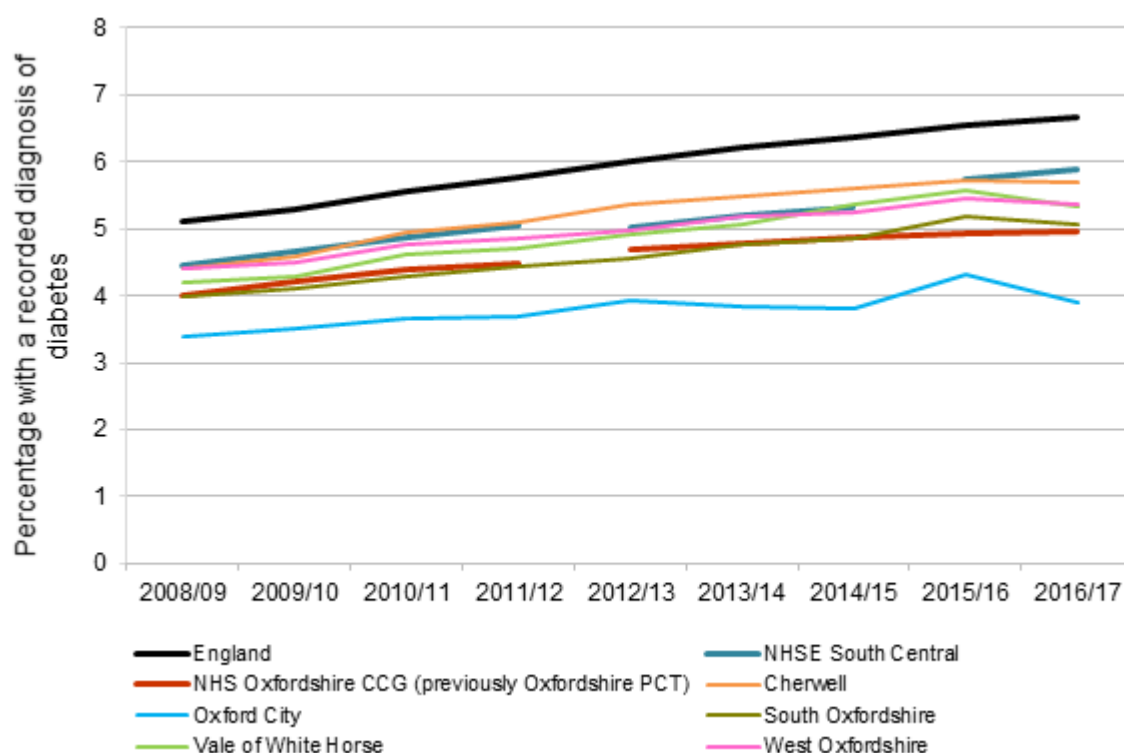
	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	27,925	29,469	+1,544
NHS Oxfordshire %	4.92	4.97	+0.04pp
South of England (health region) %	5.99	6.14	+0.15pp
England %	6.54	6.67	+0.13pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

QOF data for GP practices located within Oxfordshire's districts shows that:

- All five district council areas in Oxfordshire have significantly lower percentages of patients recorded with diabetes than the England and regional averages.
- When compared with the Oxfordshire average:
 - Oxford City has a significantly lower percentage of patients recorded with diabetes.
 - Cherwell, Vale of White Horse and West have a significantly higher percentage of patients recorded with diabetes.

Figure 66 Percentage of patients aged 17+ with a recorded diagnosis of diabetes in the GP registered population 2004-05 to 2016-17



Source: NHS Digital; quality and outcomes framework



Data has been updated in this version



Data has been reviewed and is unchanged

The Health Survey for England 2015 shows the prevalence of diabetes as higher for men than women and significantly higher in those who are overweight or obese (this data is not included in the HSE 2016 update).

Table 35 Diabetes status, as % of people aged 16+, by body mass index (BMI) status and sex (England from HSE 2016)

	Diabetes status (%)	BMI status			
		Normal	Overweight	Obese	Total
Men	Diagnosed diabetes	3	5	8	6
	Undiagnosed diabetes	1	2	8	3
	Total diabetes – men	4	8	17	9
Women	Diagnosed diabetes	2	4	9	5
	Undiagnosed diabetes	1	2	6	2
	Total diabetes – women	3	5	14	7
All adults	Diagnosed diabetes	2	5	9	5
	Undiagnosed diabetes	1	2	7	3
	Total diabetes – all adults	3	7	15	8

Source: Health Survey for England 2015. Aged 16 and over with both valid height and weight measurements, and glycated haemoglobin measurement



Data has been updated in this version



Data has been reviewed and is unchanged

5.12 Hypertension (high blood pressure)

Hypertension is also known as high blood pressure. It is often called ‘the silent killer’ as, if left untreated, increases the risk of a heart attack or stroke.

Risk factors for hypertension⁷⁷ include being over 65 years of age, family history, having African or Caribbean descent, being overweight, poor diet, lack of exercise, excessive alcohol and coffee consumption.

 In 2016-17 there were around **89,900** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of Hypertension, up from 85,800 in 2015-16. The prevalence increased from 12.29% of patients to 12.31%, remaining below the national and regional averages.

Table 36 GP-registered patients with a diagnosis of Hypertension (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	85,799	89,882	+4,083
NHS Oxfordshire %	12.29	12.31	+0.02pp
South of England (health region) %	14.05	14.14	+0.09pp
England %	13.79	13.83	+0.04pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

QOF data for GP practices located within Oxfordshire's districts shows that:

- West Oxfordshire GPs have had a significantly higher percentage of patients with a recorded diagnosis of hypertension than England
- Oxford City has a significantly lower percentage of patients with a recorded diagnosis of hypertension than all other local authorities in Oxfordshire.

The Health Survey for England 2015 shows the prevalence of Hypertension is higher for men than women and significantly higher in those who are overweight or obese (this data is not included in the HSE 2016 update).

⁷⁷ [http://www.nhs.uk/Conditions/Blood-pressure-\(high\)/Pages/Causes.aspx](http://www.nhs.uk/Conditions/Blood-pressure-(high)/Pages/Causes.aspx)



Data has been updated in this version



Data has been reviewed and is unchanged

 **Table 37 Hypertension status, as % of people aged 16+, by body mass index (BMI) status and sex (England from HSE 2015)**

	Hypertension categories (%)	BMI status			
		Normal	Overweight	Obese	Total
Men	Normotensive untreated	79	74	57	73
	Hypertensive controlled	7	8	15	9
	Hypertensive uncontrolled	3	5	7	5
	Hypertensive untreated	11	13	21	13
	All men with hypertension	21	26	43	27
Women	Normotensive untreated	82	76	63	77
	Hypertensive controlled	6	8	13	8
	Hypertensive uncontrolled	4	6	10	6
	Hypertensive untreated	8	11	14	9
	All women with hypertension	18	24	37	23
All adults	Normotensive untreated	81	75	60	75
	Hypertensive controlled	6	8	14	9
	Hypertensive uncontrolled	3	6	9	5
	Hypertensive untreated	10	12	17	11
	All adults with hypertension	19	25	40	25

Source: Health Survey for England 2016. Aged 16 and over with three valid blood pressure measurements, and both valid height and weight measurements.

5.13 Asthma

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

 In 2016-17 there were around **42,200** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with asthma up from 40,100 in 2015-16. The prevalence increased from 5.75% of patients to 5.78% and remained below the regional and national averages.

Table 38 GP-registered patients with Asthma (count and % of list)

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	40,087	42,213	+2,126
NHS Oxfordshire %	5.75	5.78	+0.04pp
South of England (health region) %	6.04	6.10	+0.06pp
England %	5.91	5.94	+0.04pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



Data has been updated in this version



Data has been reviewed and is unchanged

5.14 Chronic Obstructive Pulmonary Disease (lung diseases)

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 2016-17 there were around **9,900** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with a diagnosis of Chronic Obstructive Pulmonary Disease. This was an increase of 500 on the number in 2015-16 (9,400). The prevalence increased from 1.34% of patients to 1.36%, remaining below the regional and national averages.

Table 39 GP-registered patients with Epilepsy (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	9,381	9,897	516
NHS Oxfordshire %	1.34	1.36	+0.02pp
South of England (health region) %	1.71	1.76	+0.04pp
England %	1.85	1.87	+0.03pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

5.15 Epilepsy

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

 In 2016-17 there were around **4,100** GP-registered patients in the Oxfordshire Clinical Commissioning Group area who were receiving drug treatment for Epilepsy, up from just under 4,000 in 2015-16. The prevalence remained the same and below the regional and national averages.

Table 40 GP-registered patients with Epilepsy (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	3,953	4,131	178
NHS Oxfordshire %	0.71	0.71	0pp
South of England (health region) %	0.78	0.79	+0.01pp
England %	0.8	0.8	0pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



Data has been updated in this version

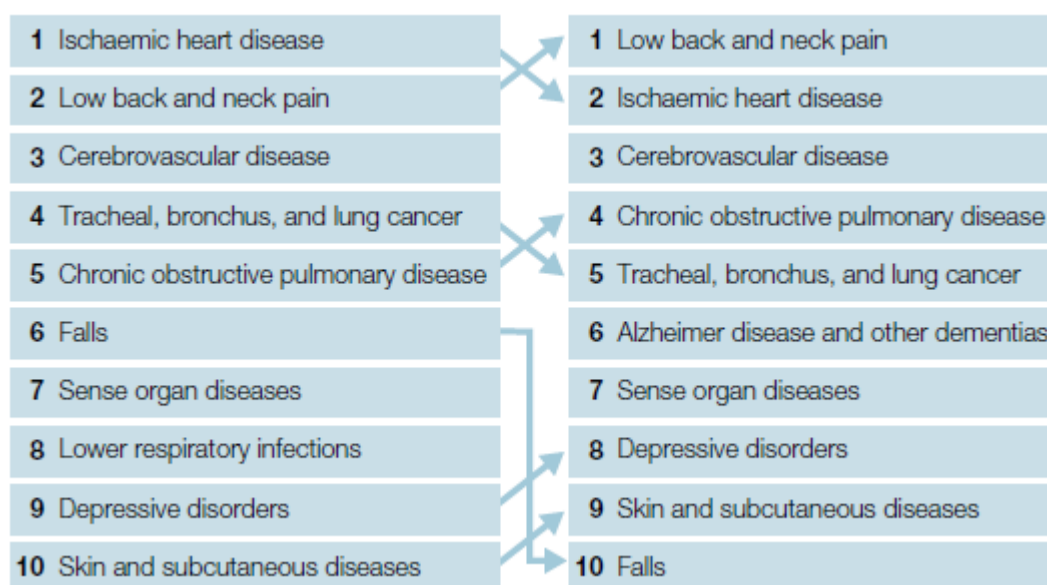


Data has been reviewed and is unchanged

5.16 Musculoskeletal disorders (Knee and Back pain)

According to Public Health England, in 2013, low back and neck pain was the top cause of disability adjusted life years lost, moving up from the second highest cause in 1990.

Figure 67 Change in the main causes of disability adjusted life years lost in England between 1990 and 2013



Source: Public Health England Strategic plan 2016

About Disability-Adjusted Life Year (DALY)

One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences.

http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/



Data has been updated in this version



Data has been reviewed and is unchanged

 Prevalence data for Musculoskeletal conditions (MSK) in the recently released Public Health England MSK tool ⁷⁸ has been derived from the Arthritis Research UK MSK Calculator.

Using the MSK tool prevalence estimates and the most recent population data (ONS 2016) gives an estimate for Oxfordshire of:

- **49,600** people aged 45 and over with lower back pain
- **50,200** people aged 45 and over with chronic knee pain

Table 41 Estimated number of people aged 45 and over with lower back pain or chronic knee pain (using 2016 population estimates)

	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire	Oxfordshire total
Population aged 45 and over (ONS 2016)	64,757	47,646	67,023	60,473	52,483	292,382
Prevalence of lower back pain in people aged 45 or over	17.3%	14.0%	17.8%	17.5%	17.6%	17.0%
Count of people with lower back pain aged 45 or over	11,200	6,700	11,900	10,600	9,200	49,600
Prevalence of chronic knee pain in people aged 45 or over	18.4%	16.0%	16.9%	17.5%	16.7%	17.2%
Count of people with chronic knee pain aged 45 or over	11,900	7,600	11,300	10,600	8,800	50,200

Sources: PHE Musculoskeletal conditions tool (Dec 2017) and ONS mid-year population estimate for 2016.

Notes on source from PHE tool...

For lower back pain, the prevalence source was the Health Survey for England 2011. Severity of back pain is determined using the chronic pain grade based on GCPS version 2.0. No severe back pain was defined as Grade 0 and Grade 1 (low intensity). Severe back pain was defined as Grade 2 (high intensity) or 3 (moderately limiting) or 4 (severely limiting). In the model, general back pain is reported as the prevalence for lower back pain which is grade 0 to grade 4.

For knee pain, the source for prevalence was knee pain due to OA taken from the English Longitudinal Study of Ageing (ELSA)-Waves 1 (2000/01) to Wave 5 (2010/11).

 The national 2017, Health and Safety Executive report⁷⁹ on Work Related Musculoskeletal Disorders (WRMSDs) found that:

- The total number of WRMSDs cases (prevalence) in 2016/17 was 507,000 out of a total of 1,299,000 for all work-related illnesses, 39% of the total and a rate of 1,550 cases per 100,000 workers. The rate is not statistically significantly different from the previous year.
- The rate of total self-reported work-related musculoskeletal disorders showed a generally downward trend.

⁷⁸ Public Health England Musculoskeletal conditions: return on investment tool, released December 2017
<https://www.gov.uk/government/publications/musculoskeletal-conditions-return-on-investment-tool>

⁷⁹ <http://www.hse.gov.uk/Statistics/causdis/musculoskeletal/index.htm>



Data has been updated in this version



Data has been reviewed and is unchanged

- The number of new cases of WRMSDs (incidence) in 2016/17 was 159,000, an incidence rate of 480 cases per 100,000 workers. This rate is not statistically significantly different from the previous year.
- An estimated 8.9 million working days were lost due to WRMSDs in 2016/17, an average of 17.6 days lost for each case. This is not statistically significantly different from the previous year.
- Work-related musculoskeletal disorders account for 35% of all working days lost due to work-related ill health. Working days lost per worker due to self-reported work-related musculoskeletal disorders showed a generally downward trend up to around 2010/11; since then the rate has remained broadly flat.
- Construction, Agriculture, forestry and fishing, Transportation and storage and Human health and social work activities remain the industries with significantly higher rates of WRMSDs when compared with the rates for all industries.

5.17 Sight loss

A Certification of Vision Impairment (CVI) certifies a person as either sight impaired (partially sighted) or severely sight impaired (blind). The CVI enables local government to offer registration as blind or partially sighted and other relevant advice and support. Registers are maintained by local authorities.

 As of 2016-17 there were 2,360 people in Oxfordshire that are registered as blind or partially sighted, equivalent to a crude rate of 345 per 100,000 people. This was well below the rate in England (526) and the South East region (486)⁸⁰.

 The RNIB estimates that, as of 2016, there was an estimated total of 21,110 people living with some degree of sight loss in Oxfordshire. The estimated prevalence is 3.1% (the same as England).

The districts with the highest estimated prevalence of people with mild to severe sight loss in Oxfordshire were South Oxfordshire and West Oxfordshire.

Table 42 Number of people estimated to be living with sight loss in Oxfordshire (2016 and future estimates to 2030)

	2016	2020	2025	2030
Mild	13,630	15,050	17,090	19,560
Moderate sight loss	4,690	5,160	5,800	6,570
Severe sight loss	2,800	3,130	3,620	4,200
Total	21,110	23,340	26,510	30,330

⁸⁰ Source: NHS Digital <http://digital.nhs.uk/catalogue/PUB30161> The SSDA902 data is collected every three years from Councils with Adult Social Services Responsibilities (CASSRs). In 2016-17, it was collected as part of the Short and Long Term (SALT) activity collection.



Data has been updated in this version



Data has been reviewed and is unchanged

Table 43 Estimated number of people living with sight loss by district (2016)

	Mild sight loss	Moderate sight loss	Severe sight loss	Total	Prevalence
Cherwell	2,920	1,010	600	4,520	3.1%
Oxford	2,290	780	450	3,520	2.2%
South Oxfordshire	3,140	1,080	660	4,880	3.5%
Vale of White Horse	2,810	970	580	4,360	3.4%
West Oxfordshire	2,470	850	510	3,830	3.5%
Oxfordshire	13,630	4,690	2,800	21,110	3.1%

Source: RNIB Sight Loss Data Tool

Blind and partially sighted children

 RNIB estimate⁸¹ that there are over 25,000 blind and partially sighted children (0-16 years) in the UK and around 15,000 aged 17-25 years. Around half of those aged 0-16 years will have additional disabilities and/or special educational needs.

In Oxfordshire estimated numbers are:

- 259 blind and partially sighted children 0-16 years
- 32 blind and partially sighted young people 17-18 years and
- 130 blind and partially sighted young people 19-25 years
- 91 pupils with a statement of special educational needs (SEN) with vision impairment as their primary SEN

Preventable sight loss

 Crude rates (2015-16) of preventable sight loss from age-related macular degeneration (AMD), glaucoma and diabetic eye disease are shown in the table below. The numbers (count) in Oxfordshire are relatively low.

Table 44 Crude rates of preventable sight loss from age-related macular degeneration, glaucoma and diabetic eye disease 2015-16

	Oxfordshire count	Oxfordshire rate	South East region	England
Age-related macular degeneration (AMD) – 65+ years	97	81.9	101.5	114.0
Glaucoma – 40+ years	28	8.4	10.3	12.8
Diabetic eye disease – 12+ years	16	2.8	2.7	2.9

Source: Public Health Outcomes Framework (Indicators 4.12i, ii, iii)

⁸¹ RNIB sight loss data tool <http://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics/sight-loss-data-tool>



Data has been updated in this version



Data has been reviewed and is unchanged

5.18 Hearing loss

11 million people are currently living with hearing loss in the UK. Hearing loss means not just the big things in life like staying in employment; it affects everyday things like being able to hear the door-bell or crossing the road⁸².

 As reported in the 2016 Oxfordshire JSNA, hearing loss can be socially isolating and has been associated with increased risk of physical and mental health problems.⁸³ Nationally, around one in six people are thought to have some form of hearing loss.⁸⁴

 Data on people registered as deaf or hard of hearing was collected every three years up to 2010.⁸⁵ 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.

5.19 Tuberculosis (TB)

The rate of Tuberculosis (TB) per 100,000 population in England has fallen over recent years.

 Data at a local level are not strictly comparable due to averaging of data over a three-year period. Overall, however, Oxfordshire has a slightly lower incidence rate than England and South East Public Health England Centre.

Oxford City continues to have a significantly higher rate of Tuberculosis than Oxfordshire as a whole.

⁸² Source: Action on Hearing Loss <https://www.actiononhearingloss.org.uk/>

⁸³ 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>

⁸⁴ Action on hearing loss statistics (accessed January 2016): <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>

⁸⁵ 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>

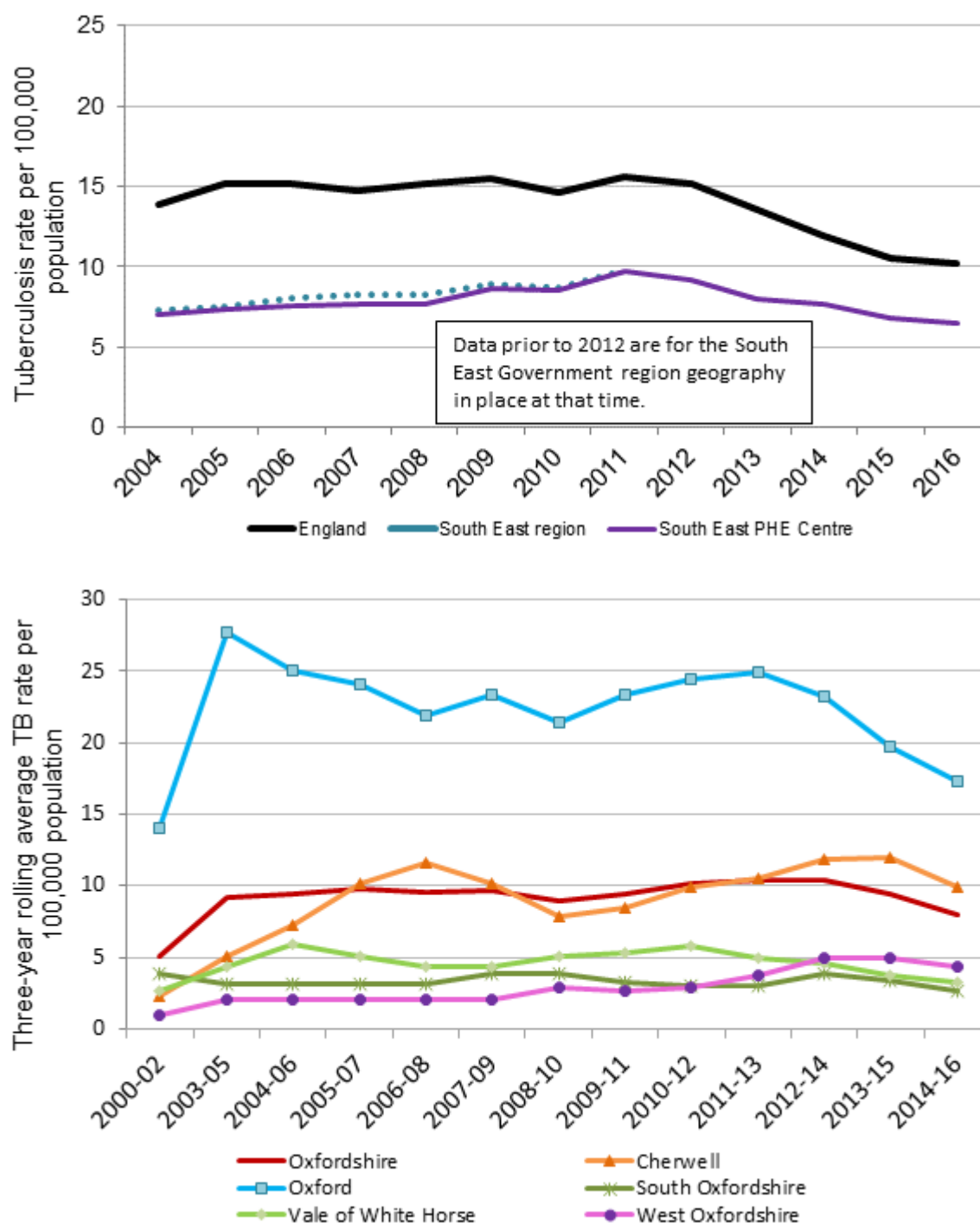


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 68 Tuberculosis (TB) - Rate per 100,000 population (2004 to 2016)



Source: Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

After the Health and Social Care Act 2012, data were provided at different geographic levels. Data relating to Tuberculosis Incidence are supplied at district level and for Public Health England (PHE) centres. Data for Oxfordshire are calculated using district level numbers. A three-year average is given which, at district level, often remains below 10. Numbers below 10 are suppressed to ensure patient confidentiality.



Data has been updated in this version



Data has been reviewed and is unchanged

6 Lifestyles

This chapter presents data on lifestyle factors that affect health and wellbeing, such as food, weight, exercise, smoking, alcohol and drugs. Further resources are available online, by visiting the [JSNA – Lifestyles webpage](#).

6.1 Lifestyles – key findings

This section highlights the key messages from the review of data on Lifestyles (data sources and research references are provided with the detailed data in the remainder of this chapter).

Food and nutrition, excess weight and obesity

- There is currently no standard measure of food security/poverty.
- There are over 20 food banks in Oxfordshire, most of which operate independently.
- An estimated 55% of people aged 16 or over in Oxfordshire are classified as overweight or obese. This is below the national average.
- The latest data from the National Child Measurement Programme shows a similar level of in obesity of younger children (aged 4-5 years) in Oxfordshire and a slight increase in obesity of children aged 10-11.
- In the 2016/17 academic year, a measure of prevalence of severe obesity was introduced. In Oxfordshire, around 110 (1.4%) reception year children were severely obese. In year 6, around 220 (3.4%) children were severely obese. Levels were highest in Oxford City where 2.7% children in reception year and 4.8% children in Year 6 were severely obese.

Breastfeeding

- Rates of breastfeeding at 6-8 weeks after birth in Oxfordshire remain above the national average.

Physical activity

- Survey data for England shows a significant decline (2008 to 2012) in the proportion of boys meeting physical activity recommendations. Among girls there has been no significant change.
- Oxford and Vale of White Horse were each better than the England average on the proportion of people who were inactive according to the new Active Lives survey (replacing Active People).

Volunteering

- National data shows levels of volunteering have remained at similar levels since 2001.
- Surveys by South Oxfordshire and Vale of White Horse district councils show that the top reasons residents gave for not volunteering were work commitments and having to look after children/the home. There was a substantial minority (8% in South and 12% in Vale) who had “not thought about” volunteering, indicating a potential to increase the number of active volunteers.



Data has been updated in this version



Data has been reviewed and is unchanged

- As an example of community volunteering: voluntary effort is currently supporting 67 community transport schemes in Oxfordshire.

Smoking

- Health survey for England data for 2016 shows a national decline in proportion of adults smoking and a decline in the proportion of children smoking.
- In 2016 an estimated 11.9% of adults in Oxfordshire were smokers (down from 15.5% in 2015), statistically lower than the England average. Smoking prevalence in all of Oxfordshire's districts was either below or similar to national and regional averages.
- Smoking prevalence in adults in routine and manual occupations was estimated at 24.5% in Oxfordshire, over double the rate of all adults and similar to the national average.
- Smoking at time of pregnancy in Oxfordshire has reduced to 7.7%, remaining below the England average.

Alcohol and drugs

- According to the 2016 Health survey for England, alcohol consumption in general has remained similar in adults and declining in children.
- Admissions for alcohol-related conditions were better than the England average in Oxfordshire overall and in rural districts. Oxford City had a similar rate to the national average.
- 6 wards in Oxfordshire had a significantly higher rate of hospital admissions linked to alcohol, all in Oxford city.
- The rate of hospital admissions for alcohol-specific conditions in females under 18 in Oxfordshire has remained statistically above the national average in the latest data. The rate for males in Oxfordshire was similar to average.
- The number of recorded crimes for possession of drugs in Oxfordshire has declined. The rate of drugs possession crimes in Oxford remains above the average for the Thames Valley area.

Abuse and exploitation

- Data from Thames Valley Police shows an increase in recorded victims of abuse and exploitation in Oxfordshire. In 2017 there were:
 - Around 11,400 recorded victims of domestic abuse crimes and incidents (+2% since 2016).
 - 611 recorded victims of rape offences (up from 548 in 2016, +11%).
 - 69 recorded victims of Honour-based violence in Oxfordshire (up from 61 in 2016, +15%).
 - 106 recorded victims of modern slavery, almost three times the number in 2016 (37).
- The exception was the number of recorded victims of Child Sexual Exploitation which declined from 170 in Oxfordshire in 2016 to 106 in 2017.

Teenage conceptions



Data has been updated in this version



Data has been reviewed and is unchanged

- The latest Office for National Statistics data shows a continued decline in the number of conceptions to women aged under 18 regionally and nationally.
- Between 2014 and 2015, there was a decline in the number and rate of under 18 conceptions in Oxfordshire.

Sexually transmitted infections

- Gonorrhoea diagnoses have increased nationally and in Oxfordshire, which may be due in part to the introduction of the new test for gonorrhoea in August 2012.
- Since 2011, the rate of diagnosis of gonorrhoea in Oxford has increased at above the national rate.

6.2 Food and nutrition, excess weight and obesity

Food security and food poverty

There is currently no standard measure of food security/poverty.

 A quantitative study on child hunger in London by Ipsos MORI⁸⁶ found that for 10% of children the school lunch is their biggest meal of the day and 9% of children “sometimes” or “often” go to bed hungry.

The 2014 Evidence Review for the All-Party Parliamentary Inquiry into Hunger in the United Kingdom⁸⁷ highlighted the issue of rural hardship..

.. evidence highlighting the longstanding difficulties facing poorer families who live in wealthier parts of the country, and who may be struggling to afford life’s essentials.

 There are over 20 food banks across Oxfordshire, most of which operate independently (with many supported by local churches):

Cherwell

- The Trussell Trust food banks at four locations in Banbury and one in Bicester
- Banbury Young Homeless Project (BYHP) food bank
- Banbury Food for Charities supplies registered charities in Banbury and the surrounding area

Oxford

- Oxford Community Emergency Foodbank, at Littlemore and Hollow Way
- Community Cupboard at Rose Hill
- Oxford Food bank supplies about 80 registered charities (not individuals directly) in Oxford, Abingdon and Didcot

South Oxfordshire

- Didcot Baptist Church food bank
- Wallingford Emergency food bank
- Thame food bank
- NOMAD Youth and Community Project food bank, Henley-on-Thames

⁸⁶ <https://www.ipsos-mori.com/researchpublications/publications/1585/Child-Hunger-in-London.aspx>

⁸⁷ <https://feeding-britain.org/>



Data has been updated in this version



Data has been reviewed and is unchanged

- FareShare Thames Valley redistributes food to charities in the area

Vale of White Horse

- Abingdon Emergency food bank
- Faringdon Family Centre food bank
- Wantage and Grove food bank

West Oxfordshire

- Trussell Trust Witney and West Oxfordshire food bank
- North Oxfordshire community food bank (Chipping Norton, Woodstock, Kidlington)

Most food banks require referral, but self-referral is possible at some organisations and there are also charities and organisations in Oxfordshire that provide free or subsidised meals available to all.

Within Oxford, a partnership between Oxford City Council, Feeding The Gaps and Good Food Oxford has created a map and database of services⁸⁸ providing free or subsidised food.

 A qualitative study on Food Poverty in Oxford⁸⁹ carried out in Barton and Rose Hill (Dec 2015) included interviews with 21 residents considered to be in food poverty. From this research, the main drivers of food poverty were found to be a combination of economic difficulties in general and the perceived high cost of food.

Access to local food stores did not come up as a major issue in this study, however a lack of availability of fresh food was mentioned by “a few older interviewees with limited mobility”.

 A 2017 report⁹⁰ by the Trussell Trust⁹¹ suggests that the roll out of Universal Credit has increased the use of foodbanks.

- *Foodbanks in areas of full Universal Credit rollout to single people, couples and families, have seen a 16.85% average increase in referrals for emergency food, more than double the national average of 6.64%.*
- *The effect of a six-plus week waiting period for a first Universal Credit payment can be serious, leading to foodbank referrals, debt, mental health issues, rent arrears and eviction. These effects can last even after people receive their Universal Credit payments, as bills and debts pile up.*

According to Oxfordshire’s Citizens Advice agencies: as of January 2018, *it is too early to notice any Universal Credit trends in Oxfordshire as it has only just been introduced across the county.*

⁸⁸ <http://goodfoodoxford.org/good-food-for-everyone/food-access-services-map/>

⁸⁹ Food poverty in Oxford: A qualitative study in Barton and Rose Hill (Dec 2015)
<http://goodfoodoxford.org/blog/giving-voice-to-food-poverty/>

⁹⁰ <https://www.trusselltrust.org/wp-content/uploads/sites/2/2017/04/Early-Warnings-Universal-Credit-and-Foodbanks.pdf>

⁹¹ The Trussell Trust runs a network of over 425 foodbanks, who provide three days’ nutritionally balanced food and support to people in crisis in the UK.



Data has been updated in this version



Data has been reviewed and is unchanged

Excess weight in adults

As reported in the latest Health survey for England⁹² there has been a decline in the proportion of adults of a normal weight nationally.



- Between 1993 and 2016, adults with a normal body mass index (BMI) decreased from 41% to 33% among men and from 49% to 41% among women.

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 more during the preceding 12 months. The quality of the data is dependent on recording within practices.

In 2016-17 there were around **45,900** GP-registered patients in the Oxfordshire Clinical Commissioning Group who were recorded as being obese, up from 43,200 in 2015-16. The prevalence increased from 7.55% of patients to 7.85%, remaining below the national and regional averages.

Table 45 GP-registered patients recorded as being obese (count and % of list)

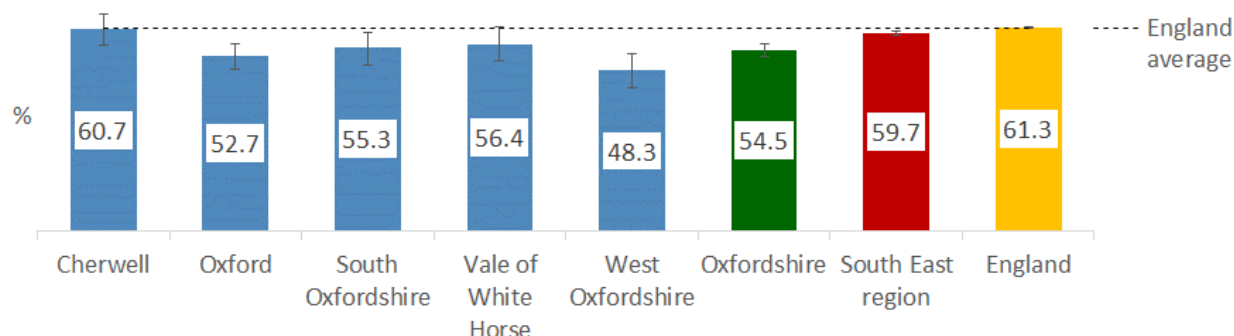
	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	43,231	45,905	
NHS Oxfordshire %	7.55	7.85	+0.30pp
South of England (health region) %	8.58	8.38	+0.17pp
England %	9.45	9.65	+0.20pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

The latest survey data for Oxfordshire on excess weight covers the year 2015/16. This estimates that 54.5% of people aged 18 or over in Oxfordshire are classified as overweight or obese, lower than the average for England (61.3%) or the South East (59.7%).

Adults in Oxford City, South Oxfordshire and West Oxfordshire were less likely to be overweight than those in England overall. This is a new survey so it cannot be compared to previous data.

Figure 69 % of people aged 18 or over classified as overweight or obese 2015-16



Source: Public Health England, Public Health Outcomes Framework from Active Lives survey 2015-16

⁹² <https://digital.nhs.uk/catalogue/PUB30169>



Data has been updated in this version



Data has been reviewed and is unchanged

Excess weight in children

 Data in this section is from the National Child Measurement Programme. The latest data are for 2016-17.

About the National Child Measurement Programme

The National Child Measurement Programme (NCMP) is operated jointly by the Department of Health (DH) and Department for Education (DfE). It was first established in 2007. Children in Reception Year and Year 6 are weighed and measured during every school year.

NCMP produces a national report which provides high-level analysis of the prevalence of 'underweight', 'healthy weight', 'overweight' and 'obese' children. Prevalence of 'severe obesity' has been added for the year 2016-17.

Some schools/pupils choose to opt out of the programme. In 2016-17 the participation rate in reception year for England was 95.8%. For Oxfordshire, the participation rate was 96.7% which is higher than in previous years (e.g. in 2010-11 it was 92.9%). In Year 6 the participation rate was 94.2% in England and 94.2% in Oxfordshire.

The high participation rate and large sample size means that 95% confidence intervals for prevalence estimates at national level are very narrow (indicating a small margin of potential error).

Note that improvements in data quality over time can affect prevalence figures. This should be considered when making comparisons over time as it may partly explain any observed changes; both significant and non-significant. <http://content.digital.nhs.uk/ncmp>

As of 2016-17, around 1,460 (20%) reception children, aged 4 or 5, in Oxfordshire were overweight or obese. In year 6, aged 10 or 11, there were around 1,910 children overweight or obese and the proportion was higher at 30%.

Between 2015-16 and 2016-17, the prevalence of obesity in Oxfordshire did not change in reception year and increased in year 6.

- In reception obesity remained at 7%, and in year 6 increased from 16% to 16.9%.
- The change in obesity in Oxfordshire's districts varied, with some increasing and some reducing:
 - In Cherwell, obesity in reception aged children decreased from 7.3% to 6.9% and Year 6 increased from 17.4% to 18.8%;
 - In Oxford, obesity in reception decreased slightly from 8.8% to 8.6% and Year 6 increased from 20.2% to 21.3%;
 - For South Oxfordshire, there has been a decrease in reception aged children from 6.6% to 6.1% and an increase in Year 6 children from 11.8% to 12.9%;
 - In Vale of White Horse there has been an increase in reception and Year 6 children (reception rose from 5.1% to 6.9% and Year 6 from 14.5% to 16%);
 - For West Oxfordshire, reception year remained at 6.7% and Year 6 prevalence decreased from 15.6% to 14.7%.

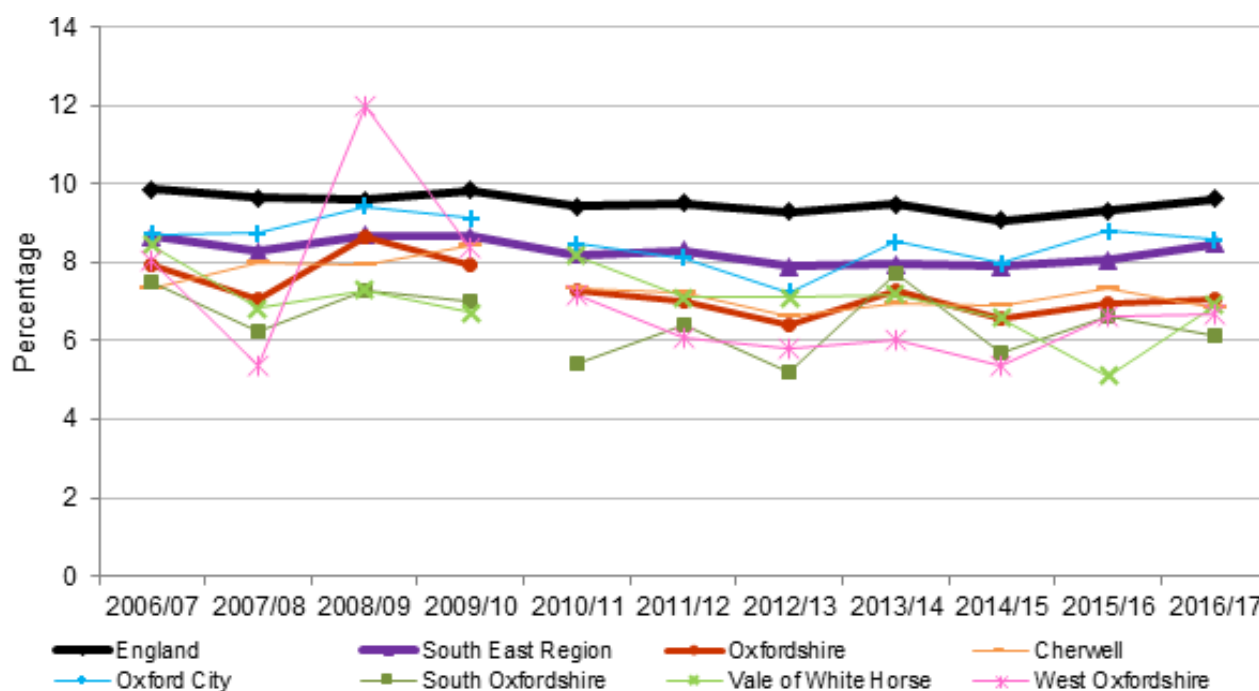


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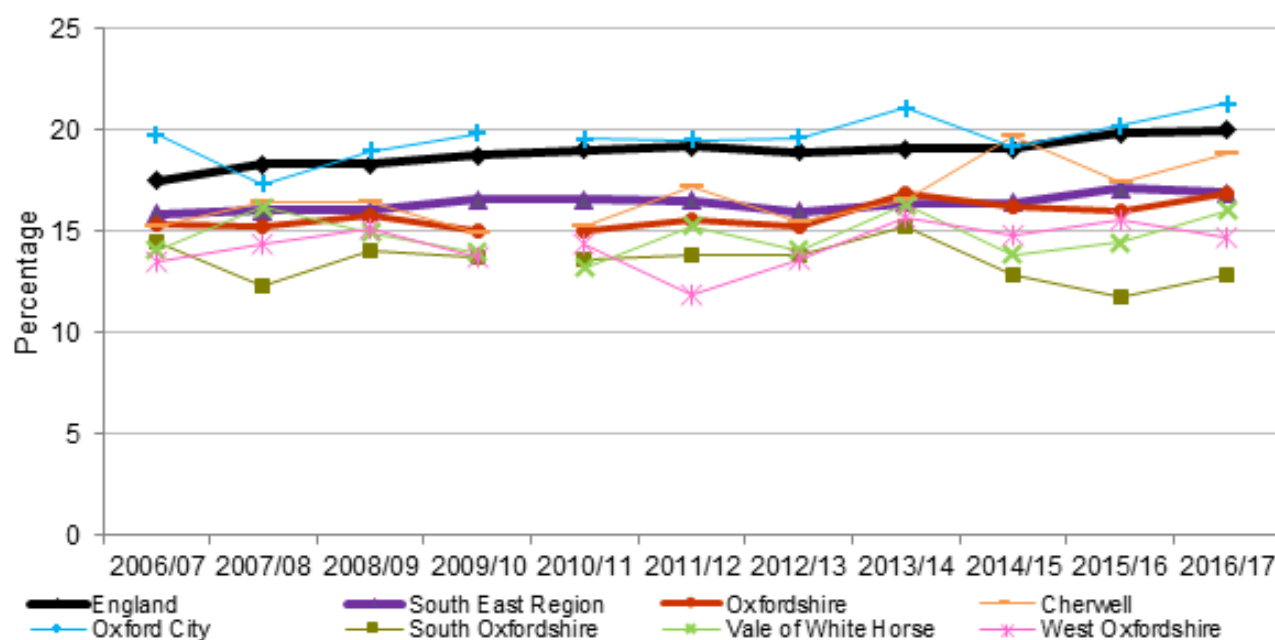
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Figure 70 Percentage of children in Reception Year (aged 4-5 years) who are obese - 2006-07 to 2016-17 (academic years)



Source: National Child Measurement Programme (via NHS Digital)

Figure 71 Percentage of Year 6 children (ages 10-11 years) who are obese - 2006-07 to 2016-17 (academic years)



Source: National Child Measurement Programme (via NHS Digital)



Data has been updated in this version



Data has been reviewed and is unchanged

In the 2016/17 academic year, a measure of prevalence of **severe obesity** was introduced. In Oxfordshire, around 110 (1.4%) reception year children were severely obese. In year 6, around 220 (3.4%) children were severely obese. Levels were highest in Oxford City where 2.7% children in reception year and 4.8% children in Year 6 were severely obese.

Low birth weight babies

Low birth weight is a major cause of infant mortality in the UK and has an influence on future adult health status.

Risk factors for low birth weight include:

- Socio economic status
- Genetics
- The health of the mother, particularly during the pregnancy including maternal smoking, substance misuse, nutritional status and maternal weight
- Ethnicity
- Environmental factors
- Mother's age – mothers under 20 are more likely to have a baby with low birth weight
- Multiple pregnancy



In 2015, there was a rate of 6.2% live and still births with birth weights under 2500 grams in Oxfordshire compared with 7.4% nationally⁹³.

Between 1998 and 2015, Oxfordshire had a significantly lower percentage of low birth weight infants than England over most of this time period.

Data for Oxfordshire has had a higher proportion of low birth weight babies than South East region for some years during this time period. However, the differences are not statistically significant.

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.



As of 2015-16⁹⁴ **82.5%** of mothers in Oxfordshire initiated breastfeeding. This rate is similar to the previous year and is significantly higher than the England average (74%) and that for the South East (77.3%).



Data for 2016-17⁶ shows that, at 6-8 weeks after birth, **62%** of mothers in Oxfordshire were breastfeeding, this was well above the national average of 44%.

⁹³ Public Health England, Breastfeeding and Early Years profiles, data for Oxfordshire in 2016-17 not available as of Feb 2018

⁹⁴ Public Health England, Public Health Outcomes indicators



Data has been updated in this version



Data has been reviewed and is unchanged

6.3 Physical activity

According to Public Health England, low physical activity is one of the top 10 causes of disease and disability in England⁹⁵.

July 2016 guidance from Public Health England sets out the benefits of physical activity. As well as strengthening muscles and helping to control weight, physical activity can:

- play a critical role across all elements of cancers; prevention, treatment, recovery and reducing the risk of recurrence
- boost mental wellbeing and help reduce social isolation, a risk factor for depression.

The Health Survey for England collects data on children's physical activity, but not every year. This section is based on data collected in 2015 and earlier years.

Excluding school-based activities, 22% of children aged 5 to 15 in the Health Survey for England 2015 met the physical activity guidelines of being at least moderately active for a minimum of 60 minutes every day.

There has been a decline in the proportion of boys meeting physical activity recommendations.

- Among boys, there was a decrease in the proportion meeting physical activity recommendations between 2008 and 2012, falling from 28% in 2008 to 21% in 2012. It has remained at the lower level in 2015, at 23%. Among girls there has been no statistically significant change in the proportion meeting physical activity recommendations over the period, with 19% in 2008 and 20% in 2015

About the Health Survey for England

The Health Survey for England is a series of annual surveys designed to measure health and health-related behaviours in adults and children living in private households in England.

The survey consists of an interview and nurse visit. It has a series of core elements that are included every year or alternate years, and special topics that are included in selected years. Every year topics include general health, social care, smoking, drinking, height measurements, blood pressure measurements, adult blood samples and child saliva samples.

<https://www.gov.uk/government/statistics/health-survey-for-england-2016-findings-and-trend-tables>

⁹⁵ <https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day#the-benefits-of-physical-activity>



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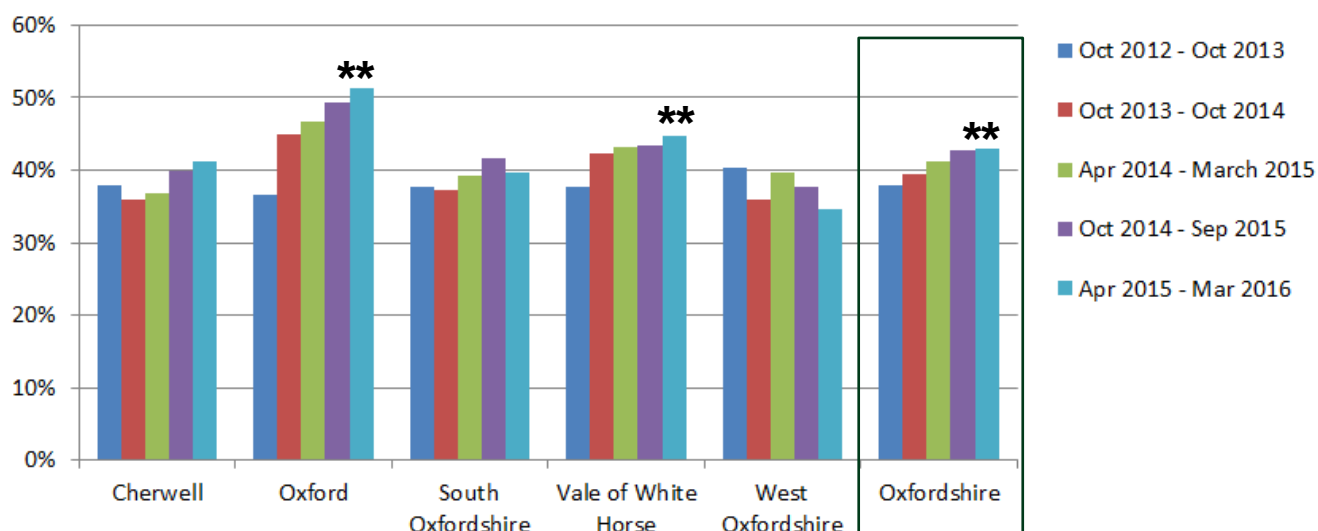


Data has been reviewed and is unchanged

Local data on physical activity of adults is from the Active People survey now redesigned and renamed the Active Lives survey⁹⁶. The new Active Lives findings are not comparable to the previous results.

As reported by the (old) active people survey of Oct12-Oct13 and Apr15-Mar16, there was a statistically significant increase in the proportion of people participating in sport in Oxfordshire as a whole and in Oxford and the Vale of White Horse districts.

Figure 72 Sports participation indicator (old method) - the number of people aged 14 and over participating in at least 30 minutes of sport at moderate intensity at least once a week.



Source: Sport England Active People Survey; ** statistically significant increase from Oct12-13 to 2015-16

⁹⁶ <https://www.sportengland.org/research/active-lives-survey/>



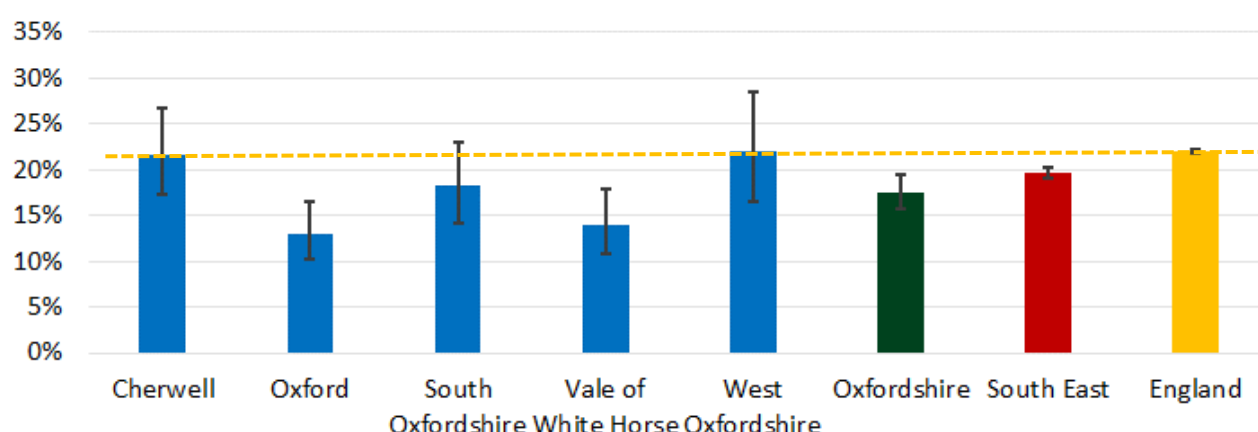
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Data has been reviewed and is unchanged

Oxford and Vale of White Horse were each better than the England average on the proportion of people who were INACTIVE according to the Active Lives survey. Cherwell, South and West Oxfordshire districts were similar to the national average.

 **Figure 73 Proportion of people aged 16+ INACTIVE (less than 30 minutes per week, including walking and gardening) November 15-16**



Source: Sport England Active Lives Survey;

Depending on the number of minutes of moderate intensity equivalent (MIE) physical activity, people are described as:

- Inactive – Doing less than 30 minutes a week
- Fairly active - Doing 30-149 minutes a week
- Active – Doing at least 150 minutes a week

Moderate activity is defined as activity where you raise your heart rate and feel a little out of breath.

About the Active Lives survey

The Active Lives survey is a “push to web” survey.

It involves four postal mailouts designed to encourage participants to complete the survey online. There is also the option to take part via telephone for those whose first language is not English, and for those who may find online or paper completion difficult, for example those who are visually impaired.

The overall sample size will be around 198,250 people each year. The minimum annual sample size for each English local authority (excluding the City of London and Isles of Scilly) will be 500. Active Lives results are published every six months.

The latest findings - for the year to mid-May 2017 - were published in October 2017. Full year results covering the period mid-November 2016 to mid-November 2017 will be released March 2018.

<https://www.sportengland.org/research/active-lives-survey/method-behind-active-lives/>



Data has been updated in this version



Data has been reviewed and is unchanged

6.4 Volunteering

NCVO defines volunteering as “any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. Central to this definition is the fact that volunteering must be a choice freely made by each individual.”⁹⁷

There are a range of studies highlighting health benefits of volunteering and Age UK has carried out a review of evidence on older people as volunteers⁹⁸ which found the most reported benefits are around physical, mental and emotional wellbeing, such as improved self-reported health, improved cognition, general mental health, increased life satisfaction, higher levels of social support and interaction, and improvements in the ability to cope with one’s own illness (especially depression).

 The Community Life survey⁹⁹ is the main source of data on the extent of volunteering in England with a sample size of around 3,000. In 2016-17 just over a quarter (27%) of respondents participated in formal volunteering at least once a month, this has been at a similar level since 2001.

- *Levels of volunteering have decreased between 2013-14 and 2016-17, with the proportion of adults who had engaged in any volunteering in the last 12 months falling from 70% to 63% and the proportion who had engaged once a month falling from 44% to 39% in this period. However, the proportion of adults who had engaged in formal volunteering, both annually and monthly, levelled off in 2016-17.*

There is no single source of comprehensive data on volunteering in Oxfordshire.

Volunteering in Oxford

 A November 2016 survey of voluntary groups in Oxford¹⁰⁰ had a response from 185 organisations (out of an estimated total of 900-1,000 in the city).

These organisations together employ around 13,800 volunteers equivalent to 10% of the population of the city aged 17 and over.

Organisations reported that volunteers in Oxford provide support in a variety of roles:

- The majority (75%) support frontline services. This may include mentors, helpers, befrienders, sports coaches, gardeners, cooks, tutors.
- 14% provide additional capacity by supporting back office functions, including communications, fundraising, volunteer recruitment.
- A small but significant number of volunteers (11%) provide governance support by contributing to trustee boards, steering committees or as school governors.

⁹⁷ <https://www.ncvo.org.uk/policy-and-research/volunteering-policy>

⁹⁸ Age UK Older People as Volunteers Evidence review

⁹⁹ <https://www.gov.uk/government/collections/community-life-survey>

¹⁰⁰ Oxford City Council Volunteering Research Project November 2016 carried out with support from OCVA, Community Action Groups and the Oxford Hub



Data has been updated in this version



Data has been reviewed and is unchanged

Volunteering in South Oxfordshire and Vale of White Horse

South Oxfordshire and Vale of White Horse District Councils carry out residents' surveys every 2 years which include questions on volunteering¹⁰¹.

 The most recent surveys found that the proportion of people, aged over 16, who had undertaken unpaid voluntary work in the past 12 months was:

- South Oxfordshire 29%
- Vale of White Horse 19%

The top reasons residents of South and Vale gave for not volunteering were work commitments and having to look after children/the home. There was a substantial minority (8% in South and 12% in Vale) who had not thought about volunteering, indicating a potential to increase the number of active volunteers.

 **Table 46 Reasons why residents have not been involved in unpaid voluntary work in the last 12 months (2015-16)**

	South Oxfordshire		Vale of White Horse	
	count	percent	count	percent
I have work commitments	378	39%	385	36%
I have to look after children/the home	177	18%	179	17%
I have other things to do in my spare time	124	13%	171	16%
I've never thought about it	73	8%	131	12%
I'm too old	93	10%	82	8%
Other	124	13%	117	11%
TOTAL	969	100%	1065	100%

Source: South Oxfordshire residents' survey 2015-16 and Vale of White Horse residents' survey 2015-16; note this survey is carried out once every two years so this is still the most recent data

¹⁰¹ South Oxfordshire Residents' survey 2015/16

http://www.southoxon.gov.uk/ccm/support/dynamic_serve.jsp?ID=535687607&CODE=7B6EA465A82E8B9DCED66CCE97292BF8

Vale of White Horse Residents' Survey 2015/16

http://www.whitehorsedc.gov.uk/java/support/dynamic_serve.jsp?ID=535688632&CODE=60FA7EC1248E352E99E300CB94B818DA



Data has been updated in this version

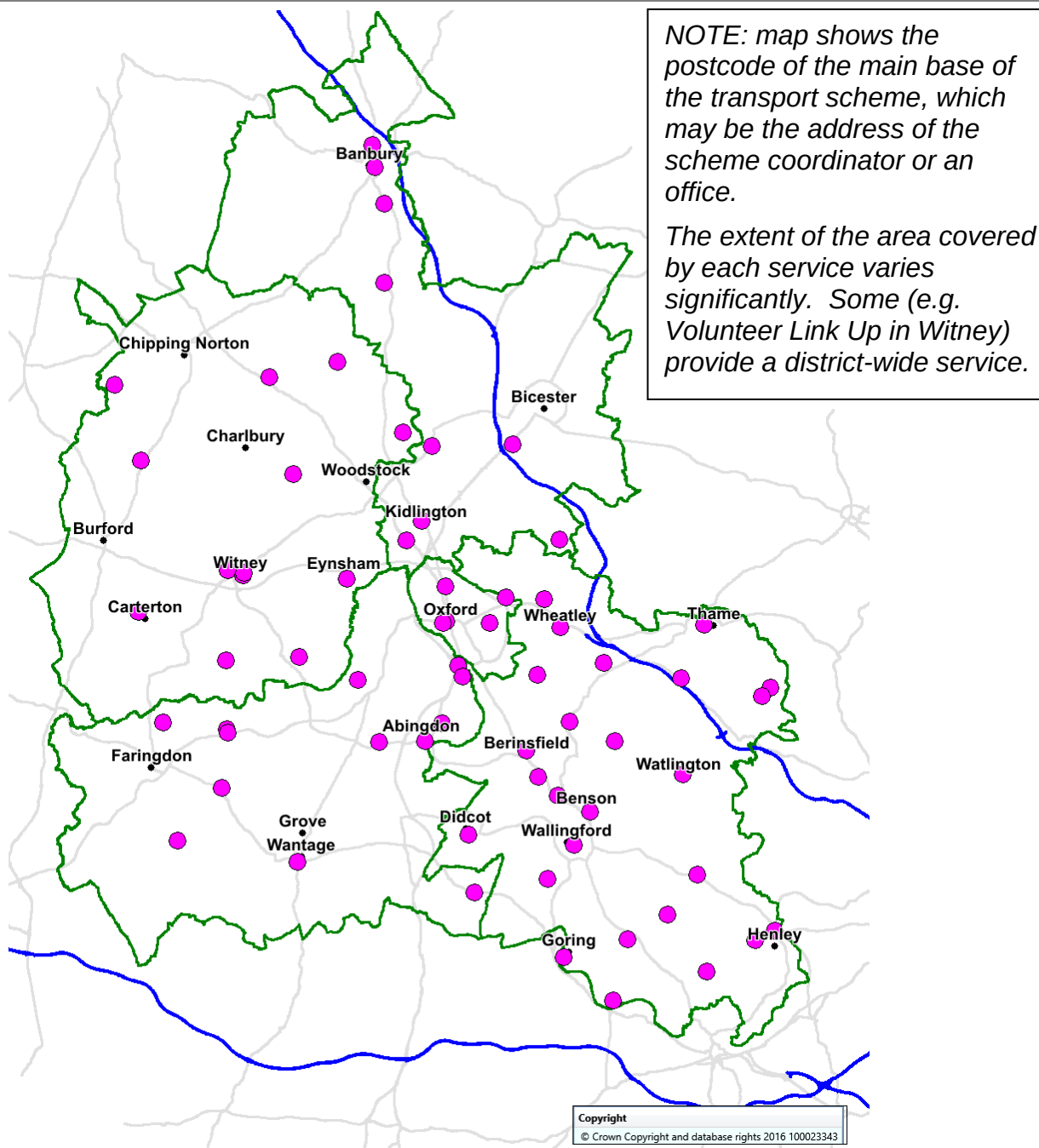


Data has been reviewed and is unchanged

Community Volunteering

Volunteers are actively providing a range of community services in Oxfordshire including community transport schemes. According to Community First Oxfordshire, as of January 2018, there were 67 community transport schemes active in Oxfordshire.

Figure 74 Location of Community Transport schemes in Oxfordshire (January 2018)



Source: Community First Oxfordshire January 2018; mapping by Oxfordshire County Council



Data has been updated in this version



Data has been reviewed and is unchanged

6.5 Smoking

Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is estimated that 17% all deaths in 2014 were attributable to smoking¹⁰².

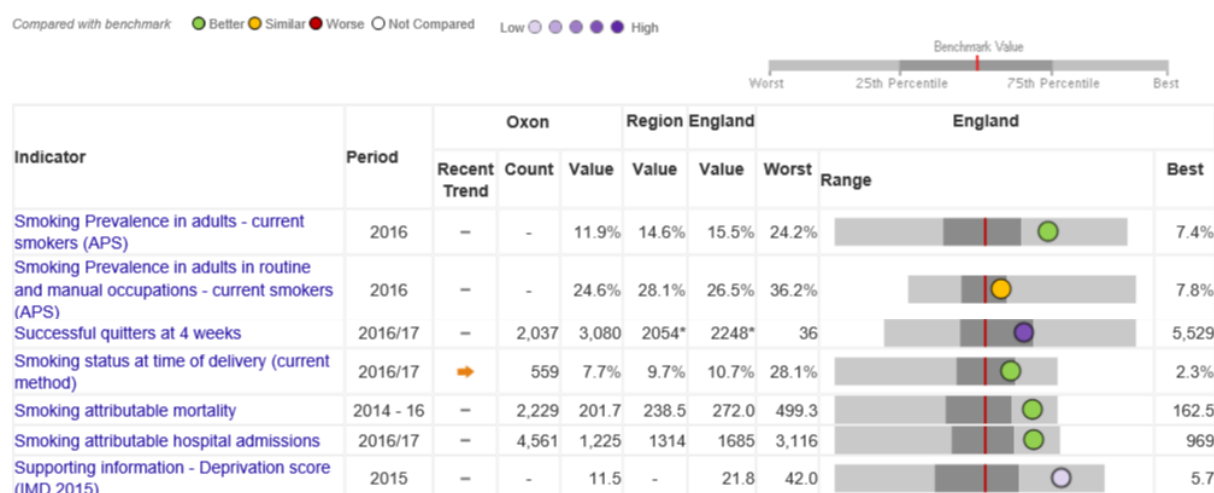
+ Health survey for England data for 2016 shows a national decline in proportion of adults smoking.

- Since 1993 there has been a steady decline in the proportion of men and women who were current smokers, from 28% to 20% in 2016 among men, and from 26% to 16% among women.

+ In 2016 an estimated **11.9%** of adults in Oxfordshire were smokers (down from 15.5% in 2015), statistically lower than the England average. Smoking prevalence in all of Oxfordshire's districts was either below or similar to national and regional averages.

Smoking prevalence in adults in routine and manual occupations was estimated at 24.5% in Oxfordshire, over double the rate of all adults and similar to the national average.

+ Figure 75 Local tobacco profile for Oxfordshire



Source: Public Health England [Local Tobacco Profiles](#)

= The Health survey for England 2015 reported on use of e-cigarettes which may help smokers quit or reduce tobacco consumption. This was not included in the latest Health survey 2016.

- In 2015, 5% of adults were currently using e-cigarettes. This is a small increase from HSE2013, when 3% of adults were e-cigarette users.

¹⁰² Source: NHS Digital, Statistics on Smoking, England – 2016



Data has been updated in this version



Data has been reviewed and is unchanged

- The prevalence of ever having used e-cigarettes was much higher among current smokers (40%). Only 1% of those who had never smoked had ever used an e-cigarette.

Smoking among children

 Health survey for England data for 2016 shows a national decline in proportion of children smoking.

- The proportion of children aged 8 to 15 who had ever smoked has decreased overall, from 18% of boys and 20% of girls in 1997 to 6% of boys and 3% of girls in 2016.

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 data (2016-17) shows that smoking at time of delivery in Oxfordshire was 7.7%, remaining at a similar level since 2010-11. This continues to be lower than England (10.7%) but indicates there are nearly 560 women smoking during pregnancy.

6.6 Alcohol and drugs

 According to the December 2016 *Public health burden of alcohol: evidence review*¹⁰³ there are three major categories of alcohol-related health, social and economic costs:

- the direct economic costs of alcohol consumption, for example, costs to health and social care, the police and criminal justice system and the unemployment and welfare systems.
- the indirect costs of alcohol consumption, for example, lost productivity due to absenteeism, unemployment, decreased output, reduced earnings potential and lost working years due to premature pension or death.
- the intangible costs of alcohol consumption, for example, costs assigned to pain and suffering, poor quality of life, or costs from money spent on alcohol in families where the money is needed for other things.

Over half (55%) of all admissions for mental and behavioural disorders due to alcohol use were in the lowest three socioeconomic deciles, and these three groups also accounted for 53% of all admissions for alcoholic liver disease, 53% of all admissions for intentional injuries and 51% of all admissions for alcohol-related complications in pregnancy and childbirth.

 According to the 2016 Health survey for England, alcohol consumption in general has been declining in children.

- There has been no statistically significant change in weekly alcohol consumption since 2011. In 2016, average consumption was 16.0 units per week for men and 9.1 units for women.
- The proportion of children aged 8 to 15 reporting ever having had a proper alcoholic drink (a whole drink, not just a sip) fell from 45% in 2003 to 15% in 2016.

¹⁰³ <https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review>



Data has been updated in this version



Data has been reviewed and is unchanged

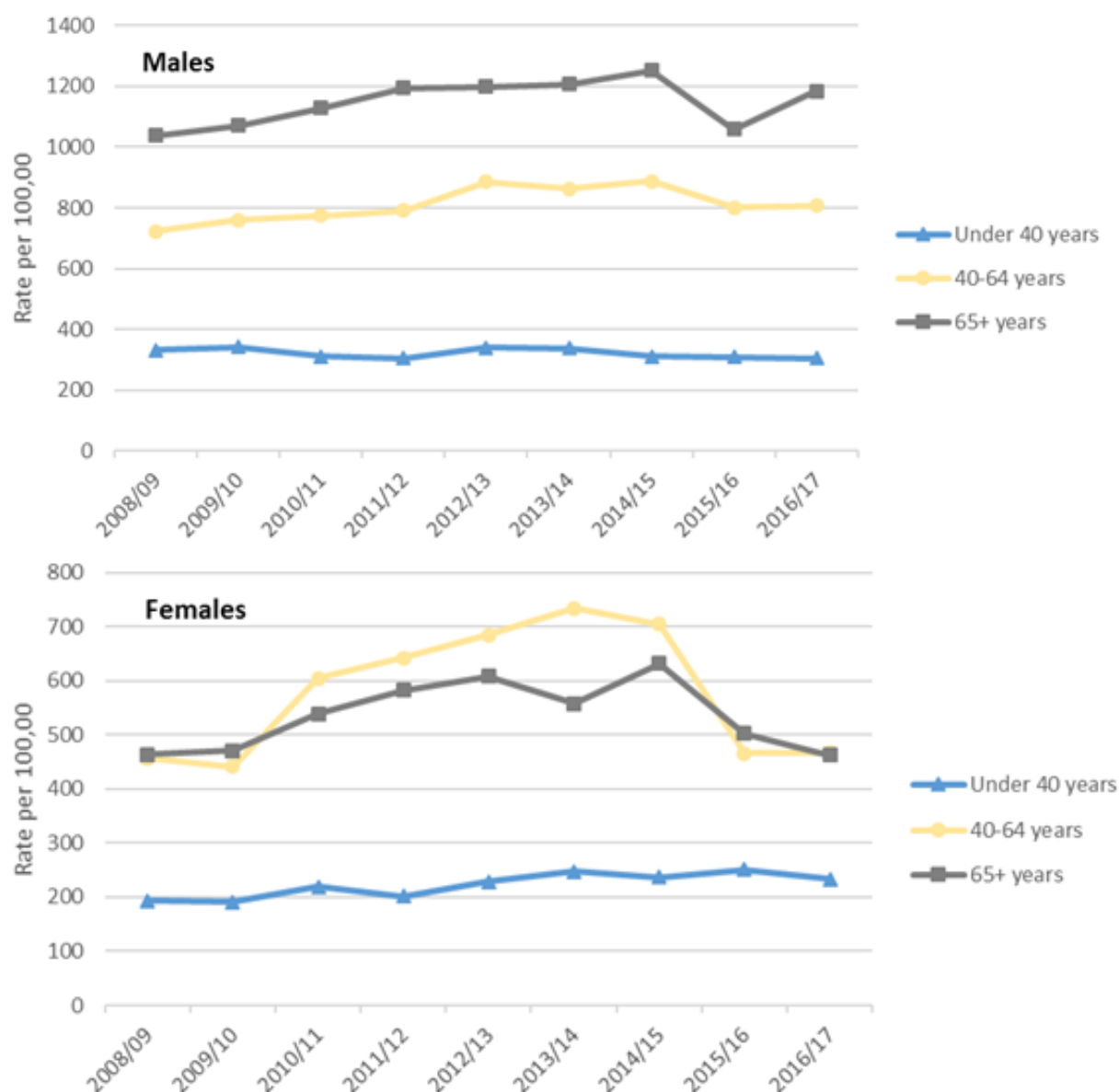
Alcohol and health in Oxfordshire



Data on hospital admissions for alcohol-related conditions in Oxfordshire shows that:

- Overall males continue to have higher rates than females for alcohol-related admission episodes.
- Between 2008/09 and 2016/17 there was no statistically significant change in the rate of admissions for alcohol-related conditions in Oxfordshire

Figure 76 Admission episodes for alcohol-related conditions (narrow), directly standardised rate per 100,000 people, Oxfordshire males and females by age



Definition: Admissions to hospital where the primary diagnosis is an alcohol-attributable code or a secondary diagnosis is an alcohol-attributable external cause code. Source: Public Health England Local Alcohol Profiles from Hospital Episode statistics and ONS population estimates.



Data has been updated in this version

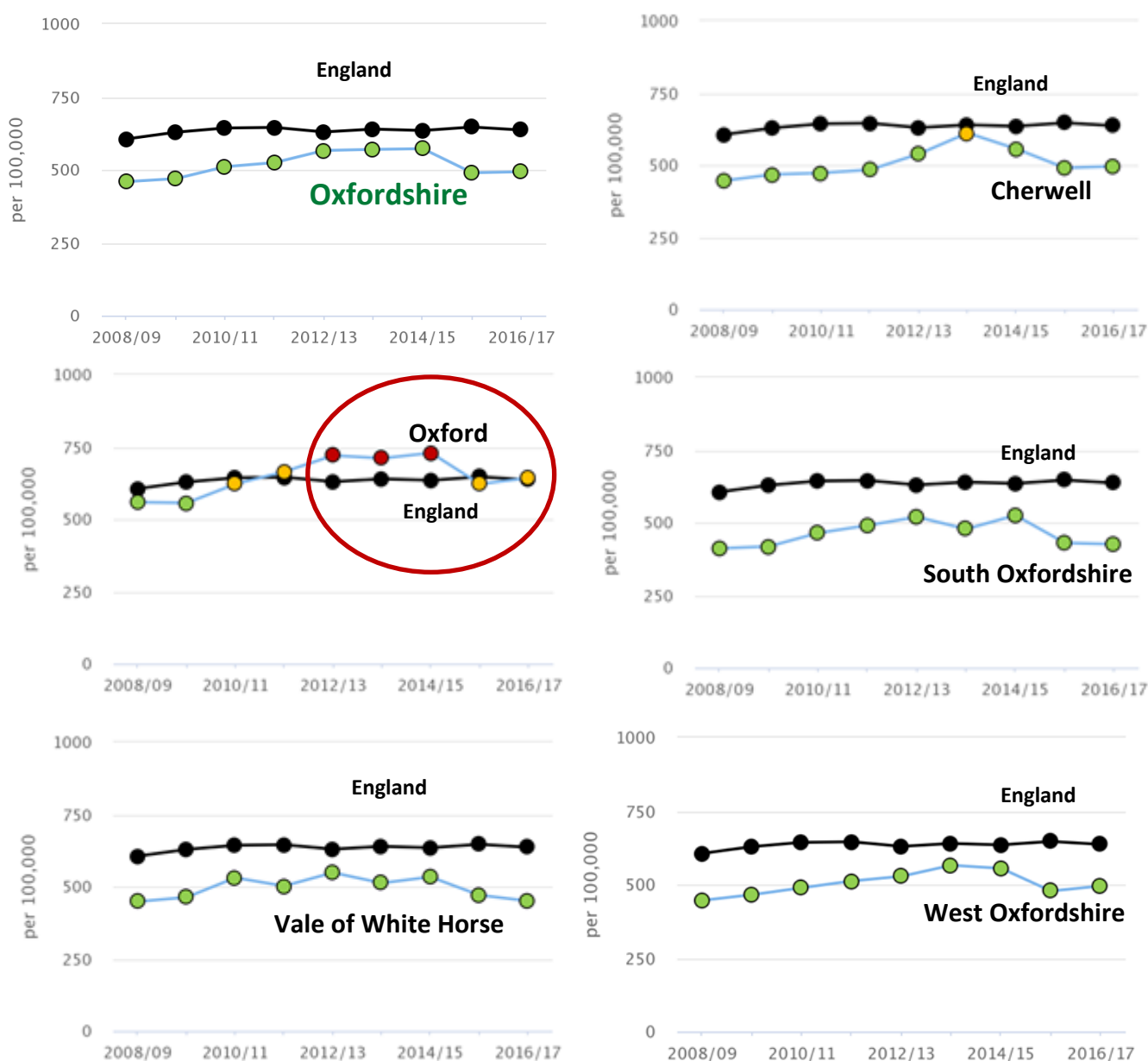


Data has been reviewed and is unchanged

Admissions for alcohol-related conditions were better than average in Oxfordshire compared with England.

In 2016/17, Oxford had a similar rate of admissions to England; all other districts were better than average.

Figure 77 Admission episodes for alcohol-related conditions (narrow), directly standardised rate per 100,000 people



Source: Public Health England Alcohol Profiles from Hospital Episode statistics and ONS population estimates



Data has been updated in this version



Data has been reviewed and is unchanged

➔ At a ward level, data for 2011-12 to 2015-16 shows 6 wards in Oxfordshire with a significantly higher rate of hospital admissions for alcohol attributable conditions, all in Oxford city.

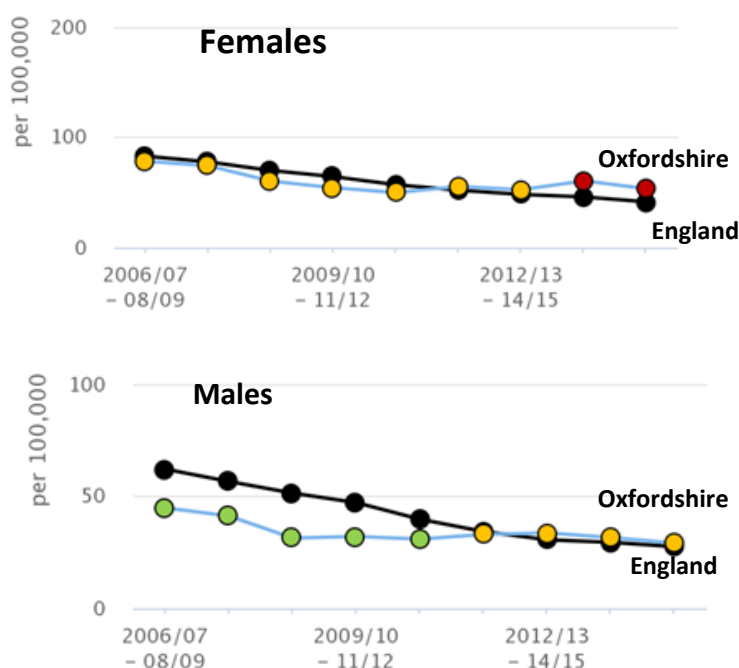
See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in admissions for alcohol attributable conditions across Oxfordshire

Alcohol admissions in under 18s

The number of under 18s in Oxfordshire admitted to hospital for alcohol-specific conditions in the three-year period 2014/15 to 2016/17 was **174**.

The rate of hospital admissions for alcohol-specific conditions in females under 18 in Oxfordshire increased in 2013/14-2015/16 to statistically above the national average, and has remained above average in the latest data (2014/15-2016/17). The rate for males in Oxfordshire was similar to average.

➔ **Figure 78 Hospital admissions for alcohol-specific conditions, under 18s, crude rate per 100,000 population, Oxfordshire**



Females count (2014/15-2016/17) = 111

Males count (2014/15-2016/17) = 63

Source: Public Health England Alcohol Profiles from Hospital Episode statistics and ONS population estimates



Data has been updated in this version



Data has been reviewed and is unchanged

Alcohol-related deaths



Nationally the rate of alcohol-related deaths (deaths caused by diseases known to be related to alcohol consumption, such as cirrhosis of the liver) per 100,000 population (age standardised) for males and females has declined since the peak in 2008¹⁰⁴.

In recent years, for people in the UK, rates of alcohol-related deaths have remained at a similar level, with no statistical differences in the all person rate since 2012.

In 2016 there was a total of 224 alcohol-related deaths in Oxfordshire¹⁰⁵, the largest number was in Cherwell (55) followed by Oxford (51), South Oxfordshire (47), Vale of White Horse (39) and West Oxfordshire (32).

In Oxfordshire, the rates of alcohol-specific and alcohol-related deaths were each statistically better than the national average. Districts in Oxfordshire were similar to or better than average.

Drugs and health in Oxfordshire

Local data on the health impact of drug use is limited.



Police recorded crime data from Thames Valley Police¹⁰⁶ shows between 2015-16 and 2016-17 (Dec to Nov) there was a decline in the number of “possession of drugs” crimes in each reporting area of Oxfordshire (Cherwell & West, Oxford, South & Vale).

The rate of possession of drugs crimes per 1,000 population (Dec16 to Nov17) was below the Thames Valley (1.52) average in Cherwell & West (1.29) and in South & Vale (0.88) and above average in Oxford (2.28).

Drugs-related deaths



Combined data from 2014-16 gives a total of 53 drugs related deaths in Oxfordshire, half of which were in Oxford.

The rate of deaths from drug misuse (not including alcohol and tobacco) was statistically below the national average in Oxfordshire, South Oxfordshire and Vale of White Horse.

¹⁰⁴

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2015>

¹⁰⁵Public Health England Local Alcohol Profiles

¹⁰⁶ Source: [Performance Figures 2016-17](#), Thames Valley Police

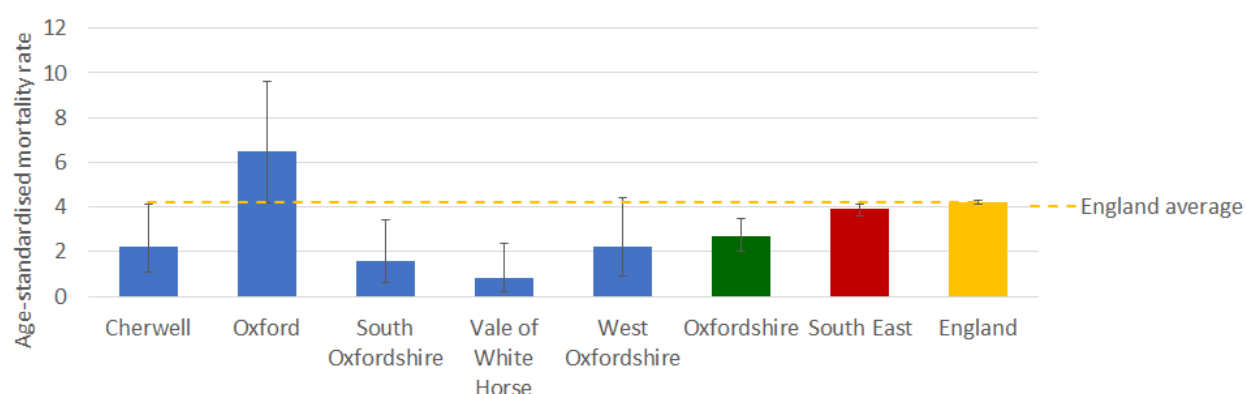


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 79 Age-standardised mortality rate for deaths related to drug misuse, persons (2014-16)



Source: ONS, [Drug misuse deaths by Local Authority](#) released August 2017

About Deaths related to drug misuse: description and ICD-10 Codes

- Mental and behavioural disorders due to drug use (excluding alcohol and tobacco) F11–F16, F18–F19
- Accidental poisoning by drugs, medicaments and biological substances X40–X44
- Intentional self-poisoning by drugs, medicaments and biological substances X60–X64
- Assault by drugs, medicaments and biological substances X85
- Poisoning by drugs, medicaments and biological substances, undetermined intent Y10–Y14

6.7 Abuse and exploitation

Domestic Violence and abuse

The cross-government definition¹⁰⁷ 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



In Oxfordshire in 2017, Thames Valley Police recorded a total of:

¹⁰⁷ <https://www.gov.uk/guidance/domestic-violence-and-abuse>



Data has been updated in this version



Data has been reviewed and is unchanged

- 3,352 domestic abuse crimes (+6% compared with 2016)
- 8,566 domestic abuse incidents (at a similar level to 2016)
- 11,446 victims of domestic abuse crimes and incidents (+2% compared with 2016)
-

District-level data shows the greatest number of recorded victims of domestic abuse was in Oxford and the greatest increase in recorded victims between 2016 and 2017 was in South Oxfordshire (+11%) and West Oxfordshire (+10%).

 **Table 47 Number of Victims of Domestic Abuse (Crime and Incidents) in Oxfordshire, calendar year**

	2014	2015	2016	2017	2016 to 2017	% change
Cherwell	2,455	2,860	2,878	2,999	121	4%
Oxford	2,965	3,166	3,278	3,174	-104	-3%
South Oxfordshire	1,694	1,760	1,742	1,934	192	11%
Vale of White Horse	1,588	1,696	1,880	1,777	-103	-5%
West Oxfordshire	1,333	1,385	1,416	1,562	146	10%
Oxfordshire TOTAL	10,035	10,867	11,194	11,446	252	2%

Source: Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018)

The oldest victim in 2017 in Oxfordshire was aged 101.

Between 2016 and 2017:

- The number of younger victims of domestic abuse in Oxfordshire (aged under 25) increased slightly.
- The 18-24 age group saw the biggest increase in numbers (+130).
- The greatest percentage increase by broad age was in the older age group 50-64 (+8%).



Data has been updated in this version



Data has been reviewed and is unchanged

Table 48 Victims of Domestic Abuse (Crime and Incidents) in Oxfordshire, by age

	2014	2015	2016	2017	2016 to 2017	% change
0-15	128	141	114	95	-19	-17%
16-17	281	359	377	297	-80	-21%
18-24	2,023	2,116	2,087	2,217	130	6%
25-49	5,918	6,421	6,697	6,825	128	2%
50-64	1,224	1,339	1,417	1,534	117	8%
65-79	300	328	364	358	-6	-2%
80+	68	92	110	90	-20	-18%
Total (excluding age not recorded)	9,942	10,797	11,166	11,416	250	2%

Source: Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018)



Domestic abuse victims by gender

- Overall in Oxfordshire in 2017, of the victims with a recorded gender (the majority): 77% of victims were female and 23% were male, similar to previous years.
- The gender split was similar in all districts with a slightly higher proportion of female victims in Oxford (78%) and Vale of White Horse (78%) and a slightly lower proportion of female victims in West Oxfordshire (73%)



Domestic abuse victims by ethnicity:

- Overall in Oxfordshire in 2017, of the victims with a recorded ethnicity: 91% of victims were White ethnic background and 9% were non-White.
 - Asian 4%; Mixed 2%; Black 2%.
- In Oxford, as expected from the more ethnically diverse population, 80% of victims were White and 20% were non-White.
 - Asian 10%; Mixed 3%; Black 5%.
- Note that caution is needed in interpreting this data as there is a relatively high rate of victims without an ethnic group recorded (26% of the total).

Rape



Between 2016 and 2017, Thames Valley Police recorded an increase in the total number of recorded victims of rape offences in Oxfordshire from 548 in 2016 to 611 in 2017 (+11%).

The greatest number of recorded rape victims was in Oxford (36% of the total for Oxfordshire) and the greatest increase in victims between 2016 and 2017 was in South Oxfordshire (+11%, 28 additional victims).



Data has been updated in this version



Data has been reviewed and is unchanged

 **Table 49 Number of Victims of Rape (Crime and Crime Related Occurrence) in Oxfordshire, calendar year**

	2014	2015	2016	2017	2016 to 2017	% change
Cherwell	82	112	128	136	8	6%
Oxford	147	231	228	222	-6	-3%
South Oxfordshire	40	70	70	98	28	40%
Vale of White Horse	50	64	69	82	13	19%
West Oxfordshire	49	47	53	73	20	38%
Oxfordshire TOTAL	368	524	548	611	63	11%

Source: Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018); The above data is for all victims of rape offences

Reported crime is all reports of crime recorded on the crime recording system.

Reported crime is made up of Finally Recorded Crime, Crime Related Occurrences and Cancelled Crimes.

Crime Related Occurrence: This term is used to describe a record of an incident which has come to the attention of the police, which, on the Balance of Probabilities would normally amount to a notifiable crime, but a resultant crime has not been recorded. The specific circumstances where this would happen are

1. The incident is reported by a third party and either
 - The alleged victim declines to confirm the crime or
 - The alleged victim cannot be traced
2. The incident is being dealt with by another police force
3. The National Crime Recording Standard or Home Office Counting Rules for Recording Crime direct that a crime should not be recorded

Cancelled Crime: An offence can only be cancelled if it has been recorded as a crime. The situations when a crime can be cancelled are governed by the Home Office Counting Rules for Recorded Crime. Specific circumstances when an offence can be cancelled are:

- The offence was committed in another force area.
- There is additional verifiable information which determines that no notifiable crime has been committed.
- The crime constitutes part of a crime already recorded.
- The crime was recorded in error.
- The crime was recorded as an assault and there is additional verifiable information that the offender acted in self-defence.
- The crime is an offence of fraud and there clear auditable information that shows that the offender has been dealt with in another jurisdiction.

Source: Thames Valley Police Performance Team



Data has been updated in this version



Data has been reviewed and is unchanged

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. 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.

Statutory guidance published in April 2016 introduced a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18s, which they identify in the course of their professional work, to the police.

-  The NHS Digital FGM annual report for 2016-17¹⁰⁸ shows that:
- in the South of England Commissioning region, there were 580 newly recorded cases of FGM reported, and 1,415 attendances where FGM was identified or a procedure for FGM was undertaken.
 - For NHS Oxfordshire CCG, there were 10 newly recorded cases of FGM and 15 attendances (rounding applied).

-  In Oxfordshire in 2017, Thames Valley Police recorded a total of 5 victims of Female Genital Mutilation (crime and non-crime)¹⁰⁹.

Forced Marriage

-  The number of cases of possible forced marriage being supported by the UK Forced Marriage Unit had been declining until the most recent year of data (2016).
- In 2016 the UK Forced Marriage Unit gave advice or support related to a possible forced marriage in 1,428 cases nationwide¹¹⁰. This was up from 1,220 in 2015 (+17%). 10% of the cases were in the South East, compared with 11% in 2012.
-  In Oxfordshire: for the four-year period Jan 2014 to Dec 2017, Thames Valley Police recorded no (zero) victims of Forced Marriage¹¹¹.

Honour-based Violence

According to the Crown Prosecution Service guidance:

There is no specific offence of "honour based crime". It is an umbrella term to encompass various offences covered by existing legislation. Honour based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive

¹⁰⁸ NHS Digital: [Female Genital Mutilation \(FGM\) Annual Report](#) 2016/17 July 2017

¹⁰⁹ Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018)

¹¹⁰ Forced marriage Unit Statistics: <https://www.gov.uk/government/statistics/forced-marriage-unit-statistics-2016>

¹¹¹ Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018) Forced Marriage data is for all victims of offences where either the Home Office Stats Code has been recorded as 03605 or the Classification has been recorded as Forced Marriage Offences.



Data has been updated in this version



Data has been reviewed and is unchanged

that a relative has shamed the family and/or community by breaking their honour code.

 The number of victims of Honour-based violence in Oxfordshire appears to have increased from 18 recorded by Thames Valley Police in 2014 to 69 in 2017.

The majority of victims in the 4-year period 2014-2017 were residents of Oxford city (61%). 23% were resident in Cherwell and 8% in Vale of White Horse.

 **Table 50 Number of Victims of Honour Based Violence All Occurrences (Crime and Crime Related Occurrence) in Oxfordshire, calendar year**

	2014	2015	2016	2017	2014-17	% of total
Cherwell	10	5	15	10	40	23%
Oxford	5	16	36	47	104	61%
South Oxfordshire	0	2	1	5	8	5%
Vale of White Horse	2	0	8	3	13	8%
West Oxfordshire	1	1	0	4	6	4%
Oxfordshire TOTAL	18	24	60	69	171	100%

Source: Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018); The above data is for all victims of offences where either the HBV Latest or HBV Finalisation qualifier has been used or the Occurrence Type or Classification has been recorded as Honour Based Violence – Crime Related Occurrence.

Child Sexual Exploitation

In February 2017, the government published *Child sexual exploitation: definition and guide for practitioners*¹¹² setting out a definition of child sexual exploitation, potential vulnerabilities and indicators of abuse and appropriate action to take in response.

The definition of Child Sexual Exploitation from this guidance is:

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

 In 2017, Thames Valley Police recorded a total of 106 victims of Child Sexual Exploitation in Oxfordshire, almost 40% below that in 2016 (170) with the greatest reduction in Oxford (21 in 2017 compared with 94 in 2016).

¹¹² <https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners>



Data has been updated in this version



Data has been reviewed and is unchanged

Over 40% (44%) of victims recorded in the four years between 2014 and 2017 were in Oxford city and a further 26% were in Cherwell.

 **Table 51 Number of Victims of Child Sexual Exploitation (Crime and Crime Related Occurrence) in Oxfordshire, calendar year**

	2014	2015	2016	2017	Total 2014-17	% of total
Cherwell	38	29	41	36	144	26%
Oxford	36	92	94	21	243	44%
South Oxfordshire	8	15	16	24	63	11%
Vale of White Horse	26	16	10	16	68	12%
West Oxfordshire	6	11	9	9	35	6%
Oxfordshire TOTAL	114	163	170	106	553	100%

Source: Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018); The above CSE data is for all victims of offences where either the 'Child Sexual Exploitation' qualifier has been used or the Occurrence Type has been recorded as 'Suspected CSE – Crime Related Incident'

Modern slavery

From 1 November 2015, as set out in the Modern Slavery Act 2015, specified public authorities (including all police forces and local authorities), have a duty to notify the Home Office of any individual encountered in England and Wales who they believe is a suspected victim of slavery or human trafficking.

Thames Valley Police recorded 106 victims of Modern Slavery in Oxfordshire in 2017, almost 3 times the number recorded in 2016 (37).

 **Table 52 Number of Victims of Modern Slavery and Trafficking Offences in Oxfordshire, calendar year**

	2016	2017	Total 2016-2017	% of total
Cherwell	12	30	42	29%
Oxford	20	50	70	49%
South Oxfordshire	1	6	7	5%
Vale of White Horse	2	15	17	12%
West Oxfordshire	2	5	7	5%
Oxfordshire TOTAL	37	106	143	100%

Source: Thames Valley Police Crime Recording System - Niche RMS (extracted Jan 2018). The above data is for all victims of Modern Slavery and Trafficking offences. Modern Slavery offences have been identified where either the HO Category Number is 106 or the Modern Slavery Finalisation Qualifier has been used. Trafficking offences have been identified where either the classification or Occurrence Type has been recorded as Trafficking for Sexual exploitation (out of, into, within the UK) and Trafficking for non-sexual Exploitation (out of, into, within the UK)



Data has been updated in this version



Data has been reviewed and is unchanged

6.8 Oral health

Tooth decay is a predominantly preventable disease. Significant levels remain, resulting in pain, sleep loss, time off school and, in some cases, treatment under general anaesthetic.¹¹³

 Data from Public Health England shows that in Oxfordshire, 77.3% of 5 year olds were free of dental decay in 2014-15, similar to the national average. This is an improvement on the rate in 2011-12 when Oxfordshire was statistically below (worse than) the national average. The rate was lowest in Oxford where 67% of 5 year olds were free from dental decay in 2014-15 (worse than average).

 **Table 53 Proportion of five-year-old children free from dental decay (2010-11 and 2014-15)**

	2011-12			2014-15		
	Count	Percentage	vs Eng av	Count	Percentage	vs Eng av
Cherwell	198	56.2	WORSE	232	78.2	SIMILAR
Oxford	150	61.0	WORSE	210	67.2	WORSE
South Oxfordshire	193	84.9	BETTER	223	78.6	BETTER
Vale of White Horse	198	81.2	BETTER	225	79.4	SIMILAR
West Oxfordshire	130	59.1	WORSE	249	81.2	BETTER
Oxfordshire	869	67.1	WORSE	1,139	77.3	SIMILAR

Source: Public Health England, Public Health Outcomes Framework, denominator is total number of examined children in the area. Note that parental permission is required for dental examination and may affect the results.

6.9 Teenage conceptions

 In 2015 there was a total of 148 conceptions to women aged under 18 in Oxfordshire, below the number in 2014 (190).

Between 2014 and 2015 there was a decline in the number and rate of teenage conceptions in Oxfordshire, and a decline regionally and nationally.

¹¹³ Public Health England, definition of indicator "Proportion of five-year-old children free from dental decay"



Data has been updated in this version



Data has been reviewed and is unchanged

Table 54 Number and rate (per 1,000) of conceptions to women aged under 18

	2014		2015		change
	Number	Rate	Number	Rate	
Cherwell	55	20.6	37	13.9	↓
Oxford	54	23.7	38	17.2	↓
South Oxfordshire	26	10.8	29	12.2	↑
Vale of White Horse	38	18	20	9.4	↓
West Oxfordshire	17	9.2	24	13.0	↑
Oxfordshire	190	16.8	148	13.2	↓
South East		18.8		17.1	↓
England		22.8		20.8	↓

Source: ONS conception statistics (released March 2017)

6.10 Sexually Transmitted Infections

As of 2016, the rate of new diagnoses of Sexually Transmitted Infections (STIs) per 100,000 population (aged 15 to 64) in Oxfordshire was 742. This was significantly below the rate for England (795). The rate for Oxford city remained above average (1,280). There has been little change in rate of diagnoses since 2012.

Gonorrhoea

Gonorrhoea causes avoidable sexual and reproductive ill-health. Gonorrhoea is used as a marker for rates of unsafe sexual activity. This is because the majority of cases are diagnosed in genitourinary medicine (GUM) settings, and consequently the number of cases may be a measure of access to sexually transmitted infection (STI) treatment. Infections with gonorrhoea are also more likely than chlamydia to result in symptoms¹¹⁴.

Gonorrhoea diagnoses have increased nationally and in Oxfordshire, 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 men who have sex with men.

Since 2011, the rate of diagnosis of gonorrhoea in Oxford has increased at above the national rate.

Note that the increased number of diagnoses in 2015 was due to the testing method used at the time. Following an audit of cases and a further period of external validation of tests it was found that there was a number of false positive cases.

A new method of secondary testing of samples is in place since 2015 which has created a more robust testing procedure and seen a reduction in positive cases.

¹¹⁴ Public Health England definition of indicator of rate of diagnosis of gonorrhoea

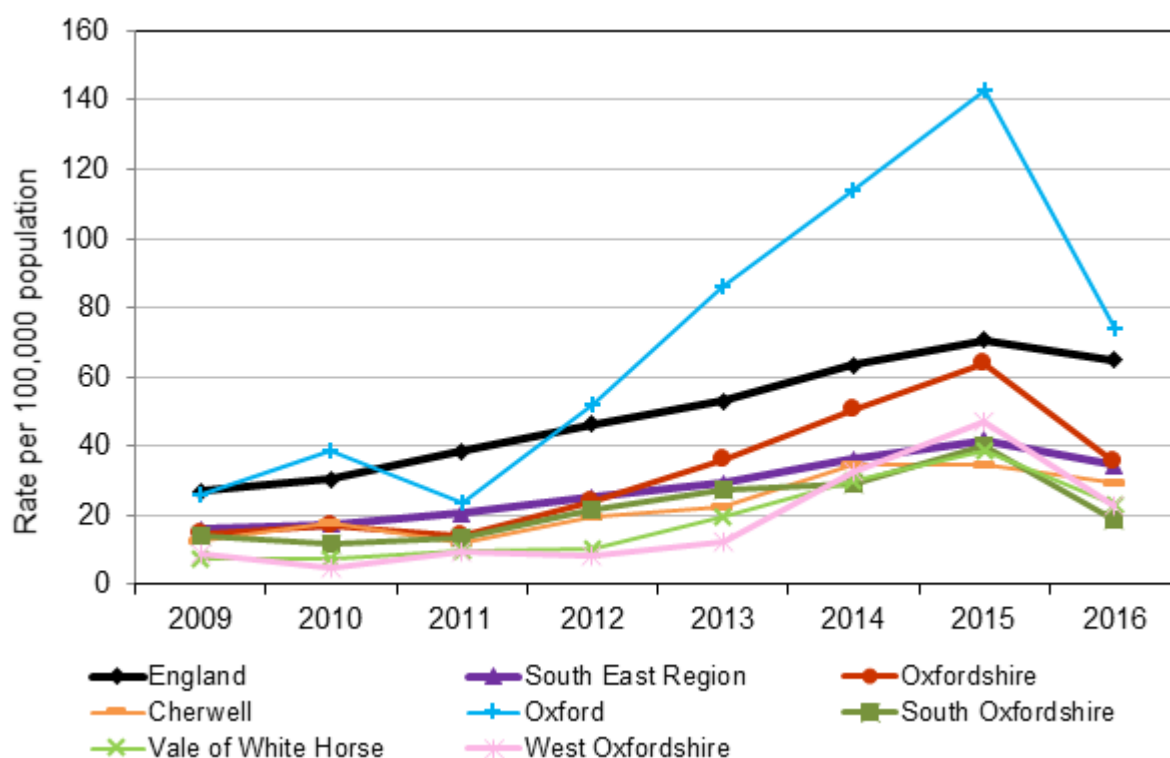


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Figure 80 Rate of diagnoses of gonorrhoea in Genito-urinary Medicine (GUM) clinics per 100,000 population (all ages) 2009 to 2016 (calendar years)



Source: Public Health England / Health Protection Agency - Sexual and Reproductive Health Profiles

Notes: Data represent the number of diagnoses reported and not the number of people diagnosed.

Data available by patient residence - data represent STI diagnoses among people accessing services located in England who are resident in England. If patient residence is not known that data has been excluded.

Crude rates are not adjusted for factors such as age, sex and ethnicity and have been recalculated for 2009, 2010, 2011 and 2012. Confidence intervals have been calculated locally.

Chlamydia

Chlamydia was the most commonly diagnosed STI in 2016. 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.

Over the past five years there has been little change nationally, regionally or locally. Within the districts in Oxfordshire, there is more fluctuation and, except for Oxford City, the rate has increased but is now levelling off. Oxford City rates have dropped significantly but have recently levelled off.

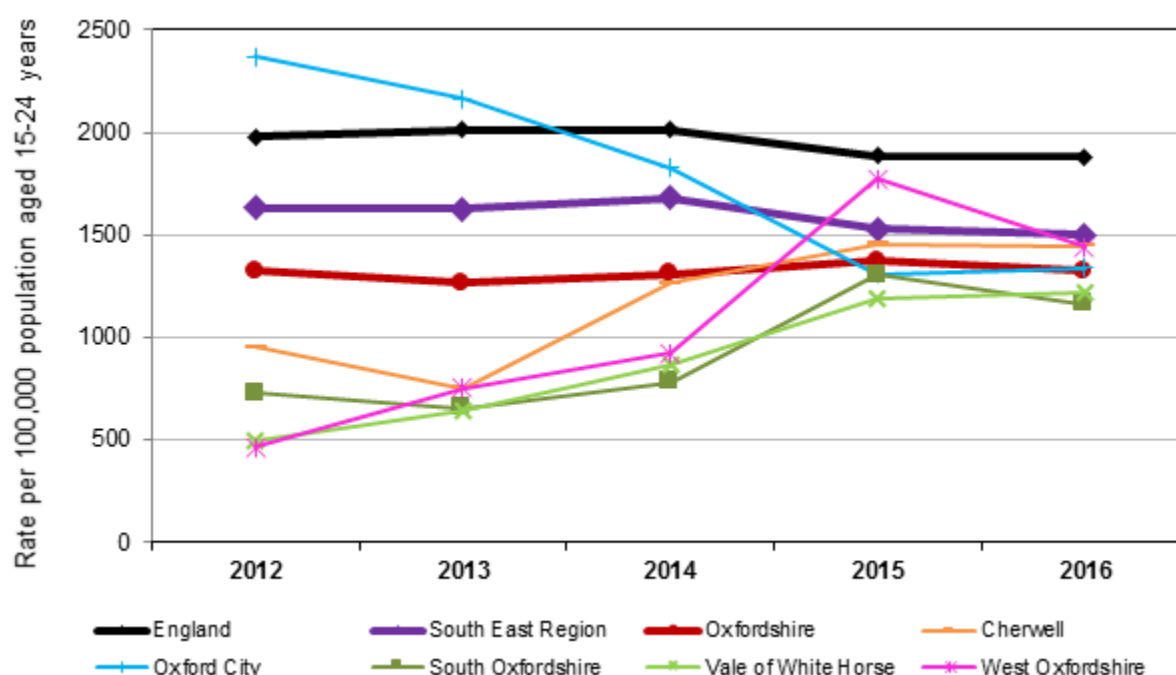


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Figure 81 Diagnoses of chlamydia per 100,000 population (aged 15-24 years) 2012 to 2016 (calendar year)



Source: Data accessed via the National Chlamydia Screening Programme website

Notes: Data represent chlamydia tests and diagnoses among people accessing services in England, who are residents in England. Data includes all screening tests, diagnostic tests and tests on contacts. Data represents the number of tests and diagnoses reported, and not the number of people tested or diagnosed. Data presented is based on tests with confirmed positive and negative results only. Tests with equivocal, inhibitory and insufficient results have been excluded as most people with these results are re-tested. Confidence intervals are calculated locally.

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.



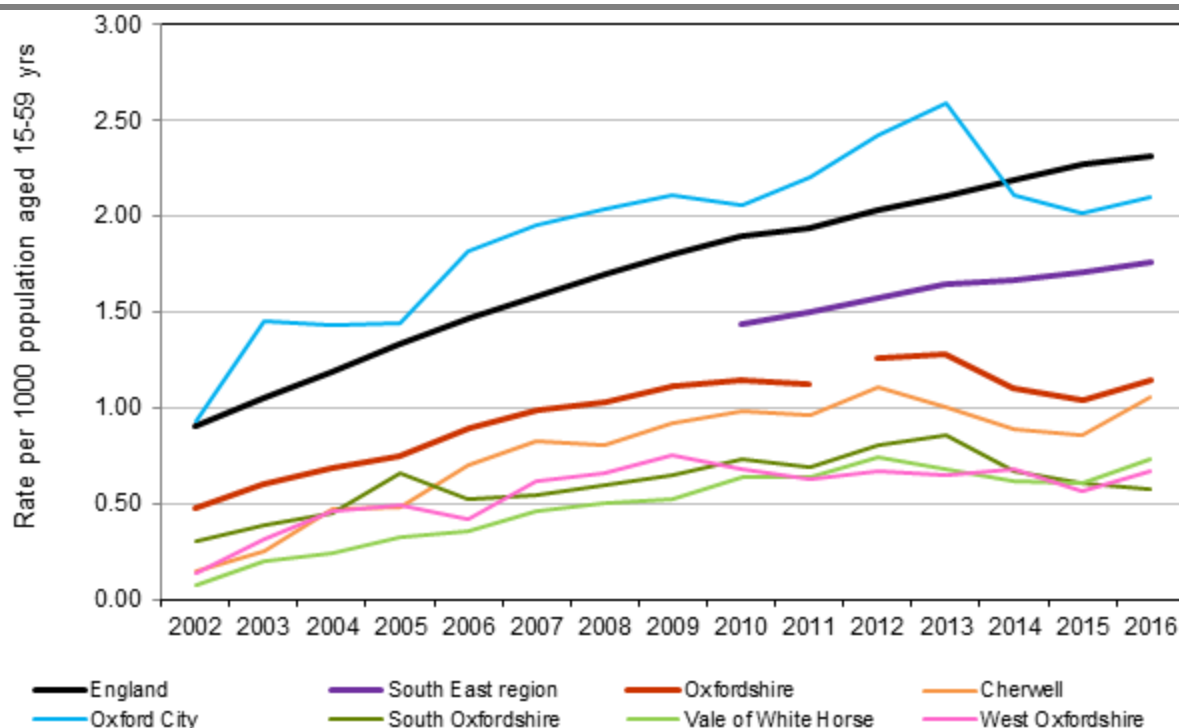
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Overall in Oxfordshire the prevalence rate of HIV is significantly lower than the national average. However more than half of the people with HIV live in Oxford City which, until recently, has had a significantly higher prevalence rate than England.

Figure 82 Prevalence of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 yrs 2002 to 2016 (calendar years)



Source: Public Health England Sexual and Reproductive Health Profiles

Notes: The numerator only covers individuals who have received a HIV diagnosis and will therefore be an under-estimation of actual numbers of people living with HIV who remain undiagnosed and untreated. Crude rates are not adjusted for factors such as age, sex and ethnicity. In addition, numbers do not include people who are undiagnosed.



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Data has been reviewed and is unchanged

7 Service use

This chapter 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 Service use – key findings

This section highlights the key messages from the review of data on Service Use (data sources and research references are provided with the detailed data in the remainder of this chapter).

Healthcare workforce

- In September 2017, there was a total of 644 advertised vacancies (full time equivalents) for Oxford Health NHS FT, Oxford University Hospitals NHS FT and Oxfordshire CCG. 44% were for nurses/midwives and 22% were administrative and clerical.
- Care Quality Commission analysis shows that from mid-2016 to mid-2017 Oxfordshire NHS Acute staff turnover for nursing & midwifery staff, other clinical and non-clinical staff was well above the England average.

Use of health services

- Use of health services is increasing overall and per person. The number of times people visit their doctor or are treated in hospital has increased significantly in Oxfordshire (and nationally), especially in the older age group.
- According to the 2017 GP Patient Survey, after contacting an NHS service outside of GP surgery hours, 30% of Oxfordshire respondents attended A&E (34% nationally).
- The proportion of hospital inpatients with complicating comorbidities is increasing. In 2012-13 the proportion was 10.3% of inpatient spells and by 2016-17 this had increased to 11.8%. The district with the highest proportion of patients with complicating comorbidities was Oxford City.
- In 2016-17 there was around 12,000 inpatient spells for Oxfordshire residents aged 85 and over, 10% of the total number of inpatient spells.
- Oxfordshire County Council forecasts suggest a potential increase of inpatient spells for people aged 85+ from 12,000 in 2016-17 to 18,400 by 2031-32 (+6,800).
- In 2016-17 Ambulance data show the top condition for Oxfordshire residents was falls, 11% of the total.
- Oxfordshire's comparative rates of injuries due to falls in people aged 65+ and for people aged 80+ has improved, from statistically worse than average to similar to the South East average.



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Data has been reviewed and is unchanged

- In 2016-17 the average daily rate of delayed transfers of care (DTOC) within Oxfordshire in 2016-17 was 25.7 (people aged 18 and over per 100,000). This rate has fallen since the previous year but remains significantly higher than the average rate for England of 15.
 - Care Quality Commission analysis shows the greatest difference between Oxfordshire and national/regional averages from February 2017 to August 2017 was people waiting for a care package at home or community equipment/adaptations, where Oxfordshire was over 3 times the average rate per 100,000 people of comparator areas.
- In the past year, there has (again) been an increase in the number of people referred for treatment to Oxford Health mental health services, particularly children and young people.
 - Between 2011-12 and 2016-17, the number of patients referred to Oxford Health mental health services overall increased by 22%. The number of patient referrals aged 10-14 increased by 70% and aged 15-19 increased by 80%
- As of December 2017, two thirds (66%) of young people, in the Oxfordshire Clinical Commissioning Group area referred to CAMHS, were seen within 12 weeks. In the previous 3 months (Sept-Nov17), less than half of referrals were seen within 12 weeks.

Use of social care services

- The majority (60%) of Oxfordshire's long term social care clients are older people aged 65 and over. A quarter (25%) of people receiving social care support are people with learning disabilities.
- Oxfordshire County Council forecasts suggest a potential increase of older social care clients aged 85+, from 1,900 in 2017 to 2,900 by 2031.
- Between 2015-16 and 2016-17 there was a 9% drop in the number of adults provided with short-term reablement services.
- There has been an increase in the proportion of older social care clients supported at home, from 44% of older clients in 2012 to 59% in 2017.
- By district, the highest number of older people being supported with long-term social care services as of end March 2017 was in Cherwell. The highest rate per 1,000 population was Oxford City.
- Oxfordshire County Council estimates that: of the total number of older people receiving care in Oxfordshire, 40% (4,200) are being supported by the County Council or NHS funding and 60% (6,300) are self-funding their care.
- Oxfordshire has seen increases in the number of children referred to social care, children on protection plans and children who are looked after.
 - The number of children on protection plans in Oxfordshire has been rising in recent years, and the rate is now above the South East average and just below the national average.
 - The rate of looked after children in Oxfordshire remains below the national and regional averages, but the number of cases increased each year since 2013 and is now above the rate of similar authorities.



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Data has been reviewed and is unchanged

- In a trend related to this increase in placements, in 2016-17 the proportion of looked after children placed out of Oxfordshire (and more than 20 miles from home) increased. This was against the trend for statistical neighbours where the rate of placements out of area declined.
- Care leavers in Oxfordshire are less likely than average to be in employment, education or training.

Community safety, Citizens Advice, Troubled families

- The vast majority of victims of doorstep crime and rogue traders were older people and Oxfordshire Trading Standards has seen a repeat targeting of elderly and vulnerable victims.
- A higher than average proportion of clients of Oxfordshire's Citizens Advice services were disabled (31% compared with 14% with activities limited by health or disability in Oxfordshire in 2011). The district with the greatest number of clients with multiple health impairments was Oxford.
- Reflecting on recent trends, Citizens Advice agencies in Oxfordshire have commented:
 - *We have seen significant increases in relation to benefits, in particular Housing Benefit, Personal Independence Payments and Employment and Support Allowance. The latter two is certainly due to an increase in withdrawal or refusal of benefits at medical assessment stage for ESA, and in transitioning from DLA to PIP. This will have impacted on other benefits as premium entitlements are lost and other benefits re-evaluated and potentially lost.*
 - *It is possibly too early for us to notice any Universal Credit trends as this has only just been introduced here in Oxfordshire.*
- Around 2,800 families have been identified in Oxfordshire for the second phase of the Troubled Families (Think Families) programme. Over half (61%) met the national criteria on worklessness, 47% met the criteria on domestic abuse and 37% were families where children need help (in need or subject to a child protection plan).

Access to services

- National data shows that a significantly lower proportion of disabled people used the internet to find information about goods and services (57% disabled compared with 80% not disabled).
- Areas of rural Oxfordshire classified as 2 miles or more from a GP surgery cover almost a third of the younger population (aged 0-15, 32%) and a third of the older population (aged 65+, 34%) in rural districts.



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7.2 Primary health care

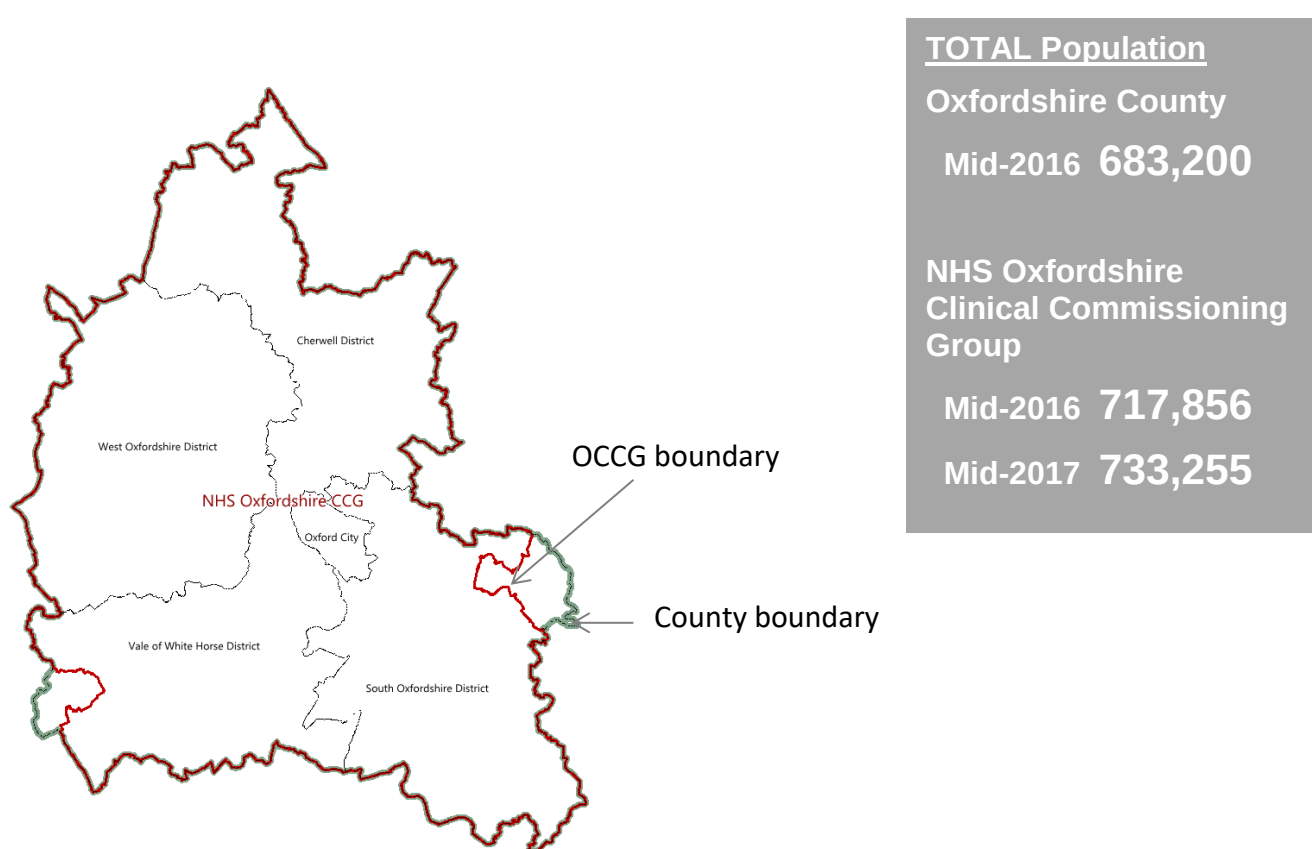
Oxfordshire Clinical Commissioning Group area

 Between mid-2016 and mid-2017 the Oxfordshire Clinical Commissioning Group (OCCG) GP registered population increased by 2% to a total of **733,255**.

Comparing the Oxfordshire Clinical Commissioning Group (OCCG) GP registered population in mid-2016 with ONS population estimate for Oxfordshire shows the GP practice population as 34,700 above the estimated population of Oxfordshire county.

This is a result of (a) slightly different geographical boundaries; (b) some residents of neighbouring counties being registered with Oxfordshire GPs; (c) possible delays in deregistering patients from practice lists, especially students.

Figure 83 Oxfordshire Clinical Commissioning Group boundary



Source: Map from NHS South, Central and West Commissioning Support Unit



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Oxfordshire is sub-divided into 5 district areas and 6 Clinical Commissioning Group locality areas.

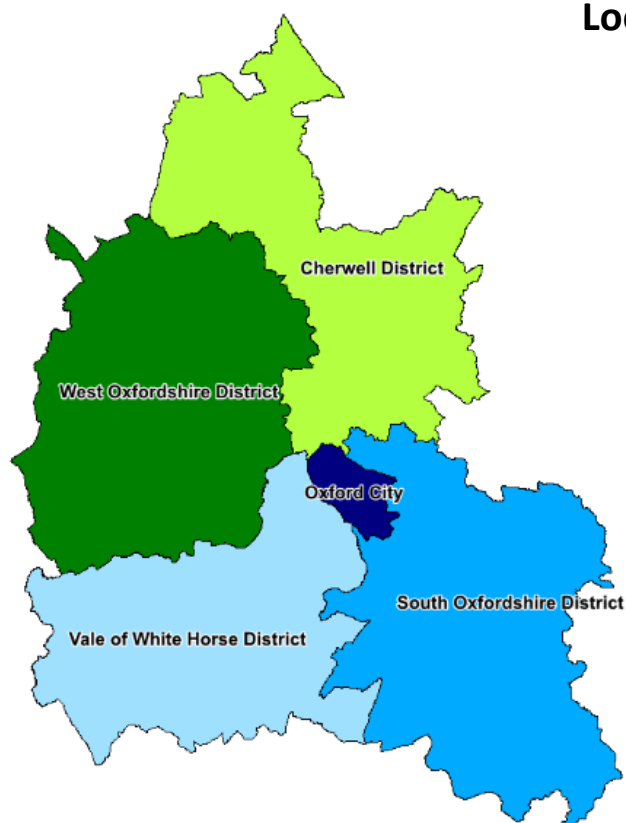
Districts

Cherwell
Oxford
South Oxfordshire
Vale of White Horse
West Oxfordshire

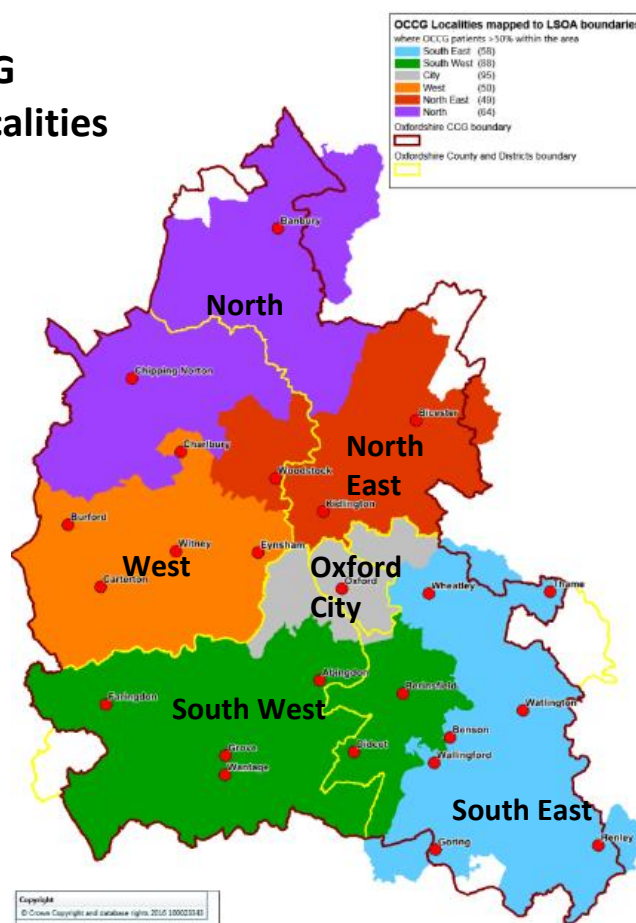
OCCG Localities

North
North East
West
Oxford City
South West
South East

Districts



CCG Localities



Locality mapping based on patients registered to GP practices within Oxfordshire Clinical Commissioning Group by Lower Super Output Area



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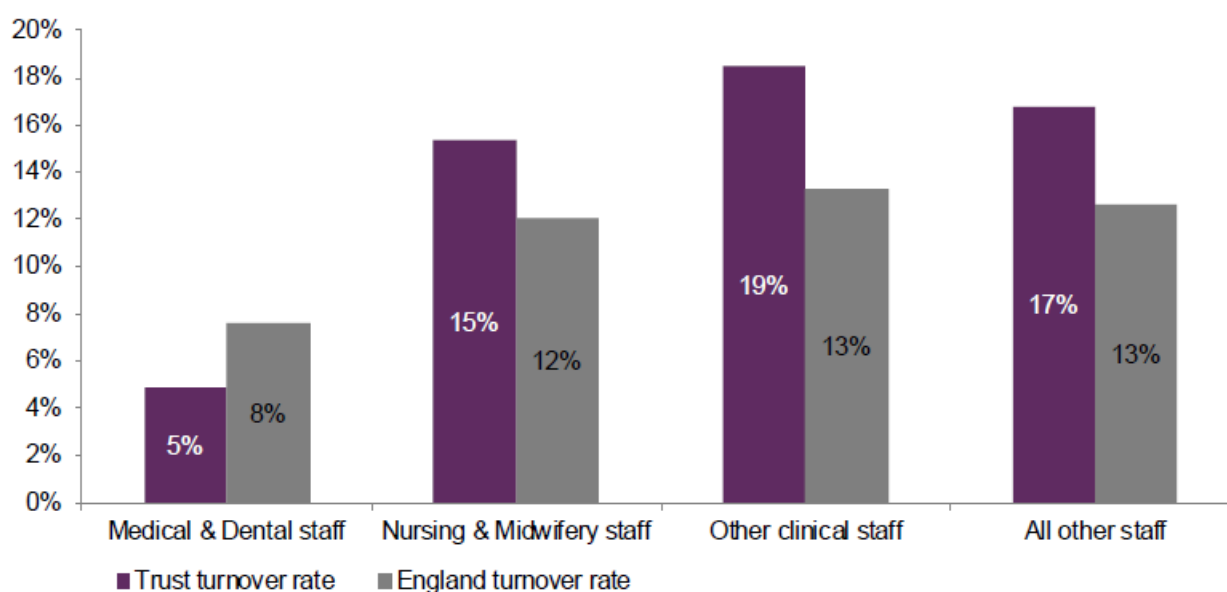
Healthcare workforce

➔ As of September 2017, there were 406 full time equivalent GPs (including salaried, retainers, registrars and locums) in Oxfordshire CCG practices, 59.5 per 100,000 population¹¹⁵. This was just below the national average of 60.3 per 100,000 population.

NHS experimental vacancy statistics published January 2018¹¹⁶ include comparative organisational level vacancy data for the first time. This shows a total of 644 advertised vacancies (full time equivalents) for Oxford Health NHS FT, Oxford University Hospitals NHS FT and Oxfordshire CCG in September 2017. 44% were for nurses/midwives and 22% were administrative and clerical.

Care Quality Commission analysis shows that from mid-2016 to mid-2017 Oxfordshire NHS Acute staff turnover for nursing & midwifery staff, other clinical and non-clinical staff was well above the England average.

Figure 84 NHS Acute Staff Turnover 1Jul16 to 30Jun17



Source: CQC analysis. Levels of staff turnover and stability within acute hospital services between 01 July 2016 and 30 June 2017. Oxfordshire is Oxford University Hospitals NHS Foundation Trust. Turnover data is based on headcount and shows people leaving or returning to active service.

¹¹⁵ General Practice Provisional Tables September 2017 <https://digital.nhs.uk/catalogue/PUB30149>; ONS 2016 mid-year population estimate

¹¹⁶ NHS Vacancy Statistics England, February 2015 - September 2017, Provisional Experimental Statistics, January 23, 2018



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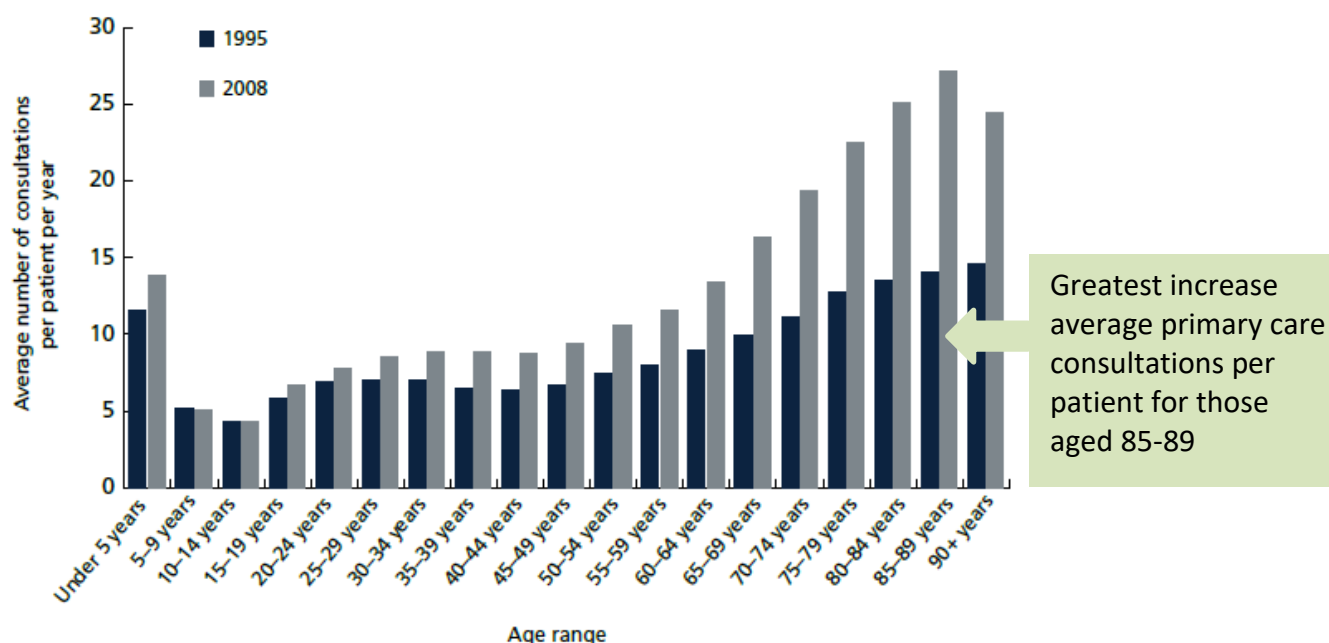


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Contact with GPs

 National data suggests that the number of primary care consultations per patient per year has increased significantly, especially in the older age groups.

Figure 85 Change in the average number of primary care consultations per patient per year in England 1995 to 2008



Source: The 2022 GP Compendium of evidence, Royal College of General Practitioners; data from Hippisley-Cox J, Vinogradova Y. Trends in consultation rates in general practice 1995/96 to 2008/9. Datasets are available from <https://data.gov.uk/dataset/trends-in-consultation-rates-in-general-practice>

More recent analysis comparing 2007 to 2014 primary care consultations¹¹⁷ has shown this trend continuing.

 A study carried out by the Oxfordshire Clinical Commissioning Group, based on data from 12 (self-selecting) OCCG Practices, shows an increase in consultation rates in the older age bands, similar to the national trend.

- The number of consultations per person aged 80 and over doubled between 2009-10 and 2013-14.

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.

¹¹⁷ Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)00620-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00620-6/abstract)



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About the GP Patient Survey

The GP Patient Survey (GPPS) is an England-wide survey, providing practice-level data about patients' experiences of their GP practices.

Ipsos MORI administers the survey on behalf of NHS England.

The survey measures patients' experiences across a range of topics, including:

- Making appointments
- Waiting times
- Perceptions of care at appointments
- Practice opening hours
- Out-of-hours services

The GP Patient Survey provides data at practice level using a consistent methodology, which means it is comparable across organisations and over time.

The survey has limitations:

- Sample sizes at practice level are relatively small.
- The survey does not include qualitative data which limits the detail provided by the results.
- The data are provided twice a year rather than in real time.

The July 2017 GPPS results report on the wave of fieldwork carried out in January to March 2017.

In NHS OXFORDSHIRE CCG, 20,111 questionnaires were sent out, and 8,157 were returned completed. This represents a response rate of 41% (similar to the previous year).

<http://gp-patient.co.uk>

Use of GP services

 The 2017 GP Patient survey shows that 67% of respondents in the Oxfordshire Clinical Commissioning Group area had seen or spoken to a GP within the last six months. This was similar to the England rate (68%) and similar to Oxfordshire CCG rate in 2016 (68%).

Satisfaction with GP services overall in Oxfordshire was significantly higher than for England. 89% rated their GP surgery as good (very good or fairly good) compared with 85% nationally.

Out of hours contact

 According to the 2017 GP Patient Survey, when contacting an NHS service outside of GP surgery hours, a higher proportion than average of Oxfordshire respondents made contact by telephone (74% in Oxfordshire CCG compared with 61% across England) and a slightly lower than average proportion went to A&E (30% in Oxfordshire CCG compared with 34% nationally).

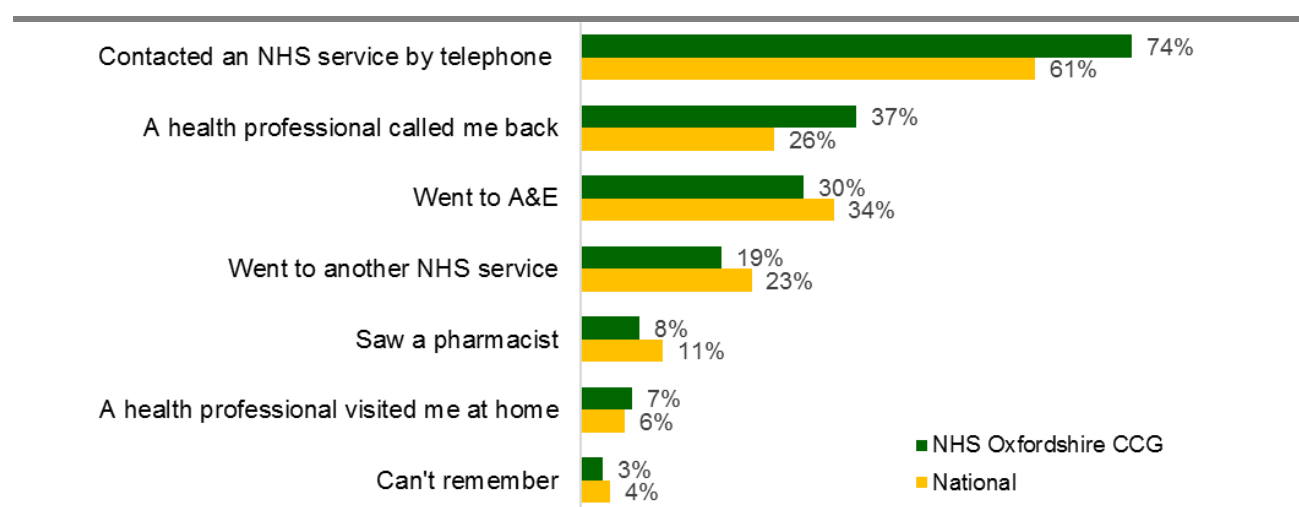


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Figure 86 Services contacted out of hours (Q: Considering all of the services you contacted, which of the following happened on that occasion?) 2017



Source: GP Patient Survey 2017 (Jan-Mar 2017 wave); Base: All those who tried to contact an NHS service when GP surgery closed in the past 6 months: National 140,428; CCG 1,677



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7.3 Secondary Health Care

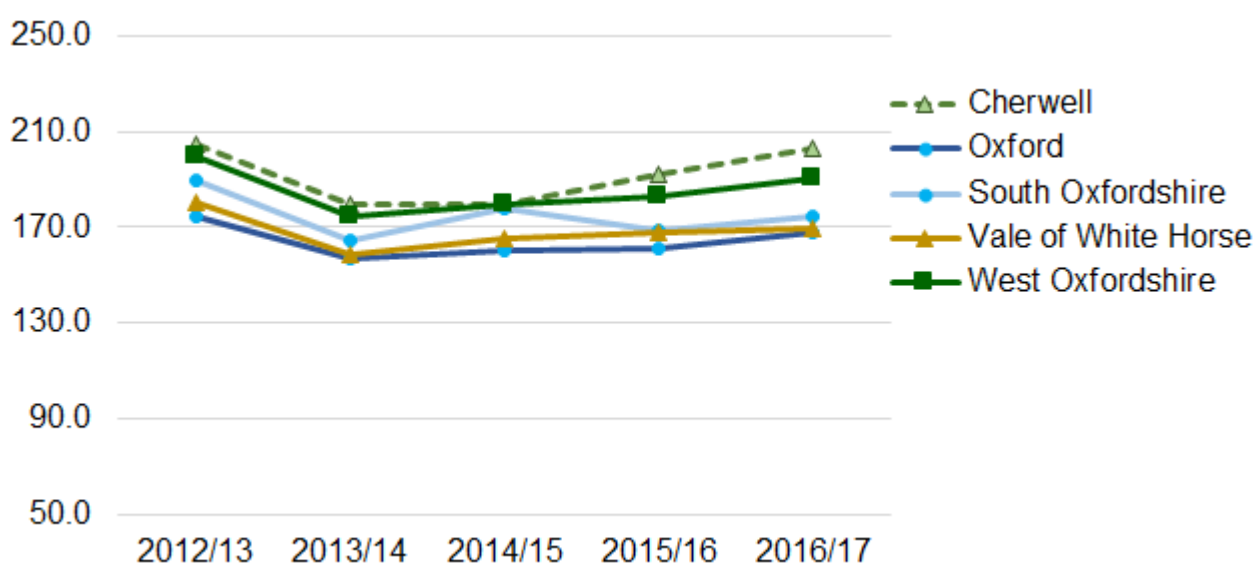
Data on hospital inpatient activity, ambulance activity and data on complex patients is new to this 2018 JSNA update.

Hospital inpatient activity

➔ According to hospital inpatient data provided by the NHS South, Central and West Commissioning Support Unit, there was a total of **123,300** inpatient spells for residents of Oxfordshire in 2016-17. This was just below the total number in 2012-13 (125,100).

The rate per 1,000 population in Oxfordshire's districts was highest in Cherwell and West Oxfordshire.

Figure 87 Inpatient spells, crude rate per 1,000 population



Source: data provided by NHS South, Central and West Commissioning Support Unit, analysis by Oxfordshire County Council; note that chart does not start at 0

The proportion of hospital patients with complicating comorbidities¹¹⁸ is increasing. In 2012-13 the proportion was 10.3% of inpatient spells and by 2016-17 this had increased to 11.8%.

The district with the highest proportion of patients with complicating comorbidities was Oxford City (17.1% in 2016-17, compared with 11.8% across Oxfordshire).

¹¹⁸ *Complicating Comorbidities* are additional factors that may make the patient event more complicated, for example if a patient is very old or very young, or if the patient suffers from other conditions or injuries that may cause complications.



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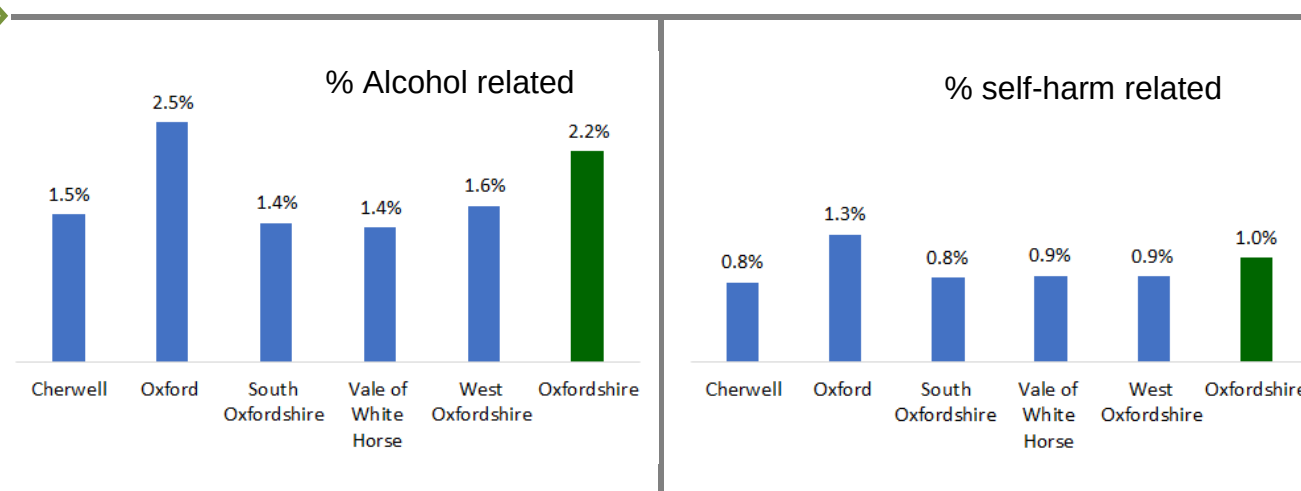
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**Table 55 Proportion of inpatients with complicating comorbidities by district**

	2012-13	2013-14	2014-15	2015-16	2016-17
Cherwell	11.2%	12.8%	13.5%	13.5%	15.8%
Oxford	13.3%	14.0%	14.5%	15.2%	17.1%
South Oxfordshire	10.0%	10.7%	10.8%	12.0%	13.5%
Vale of White Horse	11.7%	12.2%	12.9%	13.6%	15.8%
West Oxfordshire	10.7%	11.5%	12.2%	12.6%	13.9%
Oxfordshire	10.3%	10.2%	11.1%	10.8%	11.8%

Source: data provided by NHS South, Central and West Commissioning Support Unit, analysis by Oxfordshire County Council

Oxford City had a highest proportion of inpatients with alcohol-related admissions and inpatients related to self-harm.

Figure 88 Proportion of inpatient spells that were alcohol related or self-harm related 2016-17

Source: data provided by NHS South, Central and West Commissioning Support Unit, analysis by Oxfordshire County Council



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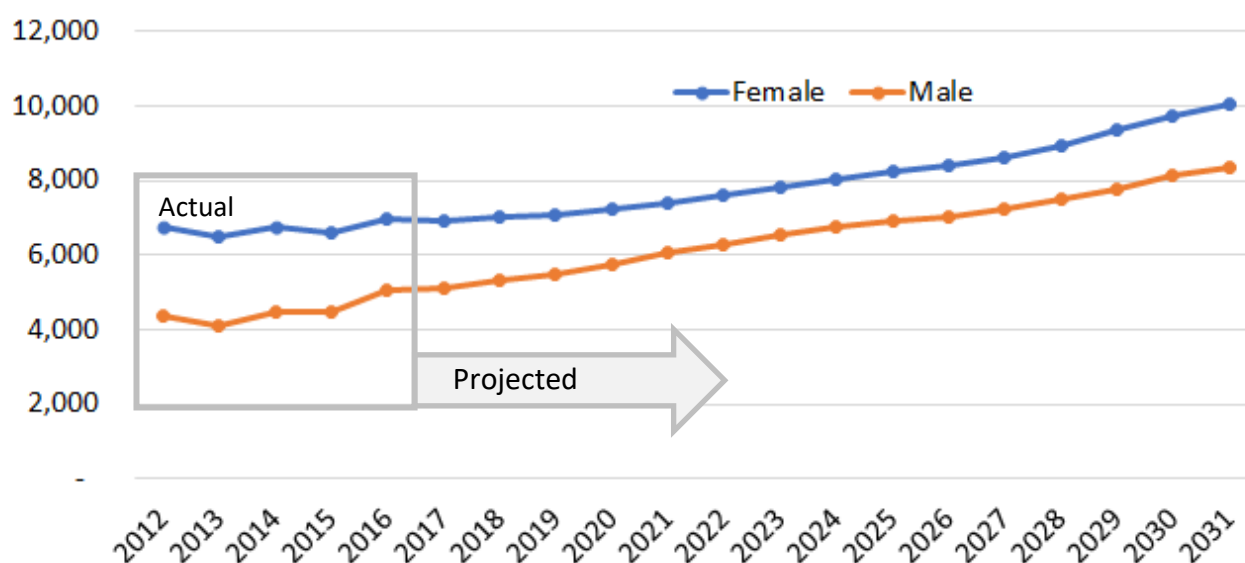
Hospital inpatients aged 85 and over



In 2016-17 there was around 12,000 inpatient spells for Oxfordshire residents aged 85 and over, 10% of the total number of inpatient spells.

Assuming that the over 85 population continues to need inpatient services at the same rate as the past 3 years, and using the forecast growth in population (County Council Feb18), gives a potential increase of an additional 6,400 inpatient spells for people aged 85+ by 2031-32 to a total of 18,400.

Figure 89 Actual and projected number of inpatient spells for Oxfordshire residents aged 85+



Source: Inpatient activity from NHS South, Central and West CSU; ONS population estimates and Oxfordshire County Council population forecasts (Mar18). Rate calculated using 3-year average of actual inpatient spells 2014-15 to 2016-17 and applying this rate to the forecast for Oxfordshire's 85+ population. Year is mid-year for population estimates and financial year for inpatient spells (2012 = 2012-13).

Table 56 Actual and projected number of inpatient spells for Oxfordshire residents aged 85+

	ACTUAL	PROJECTED			CHANGE
	2016-17	2021-22	2026-27	2031-32	2016-17 to 2031-32
Females	7,000	7,400	8,400	10,000	3,000
Males	5,000	6,100	7,000	8,300	3,300
TOTAL	12,000	13,500	15,400	18,400	6,400

Source: Inpatient activity from NHS South, Central and West CSU; ONS population estimates and Oxfordshire County Council population forecasts (Mar18). Rate calculated using 3-year average of actual inpatient spells 2014-15 to 2016-17 and applying this rate to the forecasts for Oxfordshire's 85+ population.



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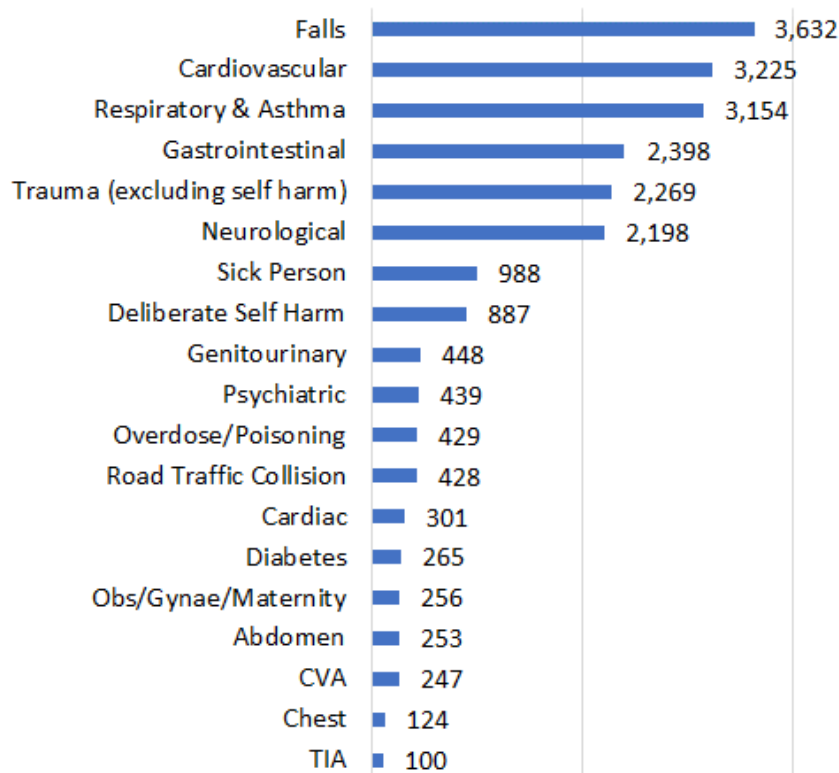
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Use of Ambulance services



In 2016-17 there was a total of 32,100 ambulance trips matched to A&E or inpatient records for Oxfordshire residents. The top condition/complaint was falls, accounting for 3,600 ambulance trips, 11% of the total.

Figure 90 Ambulance trips by condition* – Oxfordshire residents 2016-17

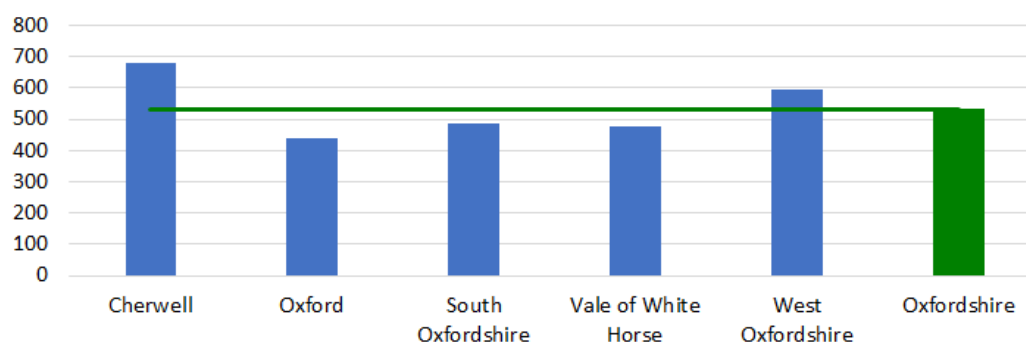


Source: Ambulance activity data provided by NHS South, Central and West Commissioning Support Unit;

*refers to the presenting ailment of the patient when the 999/111 call is made. These condition categories are created by grouping similar conditions present in the ambulance data and were created without clinical input and as such should be treated as broadly indicative

The rate per population of Ambulance service activity due to falls was above the county average in Cherwell and West Oxfordshire.

Figure 91 Ambulance trips due to FALLS, crude rate per 100,000 population 2016-17



Source: Ambulance activity data provided by NHS South, Central and West Commissioning Support Unit, ONS 2016 population estimate



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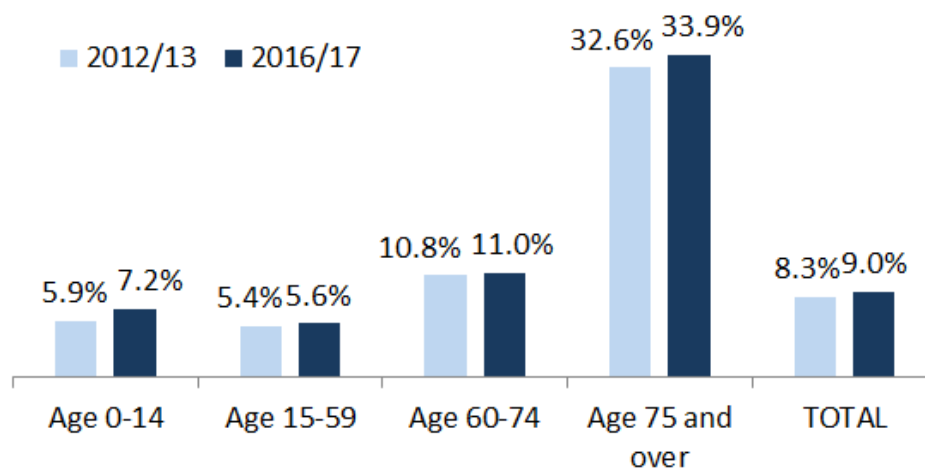
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Emergency hospital admissions

 Between 2012-13 and 2016-17, the proportion of emergency hospital admissions for patients registered to OCCG practices increased from 8.3% to 9% (as a percentage of the ONS estimate of resident population).

The greatest increases have been in the age groups 0-14 and 75+.

Figure 92 Emergency hospital admissions patients registered to Oxfordshire CCG practices, as % of population



Source: NHS South, Central and West Commissioning Support Unit; ONS population estimates for Oxfordshire county



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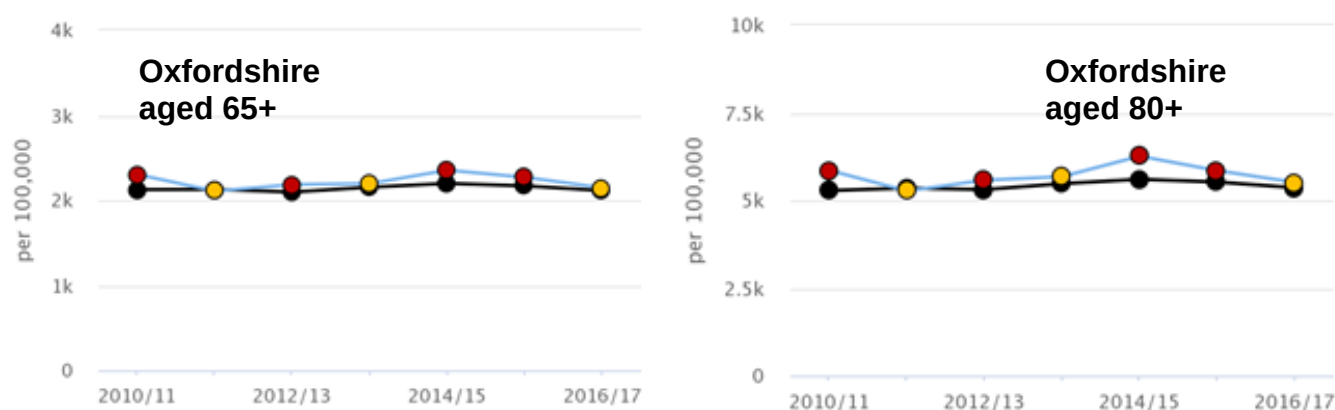
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Emergency admissions for injuries due to a fall

➔ According to Public Health England data, in 2016-17 there was a total of 2,683 emergency hospital admissions due to falls in Oxfordshire for people aged 65 and over of which the majority (1,850, 69%) were admissions for people aged 80 and over.

As of 2016-17 Oxfordshire was statistically similar to the England and South East average rates of injuries due to falls in people aged 65 and over, and for people aged 80 and over. In each age group the rate was statistically similar in both males and females.

Figure 93 Emergency hospital admissions due to falls in people aged 65+ and 80+ (directly age-sex standardised rate per 100,000)



Source: Public Health Outcomes Framework

Within the districts, emergency hospital admissions for falls in people aged 65+ were statistically above average in Oxford, and below average in South Oxfordshire in the latest year of data.

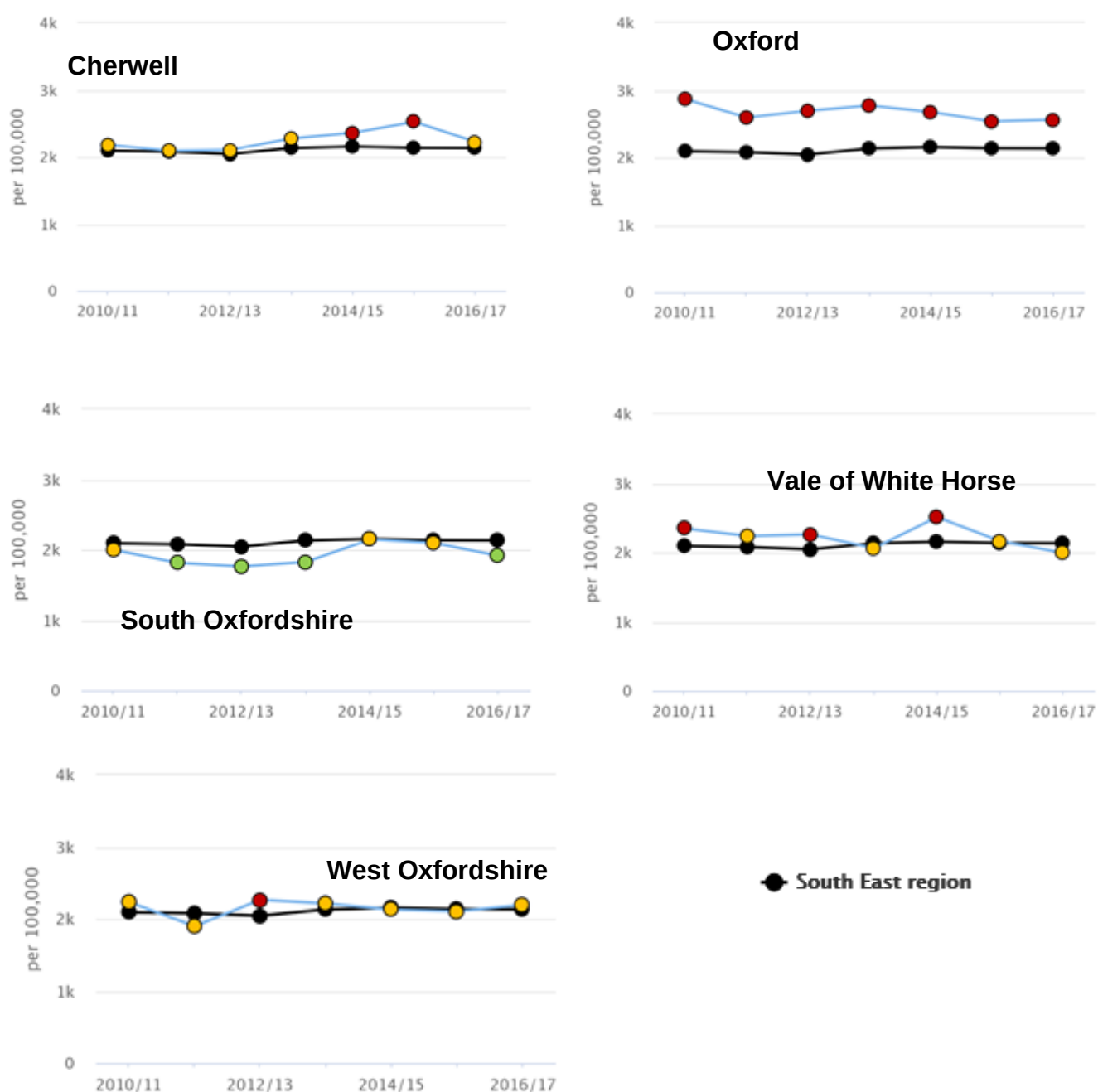


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Figure 94 Emergency hospital admissions due to falls in people aged 65+ (directly age-sex standardised rate per 100,000)



Source: Public Health Outcomes Framework



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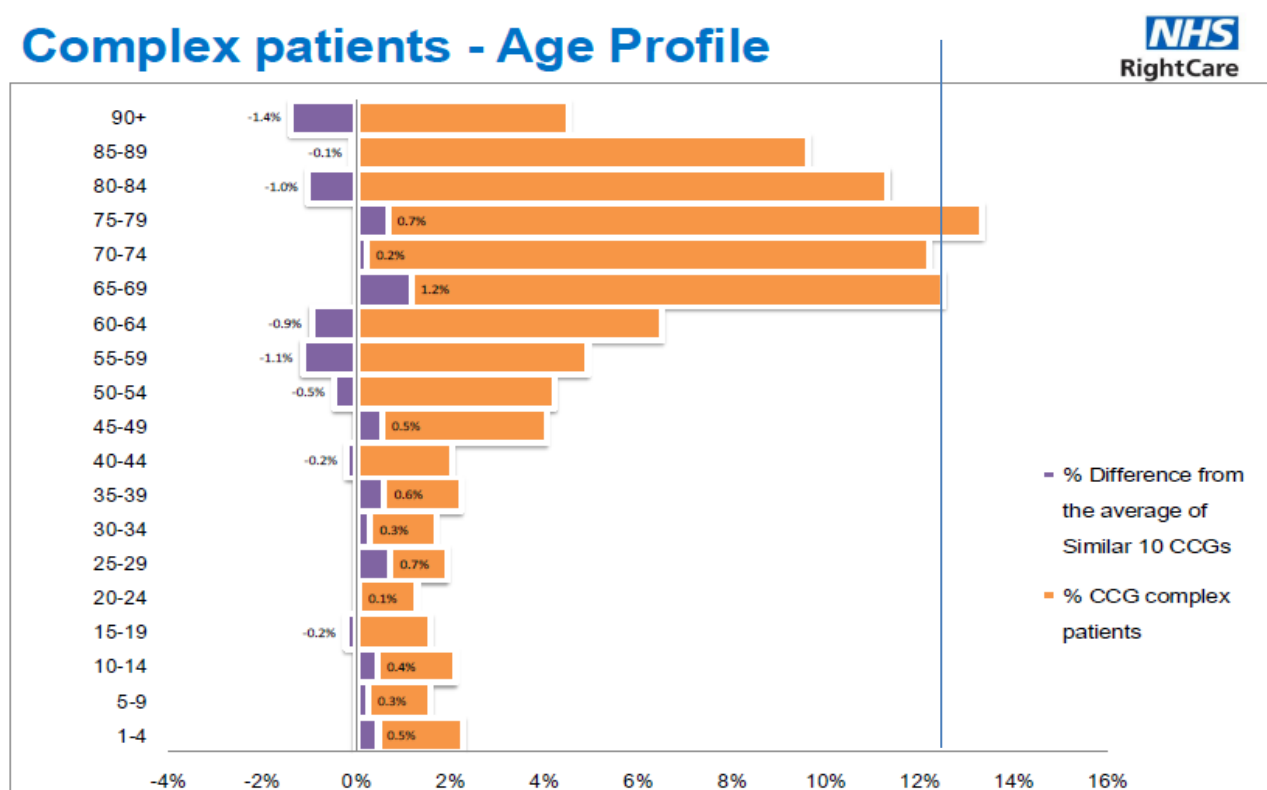
Complex patients and Co-morbidities

The NHS¹¹⁹ Rightcare pack for Oxfordshire CCG shows information on complex patients.

- Data on “complex patients” include analysis on inpatient admissions, outpatient and A&E attendances for the 2% of patients that your CCG spends the most on for inpatient admissions in 2015/16. Nationally the most common conditions of admissions for complex patients are circulation; cancer; and gastro-intestinal problems.
- Whilst this NHS analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients who will require the most treatment across the health and care system. However, it is not possible to include analysis on mental health patients as they are not captured fully in these datasets.

➔ Almost two thirds (64%) of Oxfordshire CCG’s complex patients are aged over 65+. The proportion aged 65 to 79 was above average of 10 similar CCGs.

Figure 95 Age profile of Oxfordshire CCG complex patients and % difference from the average of Similar 10 CCGs 2015-16



Source: Rightcare “Commissioning for Value – where to look pack” for Oxfordshire CCG (Jan 2017)

¹¹⁹ Rightcare “Commissioning for Value – where to look pack” for Oxfordshire CCG (Jan 2017)
<https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-oxfordshire-jan17.pdf>



Data has been updated in this version



Data has been reviewed and is unchanged

“Co-morbidities” is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder.

The following chart shows the count of Oxfordshire Clinical Commissioning Group complex patients by main condition and co-morbidity conditions.

This shows, for example, that of the 519 patients admitted for Gastro intestinal conditions in 2015-16, 172 also had admissions for a Cancer condition. Of the 497 patients admitted for Cancer conditions, 139 also had admissions for a Respiratory condition.

Figure 96 Complex patients – co-morbidities (NHS Rightcare) 2016-17

Main conditions	Co-morbidity 1	Co-morbidity 2	Co-morbidity 3	Co-morbidity 4	Co-morbidity 5
Gastro intestinal	Cancer	Respiratory	Circulation	Neurological	Genito Urinary
519 patients	172	136	116	129	112
Cancer	Gastro intestinal	Respiratory	Circulation	Genito Urinary	Neurological
497 patients	172	139	97	91	101
Circulation	Respiratory	Gastro intestinal	Neurological	Cancer	Genito Urinary
511 patients	165	116	129	97	104
Respiratory	Circulation	Cancer	Gastro intestinal	Neurological	Genito Urinary
469 patients	165	139	136	137	104
Neurological	Gastro intestinal	Circulation	Respiratory	Cancer	Genito Urinary
444 patients	129	129	137	101	106

Source: Rightcare “Commissioning for Value – where to look pack” for Oxfordshire CCG (Jan 2017)

Interpreting co-morbidities: Co-morbidities are ranked by the number of different conditions (based on programme budgeting subcategories) that patients are admitted for. This ranking may be different if based on the number of patients that have had an admission for each condition



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Hospital Discharge and Delayed Transfers of Care

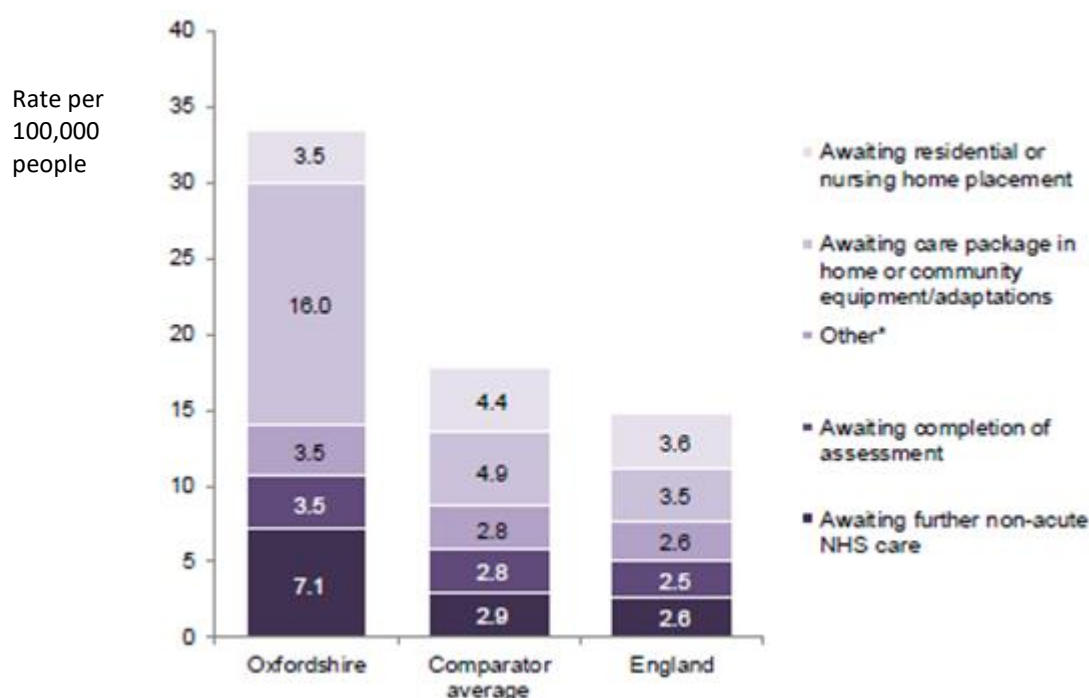
A delayed transfer of care occurs when a patient is deemed medically fit to depart from their current care, but is unable to do so because of non-clinical reasons, for example because the patient is awaiting a care package in their own home, or further non-acute care.

➔ In 2016-17 the average daily rate of delayed transfers of care (DTC) within Oxfordshire was 25.7 people aged 18 and over per 100,000.¹²⁰ This was down from 29.4 in 2015-16.

The rate for Oxfordshire in 2016-17 was significantly higher than the average rate for England of 15 per 100,000 people.

Care Quality Commission analysis of DTC by reason shows the greatest difference between Oxfordshire and national/regional averages from February 2017 to August 2017 was people waiting for a care package at home or community equipment / adaptations, where Oxfordshire was over 3 times the average rate per 100,000 people of comparator areas.

Figure 97 Average daily delayed transfers of care per 100,000 people aged 18+ by reason (Feb17 to Aug17)



Source: Care Quality Commission analysis from NHS England and ONS 2015 mid-year estimate; 'Further non-acute NHS care' includes community and mental health care, intermediate care, rehabilitation services etc. 'Other' includes public funding, patient or family choice, disputes and housing. The categories are self-reported categories. Different LAs show a large variation in how frequently they report in the 'Other' category. For more info see: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtcc-v1.09.pdf> page 13 onwards

¹²⁰ NHS Delayed Transfers of Care Statistics: <http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/>



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Data has been reviewed and is unchanged

7.4 Mental Health Services

National data

Adults accessing mental health treatment

 The national survey of mental health and wellbeing¹²¹ has found that an increasing proportion of adults with mental health conditions, such as anxiety or depression, were accessing mental health treatment and more likely to discuss their mental health with a GP.

- One person in three with common mental disorders (mainly depression or anxiety) reported current use of mental health treatment in 2014, an increase from the one in four who reported this in 2000 and 2007. This was driven by steep increases in reported use of psychotropic medication. Increased use of psychological therapies was also evident among people with more severe mental disorder symptoms.
- Since 2007, people with common mental disorders had become more likely to use community services and more likely to discuss their mental health with a GP.

Detentions in hospital under the Mental Health Act

NHS Digital has published Mental Health Act detentions data for 2016/17¹²² including by NHS providers. The latest data cannot be compared with previous years.

 *The way these statistics are sourced and produced has changed. Coverage is also incomplete this year. As a result, 2016/17 figures are not directly comparable to previous years. 45,864 new detentions were recorded in 2016/17 and 4,966 new Community Treatment Orders (CTOs), but the overall national totals will be higher as not all providers submitted data. For the subset of providers that submitted good quality¹ detentions data in both 2015/16 and 2016/17, we estimate there was an increase in detentions of around 2 per cent from last year. Further information is provided in the Background Data Quality Report.*

As at 31 March 2017 Oxford Health NHS Foundation Trust recorded 320 people detained in hospital and 100 people subject to Community Treatment Orders.

¹²¹Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014
<http://content.digital.nhs.uk/catalogue/PUB21748>

¹²²Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics October 2017
<https://digital.nhs.uk/catalogue/PUB30105>



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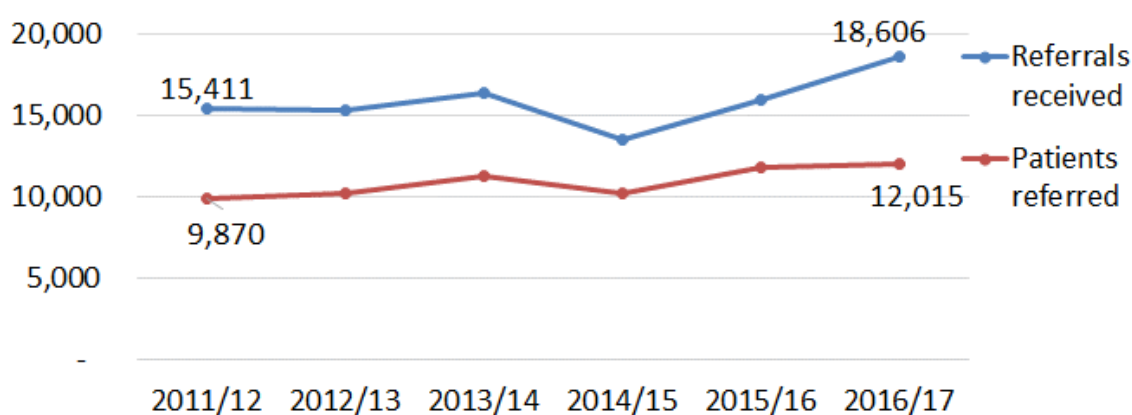
Oxford Health Mental Health Referrals

There has been an increase in the total number of referrals and in the number of patients referred to mental health services in Oxfordshire.



- In 2016-17, 12,000 Oxfordshire residents were referred to Oxford Health NHS Foundation Trust mental health services and seen at least once.¹²³ This represents an increase of around 2,100 (22%) since 2011-12.
- Some patients were referred more than once during the year and the number of referrals was around 18,600 an increase of 21% since 2011-12.

Figure 98: Number of Oxfordshire residents referred to Oxford Health NHS FT mental health services and number of referrals (2011-12 to 2016-17)



Source: Oxford Health NHS Foundation Trust



The 15-19 age group continued to make up the largest proportion and number of patients referred to Oxford Health mental health services in 2016-17 and has seen the biggest increase since 2011-12

- Between 2011-12 and 2016-17, the number of patients referred overall increased by 22%. The number of patient referrals aged 15-19 increased by 80%

There was also a significant increase of referrals of patients in the younger age group aged 10-14 (+67%).

¹²³ Data in this section has been provided by Oxford Health NHS Foundation Trust

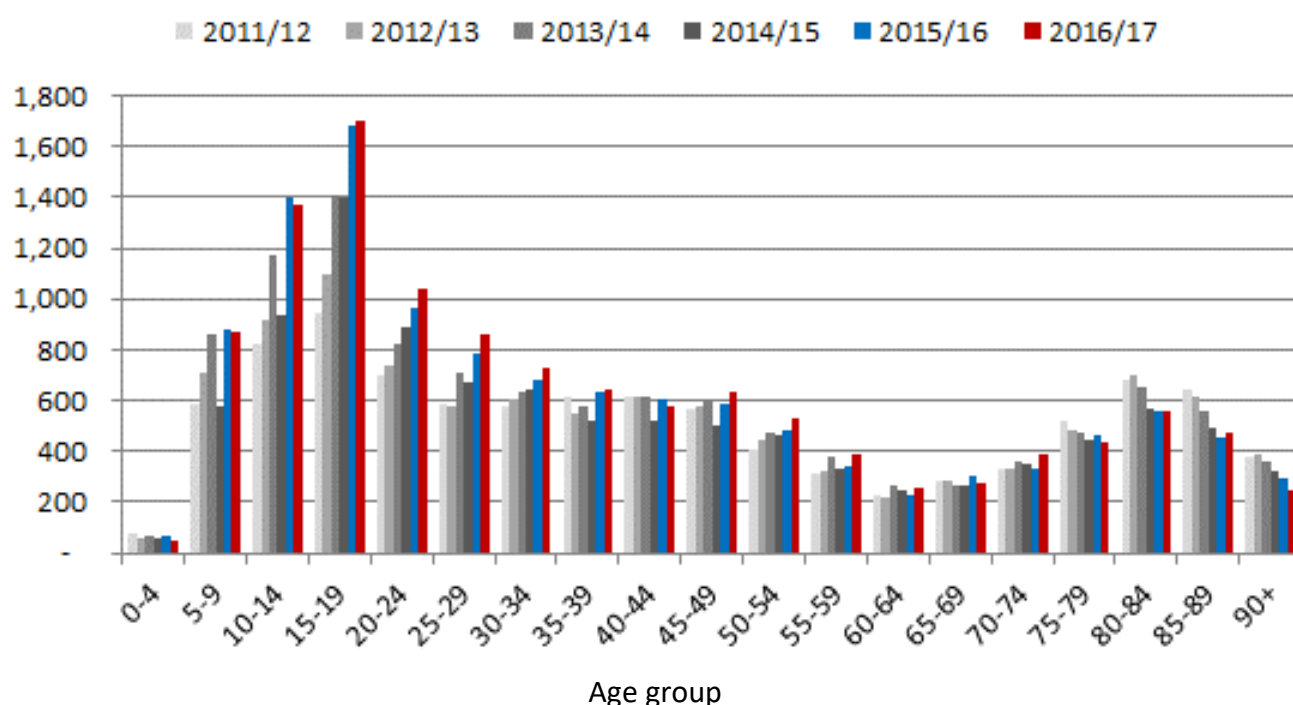


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Figure 99 Number of Oxfordshire residents referred to Oxford Health mental health services (2011-12 to 2016-17)



Source: Oxford Health NHS Foundation Trust

As a result, the mental health speciality with the greatest increase in referrals was Child and Adolescent Mental Health services (CAMHS Oxfordshire).

- Between the 2011-12 and 2016-17 patient referrals to CAMHS increased from 2,600 to 4,900 (+2,200, 86%).

Waiting times for CAMHS

In December 2017, two thirds (66%) of young people referred to CAMHS in the Oxfordshire Clinical Commissioning Group area, were seen within 12 weeks. In the previous 3 months (Sept-Nov17), less than half of referrals were seen within 12 weeks.

The localities with the lowest rates were North East and South East Oxfordshire. These areas each dropped to below 30% in 1 of the past 8 months of data.

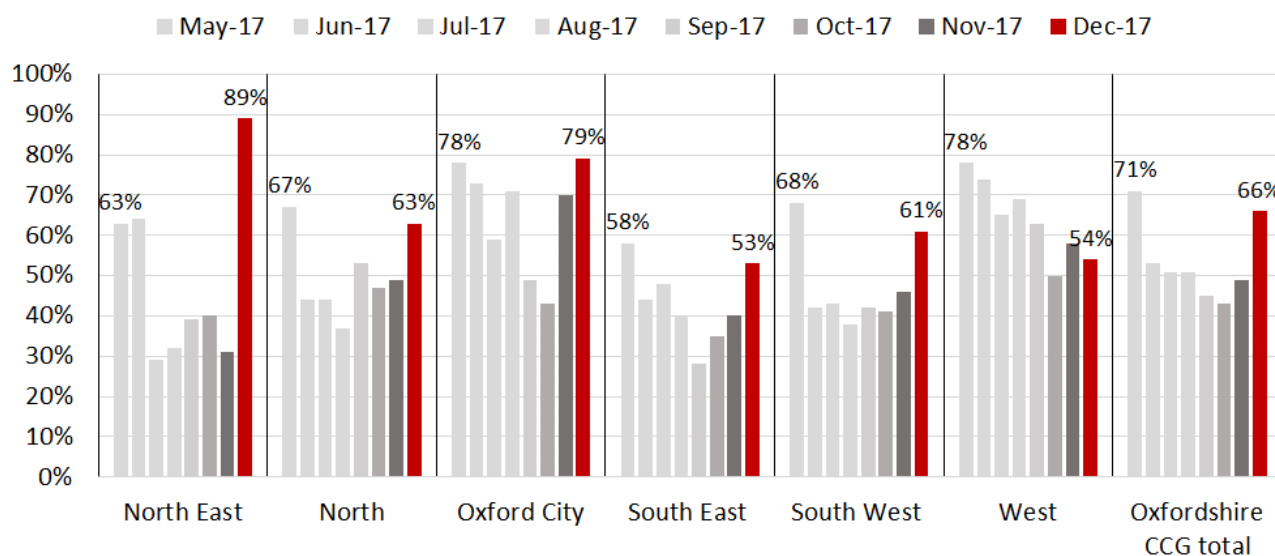


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Figure 100 Waiting times for CAMHS services – percentage of young people seen within 12 weeks by Oxfordshire Clinical Commissioning Group locality



Source: Oxfordshire County Council from data provided by OCCG for PAQA. Includes PCAMHS & Core CAMHS, LD, Horizon, Neuro, excluding all other teams

Table 57 Waiting times for CAMHS services – percentage of young people seen within 12 weeks by Oxfordshire Clinical Commissioning Group locality

Locality	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
North East	63%	64%	29%	32%	39%	40%	31%	89%
North	67%	44%	44%	37%	53%	47%	49%	63%
Oxford City	78%	73%	59%	71%	49%	43%	70%	79%
South East	58%	44%	48%	40%	28%	35%	40%	53%
South West	68%	42%	43%	38%	42%	41%	46%	61%
West	78%	74%	65%	69%	63%	50%	58%	54%
Oxfordshire CCG total	71%	53%	51%	51%	45%	43%	49%	66%

Source: provided by OCCG for PAQA. Includes PCAMHS & Core CAMHS, LD, Horizon, Neuro, excluding all other teams



Data has been updated in this version



Data has been reviewed and is unchanged

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 needs 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 four years from January 2014 to December 2017, there was a total of **1,129** Section 136 detentions in Oxfordshire of which 518 (46%) were in Oxford.

Cherwell saw a slight increase between 2016 and 2017, from 50 to 53 detentions. The numbers have fallen in other Oxfordshire districts.



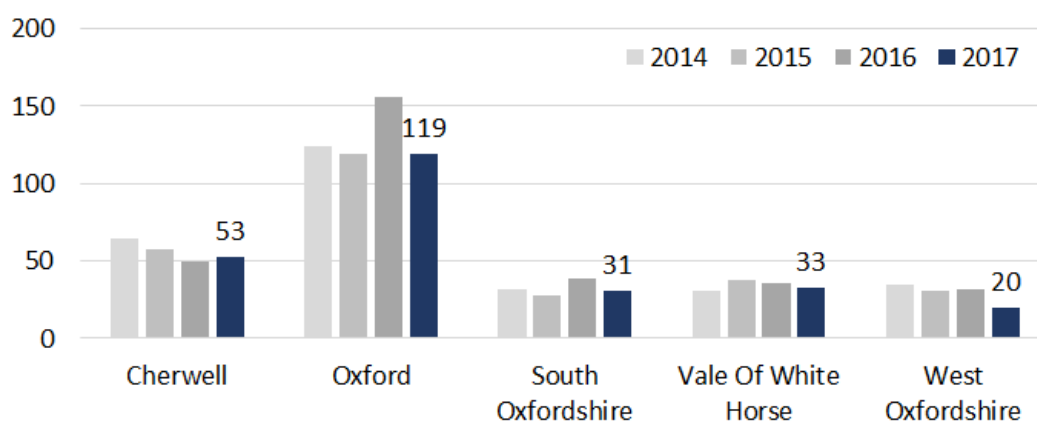
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Figure 101 Number of Section 136 detentions 2014 to 2017



Source: Thames Valley Crime Recording System - NICHE RMS & Mental Health Master, extracted Jan18



From January to December 2017:

- Over half (57%) of the detainees were male.
- Almost two thirds (64%) were aged under 40.

7.5 Drug and Alcohol Treatment Services

In 2016/17 there were 1,963 adults (aged 18 and over) in specialist drug treatment in Oxfordshire¹²⁴. This was a similar number to each of the previous 4 years.

The majority of those in drug treatment were aged between 30 to 49.

The number of adults in treatment for alcohol only in Oxfordshire in 2016-17 was 604, the majority of whom were aged 30 to 59.

In 2016/17 the number of young people (aged under 18 years) in specialist substance misuse services in Oxfordshire was 102.

- 69 began using their main substance before they reached 15 years of age
- 45 were using more than one substance
- 20 reported being affected by others' substance misuse.

Referrals were predominantly from education services and children and family services.

¹²⁴ Source: NDTMS - Adults and YP commissioning support pack 2018-19: key data



Data has been updated in this version



Data has been reviewed and is unchanged

7.6 Social care

Many people with care needs require both health and social care and the distinction between health and social care is not always clear. Oxfordshire County Council and the Clinical Commissioning Group have pooled some of their money together to provide more efficient commissioning of care and better integration of health and social care services.

Note that social care client data published in *NHS Digital, Adult Social Care Activity and Finance: England 2016-17* does not include all social care clients funded by the pooled budget in Oxfordshire.

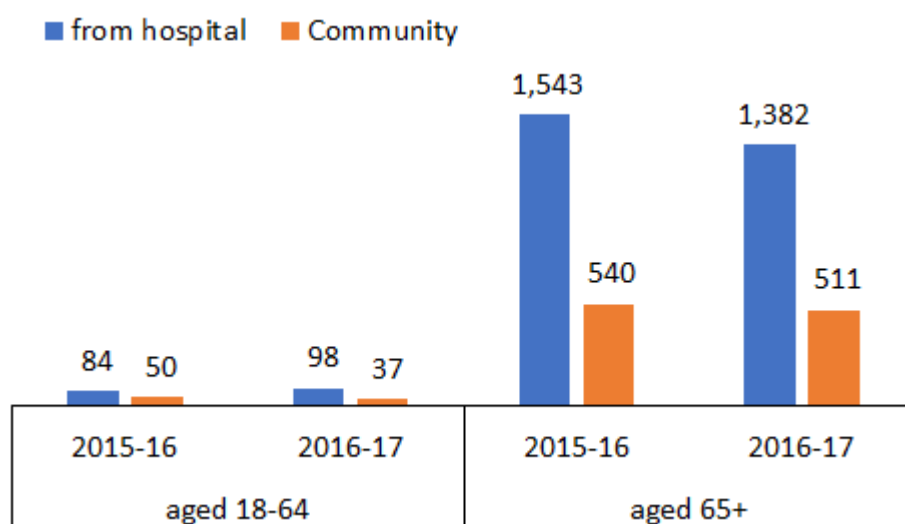
Short-Term (Reablement) Adult Social Care

'Reablement' is a social care service aimed at supporting people to regain independence that may have been reduced or lost through illness or disability.

➔ In 2016-17, a total of 2,028 adults in Oxfordshire were provided with reablement services by Oxfordshire County Council, below the number in 2015-16 (2,217, -9%).

The vast majority (93%) of people provided with reablement services were aged 65+ and around three quarters (73%) of the total received a service following a stay in hospital.

Figure 102 Number of people provided with reablement social care services, 2015-16 and 2016-17



Source: Oxfordshire County Council



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Long-Term Adult Social Care

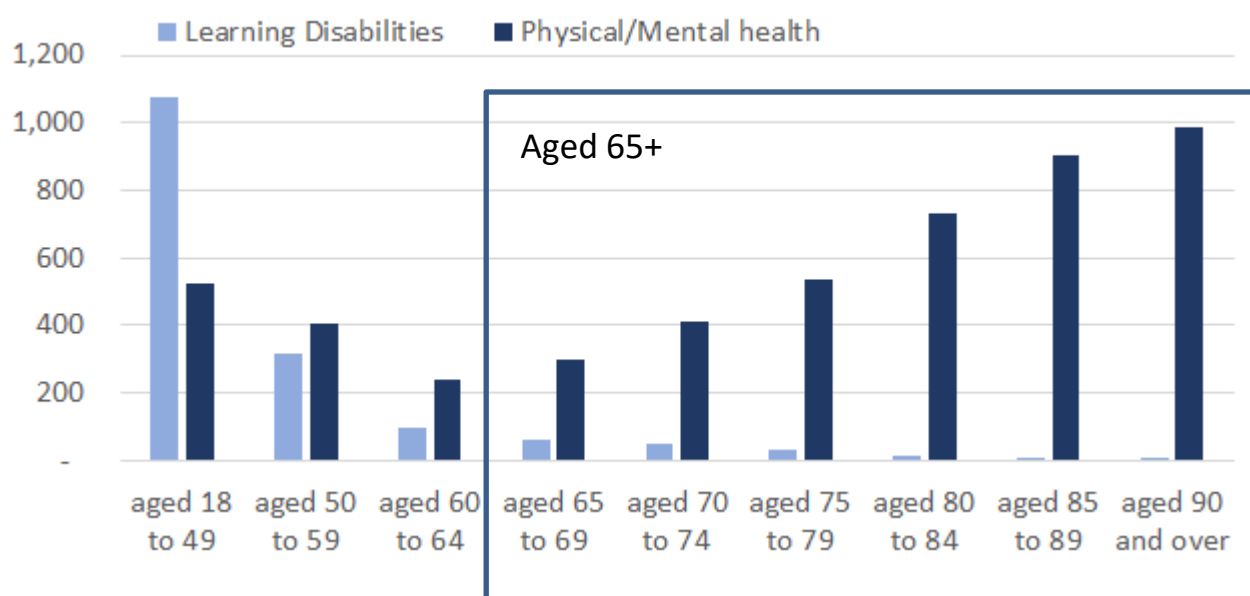


At the end of March 2017 there were **6,713** adults in Oxfordshire receiving long-term social care from Oxfordshire County Council, up from 6,214 in March 2016 (+8%).

The majority (60%) of Oxfordshire's long term social care clients are older people aged 65 and over.

A quarter (25%) of people receiving social care support are people with learning disabilities.

Figure 103 Number of adults provided with long-term social care services by Oxfordshire County Council 2016-17 by broad age and category



Source: Oxfordshire County Council

As of March 2017, 1,900, equivalent to 11% of the population aged 85 and over¹²⁵ in Oxfordshire was receiving long-term social care services provided by Oxfordshire County Council.

Demand for services is expected to continue to grow in the future as a result of:

- an increase in people with a learning disability needing social care support.
 - 30% of people in Oxfordshire with a learning disability first approach the council for services after their 25th birthday. For many this is because their parents can no longer provide all their care. The average age of a service user with learning disability is 44 and over a third are over 50.
- the predicted growth in the older population in Oxfordshire (see chapter 2).

¹²⁵ Denominator is ONS 2016 mid-year estimate



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Data has been reviewed and is unchanged

Applying the predicted growth in Oxfordshire's population aged 85+ (Oxfordshire County Council forecasts Feb18) to the proportion of social care clients in the age group 85+, gives a potential increase of +1,000 clients aged 85+ by 2031 to a total of 2,900.

Table 58 Potential growth in number of people aged 85+ needing long-term social care services in Oxfordshire by 2031

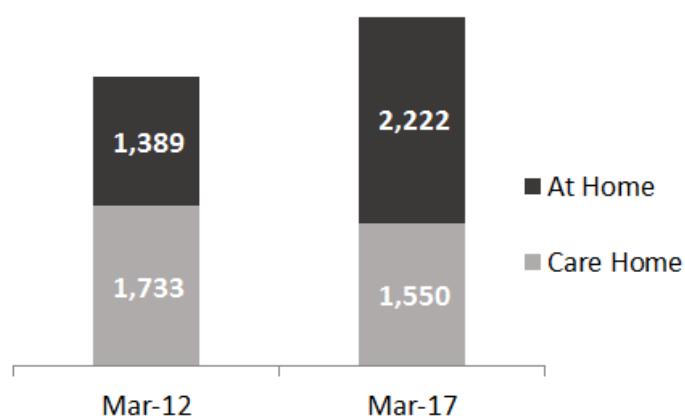
	March 2017	March 2031	Change
Population aged 85+	17,000	26,400	
Social care clients aged 85+	1,900	2,900	+1,000

Source: Oxfordshire County Council

Care setting

 There has been an increase in the proportion of older social care clients supported at home, from 44% of older clients in 2012 to 59% in 2017.

Figure 104 Older clients of long-term social care services provided by Oxfordshire County Council receiving services at home vs in a care home



Source: Oxfordshire County Council; excludes learning disabilities, physical disabilities and other services



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Data has been reviewed and is unchanged



By district, the highest number of older people being supported with long-term social care services as of end March 2017 was in Cherwell. The highest rate per 1,000 population was Oxford City.

Table 59 Older clients of long-term social care services provided by Oxfordshire County Council by setting: count and rate per 1,000 population aged 65+ (March 2017)

	Care home		Supported at home		Total	
	Count	Rate	Count	Rate	Count	Rate
Cherwell	297	11.5	571	22.1	868	33.6
Oxford	274	14.9	408	22.2	682	37.1
South Oxfordshire	282	9.9	376	13.2	658	23.2
Vale of White Horse	258	10.0	442	17.2	700	27.2
West Oxfordshire	336	14.8	404	17.8	740	32.6
Oxfordshire total	1,447	12.0	2,201	18.2	3,648	30.1

Source: Oxfordshire County Council, ONS 2016 population estimates; excludes those supported outside Oxfordshire

Adult Social Care User Survey

About the Adult Social Care User Survey

For the last six years, councils have surveyed users of social care aged 18 and over as part of a national survey. 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 2016-17 survey, 563 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.

<http://www.hscic.gov.uk/socialcare/usersurveys>



In 2016-17, social care-related quality of life in Oxfordshire remained at a similar level to the previous five years. It also remained above the national average and above average for shire counties.

The proportion of care users who were very satisfied with their care and support in 2016-17 was 67.7%, above the national average of 64.7%.

The proportion of respondents who find it "very easy" or "fairly easy" to find information about services in Oxfordshire was below average: 72.5% in Oxfordshire, compared with 73.5% nationally and 74.5% in the South East.



Data has been updated in this version



Data has been reviewed and is unchanged

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.¹²⁶ 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.

Disabled Facilities Grants

 Between January 2017 and December 2017, there was a total of 1,191 applications for a Disabled Facilities Grant, the majority (59%) from people living in social rented housing. The district with the highest number of applications was Cherwell.

Table 60 Applications for Disabled Facilities Grants Jan to Dec 2017

	Cherwell	Oxford City	South Oxon	Vale of WH	West Oxon	Not Recorded	Un-known	TOTAL	
Owner Occupier	89	4	62	38	53	164	13	423	36%
Private Rented	9	1	2	8	5	16	1	42	4%
Social rented	88	178	93	76	62	180	20	697	59%
Not recorded	4	1	5	4	1	13	1	29	2%
TOTAL	190	184	162	126	121	373	35	1,191	100%

Source: Oxfordshire County Council LAS

About Disabled Facilities grants

Local Authorities provide Disabled Facilities Grants for people who are disabled and need to make changes to their home, for example to:

- widen doors and install ramps
- improve access to rooms and facilities - e.g. stairlifts or a downstairs bathroom
- provide a heating system suitable for needs
- adapt heating or lighting controls to make them easier to use

<https://www.gov.uk/disabled-facilities-grants>

¹²⁶ The LGBT ASCOF Companion Document (LGBT Foundation, 2015): <http://lgbt.foundation/get-support/downloads/detail/?downloadid=365>



Data has been updated in this version



Data has been reviewed and is unchanged

Self-funding care

 Oxfordshire County Council estimates that: of the total number of older people receiving care in Oxfordshire, 40% (4,200) are being supported by the County Council or NHS funding and 60% (6,300) are self-funding their care.

Table 61 Estimate of older people who are self-funding long term care in Oxfordshire

	Count
1. OCC and NHS funded care home beds	
1.1 People aged 65+ in Care homes* who are OCC funded (end March 2017)	1,568
1.2 Care home beds NHS funded (end March 2017)	175
2. Total care home beds	
2.1 Total Care home beds for older people (CQC as of 1 April 2017)	4,895
2.2 Estimate of total Care home beds in use (OCC estimate 90%)	4,226
Estimate of Care home beds occupied by self-funders	2,482
3. Care at home	
3.1 People aged 65+ receiving OCC funded care in own home (end March 2017)	2,496
3.2 Ratio of self-funders at home VS self-funders in care homes (data from national seminar on Funding Reform July 2013)	1.55
Estimate of people self-funding care at home	3,865
TOTAL self-funding	6,300
TOTAL supported by OCC or NHS	4,200
Grand total#	10,600

*excludes respite and temporary provision; #rounding means this does not sum



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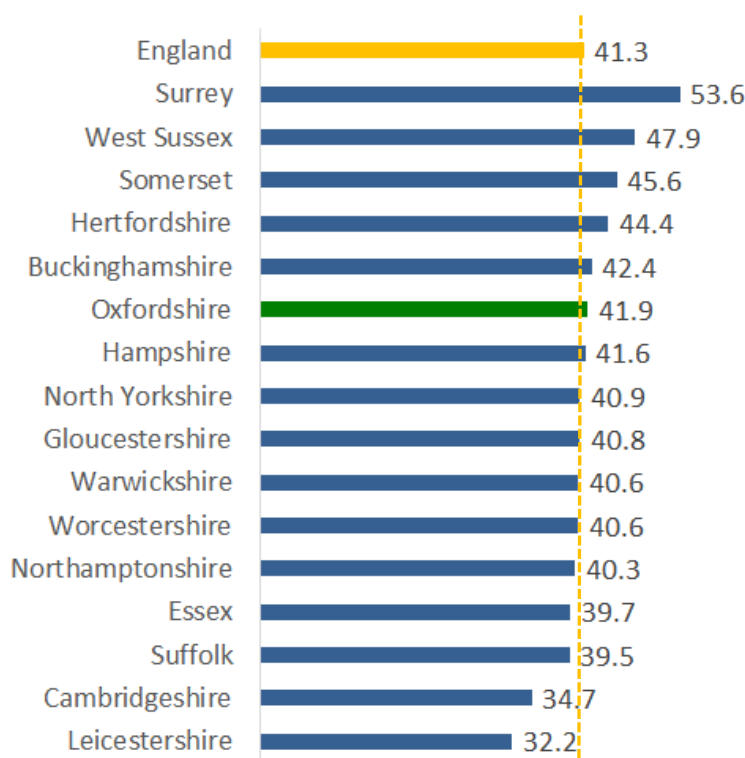
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Care home beds

As of 1 January 2018, there were 5,068 care home beds for older people in Oxfordshire¹²⁷ of which around three quarters include nursing care.

The rate of care home beds for older people per population aged 65+ in Oxfordshire was 41.9 per 1,000 people, similar to the national average and 6th highest out of Oxfordshire's set of 16 statistical neighbours.

Figure 105 Rate of care home beds (1 Jan 2018) for older people per 1,000 people aged 65+



Source: CQC care directory 1 January 2018, extract for care homes for older people; ONS mid-year population estimates 2016 for people aged 65+

Table 62 Number of care home beds for older people (1 Jan 2018)

	All	with nursing		incl dementia	
Cherwell	1,164	961	83%	1,067	92%
Oxford	691	416	60%	455	66%
South Oxfordshire	1,038	900	87%	905	87%
Vale of White Horse	966	709	73%	778	81%
West Oxfordshire	1,209	932	77%	936	77%
Oxfordshire	5,068	3,918	77%	4,141	82%

Source: CQC care directory 1 January 2018, mapped to district by Oxfordshire County Council

¹²⁷ CQC care directory 1 January 2018 <http://www.cqc.org.uk/about-us/transparency/using-cqc-data>

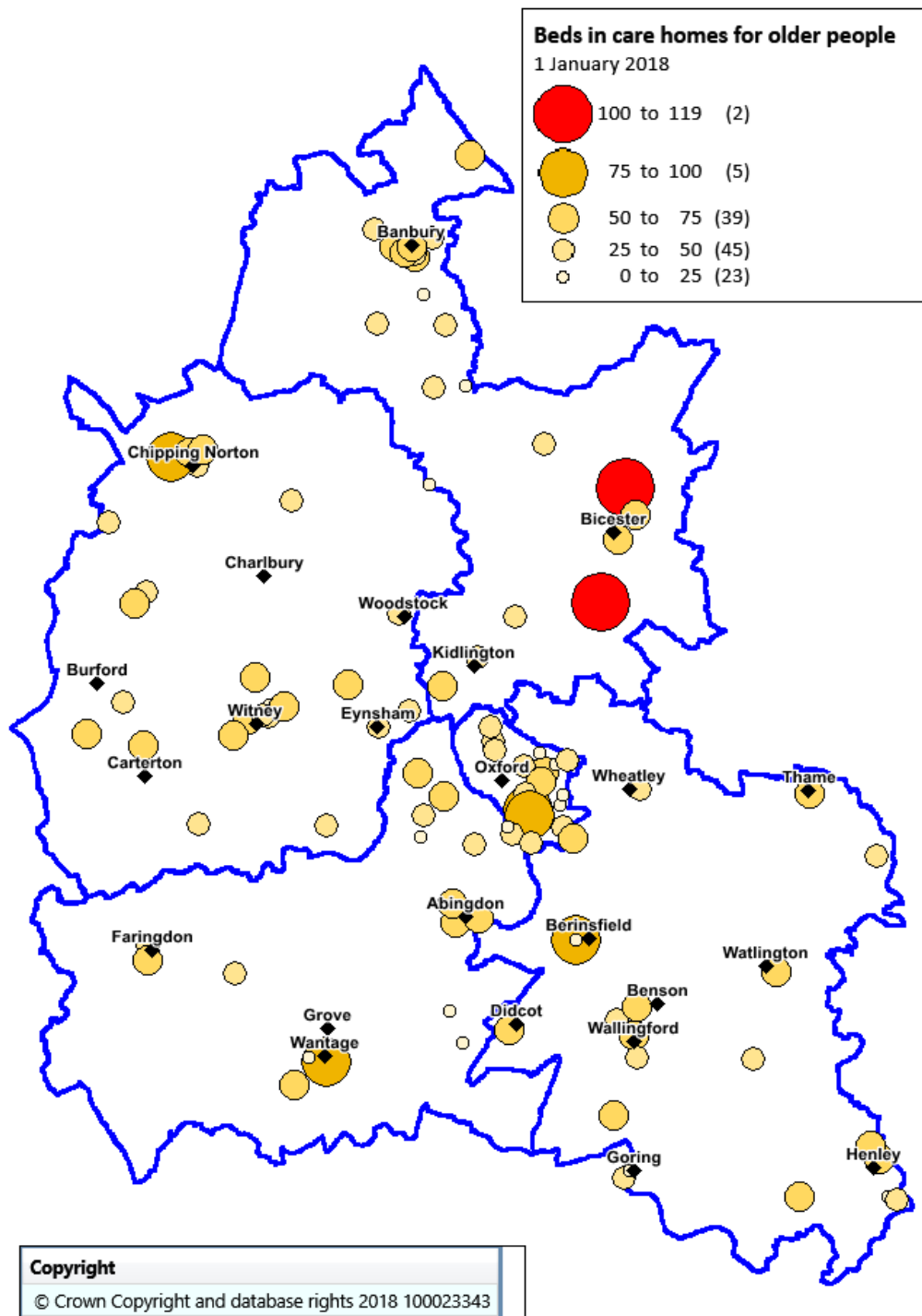


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Figure 106 Care home beds for older people in Oxfordshire



Source: CQC care directory 1 January 2018; mapping by Oxfordshire County Council



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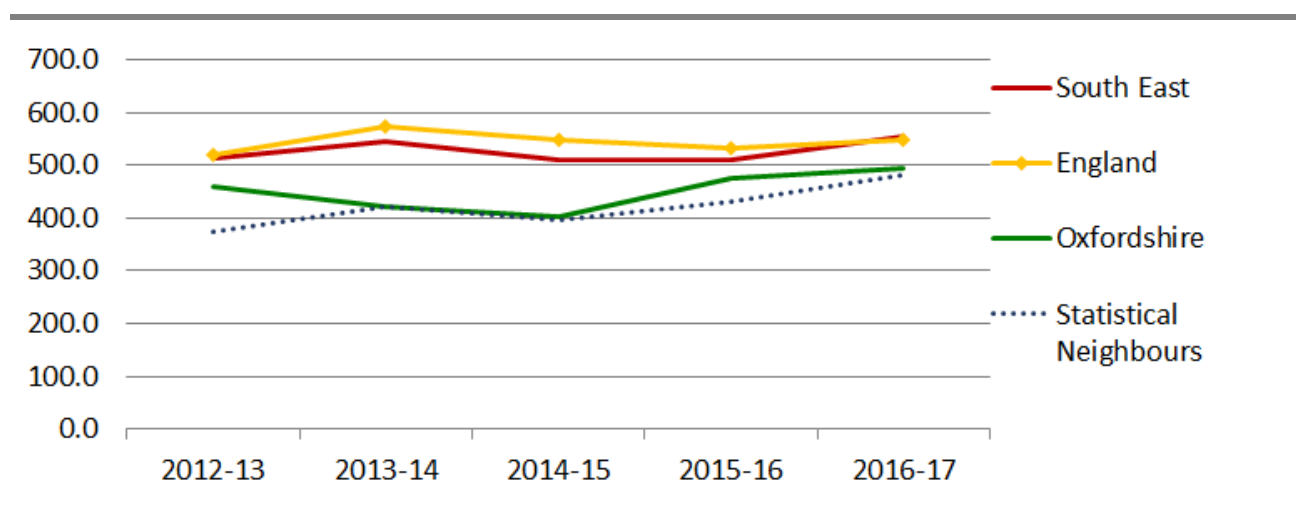
Children's Social Care

Referrals

As of the end of March 2017 there were **7,066** referrals to child social care in Oxfordshire related to **6,429** children.

The rate of referrals in Oxfordshire (per 10,000 children aged 0-17) is below the national and regional averages. The number of referrals has increased for the past 2 years and remains above the rate of similar authorities.

Figure 107 Rates of referrals to Children's Social Care (as at 31 March each year) per 10,000 children aged 0-17



Source: Department for Education

Around one third of referrals (34%) in Oxfordshire were from the police, above the England average of 27.5%.

Just over one fifth (22%) of referrals in Oxfordshire were from schools, also above the England average (20%).

Child Protection Plans

 As of the end of March 2017 there were **609** children in Oxfordshire who were the subject of a child protection plan, up from 571 in March 2016. In two thirds of cases (66%) this was because of neglect rather than physical or emotional abuse.

Overall, the rate of children on protection plans has tended to be lower locally than nationally. However, the number of children on protection plans in Oxfordshire has been rising in recent years, and the rate is now above the South East average and just below the national average.

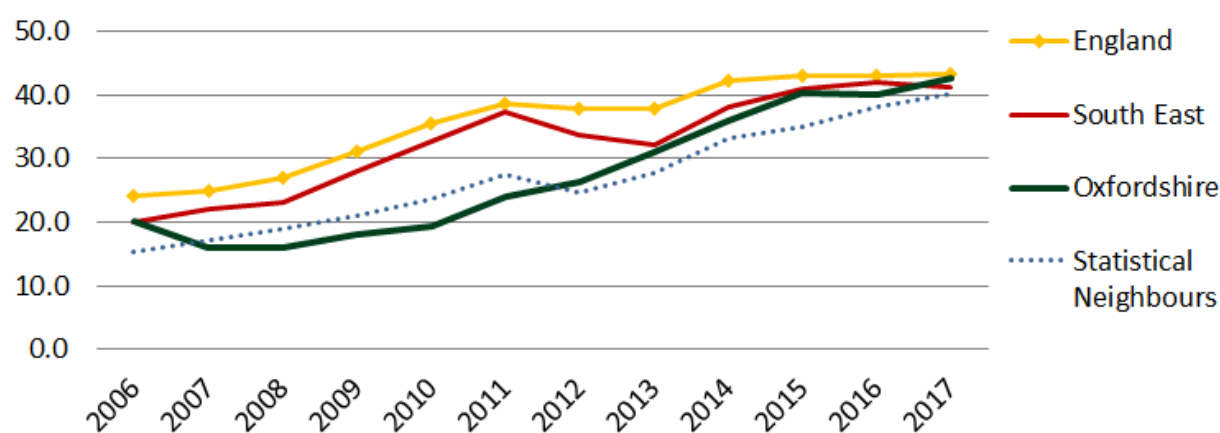


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Figure 108 Rate of children who were the subject of a child protection plan at 31 March each year per 10,000 children aged 0-17

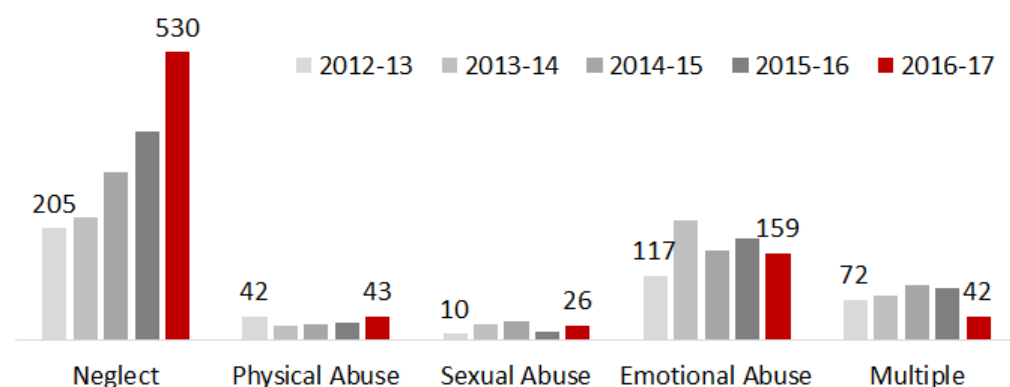


Source: Department for Education



The category of abuse that has seen the greatest increase in numbers of children subject to child protection plans in Oxfordshire over the past 5 years is “neglect”.

Figure 109 Count of children in Oxfordshire subject to child protection plan by initial category of abuse



Source: Department for Education

Factors such as parental mental health, drug/alcohol abuse or domestic violence increase the risk of children becoming subject to a child protection plan.

In 2016-17, this “toxic trio” (mental health, drug/alcohol abuse or domestic violence), affected 60% of children in Oxfordshire with child social care assessment(s).



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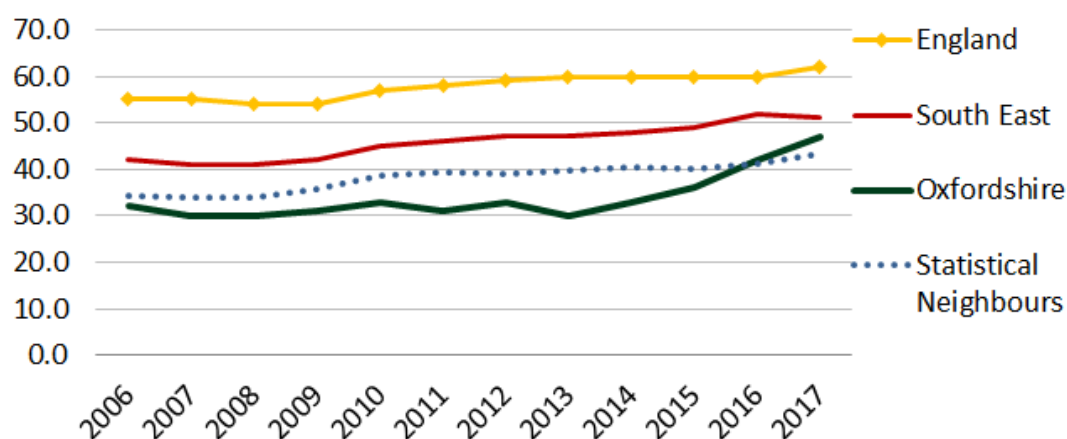
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Looked After Children

➔ As of the end of March 2017 there were **665** looked after children in Oxfordshire, up from 595 in March 2016.

The rate of looked after children in Oxfordshire remains below the national and regional averages, but the number of cases increased each year since 2013 and is now above the rate of similar authorities.

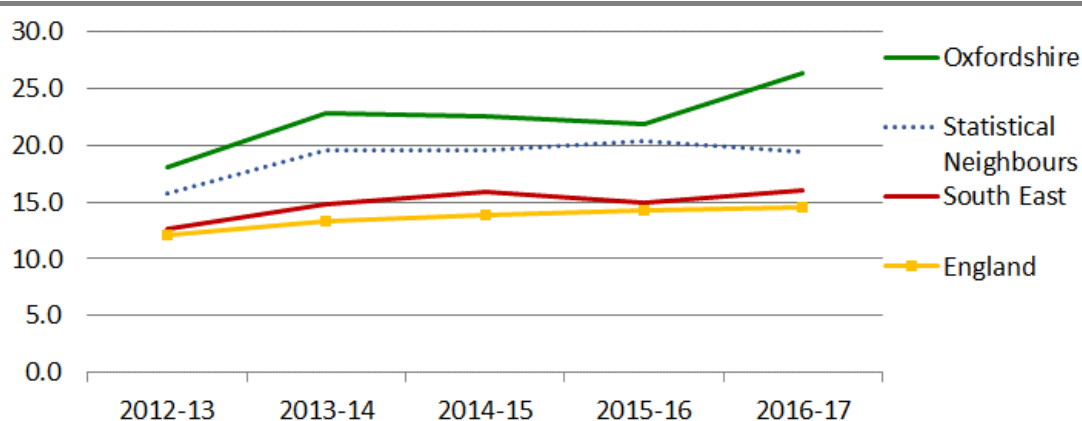
Figure 110 Rates of Looked After Children (as at 31 March each year) per 10,000 children



Source: Department for Education SFR50/2017

➔ In a trend related to this increase in placements, in 2016-17 the proportion of looked after children placed out of Oxfordshire (and more than 20 miles from home) increased. This was against the trend for statistical neighbours where the rate of placements out of area declined.

Figure 111 Proportion of Looked After Children placed out of county and more than 20 miles from home



Source: Department for Education



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Data has been reviewed and is unchanged

 During the year 2016-17, there were 55 looked after children who were unaccompanied asylum-seeking children (UASC) in Oxfordshire, down from 60 in 2015-16 (rounding applied).

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.¹²⁸

 As of 31 March 2017, there were **230** care leavers¹²⁹ in Oxfordshire. Of these, **90** (39%) were not in education, employment or training and the education/employment status of a further 30 was unknown.

Benchmarking data from 2013-14 and 2016-17 shows Oxfordshire as below average on the proportion of care leavers in employment, education or training.

Table 63 Care leavers aged 19 to 21 in employment, education or training

	2012-13	2013-14	2014-15	2015-16	2016-17
Oxfordshire	71	30	38	45	47
Statistical Neighbours	60.8	44.1	51.4	48.9	50.5
England	58	45	48	49	50
South East	56	38	47	47	50

Source: Children's Services Analysis Tool Oxfordshire County Council

¹²⁸ 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* (The Centre for Social Justice, January 2015): <http://www.centreforsocialjustice.org.uk/publications/finding-their-feet>

¹²⁹ Care leavers now aged 19, 20 and 21 who were looked after for a total of at least 13 weeks after their 14th birthday including some time after their 16th birthday



Data has been updated in this version



Data has been reviewed and is unchanged

7.7 Community safety services

Victims of dwelling fires

 In 2016-17 there was a total of 44 people injured and 4 people killed as a result of a dwelling fire in Oxfordshire (56 and 2 in 2015-16).

Table 64 Injuries due to dwelling fires 2010-11 to 2016-17

DWELLING FIRES	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Total Number of Dwelling Fires	490	499	471	417	463	385
Accidental or unknown cause	461	480	450	402	446	358
Deliberate cause	29	19	21	15	17	27
All Injuries due to fire	52	67	67	42	54	43
Serious Injuries due to fire	5	3	5	3	2	1
All Dwelling Fire Fatalities	2	4	2	2	3	4
Fatalities due to fire*	1	4	2	2	2	4

Source: Oxfordshire County Council; * Excludes Fatalities confirmed as non-fire related

Between 2010-11 and 2016-17, of those who were killed or injured (where age was recorded) a third were aged in their 20s and 30s and just under a third (29%) were people aged 60 and over.

Victims of doorstep crime and rogue traders

 In 2016-17 there were **377** people who were victims of doorstep crime or rogue traders in Oxfordshire. The majority of rogue traders were 'selling' garden and landscape services followed by roofing.

The vast majority of victims were older people and Oxfordshire Trading Standards has seen a repeat targeting of elderly and vulnerable victims.

- In 2016-17, 87% of victims of doorstep crime and rogue traders (where age was recorded) were aged over 60 (count=145).

The number of victims has been at a similar level for the past 3 years and remains below a peak of 627 in 2013-14.

Table 65 Victims of doorstep crime and rogue traders

District	2012-13	2013-14	2014-15	2015-16	2016-17
Cherwell	78	99	80	83	80
Oxford City	67	66	115	85	101
South Oxfordshire	83	97	42	63	73
Vale of White Horse	97	89	56	80	58
West Oxfordshire	48	79	50	49	53
SUM of districts	373	430	343	360	365
<i>District not recorded</i>	20	197	34	19	12
TOTAL Oxfordshire	393	627	377	379	377



Data has been updated in this version



Data has been reviewed and is unchanged

7.8 Citizens Advice services

Oxfordshire has open-door Citizens Advice services based in offices in Abingdon, Banbury, Bicester, Didcot, Henley, Thame, Oxford and Witney plus outreach and specialist services.

National Citizens Advice research¹³⁰ has found that:

- *2 in every 3 people who approach Citizens Advice say they are stressed, anxious or depressed. Of these, 4 in 5 (80%) said they felt less stressed, depressed or anxious after receiving advice. 1 in 2 said their physical health had improved.*
- *GPs say 20% of consultations involve requests for help on non-health issues.*

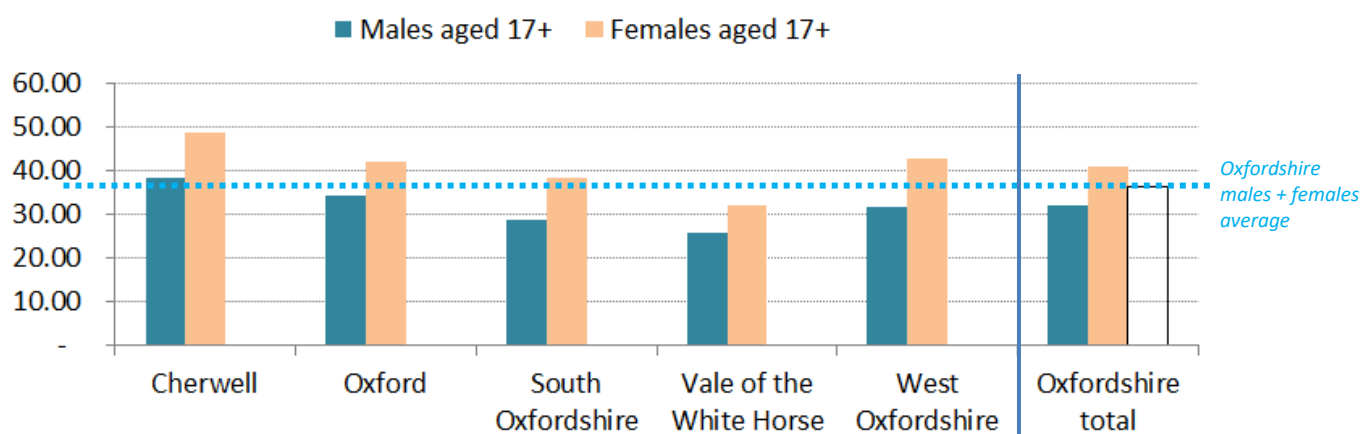
The total number of clients accessing Citizens Advice services in Oxfordshire in 2016-17 was similar to the previous year (25,400 in 2016-17 vs 25,600 in 2015-16).

The majority (80%) accessed benefits, debt, housing and employment services and this number increased from 19,400 in 2015-16 to 20,300 in 2016-17 (+4%).

Clients by gender

In all districts in Oxfordshire in 2016-17, females were more likely than males to have accessed Citizens Advice services.

Figure 112 Citizens Advice clients* by gender per 1,000 population (crude rate) 2016-17



Source: Citizens Advice Agencies Oxfordshire, ONS 2016 population estimates; * not including clients of Consumer services

Clients by ethnicity

The proportion of ethnic minority groups accessing Citizens Advice services has remained well above the proportion of ethnic minority groups in the general population.

- In 2016-17 (as in 2015-16), just over a quarter (28%) of Citizens Advice clients of housing, employment, benefits and debt services in Oxfordshire were from ethnic

¹³⁰ Citizens Advice (2014) Findings from national outcomes and impact research



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Data has been reviewed and is unchanged

minority groups (non-white British). This was well above the proportion of the total population with ethnic minority backgrounds as at 2011 of 16% (Census 2011).

- In Oxford in 2016-17, over half (55%) of Citizens Advice clients of housing, employment, benefits and debt services were from ethnic minority groups, up from 36% in 2011.



Clients by age

Citizens Advice clients had a higher proportion of people in the age range 25 to 64 than average for the population.

- 75% of Citizens Advice clients (aged 17+) of housing, employment, benefits and debt services in 2016-17 were aged 25 to 64. This was above the proportion of people aged 25 to 64 of the total population in Oxfordshire (64%, ONS mid-2016).



Clients recorded as disabled

Over a quarter (6,200, 31%) of Citizens Advice clients of housing, employment, benefits and debt services in Oxfordshire were recorded as disabled. This was over double the proportion of people in households with disabilities in the general population in 2011 (Census 2011, 13.6%).

Between 2015-16 and 2016-17 the number of Citizens Advice clients of housing, employment, benefits and debt services with disabilities increased by 22% (from 5,100 to 6,200).

Of Citizens Advice clients with disabilities in 2016-17, 40% had a long-term health condition, just under a quarter (23%) had a physical or sensory impairment and 20% (count=1,229) had a mental health problem.

As in 2015-16, the district with the greatest number of clients with a disability was Cherwell. The district with the greatest number of clients with multiple health impairments was Oxford.

Figure 113 Citizens Advice clients* recorded as disabled by disability type 2016-17

	Cherwell	Oxford	South Oxon	Vale of WH	West Oxon	Oxfordshire total	
Long term health condition	560	644	477	335	493	2,509	40%
Mental health problem	343	264	203	193	226	1,229	20%
Physical or sensory impairment	397	251	282	204	265	1,399	23%
Learning difficulty or cognitive impairment	67	49	35	37	47	235	4%
Multiple impairments	88	120	63	64	101	436	7%
Other	160	82	48	51	54	395	6%
Total with disability	1,615	1,410	1,108	884	1,186	6,203	100%

Source: Citizens Advice Agencies Oxfordshire; *not including clients of Consumer services



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Feedback on trends from Citizens Advice agencies in Oxfordshire

 Reflecting on recent trends, Citizens Advice agencies in Oxfordshire have commented:

- *We have seen significant increases in relation to benefits, in particular Housing Benefit, Personal Independence Payments and Employment and Support Allowance. The latter two is certainly due to an increase in withdrawal or refusal of benefits at medical assessment stage for ESA, and in transitioning from DLA to PIP. This will have impacted on other benefits as premium entitlements are lost and other benefits re-evaluated and potentially lost.*
- *It is possibly too early for us to notice any Universal Credit trends as this has only just been introduced here in Oxfordshire.*

 A study by Citizens Advice UK¹³¹ into non-health demands on GPs found that 80% of the 824 GPs interviewed reported that dealing with non-health queries resulted in decreased time available to treat other patients' health issues, with almost a fifth (19%) of their consultation time being spent on non-medical matters. The most common issues raised were personal relationships, housing, employment, welfare & benefits and debt.

84% of GPs said that they refer patients to an advice agency in the community and only 31% reported that they were able to advise patients adequately themselves.

¹³¹ Caper, K & Plunkett, J (2015), A very general practice: How much time do GPs spend on issues other than health? Citizens Advice <https://www.citizensadvice.org.uk/about-us/policy/policy-research-topics/health-and-care-policy-research/public-services-policy-research/a-very-general-practice-how-much-time-do-gps-spend-on-issues-other-than-health/>



Data has been updated in this version



Data has been reviewed and is unchanged

7.9 Troubled families programme

Oxfordshire's *Troubled Families – Think Families* programme identifies families most in need of intensive support through a combination of measures including:

- Parents or children involved in crime or anti-social behaviour.
- Children who have not been attending school regularly.
- Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan.
- Adults out of work or at risk of financial exclusion or young people at risk of worklessness.
- Families affected by domestic violence and abuse.
- Parents or children with a range of health problems.

About the Troubled Families Programme

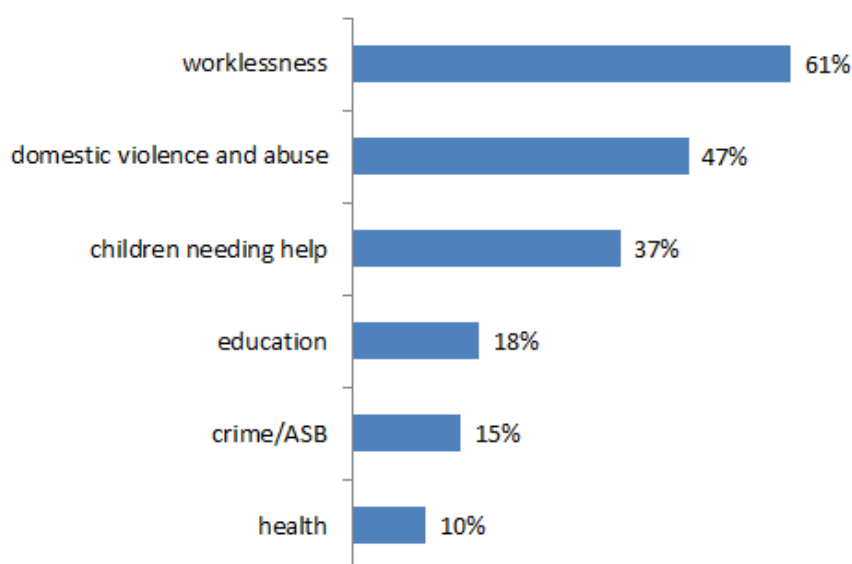
- The first phase of the Troubled Families programme ran from 2012 to 2015
- It set a target to work with, and 'turn around', families with multiple problems
- Problems included crime, anti-social behaviour, truancy and unemployment
- Local authorities ran the programme and received payment-by-results from central Government
- The programme was expanded for 2015-2020 to work with 400,000 additional families
- Second phase targeted additional problems, including domestic violence, health, drug abuse, mental health and children at risk

The Troubled Families programme (England) House of Commons briefing paper 20 Oct 2016



As of 31 December 2017, there was a total of **2,814** families identified in Oxfordshire, 61% of which met the national criteria on worklessness, 47% met the criteria on domestic abuse and 37% were families where children need help (in need or subject to a child protection plan).

Figure 114 Troubled families identified in Oxfordshire by criteria (end December 2017)



Source: Oxfordshire County Council



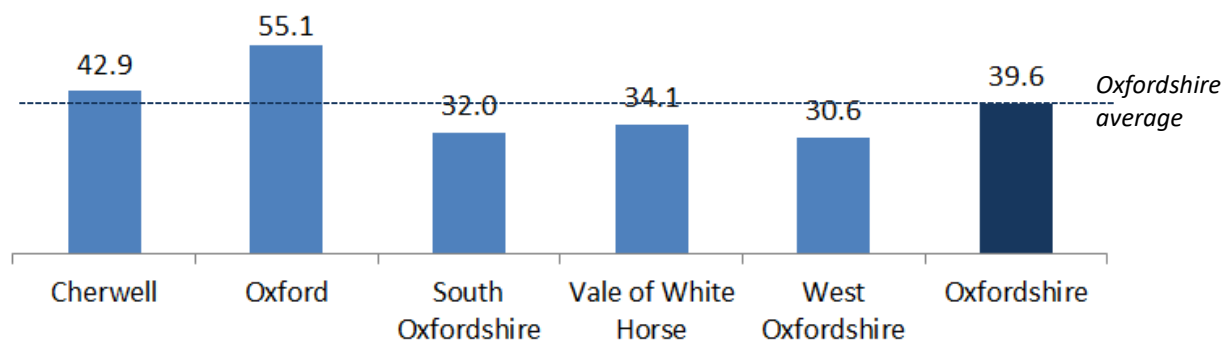
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➔ The rate per 1,000 families of those identified by the Troubled Families programme was highest in Oxford (55 per 1000) and lowest in West Oxfordshire (30.6).

Figure 115 Troubled Families rate per 1,000 families by district (31 December 2017)



Source: Oxfordshire County Council; denominator is number of households with dependent children from table KS105EW - Household composition ONS Census 2011

Table 66 Troubled Families count and rate (31 December 2017)

	Troubled Families (count)	% of total in Oxfordshire	TF rate* per 1,000 families
Cherwell	741	26%	42.9
Oxford	816	29%	55.1
South Oxfordshire	471	17%	32.0
Vale of White Horse	447	16%	34.1
West Oxfordshire	339	12%	30.6
Oxfordshire	2,814	100%	39.6

Source: Oxfordshire County Council; *denominator is number of households with dependent children from table KS105EW - Household composition ONS Census 2011



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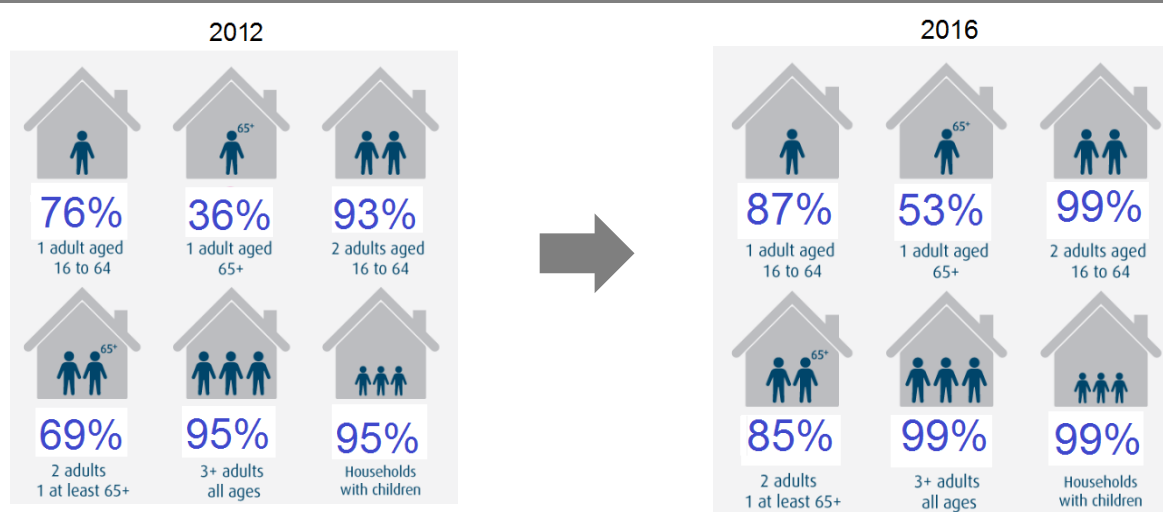
7.10 Access to services

Use of the internet

Data on internet use is limited. The statistics in this section are from the ONS Opinions and Lifestyle survey.

Between 2012 and 2016, the proportion of internet-connected households increased for each household type in Great Britain. Households occupied by a single older person (aged 65+) remained the household type with the lowest proportion of internet-connected households (53% in 2016).

Figure 116 Internet connection by household type



Source: ONS Opinions and Lifestyle survey, ONS infographic

<https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2016#quality-and-methodology>

A significantly lower proportion of disabled people used the internet to find information about goods and services (57% disabled compared with 80% not disabled).

Table 67 Using the internet to find goods and services (95% confidence intervals) 2016

	Lower limit	Survey estimate	Upper limit
Disability status			
Equality Act disabled ¹	52	57	61
Not Equality Act disabled	78	80	82

Base: Adults (aged 16+) in Great Britain.

Source: Office for National Statistics

1. Equality Act disabled refers to those who have a health condition or illness in line with the Equality Act definition of disability.



Data has been updated in this version



Data has been reviewed and is unchanged

Distance to health services

 The Indices of Deprivation 2015 includes an indicator of the average road distance to a GP surgery indicator.

Out of the total of 407 Lower Super Output Areas¹³² (LSOAs) in Oxfordshire, 101 (31%) were 2 miles or more (3.2km) from the nearest GP surgery, covering a total population of 157,000 (25%) as of 2011.

There were no areas of Oxford City classified as 2 miles or more from a GP surgery. Areas classified as 2 miles or more from a GP surgery in rural districts in Oxfordshire covered:

- 3,700 households with no car (23% of total households in rural districts)
- 30,300 people aged 0-15 (32% of the total in rural districts)
- 28,800 people aged 65 and over (34% of the older population in rural districts).

The following map shows the areas of Oxfordshire that are ranked most deprived on the wider subdomain of Geographical Access to Services – including distance to GP, supermarket, post office and primary school – overlaid with locations of Oxfordshire's GPs.

¹³² Lower Super Output Areas have an average of roughly 1,500 residents and 650 households. Measures of proximity (to give a reasonably compact shape) and social homogeneity (to encourage areas of similar social background) are also included.

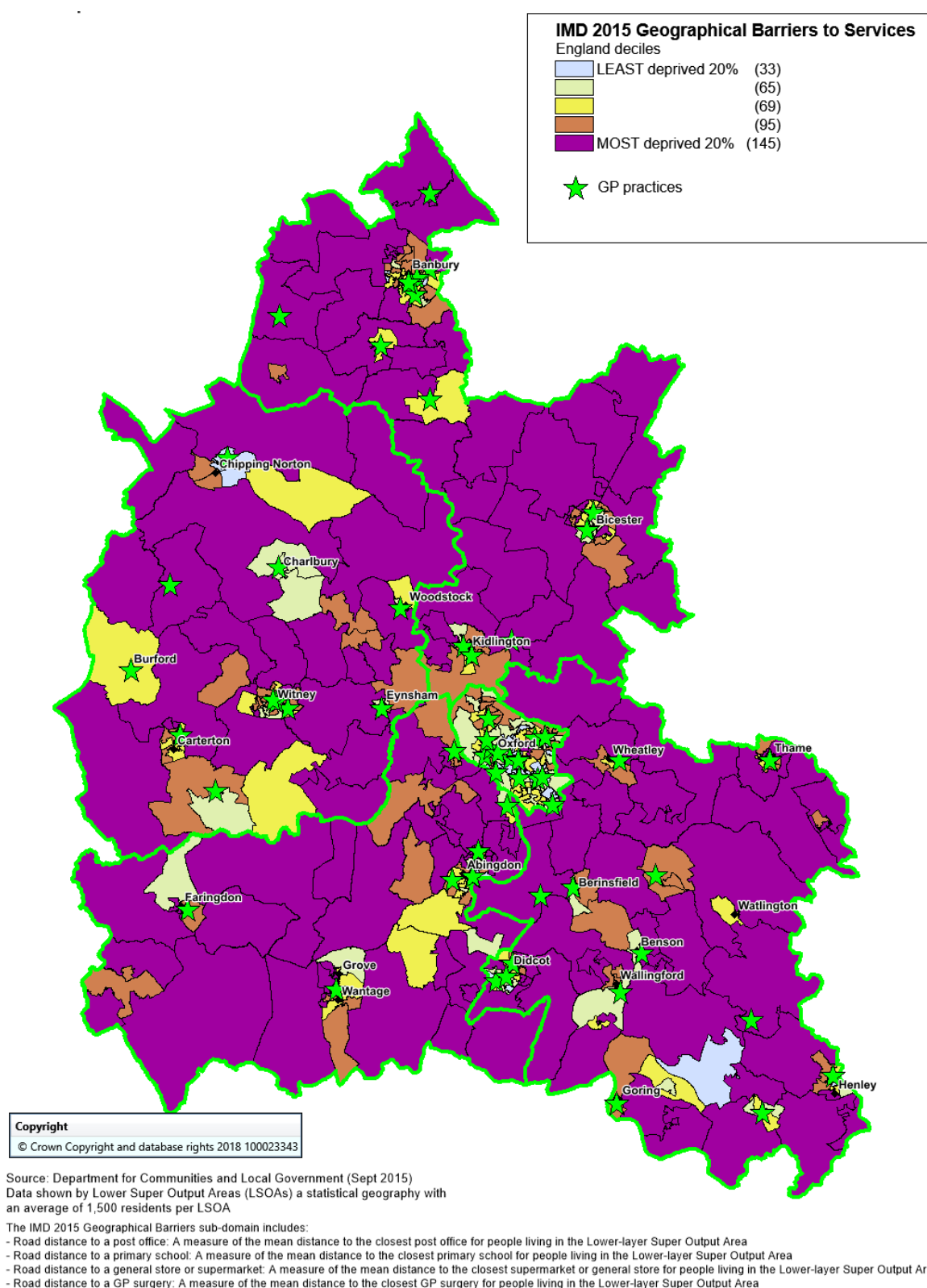


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Data has been reviewed and is unchanged

Figure 117 Geographical barriers to services (IMD 2015) showing locations of GP practices



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Data has been reviewed and is unchanged

8 Gaps in evidence and areas for further research

This section lists areas where evidence is currently lacking or could be improved.

Population and population groups

- More recent data (than the Census 2011 survey) on ethnicity
- Local data on sexual orientation and gender reassignment

Wider determinants

- Changes in the economy in the view of the Oxfordshire Local Enterprise Partnership
- forecast change in number and type of jobs
- Part time employment and income
- Impact of Universal Credit
- Quality of housing
- Families living in Houses of Multiple Occupation
- More on traffic growth and impact on health
- Monitoring data on walking and cycling (active travel)

Lifestyles

- Local data on volunteering including who volunteers and impact on health
- Data on adults learning new skills

Service use

- Distance and travel options to health services by population group (including equalities groups).

ANNEX TO THIS REPORT

Health Inequalities Basket of Indicators



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Data has been reviewed and is unchanged

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Oxfordshire Pharmaceutical Needs Assessment 2018

Issue Date: 9 March 2018

Version: Draft 3.6



A. Executive Summary

Pharmaceutical Services in Oxfordshire

In 2005 the national framework for community pharmaceutical services identified three levels of pharmaceutical service: essential, advanced and enhanced. The purpose of this pharmaceutical needs assessment (PNA), is to identify overall pharmacy and medicines management needs for the population and to identify how, within the existing contractual framework, these needs can be addressed.

Oxfordshire Health and Wellbeing board (HWB) wishes to ensure all opportunities provided within the currently funded, essential and advanced service elements of the community pharmacy contractual framework are fully utilised to ensure maximum health gain for its population.

Oxfordshire is well provided for with respect to dispensing pharmaceutical services. There are:

- 98 standard community pharmacies
- 12 (twelve) 100 hours' community pharmacies
- 2 distance selling / internet pharmacy
- 1 dispensing appliance contractor
- 25 dispensing doctor practices

(Data supplied by NHS England Thames Valley Regional Team)

In Oxfordshire community pharmacies are accessible and many offer extended opening times, often late into the evenings and/or at weekends. Figures in 2014 showed that Oxfordshire has slightly less than the national average of pharmacies per 10,000 head of population. However, there are 23 dispensing practices across Oxfordshire (1023 in England). This is due to the rural nature of the county.

Essential Pharmaceutical Services

Community pharmacies in Oxfordshire receive national funding to provide both essential and advanced pharmaceutical services, within the national framework.

Essential services are those which each community pharmacy must provide. All community and distance selling/internet pharmacies with NHS contracts provide the full range of essential services. These are:

- Dispensing medicines and actions associated with dispensing
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public Health (promotion of healthy lifestyles)
- Signposting
- Support for self-care
- Clinical governance

Advanced Services

Pharmacies may choose whether to provide these services or not. These include:

:

- Medicines use review (MUR) and prescription intervention services
- New medicines services (NMS)
- Stoma appliance customisation (SAC)
- Appliance use review (AUR)

Advanced services have nationally agreed specifications and payments and pharmacies must meet certain requirements. They are funded by the NHS and no charge is incurred by patients.

Three national target groups for Medicines Use Reviews (MURs) were introduced in October 2011; a fourth target group was agreed in September 2014 (Cardiovascular risk) and was implemented from 1st January 2015. The national target groups are:

- patients taking high risk medicines;
- patients recently discharged from hospital who had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge;
- patients with respiratory disease; and
- patients at risk of or diagnosed with cardiovascular disease and regularly being prescribed at least four medicines.

From 1st April 2015, community pharmacies must carry out at least 70% of their MURs within any given financial year on patients in one or more of the above target groups.

Enhanced and Local Commissioned Services

Enhanced services are those services directly commissioned by NHS England. Pharmacy contractors may provide Locally Commissioned Services (LCS) commissioned by Local Authorities (LA) or by Clinical Commissioning Groups (CCG). Although LCS are not enhanced services, they reflect the services that could be (and in other parts of the country are) commissioned by NHS England.

There are currently five LCS commissioned from community pharmacies by Oxfordshire County Council (OCC) OR Oxfordshire CCG (OCCG):

- Emergency hormonal contraception (EHC) (OCC)
- Supervised consumption of opiate substitute therapy (OCC)
- SWOP Needle exchange service (OCC)
- Palliative care (OCCG)
- Minor ailments (OCCG)

The Oxfordshire Health and Wellbeing Board has overseen significant needs and health assessment work, including Joint Strategic Needs Assessment (JSNA) on an annual basis, development of the Joint Health and Wellbeing Strategy and updating what is known about new housing developments within the lifetime of the PNA and beyond.

Summary of main issues

The Steering Group (on behalf of Oxfordshire Health and Wellbeing Board) revised this PNA and considered access (distance, travelling times and opening hours) as the most important factor in determining the extent to which the current provision of pharmaceutical services meets the needs of the population.

The Steering Group considers access to a pharmacy of primary importance during normal working hours and at times when GP surgeries are open. Where there are no pharmacies but a GP dispensing service, the steering group consider the latter to mitigate against any potential gap in need for pharmaceutical services. It is also noted that dispensing practices can only provide limited essential pharmaceutical services and only to identified patients of the practice. There are further pharmaceutical services available from a community pharmacy provided to a broader client base. The steering group also recognises that there are some GP practices that are open at different times to nearby pharmacies.

Generally, community pharmacies in Oxfordshire are well distributed, are accessible and offer a convenient service to patients and members of the public. They are available on weekdays and at the weekend (often until late at night) without the need for an appointment.

There are pharmacies providing 100-hour provision and several pharmacies providing supplementary hours into evenings and weekends. While the steering group would wish pharmacies to mirror these opening hours they consider that people could reasonably wait until pharmacies open the next morning or that they could reasonably travel during evenings and weekends to where pharmaceutical services are provided at those times.

The steering group reviewed any changes to pharmaceutical services alongside future or newly built housing developments to ascertain if anything had changed since the previous PNA was published in 2015. Where it is considered there is a gap or room for improvement, this has been identified in each locality district.

Key Findings

Oxfordshire is a relatively affluent county with pockets of deprivation in urban areas. It is well provided with pharmaceutical services.

Across Oxfordshire the number of pharmacies per 100,000 population is less than the national average. However, the number of dispensing practices is greater than the national average.

All pharmacies can make full use of NHS Choices and other internet-based information sources to promote their services, to improve communications so patients, carers and other users are aware of the range and availability of all services. [NHS Choices](#) website enables the user to check the services provided at their nearest pharmacy, and gives a map with directions.

Oxfordshire is in no need of further premises to provide pharmaceutical services. However, there are opportunities for improvement and better access to pharmaceutical services for residents of Caversfield, Upper Heyford, Berinsfield, Hanborough and Shipton-under-Wychwood.

When local housing developments are considered over the next three years it is concluded that, in relation to the current provision of pharmacies, a gap in pharmaceutical services is unlikely to exist during the lifetime of this PNA.

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B. Introduction

The purpose of the pharmaceutical needs assessment (PNA) is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a Health and Wellbeing Board's (HWB) area for a period of up to three years, linking closely to the Joint Strategic Needs Assessment (JSNA).

Whilst the JSNA focuses on the general health needs of the population of Oxfordshire, the PNA looks at how some health needs can be met by pharmaceutical services commissioned by NHS England.

If a person (a pharmacy or a dispensing appliance contractor (DAC)) wants to provide pharmaceutical services, they are required to apply to NHS England to be included in the pharmaceutical list for the HWB's area in which they wish to have premises. In general, their application must offer to meet a need that is set out in the HWB's PNA, or to secure improvements or better access similarly identified in the PNA. There are however some exceptions to this e.g. applications offering benefits that were not foreseen when the PNA was published ('unforeseen benefits applications').

As well as identifying if there is a need for additional premises, the PNA will also identify whether there is a need for an additional service or services, or whether improvements or better access to existing services are required. Identified needs, improvements or better access could either be current or will arise within the lifetime of the PNA.

Whilst the PNA is primarily a document for NHS England to use to make commissioning decisions, it may also be used by local authorities (LA) and clinical commissioning groups (CCG). A robust PNA will ensure those who commission services from pharmacies and dispensing appliance contractors (DAC) can ensure services are targeted to areas of health need, and reduce the risk of overprovision in areas of less need. It is not a stand-alone document. It is important that the PNA contributes to and becomes an integral part of the Oxfordshire JSNA.

Oxfordshire overview

Oxfordshire is the most rural county in the South East of England. The 2011 Census showed Oxfordshire had a population of 653,800 people. The mid-year estimate for 2016 was 683,169. Over half of the population live in towns or villages of less than 10,000 people. The total population of Oxfordshire has increased by 8% over the last ten years (48,500 people) and is predicted to increase by over 20% by the year 2026.

Oxfordshire has major education and tourism industries and the 2011 Census indicates there were 5,500 short-term migrants in Oxfordshire. Oxfordshire has consistently high levels of employment; the workforce is amongst the most highly-qualified in the country. World-class business clusters include bioscience and scientific research.

The adopted and draft plans prepared by Oxfordshire District Councils, together set out housing growth in Oxfordshire of 34,300 by the end of March 2022 and a further 47,200 homes by end March 2031, a total of 81,500 new homes in the next 15 years. Further details can be found in Appendix D.

Provider Landscape

There are many organisations involved in the healthcare system in Oxfordshire:

- Oxfordshire Clinical Commissioning group (CCG).
- Oxfordshire County Council (OCC), responsible for (amongst other things), public health and social care in Oxfordshire.
- Five district councils, responsible for housing and other areas that may influence health.
- Primary care including GP practices, GPs providing core primary care services, optometrists, pharmacies and dental practices.
- Oxford University Hospital NHS Foundation Trust (OUH), provides specialist, acute, elective and community based healthcare. It consists of four main hospitals, John Radcliffe, Churchill, Nuffield and Horton General Hospitals.
- Oxford Health NHS Foundation trust (OHFT) provides a range of specialist mental health services in five different localities as well as physical healthcare to people in Oxfordshire including community services
- South Central Ambulance Services (SCAS) provide the blue light emergency response to 999 calls as well as non-emergency patient transport services. They also provide the NHS 111 telephone round-the-clock service for the four counties in South Central region (Oxfordshire, Buckinghamshire, Berkshire and Milton Keynes) plus Bedfordshire and Luton.
- NHS Central Southern Commissioning Support Unit (CSCSU).
- Third sector providers which include a myriad of voluntary and charitable enterprises with a focus on health, for example palliative care support.

Health and social care commissioning is jointly governed through the Oxfordshire HWB. The HWB partnerships provide an opportunity for county and district councillors, CCGs and other partners to work together to achieve the shared vision for improving health and wellbeing. The work focuses on trying to stop or delay people becoming unwell and promoting ways to keep healthy.

The main CCG responsible for planning, designing and paying for healthcare in Oxfordshire is Oxfordshire CCG. However, Aylesbury Vale CCG also includes parts of Oxfordshire around Thame and Chinnor and Swindon CCG includes one dispensing GP practice in Shrivenham (also situated in Oxfordshire).

This document provides an overview of the health of Oxfordshire residents, encompassing some of the key messages. Further in-depth analysis can be found in the Joint Strategic Needs Assessment for Oxfordshire and other needs assessments listed at Oxfordshire Insights:

<http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment>

Joint Health and Wellbeing Strategy

Oxfordshire's Joint Health and Wellbeing Strategy 2015-19 sets out the priorities Oxfordshire HWB would like all partners to continue to work together effectively for the health and wellbeing of the population in Oxfordshire. The strategy and its priorities have been developed based on evidence of local need described in the JSNA.

Children and Young People

1. All children have a healthy start in life and stay healthy into adulthood
2. Narrowing the gap for our most disadvantaged and vulnerable group
3. Keeping all children and young people safe
4. Raising achievement for all children and young people

Adult Health and Social Care

5. Living and working well, adults with long term conditions (LTC), physical or learning disability or mental health problems living independently and achieving their full potential
6. Support older people to live independently with dignity whilst reducing the need for care and support
7. Working together to improve quality and value for money in the health and social care system

Health Improvement

8. Preventing early death and improving quality of life in later years
9. Preventing chronic disease through tackling obesity
10. Tackling the broader determinants of health through better housing and preventing homelessness
11. Preventing infectious disease through immunisation

This year's revision can be found at the following link:

<https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf>

Director of Public Health Annual Report

Every Director of Public Health must complete an annual report each year. It uses science and fact to describe the health of Oxfordshire and to make recommendations for the future. It is for all people and all organisations.

The Director for Public Health Annual Report 2016-17 expands on areas addressed in Joint Health and Wellbeing Strategy to address the public health priorities for Oxfordshire. The report is split into six sections:

- The Demographic Challenge
- Building Healthy Communities
- Breaking the Cycle of Disadvantage
- Lifestyle and Preventing Disease Before It Starts
- Mental Health
- Fighting Killer Diseases

These topics are dealt with one by one in the report. The current issues and recent action are laid out.

The full report can be found at the link below:

http://mycouncil.oxfordshire.gov.uk/documents/s39137/CA_OCT1717R13%20Director%20of%20Public%20health%20annual%20Report.pdf

Oxfordshire Clinical Commissioning Group (CCG)

Sustainability and Transformation Plan

The Sustainability and Transformation Plan for the Buckinghamshire, Oxfordshire and Berkshire West area (known as the BOB STP) is being developed as 2 linked initiatives:

- An overarching plan for the whole Buckinghamshire, Oxfordshire and Berkshire West area.** In formulating this plan the demands on the health and social care system were identified as follows:

Over the next five years, we face the following challenges across the area:

- *Significant increases in population due to new housing growth*
- *Pockets of deprivation where communities are not as healthy as they could be*
- *An increase in demand for services, especially for frail older people who often have more than one health and care need*

- *Difficulty in recruiting and retaining staff due to the high cost of living, which leads to inconsistent levels of care and unsustainable services*
- *Ageing NHS buildings which are not fit for modern use*
- *Variable access to some specialised services and other treatments*
- *People having to travel out of our area for specialised mental health care.*

The whole plan can be found here: <https://www.bobstp.org.uk/>

b. **The Oxfordshire Transformation Plan.** This is one of three County-wide Transformation Plans within the BOB area (the others being for Buckinghamshire and Berkshire West).

Phase 1 of the Oxfordshire plan covered the following areas of the healthcare system:

- *Changing the way hospital beds are used and increasing care closer to home*
- *Planned care services at the Horton General Hospital*
- *Acute stroke services*
- *Critical care*
- *Maternity.*

The proposals were subject to public consultation (January – April 2017) and decisions were made at a CCG Board meeting in August 2017.

At the time of drafting this PNA there is public engagement activity underway on Phase 2 of the Oxfordshire Transformation Plan, which includes discussion on primary care and locality plans.

Details and outcomes can be found on the CCG website www.oxfordshireccg.nhs.uk

GP 5-year forward view

The General Practice Forward View (GP Forward View), published in April 2016¹, recognises that General practice is at the heart of the care provided by the NHS although it faces many pressures such as increase in demand and subsequent workload. It highlighted the need to invest in general practice has never felt more important for the long-term sustainability of the NHS and commits to an extra £2.4 billion a year to support general practice services by 2020/21. The aim is to improve patient care and access, and invest in new ways of providing primary care.

In Oxfordshire, a Primary Care Framework² has been developed which sets out the strategic vision for primary care over the next 5-10 years so that it remains the cornerstone of our NHS. Under this umbrella each of the 6 localities is developing a plan to address the local needs and demands as well as to support primary care sustainability. Currently the CCG is engaging with the public on draft plans with the aim to publish the plans on the CCG website at the end of January 2018.

¹ General Practice Forward View; NHS England; <https://www.england.nhs.uk/gp/gpforwardview/about/>

² <http://www.oxfordshireccg.nhs.uk/key-occg-publications/occg-primary-care-framework/32373>

As part of this NHS England is investing £500 million in a national sustainability and transformation package to support GP practices, which includes additional funds from local clinical commissioning groups (CCGs).

Background and Legislation

The Health Act 2009

The Health Act 2009 made amendments to the National Health Service (NHS) Act 2006 stating each Primary Care Trust (PCT) must, in accordance with regulations: Assess needs for pharmaceutical services in its area

- Publish a statement of its first assessment and of any revised assessment

The regulations stated a PNA must be published by each PCT by 1st February 2011. There was a duty to rewrite the PNA within three years or earlier if there were any significant changes which would affect the current or future pharmaceutical needs within the PCT's locality. This meant that subsequently revised PNAs were due to be produced by February 2014.

However, the **Health and Social Care Act 2012** brought about the more wide-ranging reforms to the NHS. These reforms included the abolition of PCTs and the introduction of CCGs who now commission most NHS services. Public Health functions however were transferred to Local Authorities (LAs).

www.legislation.gov.uk/ukpga/2009/21/part/3/crossheading/pharmaceutical-services-in-england

The Health and Social Care Act 2012

To ensure integrated working, plan how best to meet the needs of the population and tackle local inequalities in health, the 2012 legislation called for HWBs to be established and hosted by LAs. These boards should bring together the NHS, public health, adult social care and children's services, including elected representatives and local Healthwatch.

The Health and Social Care Act 2012 transferred responsibility for the developing and updating of PNAs to HWBs. PNAs should be updated on a three-yearly basis.
<http://www.legislation.gov.uk/ukxi/2013/349/contents/made>

Pharmaceutical and Local Pharmaceutical Services Regulations 2013 amended December 2016

Under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 amended December 2016, the newly established HWB must publish its first PNA by 1st April 2015

The preparation and consultation on the PNA should take account of the local JSNA and other relevant local strategies to prevent duplication of work and multiple consultations with health groups, patients and the public.

This PNA, to be published by the HWB in April 2018, will last for a period of up to three years. HWB will also be required to publish revised assessments if significant changes to the need for pharmaceutical services are identified, unless this is considered a disproportionate response.

As part of developing the PNA, the HWB must undertake a consultation for a minimum of 60 days. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 list those persons and organisations that the HWB must consult with.

The health and social care act 2012 also transferred responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list from PCTs to NHS England. The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor (DAC) premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Such decisions are appealable to the NHS Resolution's Family Health Services Appeal Unit (FHSAU), and decisions made on appeal can be challenged through the courts. PNAs will also inform the commissioning of enhanced services from pharmacies by NHS England, and the commissioning of services from pharmacies by the LA and other local commissioners e.g. CCGs.

<http://www.legislation.gov.uk/uksi/2013/349/regulation/6/made>

NHS England

From April 2013, NHS England has taken on many of the functions of the former PCTs regarding commissioning of primary care health services, as well as some nationally-based functions previously undertaken by the Department of Health. The new arrangements comprise a single operating model for the commissioning of primary care services, which up until now has been done differently by PCTs and their predecessors.

NHS England South is the regional arm and the South-Central Team focus on the Thames Valley region, working with partners to oversee the quality, safety of the NHS and promoting patient and public engagement. The local team has specific roles in relation to the support and assurance of the ten CCGs across Buckinghamshire, Berkshire and Oxfordshire and directly commissions primary care services and public health screening and immunisation programmes.

The Regional Teams have many roles, some of which play an important role in pharmaceutical services. These include:

- Assess and assure performance

- Undertake direct commissioning of primary care services (dental, pharmacy and optometry)
- Manage and cultivate local partnerships and stakeholder relationships, including membership of local HWBs.
- Emergency planning, resilience and response
- Ensure quality and safety

Pharmacy Contractual Framework

NHS England does not hold contracts with pharmacy contractors, unlike the arrangements for general practitioners (GPs), dentists and optometrists. Instead they provide services under a contractual framework, details of which (their terms of service) are set out in schedule 4 of the 2013 regulations and in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.

<https://www.gov.uk/government/publications/pharmaceutical-services-advanced-and-enhanced-services-england-directions-2013>

Pharmacy contractors provide three types of service that fall within the definition of pharmaceutical services. They are; essential, advanced and enhanced.

Essential Services

Essential services are those which each community pharmacy must provide. All community and distance selling/internet pharmacies with NHS contracts provide the full range of essential services. These are:

- Dispensing medicines and actions associated with dispensing
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public Health (promotion of healthy lifestyles)
- Signposting
- Support for self-care
- Clinical governance

Public Health: Pharmacies are required to deliver up to six public health campaigns throughout the year to promote healthy lifestyles.

Signposting and Referral: This is the provision of information from other health and social care providers or support organisations to people visiting the pharmacy, who require further support, advice or treatment. It provides contact information and/or how to access further care and support appropriate to their needs, which cannot be provided by the pharmacy.

As part of their system of clinical governance pharmacies must have appropriate safeguarding procedures for service users. Contractors are responsible for ensuring relevant staff providing pharmaceutical services to children and vulnerable adults are aware of the safeguarding guidance and the local safeguarding arrangements. ***The governance element to essential services also includes public engagement***

and clinical audits in addition to standards for pharmacy staff and the ability of pharmacies to deliver all pharmaceutical services in an effective way.

Opening hours: core and supplementary

Pharmacies are required to open for 40 hours per week. These are referred to as core opening hours, however many choose to open for longer and these additional hours are referred to as supplementary opening hours. Between April 2005 and August 2012, some contractors successfully applied to open new premises based on being open for 100 core opening hours per week (referred to as 100 hour pharmacies), which means that they are required to be open for 100 hours per week, 52 weeks of the year (apart from weeks which contain a bank or public holiday, or Easter Sunday). These 100-hour pharmacies remain under an obligation to be open for 100 hours per week. Additionally, these pharmacies may open for longer hours.

The proposed opening hours for each pharmacy are set out in the initial application, and if the application is granted and the pharmacy subsequently opens then these form the pharmacy's contracted opening hours. The contractor can subsequently apply to change their core opening hours. NHS England will assess the application against the needs of the population of the HWB area as set out in the PNA to determine whether to agree to the change in core hours or not.

If a contractor wishes to change their supplementary opening hours they simply notify NHS England of the change, giving at least three months' notice.

NHS Choices advertises 'opening hours' to the public (www.nhs.uk). Community pharmacies also produce their own information leaflets detailing opening hours, which are available from individual pharmacies.

Advanced Services

Pharmacies may choose whether to provide these services or not. If they choose to provide one or more of these services, they must meet certain requirements and must be fully compliant with the essential services and clinical governance requirements.

Medicines Use Review and Prescription Intervention Service (MUR)

Accredited pharmacists undertake a structured review with patients on multiple medicines, particularly those receiving medicines for long term conditions (LTCs), such as diabetes, coronary heart disease (CHD), and chronic obstructive pulmonary disease (COPD). The MUR process attempts to establish a picture of the patient's use of their medicines, both prescribed and non-prescribed. The review helps a patient understand their therapy and can identify any problems they are experiencing along with possible solutions. A report of the review is provided to the patient and to the patient's GP where there is an issue for them to consider.

Appliance Use Review (AUR) can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs can improve the patient's knowledge and use of their appliance(s) by:

- Establishing the way in which the patient uses the appliance and the patient's experience of such use.

Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient.
Advising the patient on the safe and appropriate storage of the appliance.
Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

Stoma Appliance Customisation (SAC)

The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

New Medicines Service (NMS) is the latest nationally developed service for community pharmacy. It is designed to provide early support to patients to maximise the benefits of the medication they have been prescribed.

The purpose of the NMS is to promote the health and well-being of patients who are prescribed new medicines for LTCs to:

- Help reduce the symptoms and long-term complications of the LTC
- Identify problems with the management of the condition and the need for further information or support

Additionally, the service will help patients:

- Make informed choices about their care
 - Self-manage their LTC
 - Adhere to the agreed treatment programme
- Make appropriate lifestyle changes

Flu Vaccination - Advanced Service. NHS England commissions this service on an annual basis for specified patient groups over 65yrs, at risk groups excluding children.

Pilots. NHS England ***does commission additional services on a pilot basis. In 2017, the National Urgent Medicines Service Advanced Service (NUMSAS) can be provided by community pharmacies. However, for the purposes of the PNA these services have not been included. Should they become commissioned on an ongoing basis this PNA will be updated to reflect the change.***

Enhanced and Locally Commissioned Services (LCS)

Enhanced services are those services directly commissioned by NHS England. Pharmacy contractors may provide LCS commissioned by LAs and CCGs.

LCS are included within the list of pharmaceutical services to provide a comprehensive assessment of services for Oxfordshire.

There are currently five LCS commissioned from community pharmacies by Oxfordshire County Council (OCC) OR Oxfordshire CCG (OCCG). These services include:

Emergency hormonal contraception (EHC)
Supervised consumption of opiate substitute therapy (OCC)
SWOP Needle exchange service (OCC)
Palliative care (OCCG)
Minor ailments (OCCG)
(The commissioning organisations are shown in brackets).

Local Pharmaceutical Services (LPS)

LPS contracts allow NHS England to commission services, from a pharmacy, which are tailored to specific local requirements. LPS complement the national contractual arrangements but are an important local commissioning tool. LPS contracts provide flexibility to include a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national contractual arrangements. For the purposes of the PNA the definition of pharmaceutical services includes LPS.

Dispensing Doctors

Dispensing doctors provide services to patients mainly in rural areas and often where there are no community pharmacies or where access is restricted. Oxfordshire HWB has several rural areas which have pharmaceutical services provided by dispensing doctors.

A patient may at any time request that a doctor provides them with pharmaceutical services, however the patient must meet criteria and they must be on the patient list of a doctor who is registered to provide pharmaceutical services.

These include one or more of the following:

- The patient lives in a controlled locality (a rural area determined locally in line with the regulations and after consideration of a wide range of factors) and is more than 1mile /1.6km from a pharmacy premises.
- The patient can demonstrate they would have serious difficulty in obtaining any necessary drugs or appliances from a pharmacy because of distance or inadequacy of communication. This does not include lack of transport.

Dispensing Appliance Contractors (DACs)

DACs dispensing “specified appliances” such as stoma, catheter or incontinence appliances are required to provide:

- Home delivery services.
- Reasonable supplies of supplementary items such as disposable wipes.
- Access to expert clinical advice.

DACs can dispense against repeatable prescriptions, and are required to participate in systems of clinical governance. They provide services nationally and serve large geographical areas, including those where they are based.

They may choose whether to offer an appliance usage review (AUR) service.

Oxfordshire HWB area has one appliance contractor.

Distance Selling Pharmacies

Online pharmacies, internet pharmacies, or mail order pharmacies operate over the internet and send orders to customers through the mail or shipping companies.

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 detail conditions for distance selling pharmacies:

- To provide the full range of essential services during opening hours to all persons in England presenting prescriptions;
- Cannot provide essential services face to face;
- Must have a responsible pharmacist in charge of the business at the premises throughout core and supplementary opening hours; and
- Must be registered with the General Pharmaceutical Council (GPhC)
- Patients have the right to access pharmaceutical services from any community pharmacy including those operating on-line.

There are two internet pharmacies based in Oxfordshire HWB area.

Prison Pharmacies

Oxfordshire has two prisons; HMP Bullingdon and HMP Huntercombe. Pharmaceutical services for these populations are not included in the PNA. Prisons are not included within the scope of a PNA.

C. PNA Process Summary

Summary of Overall Process

A PNA steering group was established whose purpose was to ensure that the HWB revise the previous (robust) PNA and complies with the 2013 regulations and the needs of the local population. Members of the steering group included the key stakeholders responsible for the commissioning and provision of pharmaceutical services in Oxfordshire. A full list of members is at appendix A.

In developing the PNA, Oxfordshire HWB area was considered by locality (District Councils), including data based on smaller geographical areas (lower super output area (LSOA)) basis for both population needs and service. Each locality reflects the District Councils of Oxfordshire areas and reflects the localities described in the JSNA.

The analysed data was mapped against specific population statistics and overlaid with pharmaceutical service provision. Initially, essential pharmaceutical services provided via community pharmacies alone were considered against highest needs (including proximity and access times). Distance to access pharmaceutical services was estimated and mapped for both driving and walking distance times.

Several factors were taken into consideration when assessing what would be a reasonable distance for a resident to travel to access pharmaceutical services within the HWB area. The assessment included:

- Average walking speeds (2.5 miles per hour/ 4kmp)
- Government statutory walking distance for schools (8 years and younger)
- Access to public transport during working hours and 'off peak'
- Access to private transport

Although walking speeds can vary greatly depending on factors such as height, weight, age, terrain, surface, load, culture, effort, and fitness, an average walking speed of 2.5mph (4kph) has been used as recommended by Bristol Healthy Schools (Bristol City Council). This provides an average speed combining all; ages, abilities, road conditions and terrains. Fit, healthy individuals usually have an average walking speed of over 3 mph. Oxfordshire is a rural county and those people living in villages might expect to travel further to amenities than those living in the towns.

An alpha/numeric index is used on the mapping to identify premises providing pharmaceutical services, which can be found at the following appendices:

- B. Indexed table of pharmacy premises for Oxfordshire
- C. Indexed table of doctor dispensing list premises for Oxfordshire

Pharmacies outside Oxfordshire but nearby are also indicated on Maps 1-6.

For the purpose of complying with 2013 Regulations, Schedule 1

Statements must be provided within a PNA with information on the following:

- Necessary services: current provision
- Necessary services: gaps in provision
- Other relevant services: current provision
- Improvements and better access: gaps in provision
- Other NHS Services
- How assessment was carried out
- Map of provision for the whole area and individual maps for each locality.

Oxfordshire PNA 2018 provides information on the current provision, other NHS services and how the assessment was carried out, as well as an updated map of provision of services and an overview of the population of Oxfordshire. In addition, each locality section includes:

- Pharmaceutical services available within the area, including Dispensing GP Practices and those providing Advanced Services; Medicines User Review (MUR) or New Medicines Service (NMS).
- An overview of the population and future forecasts for each age group.
- Brief overview of health issues and future needs.
- A statement on improvement and better access.
- Pharmaceutical needs with a focus on general access, advanced services and gaps in service provision.
- A table showing access to the nearest pharmacy for those areas where distance or travel time exceeds the criteria set by the Steering Committee.

Consultation

Introduction

Oxfordshire Health and Wellbeing Board is under a statutory obligation to draft and consult upon a review of the Pharmaceutical Needs Assessment (PNA) every three years in accordance with the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The PNA is designed to assess the current provision of pharmaceutical services, have regard to any specified future circumstance where the current position may materially change and identify any current and future gaps in pharmaceutical services. The PNA assists NHS England in determining market entry applications by pharmacists for new, additional or relocated premises, hours or pharmaceutical services.

Whilst not statutorily pharmaceutical services, there may be services commissioned by the Local Authority or Clinical Commissioning Group that inform the conclusions reached in this process and may assist those organisations in considering their commissioning intentions of other local services from pharmacies.

The consultation was conducted from 8 Dec 2017 to 5 Feb 2018 to seek views on agreement of the contents of the draft PNA and whether it addressed issues that were considered relevant to the provision of pharmaceutical services. There was a short survey for completion.

Consultation Process

To complete the consultation process, the HWB has consulted with those parties identified under Regulation 8 of the NHS (Pharmaceutical and Local Pharmaceutical Services Regulations) 2013, to establish if the draft PNA addresses issues that they considered relevant to the provision of pharmaceutical services.

Examples of statutory consulted parties included:

- Oxfordshire LPC
- Oxfordshire LMC
- Healthwatch, Oxfordshire
- Oxford Heath NHS Foundation Trust
- Oxford University Hospital NHS Trust
- Neighbouring HWB areas such as Buckinghamshire and Swindon
- Those on the pharmaceutical and doctor dispensing lists.

In addition, other local stakeholders were invited to consult on the draft. These included voluntary groups, commissioners such as local CCGs, neighbouring NHS Trusts and patient groups.

Results

There were 20 survey responses, some of which were received outside the consultation questionnaire. The consultation did not require responses to every question but, as there were a low number overall, the proportion of survey responses are shown for each question.

Survey questions	Yes	No	Don't know
Q1. Has the purpose of the Oxfordshire Pharmaceutical Needs Assessment (PNA) been explained?	85%		
Q2. Has the scope of the PNA been explained sufficiently?	77%		
Q3. Are localities clearly defined throughout the draft PNA?	67%		25%
Q4. Does the PNA reflect the current provision of pharmaceutical services within Oxfordshire?	88%		
Q5. Are there any gaps in service provision; i.e. when, where and which services are available that have not been identified in the PNA?		56%	

Survey questions	Yes	No	Don't know
Q6. Does the draft PNA reflect the needs of the Oxfordshire population?		13%	50%
Q7. Has the PNA provided adequate information to inform market entry decisions?	62.5%	0.0%	37.5%
Q8. Has the PNA provided adequate information to inform how services may be commissioned in the future?	38%		50%
Q9. Has the PNA provided enough information to inform future service provision and plans for pharmacies and dispensing appliance contractors?	50%		50%
Q10. Are there any services that could be provided in the community pharmacy setting in the future that have not been highlighted?	See table below for suggested services.		
Q11. Do you agree with the conclusions of the PNA?	50%	12.5%	37.5%
Q12. Do you have any further comments?	See table below for additional comments.		

Comments received from respondents are summarised in the table below.

Comments	Response
One comment on lack of webpage content and two comments regarding the language being too complex for lay-readers.	All comments are acknowledged and, where applicable, will be taken into consideration in future revisions of the PNA. The consultation opening webpage is designed to give a summary of what the PNA is, how to take part and what happens to the survey results. Consideration was taken to balance the level of detail and scope of organisations and services included. Further simplifications are difficult to achieve whilst meeting the regulatory requirements.
One comment on the availability of Naloxone and whether use would be widened as an emergency antidote for overdoses caused by heroin and other opiates.	Naloxone is not available through pharmacies without a prescription. It is available through the separately commissioned Drug Service.

Comments	Response
A comment received was a user's perception of pharmacy becoming busier and unable to fulfil repeat prescription need in a required timeframe; also, having access to a pharmacy is not the same as the pharmacy being able to deliver the service to the end user.	The PNA focuses on location of services to ensure there are no gaps in Oxfordshire. The concerns of the user about level of service are noted and suggest that this is raised at a local level with the pharmacy. Local pharmacies will be able to inform users how long it takes to dispense a repeat prescription once it has been provided by the GP.
Comment on the need for 24-hour pharmacies within walking distance of all Out of Hours GP Centres in Oxfordshire.	There is no statutory requirement to provide 24-hour pharmacy services. The PNA includes information in each locality about pharmaceutical need and access to 100-hour pharmacies. Where there appears to be a gap this is addressed in a table within each locality section showing access to the nearest pharmacy.
A comment on the assumption of capability of walking or having access to a car.	This comment is acknowledged; it is recognised that walking is more difficult for some. Some pharmacies provide a delivery service but this is not an NHS service. Users should check with their local pharmacy.
A comment on the plans to commission the National Urgent Medicines Service Advanced Service (NUMSAS) as not all calls processed could be referred into a NUMSAS pharmacy.	The National Urgent Medicines Service Advanced Service is a pilot. This has been extended to September 2018. The on-going evaluation of the pilot is under development (by NHS England) and a key part of that is the patient feedback, so encouraging completion of the patient questionnaire after a patient has received NUMSAS is important. Pharmacies can choose to opt in to this service if they fulfil the eligible criteria.
Comments on additional services that could be provided in pharmacies: • Full minor ailment service or GPs triage service • Widening the availability of naloxone for the emergency treatment of opiate overdose. • childhood vaccinations, dementia support for patients and carers, flu protection for children, other vaccinations for adults; CV risk screening; management of long term conditions.	The scope of the PNA is to inform the commissioning process; the comments about services that could be commissioned and provided in the future will be brought to the attention of relevant organisations.

Comments	Response
A comment that patients with serious health problems were being encouraged to use pharmacies rather than going to see their doctor.	This comment is noted and will be brought to the attention of relevant organisation(s).
A general comment about consultation not being appropriate for the public as it was difficult to provide meaningful feedback.	Comments are welcome from a wide range of organisations and individuals. It is recognised that the PNA is a legal requirement and may appear complex to some readers. The 2015 update of the PNA included a User Survey. As this version for 2018 was a revision it was not considered necessary to carry out a further User Survey. However, this will be noted for the next review in 2021.
A few comments on accuracy of pharmacies and distance to the nearest where gaps were noted.	Points acknowledged. The most recent list of pharmacies and opening times are updated in the final published document and any discrepancies in mileage will be rectified before publication.
One comment from a neighbouring council acknowledging that the need of local population had been addressed. However, a request that consideration be taken for new or existing housing developments across the border where residents might choose to access services.	Positive comments are welcomed. Consideration of housing across the borders can be taken in future revisions. PNAs are renewed or revised every three (3) years.

D. Oxfordshire HWB Area

Overview

Oxfordshire residents generally enjoy good health and wellbeing. Most people can expect to live a long life, achieve well and have access to good quality employment. However, there is still unnecessary burdens of preventable illness that are increasing, and not all groups enjoy the same success and health as most Oxfordshire residents. A comprehensive approach to prevention is needed to ensure illness rates do not increase as the population ages, especially as unhealthy behaviours are common. Health and Social Care services also need to adapt to meet the needs of increased numbers of older people and those with long term conditions (LTCs).

Oxfordshire is divided into five localities (districts), each with slightly differing health needs, therefore each are considered for the purposes of the PNA in addition to the overall picture for the HWB area.

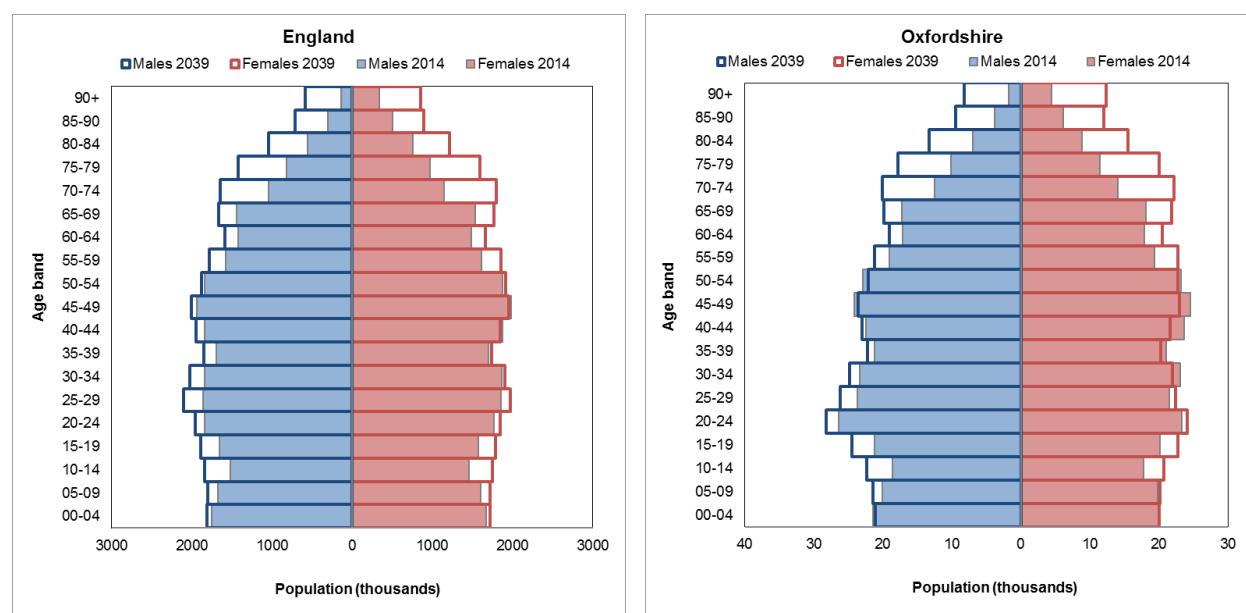
Population

The county of Oxfordshire has a population of 683,169 people (ONS mid-year estimates for 2016). The number of people registered with Oxfordshire GPs is 725,823 (October 2016). The number of people registered with a GP does not reflect the actual number of people using local services, and is likely to include the records of people who remain registered despite leaving the area, as well as people who live in neighbouring counties but are registered with GPs in Oxfordshire. Hence the GP registered population being higher than the county population.

The gender split for the county is on par with the national average, with 51% females and 49% males. The age profile for the county is like the national average across most age groupings. The largest difference is among those aged in their twenties, with larger proportions in these age groups in Oxfordshire compared to nationally.

The county's population is growing. This is due to increased inward migration, particularly in the urban hubs of Oxford and Banbury, and the increasing life expectancy of the existing population, particularly in the rural areas of the county. The proportion of older people is likely to continue increasing and this will have implications on service demand.

Figure 1: Population estimates for Oxfordshire compared to England (2014 mid-year estimates) including 2039 projections by each age group and sex (ONS)



Age

Oxfordshire's population continues to age: older age groups are experiencing greater growth than younger groups. The population over 65 years will represent a much larger proportion of the population in 2039 than they did in 2014. The profile of the working age population is changing; there will be smaller proportions representing working age groups, except for those in their 60s (due to pension changes). Although the younger population will increase Fig.1 shows that the proportion of young people will be lower by 2039.

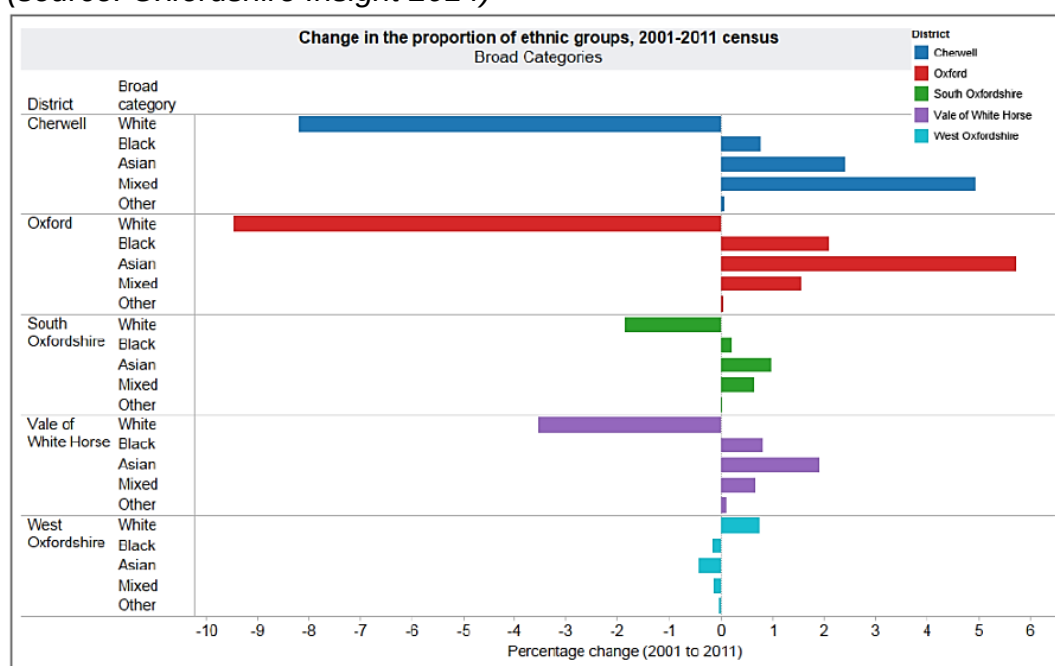
Ethnicity

The ethnic composition of Oxfordshire has changed and the county's black or minority ethnic (BME) communities have grown - the 2011 Census indicate they now make up 9.2% of the total population (in 2001 it was 4.9%).

There has been a growth in people from white backgrounds other than British or Irish, who now account for 6.3% of the population (up from 4% in 2001). Much of this increase can be explained by a movement of people from the countries which joined the EU in 2004 and 2007. In 2011, 13,000 residents in Oxfordshire were born in these countries, with more than half born in Poland (7,500 people; 2,700 residents in Oxford and 2,300 in Banbury).

The proportion of people from a non-white ethnic background varies by district. The change in ethnicity across each district is shown in the chart below. Oxford City and Cherwell have seen the largest increases in the latest Census (2011).

Figure 2 shows changes in BME Groups for Oxfordshire districts 2001 to 2011 (source: Oxfordshire Insight 2014)



Oxford City saw a 5.8% increase in people of Asian ethnicity (in 2011 Census), the largest increase of any broad category. There was a 4.9% increase in the proportion of people of mixed ethnicity in Cherwell. West Oxfordshire is the only district where there was a reduction in the proportion of people from BME communities since the previous Census.

Religion

60% of the county's population are Christian, whilst 28% do not have any religion. The county's Muslims make up 2.4% of the populace. The proportion of Hindus in Oxfordshire in 2011 was 0.6%. The size of the county's Jewish population is 0.3%. The growth and size of county's Buddhist population (0.5%) is in line with the regional and national figures.

People with Disabilities

Disability-free life expectancy is increasing at a faster rate than life expectancy, meaning not only are people living longer, in the future they might be expected to be living in good health and free of disability for longer towards the end of their lives. 90,000 people countywide are limited in their daily activities by a long-term health problem or disability. This equates to 14% of the population. A smaller proportion (8%) reported that their activities were 'limited a lot' by their condition. These proportions are broadly similar across the districts. However, there is some variation in the rates for specific age groups across districts, with Oxford (24.7%) and Cherwell (23.2%) containing higher rates among people over 65 than the county average (21.6%).

12,400 people in households and aged 85 and over are living with day-to-day activities significantly limited by a health problem or disability. This is equivalent to 49% of the total resident population aged 85 in households. Cherwell, Oxford and Vale of White Horse Districts are above the regional average on this measure.

Life expectancy and death rates

The most recent set of 3-year Life Expectancy data shows that, between 2013-15 and 2014-16, Life Expectancy for males and females in Oxfordshire each increased.

- Male Life Expectancy increased from 81.2 to 81.4 (+0.2 years)
- Female Life Expectancy increased from 84.3 to 84.6 (+0.3 years)

Between 2001-03 and 2014-16, the gap between male and female Life Expectancy decreased from 4.1 years to 3.2 years.

The county's population is growing. Historically this has mainly been as result of increasing life expectancy and natural change (births minus deaths). Oxfordshire's population is forecast to continue ageing. The proportion of the population that is aged 65 and over is predicted to increase from 18% in 2016 to 20% in 2031. Over the same period the working aged population (18-64 years) is expected to fall from 62% of the total to 60% by 2031.

Older People

Improvements in health mean that people are living longer. There were over 120,000 people aged 65+ in Oxfordshire in 2016 of whom more than 17,000 were aged 85+.

At the end of March 2017 there were 6,713 adults in Oxfordshire receiving long-term social care from Oxfordshire County Council, up from 6,214 in March 2016 (+8%). This was well above the growth in Oxfordshire's population aged 65+ over the past 2 years of +2%.

Other population groups

Armed forces personnel

The district in Oxfordshire with the largest number of residents in receipt of Armed Forces Pension, War pension and Armed forces compensation scheme was West Oxfordshire.

Carers

The 2011 Census suggests that 9.4% of the Oxfordshire population provide some level of informal care to a relative or friend. This equates to approximately 60,000 people, of whom 72% provided between 1 and 19 hours of care per week, 10% provided between 20 and 49 hours, and 18% provided more than 50 hours. Nationally, approx. 3% of the population provide more than 50 hours of care compared to 1.7% for Oxfordshire (ONS).

By the end of March 2017, the Oxfordshire Young Carers Service had identified and supported a total of 2,684 children and young adults (aged up to 25 years) who provide unpaid care to a family member. This is an increase from number in March 2016 (2,281).

Wider determinants of Health & Wellbeing

The wider determinants of health and wellbeing include education, employment, housing, income, social networks and the environments in which people live and work. These factors are strong predictors of health and wellbeing but they can also impact on the lifestyle choices people make.

Deprivation

The 2015 Index of Multiple Deprivation (IMD), Oxfordshire ranks as the 12th least deprived (out of 18) upper tier LA in the South-East region (where 1 is most deprived). However, 15 of Oxfordshire neighbourhoods (Lower Super Output Areas (LSOAs)) rank among the 20% most deprived in England. These areas experience significantly poorer outcomes in terms of health, education, income and employment, and include areas of South East Oxford, Banbury and Abingdon.

Education

Oxfordshire had an above-average proportion of people with higher qualifications and a below-average proportion of people with no qualifications (2011 Census).

Housing and homelessness

House prices in Oxfordshire continue to increase at a higher rate than earnings. The Centre for Cities report 2018 again ranks Oxford as the least affordable UK city for housing. House prices in Oxford were 17.3 times annual salaries (up from 16.7 in 2016). In Burnley, the most affordable city, this figure was 4.2. In Oxford City, social rents in 2016 were 17% above the national average.

There has been an increase in presenting as homeless in Oxfordshire. Loss of private rented accommodation is a common reason for homelessness which outnumbers exclusion by family/friends in some districts. However, there has been a reduction in young people accepted as homeless. Rough sleeping continues to increase in Cherwell and Oxford.

There are significant housing developments across Oxfordshire with proposals of around 34,500 new homes forecast to be built between April 2018 and 2022. Much of new planned housing will be in the Cherwell (10,300) and Vale of White Horse (10,000) district areas but all districts, including Oxford City have plans to develop.

In Cherwell, Banbury and Bicester will see larger developments with approximately 2,100 additional dwellings planned elsewhere including Upper Heyford. Within Oxford City smaller developments totalling 2,600 dwellings are planned for Wolvercote, Barton and Littlemore.

South Oxfordshire plans significant growth in Didcot with smaller developments in Berinsfield, Chalgrove, Chinnor, Crowmarsh, Henley, Thame and Wallingford as well as 1,783 elsewhere, bringing the total to 6,600. Vale of White Horse developments are principally in Grove, Wantage and Didcot (Valley Park) with smaller developments in Abingdon, Faringdon and Kingston Bagpuize.

West Oxfordshire's housing developments total 5,080 with 1,000 of these in Witney. Other areas that feature with smaller developments are Carterton, Chipping Norton and Eynsham.

Appendix D contains further detail on Local Plans and housing development.

Morbidity

Data on mortality and morbidity suggests Oxfordshire residents are less likely than those of the wider region to die early from cancers and circulatory diseases but that the identification of cancers is above the regional rate.

Diabetes

There are almost 29,500 people aged 17 years and over diagnosed with Diabetes registered with an Oxfordshire GP, which is increasing but remains below the national average rate (GP Quality & Outcomes Framework (QoF) 2016-17). This gives some indication of the prevalence of the disease.

Cancer

New cancer cases (3,373) has been steadily increasing across all areas in men and women of all ages; In 2014/15 there was a slight decline. The crude incidence rate of cancer (per 100,000 population) is slightly lower for Oxfordshire CCG than the South-Central region and England. In terms of prevalence (number of people living with cancer) there were 21,222 registered with a GP in Oxfordshire (all ages) with a diagnosis of cancer (2016/17).

Circulatory diseases

The estimated prevalence of stroke and coronary heart disease (CHD) is taken from GP registers (QoF). The proportion of patients registered with a GP in Oxfordshire CCG and diagnosed with heart disease or stroke remains below the regional and national average.

Obesity

The rise in obesity both nationally and locally has caused concern. There is little robust data at a local level for adults. The latest data from the Active Lives Survey indicates that the proportion of adults (18+ years) in Oxfordshire who are overweight (including obese) is more than half (54%). This is one of the lowest in the South East of England. The National Child Measurement Programme gives more robust obesity data for children in Reception Year and Year 6 since 2006/7, which means good trend data is available. Oxfordshire remains significantly lower than the national average but children in year 6 have a higher prevalence of obesity than those in reception year.

Once established, obesity is difficult to treat so prevention and early intervention are important. Being obese or overweight can increase the risk of developing a range of serious diseases in later life. There is a strong relationship between deprivation and childhood obesity as reported in the National Child Measurement Programme (NCMP) report.

Physical activity

Of the adult population (19+ years) in Oxfordshire, 70.2% are physically active (described as doing at least 150 minutes per week at a moderate intensity equivalent as recommended by the Chief Medical Officer. These data are based on Active Lives Survey data conducted by Sport England and weighted to represent the demographic population of each geographic area. Oxfordshire has a significantly higher proportion than the national average.

Mental Health and Wellbeing

Mental illness impacts on people's lives and mental ill health presents a complex public health problem. Mental health has been a priority area for policymakers to tackle for many years. The Health Survey for England shows that, for England:

- 26% of adults reported having ever been diagnosed with at least one mental illness.
- Women were more likely than men to report ever having been diagnosed with a mental illness (33% compared with 19%).
- 19% of adults reported that they had ever been diagnosed with depression, including post-natal depression. This was the most frequently reported diagnosis.
- 8% of adults reported ever being diagnosed with panic attacks.
- 6% of adults reported ever being diagnosed with generalised anxiety disorder.
- Lifetime prevalence of other conditions was very low, at 3% or less.
- Men and women living in lower income households were more likely to have ever been diagnosed with a mental illness than those living in higher income households: 27% of men and 42% of women in the lowest income quintile compared with 15% of men and 25% of women in the highest.
- Adults were also asked if they had ever self-harmed or attempted suicide. Overall 3% of men and 5% of women reported they had self-harmed, and 4% of men and 7% of women reported suicide attempts.
- People who had ever been diagnosed with a mental illness were much more likely to have self-harmed, or to have made a suicide attempt, than those who had never been diagnosed.

GP registers in Oxfordshire in 2016/17 indicate that almost 57,000 adults (18+ years) are diagnosed and living with depression (9.7%; England average 9.1%).

The estimated prevalence of diagnosed common mental health disorders (16-74 years) in 2014/15 was 13.9% (61,600 people). This will include clinical depression, bipolar disorder, dementia, schizophrenia and anxiety disorders. Symptoms may include changes in mood, personality, personal habits and/or social withdrawal.

A small but significant number of people experience severely disabling mental health conditions such as schizophrenia and bipolar disorders. An estimated 0.8% of patients (all ages) registered with a GP in Oxfordshire (5,822) have such a diagnosis.

Mortality

Cancer

Cancer continues to be the leading cause of death in Oxfordshire (for the combined years 2014, 2015 and 2016), accounting for 28% of deaths in males and 23% of deaths in females.

Smoking remains the biggest single cause of cancer. Smoking causes 8 out of 10 lung cancer deaths (Cancer Research UK). Figures taken from the Active People Survey 2016 indicate that smoking prevalence in Oxfordshire is 11.9%. This is significantly lower than the national average

Circulatory diseases

This is the second highest cause among males:

- Heart disease (affecting the supply of blood to the heart), 13% of deaths.

Mortality from heart disease has declined nationally and in Oxfordshire.

Stroke or Transient Ischaemic Attack (TIA) occur when the blood flow to an area of the brain is cut off, depriving the brain cells of oxygen. The mortality rate for stroke in Oxfordshire is lower than the England and South East average.

Dementia and Alzheimer Disease

In females, Dementia and Alzheimer disease is the second highest cause of death, account for 17% of deaths in women.

E. How Pharmaceutical Services can meet Population Need

Pharmaceutical services: an overview

Pharmacists are health professionals who have, and are recognised to have, a specific expertise in the use of medicines. Pharmacies provide a convenient and less formal environment for people to access readily available professional advice and support to deal with everyday health concerns and problems.

Within the PNA, each locality has been considered in terms of specific population needs. In general, pharmaceutical services across Oxfordshire and England can meet patients' needs through a wide range of services.

Everyone will at some stage require prescriptions to be dispensed irrespective of whether they are in one of the groups identified in the Health and Wellbeing strategy or Public Health annual report. This may be for a one-off course of antibiotics or for medication that they need to take, or an appliance that they will need to use, for the rest of their life to manage a LTC. This health need can only be met within primary care by the provision of pharmaceutical services by pharmacies, DACs or dispensing doctors, and is applicable to all public health themes.

Coupled with this is the safe collection and disposal of unwanted or out of date dispensed drugs. Both NHS England and community pharmacies have a duty to ensure that people living at home, in a children's home or in a residential care home can return unwanted or out of date dispensed drugs for their safe disposal.

The contractual framework for pharmacies requires pharmacy contractors to have monitoring arrangements in respect of compliance with the Equality Act 2010 in place (in terms of facilities and patient assessments), thereby pharmacies that do not have wheelchair access have another mechanism of enabling access.

Pharmacies can provide a variety of aids and advice to patients to support them in making it easier to take and remember their medications. This should be supported by a formal assessment. Depending on the outcome, a community dosage system (or tablet tray) may be recommended. If it is determined by the pharmacist that a dosage system is the most appropriate option, medicines will be dispensed this way at no cost to the patient. Some pharmacies offer this service to other patients either free or at a small charge if they simply find this method of dispensing convenient. Other assistance and support may be provided by the provision of memory cards, easy-open tops or packaging or through simply printing in large or coloured font.

When patients present with prescriptions and they appear to have either a LTC, such as diabetes, or be at risk of CHD (especially those with high blood pressure) from smoking or are overweight, the pharmacy is required to give appropriate advice with the aim of increasing their knowledge and understanding of the health issues which are relevant to that person's circumstances.

All the pharmacies are required, as part of their system of clinical governance, to have appropriate safeguarding procedures for service users. Contractors are responsible for ensuring that staff members who provide pharmaceutical services to

children and vulnerable adults are aware of the safeguarding guidance and the local safeguarding arrangements. This includes the reporting of concerns to improve awareness of and their ability to act upon indications that a child or vulnerable adult may be being abused, or at risk of abuse or neglect. Victims of abuse, neglect or violence may approach pharmacies on a high street for superficial advice, regarding injuries rather than seek direct help. Frequent purchases of medications can also be signs of safeguarding issues.

Accessing the right service

The contractual framework for community pharmacy in England and Wales requires each pharmacy to complete an audit each year at the request of NHS England on a specific topic. The latest topic (2016-17) was for repeat medication services and medicines waste.

The practice-based audit explores the different types of repeat medication services being used in community pharmacies in England and assess their contributions to ongoing patient care.

This audit was undertaken by a range of community pharmacies as a mechanism to determine whether current repeat medication systems prevent prescribed but unnecessary or inappropriate prescription items from reaching patients. In addition, it will support pharmacy teams in reviewing their current systems and reflecting on whether they are operating as efficiently as possible.

Health inequalities

Deprivation is a significant issue for some areas of Oxfordshire and is a wider determinant of health outcomes. Whilst none of the recommendations in the wider determination of health section can be addressed directly by the provision of pharmaceutical services, the provision of essential and advanced services is key to ensuring people can have their prescriptions dispensed (free to eligible people) and can benefit from a range of associated services as part of the NHS, including signposting to relevant social care and financial support services.

Mental health and wellbeing

Pharmacies can contribute to the support for emotional health and wellbeing by providing accessible and comprehensive information and advice to patients and carers about what help and support is available to them. They can 'signpost' to support networks, other healthcare professionals and the third sector.

Addressing unhealthy lifestyles (obesity & excessive alcohol intake)

Each year pharmacies are required participate in up to six campaigns at the request of NHS England. This involves the display and distribution of leaflets provided by NHS England. In addition, pharmacies are required to undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation.

Pharmaceutical Services in Oxfordshire

Oxfordshire has a good number of dispensing pharmaceutical services. There are:

- 98 standard community pharmacies
- 12 100-hours community pharmacies
- 2 distance selling / internet pharmacy
- 1 dispensing appliance contractor
- 25 dispensing doctor practices

Data supplied by NHS England Thames Valley Area Team and Oxfordshire CCG

The community pharmacies are accessible and many offer extended opening times, often late into the evenings and/or at weekends, to suit patients and consumers.

Figures in 2014 showed that Oxfordshire has slightly less than the national average of pharmacies per 10,000 head of population. However, there are 25 dispensing practices across Oxfordshire (1023 in England). This is due to the rural nature of the county.

There are three tiers of services in the NHS Pharmacy Contract:

Essential Services – services that must be normally be provided by all pharmacy contractors (such as dispensing medicines and appliances, repeat dispensing, disposal of unwanted medicines, promotion of healthy lifestyles, signposting and support for self-care).

Advanced Services – services that require accreditation of the pharmacist providing the service and/or specific requirements to be met regarding premises (such as Medicine Use Reviews and New Medicines Service).

Locally Commissioned Services – services commissioned locally by several different routes including Local Authorities, CCGs and local NHS England team. These will vary by locality.

Access to essential services

There are currently over 141 dispensing contractors in Oxfordshire, 116 of which are community pharmacies which are accessible with 12 offering extended opening times. These are often late into the evenings and/or at weekends, to suit patients and consumers.

The latest information from [Pharmaceutical Services Negotiating Committee](http://psnc.org.uk/)³ shows that:

- 89% of the population in England has access to a community pharmacy within a 20-minute walk;
- Over 99% of those in areas of highest deprivation are within a 20-minute walk of a community pharmacy; and

³ <http://psnc.org.uk/>

- as the accessibility of community pharmacies is greatest in areas of higher deprivation, they may have an important role to play in reducing inequalities.

Information provided in the last PNA for Oxfordshire indicated that for Oxfordshire residents access within a 20-minute walk was much lower than this (56.4%) primarily due to the rural nature of the county. However over 80% could access a pharmacy within a 5-minute drive and no areas are identified as having more than a 5-mile or 20-minute drive within the current PNA.

Details of pharmacies are updated and available on the NHS Choices website <http://www.nhs.uk>.

Map 1 shows the location of all pharmaceutical services within and immediately surrounding the county of Oxfordshire. Different symbols are used to identify each of the categories: Standard pharmacy, 100-hour pharmacy, Distance Selling Practice, Dispensing Appliance Contractor and Dispensing GP practices. This map fulfils the statutory requirement to provide a map of the premises providing pharmaceutical services as set out in 2013 regulations.

Oxfordshire pharmaceutical service premises are labelled on the map by an index number. These can be found at Appendices B (Pharmacies) and C (Dispensing GP Practices).

Descriptions of pharmacy opening hours, choice of pharmacy and access to advanced services are considered by locality in Section E.

Access to advanced services

- Medicines Use Review (MUR) - most community pharmacies (94%) in Oxfordshire currently provide the MUR service. Further details are provided by locality.
- New Medicines Service (NMS) - provided by 91% of the pharmacies in Oxfordshire, additional information is provided by locality.
- Appliance Use Review (AUR) - in Oxfordshire, one contractor provides the AUR service, the DAC in Charlbury.

Flu Vaccination

NHS flu services are commissioned by Public Health England annually. As of 20 October 2017, 98 community pharmacies in Oxfordshire are providing the flu vaccination. Pharmacies in neighbouring areas such as Buckinghamshire and Berkshire are also providing the service. Residents of Oxfordshire can access the flu vaccination service at any of these pharmacies, which totals 312 locations in Thames Valley area. However eligible patients who do not have any contra-indications to vaccination will be offered vaccination by any pharmacist in England at NHS expense.

The pharmacies are not commissioned to offer flu vaccination to anyone under 18.

The eligible groups for the 2017/18 service are:

- all people aged 65 years and over (including those becoming age 65 years by 31 March 2017);
- people aged 18 to less than 65 years with one or more of the following medical conditions:
 - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis;
 - chronic heart disease, such as heart failure;
 - chronic kidney disease at stage three, four or five;
 - chronic liver disease;
 - chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability;
 - diabetes;
 - immunosuppression, a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment);
 - asplenia or splenic dysfunction;
 - morbid obesity
 - pregnant women aged 18 or over (including those women who become pregnant during the flu season);
 - people aged 18 or over living in long-stay residential care homes or other long-stay care facilities;
 - carers aged 18 or over; or
 - household contacts of immunocompromised individuals who are aged 18 or over; or
 - care workers and domiciliary care workers.

Locally Commissioned Services (LCS) Services

Emergency Hormonal Contraception (EHC)

Emergency contraception helps prevent unwanted pregnancy after unprotected sex. It is available in three main forms, Levonelle® (effective for up to 72 hours after unprotected sex) and ellaOne® or an emergency Intrauterine Device (IUD), both of which can be used up to 120 hours after having unprotected sex.

Community pharmacy is an important provider of sexual health services to young people in Oxfordshire and able to provide Levonelle® free to young women under 21 years of age under a Patient Group Direction (PGD) as well as signposting to the online chlamydia testing service as appropriate.

The service aims to achieve the following outcomes;

- Reduced unintended and unwanted pregnancies;
- Improve sexual and reproductive health in the local population;
- Reduced sexual and reproductive health inequalities affecting young people, more socially disadvantaged groups and some BME groups;
- Reduced burden on secondary care services, particularly abortion services, maternity services and ongoing care and support to young families.

Service objectives include:

- Free access to EHC for all young women aged 21 years and under, within 72 hours of an individual having unprotected sexual intercourse or a failure of a contraceptive method;
- Providing sexual health information and advice to develop increased knowledge, especially in high-need communities;
- Ensuring that the Service is acceptable and accessible to young people;
- Signposting together services such as the Integrated Sexual Health Service;
- Assess all Service Users for any potential safeguarding risk.

Safer sex messages are crucial in improving the health of sexually active young people and contribute to the multi-agency approach that helps reduce the rate of unwanted conceptions and pregnancies.

As of November 2017, 94 pharmacies were commissioned to provide the sexual health service by OCC Public Health. See the link below for a list of the approved Oxfordshire pharmacies.

http://oxme.info/cms/sites/default/files/oxfordshire_pharmacies_ehc_september2017.pdf

Supervised Consumption of Opiate Substitute Therapy

Supervised Consumption of Opiate Substitution Therapy support clients by ensuring compliance with agreed treatment plans. The main aim of this service is to provide a comprehensive service to drug users that will reduce drug related harm and potential death. Medications, including methadone and buprenorphine, can be dispensed in specified instalments, as per the patient's prescription, where each dose is supervised by a Community Pharmacist to ensure the dose is correctly consumed by the service user for whom it is intended. Doses are dispensed for the client to take away to cover days when the pharmacy is closed.

Pharmacies support clients by:

- optimising compliance with treatment
- liaising with other clinicians and key workers managing the care of the patient.
- providing advice on harm reduction and safer injecting practices to drug misusers.
- signposting customers to the most appropriate support service available

Supervised consumption aims to reduce the risk to local communities of:

- over or under-usage of medicines
- diversion of prescribed medicines onto the illicit drugs market
- pressure on vulnerable individuals to relinquish their medication
- accidental exposure to the prescribed medicines.

As of February, 2018 there were 98 pharmacies across the county that were commissioned to provide this service by OCC Public Health.

Needle Exchange Service – Sterile Works from Oxfordshire Premises (SWOP)

Pharmacies provide sterile needles, syringes and sharps containers to service users who inject illicit drugs and/or non-prescribed performance and image-enhancing drugs (PIEDS) in return for used equipment. They promote safe injecting practices and reduce transmission of infections by people who inject drugs.

The principle aim of the SWOP service is to provide a harm reducing intervention which:

- Reduces transmission of blood borne viruses by substance misusers;
- Reduces the impact on the local community of drug-injecting waste;
- Reduces the number of drug-related deaths;
- Reduces the burden on the local health and social care system caused by injecting drug use;
- Reduces the risk-taking behaviours of injecting drug users, such as sharing needles and syringes.

The Key Service Objectives are to:

- Provide access to SWOP paraphernalia, which may include Single Use Kits, larger packs or other packs as necessary, and associated materials to promote safe injecting practice;
- Provide safe disposal for used injecting equipment (works);
- Offer a Service User-friendly, non-judgemental, confidential service to drug users in their local community;
- Provide support and advice to the Service User, including referral to drug treatment services; to include access to other public health services including Emergency Hormonal Contraception and smoking cessation;
- Increase Service User choice through offering flexible opening times and locations;
- Reduce inequalities and improve access to services for people from specific groups such as homeless people, women who inject drugs, and men who have sex with men with substances (often called 'Chemsex').

As of February 2018 there were 38 pharmacies across the county that were commissioned to provide this service by OCC Public Health.

Palliative Care

Some medicines used in palliative care are not always available in all community pharmacies. Oxfordshire CCG has a long-standing scheme running (the 'Guaranteed Provision of Palliative Care Drugs in the Community' scheme) which aims to *ensure* the availability of a set range of palliative care drugs in several Community Pharmacies across Oxfordshire. The service improves access to palliative care medicines for patients, carers and healthcare professionals when they are required to ensure that there is no delay to treatment, whilst also providing access and choice. There are eight pharmacies providing this scheme in Oxfordshire (Oxfordshire CCG data September 2017) although many more will keep these medicines routinely anyway. The pharmacies in the scheme are spread across the

county and offer a range of opening hours including weekends, to improve access. This service is commissioned by Oxfordshire CCG.

The aim of the service is to support independent living. Other aims include improving access to palliative care medicines, reducing unnecessary delay in obtaining them and ensuring that patients receive timely care. Improved clinical management of end of life care and anticipatory prescribing reduces the need to access palliative care medication out-of-hours.

Pharmacies outside Oxfordshire

Patients have a choice of where they access pharmaceutical services. This may be close to their GP practice, their home, their place of work or where they go for shopping, recreational or other reasons. Consequently, not all the prescriptions written for Oxfordshire patients are dispensed within the area.

Of the total number of prescribed items by Oxfordshire clinicians for April 2016 to March 2017, 89.5% of the items were dispensed within the county and 10.5% were dispensed outside the county (ePACT data).

Oxfordshire residents access pharmaceutical services from community pharmacies located within other HWB areas. Patients can access essential and advanced services, including the dispensing of prescriptions from any pharmacy in the UK.

Enhanced and/or LCS have specific criteria which usually restricts the services to their GP registered population.

F. Oxfordshire localities

The localities used mirror those of Oxfordshire District Councils and are consistent with the Oxfordshire JSNA and PHE Health Locality Profiles. These are not the same as the six Oxfordshire CCG localities, as additional geographical locations are contained within the Oxfordshire HWB area, as previously described. Where a locality has differing health needs from Oxfordshire they are considered.

The five localities are:

- Cherwell
- Oxford
- South Oxfordshire
- Vale of White Horse
- West Oxfordshire

Maps 2-6 show pharmacy services for each District Council and a further map is available in Appendix D showing areas where housing developments are expected.

Principles in assessing gaps in provision

To assess the provision of pharmaceutical services against the needs of the population, the HWB considers access (distance, travelling times and opening hours) as the most important factor in determining the extent to which the current provision of pharmaceutical services meets the needs of the population.

The HWB considers the access to pharmacy of primary importance during normal working hours and at times when GP surgeries are open. Where there is no pharmacy but a GP dispensing premise nearby, the HWB considers the latter to mitigate against any potential gap in need for pharmaceutical services.

For the purposes of determining whether residents require better access and towards identifying improvements for pharmaceutical services, the HWB determined that services should be available within five miles and a 20-minute drive, due to the rural nature of many of the areas in Oxfordshire. Using NHS Choices and the AA route planner, settlements with current pharmaceutical services were analysed to assess if they were:

- outside the 1mile (1.6km) buffer of a pharmacy that provided both normal and out-of-hours services
- serviced by a GP dispensing practice without an alternative pharmacy in the immediate vicinity.

Where GPs opened before 9am and local pharmacies opened at 9am, this was determined to meet the standard of necessary access, as few patients would have to wait more than a reasonably short amount of time. In conjunction with the increased number of extended-hours pharmacies in the county and the custom and practice that pharmacies mirror the opening and closing times of GP surgeries where possible, this was determined appropriate to meet the necessary needs of patients.

Where pharmaceutical services were provided in small settlements by GP dispensing practices alone, during normal working hours (Monday to Friday up to 6:30pm) the nearest pharmacy was located by NHS Choices. If it was found to be more than five miles away and would take 20 minutes or more to drive to (via AA route planner), then this would be considered an area for greater improvement and better access to pharmaceutical services.

When pharmaceutical services were not available in the proximity of GP surgeries after 6:30pm, when surgeries are providing services through extended hours, the nearest pharmacy that was open was located by NHS Choices (this sometimes identified a pharmacy in another HWB area). Notwithstanding whether it was found to be more than five miles away and would take 20 minutes or more to drive to (via AA route planner), the availability of GP extended hours would be considered an area for greater improvement and better access to pharmaceutical services. This principle was repeated for weekend access, including Sundays.

The minimum standard for access to pharmaceutical services was set at 4 hours, preferably on a Saturday morning, regardless as to whether the GP surgery is open. The Oxfordshire pharmacy access analysis is shown by locality.

Cherwell

Overview

This locality contains the towns of Bicester, Kidlington and Banbury. It has an estimated total resident population of 146,338 (ONS 2016 mid-year estimates) and is serviced by:

- 23 pharmacies, four of which are 100-hour pharmacies
- 1 Distance selling pharmacy
- 8 GP dispensing practice locations

The Cherwell locality has at least one pharmacy providing essential services from 7am to 11pm Monday to Saturday and 7:30am to 8pm on a Sunday. The table below shows the pharmaceutical services in Cherwell locality including the opening hours and trading names.

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
58	Parade Pharmacy Kidlington	OX5 1DB	Mon: 09:00-18:30 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-17:30 Sun:	Mon: 09:00-12:00; 14:30-18:30 Tue: 09:00-12:00; 14:30-18:30 Wed: 09:00-12:00; 14:30-18:30 Thu: 09:00-12:00; 14:30-18:30 Fri: 09:00-12:00; 14:30-18:30 Sat: 09:00-11:00; 14:30-15:00 Sun:
59	Lloyds pharmacy Kidlington	OX5 2BP	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 09:00-17:30 Sun:	Mon: 08:30-12:30; 15:30-18:30 Tue: 08:30-12:30; 15:30-18:30 Wed: 08:30-12:30; 15:30-18:30 Thu: 08:30-12:30; 15:30-18:30 Fri: 08:30-12:30; 15:30-18:30 Sat: 09:00-11:00; 14:30-17:30 Sun:
60	Kidlington Pharmacy Kidlington 100 hours	OX5 1AP	Mon: 07:30-22:30 Tue: 07:30-22:30 Wed: 07:30-22:30 Thu: 07:30-22:30 Fri: 07:30-22:30 Sat: 07:30-20:00 Sun: 07:30-20:00	Mon: 07:30-22:30 Tue: 07:30-22:30 Wed: 07:30-22:30 Thu: 07:30-22:30 Fri: 07:30-22:30 Sat: 07:30-20:00 Sun: 07:30-20:00
61	Lloyds Pharmacy Ltd Kidlington 100 hours	OX5 2PE	Mon: 07:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00	Mon: 07:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00
114	Westlake Pharmacy Yarnton	OX5 1NQ	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
11	Frosts Pharmacy Banbury	OX16 1XE	Mon: 08:30-18:00 Tue: 08:30-18:00 Wed: 08:30-18:00 Thu: 08:30-18:00 Fri: 08:30-18:00 Sat: 09:00-12:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
12	Oxford Online Pharmacy Banbury Distance Selling Premises	OX15 6AY	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-12:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
13	Boots the Chemists Banbury	OX16 5UH	Mon: 08:30-17:30 Tue: 08:30-17:30 Wed: 08:30-17:30 Thu: 08:30-17:30 Fri: 08:30-17:30 Sat: 08:30-18:00 Sun: 10:30-16:30	Mon: 11:00-16:00 Tue: 11:00-16:00 Wed: 10:30-16:30 Thu: 10:30-16:30 Fri: 10:30-16:30 Sat: 10:30-16:30 Sun: 10:30-16:30
14	Cox & Robinson Pharmacy Banbury	OX16 0AH	Mon: 08:30-13:00; 14:00-18:00 Tue: 08:30-13:00; 14:00-18:00 Wed: 08:30-13:00; 14:00-18:00 Thu: 08:30-13:00; 14:00-18:00 Fri: 08:30-13:00; 14:00-18:00 Sat: Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
15	Cox & Robinson Pharmacy Banbury	OX16 9AD	Mon: 08:30-13:00; 14:00-18:30 Tue: 08:30-13:00; 14:00-18:30 Wed: 08:30-13:00; 14:00-18:30 Thu: 08:30-13:00; 14:00-18:30 Fri: 08:30-13:00; 14:00-18:30 Sat: 09:00-13:00 Sun:	Mon: 08:30-13:00; 14:00-18:30 Tue: 08:30-13:00; 14:00-18:30 Wed: 08:30-13:00; 14:00-18:30 Thu: 08:30-13:00; 14:00-18:30 Fri: 08:30-13:00; 14:00-18:30 Sat: 09:00-13:00 Sun:
16	Lloyds Pharmacy Ltd Banbury	OX16 9XA	Mon: 08:00-13:30; 14:30-21:00 Tue: 08:00-13:30; 14:30-21:00 Wed: 08:00-13:30; 14:30-21:00 Thu: 08:00-13:30; 14:30-21:00 Fri: 08:00-13:30; 14:30-21:00 Sat: 08:00-13:30; 14:30-20:00 Sun: 10:00-16:00	Mon: 09:00-13:30; 14:30-17:00 Tue: 09:00-13:30; 14:30-17:00 Wed: 09:00-13:30; 14:30-17:00 Thu: 09:00-13:30; 14:30-17:00 Fri: 09:00-13:30; 14:30-18:00 Sat: 09:00-13:00 Sun:
17	Superdrug Pharmacy Banbury	OX16 5UN	Mon: 08:30-18:00 Tue: 08:30-18:00 Wed: 08:30-18:00 Thu: 08:30-18:00 Fri: 08:30-18:00 Sat: 08:30-18:00 Sun: 10:30-16:30	Mon: 09:00-13:00; 15:00-17:30 Tue: 09:00-13:00; 15:00-17:30 Wed: 09:00-13:00; 15:00-17:30 Thu: 09:00-13:00; 15:00-17:30 Fri: 09:00-13:00; 15:00-17:30 Sat: 09:00-13:30; 14:30-17:30 Sun:
18	Boots UK Ltd Banbury	OX16 1LX	Mon: 09:00-20:00 Tue: 09:00-20:00 Wed: 09:00-20:00 Thu: 09:00-20:00 Fri: 09:00-20:00 Sat: 09:00-18:00 Sun: 10:00-16:00	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
19	Rowlands Pharmacy Banbury	OX16 0EN	Mon: 09:00-13:00; 13:20-18:00 Tue: 09:00-13:00; 13:20-18:00 Wed: 09:00-13:00; 13:20-18:00 Thu: 09:00-13:00; 13:20-18:00 Fri: 09:00-13:00; 13:20-18:00 Sat: 09:00-17:30 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
20	Knights Pharmacy Banbury	OX16 3WT	Mon: 09:00-20:00 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
23	Lloyds Pharmacy Ltd Bicester 100 hours	OX26 6FA	Mon: 08:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00	Mon: 08:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00
24	Lloyds pharmacy Bicester	OX26 6DR	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 09:00-13:00 Sun:	Mon: 08:30-12:30; 14:30-18:00 Tue: 08:30-12:30; 14:30-18:00 Wed: 08:30-12:30; 14:30-18:00 Thu: 08:30-12:30; 14:30-18:00 Fri: 08:30-12:30; 14:30-18:00 Sat: 09:00-10:30; 12:00-13:00 Sun:
25	Boots the Chemists Bicester	OX26 6JJ	Mon: 08:45-17:30 Tue: 08:45-17:30 Wed: 08:45-17:30 Thu: 08:45-17:30 Fri: 08:45-17:30 Sat: 08:45-17:30 Sun: 10:00-16:00	Mon: 09:30-13:00; 14:00-17:30 Tue: 09:30-13:00; 14:00-17:30 Wed: 09:30-13:00; 14:00-17:30 Thu: 09:30-13:00; 14:00-17:30 Fri: 09:30-13:00; 14:00-17:30 Sat: 09:30-13:00; 14:00-15:30 Sun:
26	Bicester Pharmacy Bicester	OX26 4HB	Mon: 09:00-13:00; 14:00-18:30 Tue: 09:00-13:00; 14:00-18:30 Wed: 09:00-13:00; 14:00-18:30 Thu: 09:00-13:00; 14:00-18:30 Fri: 09:00-13:00; 14:00-18:30 Sat: Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
27	Jardines Pharmacy Bicester	OX26 6XX	Mon: 09:00-13:00; 14:00-18:30 Tue: 09:00-13:00; 14:00-18:30 Wed: 09:00-13:00; 14:00-18:30 Thu: 09:00-13:00; 14:00-18:30 Fri: 09:00-13:00; 14:00-18:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
29	Superdrug Pharmacy Bicester	OX26 6JJ	Mon: 08:30-18:00 Tue: 08:30-18:00 Wed: 08:30-18:00 Thu: 08:30-19:00 Fri: 08:30-19:00 Sat: 08:30-18:00 Sun: 10:00-16:00	Mon: 09:00-13:00; 15:00-17:30 Tue: 09:00-13:00; 15:00-17:30 Wed: 09:00-13:00; 15:00-17:30 Thu: 09:00-13:00; 15:00-17:30 Fri: 09:00-13:00; 15:00-17:30 Sat: 09:00-13:30; 14:30-17:30 Sun:

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
30	Ahmeys Pharmacy Bicester 100 hours	OX26 6AA	Mon: 08:00-23:00 Tue: 08:00-23:00 Wed: 08:00-23:00 Thu: 08:00-23:00 Fri: 08:00-23:00 Sat: 08:00-23:00 Sun: 09:00-19:00	Mon: 08:00-23:00 Tue: 08:00-23:00 Wed: 08:00-23:00 Thu: 08:00-23:00 Fri: 08:00-23:00 Sat: 08:00-23:00 Sun: 09:00-19:00
31	Co-op Pharmacy Bicester	OX26 3HA	Mon: 09:00-13:15; 13:45-18:00 Tue: 09:00-13:15; 13:45-18:00 Wed: 09:00-13:15; 13:45-18:00 Thu: 09:00-13:15; 13:45-18:00 Fri: 09:00-13:15; 13:45-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
32	Bloxham Pharmacy Bloxham	OX15 4LU	Mon: 08:45-13:00; 14:00-18:15 Tue: 08:45-13:00; 14:00-18:15 Wed: 08:45-13:00; 14:00-18:15 Thu: 08:45-13:00; 14:00-18:15 Fri: 08:45-13:00; 14:00-18:15 Sat: Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:

*Standard pharmacy unless otherwise noted

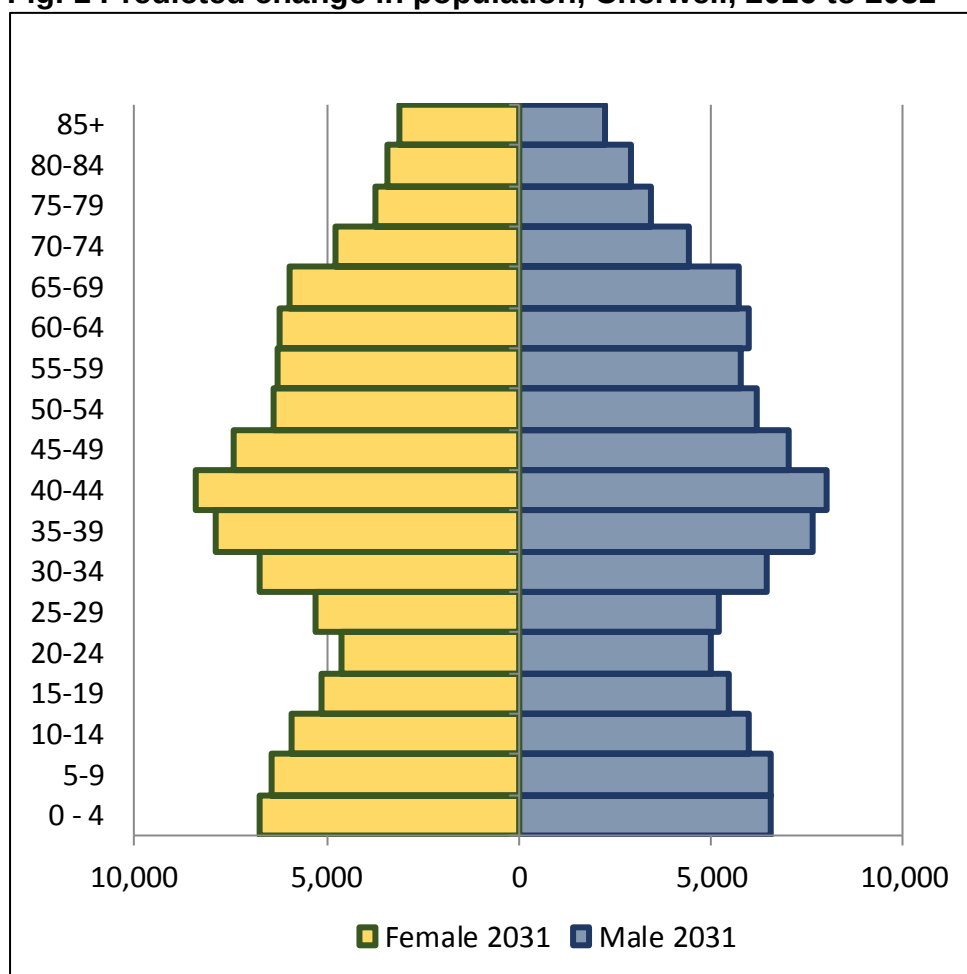
List of Dispensing GP Practices in Cherwell

Map Index	PRACTICE NAME	Address	Postcode
A	Islip Surgery	Bletchington Road, Islip, Oxford	OX5 2TQ
L	Montgomery House Surgery	Piggy Lane, Bicester	OX266HT
O	Alchester Medical Group	9 Nightingale Place, Bicester	OX266XX
S	Bicester Health Centre Coker Close	Bicester	OX266AT
T	Deddington Health Centre	Earls Lane, Deddington	OX150TQ
U	Cropredy Surgery	Claydon Road, Cropredy	OX171FB
V	Bloxham Surgery	Church Street, Bloxham	OX154ES
W	Sibford Surgery	Sibford Gower, Banbury	OX155RQ

Population

- As of mid-2016 the estimated population of Cherwell was **148,200** residents.
- By 2031, Oxfordshire County Council forecasts, based on expected growth in housing, estimates the population of Cherwell will increase to **205,000** residents (+38%). See Figure 1.
- The population of children and young people aged 0-17 is expected to increase by 38% to 12,300 residents.
- The population aged 85 and over is expected to increase by 56% to 5,400 residents.

Fig. 1 Predicted change in population, Cherwell, 2016 to 2031



Health issues

There are some areas within Cherwell that are among the most deprived in Oxfordshire which are relatively small. It is likely that this influences some of the inequalities within the locality e.g. a larger proportion of patients registered with a GP with a diagnosis of Diabetes; a higher rate of hospital admissions for self-harm in some areas. The ONS Census in 2011 indicated that Cherwell had a higher rate of carers combining full-time work and caring for a relative.

Obesity in reception age children increased from 6.9% in 2014-15 to 7.3% in 2015-16. In Year 6 children (aged 10 or 11) obesity reduced from 19.7% to 17.4%.

Future needs

The current level of pharmacy services provides good accessibility to residents of Cherwell for the lifetime of this PNA.

Improvement and better access

Planned housing developments in the areas of Caversfield and Upper Heyford within the life of this PNA mean that an increased number of residents may have to travel further to access essential services in the evenings and on Sundays.

Pharmaceutical needs

General access

The residents of Cherwell have 31 locations in which to access pharmaceutical services. The towns, which are densely populated and have highest levels of deprivation (Banbury, Bicester, and Kidlington), are all served by pharmacies which open at evenings and weekends. Bicester and Kidlington each have 100 hour pharmacies.

Advance services

All community pharmacies in Cherwell provide either the MUR service or both the MUR & NMS service.

The table below shows pharmacies delivering advanced services in Cherwell locality (NHS England AT October 2017).

PHARMACY NAME	PHARMACY ADDRESS	MUR /NMS		LOCATION
AHMEYS PHARMACY	2 MARKET SQUARE	MUR	NMS	BICESTER
BICESTER PHARMACY	134 BUCKINGHAM CRESCENT	MUR	NMS	BICESTER
BLOXHAM PHARMACY	HIGH STREET	MUR	NMS	BLOXHAM
BOOTS UK LIMITED	BANBURY CROSS RETAIL PARK	MUR	NMS	BANBURY
BOOTS UK LIMITED	12-14 CASTLE QUAY	MUR	NMS	BANBURY
BOOTS UK LIMITED	33-35 SHEEP STREET	MUR	NMS	BICESTER
CO-OP PHARMACY	UNIT 5 BARBERY PLACE	MUR	NMS	BICESTER
COX & ROBINSON PHARMACY	10 HORSEFAIR	MUR	NMS	BANBURY
COX & ROBINSON PHARMACY	SOUTH BAR HOUSE	MUR	NMS	BANBURY
FROSTS PHARMACY	HARDWICK SHOPPING CENTRE	MUR		BANBURY
JARDINES PHARMACY	2 NIGHTINGALE PLACE	MUR	NMS	BICESTER
KIDLINGTON PHARMACY	KIDLINGTON HEALTH CENTRE	MUR	NMS	KIDLINGTON
KNIGHTS PHARMACY	UNIT 2	MUR	NMS	BANBURY
LLOYDS PHARMACY LTD	J SAINSBURY STORE	MUR	NMS	KIDLINGTON
LLOYDSPHARMACY	642 OXFORD ROAD	MUR	NMS	BANBURY
LLOYDSPHARMACY	THE OLD BARN	MUR	NMS	BICESTER
LLOYDSPHARMACY	SAINSBURY'S STORE	MUR	NMS	BICESTER
LLOYDSPHARMACY	25 OXFORD ROAD	MUR	NMS	KIDLINGTON
PARADE PHARMACY	18 THE PARADE	MUR	NMS	KIDLINGTON
ROWLANDS PHARMACY	58 ORCHARD WAY	MUR		BANBURY
SUPERDRUG CHEMISTS	39 SHEEP STREET	MUR	NMS	BICESTER
SUPERDRUG PHARMACY	34-35 CASTLE QUAY	MUR	NMS	BANBURY
WESTLAKE PHARMACY	75 SPENCER AVENUE	MUR	NMS	YARNTON

Gaps in service provision

Bloxham is served by both a community pharmacy and a dispensing GP practice but these are not open at weekends. Other small towns such as Deddington, Cropredy, Sibford Gower and Islip are served by a dispensing GP practice. The closest community pharmacies accessible to residents of these villages outside GP practice hours are described in the table below.

Hook Norton has been added to the table below as it has no access to pharmacy services in the immediate vicinity. Where the distance or travel time exceeds the criteria set by the Steering Committee is marked in red. Two reds would indicate scope for improvements and better access to services is required.

Location	Nearest pharmacy	Distance	Driving time
Deddington	Lloyds Pharmacy (Sainsbury's), Banbury	4.9 miles	11 minutes
	Cox & Robinson South Bar, Banbury	5.4 miles	12 minutes
Cropredy	Boots, Lockheed Close Banbury	3.2 miles	9 minutes
	Superdrug, Cherwell Walk, Banbury	3.8 miles	10 minutes
Sibford Gower	Lloyds Pharmacy (Sainsbury's), Banbury	6.5 miles	18 minutes
Hook Norton	Chipping Norton Pharmacy Chipping Norton	4.2 miles	13 minutes
Islip	Lloyds Pharmacy (Sainsbury's), Kidlington	2.1 miles	9 minutes
Bloxham	Lloyds Pharmacy (Sainsbury's), Banbury	2.6 miles	9 minutes

Although residents of Sibford Gower and Deddington are more than 5 miles away from access to essential pharmaceutical services outside normal access hours, the journey times are less than 20 minutes.

Oxford

Overview

The locality includes Oxford City and the immediate surroundings. It has a total resident population of 161,291 (ONS mid-year estimates for 2016) and is serviced by:

- 30 Pharmacies
 - Three of which are 100 hour pharmacies
 - One is a distance selling pharmacy

The Oxford locality has at least one pharmacy providing essential services from early morning until late at night on Monday to Saturday and from 9am to late at night on a Sunday.

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
63	Rowlands Pharmacy Oxford	OX4 1GE	Mon: Tue: Wed: Thu: Fri: Sat: 09:00-13:00 Sun: Closed	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
64	Boots the Chemists Oxford	OX1 3HL	Mon: 07:00-22:00 Tue: 07:00-20:00 Wed: 07:00-22:00 Thu: 07:00-21:00 Fri: 07:00-22:00 Sat: 07:00-22:00 Sun: 11:00-17:00	Mon: 10:00-16:30 Tue: 10:00-16:30 Wed: 10:00-16:30 Thu: 10:00-16:30 Fri: 10:00-16:30 Sat: 09:00-16:30 Sun:
65	Ahmeys Late Night Pharmacy Oxford	OX4 2EA	Mon: 08:00-21:00 Tue: 08:00-21:00 Wed: 08:00-21:00 Thu: 08:00-21:00 Fri: 08:00-21:00 Sat: 09:00-21:00 Sun: 11:00-17:00	Mon: 09:00-13:00; 14:30-18:00 Tue: 09:00-13:00; 14:30-18:00 Wed: 09:00-13:00; 14:30-18:00 Thu: 09:00-13:00; 14:30-18:00 Fri: 09:00-13:00; 14:30-18:00 Sat: 10:00-12:30 Sun:
66	Woodlands Pharmacy Oxford	OX2 0BU	Mon: 09:00-17:30 Tue: 09:00-17:30 Wed: 09:00-17:30 Thu: 09:00-17:30 Fri: 09:00-17:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 13:30-17:30 Tue: 09:00-13:00; 13:30-17:30 Wed: 09:00-13:00; 13:30-17:30 Thu: 09:00-13:00; 13:30-17:30 Fri: 09:00-13:00; 13:30-17:30 Sat: Sun:
67	Rowlands Pharmacy Oxford	OX2 7BY	Mon: 08:30-14:20; 14:40-17:30 Tue: 08:30-14:20; 14:40-17:30 Wed: 08:30-14:20; 14:40-17:30 Thu: 08:30-14:20; 14:40-17:30 Fri: 08:30-14:20; 14:40-17:30 Sat: Sun:	Mon: 08:30-14:00; 15:00-17:30 Tue: 08:30-14:00; 15:00-17:30 Wed: 08:30-14:00; 15:00-17:30 Thu: 08:30-14:00; 15:00-17:30 Fri: 08:30-14:00; 15:00-17:30 Sat: Sun:

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
68	Boswells of Oxford Ltd Oxford	OX1 3AG	Mon: 09:30-18:00 Tue: 09:30-18:00 Wed: 09:30-18:00 Thu: 09:30-18:00 Fri: 09:30-18:00 Sat: 09:00-18:00 Sun: 11:00-17:00	Mon: 09:30-14:00; 15:00-17:00 Tue: 09:30-14:15; 14:45-17:00 Wed: 09:30-14:15; 14:45-17:00 Thu: 09:30-14:15; 14:45-17:00 Fri: 09:30-14:15; 14:45-17:00 Sat: 09:00-14:30 Sun:
69	Woodstock Road Chemist Oxford	OX2 6HJ	Mon: 08:30-19:00 Tue: 08:30-19:00 Wed: 08:30-19:00 Thu: 08:30-19:00 Fri: 08:30-19:00 Sat: 09:00-18:30 Sun: 09:00-18:30	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:
70	The Leys Pharmacy Rosehill Oxford	OX4 4JA	Mon: 09:00-18:30 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-14:00 Sun:	Mon: 09:30-17:30 Tue: 09:30-17:30 Wed: 09:30-17:30 Thu: 09:30-17:30 Fri: 09:30-17:30 Sat: Sun:
71	Rowlands Pharmacy Oxford	OX4 2NB	Mon: 09:00-13:00; 13:20-19:00 Tue: 09:00-13:00; 13:20-19:00 Wed: 09:00-13:00; 13:20-19:00 Thu: 09:00-13:00; 13:20-19:00 Fri: 09:00-13:00; 13:20-19:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
72	Rowlands Pharmacy Oxford	OX4 4DH	Mon: 08:45-13:00; 14:00-18:00 Tue: 08:45-13:00; 14:00-18:00 Wed: 08:45-13:00; 14:00-18:00 Thu: 08:45-13:00; 14:00-18:00 Fri: 08:45-13:00; 14:00-18:00 Sat: 08:45-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
73	Boots the Chemists Oxford	OX4 1UT	Mon: 09:00-13:30; 14:30-18:00 Tue: 09:00-13:30; 14:30-18:00 Wed: 09:00-13:30; 14:30-18:00 Thu: 09:00-13:30; 14:30-18:00 Fri: 09:00-13:30; 14:30-18:00 Sat: 09:00-13:30; 14:30-18:00 Sun: 10:00-16:00	Mon: 09:00-13:30; 14:30-17:00 Tue: 09:00-13:30; 14:30-17:00 Wed: 09:00-13:30; 14:30-17:00 Thu: 09:00-13:30; 14:30-17:00 Fri: 09:00-13:30; 14:30-17:00 Sat: 09:00-13:30; 14:30-15:00 Sun:
74	Cowley Pharmacy Oxford 100 hours	OX4 1UH	Mon: 07:00-21:00 Tue: 07:00-21:00 Wed: 07:00-21:30 Thu: 07:00-21:30 Fri: 07:00-21:30 Sat: 07:00-21:30 Sun: 07:00-21:00	Mon: 07:00-21:00 Tue: 07:00-21:00 Wed: 07:00-21:30 Thu: 07:00-21:30 Fri: 07:00-21:30 Sat: 07:00-21:30 Sun: 07:00-21:00
75	Boots the Chemists Oxford 100 hours	OX4 6XJ	Mon: 08:00-24:00 Tue: 08:00-24:00 Wed: 08:00-24:00 Thu: 08:00-24:00 Fri: 08:00-24:00 Sat: 08:00-22:00 Sun: 10:30-16:30	Mon: 08:00-24:00 Tue: 08:00-24:00 Wed: 08:00-24:00 Thu: 08:00-24:00 Fri: 08:00-24:00 Sat: 08:00-22:00 Sun: 10:30-16:30

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
76	Boots the Chemists Oxford	OX2 7HQ	Mon: 08:30-13:00; 14:00-18:00 Tue: 08:30-13:00; 14:00-18:00 Wed: 08:30-13:00; 14:00-18:00 Thu: 08:30-13:00; 14:00-18:00 Fri: 08:30-13:00; 14:00-18:00 Sat: 08:30-13:00; 14:00-18:00 Sun: 10:00-16:00	Mon: 09:00-13:00; 14:00-16:30 Tue: 09:00-13:00; 14:00-16:30 Wed: 09:00-13:00; 14:00-16:30 Thu: 09:00-13:00; 14:00-16:30 Fri: 09:00-13:00; 14:00-16:30 Sat: 09:00-13:00; 14:00-17:30 Sun:
77	Jhoots Pharmacy Ltd Oxford	OX2 6AJ	Mon: 08:45-18:15 Tue: 08:45-18:15 Wed: 08:45-18:15 Thu: 08:45-18:15 Fri: 08:45-18:15 Sat: 09:00-13:00 Sun:	Mon: 08:45-12:45; 14:00-18:00 Tue: 08:45-12:45; 14:00-18:00 Wed: 08:45-12:45; 14:00-18:00 Thu: 08:45-12:45; 14:00-18:00 Fri: 08:45-12:45; 14:00-18:00 Sat: Sun:
78	Bliep Chemist Oxford	OX1 4RA	Mon: 09:00-13:30; 14:00-17:30 Tue: 09:00-13:30; 14:00-17:30 Wed: 09:00-13:30; 14:00-17:30 Thu: 09:00-13:30; 14:00-17:30 Fri: 09:00-13:30; 14:00-17:30 Sat: Sun:	Mon: 09:00-13:30; 14:00-17:30 Tue: 09:00-13:30; 14:00-17:30 Wed: 09:00-13:30; 14:00-17:30 Thu: 09:00-13:30; 14:00-17:30 Fri: 09:00-13:30; 14:00-17:30 Sat: Sun:
79	Rowlands Pharmacy Oxford Distance selling premises	OX4 6NG	Mon: 08:30-16:30 Tue: 08:30-16:30 Wed: 08:30-16:30 Thu: 08:30-16:30 Fri: 08:30-16:30 Sat: Sun:	Mon: 08:30-16:30 Tue: 08:30-16:30 Wed: 08:30-16:30 Thu: 08:30-16:30 Fri: 08:30-16:30 Sat: Sun:
80	Barton Pharmacy Barton	OX3 9LU	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:
81	Lloyds pharmacy Blackbird Leys	OX4 7EX	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 09:00-13:00 Sun:	Mon: 08:30-14:30; 16:30-18:30 Tue: 08:30-14:30; 16:30-18:30 Wed: 08:30-14:30; 16:30-18:30 Thu: 08:30-14:30; 16:30-18:30 Fri: 08:30-14:30; 16:30-18:30 Sat: Sun:
84	Superdrug Pharmacy Cowley	OX4 3UZ	Mon: 08:30-17:30 Tue: 08:30-17:30 Wed: 08:30-17:30 Thu: 08:30-17:30 Fri: 08:30-17:30 Sat: 09:00-13:30; 14:00-17:30 Sun:	Mon: 09:00-13:00; 15:00-17:30 Tue: 09:00-13:00; 15:00-17:30 Wed: 09:00-13:00; 15:00-17:30 Thu: 09:00-13:00; 15:00-17:30 Fri: 09:00-13:00; 15:00-17:30 Sat: 09:00-13:30; 14:30-17:30 Sun:
85	The Leys Pharmacy Greater Leys 100 hours	OX4 7EX	Mon: 07:00-22:00 Tue: 07:00-22:00 Wed: 07:00-22:00 Thu: 07:00-22:00 Fri: 07:00-13:00; 14:00-22:00 Sat: 07:00-22:00 Sun: 09:00-20:00	Mon: 07:00-22:00 Tue: 07:00-22:00 Wed: 07:00-22:00 Thu: 07:00-22:00 Fri: 07:00-13:00; 14:00-22:00 Sat: 07:00-22:00 Sun: 09:00-20:00

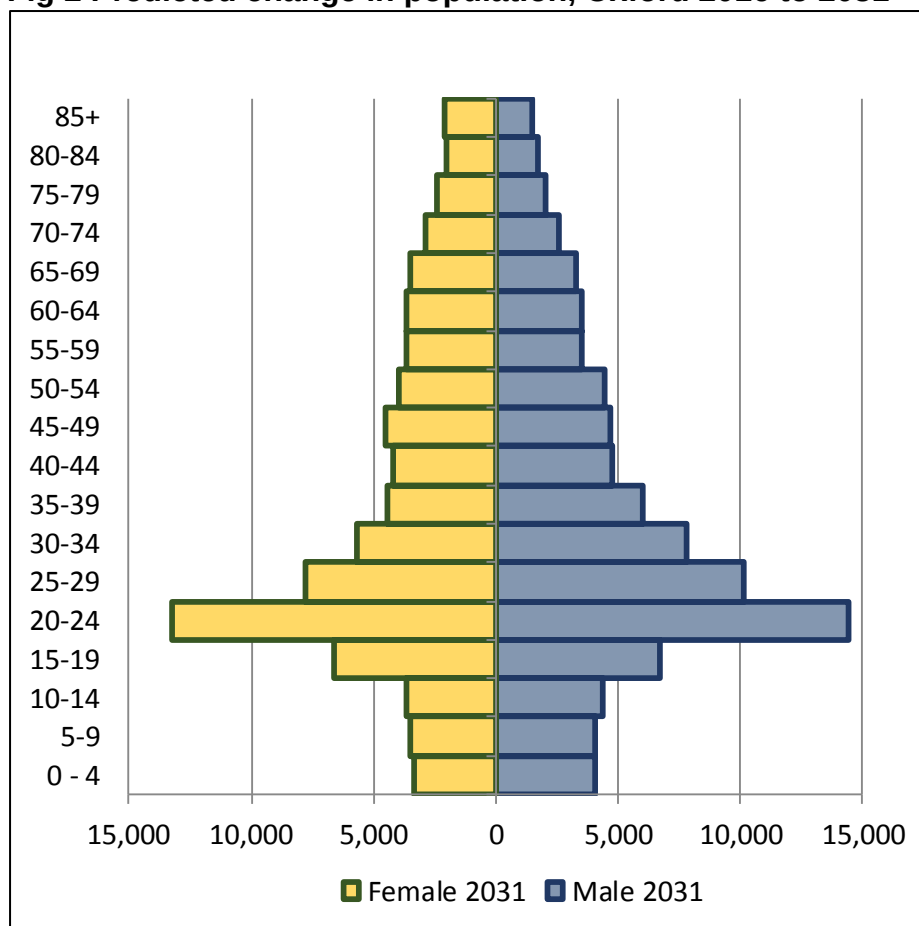
Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
86	Rowlands Pharmacy Headington	OX3 9BH	Mon: 09:00-13:00; 13:30-18:30 Tue: 09:00-13:00; 13:30-18:30 Wed: 09:00-13:00; 13:30-18:30 Thu: 09:00-13:00; 13:30-18:30 Fri: 09:00-13:00; 13:30-18:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
87	Your Local Boots Pharmacy Headington	OX3 9JA	Mon: 08:30-13:00; 14:00-18:00 Tue: 08:30-13:00; 14:00-18:00 Wed: 08:30-13:00; 14:00-18:00 Thu: 08:30-13:00; 14:00-18:00 Fri: 08:30-13:00; 14:00-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
88	Roundway pharmacy Headington	OX3 8DH	Mon: 08:30-18:00 Tue: 08:30-18:00 Wed: 08:30-18:00 Thu: 08:30-18:00 Fri: 08:30-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:
89	Rowlands Pharmacy Headington	OX3 8RA	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00; 14:00-17:30 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
90	Boots the Chemists Headington	OX3 9AJ	Mon: 09:00-17:30 Tue: 09:00-17:30 Wed: 09:00-17:30 Thu: 09:00-17:30 Fri: 09:00-17:30 Sat: 09:00-17:30 Sun:	Mon: 09:00-13:30; 14:30-17:30 Tue: 09:00-13:30; 14:30-17:30 Wed: 09:00-13:30; 14:30-17:30 Thu: 09:00-13:30; 14:30-17:30 Fri: 09:00-13:30; 14:30-17:30 Sat: 09:00-11:30 Sun:
92	Lloyds Pharmacy Littlemore	OX4 4XR	Mon: 08:00-12:00; 13:00-21:00 Tue: 08:00-12:00; 13:00-21:00 Wed: 08:00-12:00; 13:00-21:00 Thu: 08:00-12:00; 13:00-21:00 Fri: 08:00-12:00; 13:00-21:00 Sat: 08:00-12:00; 13:00-20:00 Sun: 10:00-17:00	Mon: 09:00-12:00; 13:00-17:00 Tue: 09:00-12:00; 13:00-17:00 Wed: 09:00-12:00; 13:00-17:00 Thu: 09:00-12:00; 13:00-17:00 Fri: 09:00-12:00; 13:00-17:00 Sat: 09:00-12:00 Sun: 11:00-13:00
93	Rowlands Pharmacy Summertown	OX2 7HQ	Mon: 09:00-14:00; 14:20-18:00 Tue: 09:00-14:00; 14:20-18:00 Wed: 09:00-14:00; 14:20-18:00 Thu: 09:00-14:00; 14:20-18:00 Fri: 09:00-14:00; 14:20-18:00 Sat: 09:00-14:00 Sun:	Mon: 09:00-14:00; 15:00-18:00 Tue: 09:00-14:00; 15:00-18:00 Wed: 09:00-14:00; 15:00-18:00 Thu: 09:00-14:00; 15:00-18:00 Fri: 09:00-14:00; 15:00-18:00 Sat: Sun:
94	Marston Pharmacy Marston	OX3 0JR	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 09:00-17:30 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
95	Northway Pharmacy Northway	OX3 0LY	Mon: 08:30-18:00 Tue: 08:30-18:00 Wed: 08:30-18:00 Thu: 08:30-18:00 Fri: 08:30-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-12:30; 13:00-17:30 Tue: 09:00-12:30; 13:00-17:30 Wed: 09:00-12:30; 13:00-17:30 Thu: 09:00-12:30; 13:00-17:30 Fri: 09:00-12:30; 13:00-17:30 Sat: Sun:

Population

- As of mid-2016 the estimated population of Oxford was **161,400** residents.
- By 2031, Oxfordshire County Council forecasts, based on expected growth in housing, estimates the population of Oxford will increase to **170,500** residents (+6%).
- The population of children and young people aged 0-17 is expected to decline by 7% to 2,100 residents.
- The population aged 85 and over is expected to increase by 26% between 2016 and 2031 to 3,600 residents.

Over half of births in Oxford in 2015 were to mothers born outside the UK, the highest proportion of which was to mothers born in Europe.

Fig 2 Predicted change in population, Oxford 2016 to 2031



Health Issues

Some areas within Oxford City are among the most deprived nationally. Obesity in reception aged children (aged 4 or 5) and Year 6 children (aged 10 or 11) have each increased. Reception increased from 8.0% to 8.8% and Year 6 increased from 19.2% to 20.2%. Hospital admission episodes for alcohol-related conditions in

adults have increased in Oxford in recent years and remain above the national and regional averages.

Future needs

There is no future need for further pharmacy services in Oxford City in the lifetime of this PNA.

Improvement and better access

There are no areas in Oxford that could be better improved for better access to pharmacy services in the lifetime of this PNA. However planned housing development in Barton in the three years following the life of this PNA, will mean that an increased number of residents may have to travel further to access essential services in the evenings and on Sundays

Pharmaceutical need

General access: The residents of Oxford have 30 locations in which to access pharmaceutical services by means of a community pharmacy. There are three 100-hour pharmacies offering extended hours, either during the week or at weekends.

There is one residential area in the locality, which has less choice and access to pharmaceutical services at a weekend (Barton) as the pharmacy located there does not open at weekends. Residents of Barton are in easy reach of several pharmacies in Headington, which is within the 1mile (1.6km) buffer. Barton is also serviced by a good bus route.

Advanced services: 29 of the pharmacies in Oxford City provide either the MUR service or both the MUR & NMS service and these are shown in table below.

PHARMACY NAME	PHARMACY ADDRESS	MUR /NMS		LOCATION
AHMEYS LATE NIGHT PHARMACY	150 OXFORD ROAD	MUR	NMS	OXFORD
BARTON PHARMACY	6 UNDERHILL CIRCUS		NMS	HEADINGTON
BLIEP CHEMIST	190 ABINGDON ROAD	MUR		OXFORD
BOOTS UK LIMITED	6-8 CORNMARKE STREET	MUR	NMS	OXFORD
BOOTS UK LIMITED	221 BANBURY ROAD	MUR	NMS	OXFORD
BOOTS UK LIMITED	96 LONDON ROAD	MUR	NMS	HEADINGTON
BOOTS UK LIMITED	151 COWLEY ROAD	MUR	NMS	OXFORD
BOOTS UK LIMITED	OXFORD RETAIL PARK	MUR		OXFORD
BOSWELLS OF OXFORD LTD	BOSWELLS ARCADE	MUR		OXFORD
COWLEY PHARMACY	258 COWLEY ROAD	MUR		OXFORD
JHOOTS PHARMACY LTD	116 WALTON STREET	MUR	NMS	OXFORD
LLOYDSPHARMACY	J SAINSBURY STORE	MUR	NMS	OXFORD
LLOYDSPHARMACY	HEALTH CENTRE	MUR		OXFORD
LLOYDSPHARMACY	HEALTH CENTRE		NMS	OXFORD
MARSTON PHARMACY	11-13 OLD MARSTON RD	MUR	NMS	OXFORD
NORTHWAY PHARMACY	2 CHERWELL DRIVE	MUR	NMS	HEADINGTON

PHARMACY NAME	PHARMACY ADDRESS	MUR /NMS		LOCATION
ROWLANDS PHARMACY	194 BANBURY ROAD	MUR	NMS	OXFORD
ROWLANDS PHARMACY	227 BANBURY ROAD	MUR	NMS	OXFORD
ROWLANDS PHARMACY	13 ATKYNS ROAD	MUR	NMS	HEADINGTON
ROWLANDS PHARMACY	57 OSLER ROAD	MUR	NMS	HEADINGTON
ROWLANDS PHARMACY	EAST OXFORD HC	MUR	NMS	OXFORD
ROWLANDS PHARMACY	17 IVY CLOSE	MUR	NMS	OXFORD
ROWLANDS PHARMACY	1 HENLEY AVENUE	MUR	NMS	OXFORD
SUPERDRUG PHARMACY	UNIT5	MUR	NMS	OXFORD
THE LEYS PHARMACY	SPAR SUPERMARKET	MUR	NMS	OXFORD
THE LEYS PHARMACY ROSEHILL	6A COURTLAND ROAD	MUR		OXFORD
THE ROUNDWAY PHARMACY	3 THE ROUNDWAY	MUR		HEADINGTON
WOODSTOCK ROAD CHEMIST	59 WOODSTOCK ROAD	MUR	NMS	OXFORD
YOUR LOCAL BOOTS PHARMACY	BURY KNOWLE HC	MUR	NMS	HEADINGTON

Gaps in service provision

There are no gaps in service provision for residents in Oxford City.

South Oxfordshire County Council

Overview

This locality contains the towns of Didcot, Wallingford, Henley and Thame. It has a total resident population of 138,128 (ONS mid-year estimates 2016) and is serviced by:

- 19 pharmacies including one 100-hour pharmacy
- 6 GP dispensing practices

The South Oxfordshire locality has at least one pharmacy providing essential services from 7am to 10pm on Mondays to Saturdays and 10am to 4pm on a Sunday.

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
53	Lloyds pharmacy Goring	RG8 9AT	Mon: 09:00-17:30 Tue: 09:00-17:30 Wed: 09:00-17:30 Thu: 09:00-17:30 Fri: 09:00-17:30 Sat: 09:00-17:00 Sun:	Mon: 09:00-13:00; 14:00-17:00 Tue: 09:00-13:00; 14:00-17:00 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:00 Sat: 09:00-13:00 Sun:
54	Henley Pharmacy Henley	RG9 2BA	Mon: 08:45-17:30 Tue: 08:45-17:30 Wed: 08:45-17:30 Thu: 08:45-17:30 Fri: 08:45-17:30 Sat: 08:45-17:30 Sun:	Mon: 09:00-13:00; 14:00-17:00 Tue: 09:00-13:00; 14:00-17:00 Wed: 09:00-13:00; 14:00-17:00 Thu: 09:00-13:00; 14:00-17:00 Fri: 09:00-13:00; 14:00-17:00 Sat: 09:00-13:00; 14:00-15:00 Sun:
55	Tesco Pharmacy Henley	RG9 4HA	Mon: 09:00-20:00 Tue: 09:00-20:00 Wed: 09:00-20:00 Thu: 09:00-20:00 Fri: 09:00-20:00 Sat: 08:00-19:00 Sun: 10:00-16:00	Mon: 09:00-12:00; 13:00-18:00 Tue: 09:00-12:00; 13:00-18:00 Wed: 09:00-12:00; 13:00-18:00 Thu: 09:00-12:00; 13:00-18:00 Fri: 09:00-12:00; 13:00-18:00 Sat: Sun:
56	Boots the Chemists Henley	RG9 2BA	Mon: 08:30-14:00; 15:00-18:00 Tue: 08:30-14:00; 15:00-18:00 Wed: 08:30-14:00; 15:00-18:00 Thu: 08:30-14:00; 15:00-18:00 Fri: 08:30-14:00; 15:00-18:00 Sat: 08:30-14:00; 15:00-18:00 Sun: 10:30-16:30	Mon: 09:30-14:00; 15:00-17:15 Tue: 09:30-14:00; 15:00-17:15 Wed: 09:30-14:00; 15:00-17:15 Thu: 09:30-14:00; 15:00-17:15 Fri: 09:30-14:00; 15:00-17:00 Sat: 09:30-14:00; 15:00-17:00 Sun:
57	Your Local Boots pharmacy Henley	RG9 2DZ	Mon: 08:30-13:30; 14:00-18:30 Tue: 08:30-13:30; 14:00-18:30 Wed: 08:30-13:30; 14:00-18:30 Thu: 08:30-13:30; 14:00-18:30 Fri: 08:30-13:30; 14:00-18:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
96	Day Lewis Pharmacy Sonning Common	RG4 9SJ	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00; 14:00-17:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
116	Boots the Chemist Thame	OX9 3JZ	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 08:30-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:00 Tue: 09:00-13:00; 14:00-17:00 Wed: 09:00-13:00; 14:00-17:00 Thu: 09:00-13:00; 14:00-17:00 Fri: 09:00-13:00; 14:00-17:00 Sat: 09:00-13:00 Sun:
117	Boots the Chemists Thame	OX9 2BU	Mon: 09:00-17:30 Tue: 09:00-17:30 Wed: 09:00-17:30 Thu: 09:00-17:30 Fri: 09:00-17:30 Sat: 09:00-17:30 Sun: 10:00-16:00	Mon: 09:30-13:30; 14:30-17:00 Tue: 09:30-13:30; 14:30-17:00 Wed: 09:30-13:30; 14:30-17:00 Thu: 09:30-13:30; 14:30-17:30 Fri: 09:30-13:30; 14:30-17:30 Sat: 09:30-13:30; 14:30-17:00 Sun:
21	Lloyds pharmacy Benson	OX10 6RP	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 10:00-12:30 Sun:
22	Berinsfield Pharmacy Berinsfield	OX10 7NE	Mon: 08:45-18:30 Tue: 08:45-18:30 Wed: 08:45-18:30 Thu: 08:45-18:30 Fri: 08:45-18:30 Sat: Sun:	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:
37	Chalgrove Pharmacy Chalgrove	OX44 7SS	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:15-17:30 Tue: 09:00-13:00; 14:15-17:30 Wed: 09:00-13:00; 14:30-17:30 Thu: 09:00-13:00; 14:15-17:30 Fri: 09:00-13:00; 14:15-17:30 Sat: 09:00-13:00 Sun:
44	Lloyds pharmacy Didcot	OX11 7JH	Mon: 08:00-18:00 Tue: 08:00-18:00 Wed: 08:00-18:00 Thu: 08:00-18:00 Fri: 08:00-18:00 Sat: 09:00-17:00 Sun:	Mon: 09:00-12:30; 14:00-17:30 Tue: 09:00-12:30; 14:00-17:30 Wed: 09:00-12:30; 14:00-17:30 Thu: 09:00-12:30; 14:00-17:30 Fri: 09:00-12:30; 14:00-17:30 Sat: 09:00-14:00 Sun:
45	Lloyds Pharmacy Ltd Didcot 100 hours	OX11 7ND	Mon: 07:00-22:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00	Mon: 07:00-22:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
46	Tesco Pharmacy Didcot	OX11 9BZ	Mon: 08:30-21:00 Tue: 08:30-21:00 Wed: 08:30-21:00 Thu: 08:30-21:00 Fri: 08:30-21:00 Sat: 08:00-19:00 Sun: 10:00-16:00	Mon: 09:00-13:00; 14:00-17:00 Tue: 09:00-13:00; 14:00-17:00 Wed: 09:00-13:00; 14:00-17:00 Thu: 09:00-13:00; 14:00-17:00 Fri: 09:00-13:00; 14:00-17:00 Sat: 09:00-14:00 Sun:
47	Your Local Boots pharmacy Didcot	OX11 7XT	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
48	Lloyds pharmacy Didcot	OX11 0BB	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 09:00-12:00 Sun:	Mon: 08:30-14:00; 16:30-18:30 Tue: 08:30-14:00; 16:30-18:30 Wed: 08:30-14:00; 16:30-18:30 Thu: 08:30-14:00; 16:30-18:30 Fri: 08:30-14:00; 16:30-18:30 Sat: 09:30-12:00 Sun:
49	Boots the Chemists Didcot	OX11 7LG	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: 09:00-18:00 Sun: 10:00-16:00	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
97	Rowlands Pharmacy Wallingford	OX10 9NS	Mon: 09:00-13:00; 13:20-17:30 Tue: 09:00-13:00; 13:20-17:30 Wed: 09:00-13:00; 13:20-17:30 Thu: 09:00-13:00; 13:20-17:30 Fri: 09:00-13:00; 13:20-17:30 Sat: 09:00-13:00 Sun: Closed	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
98	Lloyds pharmacy Wallingford	OX10 0AD	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: 09:00-17:30 Sun:	Mon: 09:00-12:30; 14:30-18:00 Tue: 09:00-12:30; 14:30-18:00 Wed: 09:00-12:30; 14:30-18:00 Thu: 09:00-12:30; 14:30-18:00 Fri: 09:00-12:30; 14:30-18:00 Sat: 09:00-11:30; 15:00-17:30 Sun:
99	Boots the Chemists Wallingford	OX10 0EG	Mon: 08:30-18:00 Tue: 08:30-18:00 Wed: 08:30-18:00 Thu: 08:30-118:00 Fri: 08:30-118:00 Sat: 8:30-17:30 Sun: 10:00-16:00	Mon: 09:30-13:30; 14:30-17:30 Tue: 09:30-13:30; 14:30-17:30 Wed: 09:30-13:30; 14:30-17:30 Thu: 09:30-13:30; 14:30-17:30 Fri: 09:30-13:30; 14:30-17:30 Sat: 09:30-13:30; 14:30-15:30 Sun:
104	Watlington Pharmacy Watlington	OX49 5PU	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
105	The Co-operative Pharmacy Wheatley	OX33 1XX	Mon: 08:45-14:00; 14:30-18:30 Tue: 08:45-14:00; 14:30-18:30 Wed: 08:45-14:00; 14:30-18:30 Thu: 08:45-14:00; 14:30-18:30 Fri: 08:45-14:00; 14:30-18:30 Sat: 08:45-13:00 Sun:	Mon: 09:00-13:00; 14:30-18:30 Tue: 09:00-13:00; 14:30-18:30 Wed: 09:00-13:00; 14:30-18:30 Thu: 09:00-13:00; 14:30-18:30 Fri: 09:00-13:00; 14:30-18:30 Sat: Sun:
115	Lloyds pharmacy Chinnor	OX39 4PG	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:45-18:00 Tue: 09:00-13:00; 14:45-18:00 Wed: 09:00-13:00; 15:00-18:00 Thu: 09:00-13:00; 14:45-18:00 Fri: 09:00-13:00; 14:45-18:00 Sat: 09:00-13:00 Sun:

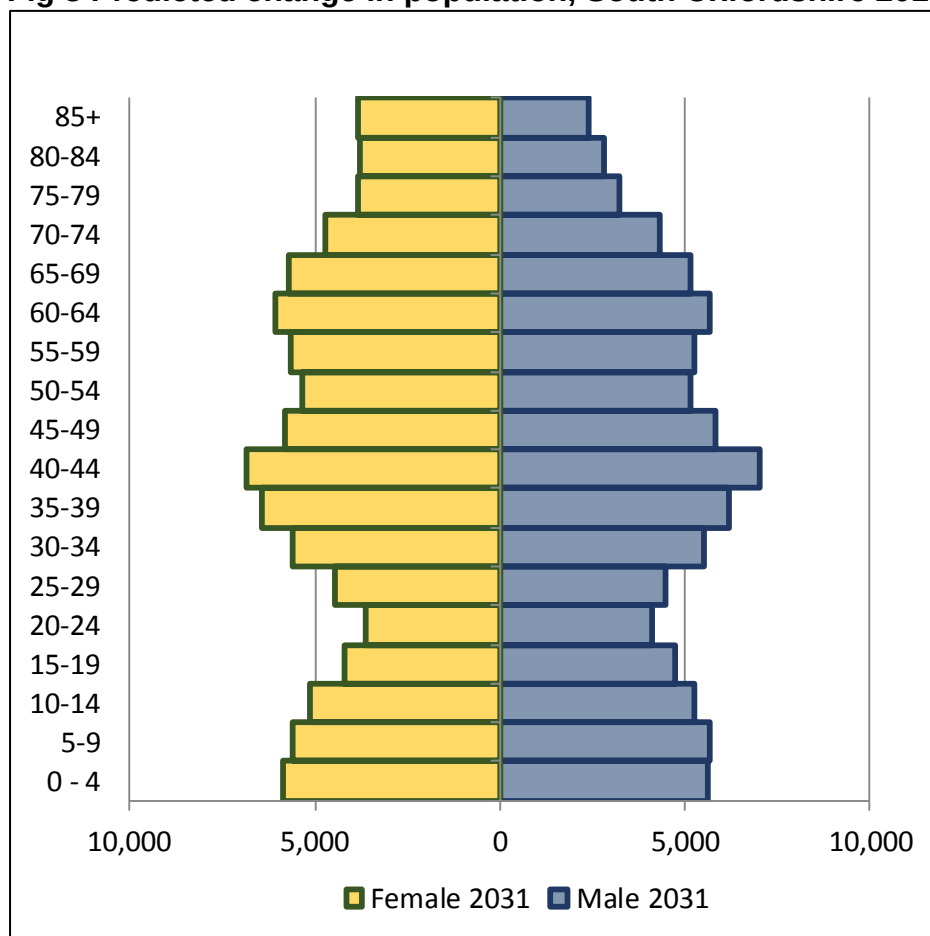
List of Dispensing GP practices

Map Index	PRACTICE NAME	Address	Postcode
D	Morland House Surgery	London Road, Wheatley	OX331LU
E	Nettlebed Surgery	Nettlebed	RG9 5AJ
G	Sonning Common Health Centre	Wood Lane, Sonning Common	RG4 9SW
J	Clifton Hampden Surgery	Watery Lane, Clifton Hampden	OX143EL
K	Wallingford Medical Practice	Reading Road, Wallingford	OX109DU
X	Goring and Woodcote Medical Practice	Red Cross Road, Goring	RG8 9HG

Population

- As of mid-2016 the estimated population of South Oxfordshire was **139,600** residents.
- By 2031, Oxfordshire County Council forecasts, based on expected growth in housing, estimates the population of Cherwell will increase to **180,800** residents (+%).
- The population of children and young people aged 0-17 is expected to increase by 30% to 9,000 residents.
- The population aged 85 and over is expected to increase by 61% between 2016 and 2031 to 6,200 residents.

Fig 3 Predicted change in population, South Oxfordshire 2016 to 2031



Health Issues

There has been an increase in obesity of reception age children from 5.7% to 6.6% and a decrease from 12.8% to 11.8% for Year 6 children (aged 10 or 11). In 2016 there were around 1,700 police recorded victims of domestic abuse (crime and incidents) in South Oxfordshire, a decline of -1% from the previous year.

Future needs

Housing development in South Oxfordshire is predominantly in Didcot area with other smaller developments elsewhere. This does not create a need for further pharmacies in the lifetime of this PNA.

Improvement and better access

Planned housing developments in South Oxfordshire are mostly located in the Didcot area which is well provided for in terms of pharmaceutical services. There are no suggestions for improvement or better access within the lifetime of this PNA.

Pharmaceutical needs

General access

The residents of South Oxfordshire have 29 locations in which to access pharmaceutical services. The towns, which are densely populated (Didcot, Thame and Henley), are all served by pharmacies with extended opening times including evenings and weekends. Didcot has one 100-hour pharmacy. Smaller towns such as Wheatley, Goring and Sonning Common are served by both community pharmacies and dispensing GP practices.

Advanced services

All 23 community pharmacies in the locality provide either the MUR service or both MUR & NMS services. The pharmacies delivering advanced services in South Oxfordshire are in the table below

PHARMACY NAME	PHARMACY ADDRESS	MUR /NMS		LOCATION
BERINSFIELD PHARMACY	BERINSFIELD HC	MUR	NMS	WALLINGFORD
BOOTS UK LIMITED	7/8 MARKET PLACE	MUR		WALLINGFORD
BOOTS UK LIMITED	130B THE BROADWAY	MUR	NMS	DIDCOT
BOOTS UK LIMITED	4-5 HIGH STREET	MUR	NMS	THAME
BOOTS UK LIMITED	THE HEALTH CENTRE	MUR	NMS	THAME
BOOTS UK LIMITED	5/7 BELL STREET	MUR	NMS	HENLEY ON THAMES
BOOTS UK LIMITED	7/8 MARKET PLACE		NMS	WALLINGFORD
DAY LEWIS PHARMACY	19B WOOD LANE	MUR	NMS	READING
HENLEY PHARMACY	25 BELL STREET	MUR		HENLEY-ON-THAMES
IN-STORE PHARMACY	TESCO STORE	MUR	NMS	HENLEY-ON-THAMES
LLOYDSPHARMACY	20-21 MARKET PLACE	MUR	NMS	WALLINGFORD
LLOYDSPHARMACY	23 HIGH STREET	MUR	NMS	WALLINGFORD
LLOYDSPHARMACY	WOODLANDS MEDICAL CTR	MUR	NMS	DIDCOT
LLOYDSPHARMACY	DIDCOT HEALTH CENTRE	MUR	NMS	DIDCOT
LLOYDSPHARMACY	CENTRAL DRIVE	MUR	NMS	DIDCOT
LLOYDSPHARMACY	SHOP 5	MUR	NMS	CHINNOR
LLOYDSPHARMACY	HIGH STREET	MUR	NMS	GORING-ON-THAMES
ROWLANDS PHARMACY	1 THE POUND	MUR	NMS	WALLINGFORD
TESCO STORES LIMITED	THE PHARMACY	MUR	NMS	DIDCOT
THE CO-OPERATIVE PHARMACY	39 HIGH STREET	MUR	NMS	WHEATLEY
WATLINGTON PHARMACY	MARKET PLACE	MUR		WATLINGTON
YOUR LOCAL BOOTS PHARMACY	5 LOSTOCK PLACE	MUR		DIDCOT
YOUR LOCAL BOOTS PHARMACY	WEST LANE	MUR	NMS	HENLEY-ON-THAMES

Gaps in service provision

Apart from the village of Nettlebed, where dispensing GPs are located, in South Oxfordshire there is also the choice of at least one community pharmacy in the immediate vicinity. The closest pharmacies for residents of Nettlebed are in Henley

or Sonning Common which are less than 5 miles and approximately 10 minutes' drive away (calculations by AA route planner).

Across the locality, where there are pharmaceutical services, evening access is not provided in Chinnor. The GP practice in Chinnor opens for an evening surgery 18:30 to 19:50 each Wednesday. The closest pharmacy for patients in Chinnor on a week day evening after 19:00 is in High Wycombe, which is approximately 8 miles away, taking approximately 19 minutes to drive to (calculations by Google route planner). GP surgeries which offer extended opening hours, such as that in Chinnor, can review this additional service on a quarterly basis and although it may not be long term, it would be expected that local pharmacies would consider these GP services when reviewing their own opening hours.

Across the locality where there are current pharmaceutical services, weekend access is not provided for in Berinsfield. The GP practice in Berinsfield opens for a Saturday morning surgery 8:00am to 11:00am. The closest pharmacy for patients in Berinsfield on a Saturday are shown in the table below ([NHS choices](#)):

Village	Nearest pharmacy	Distance	Driving time
Berinsfield	Chalgrove Pharmacy Chalgrove	3.9 miles	12 minutes
	Lloyds Pharmacy Benson	4 miles	9 minutes
	Leys Pharmacy Greater Leys	4 miles	13 minutes

Vale of White Horse

Overview

This locality contains the towns of Abingdon, Faringdon and Wantage. It has a total resident population of 128,738 (ONS mid-year estimates 2016) and is serviced by:

- 18 pharmacies, two of which are 100 hour pharmacies
- 3 GP dispensing practices

The Vale of White Horse locality has at least one pharmacy providing essential services from 7am to 11pm Monday to Saturday, and 9am to 10pm on a Sunday.

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
51	Your Local Boots pharmacy Faringdon	SN7 7HP	Mon: 09:00-13:00; 14:00-18:30 Tue: 09:00-13:00; 14:00-18:30 Wed: 09:00-13:00; 14:00-18:30 Thu: 09:00-13:00; 14:00-18:30 Fri: 09:00-13:00; 14:00-18:30 Sat: 09:00-13:00; 14:00-17:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00 Sun:
52	Faringdon Pharmacy Faringdon 100 hours	SN7 7AE	Mon: 07:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-23:00 Sun: 09:00-13:05	Mon: 07:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-23:00 Sun: 09:00-13:05
83	Lloyds pharmacy Botley	OX2 9LH	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 09:00-17:30 Sun:	Mon: 08:30-13:00; 15:00-17:30 Tue: 08:30-13:00; 15:00-17:30 Wed: 08:30-13:00; 15:00-17:30 Thu: 08:30-13:00; 15:00-17:30 Fri: 08:30-13:00; 15:00-17:30 Sat: 09:00-14:00 Sun:
91	Avicenna Pharmacy Kennington	OX1 5PG	Mon: 09:00-13:00; 14:00-18:30 Tue: 09:00-13:00; 14:00-18:30 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:30 Fri: 09:00-13:00; 14:00-18:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00 Sun:
1	Jhoots Pharmacy Abingdon	OX14 3QT	Mon: 09:00-18:30 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-14:00 Sun: Closed	Mon: 09:00-13:00; 15:30-18:30 Tue: 09:00-13:00; 15:30-18:30 Wed: 09:00-13:00; 15:30-18:30 Thu: 09:00-13:00; 15:30-18:30 Fri: 09:00-13:00; 15:30-18:30 Sat: 09:00-14:00 Sun:
2	Consult Pharmacy Abingdon 100 hours	OX14 1AH	Mon: 08:00-22:30 Tue: 08:00-22:30 Wed: 08:00-22:30 Thu: 08:00-22:30 Fri: 08:00-22:30 Sat: 08:00-22:30 Sun: 09:00-22:00	Mon: 08:00-22:30 Tue: 08:00-22:30 Wed: 08:00-22:30 Thu: 08:00-22:30 Fri: 08:00-22:30 Sat: 08:00-22:30 Sun: 09:00-22:00

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
3	Tesco Pharmacy Abingdon	OX14 1TU	Mon: 08:00-20:00 Tue: 08:00-20:00 Wed: 08:00-20:00 Thu: 08:00-20:00 Fri: 08:00-20:00 Sat: 08:00-20:00 Sun: 10:00-16:00	Mon: 09:00-13:00; 14:00-17:00 Tue: 09:00-13:00; 14:00-17:00 Wed: 09:00-13:00; 14:00-17:00 Thu: 09:00-13:00; 14:00-17:00 Fri: 09:00-13:00; 14:00-17:00 Sat: 09:00-13:00; 14:00-15:00 Sun:
4	Reynolds Way Pharmacy Abingdon	OX14 5JT	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:
5	North Abingdon Pharmacy Abingdon	OX14 1XR	Mon: 08:30-13:00; 14:00-18:30 Tue: 08:30-13:00; 14:00-18:30 Wed: 08:30-13:00; 14:00-18:30 Thu: 08:30-13:00; 14:00-18:30 Fri: 08:30-13:00; 14:00-18:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-12:15; 14:00-18:00 Tue: 09:00-12:15; 14:00-18:00 Wed: 09:00-12:15; 14:00-18:00 Thu: 09:00-12:15; 14:00-18:00 Fri: 09:00-12:00; 14:00-18:00 Sat: 09:00-13:00 Sun:
6	Avicenna Pharmacy Abingdon	OX14 3JF	Mon: 09:00-17:30 Tue: 09:00-17:30 Wed: 09:00-17:30 Thu: 09:00-17:30 Fri: 09:00-17:30 Sat: 09:00-13:30 Sun:	Mon: 09:00-13:00; 13:30-17:30 Tue: 09:00-13:00; 13:30-17:30 Wed: 09:00-13:00; 13:30-17:30 Thu: 09:00-13:00; 13:30-17:30 Fri: 09:00-13:00; 13:30-17:30 Sat: Sun:
7	Boots the Chemists Abingdon	OX14 3QT	Mon: 08:30-17:30 Tue: 08:30-17:30 Wed: 08:30-17:30 Thu: 08:30-17:30 Fri: 08:30-17:30 Sat: 08:30-17:30 Sun:	Mon: 09:30-14:00; 15:00-17:30 Tue: 09:30-14:00; 15:00-17:30 Wed: 09:30-14:00; 15:00-17:30 Thu: 09:30-14:00; 15:00-17:30 Fri: 09:30-14:00; 15:00-17:30 Sat: 09:30-14:00; 15:00-15:30 Sun:
8	Apollo Pharmacy Abingdon	OX14 4RR	Mon: 08:30-13:15; 14:15-17:30 Tue: 08:30-13:15; 14:15-17:30 Wed: 08:30-13:15; 14:15-17:30 Thu: 08:30-13:15; 14:15-17:30 Fri: 08:30-13:15; 14:15-17:30 Sat: 09:00-15:00 Sun:	Mon: 08:30-13:15; 14:15-17:30 Tue: 08:30-13:15; 14:15-17:30 Wed: 08:30-13:15; 14:15-17:30 Thu: 08:30-13:30; 14:15-17:30 Fri: 08:30-13:15; 14:15-17:30 Sat: Sun:
9	Lloyds pharmacy Abingdon	OX14 2QA	Mon: 09:00-18:30 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-17:30 Sun:	Mon: 09:00-13:00; 15:30-18:30 Tue: 09:00-13:00; 15:30-18:30 Wed: 09:00-13:00; 15:30-18:30 Thu: 09:00-13:00; 15:30-18:30 Fri: 09:00-13:00; 15:30-18:30 Sat: 09:00-14:00 Sun:
100	Boots the Chemists Wantage	OX12 8AW	Mon: 09:00-17:30 Tue: 09:00-17:30 Wed: 09:00-17:30 Thu: 09:00-17:30 Fri: 09:00-17:30 Sat: 09:00-17:30 Sun: 10:00-16:00	Mon: 09:30-12:30; 13:30-17:30 Tue: 09:30-12:30; 13:30-17:30 Wed: 09:30-12:30; 13:30-17:30 Thu: 09:30-12:30; 13:30-17:30 Fri: 09:30-12:30; 13:30-17:30 Sat: 09:30-12:30; 13:30-15:30 Sun:
101	Cleggs Pharmacy Wantage	OX12 9AJ	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: 09:00-17:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:

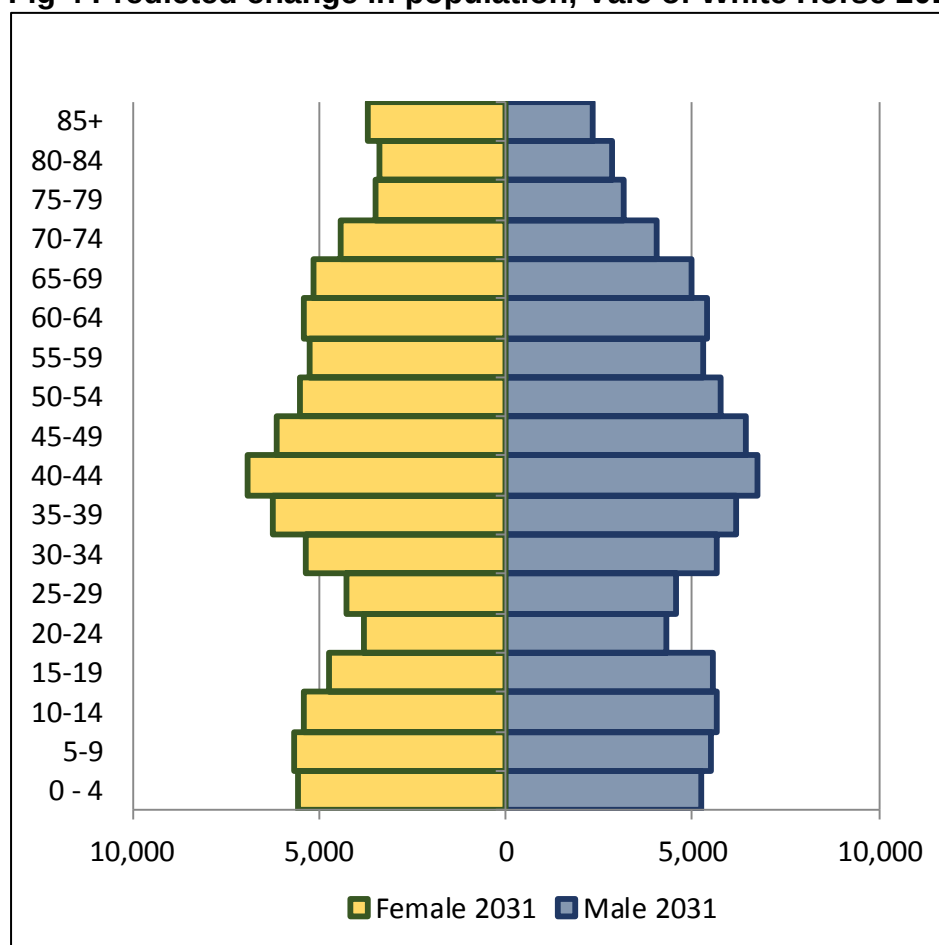
Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
102	Lloyds pharmacy Wantage	OX12 9BN	Mon: 08:30-19:00 Tue: 08:30-19:00 Wed: 08:30-19:00 Thu: 08:30-19:00 Fri: 08:30-19:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 15:00-18:30 Tue: 09:00-13:00; 15:00-18:30 Wed: 09:00-13:00; 15:00-18:30 Thu: 09:00-13:00; 15:00-18:30 Fri: 09:00-13:00; 15:00-18:30 Sat: 09:30-12:00 Sun:
103	Bretts Pharmacy Grove	OX12 7JZ	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-16:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
113	Wootton Pharmacy Wootton	OX13 6DN	Mon: 09:00-13:00; 14:00-18:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-18:30 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-18:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-18:30 Sat: 09:00-13:00 Sun:

Map Index	PRACTICE NAME	Address	Postcode
I	Elm Tree Surgery	21a High Street, Shrivenham	SN6 8AG
M	Marcham Road Health Centre	Marcham Road, Abingdon	OX141BT
R	White Horse Medical Centre	Volunteer Way, Faringdon	SN7 7YU

Population

- As of mid-2016 the estimated population of Vale of White Horse was **129,400** residents.
- By 2031, Oxfordshire County Council forecasts, based on expected growth in housing, estimates the population of Vale of White Horse district will increase to **179,900** residents (+38%).
- The population of children and young people aged 0-17 is expected to increase by 43% to 11,800 residents.
- The population aged 85 and over is expected to increase by 66% between 2016 and 2031 to 6,000 residents.

Fig 4 Predicted change in population, Vale of White Horse 2016 to 2031



Health Issues

In Vale of White Horse there has been a decrease in obesity of reception age children to 5.1% (from 6.6%) and an increase in Year 6 children (aged 10 or 11) to 14.5% (from 13.9%). Between the active people survey of Oct12-Oct13 and Apr15-Mar16, there was a statistically significant increase in the proportion of people participating in sport in Oxfordshire and in Vale of White Horse. In 2016 there were around 1,900 police recorded victims of domestic abuse (crime and incidents) in Vale of White Horse, an increase of 11% from the previous year.

Future need

Within the lifetime of this PNA there is no future need for further pharmacy services in Vale of White Horse.

Improvement and better access

During the lifetime of this PNA there are no suggestions for improvement or better access to pharmacy services.

Pharmaceutical need

General access

The residents of the Vale of White Horse have 21 locations in which to access pharmaceutical services. There are 18 pharmacies and three GP Dispensing Practices.

The towns, which are densely populated and will have highest levels of deprivation in Vale of White Horse (Abingdon, Wantage and Faringdon), are all served by pharmacies which open at evenings and weekends. Abingdon and Faringdon have a 100-hour pharmacy.

Advance services

Of the 18 pharmacies in Vale of White Horse, 17 of them provide MUR and/or NMS services. Please refer to the table below.

PHARMACY NAME	PHARMACY ADDRESS	MUR /NMS		LOCATION
APOLLO PHARMACY	UNIT 5A-5B MILTON PARK	MUR		Abingdon
AVICENNA PHARMACY	172 KENNINGTON ROAD	MUR	NMS	Kennington
AVICENNA PHARMACY	61 STERT STREET	MUR	NMS	Abingdon
BOOTS UK LIMITED	50/51 MARKET PLACE	MUR	NMS	ABINGDON
BOOTS UK LIMITED	27 BURY STREET	MUR	NMS	WANTAGE
BRETTS PHARMACY	11-12 MILLBROOK SQUARE	MUR	NMS	ABINGDON
CLEGG'S PHARMACY	UNIT 3, KINGS WALK	MUR	NMS	WANTAGE
CONSULT PHARMACY	11 SPRING ROAD	MUR		WANTAGE
FARINGDON PHARMACY	3 LONDON STREET	MUR	NMS	ABINGDON
IN-STORE PHARMACY	TESCO SUPERSTORE	MUR	NMS	FARINGDON
JHOOTS PHARMACY	19 BURY STREET	MUR	NMS	ABINGDON
LLOYDS PHARMACY	THE NEW HEALTH CENTRE	MUR	NMS	ABINGDON
LLOYDS PHARMACY	7 PEACHCROFT SHOPPING CTR	MUR	NMS	WANTAGE
LLOYDS PHARMACY	3-4 THE SQUARE	MUR	NMS	ABINGDON
NORTH ABINGDON PHARMACY	LONG FURLONG MEDICAL CTR	MUR		BOTLEY
REYNOLDS WAY PHARMACY	7 REYNOLDS WAY	MUR	NMS	ABINGDON
YOUR LOCAL BOOTS PHARMACY	17 MARKET PLACE	MUR	NMS	ABINGDON

Gaps in service provision

Across the locality where there are current pharmaceutical services, Milton does not have evening access. The nearest GP service to Milton is in Didcot where there are pharmaceutical services with evening hours and this is within easy access to Milton (2-3 miles).

West Oxfordshire

Overview

This locality contains the towns of Burford, Charlbury, Carterton, Chipping Norton, Woodstock and Witney. It has a total resident population of 108,674 (ONS mid-year estimates 2016) and is serviced by:

- 19 pharmacies, two of which are 100 hour pharmacies
- 8 GP dispensing practices and
- 1 Dispensing Appliance Contactor (DAC)

The West Oxfordshire locality has at least one pharmacy providing essential services from 7am to 11pm Monday to Friday, 7am to 10pm on a Saturday and 10am to 4:30pm on a Sunday.

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
38	Salts Medilink Charlbury Dispensing Appliance Contractor	OX7 3EW	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:	Mon: 09:00-15:00 Tue: 09:00-15:00 Wed: 09:00-15:00 Thu: 09:00-15:00 Fri: 09:00-15:00 Sat: Sun:
39	The Co-operative Pharmacy Charlbury	OX7 3PL	Mon: 09:00-13:00; 13:30-18:00 Tue: 09:00-13:00; 13:30-18:00 Wed: 09:00-13:00; 13:30-18:00 Thu: 09:00-13:00; 13:30-18:00 Fri: 09:00-13:00; 13:30-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 13:30-17:30 Tue: 09:00-13:00; 13:30-17:30 Wed: 09:00-13:00; 13:30-17:30 Thu: 09:00-13:00; 13:30-17:30 Fri: 09:00-13:00; 13:30-17:30 Sat: Sun:
40	Boots the Chemists Chipping Norton	OX7 5AD	Mon: 08:30-14:00; 14:30-18:00 Tue: 08:30-14:00; 14:30-18:00 Wed: 09:00-14:00; 14:30-18:00 Thu: 08:30-14:00; 14:30-18:00 Fri: 08:30-14:00; 14:30-18:00 Sat: 08:30-14:00; 14:30-17:30 Sun: 10:00-16:00	Mon: 09:30-13:45; 14:45-17:30 Tue: 09:30-13:45; 14:45-17:30 Wed: 09:30-13:45; 14:45-17:30 Thu: 09:30-13:45; 14:45-17:30 Fri: 09:30-13:45; 14:45-17:30 Sat: 09:30-13:45; 14:45-15:30 Sun:
41	The Co-operative Pharmacy Chipping Norton	OX7 5AD	Mon: 09:00-17:30 Tue: 09:00-17:30 Wed: 09:00-17:30 Thu: 09:00-17:30 Fri: 09:00-17:30 Sat: 09:00-13:00; 13:30-17:30 Sun:	Mon: 09:00-13:00; 13:30-17:30 Tue: 09:00-13:00; 13:30-17:30 Wed: 09:00-13:00; 13:30-17:30 Thu: 09:00-13:00; 13:30-17:30 Fri: 09:00-13:00; 13:30-17:30 Sat: Sun:
42	Wychwood Pharmacy Chipping Norton	OX7 6BW	Mon: 08:30-13:00; 14:00-18:00 Tue: 08:30-13:00; 14:00-18:00 Wed: 08:30-13:00; 14:00-18:00 Thu: 08:30-13:00; 14:00-18:00 Fri: 08:30-13:00; 14:00-18:00 Sat: Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:

Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
43	Chipping Norton Pharmacy 100 hours	OX7 5FA	Mon: 07:00-22:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:30-16:30	Mon: 07:00-22:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:30-16:30
10	Bampton Health Care Ltd Bampton	OX18 2LJ	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-12:00 Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
33	C Reavley Burford	OX18 4QR	Mon: 09:00-18:00 Tue: 09:00-18:00 Wed: 09:00-18:00 Thu: 09:00-18:00 Fri: 09:00-18:00 Sat: 09:00-17:30 Sun: Closed	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-13:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: 09:00-13:00 Sun:
35	Lloyds pharmacy Carterton	OX18 3AG	Mon: 08:30-18:30 Tue: 08:30-18:30 Wed: 08:30-18:30 Thu: 08:30-18:30 Fri: 08:30-18:30 Sat: 09:00-17:30 Sun:	Mon: 08:30-12:00; 14:00-17:30 Tue: 08:30-12:00; 14:00-17:30 Wed: 08:30-12:00; 14:00-17:30 Thu: 08:30-12:00; 14:00-17:30 Fri: 08:30-12:00; 14:00-17:30 Sat: 11:00-16:00 Sun:
36	Broadshires Pharmacy Carterton	OX18 1JA	Mon: 09:00-13:00; 13:30-18:30 Tue: 09:00-13:00; 13:30-18:30 Wed: 09:00-13:00; 13:30-18:30 Thu: 09:00-13:00; 13:30-18:30 Fri: 09:00-13:00; 13:30-18:30 Sat: 09:00-12:00 Sun:	Mon: 09:00-13:00; 13:30-17:30 Tue: 09:00-13:00; 13:30-17:30 Wed: 09:00-13:00; 13:30-17:30 Thu: 09:00-13:00; 13:30-17:30 Fri: 09:00-13:00; 13:30-17:30 Sat: Sun:
50	Lloyds pharmacy Eynsham	OX29 4PD	Mon: 09:00-18:30 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-17:00 Sun:	Mon: 09:00-13:00; 14:30-17:30 Tue: 09:00-13:00; 14:30-17:30 Wed: 09:00-13:00; 14:30-17:30 Thu: 09:00-13:00; 14:30-17:30 Fri: 09:00-13:00; 14:30-17:30 Sat: 09:00-14:00 Sun:
62	Hanborough Pharmacy Long Hanborough	OX29 8JL	Mon: 08:30-13:00; 14:00-18:30 Tue: 08:30-13:00; 14:00-18:30 Wed: 08:30-13:00; 14:00-18:30 Thu: 08:30-13:00; 14:00-18:30 Fri: 08:30-13:00; 14:00-18:30 Sat: Sun:	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:
106	Lloyds pharmacy Witney	OX28 3FP	Mon: 08:30-13:00; 14:00-18:30 Tue: 08:30-13:00; 14:00-18:30 Wed: 08:30-13:00; 14:00-18:30 Thu: 08:30-13:00; 14:00-18:30 Fri: 08:30-13:00; 14:00-18:30 Sat: 08:30-12:00 Sun:	Mon: 08:30-13:00; 14:30-17:30 Tue: 08:30-13:00; 14:30-17:30 Wed: 08:30-13:00; 14:30-17:30 Thu: 08:30-13:00; 14:30-17:30 Fri: 08:30-13:00; 14:30-17:30 Sat: 09:30-12:00 Sun:
107	Your Local Boots pharmacy Witney	OX28 5YP	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: 09:00-13:00; 14:00-17:30 Sun: Closed	Mon: 09:00-13:00; 14:00-18:00 Tue: 09:00-13:00; 14:00-18:00 Wed: 09:00-13:00; 14:00-18:00 Thu: 09:00-13:00; 14:00-18:00 Fri: 09:00-13:00; 14:00-18:00 Sat: Sun:

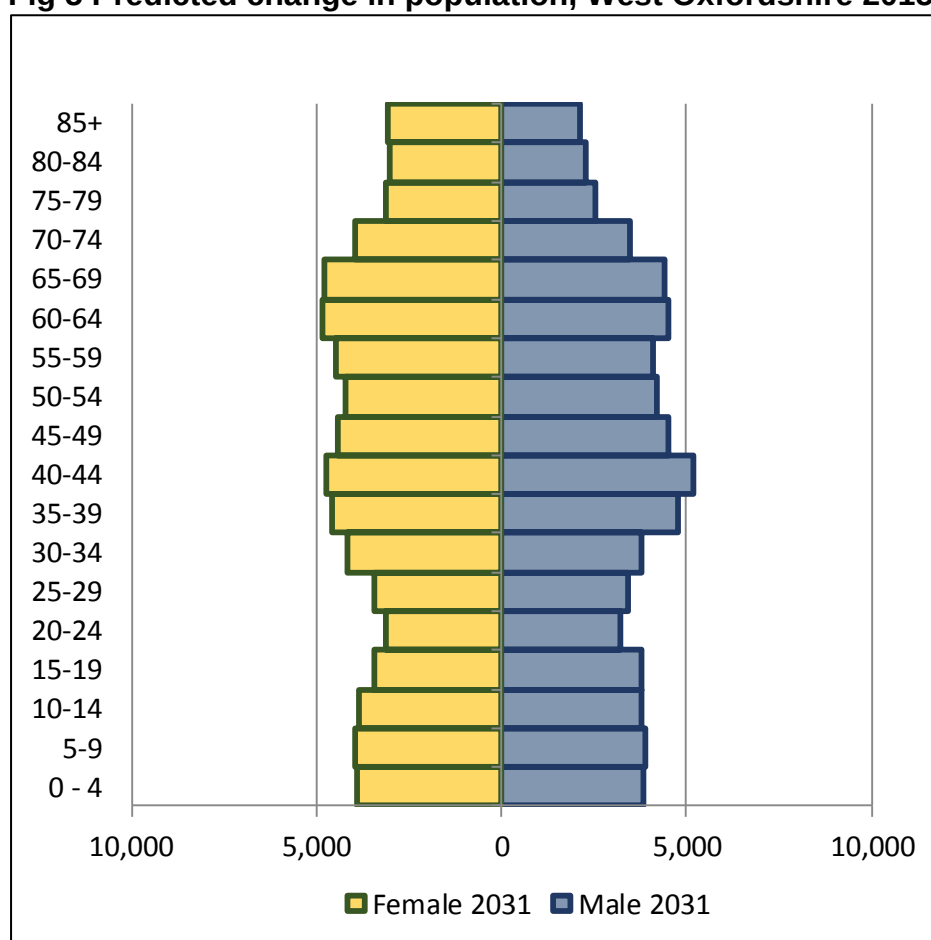
Map Index	TRADING NAME and TYPE*	POSTCODE	OPENING HOURS	CORE HOURS
108	Rowlands Pharmacy Witney	OX28 6JQ	Mon: 08:30-13:00; 13:20-18:00 Tue: 08:30-13:00; 13:20-18:00 Wed: 08:30-13:00; 13:20-18:00 Thu: 08:30-13:00; 13:20-18:00 Fri: 08:30-13:00; 13:20-18:00 Sat: 09:00-13:00 Sun:	Mon: 09:00-13:00; 14:00-17:30 Tue: 09:00-13:00; 14:00-17:30 Wed: 09:00-13:00; 14:00-17:30 Thu: 09:00-13:00; 14:00-17:30 Fri: 09:00-13:00; 14:00-17:30 Sat: 09:00-11:30 Sun:
109	Lloyds pharmacy Witney	OX28 6JS	Mon: 09:00-18:30 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-12:00 Sun:	Mon: 09:00-13:00; 15:30-18:30 Tue: 09:00-13:00; 15:30-18:30 Wed: 09:00-13:00; 15:30-18:30 Thu: 09:00-13:00; 14:30-18:30 Fri: 09:00-13:00; 14:30-18:30 Sat: 09:00-12:00 Sun:
110	Lloyds Pharmacy Ltd Witney 100 hours	OX28 4FF	Mon: 07:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00	Mon: 07:00-23:00 Tue: 07:00-23:00 Wed: 07:00-23:00 Thu: 07:00-23:00 Fri: 07:00-23:00 Sat: 07:00-22:00 Sun: 10:00-16:00
111	Boots the Chemists Witney	OX28 6HA	Mon: 09:00-17:30 Tue: 08:30-17:30 Wed: 08:30-17:30 Thu: 08:30-17:30 Fri: 08:30-17:30 Sat: 08:30-17:30 Sun: 10:00-16:00	Mon: 09:30-14:00; 15:00-17:30 Tue: 09:30-14:00; 15:00-17:30 Wed: 09:30-14:00; 15:00-17:30 Thu: 09:30-14:00; 15:00-17:30 Fri: 09:30-14:00; 15:00-17:30 Sat: 09:30-14:00; 15:00-15:30 Sun:
112	Woodstock Pharmacy	OX20 1TF	Mon: 09:00-18:30 Tue: 09:00-18:30 Wed: 09:00-18:30 Thu: 09:00-18:30 Fri: 09:00-18:30 Sat: 09:00-17:00 Sun:	Mon: 09:00-17:00 Tue: 09:00-17:00 Wed: 09:00-17:00 Thu: 09:00-17:00 Fri: 09:00-17:00 Sat: Sun:

Map Index	PRACTICE NAME	Address	Postcode
B	Eynsham Medical Centre	Conduit Lane, Eynsham	OX294QB
F	Windrush Medical Practice Witney	Welch Way, Witney	OX286JS
H	Chipping Norton Health Centre	12 West Street, Chipping Norton	OX7 5AA
N	The Wychwood Surgery	Meadow Lane, Shipton under Wychwood	OX7 6BW
P	Sheep Street Surgery Burford	59 Sheep Street, Burford	OX8 4LS
Y	Broadshires Health Centre	Broadshires Way, Carterton	OX181JA
Z	Charlbury Medical Centre	Enstone Road, Charlbury	OX7 3PQ

Population

- As of mid-2016 the estimated population of West Oxfordshire was **148,200** residents.
- By 2031, Oxfordshire County Council forecasts, based on expected growth in housing, estimates the population of Cherwell will increase to **205,000** residents (+38%).
- The population of children and young people aged 0-17 is expected to increase by 22% to 4,900 residents.
- The population aged 85 and over is expected to increase by 56% between 2016 and 2031 to 1,900 residents.

Fig 5 Predicted change in population, West Oxfordshire 2015 to 2030



Health Issues

In West Oxfordshire, there was been an increase in obesity of reception age children from 5.4% to 6.7% and an increase in obesity of Year 6 children (aged 10 or 11) from 14.8% to 15.6%. In 2016 there were around 1,400 police recorded victims of domestic abuse (crime and incidents) in West Oxfordshire, an increase of 2% from the previous year.

Future needs

There is no future need for further pharmacy services within the lifetime of this PNA.

Improvement and better access

There are no suggestions for improvement or better access within the lifetime of this PNA.

Pharmaceutical need

General access

The residents of West Oxfordshire have 27 locations at which they can access pharmaceutical services. Eight (8) of these are GP dispensing practices.

The towns, which are densely populated (Witney and Chipping Norton), are served by pharmacies which are open at evenings and weekends; both these towns have 100-hour pharmacies.

Smaller towns such as Charlbury, Hanborough, Burford, and Eynsham are served by both community pharmacies and dispensing GP practices. Where dispensing GPs are in West Oxfordshire there is also the choice of at least one community pharmacy except Shipton and Hanborough.

Advance Services

Out of the 20 community pharmacies in the locality, 16 provide either the MUR service or both the MUR & NMS service. See table below.

PHARMACY NAME	PHARMACY ADDRESS	MUR /NMS		LOCATION
BOOTS UK LIMITED	18 HIGH STREET	MUR	NMS	CHIPPING NORTON
BROADSHIRE PHARMACY	BROADSHIRES HEALTH CTR	MUR	NMS	CARTERTON
C REAVLEY	124 HIGH STREET	MUR		OXFORD
CHIPPING NORTON PHARMACY	CHIPPING NORTON HTH CTR	MUR		CHIPPING NORTON
HANBOROUGH PHARMACY	56 CHURCHILL WAY	MUR		LONG HANBOROUGH
LLOYDSPHARMACY	7 BURFORD ROAD	MUR	NMS	CARTERTON
LLOYDSPHARMACY	COGGES SURGERY	MUR	NMS	WITNEY
LLOYDSPHARMACY	J.SAINSBURY STORE	MUR	NMS	WITNEY
LLOYDSPHARMACY	WINDRUSH HEALTH CENTRE	MUR	NMS	WITNEY
LLOYDSPHARMACY	64 ACRE END STREET	MUR	NMS	EYNHAM
ROWLANDS PHARMACY	NUFFIELD HEALTH CENTRE	MUR	NMS	WITNEY
THE CO-OPERATIVE PHARMACY	19 MARKET STREET	MUR	NMS	CHARLBURY
THE CO-OPERATIVE PHARMACY	6A HIGH STREET	MUR		CHIPPING NORTON
WOODSTOCK PHARMACY	24 HIGH STREET	MUR	NMS	OXFORD

PHARMACY NAME	PHARMACY ADDRESS	MUR /NMS		LOCATION
WYCHWOOD PHARMACY	WYCHWOOD SURGERY	MUR	NMS	SHIPTON-U-WYCHWOOD
YOUR LOCAL BOOTS PHARMACY	3 EDINGTON SQUARE	MUR	NMS	WITNEY

Gaps in service provision

Evening and weekend access is provided in Chipping Norton and Witney. Carterton, Burford, Bampton, Long Hanborough and Woodstock have pharmaceutical services for only parts of the weekend.

Residents of Shipton and Hanborough do not have access to pharmaceutical services either in the week during evening hours or at weekends within the immediate vicinity. The closest pharmacies available would be in Chipping Norton. See table below for calculated distances and driving times to weekend and/or evening services.

Town / village	Nearest pharmacy	Distance	Driving time
Carterton	Witney	5 miles	12 minutes
Shipton-under-Wychwood	Burford	4.3 miles	9 minutes
Burford	Witney	8 miles	12 minutes
Bampton	Faringdon	6.1 miles	10 minutes
Long Hanborough	Kidlington	6 miles	13 minutes
Woodstock	Kidlington	4 miles	8 minutes

Although residents of some of these smaller towns or villages are more than 5 miles away from access to late opening or weekend pharmaceutical services, the journey times are less than 20 minutes. West Oxfordshire is of a rural nature and residents living in this area may expect to drive a little further to access amenities.

G. Access to other NHS Services

The following NHS services may affect the need for pharmaceutical services within Oxfordshire HWB area.

Dispensing Doctors- Dispensary Services Quality Scheme (DSQS)

In addition to standard dispensing services, a dispensing doctor practice may also participate in the national DSQS. This scheme mirrors some of the clinical governance standards for staff, training and procedures which are contained in the essential services element of the contractual framework for pharmacies. It also enables dispensing doctor practices to undertake a dispensing review of use of medicines (DRUM). This is a face to face review with a patient to find out about their compliance with prescribed medicines, and aims to help identify any problems that they may be having. It is not equivalent to an MUR, but provides additional support to patients in taking their medication and can identify any issues. All but three of the dispensing doctor practices in Oxfordshire participate in the DSQS.

Hospital pharmacies

Hospital pharmacies are departments or services in a hospital responsible for the supply of medications to hospital wards as well as ambulatory patients. The department is headed by a senior pharmacist who directly supervises and ensures the correct dispensing, compounding, and distribution of medication to in and out-patients.

Oxford University Hospitals Foundation Trust (OUH) provides specialist, acute, elective and community based healthcare. It consists of four main hospitals, John Radcliffe, Churchill, Nuffield and Horton General Hospitals. Oxford Health NHS Foundation Trust provides a range of specialist mental health services in five different localities as well as physical healthcare to patients in Oxfordshire. Patients attending these, on either an inpatient or outpatient basis, may require prescriptions to be dispensed.

Personal Administration by GPs

Under their medical contract with NHS England there will be occasion when a GP practice personally administers an item to a patient.

When a patient requires a medicine or appliance, their GP will give them a prescription which they take to their preferred pharmacy. In some instances, the GP will supply the item against a prescription and this is referred to as personal administration as the item that is supplied will then be administered to the patient by the GP or a nurse. This is different to the dispensing of prescriptions and only applies to certain specified items for example vaccines, anaesthetics, injections, intra-uterine contraceptive devices and sutures.

For these items the practice will produce a prescription, however the patient is not required to take it to a pharmacy, have it dispensed and then return to the practice for it to be administered.

NHS 111

This three-digit number gives patients access to local NHS healthcare services 24 hours a day, 365 days a year. Calls from landlines and mobiles to 111 are free. The service is part of a national programme to make it easier for the public to access urgent health services.

The NHS 111 service gets the public through to a team of fully trained call advisers, who are supported by experienced clinicians. They will ask questions to assess symptoms and give healthcare advice needed or direct patients to the right local service. If they think an ambulance is required they will send one immediately – just as if the caller had originally dialed 999.

The 111 service is also available via 'Typetalk' for deaf or hard-of-hearing people on number 18001 111.

H. CONCLUSIONS

Community pharmacies in Oxfordshire are well distributed, are accessible and offer a convenient service to patients and members of the public. They are available on week days, evenings and at the weekend (often until late at night) without the need for an appointment.

Whilst there is no requirement for any new pharmacy premises to provide essential services, there are opportunities available to maximise existing and future services. Pharmaceutical services available are described within the document; additionally, information on services at each pharmacy and opening hours are available through NHS Choices.

By advertising and utilising the skills of community pharmacists, significant health improvements can be made to help reduce health inequalities.

The localities used mirror those of Oxfordshire District Councils and are consistent with Oxfordshire JSNA and PHE Locality Health Profiles. These localities are not the same as six Oxfordshire CCG Localities (an additional geography contained within the HWB area).

There is a need to provide improvements and better access for the population of Caversfield, Upper Heyford, Berinsfield, Hanborough and Shipton-under-Wychwood.

Key findings

Oxfordshire HWB determined that, whilst not all provision was necessary to meet the need for pharmaceutical services, the current provision within normal hours was likely to be necessary. This is described in more detail in locality sections identifying areas that may be considered as needing improvement or better access.

Based on the information available at the time of developing the PNA, no gaps in pharmaceutical service provision were identified and there is no need for further premises. However, there are opportunities for improvements or better access in some areas:

- Planned housing developments in Caversfield and Upper Heyford mean that an increased number of residents may have to travel further to access essential services.
- Planned housing development in Barton mean that an increased number of residents may have to travel further to access essential services in the evenings and on Sundays.
- Berinsfield, Hanborough and Shipton-under-Wychwood could be improved with better access at weekends.

I. SOURCES

Oxfordshire Joint Health and Wellbeing Strategy

<https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf>

Oxfordshire Joint Strategic Needs Assessment

<http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment>

Oxfordshire County Council

<https://www.oxfordshire.gov.uk/cms/>

Oxfordshire Clinical Commissioning Group

<http://www.oxfordshireccg.nhs.uk/>

NHS England

<https://www.england.nhs.uk/>

NHS Regulations

<https://www.legislation.gov.uk/uksi/2013/349/contents/made>

NHS Choices

<https://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10>

Google maps (accessed November 2017)

<https://www.google.co.uk/maps/@51.8200961,-1.4141377,11z>

Pharmacy Thames Valley

<http://www.pharmacythamesvalley.org.uk/>

Pharmaceutical Services Negotiating Committee

<http://psnc.org.uk/>

Oxfordshire District Council Locality Plans

https://www.oxford.gov.uk/info/20067/planning_policy/743/the_local_plan

<https://www.cherwell.gov.uk/info/83/local-plans>

<http://www.southoxon.gov.uk/news/2017/2017-10/residents-invited-comment-local-plan>

<http://www.whitehorsedc.gov.uk/services-and-advice/planning-and-building/planning-policy/new-local-plan-2031-part-1-strategic-sites>

<http://www.westoxon.gov.uk/news/general/local-plan-latest-news/>

Public Health England (PHE) Profiles

<https://fingertips.phe.org.uk/>

PHE Public Health Outcomes Framework (PHOF)

<https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

J. GLOSSARY

AUR	Appliance Use Review
CCG	Clinical Commissioning Group
C+YP	Children and Young People
CHD	Coronary heart disease
CSCSU	Central Southern Commissioning Support Unit
DAC	Dispensing Appliance Contractor
DPH	Director of Public Health
DSP	Distance Selling Pharmacy
EHC	Emergency hormonal contraception
FHSAU	Family Health Services Appeal Unit
GP	General Practice / Practitioner
HMP	Her Majesty's Prison
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LCS	Locally commissioned service
LPS	Local Pharmaceutical Services
LTC	Long term condition
MECC	Making every contact count
MUR	Medicines Use Review
NHS	National Health Service
NMS	New Medicines Service
OCCG	Oxfordshire Clinical Commissioning Group
OCC	Oxfordshire County Council
OHFT	Oxford Health NHS Foundation Trust
ONS	Office for National Statistics
OUH	Oxford University Hospitals NHS Foundation Trust
PCT	Primary Care Trust
PH	Public Health
PHE	Public Health England
PNA	Pharmaceutical Needs Assessment
QoF	Quality Outcomes Framework
SCAS	South Central Ambulance Service
TIA	Transient ischaemic attack

Clinical Commissioning Groups (CCG)

CCGs work with a range of providers to make sure that health services meet the needs of local people. They are responsible for commissioning community health services, hospital health services, health aspects of social and continuing care, GP prescribing and GP out of hours' services that local people use.

ePACT

A service for pharmaceutical and prescribing advisors which allows on-line analysis of the previous sixty months prescribing data held on NHS Prescription Services Prescribing Database.

Index or Indices of Multiple Deprivation (IMD)

The index of multiple deprivation (IMD) is a measure of multiple deprivations at Lower Super Output Area (LSOA) level. The model of multiple deprivation which underpins the IMD is based on the idea of distinct dimensions of deprivation which can be recognised and measured separately.

Joint Service Needs Assessment (JSNA)

The purpose of JSNA is to pull together in a single, ongoing process all the information which is available on the needs of our local population ('hard' data i.e. statistics; and 'soft data' i.e. the views of local people), and to analyse them in detail to identify the major issues to be addressed regarding health and well-being, and the actions that local agencies will take to address those issues.

Local Commissioned Service (LCS)

Local commissioned services address a gap in essential services or deliver higher than specified standards, with the aim of helping reduce demand on secondary care. These services expand the range of services to meet local need, improve convenience and extend choice.

Local Pharmaceutical Committee (LPC)

The local organisation for community pharmacy is the local pharmaceutical committee (LPC). The LPC is the focus for all community pharmacists and community pharmacy owners and is an independent and representative group. The LPC works locally with CCGs NHS England, LAs and other healthcare professionals to help plan healthcare services.

Office for National Statistics (ONS)

The office for national statistics (ONS) produces independent information to improve our understanding of the UK's economy and society.

Pharmaceutical Services Negotiating Committee (PSNC)

The pharmaceutical services negotiating committee (PSNC) is recognised by the Secretary of State for Health as the representative of community pharmacy on NHS matters.

K. APPENDICES

Map 1 - Pharmaceutical services and Dispensing GP Practices - Oxfordshire

Map 2 - Pharmaceutical services and Dispensing GP Practices – Cherwell

Map 3 - Pharmaceutical services and Dispensing GP Practices – Oxford

Map 4 - Pharmaceutical services and Dispensing GP Practices – South Oxfordshire

Map 5 - Pharmaceutical services and Dispensing GP Practices – Vale of White Horse

Map 6 - Pharmaceutical services and Dispensing GP Practices – West Oxfordshire

Appendix A – Steering Group Members List

Appendix B – Map index of pharmacies

Appendix C – Map index of GP dispensing practices

Appendix D – Housing Development Summary

Appendix E – Consultation feedback form

Joint Local Area Inspection of Special Educational Needs and Disabilities (SEND)

Introduction

- Between 25 September and 29 September 2017 Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of Oxfordshire to judge our effectiveness in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014 (covering children and young people aged 0 – 25).
- The [report](#) was published on December 4th and stated that the local authority and the area's clinical commissioning group are jointly responsible for submitting a Written Statement of Action to Ofsted within 70 days of the published report (March 8th). The Written Statement of Action should explain how the local area will tackle the following areas of significant weakness and be published on the SEND Local Offer within Oxfordshire County Council's public website:
 - the lack of clearly understood and effective lines of accountability for the implementation of the reforms
 - the quality and rigour of self-evaluation and monitoring and the limited effect it has had on driving and securing improvement
 - the quality of EHC plans
 - the timeliness of the completion of EHC plans
 - the high level of fixed-term exclusion of pupils in mainstream secondary schools who have special educational needs and social, emotional and mental health needs in particular.

Oxfordshire's WSoA is included in appendix 1, it has been approved by the SEND Programme Board, published on the Local Offer and sent off to Ofsted for ratification.

National context

- The first local area SEND inspections took place in May 2016. By May 2017, Ofsted and CQC had completed 30 inspections. Just under a third of the local areas inspected (nine) were required to provide a written statement of action. The Ofsted and CQC report '[Local area SEND inspections: one year on', October 2017](#) highlights the main findings from the first 30 inspections. The first three key findings are:
 - Children and young people identified as needing SEND support had not benefited from the implementation of the Code of Practice well enough.
 - Children and young people who have SEND were found to be excluded, absent or missing from school much more frequently than other pupils nationally.
 - School leaders had used unofficial exclusions too readily to cope with children and young people who have SEND.

There have been 10 inspections between September and December 2017 and 7/10 have been required to produce a Written Statement of Action.

Actions taken in response to Oxfordshire's joint inspection

- Since the inspection there has been an opportunity to reflect and begin to implement the learning from the experience. The spot light on SEND has raised the importance of the

area's joint responsibilities and emphasised how austerity measures have been impacting on Oxfordshire's ability to deliver the SEND reforms. A further review of the use funding will drive improvements to processes alongside the post Ofsted action

- The Programme Board overseeing the implementation has been refreshed and is now chaired by the Cabinet member for Public Health and Education, Councillor Hilary Hibbert-Biles, and reports to the Children's Trust and this Board. There is strengthened internal governance from health through to the OCCG Quality Committee, and children and adult social care reporting on SEND to senior management teams.
- Some additional resources have been assigned to strengthen services and provision for children and young people with SEND to enable the local area to fulfil its duties. These includes additional staffing for the SEN casework team, more educational psychologists and a permanent Designated Clinical Officer for SEND, funded by OCCG. Additional resources to address the pressures in children's and adult social care services are also being explored, as well as an ICT case management system to improve processes and transparency for Education, Health and Care plans.
- Services have been evaluating processes, guidance for staff , quality assurance measures and making immediate improvements. An e-learning course on Education, Health and Care Plans has been produced and went live in January to support work force developments, and the Council for Disabled Children are providing multi-agency training in May.

Progress

- In terms of progress in relation to Education, Health and Care plans, Oxfordshire is on track to complete all transfers of statements to Education, Health and Care plans (EHCP) by the statutory timeframe of March 31st (approximately 2,700 plans). Also all early years and primary to secondary EHCPs have been completed by the statutory timeframe of February 15th. Education, Health and Care plans are being sampled each week for quality assurance and there has been a 20% improvement since October.
- A performance dashboard containing targets across education, health and care is being developed and will be monitored monthly by the SEND Programme Board.

Risks

There are a number of risks identified with meeting the ambitious plan outlined in the WSoA. Risk management and mitigation will be managed on a multi-agency basis by the SEND Programme Board. Key risks to note include:

- Lack of capacity in CEF to meet demand and workload
- Lack of effective strategy and incomplete service restructure to provide efficient working practices
- Schools fail to cooperate with reforms and initiatives to improve inclusive practice.
- Failure to provide sufficient support and placements results in further exclusion
- Poor uptake on training resulting in slow progress with improving the quality of plans and therefore improving outcomes for children.
- Progress on reducing fixed term exclusions for children with SEND is slow because schools will struggle to address issues of inclusion and behaviour support within existing budgets.

- Waiting times for some services will increase, despite remedial action plans, as a result of recruitment difficulties across some specialisms e.g psychologists.

A risk register is being developed and will be presented to the SEND Programme board every month.

Conclusion

The board is recommended to consider the outcomes of Oxfordshire's inspection and its responsibilities in relation to the joint area accountability for the delivery of the Written Statement of Action.

Appendix 1 Written Statement of Action

Janet Johnson, Strategic Lead for Vulnerable Learners 08/03/18

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Oxfordshire Local Area Written Statement of Action for Special Educational Needs and Disabilities (SEND)

As local leaders we are committed to pursuing improvements for children and young with special educational needs in order to improve their lives and life chances. Our driving ambition is to provide support to children and families earlier to ensure better outcomes and to prevent escalation of their needs where possible. We want children and young people with SEND and their families to feel supported by all services and to receive high quality education, care and health provision. The Written Statement of Action outlines how Oxfordshire plans to do this.

Lucy Butler, Director for Children's Services, Oxfordshire County Council and Sula Wiltshire Director of Quality/Lead Nurse, Oxfordshire Clinical Commissioning Group

Purpose of this statement

Between 25 and 29 September 2017, Ofsted and the Care Quality Commission (CQC) jointly inspected the effectiveness of Oxfordshire's approach to implementing the special educational needs and disability (SEND) reforms as set out in the Children and Families Act 2014. The specific focus was on how the local area identifies the aspirations and needs of children and young people with SEND, meets those needs, and improves their education, health and care outcomes.

As a result of the inspection findings, Her Majesty's Chief Inspector (HMCI) determined that a Written Statement of Action is required to address **five** areas of significant weakness in Oxfordshire's practice:

- A.** the lack of clearly understood and effective lines of accountability for the implementation of the reforms
- B.** the quality and rigour of self-evaluation and monitoring and the limited effect it has had on driving and securing improvement
- C.** the quality of Education, Health and Care Plans
- D.** the timeliness of the completion of Education, Health and Care Plans
- E.** the high level of fixed term exclusion of pupils in mainstream secondary schools who have special educational needs and social, emotional and mental health needs in particular.

Oxfordshire County Council (OCC) and the Oxfordshire Clinical Commissioning Group (OCCG) are jointly responsible for submitting the written statement. The statement of action sets out:

- Our vision for improvement and the values that will drive the required change;
- The governance structure to provide strategic oversight of improvements;
- The high priority actions we will take to address the weaknesses identified by inspectors and to work towards continuous improvement.

In addition, we include:

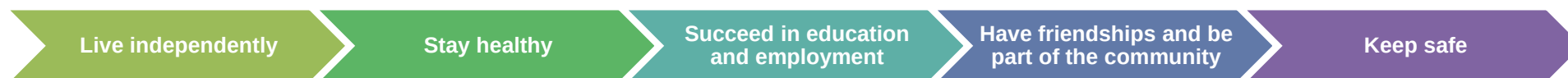
- The framework we will use to measure our performance;
- The governance structure to provide strategic oversight of improvements.

1. Our Vision and Commitments

Oxfordshire's vision for children and young people with SEND is –

“Oxfordshire, a great place to grow up and have the opportunity to become everything you want to be”

All children and young people should be able to achieve the best possible outcomes that enable them to lead successful and happy lives. Our aim is to ensure an equality of opportunity for children and young people with a Special Educational Need and/or Disability (SEND). To ensure this we are committed to raising the expectations and aspirations of all children and young people with SEND aged 0-25 so they can:



Our work will be shaped by a set of core principles to make sure everything we do is in keeping with our vision, the SEND Reforms and the Care Act 2014. These principles will drive our improvement programme. We commit to:

1. **Listen** to the views, wishes and feelings of the children, young people and their families
2. **Enable** children, young people and their parents/carers to participate as fully as possible in decisions about their lives and to work collaboratively with them
3. **Support** children, young people and their parents/carers to develop and achieve the best possible outcomes that effectively prepare them for adulthood

2. Governance (see Annex A)

The **Health and Wellbeing Board** - chaired by the Leader of the Council, provides strategic leadership for health and wellbeing across the county, ensuring integration and partnership work between the county council, public health and NHS services – will ensure that action is taken to realise this plan.

The **Children's Trust** - chaired by the Council's Lead Member for Children's Services and comprising the Lead Member for Education and Public Health, the Director of Children's Services, the Deputy Director for Joint Commissioning, the Oxfordshire CCG, health providers, school leaders, parent carers and range of partner organisations – will continue to provide strategic oversight of priorities for all children and young people in Oxfordshire, including support for children and young people with SEND.

The **SEND Programme Board** – Chaired by the Lead Member for Education and Public Health and comprising a range of education, health and social care leaders, and parent carers - will provide formal oversight of the local area's progress addressing the areas of weakness in this Statement. It will review progress monthly and hold to account the organisations responsible for improving outcomes.

Progress on the operational delivery of the actions in this Statement will be monitored by the **SEND Operations Group** with reporting processes and structures described above.

Senior leaders and Members will also be held accountable for progress by the Council's **Education and Performance Scrutiny Committees** and the **Oxfordshire Clinical Commissioning Group Board**.

A governance chart is included in Annex A.

3. What we are aiming to achieve

The actions outlined in this plan are directly linked to the five areas of weakness identified by inspectors. The outcomes we are seeking to achieve are:

- A. Oxfordshire has effective arrangements for holding leaders to account across education, health and social care through the SEND Programme Board, Children's Trust, Adults with Care and Support Needs Joint Management Group, Health and Wellbeing Board,

Oxfordshire Scrutiny Committees and the Oxfordshire Clinical Commissioning Group Board.

There are robust levels of challenge and support to agencies delivering the reforms, commitment from elected members and senior leaders and well understood routes of escalation that lead to practical changes and improve outcomes for children and young people with SEND.

- B. Oxfordshire's self-evaluation is sufficiently detailed to ensure rapid and sustained improvement in highlighted areas of weakness. Self-evaluation gives due regard to the wishes and feelings of the child, parents and family. Performance information gives a clear understanding of the impact of work on improving the effectiveness of services.
- C. Education, Health and Care Plans that meet the special educational needs of each child or young person, to secure the best possible outcomes for them across education, health and social care and, as they get older, prepare them for adulthood. EHC needs assessments and plans will:
- establish and record the views, interests and aspirations of the parents and child or young person
 - provide a full description of the child or young person's special educational needs and any health and social care need
 - establish outcomes across education, health and social care based on the child or young person's needs and aspirations and help to prepare them for adulthood.
 - specify the provision required and how education, health and care services will work together to meet the child or young person's needs and support the achievement of the agreed outcomes
 - use person-centred approaches, transparent systems and decision-making processes with clear lines of governance involving Education, Health and Care.
- D. Improved timeliness of Education, Health and Care Plans in line with targets below and in conjunction with actions relating to improving quality. *(At the time of inspection performance was 35%)*

Timeframe (new plans started in March)	% of EHC Plans completed within 20 weeks
June 2018	50%
Sep 2018	60%
Dec 2018	70%
March 2019	80 %
June 2019	90%
September 2019	100%

- E. Reduce fixed term exclusions in secondary schools for students with SEND and with Social, Emotional and Mental Health (SEMH) by 30% by December 2018. In 2016-17 2,905 days of education were lost due to fixed term exclusions of young people with SEND in Oxfordshire secondary schools; young people with SEMH needs accounted for 1,569 of those days. A 30% reduction will mean young people with SEND attend school for 871 more days in 2017-18.

4. Action plan to address the areas of weakness identified during the inspection

This section details the **priority actions** we will take to address the areas of significant weakness identified during the inspection.

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A. The lack of clearly understood and effective lines of accountability for the implementation of the reforms					Progress			
Outcome we are seeking to achieve: - Oxfordshire has effective arrangements for holding leaders to account across education, health and social care through the SEND Programme Board, Children’s Trust, Adults with Care and Support Needs Joint Management Group, Health and Wellbeing Board, Oxfordshire Scrutiny Committees and the Oxfordshire Clinical Commissioning Group Board. - There are robust levels of challenge and support to agencies delivering the reforms, commitment from elected members and senior leaders and well understood routes of escalation that lead to practical changes and improve outcomes for children and young people with SEND.					Green – Completed / embedding Amber – Progressing Red – Little or no progress			
Required outcomes	Actions	Timescale	Action owner /Accountable leader	Measures of success	Mar 2018	Jun 2018	Sep 2018	Dec 2018
1. Clear line of governance from the SEND Programme Board to the Children’s Trust, Adults with Care and Support Needs Joint Management Group and Health and Wellbeing Board.	Report on SEND progress at the Health and Wellbeing Board	Annually Next meeting date: 22 March 2018	Director of Children’s Services, Director for Adult Services, Director of Quality and OCCG Lead Nurse Chair of the SEND Programme Board	Priorities for children and young people with SEND are included in the Joint Health and Wellbeing Board Strategy (from July 2018) Specific focus on SEND annually at the Health and Wellbeing Board meeting.				
	Report on SEND progress at the Children’s Trust Board at each meeting.	Quarterly	Strategic lead for Vulnerable Learners OCC	Regular performance reporting to the Trust and appropriate				

		Next meeting date: 28 March 2018	Chair of the SEND Programme Board	escalation of issues to the Health and Wellbeing Board. Priorities focused on children and young people with SEND in the Children's Plan. Views of children and young people with SEND represented through Voices of Oxfordshire Youth (VOXY) is captured in the Children's Plan.			
	Report on SEND progress to the Adults with Care and Support Needs Joint Management Group	Bi-annually Meeting dates: 29 March 2018 & 20 Sept 2018	<i>Deputy Director for Adult Services</i> Chair of the SEND Programme Board	Bi-annual progress reporting to the Adults with Care and Support Needs Joint Management Group and appropriate escalation of multi-agency issues to the Health and Wellbeing Board.			
2. Strategic oversight of SEND across education, health, children's and adult social care.	Refresh SEND Programme Board terms of reference	March 2018	<i>Vulnerable Learners Development Manager</i> Chair of the SEND Programme Board	Terms of reference agreed and reviewed annually. Challenge and support to the agencies improving the delivery of the SEND reforms.			
	Schedule monthly meetings for the SEND Programme Board	Monthly	<i>Vulnerable Learners</i>	Good attendance by senior managers.			

			<i>Development Manager</i> Chair of the SEND Programme Board	Regular reporting and appropriate escalation of issues to Children's Trust.			
	Progress is monitored by the Pooled Budget Officers Group working to the Adults with Care and Support Needs Joint Management Group	17 April 2018 & 21 Aug 2018	<i>Integrated Locality Team Manager</i> Deputy Director for Adult Services/ Deputy Director Joint Commissioning	Quarterly highlight reports.			
	Report performance to the OCCG Quality Committee (sub-group of Board).	April 2018	<i>Designated Clinical Officer</i> Lead Commissioner Children's OCCG	Permanent Designated Clinical Officer in place by April with oversight of the SEND reforms across health service for the 0 – 25 age range, reporting to the OCCG Quality Committee.			
	Report performance and progress to Children, Education and Families Directorate Leadership Teams, Children's Management Team, and Children's Services Members Briefing.	Quarterly, starting April 2018	<i>Senior officers in children's social care</i> Director of Children's services & Director for Adult Services	Timescales and quality of EHCPs reported monthly, appropriate support and challenge to and from senior managers.			
	Report performance and progress to Strategic	Strategic Transitions	<i>Area Service Manager</i>	The number of plans finalised by 31 March prior to transfer to			

	Transitions Group, Adult Services Directorate Leadership Team, and Adult Services Members Briefing.	Group – Bi-monthly Quarterly, starting April 2018	Deputy Director for Adult Services	post 16 increases from 35% (2017) to 45% (2018) and above 60% by March 2019. Achieving targets for improved timescales for Education Health and Care Plans (reported quarterly). Support and challenge to and from senior managers recorded in minutes.				
3. Visibility and scrutiny of SEND at Education Scrutiny, Performance Scrutiny and Joint Health Overview and Scrutiny.	Regular performance reports on progress implementing the SEND action plan.	Education Scrutiny – 27 May 2018 Performance Scrutiny Committee - 24 May 2018 Health Overview and Scrutiny Committee – 19 Apr 2018	<i>Deputy Director Education & Deputy Director for Adult Services, Director of Quality, OCCG</i> Scrutiny Chairman	Officers and members held to account for progress on the SEND reforms Minutes record recommendations and scrutiny of SEND items.				

Page 342	4. Regular communications across education, health and care services, as well as parents and parent organisations	Monthly communication following each SEND Programme Board	Monthly	<i>Vulnerable Learners Development Manager</i> Chair of SEND Programme Board	You said/we did style communications published on the local offer and distributed to key service areas and parent organisations – first report published by March 2018. Increased influence of the Parents Forum through attendance at the appropriate strategic board			
		Use Practice week to gain feedback from parents.	6 monthly Next date: 8 May 2018	<i>Deputy Directors for Education and Social Care</i> Director of Children's Services	Feedback from parents highlights that the action plan is making a difference to parental experiences.			

B. The quality and rigour of self-evaluation and monitoring and the limited effect it has had on driving and securing improvement					Progress			
Outcomes we are seeking to achieve: - Oxfordshire’s self-evaluation is sufficiently detailed to ensure rapid and sustained improvement in highlighted areas of weakness. - That self-evaluation gives due regard to the wishes and feelings of the child, parents and family. - Performance information gives a clear understanding of the impact of work on improving the effectiveness of services.					Green – Completed / embedding Amber – Progressing Red – Little or no progress			
Required outcomes	Actions	Timescale	Action owner/ Accountable leader	Measures of success	Mar 2018	Jun 2018	Sep 2018	Dec 2018
1. Benchmark effectiveness of health approach to SEND reforms, identify areas of risk and develop an improvement plan.	Complete the Council for Disabled Children self-evaluation.	March 2018	Designated Clinical Officer Lead Commissioner Children’s, OCCG	Improvement plan that is co-produced with parents in place to address areas for development.				
2. Improve sharpness of self-evaluation including evaluation of performance	Develop performance dashboard with regular analysis and monitoring of performance against targets.	April 2018 Monthly analysis	Performance & Information Manager Chair of SEND Programme Board	Internal monthly monitoring of performance by Directorate Leadership Team and SEND Programme Board SEND priorities and performance indicators included in new Children’s Plan (2018). Parents will know and understand the reason for performance trends.				

	Refresh individual agency action plans and ensure coherence with this statement of action.	April 2018	<i>Area Service Manager Adult Services, Disabled Children's Manager for Social Care, SEN Casework Manager, Designated Clinical Officer</i> Deputy Director Children's Social Care, Deputy Director Adult Services	Individual agency action plans monitored and evaluated by appropriate senior management teams.			
	Refresh SEND action plan based on annual self-evaluation for sign off by the board in March 2019.	March 2019	<i>Strategic Lead for Vulnerable Leaders</i> Chair of SEND Programme Board	Refreshed SEND action plan approved by the SEND Programme Board, and reported to the Children's Trust and Health and Wellbeing Board.			
3. Co-production strengthens service improvement.	Complete a multi-agency mapping of all current co-production mechanisms	May 2018	<i>Lead Commissioner Children's</i> Deputy Director Joint Commissioning	Clear and streamlined mechanisms for listening to parents and carers to avoid duplication and confusion.			

	Work with Parent Carer organisations to look at promoting parental feedback through a single multi-agency mechanism	May 2018	<i>SEN Improvement Manager / Designated Clinical Officer / Disabled Children's Service Manager</i> Strategic Lead for Vulnerable Learners	Learning from parental feedback is used to improve practice (you said/we did approach) Parental survey results demonstrate increased levels of satisfaction. Parent forum representation at strategic level				
	Work with the Commissioning Co-Production team to build co-production and co-evaluation into the commissioning of services for SEND	June 2018	<i>Co-production lead</i> Deputy Director Joint Commissioning	Demonstrable examples where co-production has improved services and commissioning for young people with SEND.				
	Work with Voices of Oxfordshire Youth (VOXY) to look at capturing and feeding back children and young people's views through a clearly defined mechanism Build feedback from parents, carers, children and young people into the SEND dashboard, so that leaders know what changes are making a difference.	April 2018	<i>Engagement team / Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	The views of different groups of children and young people are listened to and acted upon.				

4. An effective multi-agency improvement plan for EHCPs owned by all stakeholders.	Refresh the EHCP improvement plan and work streams and ensure ownership by education, health, children and adults social care	June 2018	<i>SEN Improvement Manager, Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	Outcomes for children and young people are improved as a result of their EHCP. Evidenced from monthly monitoring of plans. Whole children's workforce understanding of how they contribute to EHC planning is improved, evidenced by feedback to E-learning and multi-agency training				

C. The quality of Education, Health and Care Plans					Progress			
Outcome we are seeking to achieve: Education, Health and Care Plans that meet the special educational needs of each child or young person, to secure the best possible outcomes for them across education, health and social care and, as they get older, prepare them for adulthood. EHC Plan assessments will: • establish and record the views, interests and aspirations of the parents and child or young person*, • provide a full description of the child or young person's special educational needs and any health and social care needs, • establish outcomes across education, health and social care based on the child or young person's needs and aspirations, and help to prepare them for adulthood. • specify the provision required and how education, health and care services will work together to meet the child or young person's needs and support the achievement of the agreed outcomes • use person-centred approaches, transparent systems and decision-making processes with clear lines of governance involving Education, Health and Care. <i>This was recognised as a strength by inspectors.</i>					Green – Completed / embedding Amber – Progressing Red – Little or no progress			
Required outcomes	Actions	Timescale	Action owner / Accountable leader	Measures of success	Mar 2018	Jun 2018	Sep 2018	Dec 2018
1. Education, health and care needs are accurately identified	Ensure social care advice for EHCPs for professionals from either universal services, or early help professionals or statutory social care teams reflect child/young person's current care needs. Revise and share adult social care template with relevant staff,	May 2018	Disabled Children Team Manager, Children's Social Care Team Manager, Adult Social Care Team Manager Deputy Director for Children's and Adult Social Care	Case sampling of EHC plans every two months show improvement (numbers of plans deemed effective) in the identification of needs across all agencies. Weekly case sampling indicates a gradual improvement in the identification of needs, through audit scores.				

	including guidance and exemplar plans. Ensure social care advice, forms from OCC early help or statutory social care workers are signed off by Team Managers.			Feedback from parents and children and young people indicates that they are getting the right outcomes as a result of the plan. This will be measured by an annual SENDIASS survey.				
	Map and review current approaches across health organisations Agree standardisation and a common approach for all health reports.	May 2018	<i>Designated Clinical Officer</i> Lead Commissioner Children's, OCCG	Common approach adopted across health providers for the identification of children with SEND. Pathway for the EHCP process (assessment, to final plan, to annual review) is embedded within Oxfordshire health services. Evidence of Designated Clinical Officer support and challenge to health services to ensure a standardised approach. Reports are comprehensive, relevant and current as evidenced through the SEND case sampling audit process, weekly review of 6 plans by SEND manager and feedback from service users through surveys.				

	Clarify what is acceptable as 'up to date' information to be included in reports to capture the current level of need and what constitutes health information.	June 2018	<i>SEN Manager, Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	Guidance on appropriate and relevant information for reports for all agencies is available.			
	Support secondary schools to include assessment information covering the full curriculum, including vocational elements.	June 2018	<i>Principal Educational Psychologist</i> Strategic Lead for Vulnerable Learners	Schools follow the revised guidance about information that they need to include in an application and then in a report for an EHCP. Wider academic and vocational needs are identified in education assessment information evidenced from quality assurance processes.			
	Provision to meet needs is specific, quantified and is outcome focused. Support health staff to appropriately specify provision in reports. Produce guidance and exemplars for health professionals to ensure they are carrying out their statutory duties in regard to specifying provision. Capture families' views on whether the health needs are being met by the provision identified in EHC plans.	June 2018	<i>Designated Clinical Officer</i> Lead Commissioner Children's, OCCG	EHC plans contain relevant and appropriate health provision that corresponds to the child's identified needs and outcomes identified. Demonstrable examples of feedback from families about improved information on health provision included in EHC plans. Accolades from service users to demonstrate effectiveness.			

	Review current participation work being carried out by health services via Health task group							
	Social care staff to ensure provision is specified in EHC plans	June 2018	<i>Disabled Children Manager & Integrated Locality Team Manager</i> Deputy Directors of Children and Adult Social Care	EHC plans consistently contain relevant care provision as identified from the child/ young person's needs. Children and Adult social care staff guidance reissued with examples of good practice on what constitutes the 'care' element of an EHCP				
	Review specificity of education provision, examining contributions from SEN teams and schools	June 2018	<i>Principal Education Psychologist</i> Strategic lead for Vulnerable Learners	Guidance and exemplars based on best national practice disseminated to SEN teams and on Schools News. Quality of plans improves evidenced by monthly quality assurance reports.				
3. Clear outcomes linked to needs and aspirations	Re-issue and improve guidance for all staff on what constitutes a good outcome, including outcomes relating to preparation for adulthood. Move the 'Writing the Outcomes' meeting to within the six-week information gathering stage of	May 2018	<i>SEN Manager, Principal Educational Psychologist, Disabled Children Manager & Integrated Locality Team Manager</i>	As evidenced from the quality assurance process: - Plans with SMART outcomes that support a holistic assessment and support plan that is aspirational and outcome focused into adulthood. - Plans include broad range of outcomes				

	the EHC assessment to ensure that provision is relevant to the desired outcomes.		Strategic lead for Vulnerable Learners	Each outcome is tracked to needs (sections B, C & D of the Plan) and provision (F/G, H1 & H2 sections) - Education outcomes reflect interests and progress for adult life, including broader academic and/or vocational outcomes.			
	Review the EHC plan format and align partner templates to ensure assessment information is clearly presented.	April 2018	<i>SEN Manager, Principal Educational Psychologist Designated Clinical Officer, Integrated Locality Team Manager</i> Strategic Lead for Vulnerable Learners	Revised template agreed by the EHCP Task Group. Format is informed by best practice and national guidance. Fit for purpose multi-agency guidance disseminated across teams.			
	Co-produce guidance with parents for all staff on what constitutes a good outcome, including outcomes relating to preparation for adulthood.	May 2018	<i>SEN Manager, SENDIASS manager, Principal Educational Psychologist Designated Clinical Officer, Integrated Locality Team Manager</i> Strategic Lead for Vulnerable Learners	Guidance produced and published on the Local Offer			

	Review the annual review process to ensure that it effectively captures progress made in achieving outcomes. Align the Adult Social Care and SEND review cycles where possible to ensure outcome focused reviews are achieved annually.	April 2018	<i>SEN Manager, Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	Feedback from parents and children and young people indicates that their views and wishes are respected and acted on in the annual review process, evidenced by annual review survey and through engagement with Parent Forum.			
	Develop a systematic process for measuring progress towards outcomes at an individual level and a process to monitor progress for all children with EHC Plans in achieving their outcomes.	July 2018	<i>SEN Manager, Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	Record maintained of whether there has been progress towards outcomes following annual review. Systematic approach in place to monitor whether outcomes are being achieved for all children and young people with EHCPs.			
4. Quality assurance processes are embedded	Create a framework of quality markers for EHC plan quality assurance.	April 2018	<i>SEN Manager, Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	Monthly reports for managers and the SEND Programme Board on the quality and timescales reflect improvements. Reduction in complaints and appeals.			
	Review 6 plans per week and gradually integrate into SEN casework team management responsibility over time.	Weekly	<i>SEN Manager</i> Strategic Lead for Vulnerable Learners	Accessible integrated data on the quality of EHC assessments.			

	Increase frequency of multi-agency audits from 6 monthly to every 2 months.	March 2018	SEN Manager, Principal Educational Psychologist, Disabled Children Manager & Integrated Locality Team Manager Strategic Lead for Vulnerable Learners	Learning from audits carried out every two months captured in single agency action plans and shared in a timely manner.			
	Increase the frequency of the EHCP Task Group meetings to every 6 weeks.	March 2018	SEN Manager, Principal Educational Psychologist, Disabled Children Manager & Integrated Locality Team Manager Strategic lead for Vulnerable Learners	Minutes show solution focused and strong multi-agency working.			
5. Statutory decision-making process (EHCP) is transparent	Review statutory decision-making panels, processes and review forums.	July 2018	SEN Manager, Disabled Children Team Manager, /Designated Clinical Officer Strategic Lead for Vulnerable Learners	Revised decision-making processes published on the Local Offer. Parents and all other agencies are clear when decisions are made and which panel made them.			

				Clear Terms of reference, and governance for decision making are published and available on the Local Offer				
	Provide training for all partner services on decision-making processes.	Sep 2018	<i>SEN Manager, Disabled Children Team Manager, /Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	Service users and families have a better experience measured by fewer complaints and appeals. Decisions are made in a timely manner as evidenced from the QA processes.				
	Review decision-making processes during transition to adulthood, including a process mapping exercise to develop the transition pathway between children's and adults.	April 2018	<i>Integrated Locality Team Manager Designated Clinical Officer, SEN Manager, Social Care Service managers</i> Deputy Director Adult Social Care	The number of plans finalised by 31 March prior to transfer to post 16 increases from 35% (2017) to 45% (2018) and above 60% by March 2019. Streamlined decision-making process understood by staff resulting in fewer complaints				
	Develop and implement a joint dispute resolution process informed by national best practice models	May 2018	<i>SEN Manager, Disabled Children Team Manager, Integrated Locality Team Manager, Designated Clinical Officer</i>	Fewer disputes (below national average) progress to the new single point of redress tribunals (starting April 2018)				

			Strategic Lead for Vulnerable Learners				
6. The workforce can confidently and competently contribute to quality EHC assessments and plans	Review capacity within existing teams to meet the improvement targets for quality and timeliness of plans.	April 2018	<i>SEN Manager, Disabled Children Manager & Integrated Locality Team Manager, Designated Clinical Officer</i> Directors for Children's and Adult Services	Staffing capacity and structures have been reviewed and revised to ensure that improvement targets can be met across education, health and social care.			
	Review the casework team to ensure sufficient confidence and competencies, and that tasks are completed by the right person at the right time.	April to Sep 2018	<i>SEN Manager, Disabled Children Manager & Integrated Locality Team Manager, Designated Clinical Officer</i> Directors for Children's and Adult Services	A SEN casework team that is sufficiently operationally robust to deliver the actions within this plan. The SEN casework re-structure is developed in line with new IT systems capabilities. Consistent quality of EHC plan, both outsourced and in house.			
	Roll out e-learning training for all staff across agencies inputting into EHC assessments.	May 2018	<i>Disabled Children Manager & Integrated Locality Team Manager,</i>	300 staff trained by May 2018 Included within mandatory training for new staff. Monthly monitoring reports and			

			<i>Designated Clinical Officer</i> Deputy Directors for Children's and Adult Social Care.	Qualitative feedback, using assistant Educational Psychologist, show impact on practice			
	Ensure central government commissioned guidance informs strategy, policy and working practices.	Sep 2019	<i>SEN Manager, Disabled Children Team Manager, Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	CDC's Securing good quality health and social care advice for education, health and care (EHC) plans is used to update guidance for staff.			
	Provide multi-agency training for professionals working on personalisation and writing outcomes.	May 2018	<i>SEN Manager, Disabled Children Team Manager, Integrated Locality Team Manager, Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners <i>SEN</i>	Good multi-agency attendance and feedback from the Council for Disabled Children training, (North, Central, South) in April/May as evidenced by attendance registers and evaluations. Surveys and feedback from professionals show increasing awareness.			
	Provide bespoke training for health teams.	Sept 2018	<i>Designated Clinical Officer</i> Lead Commissioner Children's, OCCG	Good attendance and positive evaluations of learning gained.			

	Encourage and monitor attendance at South East regional events.	Dec 2018	<i>SEN Manager/ Disabled Children Team Manager / Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners	Evidence of learning being shared and cascaded to relevant professionals. Surveys and feedback from professionals show increasing awareness.				

D. Timeliness of completing Education, Health and Care Plans	Progress

Progress

Outcome we are seeking to achieve:

- Improved timeliness in line with targets below and in conjunction with actions in section C relating to quality.

Timeframe (new plans started in March)	% of EHC Plans completed within 20 weeks
June 2018	50%
Sep 2018	60%
Dec 2018	70%
March 2019	80 %
June 2019	90%
September 2019	100%

Green – Completed /
embedding
Amber – Progressing
Red – Little or no progress

Required Outcomes	Actions	Timescale	Action owner / Accountable leader	Measures of success	Mar 2018	Jun 2018	Sep 2018	Dec 2018
Timeliness of EHCPs improves in line with targets above.	Identify source of delays across all relevant professionals participating in the assessment process	April to June 2018	SEN Manager, Disabled Children Team Manager Integrated Locality Team Manager / Designated Clinical Officer Strategic Lead for Vulnerable Learners	Members of the Education, Health and Care Task group understand the issues causing delays. Actions to improve performance are recorded in single agency action plans.				
	Accurate data supporting monthly EHCP dashboard to enable support and challenge by managers.	April 2018	SEN Manager, Performance Information Manager and SEN	Actions to improve performance are recorded in single agency action plans				

			<i>Business Support team</i>				
	Report EHCP key performance indicators to the SEND programme board	Monthly, starting April 2018	<i>Performance Information Manager and SEN Business Support team</i>	Support and challenge from board members to drive improvements in line with targets.			
2. Education, health and social care reports produced within 6 weeks	Improve communications and processes with Social Care and Health professionals.	June 2018	<i>SEN Improvement manager, Social Care Service Managers, Designated Clinical Officer</i>	High quality assessments with full engagement of young person and family completed within 6 weeks of referral, evidenced through weekly sampling of plans.			
	Weekly reporting on 6 week reports to DCO, social care and Education Psychologists	April 2018	<i>SEN Business Support team</i> SEN Manager	Monthly reporting to the SEND Programme Board show improvements in 6 week timescales.			
	Implement solutions for improving the 6 week timescale in accordance with single service action plans	April 2018	<i>Principal Educational Psychologist, Disabled Children Team Manager Integrated Locality Team Manager</i>	Timescales improve in line with targets for education, health and care.			

			<i>/Designated Clinical Officer</i> Strategic Lead for Vulnerable Learners				
3. Timely completion of plans at transition from primary to secondary education and to adulthood.	Report key performance indicators to Strategic Transition Programme Board.	Every 2 months, starting March 2018	<i>Senior Information Analyst</i> Deputy Director for Children's Social Care.	The number of plans finalised by 31 March prior to transfer to post 16 increases from 35% (2017) to 45% (2018) and above 60% by March 2019.			
	Track young people likely to need an assessment for adult social care and health services and ensure they are followed up.	Every 2 months, starting March 2018	<i>Senior Information Analyst</i> Disabled Children Manager & Integrated Locality Team Manager	Moving into Adulthood performance dashboard reported to the Strategic Transitions Board every 2 months.			
	Publish information to parents about how to access a social care assessment if they think their child may be Care Act eligible at age 18.	June 2018	<i>Disabled Children Manager & Integrated Locality Team Manager</i> Strategic lead for Vulnerable Learners	Parents have a better understanding of eligibility criteria for adult social care, evidenced from feedback from parent groups.			
	Begin year 6/7 transfer processes earlier, promoting best practice to schools, including year 5 reviews for those likely to require specialist provision.	October 2018	<i>SEN Manager</i> Strategic Lead for Vulnerable Learners	The number of year 6 /7 transfers completed by Feb 15 th is 95% in 2019. Countywide transition protocol developed.			

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				Good practice standard established to set expectations.			
4. Timely completion of response to Annual review reports	Revise processes and guidance on Annual Reviews to enable appropriate prioritisation and response.	May 2018	<i>SEN Manager</i> Strategic Lead for Vulnerable Learners	Feedback from parents and children and young people indicates that they are getting the right outcomes as a result of the plan. This will be measured by an annual SENDIASS survey.			
	Develop performance framework for annual reviews	June 2018	<i>SEN Manager</i> Strategic Lead for Vulnerable Learners	Improved timeliness of annual reviews Improved feedback from parents, survey returns following annual reviews and annual survey from SENDIASS and Parents Forum.			
Improve case management processes and transparency for parents and young people through the deployment of improved IT systems	Invite demonstrations from Liquid Logic, Capita and Open Objects	March 2018	<i>SEN Manager</i> ICT Business Service Manager	Multi-agency representatives attend presentations and comments on strengths and weaknesses.			
	Write business case for recommended IT case management solution.	April 2018	<i>ICT Business Service Manager</i> Director for Children's Services	A decision is made on an IT system to improve efficiency and a 'digital first' approach for parents and young people. Implementation plan developed.			

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E. The high level of fixed term exclusion of pupils in mainstream secondary schools who have special educational needs and social, emotional and mental health needs in particular					Progress			
Outcome we are seeking to achieve: - Reduce fixed term exclusions in secondary schools for students with SEND and with Social, Emotional and Mental Health (SEMH) needs by 30% by December 2018. In 2016-17 2,905 days of education were lost due to fixed term exclusions of young people with SEND in Oxfordshire secondary schools; young people with SEMH needs accounted for 1,569 of those days. A 30% reduction will mean young people with SEND attend school for 871 more days in 2017-18. - Reducing fixed term and permanent exclusions is a priority for Oxfordshire and a programme of work is underway to tackle the issues. The target aims to reduce the rate of fixed term exclusion in secondary schools to be lower than the statistical neighbour average by 2020. This plan details actions that specifically relate to young people with SEND, and those with SEMH in particular.					Green – Completed / embedding Amber – Progressing Red – Little or no progress			
Required outcomes	Actions	Timescale	Action owner/ Accountable Leader	Measures of success	Mar 2018	Jun 2018	Sep 2018	Dec 2018
Effective oversight of exclusions of children and young people with SEND by senior leaders, the Children’s Trust and Oxfordshire Safeguarding Children Board (OSCB).	Review of exclusions carried out by Education Scrutiny working group.	October to March 2018	<i>Deputy Director for Education</i> Education Scrutiny Committee Chairman,	Education Scrutiny’s exclusions working group to report to the committee on 14 March with their findings and recommendations - learners with SEND are covered in the report.				
	Report performance to the Performance and Quality Assurance Group (PAQA), and OSCB Education sub group, including data on learners with SEND.	Next meeting: 28 Mar 2018	<i>Performance and Information team</i> PAQA Chairman	OSCB Performance and Quality Assurance Group minutes record comments and actions to hold senior managers to account.				

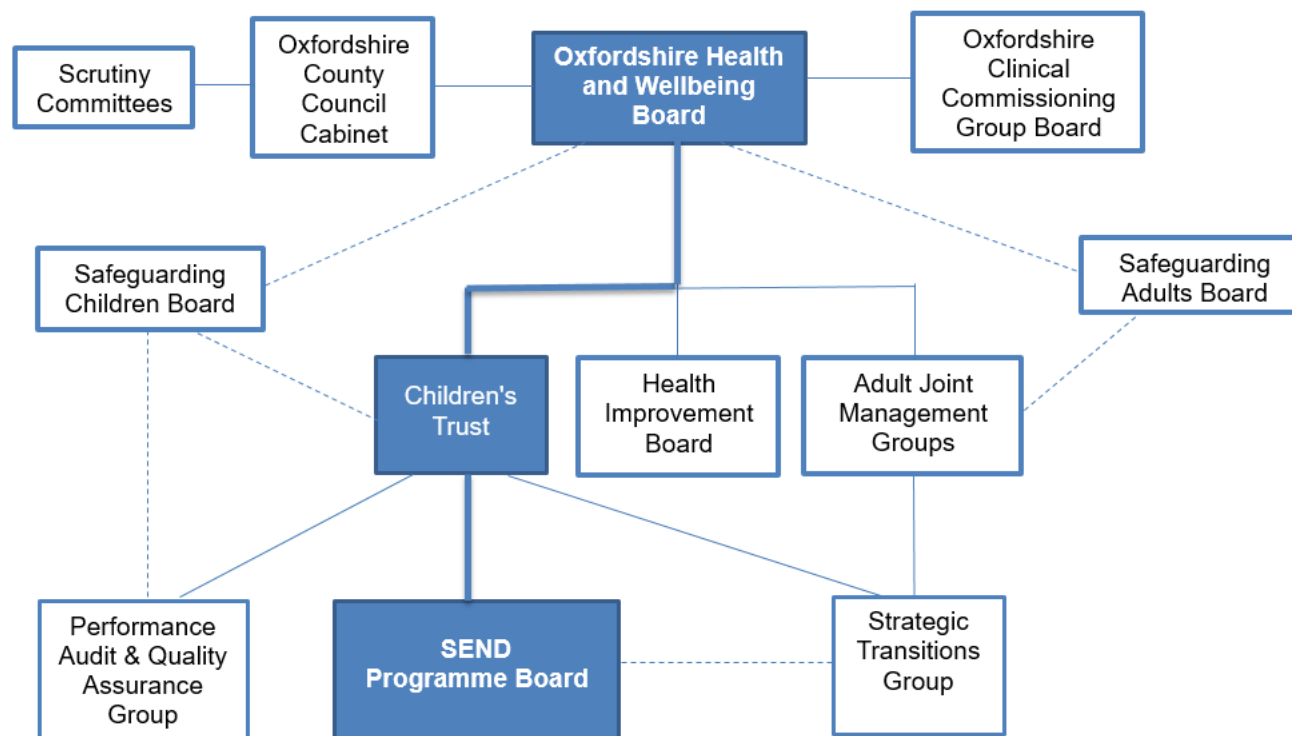
	Develop the scope for the learner engagement project (attendance, exclusions and children missing education) and ensure that it is prominent within the Council's Strategic Transformation Programme (Fit for the Future)	April 2018	<i>Senior Inclusion Consultant /Senior County Attendance Officer / Social Inclusion Officer</i> Deputy Director for Education/ Director of People's Services	Monthly highlight report to the Fit for the Future Board.				
2. Secondary schools provide effective provision for SEN pupils at risk of exclusion.	Ensure schools initiate and follow formal review processes for SEN pupils at risk of exclusions.	June 2018	<i>Senior County Attendance Officer / Social Inclusion Officer</i> Deputy Director for Education	Evidence of improvement as demonstrated by reduced exclusions for learners with SEND on the monthly dashboard.				
	Use case studies of young people with multiple exclusions to gain a better understanding of the underlying causes.	Oct 2018	<i>Senior Inclusion Consultant</i> Deputy Director for Education	Report produced on the learning gained from case studies.				
	Share best practice in developing provision and the curriculum for effectively engaging learners with SEN particularly SEMH pupils.	September 2018	<i>Senior Inclusion Consultant</i> Deputy Director for Education	Resource packs to reduce the risk of exclusions available for schools in September 2018.				
3. The 10 highest excluding secondary schools reduce fixed term exclusions of learners with SEND	Target support to the highest excluding secondary schools. Focused and integrated support from Locality	May 2018	<i>Senior Inclusion Consultant / Area Children's Social Care Manager/Designated Clinical Officer</i>	Action plans for each school developed with the community around the school (Early Help, Nursing, CAMHS, Oxfordshire School Inclusion Team,				

in line with targets above.	Community Support Services and CAMHS in-reach in these secondary schools.		Deputy Director for Education, Deputy Director Children’s Social Care, Lead Commissioner Children’s, OCCG	Educational Psychology Service, SEN Support Service) support in place. Evidence of improvement as demonstrated by reduced exclusions for learners with SEND (monthly dash board)				
	Use Reflective Practice approaches to reduce exclusions of an identified cohort of year 8 learners in two of the highest excluding secondary schools.	July 2018	Senior Inclusion Consultant Deputy Director for Education	Reduced numbers of days lost to education for the identified cohort of year 8 learners.				
	2. Revised guidance published to help schools update and improve their behaviour policies, clarifying expectations.	Ensure that strategies for encouraging positive behaviour for learners with SEMH is shared with schools	June 2018	Senior Inclusion Consultant Deputy Director for Education	Guidance available at the Annual conference in June. Updates in Schools News.			
	Develop a framework for inclusion and kite mark award for schools to celebrate good practice.	September 2018	Senior Inclusion Consultant Deputy Director for Education	Support for achieving the kite marks is available within the traded offer to schools. SEMH guidance updated and shared with schools.				
	Refresh Positive Handling Policy	September 2018	Chair of Oxfordshire Safeguarding Children Board (OSCB) Disabled Children’s Group OSCB Chairman	References to positive handling are reflected in school behaviour policies				

ANNEX A – Governance framework

Lead partner representatives on the SEND Programme Board will be responsible for reporting directly to the appropriate governance board within their organisations.

The SEND Programme Board will report to Oxfordshire’s Children’s Trust and Oxfordshire’s Health and Wellbeing Board on progress towards implementation of SEND reforms and inform them of associated risks and issues.



ANNEX B - Performance framework

	Performance measures
Numbers	Children and young people (CYP) with EHC Plan
	CYP with new EHC Plan
	CYP at SEN Support
Requests and assessment for EHC plans	Requests for statutory assessments received
	Initial requests for assessment for EHC plan refused
	CYP assessed
	CYP assessed - no plan issued
Statement/ EHC Plan transferred/ discontinued	CYP with statements or EHC plans who transferred during the 2017 calendar year
	Statements/EHC plans reviewed and discontinued
New EHC Plans	New EHC plans issued within 20 weeks (excluding exceptions)
	New EHC plans issued within 20 weeks (including exceptions)
Quality of EHC Plans	Overall quality of plans following audit
	% audited plans containing information from social care
	% audited plans containing information from health
Social care involvement for those with EHCPs	Looked After Children
	Child protection plan
	Child in need
Transfers	Early years, primary/secondary transfers completed by Feb 15th
	Post 16 transfers completed by March 31 st
Mediation & tribunals	Mediation cases held
	Tribunals logged
	Tribunals held
	Tribunals involving the single route of redress
Exclusions	Permanent exclusion (EHC plan)
	Permanent exclusion (SEND Support)
	Number children with 1+ fixed term exclusion - SEND support
	Numbers of days of education lost due to fixed term exclusions (secondary schools)
Absence	Persistent absence rate (SEND support)
	Persistent absence rate (EHC plan)
Attainment	End of key stages

Education, employment or training (EET)	% Not in education, employment or training
Feedback from children and young people	Good satisfaction ratings from surveys
Feedback from parents	Good satisfaction ratings from surveys

Glossary

OCCG	Oxfordshire Clinical Commissioning Group
SEND	Special Educational Needs and Disability
EHCP	Education, Health and Care Plan
SEMH	Social Emotional and Mental Health Needs
CAMHS	Child and Adolescent Mental Health Service
SENDIASS	Special Educational Needs and Disability Information Advice and Support Service
VOXY	Voices of Oxfordshire Youth
CYP	Children and Young People
EET	Education, employment and training

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Your voice on health and social care

Healthwatch Oxfordshire Update March 2018

1. Introduction

The full Healthwatch Oxfordshire (HWO) Board has so far met once this year, on 9th January 2018. Minutes are available on Healthwatch Oxfordshire web page:

<https://healthwatchoxfordshire.co.uk/our-reports/board-papers-and-minutes/>

Subsequently, the CQC Oxfordshire Local System Review Report has been published. Healthwatch warmly welcomes this report, with its emphasis on joined-up working and system integration. We will press hard for its full implementation.

2. Health and Wellbeing Board Governance review

The Chair and Executive Director of Healthwatch met with the Leader of Oxfordshire County Council and the Chair of the Oxfordshire Clinical Commissioning Group as part of the HWWB's governance review. Our key messages were:

- Keep the main Board to maximum of 12 - 16 members including NHS Trusts
- Keep the Board focussed on strategy: delivery of the system working together
- Delegate routine matters as much as possible to the three sub-boards
- Meet more regularly in order to drive change forward
- Reduce the volume of board papers (we have reduced our report to lead the way!)
- This is an opportunity to explore new ways of involving wider representation

(Professor George Smith will talk to this point at the board meeting)

3 Healthwatch Oxfordshire web site

In late February we launched our new web site. The site offers a unique opportunity to service users to feedback their views, experiences and rate the services they have used. Services cover the whole range of health (hospitals, GPs, emergency, dentists) to care homes, home care, supported living and more. If a service is missing, then people can ask for it to be added. Information gathered will be analysed and reported to commissioners and service users. Service providers can respond to user comments.

4 Bicester Town updates

Following the publication of our report Healthwatch Oxfordshire arranged a workshop in February. The attendees included local district and town councillors, Oxfordshire Clinical Commissioning Group, Locality Chair, Oxford Health NHS Foundation Trust, Oxfordshire County council, South Central Ambulance Service NHS Trust and Bicester Healthy New Town. Outcomes included agreement to meet again in 6-12 months time to review progress against agreed actions including:

1. Improved dental access for people in Bicester
2. Improved signposting for people to understand what service to access where
3. Plans to increase GP services in Bicester
4. A strategic plan for the community hospital in Bicester
5. Improvements in access to CAMHS

5 Project Fund

HWO Project Panel met in early March and agreed to support two voluntary sector led proposals. These are:

1. Be Free Young Carers - research into the numbers, experiences, challenges and needs of young carers in Oxford City
2. Oxford Community Aqua Wellbeing C.I.C - research into the development of champions and peer led aqua rehab sessions for MSK suffers in Oxford City.

6 Outreach activities

The focus of our activity in 2018 has been in Oxford City - particularly in Cowley, Blackbird Leys, Rosehill and Littlemore areas. A report will be available in April.

7 Voluntary Sector Forum December 2017

This Forum focussed on how Healthwatch Oxfordshire can better engage with the voluntary sector in Oxfordshire. HWO have made a commitment to improve our everyday engagement with the sector and will be launching a page on our web site before the next Forum meeting on the 27th March 2018. The March Forum meeting will focus on social prescribing with speakers from the Oxfordshire Clinical Commissioning Group and patient participation groups involved in social prescribing initiatives through out the county. Social prescribing is defined as “a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.” How it is delivered varies across the country.

8 Healthwatch correspondence

Since October 2017 HWO has written to:

- Oxford University Hospitals NHS Foundation Trust regarding A&E 4hour wait
- Oxfordshire County Council regarding changes to adult daytime support services
- BOB STP Lead regarding Stakeholder Engagement - joint letter with four BOB Healthwatch
- Oxford University Hospitals NHS Foundation Trust and Oxfordshire CCG regarding winter pressures, bed closures and delayed transfers of care

All correspondence and replies can be found on our web site at:

<https://healthwatchoxfordshire.co.uk/our-reports/campaigns-and-correspondence/>

A detailed summary of the letters and responses will be published in late March 2018.

HEALTH AND WELLBEING BOARD UPDATE REPORT FROM CHILDREN'S TRUST BOARD March 2018

This is a summary on the work of the Children's Trust Board, since the report presented to the Health and Wellbeing Board in October 2017. The Children's Trust Board met on 14 December 2017.

UPDATE:

1. Terms of Reference

The Terms of Reference were due for review and this was completed at the board meeting. Changes were made to:

- Membership, for accuracy;
- introduce a statement regarding quorum confirming that for the Board meetings to be considered quorate there must be representation from 7 of the 12 member organisations;
- include a Forward Planning system;
- the agenda template to include a standing agenda item for Voice of Oxfordshire Youth (VOXY) to report and update the Board.

2. Children and Young People's Plan 2018 – 2021

The new Children and Young People's Plan is close to the final drafting stage. Consultation and engagement was sought at the early development stage of the drafting process, in October/November 2017. This process included a very well attended engagement event for professionals. The views of children and young people was also sought from Voice of Oxfordshire Youth (VOXY) and the Children in Care Council.

The feedback helped shape the new layout of the Plan, and the content in terms of priorities against the Vision and Areas of Focus.

A small steering group put together a first draft of the Plan that was circulated for comment to all those who fed into the early development. This draft was considered at the VOXY general meeting in February and the group provided very helpful comments on layout and language.

The steering group are now considering the feedback received and re-drafting the Plan in light of this. The most recent version of the Plan will be taken to the Children's Trust Board at the end of March.

3. Oxfordshire Children's Trust and OSCB Dataset Performance report for 2016/17

The report on the combined dashboards for the Children's Trust, OSCB and Health and Wellbeing Boards was presented to the Board.

As reported previously, Oxfordshire is a great place for most children and young people to grow up and have the opportunity to become everything they want to be. We have confidence in saying this because, for example, educational attainment has increased at all key stages in 2017 to be in line or above the national average. At key stage 4 the attainment is amongst the top 25% local authorities. Further, on the Public Health Outcome Framework which measures 90 indicators, we are below average on just 14.

However, the challenge is that this is not the case for all. There are a number of indicators that are not at the level we would like them to be.

8 measures are off target.

- CAMHS waiting times are increasing, the numbers accessing services within waiting times are decreasing. The Performance Audit and Quality Assurance subgroup of the OSCB have been asked to review this.
- SEND fixed term exclusion off target. The SEND Programme Board are picking this up.
- Out of County placements for looked after children are increasing. The Corporate Parenting Manager has been asked to take a report on this issue to the OSCB Performance, Audit and Quality Assurance Sub Group.
- There is an issue with the numbers of referrals going into MASH that are not within the threshold. There will be 3 social workers recruited in the MASH to triage referrals.
- Levels of activity in social care is higher – increase in numbers of open cases, increase in numbers of child protection cases and increase in numbers of looked after children. This is being addressed through the CEF Transformation Programme.
- Hospital admissions for unintentional and deliberate injuries for young people aged 0 – 14 are rising. This is subject to rigorous monitoring within Oxford University Hospitals Trust.

As a system, we are working together but as well as sustaining the system we must look at how we change the culture. We also need to take time to feedback and to help educate partners and the public.

4. Health Inequalities Commission Implementation Plan

Jackie Wilderspin presented the Plan to the Board. The Board asked to be informed of any future meeting dates for the Implementation Group so the Children's Trust can consider further participation as required.

The presentation was well received and it was suggested the data could be used for baselines in the Community Impact Zone work in Banbury and with reference to existing work on Early Help. It was noted that a useful supplement to the data is a guide to best practice in addressing the inequalities issues.

5. Early Help Strategy

The Board were updated on progress of the Early Help strategy. School Readiness was identified as an area for further discussion and this will be on the agenda for the next Children's Trust Board meeting in March 2018.

VOXY will discuss what 'Early Help' means to young people and will feed back to the Children's Trust.

6. Educational Attainment for Vulnerable groups of children: High Needs Review: Progress Report

Key points to note are:

- Governance arrangements have been strengthened. A High Needs steering group has been established and colleagues from a range of services and schools are involved in the work streams. The steering group reports to the recently refreshed SEND Programme Board, chaired by Cllr Hilary Hibbert-Biles. Arising from weaknesses identified in the SEND Area Inspection, joint accountability across the County Council and Clinical Commissioning Board is being strengthened by the SEND Programme Board, and this in turn will report to the Health and Well Being Board.
- There is recruitment in progress for 3 Educational Psychologists and a Behaviour Lead.
- There is increasing demand for specialist provision.
- There is a strong appetite from schools to develop inclusive practices.

7. Managing Transitions

A report from the Strategic Transitions Group (STG) was presented. OSCB had previously agreed the report and were satisfied with the content. The key issue is that the STG need to have a clear understanding of the numbers of young people whose needs cannot be met by children's services and those who are ineligible for adult services. Consequently, clarity is being sought about the commitment required to meet those needs. This is in the process of being quantified with a report back to the Children's Trust in due course.

8. Self-Harm in Young People in Oxfordshire

Report presented to highlight that this issue is causing significant harm to our young people. It was raised at OSCB who asked that the report was brought to the Children's Trust. Rates are increasing. There is already a lot of good work being done at present: a Self Harm Forum, Self Harm Networks, Touring Play, CAMHS outreach, Emergency Paediatric Liaison Service, but the work needs greater co-ordination.

We only know about cases that are presented to hospital, which means there is a gap in our knowledge. There is good collaboration but the teams would benefit from a commitment to information sharing.

Public Health are proposing a countywide event with key note speakers in order to share the current understanding and agree plans going forward. This will be taking place in May 2018 and a wide range of representation would be welcomed

The Board heard that young people are keen to talk about self-harm and mental health and that this is the most pressing issued facing adolescents. social media is key, young people do not necessarily like talking about the damage done by social media to adults. 'Social Media Use' has been added to the Children's Trust Forward Plan for consideration.

9. SEND Inspection outcomes

The outcomes of the SEND inspection, and the written statement of action, will be discussed in detail at the March board meeting. The SEND Programme Board will report to the Children's Trust at each meeting and this has been included on the Trust's forward plan for 2018 – 2019.

**Children's Trust
March 2018**

Children's Trust Board

Terms of Reference (2018 - 19)

FINAL

		Date
Prepared by	Nina Bhakri	October 2016
Reviewed by:	Children's Trust Board	23 November 2016
Reviewed by:	Children's Trust Board	14 December 2017
Approved by:	Children's Trust Board	
Review Date:		March 2019

THE CHILDREN'S TRUST BOARD

TERMS OF REFERENCE

1. Introduction

- 1.1 The Children's Trust Board brings together the public, private and voluntary sectors to improve outcomes for all children and young people who live in the county.
- 1.2 This document sets out the strategic, decision making and operational structure of the Children's Trust Board and sets out the roles and responsibilities of partners.
- 1.3 This document will be reviewed and updated annually.

2. Objectives

- 2.1 The Children's Trust Board primary objectives are to ensure that effective multi agency working is in place at a strategic level across children's services and that the voice of children, young people and their families contributes to these arrangements and to decision making.

3. Purpose

- 3.1 The purpose of the Trust is to:
 1. Oversee key areas of multi-agency strategic planning for children and young people.
 2. Improve outcomes for children in relation to being successful, keeping safe, staying healthy, and being supported in relation to the agreed priority areas.
 3. Drive the integration agenda where there is evidence that integrated working will improve outcomes for children and young people.
 4. Champion the involvement of children, young people, parents and carers in partnership working with senior managers and politicians.
 5. Ensure the Health and Wellbeing Board and other partnerships are sighted on the key challenges facing children and young people in Oxfordshire.

4. Role

- 4.1 The Role of the Children's Trust Board is to:
 1. To identify and agree its shared priorities for children and young people
 2. Agree actions for improvement
 3. Agree systems and procedures for effective information sharing and collaboration
 4. Implement an agreed approach to involving children and young people.

5. Values

5.1 The Children's Trust Board will be:

1. Strategic - members of the Trust are in a position to take a strategic overview and to influence decision making and delivery within their organisation.
2. Inclusive – the Trust will be a partnership of equals, actively involving all the key players in the public, private, voluntary and community sectors and children and young people.
3. Outcome focused – The Trust will establish common priorities together with agreed actions and milestones that lead to demonstrable improvements against measurable baselines.
4. A body that promotes equality – the Trust will serve the needs of all children and young people regardless of age, sex, disability, race, religion, belief or sexual orientation.

6. Responsibilities

6.1 The responsibilities of the Trust are to:

1. Produce an annual Business Plan setting out the Trust's strategic vision, mission, priorities and goals.
2. Oversee and refresh the Children and Young Peoples Plan which commissioners must have regard to when carrying out their functions.
3. Review performance via the Children's Trust dataset which is overseen by the Performance, Audit and Quality Assurance Sub Group of both the Trust and OSCB.
4. Encourage and promote integrated working between children's services, health and social care and other local services including voluntary and public sector services and commissioners.

7. Structure

7.1 Membership:

7.1.1 Members of the Trust are required to be of sufficient seniority to be able to:

- Speak for their organisation;
- Commit their organisation on policy and practice matters;
- Hold their organisation to account.

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

1. Oxfordshire County Council: Education and Learning, Children's Social Care, Adult Social Care, Public Health, Joint Commissioning, Cabinet member for Children and Families, Cabinet member for Education and Public Health
2. Oxfordshire Clinical Commissioning Group

3. The City and District Council Members
4. Thames Valley Police
5. Oxfordshire Safeguarding Children Board
6. Oxford Health NHS Foundation Trust
7. Safer Oxfordshire Partnership
8. Oxford University Hospitals NHS Trust
9. Representation from schools and colleges
10. Representation from the local Voluntary and Community Sector
11. Parents/carers appointed by Healthwatch Oxfordshire as Healthwatch ambassadors
12. Voice of Oxfordshire Youth (VoXY)

7.1.2 Membership will be reviewed and agreed annually

7.1.3 The meetings will require attendance by 7 of the 12 organisations listed above to be considered quorate.

7.2 The Chairman:

The Trust will be chaired by the Cabinet Member for Children and Family Services, Oxfordshire County Council.

7.3 Vice Chairman:

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

8. Accountability

8.1 How the Trust is held to account:

The Trust will present regular reports to the Oxfordshire Health and Wellbeing Board, Oxfordshire Safeguarding Children Board and the Voice of Oxfordshire Youth.

8.2 How the trust holds others to account:

The Trust is not a formal decision making body in the commitment of resources. The Trust does, however, hold partners to account by the way in which it operates to build influence with partners.

9 How the Trust will Operate

9.1 The Trust will focus its resources on the following three areas where it has identified it can make a difference:

1. Early Help and Early Intervention
2. Educational Attainment for vulnerable children and young people
3. Managing transitions into adulthood

9.2 Forward Plan

The Trust will produce an annual Forward Plan to ensure clearer oversight of key risks and issues across the system. The Forward Plan will support the overall strategic direction of service delivery and escalation of issues as appropriate.

9.3 Time limited task and finish groups:

- 9.3.1 The Trust may, from time to time, establish working groups to pursue particular projects. These groups will be set up on a “task and finish” basis and will be dissolved once the project has been completed.
- 9.3.2 These groups are responsible to the Trust for delivering against agreed objectives. They will be expected to report their achievements against priorities to the Trust on a regular basis.

9.4 Meetings:

- 9.4.1 The Trust will meet four times a year and publish an annual plan for its meetings.
- 9.4.2 The agenda for three of the meetings will include a focus on at least one of the priorities listed above and also include time to consider emerging and core business.
- 9.4.3 Core business includes:
 1. Performance monitoring and management
 2. Updates from the Trust’s Task and Finish Groups
 3. New and emerging national, regional and local developments which impact on the business of the Trust.
- 9.4.4 Agendas will be presented using the “standing agenda” template in **Appendix 1**.
- 9.4.5 Annual Business Planning Meeting:

The Trust will review and update its business plan and terms of reference at its annual business planning meeting.

10 Communication, Consultation and Engagement

- 10.1 The Trust is responsible for engaging and involving children, young people, their families, carers and other local stakeholders to help shape plans and decisions about children’s services.
- 10.2 To achieve this, the Trust will work with the Voice of Oxfordshire Youth to ensure that the voice of children, young people and families influence and inform the business of the Trust.
- 10.3 Responsibility for communications for the Trust will be delegated to the Policy Team of Oxfordshire County Council.

11. Code of Conduct

11.1 A code of conduct is designed to promote public confidence in the actions of the Children's Trust Board.

11.2 Members of the Trust must comply with this code whenever they:

1. Conduct Trust business
2. Act as representative of the Children's Trust Board

(This code is available in **Appendix 2**).

12. Decision making arrangements

12.1 Where an item is placed for decision, that decision will be taken by agreement of the Trust members, by vote if necessary.

12.2 The Chairman of the Trust may initiate and coordinate out of session decision making, via written (electronic or hardcopy) communication with all Trust members.

13. Performance Management

13.1 The Trust has an agreed performance management framework that details how performance against the Children and Young People's Plan will be managed and monitored throughout the year. This is reviewed and updated annually.

14. Confidentiality and Information Sharing

14.1 Information used by the Children's Trust Board and provided to external bodies will be accurate, timely and fit for purpose.

14.2 Members of the Trust are encouraged to share information as required for the purpose of planning, developing and monitoring partnership projects and services by ensuring all data is in line with the Data Protection Act 1998.

14.3 All members of the Trust are responsible for communicating any relevant information to their organisation, unless that information is deemed confidential to a particular meeting.

Appendices

Appendix 1:

Children's Trust Board - Standing Agenda Template

Date:

Time:

Venue:

Chair:

Enquiries: (contact name, telephone number, email address)

Agenda

- 1 Welcome and introductions
- 2 Apologies
- 3 Notes from previous meeting and matters arising
- 4 Children's Trust Board Business:
 - (i) Children and Young People's Plan (2018 -21)
 - (ii) Oxfordshire Children's Trust and OSCB Dataset
Performance report for 2017 - 18
- 5 Children's Trust Board Priorities:
 - (i) Early Help Strategy
 - (ii) Educational Attainment for Vulnerable groups of children:
High Needs Review: Progress Report
 - iii) Managing Transitions: OSCB and OSAB priority area for joint
work: "Transitions from Children's to Adults' Services"
- 6 Emerging and Strategic issues
 - (i) Feedback from OSCB on emerging issues
- 7 Voice of Oxfordshire Youth – feedback, update and emerging issues
- 7 Any other Business
- 8 Close

For information:

Future meetings:

Appendix 2:

The Children's Trust Board member code of conduct

The principles underlying this code of conduct are those of the Relevant Authorities (General Principles) Order 2001 which expanded on the Nolan Principles and form the basis of the Local Authority Members' Code of Conduct:

Selflessness - Members should serve only the public interest and should never improperly confer an advantage or disadvantage on any person.

Honesty and integrity - Members should not place themselves in situations where their honesty and integrity may be questioned, should not behave improperly and should on all occasions avoid the appearance of such behaviour.

Objectivity - Members should make decisions on merit.

Accountability - Members should be accountable to the public for their actions and the manner in which they carry out their responsibilities and should co-operate fully and honestly with any scrutiny appropriate to their particular office.

Openness - Members should be as open as possible about their actions and should be prepared to give reasons for them.

Personal judgement - Members must take account of the views of others, including the groups they represent, but should reach their own conclusions on the issues before them and act in accordance with those conclusions.

Respect for others - Members should promote equality by not discriminating unlawfully against any person and by treating people with respect, regardless of their race, age, gender, sexual orientation or disability.

Duty to uphold the law - Members should uphold the law and on all occasions act in accordance with the trust that the public is entitled to place in them.

Stewardship - Members should do whatever they are able to do to ensure that the Board uses its resources prudently and in accordance with the law.

Leadership - Members should promote and support these principles by leadership, and by example, and should always act in a way that secures or preserves public confidence.

Duty to abide by the law - Members should not engage in conduct which constitutes a criminal offence

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An update of the work of the Health Improvement Board

Report to the Oxfordshire Health and Wellbeing Board

March 2018

Summary

Since the last report to the Health and Wellbeing Board, the Health Improvement Board (HIB) has met once to discuss forward planning and held one Board meeting in public.

1. Forward Planning meeting, 29th January 2018.

Councillor Anna Badcock, Chair of the Health Improvement Board, had requested an additional meeting of Board members to review recent work and discuss forward plans.

The Chairman shared some background of the board's work over recent years and what factors had helped the Board to work effectively to date.

Some of the important features have been the relatively small size of the Board; the representation from a range of partners, including all the districts; good attendance; taking the approach of a 'critical friend' to challenge ongoing work kindly and with purpose; and following issues up. Members also appreciated that they have been able to focus on a few specific priorities at a time. They appreciated the positive atmosphere at meetings and the situation of the Health Improvement Board in a network of other organisations.

Discussion on priority topics for the future included interest in further focus on health inequalities issues, including barriers to access for people with protected characteristics, such as gender or disability. Board members also want to continue monitoring a range of issues that have an impact on health, including domestic abuse, homelessness, substance misuse and mental wellbeing, recognising that some of these issues are being addressed by other partnerships.

2. Health Improvement Board Meeting, 8th February 2018

The agenda for the meeting included the following items

- Performance monitoring – it was noted that the targets set for the year have largely been met. The Board was informed that a new contract for Smoking Cessation has been let by the Public Health team and a report with more detail will be scheduled for the next meeting.
- Information on the Trailblazer project for preventing homelessness was well received. Members could see potential links to work to implement Health Inequalities Commission recommendations. A linked report was presented on the City Conversation on Rough Sleeping.
- The Basket of Inequalities Indicators stimulated interesting discussion and will be used for targeting work to reduce variation in outcomes.
- Board members agreed that a further discussion on priorities should take place by email and at the May meeting in order to inform the Prevention aspects of the Joint HWB Strategy.

- The Domestic Abuse Strategy Group reported good progress in jointly commissioning advocacy and support services in Oxfordshire. The Board members welcomed a representative from Thames Valley Police for this item.
- Keith Johnstone, Chairman of Oxfordshire Sport and Physical Activity (OxSPA), outlined the current plans for the partnership. Members appreciated that they had been consulted on options for the future and asked for an update on progress in May. It was agreed that improving levels of physical activity is an important part of the Health Improvement Board priorities in preventing ill health and members were encouraged to consider how their organisations can support OxSPA in the future.
- The Healthwatch Ambassador informed members of the new Healthwatch website which enables feedback on health and social care services to be submitted. He also announced that further small grants from Healthwatch can be applied for.

The following workshops will be arranged in the next few months:

1. A workshop on what is going on to promote Mental Wellbeing and the role of all partners on this topic will be held on 19th March. A wide range of stakeholders have been invited to contribute to a framework detailing work to improve wellbeing.
2. A learning event drawing on the work of the Healthy New Towns in Bicester and Barton is being held on April 24th 2018.
3. The Oxford Green and Blue Network will be holding a conference on 17th May called Oxford: Naturally Healthy. HWB members will be receiving invitations.

Jackie Wilderspin, March 2018

Oxfordshire Health and Wellbeing Board
Health Improvement Partnership Board

Terms of Reference

Purpose

The Oxfordshire Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

The Health Improvement Partnership Board exists to support the Health and Wellbeing Board in this purpose by delivering service change and improved outcomes through partnership working.

Responsibilities

To achieve its purpose, the Health Improvement Partnership Board has the following responsibilities:

- To demonstrate effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources.
- To drive the development and delivery of services across Oxfordshire that meet agreed priorities and objectives, as determined from the Joint Strategic Needs Assessment (JSNA).
- In particular to:
 - *Bring a coordinated and coherent approach to influencing a broad range of determinants of health to bring about health improvement,*
 - *Work together to recommend priority areas to improve health 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.*
- To meet the performance measures agreed by the Oxfordshire Health and Wellbeing Board.

Membership

The core membership of the Health Improvement Partnership Board is:

- Five district/city councillors – one of whom will be Chairman and another Vice-Chairman
- County Council Cabinet Member for Public Health
- Two Clinical Commissioning Group representatives (one clinical representative and one commissioner representative)
- Director of Public Health for Oxfordshire
- Public Health Specialist

- District Council officer representative
- Healthwatch Ambassador

In attendance

- District Councils' officer for Partnership Development

Representatives from Thames Valley Policy and Oxfordshire County Council Children's Services will also be invited to relevant Board meetings to participate in discussions around Domestic Abuse.

It is proposed that a wide range of stakeholders can be invited to Board meetings at the discretion of the Chairman. They may attend as expert witnesses and to report on implementation of plans.

Governance

The meetings of the Health Improvement Partnership Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and the Access to Information Procedure Rules, insofar as these are applicable to the Partnership Board.

The Health Improvement Partnership Board will also be subject to existing scrutiny arrangements with the Oxfordshire Joint Health Overview and Scrutiny Committee providing the lead role.

Members of the Board will be subject to the Code of Conduct applicable to the body which they represent.

The Partnership Board will meet at least once a year in public. Dates, times and places of meeting will be determined by the Chairman of the Partnership Board.

Officers from the County Council will service meetings of the Partnership Board including the preparation and circulation of agendas and minutes.

The Health and Wellbeing Board will agree terms of reference and membership for the Partnership Board. It will also agree its priorities, proposed outcomes and performance measures. The Partnership Board will review the terms of reference on an annual basis.

Draft for discussion and submission to the Oxfordshire Health and Wellbeing Board
February 2018

Health and Wellbeing Board

22nd March 2018

Reports from Joint Management Groups for Adults

Content

1. Adults with Support and Care Needs Joint Management Group report
2. Better Care Fund Joint Management group report.

Context

The Section 75 pool budget arrangements cover two pooled budgets for *Adults with care and support needs* and for the *Better Care Fund*. These budgets are overseen by two joint management groups.

Since the last Health and Wellbeing Board there have been two meetings for each of the Joint Management Groups for Adults. This paper summarises the outcomes of those meetings.

1. Adults with Support and Care Needs Joint Management Group

The Group held meetings on 5th December 2017 and 6th February 2018.

The Group considered the Period 9 performance report. Performance measures have been agreed and discussed in the Pooled Budget Officers Group

The Group approved the financial position for Period 9, which showed an increased overspend in the pooled budget. The Group discussed the reasons behind this and considered strategies for reducing the overspend.

The Group received further updates regarding:

December meeting:

- Adult Social Care Outcomes Framework report
- Market position statements
- NHS forensic risks
- Police and Crime Bill implications
- Mental health spending proposal

February meeting:

- NHS Forensic Risks
- Five Year Forward View
- Health Inequalities commission implementation
- Section 117 protocol
- Autism pathway

Next meeting: 29th March 2018.

2. Better Care Fund Joint Management Group

The Group held meetings on 23rd November 2017 and 30th January 2018

The Group discussed key messages on the budget and performance measures.

The Group considered the Period 9 performance report. Performance measures have been agreed and discussed in the Pooled Budget Officers Group.

The Group approved the financial position for Period 9, which showed an overspend in the pooled budget. The Group discussed the reasons behind this, the proportion that each partner would be liable for based on the agreed risk share and steps to manage this going forward.

Updates were received on:

November meeting

- Market position statements
- CQC local system review
- Adults social care outcomes framework
- iBCF funding activity and outcomes

January meeting

- Short beds stay review
- Frailty work
- iBCF allocation
- CQC inspection update

Next meeting: 15th March 2018

HEALTH & WELLBEING BOARD – 22 March 2018

CQC Inspection Report and Required Actions

Report by the Director for Adult Services and Chief Executive of the Clinical Commissioning Group

1. Background

Following the announcement in the Spring Budget 2017 that councils would receive an additional £2 billion to support adult social care needs, reduce pressure on the NHS and stabilise the care provider market, the CQC was asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 20 local authority areas. The onsite review of the Oxfordshire Health and Social Care system took place in November with inspectors interviewing senior system leaders, holding focus groups with frontline staff and making visits to several health and social care services.

2. CQC Report

The CQC provided system leaders with a draft report on 22nd January which detailed the findings of the review. Leaders were given five days to review the report and respond with comments regarding the factual accuracy of the report. 90% of the submitted comments were accepted and the final report was published by the CQC on Monday 12th February. The final report suggests fifteen areas for improvement as shown below. The full report is available in Annex 1.

2.1 CQC recommendations

Strategic Priorities

- a) System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. Whilst doing so a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.
- b) System leaders must address and create the required culture to support service interagency collaboration and service integration.

- c) The Older Person's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the Older Person's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.
- d) System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.
- e) System leaders must evaluate their winter plans and demand pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand.
- f) System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.
- g) System leaders must implement the STP's joint workforce strategy and work with the full range of care providers to support a competent, capable and sustainable workforce.

Operational Priorities

- h) System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.
- i) System leaders should ensure that housing support services are included within multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.
- j) System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure resources are used effectively.
- k) System leader should review methods used to identify carers' eligible for support so that they are assured that carers are receiving the necessary support and have access to services.
- l) System leaders should ensure that better advice to access information and guidance is offered to people funding their own care.
- m) Continue to embed the trusted assessor model.

Engagement Priorities

- n) System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.
- o) Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.

3. Local area summit and action plan

On 29th January system leaders and major local stakeholders came together with CQC inspectors and representatives from the Department for Health, Social Care Institute for Excellence and NHS England to discuss the findings of the report and agree actions that would be taken in response. The system was required to develop and submit an action plan to the CQC within 20 days of the report being published, which gave a deadline of 9th March.

The plan was developed by system leaders from across OCC, NHS Foundation Trusts and GP Federations. It describes a number of actions that will be taken by the system in response to the areas for improvement identified in the CQC report. Each action is assigned an owner and timeframes are given for its completion. A number of the actions listed are already in progress through existing programmes of work or action plans, where this is the case it has been referenced in the plan.

The plan was approved by the Chair and Vice Chair of the HWB ahead of its submission to the CQC on 9th March. The action plan can be found in annex 2.

4. Governance arrangements

Because of the multi-agency nature of this work, its urgency and its need to report to the Health and Wellbeing Board (HAWB) it is necessary to create a dedicated HAWB sub-group to ensure that the CQC action plan and related issues are delivered. It is proposed that the new HAWB sub-group will adopt the following design principles:

1. To oversee a transformative programme of work between all NHS organisations and Adult Social care (including oversight of the CQC action plan).
2. To deliver the requirements set out in the Joint Health and Wellbeing Strategy for adults.
3. To deliver the requirements of the refreshed Older People's Strategy.
4. To provide a clear focus for strategic decision making for the NHS and adult social care in Oxfordshire.
5. To oversee the strategic integration of community services and urgent and emergency care services.

6. To oversee a shared workforce strategy for health and adult social care.
7. To seek the views of representatives of the public, patients and voluntary organisations.
8. To adopt a programme management approach to ensure that service delivery is achieved.

The new subgroup will also ensure that strategic decisions are clearly made in a single forum, thus reducing system complexity and streamlining decision-making processes.

In order to ensure CQC compliance it is necessary to set up and convene this sub-group urgently. The HAWB are therefore requested to agree the design principles listed above, which will enable final terms of reference to be drafted. It is proposed that these TOR are agreed by the HAWB chair and vice-chair during the next month provided they adhere to the design principles described above.

5. Recommendation

The Health and Wellbeing Board are asked to note and discuss the CQC report and action plan and approve the governance arrangements.

Oxfordshire

Local system review report Health and Wellbeing Board

Date of review:
27 November to 1 December 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Head of local system review programme: Ann Ford, CQC
- Lead reviewer: Karmon Hawley, CQC

The team included:

- Three CQC reviewers
- One CQC analyst
- Five specialist advisors; one former local government director, one chief executive officer, one director of adult social care, one with a background in clinical nurse governance and one with a general practice background.

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive?**

We then looked across the system to ask:

- **Is it well led?**

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Oxfordshire County Council (the local authority), NHS Oxfordshire Clinical Commissioning Group (the CCG), Oxford Health NHS Foundation Trust (OHFT),

Oxford University Hospitals NHS Foundation Trust (OUHFT), and South Central Ambulance Service NHS Foundation Trust (SCAS)

- Members of the Oxfordshire Health and Wellbeing Board (the HWB)
- Health and social care professionals including care home and domiciliary care agency staff, social workers, GPs, urgent care staff, reablement teams, and health and social care provider representatives.
- Healthwatch Oxfordshire and voluntary, community and social enterprise sector representatives
- People using services, their families and carers during our visits to day centres and support groups and in focus groups.

We reviewed 18 care and treatment records and visited services in the local area including OUHFT and OHFT sites, intermediate care facilities, care homes, a domiciliary care agency, a GP practice, an extra care housing scheme, out-of-hours services and the urgent care centre.

The Oxfordshire context

Demographics

- 16% of the population is aged 65 and over.
- 91% of the population identifies as white.
- Oxfordshire is in the top 20% least deprived local authorities in England.

Adult social care

- 60 active residential care homes:
 - Two rated outstanding
 - 45 rated good
 - Five rated requires improvement
 - 8 currently unrated
- 74 active nursing care homes:
 - Four rated outstanding
 - 51 rated good
 - Nine rated requires improvement
 - Two rated inadequate
 - Eight currently unrated
- 113 active domiciliary care agencies:
 - Five rated outstanding
 - 81 rated good
 - Seven rated requires improvement
 - One rated inadequate
 - 19 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Oxford were almost entirely to:

- Oxford University Hospitals NHS Foundation Trust.
 - Received 92% of admissions of people living in Oxfordshire
 - Admissions from Oxfordshire made up 73% of the trust's total admission activity
 - Rated good overall.

Community services are provided by:

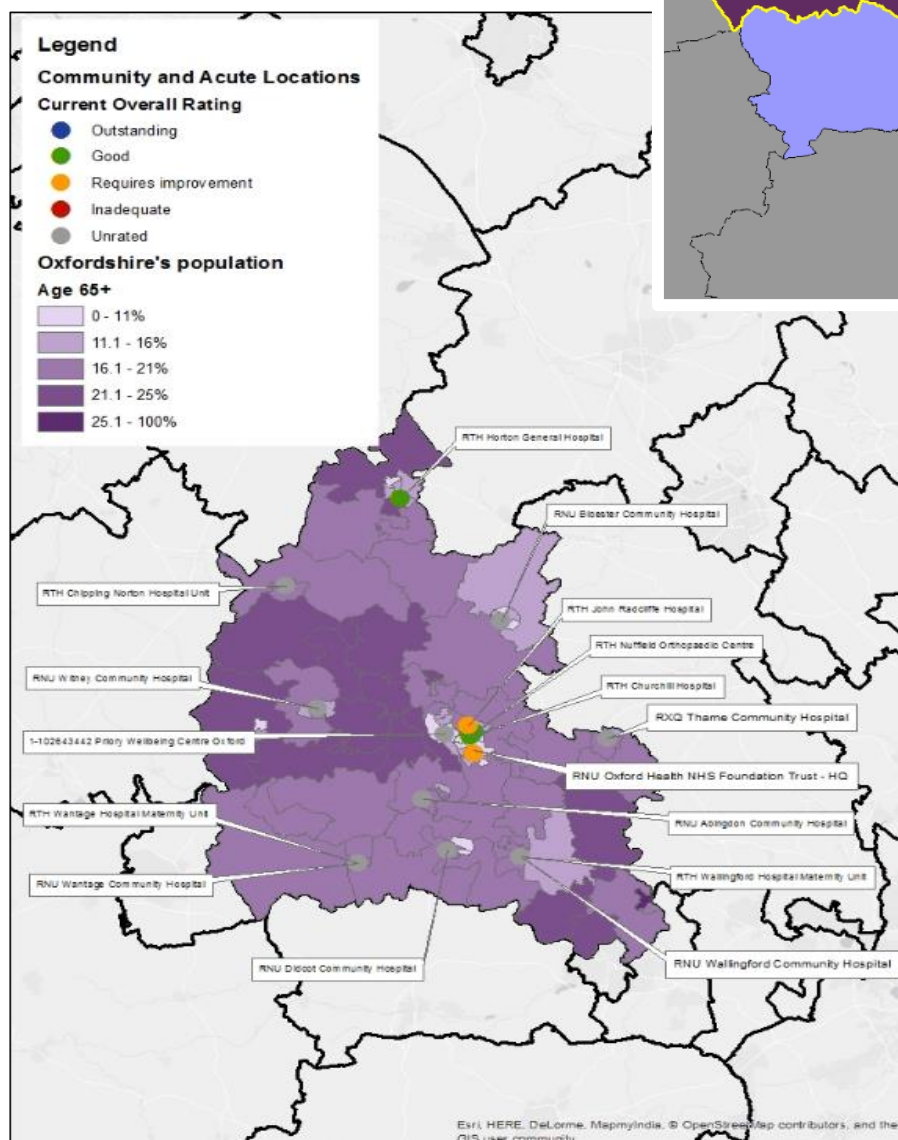
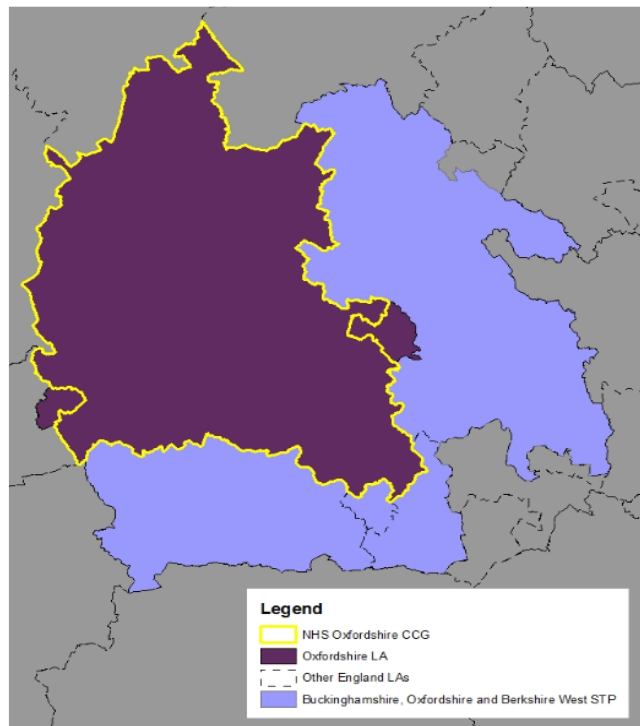
- Oxford Health NHS Foundation Trust
 - Rated good overall

GP Practices

- 72 active locations:
 - Four rated outstanding
 - 64 rated good
 - Two rated requires improvement
 - One rated inadequate
 - One currently unrated

*Acute location ratings as at 01/07/2017. ASC and GP ratings as at 29/09/2017.
Admissions percentages from 2015/16 Hospital Episode Statistics.*

Map one (right):
Location of Oxfordshire LA
within Buckinghamshire,
Oxfordshire and Berkshire
STP.
NHS Oxfordshire CCG is
also highlighted.



Map two (left):
Population of
Oxfordshire shaded by
proportion aged 65+.
Also, location and
rating of acute and
community NHS
healthcare
organisations serving
Oxfordshire.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- In Oxfordshire we found that there was a lack of whole system strategic planning and commissioning with little collaboration between system partners. We could not find a compelling shared vision for the design and delivery of services. The significance of a shared vision is that it gives clarity to staff of all organisations and people who use services about what a system is trying to achieve and it is one of the fundamental building blocks to providing joined up care .
- Although there was increased ambition to work together system leaders continued to face significant challenges in coming together to formalise their ambitions through a joint strategic approach.
- Leaders were not able to provide a comprehensive strategy for the transformation and delivery of integrated services which would consequently impact upon effective commissioning and delivery plans.
- A lack of collaboration had led to a fragmented system where there was duplication of effort and at times, a reactive tactical response to embedded performance issues such as delayed transfers of care (DTC). System leaders were considering national targets but not always applying them to their community and what is required to meet the needs of the people of Oxfordshire, for example, the strategy for older people was out of date and had expired in 2016.
- There was too much focus on service delivery when a person was at the point of crisis and little attention to prevention and early intervention services for older people with social inequalities, seldom heard groups and for those who may not be known to the system.
- The Buckinghamshire, Oxfordshire and West Berkshire (BOB) Sustainability and Transformation Partnership (STP) had little impact in delivering pan-Oxfordshire transformation. The development of local strategies to support older people who lived in Oxfordshire was a component of the Oxfordshire transformation programme. The first phase of that had concluded towards the end of 2017; the next phase of the transformation programme would be taken forwards in 2018, and so that process had not been completed at the time of the review.
- The Oxfordshire Health and Wellbeing Board (the HWB) did not have a clear role in influencing a strategic approach to support the joined up delivery of services. There was

recognition that the HWB required reconfiguration and a stronger sense of purpose. The chair and vice chair had a clear view for the development of the HWB and were keen to enact changes that would make it more effective and improve engagement with providers including the VSCE sector.

- The planned HWB review presented an opportunity for improved co-production, bringing together a full range of providers, and holding them to account for the delivery of the transformation programme, as well as providing clarity in respect of the interface with the wider STP.
- Relationships between Oxfordshire County Council (the local authority), Oxford Health NHS Foundation Trust (OHFT), NHS Oxfordshire Clinical Commissioning Group (the CCG), Oxford University Hospitals NHS Foundation Trust (OUHFT) and South Central Ambulance Service NHS Foundation Trust (SCAS) had been difficult over many years and although we found evidence that these had improved, feedback to our relational audit demonstrated that some cultural issues remained. For example, a few respondents described contrasting organisational cultures and the emergence of a blame culture in some organisations. Organisational development was required to address these barriers and create the required culture to enable better collaboration and service integration.
- The challenge for this system was to articulate its medium to longer term strategic ambitions while remaining focused on delivering continuous improvements against current performance pressures.
- Significant strategic effort is needed to ensure housing growth meets the demand of the much needed recruitment and retention of health and social care professionals and related key workers.
- Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for the STP and also at local level for Oxfordshire. System leaders were working to develop the workforce through integrated working and initiatives including working with education institutes to enable innovative approaches to growing the workforce.

Is there a clear framework for interagency collaboration?

- There was no clear framework for interagency collaboration.
- There were some agreed overarching programmes aligned to the STP such as workforce planning and urgent care performance. However, the Oxfordshire system had not yet articulated a central, unified approach for the meeting of local needs aligned to the STP's strategic aims for the wider geographical BOB STP area).

- While each individual organisation within Oxfordshire had its own governance and reporting structures there were limited joint governance arrangements in place with unclear lines of accountability between system partners. The long history of pooled budgets jointly led by the CCG and the local authority was a good platform for the sharing of targets, outcomes, risk and reward. However, arrangements to support the management of wider risks to delivery were not jointly owned, which meant that different components of the system could, and sometimes did, focus resources on managing individual organisational pressures and targets rather than seeking joint solutions.
- The recent refresh of the pooled budget (Section 75) agreements between the local authority and the CCG had provided greater clarity and focus on older people. There were some good but limited examples of joint working which were having a positive impact on people.
- System leaders told us that at a strategic level, plans for Improved Better Care Fund (iBCF) spending were developed collaboratively, with discussions involving all major stakeholders. They acknowledged that while there were a range of initiatives from individual organisations and formal and informal partnerships and strategies, more work was required to improve the resilience and responsiveness of the system. They had begun to address this gap through the transformation programme and targeted work streams.

How are interagency processes delivered?

- There were some positive examples of effective partnership and collaborative working but it was widely recognised that some cultural and organisational barriers remained, which impacted on the ability to embed interagency processes. Organisational development work is required to address these issues if integration of service provision is to be realised.
- System leaders need to continue building cross-system relationships, articulating shared governance arrangements and jointly agreeing performance criteria.
- While we found some examples of staff working in an integrated way to deliver positive outcomes for people, the system remained fragmented and frontline staff reported multiple confusing access points into the system that impacted upon care delivery, and resulted in people who needed support having to fit into the system rather than receiving individualised care.
- System leaders acknowledged problems with information sharing systems and were committed to providing integrated care records by way of interfaces between platforms, rather than fully integrated systems due to a legacy of system challenges.

What are the experiences of front line staff?

- System leaders and senior managerial staff were visible and accessible. However some operational and frontline staff felt there was a need to improve and have effective conversations and co-production opportunities so that staff and people using services could influence and shape service design and delivery.
- Frontline staff were dedicated to providing high-quality, person-centred care and working in a seamless way with colleagues across the system. However they reported heavy workloads and recruitment challenges that did not support seamless care delivery. Workforce leads across the system cited work pressures at all levels as an inhibitor to integration.
- The incompatibility of IT systems was a common problem and frontline staff faced challenges when sharing information which impacted on the ability of staff to support people effectively.

What are the experiences of people receiving services?

- The experience of people receiving health and social care services in Oxfordshire varied. The Adult Social Care Outcomes Framework (ASCOF) measures for 2016/17 showed that the percentage of older people who were satisfied with their care and support was slightly above average. In addition, CQC's ratings of adult social care locations, which include feedback from service users, show that a higher proportion of locations in Oxfordshire are rated good and outstanding compared to the national average. However we received mixed feedback from people and carers we spoke with during the review.
- People, their family and carers told us that they felt well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. The case files that we pathway-tracked demonstrated important relationships were acknowledged and the right people were involved in the person's care.
- People were treated with kindness and frontline staff were dedicated to providing person centred care, going the extra mile for people they cared for. Better Care Fund (BCF) plans supported personalisation and choice through the development of alternative models of care and investment in more flexible budgets.
- Some older people were not always seen in the right place, at the right time, by the right person. People using services, their families and carers reported multiple points of access and a fragmented approach to service provision meant that the system was confusing for people to navigate.
- People using services were complimentary about their interactions with staff and some services they received. However some people had very poor experiences of discharge from

hospital. For example, one person told us they had been discharged without the necessary care package in place and we saw a case study where appropriate support from a community healthcare professional had not been arranged on discharge. People using services also told us they had been discharged from hospital in the early hours of the morning.

- Although there was an increase in provision of primary medical services, some people reported varied access to services that meant they could wait for an appointment for up to 2 weeks. As a result, people sometimes relied on emergency services including A&E. On attending A&E people sometimes faced a long wait, especially if arriving by ambulance due to delays in handover to A&E staff.
- Although our analysis indicated that the rate of emergency admissions for over 65s in Oxfordshire had been consistently lower than the national average since 2014 and the average length of stay compared favourably against the national average, there were a significantly high number of delayed transfers of care. In addition the number of emergency readmissions was slightly higher than the national average.
- When people were admitted to hospital and needed a long term care package on discharge they were more likely to experience long delays, especially if they required complex support. People who experienced delays in moving to an appropriate care setting are at risk in terms of deterioration in their condition.
- The percentage of older people receiving reablement following discharge from hospital had decreased over the years in Oxfordshire and in 2016/17 was slightly below the national average. It also seemed that the effectiveness of these services had declined; in 2016/17 79.8% of people over 65 were still at home 91 days following discharge from hospital to a reablement service, while this performance was in line with Oxfordshire's comparator group it was below the national average of 82.5%.
- People who funded their own care experienced difficulties in accessing information in respect of support services available.
- While the ASCOF data and CQC provider ratings indicated that the percentage of older people who were satisfied with their care and support was above average, some carers we spoke with during the review felt the quality of domiciliary care was unsatisfactory, with staff not always appropriately trained to manage complex needs.
- People told us that they felt involved in their care and treatment but due to duplication in some roles and services some people had to tell their story more than once and were subject to multiple assessments.

- Some people experienced delays in social care needs assessments which impacted upon their health and wellbeing.
- The approach to co-production with people who use services, their families and carers was under developed. There were challenges engaging seldom heard groups and ensuring proactive engagement about things that mattered most to people living in the area.
- People who use services, their families and carers felt that the voluntary, community and social enterprise (VCSE) sector offered a good range of support services however concerns were raised by some carers that they were not receiving enough support and a reduction in day services had also impacted on this.

Are services in Oxfordshire well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

The alignment with the STP and the Oxfordshire transformation plan had contributed to delays in the development of local strategies to support older people who lived in Oxfordshire. The development of local strategies to support older people who lived in Oxfordshire is a component of the Oxfordshire transformation programme. The first phase of that concluded towards the end of 2017; the next phase of the transformation programme would be taken forward in 2018, and so that process had not been completed at the time of the review.

The HWB was not fully effective in its function and had not supported a clear shared strategic vision for the future of health and social care services in Oxfordshire. System leaders recognised some organisational development work was required and agreed that a joint vision and strategy was a priority. It was anticipated that the restructure of the HWB would provide the vision for integrated systems and structures.

Historical relationship issues were being addressed and relationships being rebuilt between system leaders and political leaders to enable change.

There were some good examples of the system working together to engage with people who used services, their families and carers; however a stronger approach to co-production was required.

While there was a shared commitment among system leaders to tackle challenges jointly this was not always translated into action at an operational level. There were missed opportunities to improve the system via lessons learned. Meeting the level of housing growth needed in the area to meet demand would require a significant strategic effort across all organisations.

Strategy, vision and partnership working

- There was a single local authority and a single CCG commissioning health and social care service for people in Oxfordshire and CCG commissioning services for people who lived in Oxfordshire was overseen by a single Health and Wellbeing board. There were five district councils which were responsible for services such as housing and waste collection.
- Oxfordshire was part of a wider Sustainability and Transformation Partnership covering the Buckinghamshire, Oxfordshire and West Berkshire (BOB) area footprint as a vehicle for wider system transformation planning and partnership.
- The Oxfordshire HWB was designated to provide the strategic oversight for the development of a strategy for health and social care services. The strategy at the time of our review covered the period 2015-19 and stated that it was “ultimately responsible for setting a direction for the County in partnership”. At the time of our review the HWB was not working effectively and it did not set out a clear or compelling shared vision for the delivery of health and social care services. This would impact upon effective commissioning and delivery plans. Furthermore, a shared vision gives clarity to staff of all organisations and people who use services about what a system is trying to achieve and it is one of the fundamental building blocks to providing joined up care. A number of system leaders agreed that developing a joint vision and strategy, owned by partners was a priority.
- Given its statutory role for system leadership the HWB is the right body to set, agree and lead this vision, linked also to the STP. The review of the HWB governance and membership being conducted at the time of our review presented an opportunity to reshape the HWB so it took centre stage for driving a shared vision for older people in Oxfordshire and a shared case for change. It also presented an opportunity for the system to address the challenges it faced in order to focus simultaneously on what is happening to improve the current position, and also the improvements needed for creating the right future system.
- System leaders were considering national targets but not always relating them to their community and the needs of the people of Oxfordshire. For example, we were presented with a strategy for older people which had expired in June 2016. While work was underway to review this, we were told this would not be completed until June 2018, which meant that services for older people in Oxfordshire had operated and would continue to operate for two years without a clear strategy.

- Elements of the health and wellbeing strategy, such as the integration of health and social care services, had not materialised. System leaders told us this was in part due to the development of the STP and the Oxfordshire transformation plan. 'The development of local strategies to support older people who lived in Oxfordshire is a component of the Oxfordshire transformation programme. The first phase of that had concluded towards the end of 2017; the next phase of the transformation programme would be taken forward in 2018, and so that process had not been completed at the time of the review.
- The CCG established an Oxfordshire Transformation Board in partnership with the local authority, OUHFT, OHFT, SCAS and the GP federations in 2015 to consider the transformation of services over five years. In the response to the System Overview Information Request (SOIR) system leaders indicated changes were already underway through the Oxfordshire Transformation Programme which was in two parts. Firstly, in working towards an accountable care system, and secondly, to better integrate primary, secondary care and social care services. At the time of the review there was no overarching vision for an accountable care system, and there was no evidence of commitment from partners to drive this, or a plan to achieve it.
- Work was needed to build positive relationships both politically and organisationally to reach agreement regarding transformational change. Phase one of the transformation programme could not be fully progressed because there was an ongoing judicial review of maternity services.
- System leaders recognised that there was a need to continue to improve relationships. We were told that recent changes in leadership had produced a more open culture that was more responsive to change and supportive of transformation. Although these were developing and system leaders were committed to serving the people of Oxfordshire well, feedback from 253 respondents in our relational audit showed some deep rooted issues in respect of organisational culture, trust, as well as communication and personnel challenges. For example, a lack of joint working created difficulties with communication across different organisations affecting the quality and continuity of care.
- Within Oxfordshire, leaders felt that the system was effective at addressing issues such as commissioning new services in response to the latest national initiatives. However we found that this reactive approach meant partners did not often have capacity to reflect, set plans and develop actions in a considered way to establish how they fitted with wider strategic objectives.
- There were some examples of good individual services in health and social care, and jointly commissioned services, including the Home Assessment Reablement Team (HART).

However, overall there was a lack of integration, and lack of a shared and understood joint workforce strategy.

- There were mixed views regarding the effectiveness of winter planning. Although system leaders were cautiously optimistic about their capacity to manage winter pressures, clinicians we spoke with were less so. Some of the measures put in place to manage discharges as part of winter planning such as ‘one stop’ ward rounds taking into account arrangements such as medicines to take home, were standard good practice and should be embedded in day to day discharge management rather than being seen as something new and innovative. Similarly, an improved approach to discharge planning was anticipated but far from embedded in the acute setting with limited evidence of the wider application of the high impact change model.
- Some leaders and front line staff we spoke with voiced concerns that planning for winter had been left too late and although bids for funding to support the management of winter pressures had been put in place there was little confidence in the system’s ability to cope during this period.
- The recent refresh of the pooled budget between the local authority and the CCG provided greater clarity and focus on older people, and greater transparency regarding the overall spend. The review of the HWB, along with the existing pooled budget arrangements provided the system with a good opportunity to shape a shared vision, agree priorities and develop a communications narrative to galvanise the system into joint actions.
- The level of housing growth needed in the area to meet demand requires a significant strategic effort across all organisations, with the requirement for particularly strong partnerships between Oxfordshire County Council, the district councils and the Local Enterprise Partnership. This would help with the delivery of affordable and supported accommodation, which was much-needed to support older people, and the recruitment and retention of key workers in the Oxfordshire area.
- Local housing managers talked confidently about the initiatives to support this including extra care housing and efforts were predicated on the need for up to 100,000 additional new homes. A new project had started with a stock transfer partner to look at a bespoke model of “retirement living” to reduce costs and induce people into the area.

Involvement of service users, families and carers in the development of strategy and services

- Oxfordshire has a history of public engagement and co-production. However we received feedback indicating that it has not always been effective and local people felt that they had limited influence on the design and delivery of services.

- Challenges with public engagement were recognised by the system's engagement leads. The need to do more and to use new and proactive measures for working with underrepresented groups such as black and minority ethnic groups and travellers was recognised. This was corroborated as concerns were raised about ensuring engagement took place with underrepresented groups locally, to establish what mattered to them. System leaders told us there was a commitment by the local authority to embed a culture of co-production with people who use services, their families and carers across all adult services within the next two years. A dedicated team had been deployed to undertake this work which had been reviewed by the Social Care Institute of Excellence (SCIE) and which confirmed that positive work had been taking place and that the system were committed to the programme.
- There were some good examples of the system working together to engage with people who used services, their families and carers in the development of services, for example, around community beds (at Townlands Memorial Hospital), and carers, with – 'Oxfordshire commitment to carers' (Oxfordshire Carers' Strategy - 2017 to 2020). These examples involved working closely with the local community and ongoing engagement including stakeholder reference groups. System engagement leads felt they had made positive progress but there had been no formal evaluation or lessons learned review at the time of our review.
- The OHFT Dementia Strategy had been developed in partnership with people living with dementia, their families, the voluntary sector and OHFT staff. This strategy aimed to support OHFT to provide excellent and innovative specialist care to people with dementia and those supporting them throughout their journey. However, people's experiences differed with some people who use services and carers reporting a good service and others stating that insufficient support services were offered.
- SCAS representatives attended various patient forums and patient events including working with Oxfordshire Dignity and Dementia Champions Network. It had with an established dementia lead in post and a trust wide dementia strategy, which was underpinned by the clinical strategy 'Future opportunities and priorities to further care in the community'.
- The local authority worked closely with Healthwatch Oxfordshire to disseminate and cascade information and use feedback to inform how they designed, commissioned and delivered services. However, we were told that not all feedback was used to support service design and there were times when services such as daytime support had been reduced despite very positive feedback about its effectiveness in supporting carers.

- Providers had systems in place within their individual organisations to engage with people and obtain feedback. OHFT used a range of approaches to engage, involve and listen to older people as part of service delivery, which included patients, carers and public governors co-producing strategies. They had also made a five-year commitment to rolling out the online patient feedback tool 'IWantGreatCare' across all services which the system envisaged would provide rich, real-time feedback at service, team and clinician level. OUHFT had also undertaken a large number of engagement events, for example, the Quarterly Patient and Public Forum and Annual Quality Conversation with patients and members of the public.

Promoting a culture of inter-agency and multidisciplinary working

- System leaders recognised the need to improve the culture of interagency and multidisciplinary working. The Joint Strategic Needs assessment (JSNA) informed the vision and priorities of the Oxfordshire system towards new models of care, admission avoidance and discharging people from hospital as quickly as possible. The older people's strategy was being refreshed and would be completed in June 2018.
- Although jointly commissioned services were limited, there were some examples of good services in health and social care working together. For example the project groups working on DTOC and 'stranded patients'. However, many new initiatives were being developed without a shared approach, which resulted in silo working and a need to encourage a culture of inter-agency and multidisciplinary working to provide seamless care and avoid duplication of effort.
- In the response to the SOIR, system leaders told us that at a strategic level plans for iBCF spending were developed collaboratively, with discussions involving all major stakeholders. They acknowledged that while there were a range of initiatives from individual organisations and formal and informal partnerships and strategies, more work was required to improve the resilience and responsiveness of the system. They had begun to address this gap through the transformation programme and targeted work streams.
- While there was a shared commitment among system leaders to tackle challenges jointly however this was not always translated into action at an operational level.
- There was evidence of staff working collaboratively across some organisations to deliver care, for example in community hospitals/frailty units, staff worked with medical staff from OUHFT. There was also integrated health and social care provision for mental health services. The 'Joint Enterprise' was being created between Oxford Health and the County's GP federations to look to integrate neighbourhood multidisciplinary teams across primary and community care, informed by the National Association of Primary Care 'primary care home' model.

- More work was required to ensure all providers felt like system partners and that they had representation on decision making groups. While some social care providers were positive about their relationships with commissioners, concerns were expressed in respect of commissioners understanding the limitations of what their services were able to provide and about variance in support offered to providers.

Learning and improvement across the system

- Previous reviews of the problems of DTOC in Oxfordshire had included looking at complicated pathways, workforce and service provision, and some progress had been made to address these known issues. Some pressure points had been reviewed by various elements of the system, rather than by the system as a whole, which had encouraged a fragmented, reactive response. The system was frequently in escalation which had resulted in this becoming normalised among frontline staff who accepted performance levels as a consequence of a pressured system. There was a need for more evaluation of the contributing factors to the escalation and de-escalation processes so lessons could be learned, continuous improvements made and shared system wide.
- Each organisation had sight of their own incidents and incident management but there was no single, coordinated approach to ensure lessons were shared widely across the health and social care interface. Safeguarding and Serious Incidents were appropriately managed via the Oxfordshire Safeguarding Adults Board and the Care Governance Framework.
- Although governance arrangements were in place, there were mixed views regarding how well the system was learning and improving. Concerns were raised from some system leaders, political leaders and social care providers in respect of the transparency of the system, listening to concerns when they were raised and taking positive action in response. People we spoke with felt there was a lack of ownership and acceptance of some of the issues which impeded improvements. Furthermore people felt there were limited assurances due to the fragmented system and silo working. Staff reported that issues were discussed at so many different meetings and different decisions made, it was challenging to understand and maintain governance. The system had not explored what it could do differently to improve leadership, reduce over-prescribed care and bring people who used services to the forefront of service design, delivery and outcomes.
- There was evidence of joint learning in some areas, for example the sharing of best practice in the use of the electronic system (CERNER sites) and collaboration and shared care guidance for the Oxfordshire area prescribing committee.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

There were governance arrangements across the health and social care interface to assess, monitor, share and mitigate risks but further development was needed. There were clear lines of reporting between organisations and up to system level arrangements and the STP. There was a strong demonstration of commitment in respect of the HWB and it was expected that once this had undergone reconfiguration it would become more effective in its role. Partnership boards such as the Joint Management Group had been established to encourage interagency working. A lack of digital interoperability was a barrier to providing fully integrated systems, however there was a commitment across system leaders to improve this.

Overarching governance arrangements

- The Oxfordshire Transformation Programme was the Oxfordshire component of the STP which was aligned with the HWB. The STP set out the strategic vision, delivery plans and provided an oversight of performance via the A&E Delivery Board.
- There were governance arrangements in place to support the planning and delivery of integrated care, particularly since the establishment of the Transformation Board. The Transformation Board existed to drive forward the long-term transformation of the health and social care system. The Transformation Board and A&E Delivery Board both benefitted from attendance by wider system partners including, Age UK, the Oxfordshire Association of Care Providers (OACP) and Healthwatch Oxfordshire.
- The HWB, together with its three sub-groups provided the joint forum for all aspects of the population's health and wellbeing and was chaired by the Leader of Oxfordshire County Council. Although the board was embedded in the wider system, it was due to undergo a restructure of membership. There were mixed views in respect of the effectiveness of the HWB, the level of challenge it provided and the ways in which it was aligned to and drove the system.
- The HWB had resolved to undertake a governance review with a view to exploring the potential of an Accountable Care System for Oxfordshire. This would be done in conjunction with other coordinating bodies such as the Transformation Board. The planned review of the HWB presented an opportunity to do this. Therefore the review should focus on setting a shared vision for the system and the relationship between the HWB, the Oxfordshire Transformation Programme and the STP. This would be particularly important if the HWB is to become the locus for the journey towards an Accountable Care System. This being the case, the review also offers an opportunity to co-produce and to engage care providers and the other stakeholders, such as VCSE sector organisations.

- System leaders told us that the JSNA and the health and wellbeing strategy provided oversight of further integration of health and social care, promotion of preventative services and re-shaping of NHS services outlined in the emerging Sustainability and Transformation Partnership. It also monitored related key outcomes and performance measures; however the older people's strategy was out of date.
- The long history of pooled budgets and the recent review of these was a platform for developing shared targets, outcomes, and risk strategies. The BCF Joint Management Group (JMG) monitored the resources that delivered the elements of the strategy that were within the scope of the pooled budget and provided assurance to the HWB. To provide the HWB with assurance around capacity and delivery, the revised scope of the pooled budget for 2017/18 had extended the reporting requirements of the JMG to include system indicators that were not strictly within the contracts commissioned from the pooled budgets but which the local authority and the CCG had responsibility for delivering in contracts outside of the pooled budget agreements.

Risk sharing across partners

- There were pooled budget systems and financial risk-sharing arrangements in place. However finance leads felt that should any unforeseen spending eventuality arise, there was not, at the time of our review, a robust contingency plan in place to manage overspend.
- There was evidence that the new iBCF monies had been spent on short-term solutions to target improvements against DTOC. Resources had also been used to offer incentives to care providers to enhance capacity however it was not clear that this spend was part of an overarching strategy to improve performance in the medium to long term. Although there was evidence that the more longstanding BCF had been structured strategically with financial risk sharing arrangements between the CCG and the local authority, there was less evidence on how these arrangements would be used to improve system integration or performance against DTOC under the remit of the Health and Wellbeing Board.
- All risks within the BCF were considered to be shared risks and while leaders were able to articulate how the system had responded to specific issues or pressure points, this approach was sometimes reactive and Oxfordshire was frequently responding to escalated risk. We were told these procedures did not always work and alleviate pressures as they ought. System leaders were aware of this and told us NHS England was imminently due to support an evaluation of escalation procedures to try and put a structure in place as well as address any identified gaps.

Information governance arrangements across the system

- The incompatibility of IT systems was the most common problem cited by the 97 respondents to our relational audit who supplied free-text comments. Frontline staff told us that the inability to share information electronically was a barrier to supporting people effectively. There was potential to streamline the system and improve flow and productivity through better use of technology. Some good work had been done with access to GP records but this needed to develop further to include providers such as ‘hospital at home’ teams, ambulance services and district nurses so that professionals have access to the same records and are enabled to assess and plan care and support needs effectively.
- System leaders told us they had established information sharing protocols as part of the Oxfordshire Information Sharing Framework. This was an overarching agreement which set the standards by which information could be shared, and it was developed by a multi-agency information governance steering group. All statutory organisations had agreed to the framework and in the past two years, all GP practices had also adopted this agreement.
- System leaders acknowledged the problems with information sharing systems and were committed to providing integrated care records by way of interfaces between platforms, rather than fully integrated systems due to legacy system challenges. However both OUHFT and OHFT had been awarded Global Digital Exemplar status ¹ under the national NHS programme and were well-positioned to enable this integration.
- While much had been achieved to date in Oxfordshire to enable information sharing, further significant developments were planned as part of the Oxfordshire Local Digital Roadmap (LDR). A key strategic work-stream in the LDR is ‘Records Sharing’, with an improved Oxfordshire Care Summary being one of the first deliverables. The Oxfordshire Care Summary is a Health Information Exchange; a real-time view of information held in disparate clinical systems across Oxfordshire about patients registered at Oxfordshire GP practices.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

¹ A Global Digital Exemplar is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information. Exemplars will share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible.

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

Oxfordshire was particularly challenged by workforce issues across the system and countless concerns about this were raised during our review. There were strategic plans at organisational level and STP level to align the workforce to future demand and collaborative work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway. The current workforce challenges resulted in heavy workloads for staff and impacted upon seamless care delivery and integration of services.

There were some examples of innovative approaches to responding to workforce capacity and skill set, looking at new roles and models of care. System leaders were working to develop the workforce through integrated working and initiatives including working with education institutes.

However, at the time of our reviews this work had not yet had a positive impact and workforce remained a key risk to service delivery and the meeting of need. In addition some social care providers told us they did not feel engaged in the workforce strategy and felt this was a planning omission.

System level workforce planning

- The system in Oxfordshire was particularly challenged by the issues of workforce retention and recruitment across all professions and staff grades, especially acute hospital staff (with the exception of medical and dental staff, where the turnover rate was below the national average) and in the domiciliary care market. This resulted in staff shortages, heavy workloads and impacted upon seamless care delivery and integration of services. The system completed two comprehensive studies (in 2013/14 and in 2017) of Oxfordshire's adult social care workforce in order to better understand the fundamental cause of this issue. As a result, there was recognition among system leaders that the most likely route to resolving recruitment and retention issues was through joint working across the system, and through the Oxfordshire Transformation Programme aligned with the STP and the HWB. Models of care and the unqualified workforce were being jointly explored with the STP in a bid to address a potentially unsustainable workforce. At a more local level work had taken place between the local authority, OUHFT and OHFT to look at a joint workforce strategy, also linked in with the CCG and quality committee, and this was being tested.
- Collaborative work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway led by Oxfordshire Association of Care Providers along with career structure pathways, accreditation and a bid to promote the image and profile of working in the health and social care sector. System leaders should continue to work with all partners to align and address the system-wide challenges and ensure that strategic plans are supported by data and timescales for delivery.

- Working with Health Education England, system leaders in health and social care had been trying to build on the skills of those already living in the community and work with local colleges and universities. They had also been working with district councils to address the issue of affordable housing in an attempt to encourage the workforce into the county.
- Social care providers were not always engaged in a meaningful and true partnership way. Some care providers told us they did not feel engaged in the workforce strategy and wanted to be more involved. System leaders told us they had regular contact with them and social care providers had named officers they could build links with. They felt this, along with regular meetings helped them keep up to date with the workforce strategy and oversight of workforce. Independent providers had also been able to advertise for staff on the local authority's website.

Developing a skilled and sustainable workforce

- Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for the STP and also at local level for Oxfordshire. System leaders were working to develop the workforce through integrated working and initiatives with education institutes. We found positive examples of innovative approaches to growing the workforce by, for example, working with local colleges and universities to support those students keen to pursue a career in health and social care.
- However, countless concerns were raised in regard to recruitment and retention and the impact this had on developing a skilled and sustainable workforce. It was expressed that there was too much fragmentation and more needed to be done to increase professional development and the care industry becoming professionally recognised.
- Social care providers were working together to share what was working well in an effort to harness some of the skills about retaining staff and offering training and information. The system leads for Quality and Contracts had been matching poor performing providers and good performing providers to enhance the training of the workforce.
- There was a positive emphasis on training for staff across all sectors and there was evidence of joint training events taking place, although social care provider awareness of this service was variable. Workforce leads across organisations showed determination to work across the system and they should be encouraged by senior leaders to find the space and time to develop their plans. They all cited pressure of work at all levels as being an inhibitor to integration.
- Staff experienced heavier workloads due to recruitment issues. System leaders had been looking at capabilities and the competencies of the workforce for example, delegated health

care tasks and the use of passports to allow best use of resources and reduce pressure on staff.

- Electronic Staff Record data for 2016/17 showed that the staff turnover rate for NHS staff at Oxford University Hospitals NHS Foundation Trust was higher than the national average across all staff groups, with the exception of medical and dental staff. Adult social care workforce estimates from Skills for Care showed that staff turnover rates had previously been below England and comparator averages in 2013/14, at 20.5%, but then increased over the next two years to 31.2%; above the comparator group average of 28.9% and the England average of 27.4%. Staff vacancy rates in adult social care were at 7.3% in 2015/16, which was in line with comparator averages of 7.2% and England average of 7%. It was expressed by system leaders, frontline and operational staff that the workforce challenges, cost of living and housing all had a significant impact on staff recruitment and retention.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

Commissioning strategies, underpinned by the JSNA and future projections had supported a joint approach to managing the care market and commissioning services and this provided a good platform to move forward with service and operational integration. Oxfordshire faced significant social care market issues and the system needs to make sure there is sufficient capacity and resilience to cope with an anticipated increase in demand. Given that a larger proportion of people in Oxfordshire funded their own adult social care than across comparator areas and England averages overall, the system faced challenges when negotiating care fees on a county wide basis or individual care package basis.

The system had developed an integrated commissioning function with a pooled budget but there was little evidence that much more shared working was planned. System leaders were aware of the challenges they faced and as a result of this a number of developments had taken place in regard to market shaping and models of care.

Strategic approach to commissioning

- The BOB STP outlined the strategic vision, delivery plans and provided an oversight of performance across the STP footprint. While there were some overarching programmes such as workforce and A&E systems the strategic approach to commissioning was undertaken at a local level. However the HWB did not fully set out the strategic ambition of system integration, including integrated commissioning.

- The Oxfordshire Transformation Board which comprised system leaders from the local authority, the CCG, OHFT, OUHFT, SCAS, GP federations in Oxfordshire and Healthwatch was put in place in March 2015 to consider the transformation of services over five years and bring together health and social care partners with a focus on those programmes of work that will deliver significant improvements in the Oxfordshire health and care system.
- There were some positive examples of strategic approaches to commissioning which were effective, and had enabled some co-location of multidisciplinary professionals such as the 'virtual bed' (a specialist multidisciplinary team provided care in the person's own home, while an acute bed was held for a week to ensure if the person's health deteriorated there was an allocated bed space in the community setting for them to return to) and the admission avoidance services.
- While the absence of a specific focus on an older people's strategy made it difficult to articulate joint goals, commissioning plans were focused on the JSNA and projections about future demands on the profile of the population, which was incorporated into the joint Market Position Statements. There was an intended focus on prevention and place-based models of care designed to keep people well at home. However the preventative agenda was currently underdeveloped and leaders stated that the need for public consultation to had delayed fully integrated systems and structures.
- There was a commissioning model for domiciliary care and the system had reduced the number of providers. System leaders felt this gave a clear approach to providing assurances around income streams, ability to guarantee working hours as well as improving the terms and conditions of care workers. The CQC rating for quality for providers in Oxfordshire is higher than the national average; 88% of social care providers are rated as good or outstanding compared to 80% of providers nationally. However, during the review we found that social care providers felt there were some complex commissioning arrangements and contracts that were impacting upon their ability to provide a quality service. Commissioners should evaluate the commissioning arrangements to prevent agency failures.

Market shaping

- The response to the SOIR outlined that the local authority and the CCG worked jointly together and co-produced with providers to incorporate data in the JSNA and projection of future population demand into the joint Market Position Statements (first published in 2014). This outlined their understanding of the market, expectations about future demand, future purchasing intentions and represented the shared approach to purchasing and market pressures. However, the Market Position Statements did not fully set out a clear vision so commissioners and providers could use them to plan and deliver the services required to meet people's complex needs or ensure market shaping for capacity and workforce.

- Some social care providers felt they had not been involved in market shaping and they reported concerns of conflicts of interest and mixed messages in regard to building care home capacity when some care homes had more than 10% spare capacity.
- Oxfordshire had social care market capacity challenges as seen elsewhere in the country, particularly in regard to domiciliary care but there were differing views on how to address this, and continuing issues about affordability – pay was a common issue.
- The numbers of people being supported by the local authority for adult social care was comparatively low and a higher proportion of people funded their own social care compared to the comparator and England averages. This provided different challenges for commissioners who did not have as much influence when negotiating care fees on an individual care package basis. In light of the concerns raised by some social care providers and system leaders, commissioners needed to manage relationships and negotiations in a different and more collaborative way to secure the best rates for the local authority and best quality for people. This would ensure the system was fully assured of capacity and resilience in the market. This should be reviewed as a matter of priority to ensure there is clear view of capacity in the adult social care market.
- System leaders were aware of these challenges and the longstanding pooled commissioning budgets held by the local authority and the CCG had supported a joint approach to managing the care market and as a result of this, a number of developments had taken place in regard to market shaping. For example, the local authority and the CCG jointly fund a specialist dementia nursing home from the BCF pooled budget using social care and continuing healthcare (CHC) funding to create a 25-bed block.
- The local authority had also introduced a Dynamic Purchasing System for care homes to improve access to the care home market at more affordable prices, and the CCG had supported the development of this. The fragility of the domiciliary care provider market in Oxfordshire had partly been addressed through use of iBCF funding to improve provider prices. System leaders told us that fewer agencies had exited the market since March 2017 and there had been a realignment of providers on an approved list. However social care providers reported conflicts in respect of commissioning costs despite the local authority and the CCG paying the highest rates in the country for home care.
- To make best use of resources, there was a vision to move from a bed based model to the virtual beds and the service provided by the Integrated Liaison Team. Furthermore, although not a long term model, interim beds, hub and block beds to guarantee access to affordable and quality services, were available. This model had helped develop capability and capacity in the market, especially around the needs of people with the most complex

needs. System leaders acknowledged there was a need for further specialist capacity to support people with dementia. There were plans to increase capacity and a joint tender process put in place to create more specialist nursing care beds was set to conclude by January 2018.

Commissioning support services to improve the interface between health and social care

- System leaders acknowledged the review of the pooled budget arrangements challenged the approach to market management and its efficiency to deliver the outcomes and objectives set out in the Oxfordshire health and wellbeing strategy and the BCF plans.
- This had led to a number of initiatives to improve the capacity and capability of the nursing home market, joint purchasing of complex care and hospital admission avoidance from care homes. However some of these initiatives were not fully embedded or working as effectively as they were intended; for example there were a variety of services commissioned with health and social care providers to prevent admissions to hospital and to facilitate timely discharges, such as the HART, Reablement Outreach Team and trusted assessor models. But the effectiveness of these was hindered by workforce challenges, complex pathways and delays in assessments.
- Although the analysis we undertook showed the rate of emergency admissions for over 65s in Oxfordshire had been consistently lower than the national average since 2014, there were a significantly high number of delayed transfers of care. System leaders were aware of the challenges and there was system wide recognition that the discharge pathway was complex. Therefore system leaders had mapped out the pathways in an expectation of streamlining the discharge pathway to offer the right support services and improve the interface between health and social care. The local authority and the CCG had jointly commissioned a Hospital Discharge and Reablement Service and a Community Reablement Service to bring several services together to provide a single pathway.
- There was a targeted, reactive approach to wider system pressures, resulting in preventative commissioning being under-developed. There was a lower uptake of direct payments and personal health budgets for NHS funded CHC, and a need to better utilise the VCSE sector, especially to support people ready for discharge from hospital.
- Although there were provider forums, communication between some social care providers and commissioners was reported as difficult at times and engagement was sometimes problematic. Social care providers felt they needed to be more involved in commissioning at an early stage, so that effective incentives could be discussed and for their concerns about commissioning to be listened to and responded to in a more proactive way. It was felt this would improve relationships, commissioning arrangements and service availability.

Contract oversight

- There were comprehensive systems in place to monitor the performance of commissioned services and a good response to quality issues. Commissioners were able to provide examples of how they evaluated the quality of service provision across the health and social care sector and how this helped improve activity and hold providers to account where required.
- System leaders monitored services to ensure care was appropriate and that providers delivered a quality service which met the contractual terms and conditions as well as the needs of people using services. Quality monitoring was risk based and there was shared quality monitoring between the CCG, the local authority and CQC. The system were able to demonstrate some positive outcomes as 50% of acute hospital core services, 47% of adult social care locations and 57% of primary medical locations within Oxfordshire had improved following a CQC re-inspection, which was better than both the comparator group average and the England average.
- The Oxfordshire Care Homes Association provided business intelligence and marketing information from across Oxfordshire to the system. This provided a mechanism to feedback any information or concerns. Information about people's experiences were also gathered from a range of national and local surveys, however system leaders acknowledged that they did not have the mechanisms to monitor and collate the total user experience through their pathways.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

Although there were clear lines of reporting between organisations with embedded risk sharing arrangements, due to system changes, governance arrangements were continuing to develop. There had been a long history of collaborative approaches and risk sharing arrangements, which were reviewed in line with system commitments to provide the necessary assurances.

- System leaders told us that due to a range of strategic challenges a formal review of the pooled budget arrangements took place in 2017 which concluded that the pooled budget arrangements should be re-framed. Therefore the pooled budget structure for 2017 to 2019 had been changed and system leaders set themselves strategic performance indicators relating to flow, user and patient experience and quality that would support system transformation. There was evidence of commitment from system leaders to join up their

commissioning and use resources flexibly for the benefit of people who needed health and/or social care and evidence there had been a move towards operational integration with a commitment to build multidisciplinary teams.

- The BCF pooled budget for 2017/18 had been reviewed and brought together key budgets in relation to care homes, hospital avoidance and prevention. Our analysis showed that there were far fewer residential care home beds per population aged 65+ in Oxfordshire compared to comparator areas and the England average (nearly 50% fewer - 1523 per population in Oxfordshire compared to 3049 across comparator areas and 3043 across England) with only a 1% increase in the number between April 2015 and April 2017. In contrast, there was a much higher number of nursing beds per population aged 65+ in Oxfordshire compared to comparator areas and the England average (3864 per population in Oxfordshire compared to 2750 across comparator areas and 2710 across England). The number of nursing beds had increased by 6% between April 2015 and April 2017. The number of domiciliary care provider locations per population aged 65+ in Oxfordshire was slightly above the number across comparator areas and the England average (113 compared to 99 and 110 respectively) and this number had increased by 4% between April 2015 and April 2017.
- Rates of admission to residential and nursing care homes to provide long term support for older people had been consistently lower in Oxfordshire compared with its comparator group and the England average and had reduced further in 2016/17 to 484 per 100,000 from 530 per 100,000 the previous year. Avoiding permanent admissions is a good measure of delaying dependencies.
- The system faced some significant financial challenges. OUHFT made a small surplus, but did not achieve its financial control total. The CCG was reporting a balanced budget for 2017/2018 and the local authority faced significant financial challenge across its whole budget, although social care as a whole was likely to break even. It is likely that further financial challenges will need to be tackled in future years.
- System leaders were realistic about how this would be managed. System leaders also acknowledged the difficulties faced due to a higher number of people funding their own social care and the changes in the care market with a need to manage relationships and negotiations in different and more sophisticated ways than in the past to secure the best rates for the local authority and best quality for all people.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence

Are services in Oxfordshire safe?

There was a commitment at all levels across the system to proactively maintain people in their usual place of residence; however services to prevent people from needing to access secondary care were underdeveloped and some people experienced delays in social care assessments. Systems and practices were working well for the majority of people, but more was needed to be done to ensure there was a shared view of who in Oxfordshire was at risk of hospital admission and that pilots and initiatives were fully evaluated and embedded.

- Some people experienced a delay in receiving social care needs assessments, resulting in a reliance on other services which were not best placed to meet their needs. Further concerns were raised about the effectiveness of the assessments and review processes in identifying people's complex needs. Case studies provided by local partners reflected these concerns and identified that some people in social housing were living in poverty or those with a social inequality were not identified early enough to prevent a crisis. It was only at the point of crisis that help and support was given which had a detrimental impact on people.
- A clear, in depth proposal to pilot a new frailty pathway to identify and support elderly and frail people to live well in their own homes had been drafted and was due to commence in December 2017. Oxfordshire GP federations and OHFT were also developing a joint enterprise to deliver joined-up primary and community care services through integrated neighbourhood teams. It was anticipated this would define a system wide frailty pathway, with a clear directives running through all parts of the system to care for people close to their homes.
- In an attempt to respond to system challenges, community based services such as care home support and an urgent visiting service (focussing on those at risk of admission to hospital) were available to identify those people who were frail, had complex needs or were at risk of deterioration.
- There was evidence within the case files we pathway tracked that some multidisciplinary assessments were undertaken and support put into place to keep people safe and maintain their health and wellbeing in their usual place of residence. There was universal positive feedback about these services from people, carers, families, system leaders and frontline staff.

- Care home and nursing home providers were supported to maintain people safely in their usual place of residence in a number of ways. Care Home Support Service nurses visited care homes and focussed on early intervention, prevention and improving quality of life. Formal structured teaching sessions were also offered focusing on subjects such as; recognising deterioration, falls prevention, prevention of dehydration, and pressure damage to the skin.
- A medicine optimisation initiative was in place to make more efficient the use of medicine and preventing admissions to hospital due to medication errors. The care home support service employed nurses specialising in medicines contributing to falls and pharmacists were offering additional support and training for GPs, nursing and residential home staff. GP surgeries employed pharmacists and further support was available from the CCG pharmacists. This included a pharmacist specialising in frail and elderly who was involved supporting care homes.
- Data from NHS England's Ambulance Systems Indicators showed that the SCAS routinely identified a higher proportion of calls to the ambulance emergency service as being from people for whom a locally agreed frequent caller procedure is in place than any other ambulance service in England. When these callers are identified, the SCAS team signposted them to the correct services so they received care at the right time, in the right place by the right person. The ambulance staff also worked with care homes staff who frequently used the service with a view to offering them training and support.

Are services in Oxfordshire effective?

Sometimes people did not receive a multidisciplinary approach when requiring additional support services. There were multiple and complex access points which caused confusion for people using services, carers and some frontline staff. There was some success with admission avoidance projects and services. There were widespread workforce issues across the system impacting on service delivery and staff workloads. Work was taking place in regards to recruitment and retention of staff. IT systems did not always communicate effectively which created additional workloads, reduced efficiency and put people at risk of avoidable harm as key information about their care and treatment was not easily accessible.

- A framework for an Oxfordshire Extra Care Housing Strategy for Oxfordshire County Council (January 2008) set out a commitment to invest in housing related support, extra care housing and assistive technology would support people to maintain their independence in their local community for as long as they were able and wished to do so. Although the framework had not been updated we found that investment had been forthcoming and when we visited a scheme, people using the service were positive about their experiences and told us that this enabled them to maintain their independence.

- Plans were in place to build and adapt properties that could remain a person's home for life and support longer term independence. Similarly plans to build affordable housing that would attract care and support workers in to the area were underway again with a view to providing a workforce that could support and maintain independence in a person's usual place of residence. It was important that this work continued at pace.
- Analysis of ASCOF data for 2016/17 identified that the number of people aged 65 and over entering care homes for support for long-term needs per 100,000 population was lower in Oxfordshire (484) than its comparator group average (525) and the England average (611) and had reduced over the last three years. Various pilots and projects had taken place or were underway as part of the admission avoidance work, for example, OUHFT and OHFT were running a pilot where cognitive behavioural therapy training was provided for professionals to improve medicines adherence. This pilot was in its infancy but early feedback suggested this was having a positive impact.
- Services designed to improve flow through the system and to keep people at home were evidence based but the service provision was fragmented, with multiple interfaces that increased the risk of delays in accessing services and confusion for people professionals and carers. There was not a single point of access for health and social care services, there was however a single point of access (SPA) for health services, which provided health professionals with an alternative referral route for patients needing community health services in Oxfordshire. We found that referrals were responded to in a timely way to provide support to people at risk of deterioration and avoid admission to hospital. The single point of access for health services took referrals from GPs, health professionals and more recently the general public but was separate to the social services access desk. There was a strong argument to make the single point of access more comprehensive and include adult social care services as people using services and some frontline staff, felt that there were multiple confusing access points.
- The SPA team was able to evidence positive examples of when they had utilised the trusted assessor model effectively across the system. But there was a need to work with other parts of the system to enhance the implementation of the model and fully integrate health and social care locality teams. For example, there were three Hospital at Home (H@H) services which operated to different specifications – frontline staff and social care providers felt it was sometime difficult to understand the different services offered by these teams and that further clarification was needed. This resulted in some people receiving an inconsistent multidisciplinary approach that was complex and disjointed. Case files that we pathway tracked and reviewed supported these findings.
- Access to primary care had been extended through the hub working approach, with all GPs

that were part of the GP federations working collaboratively to provide services to patients at the evenings and weekends. While this had yet to be fully stress tested, it enabled greater resilience and flexibility within the service and extended people's access to weekend and evening appointments. Our data analysis showed the provision of GP extended access was greater in Oxfordshire than in comparator areas and the England average. As at March 2017, only 2.9% of the 70 Oxfordshire GP practices surveyed offered no provision of extended access, while across comparator areas this was at 14% and across England was at 12.3%. Our analysis also showed that GP funding per patient in Oxfordshire had stayed above the England average from 2013/14 to 2015/16, and in 2015/16 was above its comparator group average (£145.76 compared to £143.67).

- There was an agreement in the BCF return for the delivery of a seven day service across the health and social care system. OUHFT was a national early implementer of seven day working and had facilitated system changes to extend routine working across a seven day week.
- The CCG had been working with the VCSE sector and OHFT to provide weekly falls prevention services to older people and was planning to extend services to begin focussing more on supporting people with long term conditions to improve health outcomes.
- System leaders and frontline staff reported widespread issues in respect of recruitment and retention across the system. In response to these challenges the local authority set out in the BCF plan that they had established a two year workforce programme, funded from the adult social care precept. There was a focus on job and career prospects and investment in additional long term staffing to manage and support the intermediate and acute care system, and to provide seven day prevention services. Despite this, staff in the acute setting continued to report heavy workloads with additional pressures of meeting targets. As the NHS England Five Year Forward View promotes a diversified skill mix in practices, some GPs had employed nurses or paramedics to do many regular reviews and some GP visits.
- Although frontline staff in health and social care services had the right skills and were provided with regular training and development, some social care providers told us they were unaware of training on offer from the local authority and CCG to support social care staff in reducing admissions to hospital.
- To some extent, staff were able to use computer systems or software to exchange and make use of information within the system; however these were not always effective, which impacted on the ability of staff to share information, especially between organisations as staff felt the risk of duplication and errors was too high to share cases.

Are services in Oxfordshire caring?

People living in Oxfordshire were involved in discussions about their care and treatment. People felt there was not enough support provided to people living with dementia and further information and support was required for carers. A commitment to personalisation was articulated in the BCF plan and the future strategic vision and staff at all levels demonstrated commitment to providing person centred care.

- People, their family and carers told us that they felt well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. The case files that we pathway-tracked demonstrated important relationships were acknowledged and the right people were involved in the person's care.
- Age UK had methods to provide people with access to networking and keeping up to date with what was happening in the health and social care sector. Support was also offered to carers, families and advocates so they too could make informed choices about future plans. However representatives in the VCSE focus group told us that there were approximately 62,000 carers a year not receiving the support they required and they had recognised they needed to be more creative and reflective.
- People were treated with kindness when they moved between health and social care services. Frontline staff were dedicated and provided person centred care, going the extra mile for the people they cared for. BCF plans supported personalisation and choice through development of alternative models of care and investment in more flexible budgets.
- Funding for day centres and community support had been reduced. This impacted on some people's wellbeing as they felt these had provided a vital service, providing a sense of purpose and reducing social isolation. This had an additional impact on carers as some felt that they needed additional support, especially as they may have difficulty accessing respite services.
- Oxfordshire's ASCOF performance in 2016/17 compared well against the England average, with the exception of DTOC. A higher percentage of older people were receiving direct payments and a lower rate of older people was being permanently admitted to residential and nursing care.
- Integrated community care teams and the H@H service provided timely support to people with a long-term condition to effectively manage their health and improve their outcomes and experience. Our analysis of data from 2011/12 to 2016/17 measuring how successfully people with long-term conditions felt the NHS supported them demonstrated that a consistently higher percentage of people in Oxfordshire felt they received sufficient support

than across comparator areas and the England average. Furthermore, 2016/17 data for the health related quality of life score for people with long-term conditions in Oxfordshire was above both the comparator and England average (0.77 compared to 0.76 and 0.74 respectively).

Are services in Oxfordshire responsive?

System leaders and frontline staff had a shared vision that a person's own home was the best place for them. However, there were multiple confusing access points into the health and social care system and the VCSE sector were keen to develop networks and referral systems.

Admission avoidance processes were in place, but further work was needed to embed them, as some were being developed in silos rather than strategically across the system.

- Social care providers reported variable experiences and outcomes and a lack of enhanced health care support. However, the GP federations were working well and being embedded. One of the aims was to try and maintain people in their normal place of residence and keep them out of hospital by use of various initiatives such as early visiting services.
- System leaders acknowledged that primary care was under significant pressure with a reduction in the number of practices and capacity challenges. People using services told us that it was difficult to get non-urgent access to GPs and they sometimes had to wait for approximately two weeks for appointments. However the GP hub now offered a seven days a week service, increasing access to a GP. The GP hub was working well and had resulted in better use of resources. Although not the only solution and professionals who may be able to help, this may address the concerns that people identified with access.
- Engagement between the VCSE sector, primary health services and acute health services was disjointed and difficult with no direct route to the hospital.
- Our data analysis of the rate of A&E attendances per 100,000 population aged 65+ who were referred by the GP without follow up showed that this was significantly lower in Oxfordshire than the England rate and had been consistently so for the past three years. Also the rate of A&E attendances from care homes per 100,000 population aged 65+ at 475 was lower than the comparator average of 878 and the England average of 979.
- Emergency admissions of older people were below the England and comparator averages. Analysis undertaken by the Department of Health showed that the rate of emergency admissions per 100,000 population aged 65 and over between March 2016 and February 2017 was lower than the national average at 22,112 in Oxfordshire compared to 24,092 across England.
- This hospital avoidance was also in part was due to initiatives such as the Emergency

Multi-Disciplinary Units (EMUs), H@H, ambulatory units and the Rapid Access Care Unit (RACU), which provided rapid support to people at risk of deterioration in their own homes to prevent avoidable admission to hospital.

- The EMUs provided a 'one stop shop' seven days a week for patients with urgent sub-acute health and social care needs to avoid an acute admission.
 - H@H provided by OHFT aimed to improve the healthcare of patients registered with an Oxfordshire GP within the patient's own home to provide a community sub-acute alternative to non-elective acute admission.
 - The RACU and ambulatory services provided an integrated, multidisciplinary care to sub acutely ill patients.
 - The H@H team worked closely with the ambulatory units to support the safe transfer of care to the person's own home and avoidance of hospital admission.
- We found some good work in place around admission avoidance but some projects were being developed in silos rather than strategically across the system detracting from the effectiveness of services. There was an urgent need to review all services offered and arrive at a coordinated strategy for service design, delivery and outcomes.
 - A Practice Care Navigator role was used to signpost people to services. This had been piloted and rolled out successfully as an effective way to improve, protect and maintain the health of older people and vulnerable patients through integration of care. People using services and multidisciplinary professionals offered positive feedback about this service as well as the community services.
 - SCAS offers an accessible community-based First Aid Unit to people in the Chipping Norton area. There are similar units run by OHFT in Wallingford and Henley. These services signposted people to available services or advice. SCAS has also set up with OUHFT a service where gerontologists who were able to give advice to nurses and GPs supporting people in nursing homes.
 - The Integrated Liaison Team facilitated person centred care in people's own homes. Care was delivered according to people's needs rather than them having to 'fit' to the services available. People using services provided positive feedback about this service. There was evidence to demonstrate that this team worked in a multidisciplinary way with other professionals to keep people at home wherever possible.
 - Case files we reviewed demonstrated these services were effective and admission avoidance had taken place where possible by use of these services. GPs felt these services were useful for patients who would otherwise be admitted to hospital and frontline staff and system leaders spoke positively of these initiatives and felt the ambulatory care was a flag ship service.

- GPs felt that the care and support provided to people living with dementia was very positive. The Age UK website signposted people towards relevant information and identified service availability. The BCF outlined how the system intended to continue to build capacity for GP diagnosis and management of dementia, raising GP awareness of post-diagnostic support services, establishing strong links between primary and secondary care and developing a model of specialist nurse support in the community.
- Availability of ambulance transport impacted on the ability to discharge people in a timely fashion. Frontline staff told us transport arrangements were often a problem which meant people could not benefit from ambulatory care due to their discharge being delayed. This on occasion also resulted in staff having to wait with patients to return home after the service had closed.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Oxfordshire safe?

Although there was a shared view of risk taking which was monitored closely, the escalation processes in the acute setting had to be used frequently. The handover times for ambulances in the A&E department impacted on the ability to respond to emergency calls. People were not always seen in a timely way once they had entered the A&E department, which meant longer waits for treatment.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. This enabled a shared view of risks to deliver services to people in crisis and was monitored closely. Dashboards regarding flow, safeguarding and incidents were provided daily to system leaders and frontline staff who told us these helped with managing escalation and staffing. However frontline staff in the acute setting told us they had to use escalation procedures frequently due to system pressures.
- During November and December 2017 Oxfordshire was at level three OPEL escalation status for 47 of the 61 days (77%). Level three OPEL status indicates that the system is 'experiencing major pressures comprising patient flow and continues to increase and that further actions are required across the system by all A&E Delivery Board Partners.'
- During the same period the system was at level four OPEL status for 2 days (3%). Lever

four OPEL status is the highest escalation level and indicates that there is 'pressure in the system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety'.

- There were also significant handover delays at OUHFT and OHFT. Data provided from SCAS for November 2017 showed that in 1080 out of 3119 cases the 15 minute handover time had not been met, representing 34.6% of the total. This impacted on the ambulance turnaround time and the ability to respond to further emergency calls. Furthermore the A&E four hour target was also increasingly being breached. Our data analysis showed that the percentage of patients seen within four hours in Oxfordshire was 86.1% in 2016/17 compared to the England average of 89.1% and the standard target of 95%, and performance had been declining over the previous two years resulting in longer waits for patients to be assessed.
- Some staff we spoke with accepted escalation and sub optimal performance as being inevitable in a pressured system.
- Senior leaders within the acute setting had begun to look at patient flow in the context of providing assurance that internal resources were being effectively maximised during periods of escalation and pressure, however at the time of our review this work had yet to be evaluated and its impact was unknown.

Are services in Oxfordshire effective?

When a person was in crisis and transferred to hospital, systems and processes were in place to prevent unnecessary admission and long lengths of stay. There were multiple pathways at the point of crisis. The introduction and investment in these pathways was helping to prevent admissions to hospital but work was required to increase staff understanding and confidence in the capabilities of different services to ensure the whole system was working effectively during surges of demand.

There were known environmental issues which had an impacted on patient flow once in the A&E department at the John Radcliffe Hospital. The lack of digital interoperability sometimes impacted on information sharing and communication.

- Although there were complex and multiple pathways when someone experienced a crisis, there were effective admission avoidance systems in place, such as the Urgent Care Centres and Minor Injuries units triaging process.
- The Thames Valley Integrated Urgent Care Service (TVIUC) was launched in September

2017. System leaders told us the recent introduction of 'Enhanced 111', presented further opportunity for collaboration between 111, OUHFT and OHFT clinicians, delivering best patient outcomes, operational performance and value. Ambulance staff told us this had seen a reduction in referrals from 999 to 111 but it was too early to provide an in depth update of the effectiveness of this service. In July 2017 SCAS's percentage of 999 calls resolved with telephone advice was 13% and the percentage of patients seen by crew without transferring to hospital was 41%, both of which were above the England average.

- Admission avoidance services had been invested in such as the ambulatory assessment unit. Frontline staff told us that if a patient needed more support and rapid diagnostics, a referral to the Emergency Admissions Unit (EAU) or EMU could also be made with the intention that the patient would be treated within a day and returned home. However, bed occupancy for Oxfordshire was often at or above the England average level throughout 2016/17 and was at 90% in the first quarter of 2017/18.
- Our analysis of HES data showed that Oxfordshire had a good performance in regards to length of stay. The Department of Health's analysis of data between March 2016 and February 2017 showed that 90% of older people admitted as emergencies in Oxfordshire were discharged within 18 days, which was below the length of stay of any of its comparator areas and in each quarter of 2016/17 the percentage of emergency admissions of older people that lasted longer than seven days was significantly lower than the national average (25% in the last quarter of 2016/17 compared to comparator average of 33% and England average of 32%). If older people were admitted to hospital from a care home, they were also likely to have shorter lengths of stays than comparator areas or the England average with 28% of emergency admissions lasting longer than 7 days in the last quarter of 2016/17 compared to the comparator average of 37% and the England average of 36%. This meant that when people were in hospital, most were only in for short periods of time.
- Due to physical space and capacity issues, there were plans to make alterations to the environment at the OUHFT John Radcliffe A&E department. The current environment did not aid flow which resulted in overcrowding in the unit. SCAS told us they experienced frequent problems with capacity as it was not uncommon for multiple ambulances to arrive at the same time. During our visit to this unit we saw people who had been brought to the department by ambulance waiting to be moved to an appropriate space in the department.
- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways and access points, provided by different staffing groups. Frontline staff reported multiple confusing access points into the system and told us that which one they would use depended on individuals' knowledge of the options. This could mean that people do not receive individualised care, and could also mean more people are sent to A&E.

- Frontline acute staff felt the pathways and access points were clear, whereas some system leaders acknowledged getting specialist support such as general medicines was more difficult. If further treatment was necessary, there continued to be multiple pathways, such as the EAU, EMU and the RACU, hospital wards or transportation home with a care package. Therefore there is a need to ensure that these pathways and access routes are well defined and communicated across the system.
- OHFT trust figures between April and October 2017 demonstrated the effectiveness of the EMU units. For example, during October 2017 690 patients out of 729 required no further treatment. Data provided from the system also demonstrated the effectiveness of the EAU for those requiring medical care; on average only 60% of the people seen in EAU were subsequently admitted to a hospital ward. The Ambulatory Assessment Unit pathway enabled multidisciplinary professionals to seek clinical advice and avoid using A&E when this wasn't needed. Frontline staff confirmed the effectiveness of these services in reducing hospital admissions. The co-location of a social worker supported decision making with non-medical issues in these departments, and GPs were also working in ambulatory care, which the GP Federation and LMC described as having a positive impact.
- If admission to hospital was not necessary people may have been sent home with additional support from the acute H@H or HART. There were missed opportunities to streamline these services as staff told us that there were three hospital at home teams and these services sometimes overlapped and duplicate calls were a problem. We saw within one case file we reviewed that at the point of crisis this system had been utilised effectively and they had been supported by the hospital at home team and a relevant care package to prevent admission to hospital. Staff also felt that inappropriate referrals were sometimes made to the HART service and the criteria were circumvented. Figures provided by system leaders at the time of our review showed that the presenting needs of people using this service remained high with 43% of hours spent on complex cases and the average hours for completed packages remaining above the expected levels.
- There was some interoperability between health and social care to allow staff to share information across the system. However concerns had been expressed by some frontline staff about accessibility to these at the point of crisis. There were a number of meetings which enabled effective communication and information sharing at strategic and operational levels. However, some social care staff reported ineffective communication when people were admitted to or discharged from hospital. For example social care providers not being informed when someone was being discharged from hospital, or not receiving essential information at the point of discharge.

Are services in Oxfordshire caring?

Frontline staff understood the importance of involving people and their families in decisions about their care. People's experiences at the time of crisis did not always promote their health and wellbeing or protect their privacy and dignity. Carers faced additional challenges and required more support at the time of crisis.

- System-wide initiatives including a 'knowing me' passport across OUHFT and OHFT were completed for all patients with dementia and remained with the patient on discharge. Our review of case files while in the acute setting showed holistic assessments of people's needs and multidisciplinary input. There were examples of carers and relatives being involved in decision making at the time of crisis and that their views and opinions were taken into account in respect of any decisions made. This ensured that the person's best interests were established and the best outcome for the person achieved with minimal distress. However, people were undergoing multiple assessments which resulted in them telling their story more than once.
- Some people's experiences at the time of crisis did not always promote their health and wellbeing, for example, we saw instances where people's privacy and dignity were compromised in the A&E department at John Radcliffe Hospital; and one person told us that although they had been seen in A&E quite quickly, they had to wait a long while for their subsequent operation. A case file pathway tracked, showed a patient had a positive, patient centred episode of intervention when admitted to hospital but, they had a 15 day delay in hospital due to waiting for HART services.
- Carers were not always fully supported at the time of crisis. Although there was a five day emergency service they could access, carers told us this did not cover out of hours and this could result in challenges for them. Nevertheless positive feedback was received about this service.
- Carers of people who were funding their own care also faced challenges at the time of crisis in securing respite services. They told us there was a lack of support from the local authority in respect of navigating the system. System leaders advised that information was on the Live Oxfordshire website for people to access should this be required.

Are services in Oxfordshire responsive?

People living in Oxfordshire did not always receive the right services during times of crisis due to the multiple confusing access points. Triage took place on arrival to A&E and there were some responsive community-based services, which people were referred to if required such as EAU, RACU and the ambulatory services which reduced some of the pressures on the hospital. However at times, people stayed on EAU for longer periods than expected and transfers to appropriate wards were delayed.

- System leaders and front line staff shared a vision of moving from bed based care to alternative models. There were systems in place to support this and prevent people being admitted to hospital at a time of crisis. For example, the H@H team could provide intravenous support at home and the SPA and the Integrated Locality Team could also help avoid admission to hospital. There was feedback from frontline staff that the SPA was dealing with calls in a timely way and making the necessary referrals to other services. Also the enhanced 111 service had employed more GPs and mental health care staff, along with pharmacists in the call centres to ensure correct streaming and advice was given.
- However due to multiple pathways at the time of crisis there were mixed views about how to access and navigate the admission pathways and the impact this had on patients, especially when someone required specialist care. The case notes we reviewed confirmed the multiple pathways and the impact these had on the patient.
- Nevertheless on arrival to A&E there were effective triaging systems and a frailty service to ensure appropriate support was sourced. The therapy team based at the John Radcliffe Hospital A&E worked with other multidisciplinary professionals to avoid admission wherever possible and accessed community beds if appropriate. Also at Horton General Hospital a coordinator managed and had oversight of the unit and the A&E nurse lead told us the impact of this was that assessments were rapid. The triaging practice at the John Radcliffe Hospital was due to change imminently and everyone arriving at the department would be triaged by a nurse who would signpost them to the different departments, such as minor injuries, Ambulatory Assessment Unit and GP streaming.
- We found when visiting the John Radcliffe Hospital that some people were staying in EAU for longer than the expected timeframe and there was a delay in transferring them to the relevant ward. While there was a reason for this in some cases, staff told us that sometimes people stayed longer if they felt they could discharge them home after the key performance indicator time rather than admitting them to a ward. We also found that people were sometimes supported at the end of their life on this unit. While in some cases this may not be avoidable, frontline staff and hospice staff based in EAU told us there were insufficient end of life beds in the community which resulted in people dying in hospital.
- System leaders told us they were investing resources in the ambulatory assessment units so they could stay open later and provide more capacity to move patients from A&E. System leaders must ensure when investing in this model that they consider the effectiveness of this service and to ensure this doesn't become another holding area.
- System leaders told us the local authority commissioned an urgent response service to provide social care for up to five days in emergency situations; including when a person

was at risk of hospital admission. In addition, the local authority contracted for a Telecare service for approximately 4000 service users; this also included an urgent response element.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Oxfordshire safe?

Some people had poor experiences on discharge home from hospital which impacted upon their health, safety and wellbeing. There were low levels of trust in discharge and medicine information due to widespread concerns in regard to its quality and timeliness.

- People did not always experience safe discharges home. People using services and social care providers raised concerns about people's experiences of discharge. We were told of examples of some people being discharged home late at night - between 02:00 and 03:00, which was unacceptable. Another person told us they were discharged home with a care package supposedly in place, only to find this was not the case when they arrived home and there was no one to provide the support they needed. They said eventually help arrived several days later but this had impacted on their confidence to be at home on their own.
- There were also widespread concerns regarding the quality and accuracy of discharge information, or about not getting any discharge data at all. This resulted in social care providers having to contact the hospital to gather more information and clarify if information was correct. Further concerns were also expressed about social workers providing information which was out of date, which provided an inaccurate picture of placement requirements. This sometimes resulted in a lack of risk sharing and responsibility and breakdown of care placements as people required more significant care than the service provider was led to believe. These findings were supported in the responses we received from registered managers of social care providers to our discharge information flow tool. Although we only received 16 responses, just over half said they received discharge summaries on 50% or fewer of the occasions that people were discharged from hospital into their care, with registered managers of domiciliary care agencies in particular reporting that they rarely received discharge summaries.
- There were also concerns about medicine management and optimisation across the system with social care providers reporting concerns such as, lack of information, delays in

receiving medicines and prescription information detailed incorrectly. The medicine optimisation team also reported poor quality discharge letters from OHFT, and gave examples of when no indication had been given that medicines were being discontinued. This would impact upon medicines administered after discharge and could impact upon a person's health and wellbeing.

- Work had taken place in the acute setting with system leaders to facilitate more effective processes. Pharmacy leads told us that new processes were in place where the pharmacist drove the processes, drug-listing the discharge summary and preparing the prescription. Patients could only be discharged once the summary was checked by a doctor. They reported this had drastically reduced errors and also the time taken to process medicines for discharge had reduced by 90 minutes.
- While the length of stay was shorter, our analysis showed that emergency readmission rates for older people had been higher than comparator and national averages throughout 2016/17 and in the last quarter of the year, the percentage of older people in Oxfordshire requiring emergency readmission within 30 days of discharge from hospital was 19.5% compared to the England average of 18.6% and comparator average of 17.7%.
- Our analysis also shows that the percentage of older people receiving reablement services following discharge from hospital was lower than the England average in 2016/17 with Oxfordshire at 2.5% per 100,000 population and the England average of 2.7%. The percentage of older people receiving reablement following hospital discharge had reduced steadily over the previous five years from 4.4% in 2011/12. It also seemed the effectiveness of these services had declined; in 2016/17 79.8% of people over 65 were still at home 91 days after discharge from hospital to a reablement service, while this performance was in line with Oxfordshire's comparator group it was below the national average of 82.5%, and Oxfordshire's performance on this measure had worsened over the last two years.

Are services in Oxfordshire effective?

There had been considerable drive at a system level to address the issues of performance in relation to delayed transfers of care in the acute and community settings, but the number of delayed transfers of care remained high at the time of our review.

The workforce did not always collaborate and share information to meet the needs of the local population which led to inconsistency in starting the discharge process. Reablement services were usually achieving good outcomes for people although performance was declining. Although people's lengths of stay in hospital were shorter, readmissions to hospital were higher indicating that some discharges may have happened too soon and people experienced delayed transfers of care if they required longer term placements.

- Social care providers and frontline staff voiced concerns about the consistency in beginning the discharge process on admission and felt that the CHC assessments were a contributing factor to DTOC. Case files we reviewed demonstrated that the time discharge planning commenced was variable and the level of detail was inconsistent. We also found a case where a person was unable to be returned home as they were waiting for CHC funding, despite having undergone several assessments. The urgent care leads told us that although discharge information was discussed frequently it may not always be recorded and this was something they were looking to improve. They also told us that lengths of stay may vary on wards and there could be delays in discharge due to patient and family choice of available care packages.
- DTOC data we analysed covering February to April 2017 (the period of time used by the Department of Health in the DTOC analysis that was used to select areas for this review) did show that delays due to patient or family choice in Oxfordshire were higher than both the comparator (1.6) and national average (1.5) rates, accounting for an average daily rate of 2.9 delayed days per 100,000 population, although it was not one of the top three reasons for delays in Oxfordshire during this time period. Later analysis covering July to September 2017 showed that delays due to patient or family choice had increased in Oxfordshire to an average daily rate of 4.4 delayed days to be the third main reason for delays.
- Efforts had been made to improve system flow and reduce DTOC. For example, Oxfordshire System Flow Executive held weekly meetings to discuss issues with system flow, stranded patients, and lengths of stay and provided oversight of bed capacity. There were daily meetings to discuss transfers of care where ongoing support was required. The system was also trying to work more proactively with tertiary areas and there was to be a change in policy about managing these DTOC.
- However there were multiple out of hospital discharge pathways and our review of case files showed estimated discharge dates were not being discussed early enough and there was a lack of strategic oversight of the discharge process. The trusted assessor model, discharge coordinators and flow leads roles were not fully effective and people still experienced delays in their discharge, especially at weekends.
- Our analysis of DTOC between April 2015 and July 2017 showed that the rate of DTOC in Oxfordshire was consistently, and often significantly, higher than average. Delays reached their peak in June 2017 at an average daily rate of 39.9 delayed days per 100,000 population aged 18 and over (compared to national rate of 13.8) and while there had been a reduction to 34.7 delayed days in July 2017 (the most recent data analysed at the point of this review), this was still over double the comparator average of 16.1 and England average

of 13.5 delayed days. More recent DTOC analysis shows performance has continued to improve in Oxfordshire, with delays dropping substantially in August 2017 to an average daily rate of 26.3 delayed days and continuing at a much lower rate than in previous months, although still higher than national or comparator rates.

- System leaders were aware of the challenges the system faced. The CCG had undertaken site visits to OUHFT and Horton to assess the Safer, Faster, Better assurance and identify blocks in the system and in July 2017, pathway workshops were held. The System Flow Executive accepted the broad conclusions from the pathway workshops and authorised the development of a pathway programme on 4 August 2017; the programme was under development at the time of our review.
- The workforce did not always collaborate and share information to meet the needs of the local population which led to inconsistency in commencing the discharge process on admission and communication at the point of discharge. Social care providers and frontline staff expressed concerns and gave an example where a district nurse had not been informed of a medical need they needed to follow up and support the person with. This could have had serious consequences for the patient and resulted in readmission to the hospital.
- Systems leaders were aware that the HART needed further development and alignment and a recovery plan and mitigating actions had been discussed during recent A&E delivery board meetings. The HART staffing trajectory was not on track and there was a gap in the projection against what the service was able to deliver. The A&E delivery board performance dashboard showed that in September 2017, HART was performing consistently below the expected delivered hours which were 8440. In September 2017 HART achieved only 6848 hours. However delivered hours had increased in November 2017 to 7343 hours.
- A lack of digital interoperability did not support frontline staff to make timely decisions as IT systems were not compatible. Frontline staff told us the current IT systems were not fully effective in supporting communication and information sharing which impacted on the discharge process.

Are services in Oxfordshire caring?

People who use services, their families and carers were not involved early enough in the discharge process. People who were funding their own care experienced difficulties in accessing essential information and were therefore not always aware of what was available to them. While VCSE organisations were supporting people on discharge, more could be done if there were better links between the acute setting and the VCSE sector. Some people were not able to access hospices and as a result died in hospital rather than their place of choice.

- Our review of case files showed a person-centred approach was adopted and wherever possible people's preferences were documented and the right people were involved in conversations about their care. However, some records showed these discussions were not always started early enough and this had impacted upon their discharge and length of stay.
- People funding their own care faced barriers to accessing advice, information and guidance about services and costs and were not always at the centre of their care and support when moving through the health and social care system. Furthermore social care providers also told us there was a lack of support for financial assessments and costs of care were not always made clear.
- There were missed opportunities for the VCSE sector to be involved in the discharge process to make it more effective and person centred. The VCSE sector felt they could do more but there were barriers to them doing so due to insufficient links with acute hospital services.
- People at the end of their life who were admitted to hospital via A&E did not always experience a rapid transfer home or to a place of preference. Frontline staff we spoke with demonstrated compassion and a good understanding of support needed for people at the end of their life and stated there were good relationships with the local hospices and care homes. However they felt there was an insufficient number of hospice beds to transfer people to if this was their preference. This meant that people sometimes died in the EAU. Staff told us they did try to make this a peaceful and compassionate experience.
- Assessment and referral conversion rates for standard CHC assessments were above the England average in the first quarter of 2017/18 with Oxfordshire's conversion rate for assessments and referrals performing at 37% compared to the England average for assessments at of 31% and referrals at 25%. However the rate of assessment and referral conversion rates for Fast Track CHC (usually used for people at the end of their life) was lower, at 89%, than the England averages of 99% and 85% respectively, which may impact on the person being transfer to their preferred place to end their life.

Are services in Oxfordshire responsive?

There were multiple pathways to facilitate discharges from the acute setting and support people to remain as independent as possible. However, people experienced a high number of delayed transfers of care. Due to system challenges and conflicting information in regard to availability of care home packages in the community it was difficult to establish if there was sufficient capacity within the market to cope with the increase in demand. A higher number of CHC assessments were undertaken in an acute setting which could lead to delays and this needs addressing as a matter of urgency.

- The views of frontline staff in respect of CHC assessment varied; some felt the process worked well, whereas others felt this contributed to DTOC. Our analysis of NHS CHC activity in the first quarter of 2017/18 showed that 36% of decision support tools were completed in an acute setting in Oxfordshire compared to the England average of 27%. A higher percentage assessments being completed in acute settings can contribute to delays. Nevertheless, the rate of NHS CHC referrals exceeding 28 days was 5.87 per 50,000 compared to the England average of 10.27.
- There were discharge coordinators in post, a discharge assurance group, and daily multidisciplinary meetings to support patients to achieve rehabilitation goals. However, Oxfordshire had a long-term problem with DTOC. In 2016/17 over 51,000 beds days were lost to delays, which while a slight improvement on the previous year (59,000 bed days lost) meant that it still was the 4th highest rate in the country and nearly three times the national average. Our data analysis of DTOC per 100,000 population aged 18+ between February and April 2017 showed that the main responsible organisation for DTOC was the NHS, accounting for an average of 16.3 delayed days per 100,000 population aged 18+, while a further 13.1 delayed days were attributed to both the NHS and social care and 4.2 delayed days were attributed to just social care. By far, the main reason reported for delayed transfers of care in Oxfordshire over this time period was “awaiting care package in own home”, accounting for an average daily rate of 15.8 delayed days per 100,000 population aged 18+.
- System leaders felt there were not enough care packages, and dementia packages for those with moderate to high needs in social care settings and this lead to delays in transfers. Frontline staff were also of the same view and there was a consensus that there was a significant delay for people with complex or mental health care needs. There were also significant issues with care packages in the community and although there had been some reconfiguration of the commissioning of these, social care providers told us they had vacancies. This did not correlate with the data held by the system and therefore the delays could not be fully understood. Acute frontline staff also told us there were issues with care packages if they needed to start midweek.
- The Department of Health’s analysis of activity showed between October 2015 and September 2016 the proportion of older people discharged over the weekend in Oxfordshire was similar to its comparator areas at 20%. However, social care providers were less likely to accept discharges over the weekend, which meant this figure was unlikely to increase.
- Patient transport accessibility also impacted on people’s experiences and resulted in delayed transfers of care. A number of these issues were caused by the OUHFT and OHFT

discharging planning process as this caused an issue with the timeliness of discharge and use of resources. Although services such as the EMU were reducing the pressures on admissions to hospital, these services were short term and reactive and frontline staff told us this did not always work well as transport services required advanced booking. These delays meant that new patients could not be admitted to the service and could result in them being referred to emergency services.

- System leaders in the ambulance service stated there were challenges due to the number of unplanned discharges. Data supplied by SCAS showed that in October 2017, 28.6% of transfers were planned and 71.4% were short notice. When a 'breaking the cycle' week had been held from 6 to 12 November 2017 the figures were 29.5% planned and 70.5% short notice. The target for short notice discharges had recently been reduced to 30%, these figures corroborated that the majority of discharges were not planned in a timely manner. Also at times there was ineffective use of transport resources, for example, there had been occasions when the ambulance service arrived on the ward but OUHFT had also booked their own transport. Frontline staff at OUHFT advised this was to ensure the patient got transferred home; if there had been delays then they would also book their own transport , but this was unwarranted and an inefficient use of resources which added to the complications of the discharge system.
- System leaders told us there had been changes over the last 20 months as they were trying to move from bed based care. They had reduced bed base by 110 beds and invested in a range of ambulatory and home based services. This meant there were a variety of services available to support people to access reablement to help them to return home including step down, hub beds and the community reablement service, which followed a discharge to assess model. However people were getting stuck in reablement beds causing a holdup in the system. Frontline staff felt this was because these beds were used inappropriately which caused additional pressure and waiting lists in some areas. HART was commissioned to deliver a discharge to assess model. However, an increase in acuity and dependency had resulted in capacity issues due to increased episode hours. The system had put in place mitigating capacity in support of this and commissioners and providers were continuing to work jointly to address the acuity and dependency issue.
- The hospital at home teams for the north and south and the Acute Hospital at Home Team were in place to facilitate discharge. However these teams created some overlap in services and staff told us that sometimes more than one member of staff arrived from different teams to support the person. Also due to insufficient packages of care in the community, people could be using this service for months and staff within this team felt that the main reason for DTOC was waiting for care packages.
- Community rehabilitation pathway 'virtual beds' were being trialled on community hospital

wards to support early discharges. This enabled the person to go home with support from the multidisciplinary team while their bed remained open. This meant if the person was unable to manage at home they still had a rehabilitation bed to come back to if needed. During our visit we observed a multidisciplinary meeting where these people were discussed to ensure their needs were being met in the community or if they needed to return to the unit.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Oxfordshire?

- There was a lack of whole system strategic planning and commissioning with little collaboration or a shared compelling vision for the design and delivery of services.
- Some strategies were not regularly refreshed and updated according to people's needs.
- We found that services for older people in Oxfordshire had operated for two years without a clear and current strategy. It was not evident that identified priorities from the JSNA were aligned with the STP and BCF priorities. The system had recognised this was a shortfall and were attempting to address this through the transformation plans and the refresh and refocus of the HWB.
- There were some positive examples of relational working and collaboration in the interests of the population's defined needs. However, overarching strategies had yet to be defined and co-production with the local population remained an area requiring further development.
- There was limited evidence of system-wide multidisciplinary team working for effective outcomes. There was some work in place regarding discharge from hospital and the community services, but there was little evidence of pathways across primary, community and secondary care that supported the wider objectives of health and wellbeing maintenance.
- A large proportion of decision making still sat separately within individual organisations but there was evidence of system wide approaches in respect of managing particular issues and challenges such as DTOC. In these instances there were shared metrics and systems for the oversight of performance and delivery.
- Historically relationships between leaders across the system had been poor, with a high

level of mistrust. Although these were developing positively the relational audit demonstrated that work was still needed to engage and include system partners, frontline staff and other key stakeholders.

- There had recently been changes in leadership in several organisations within Oxfordshire and this had encouraged an increased willingness to build trust and to work collaboratively going forward.
- The Oxfordshire Transformation Board had supported a joint approach in managing the local care market and commissioning services. The Transformation Board was seen to be providing a positive platform to support operational integration however; there was little evidence that a wider approach to full integration was planned.
- Oxfordshire was particularly challenged by workforce issues across the system. There were strategic plans at organisational levels and STP level to align the workforce to future demand and work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway. However recruitment challenges continued to have an impact on the care market. There were challenges in recruiting staff in a number of key service areas with the high cost of housing and accommodation cited as a barrier to staff retention and recruitment.
- Strategic effort was required to provide more affordable housing at pace to support the supply and maintenance of a sustainable workforce.
- System leaders acknowledged that incompatible information sharing systems were a barrier to seamless working across agencies and were committed to providing integrated care records by way of digital interfaces.
- Both OUHFT and OHFT had been awarded Global Digital Exemplar status under the national NHS programme and consequently were well-positioned to enable this integration. Further developments were planned as part of the Oxfordshire Local Digital Roadmap.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

Strategic priorities

- System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. While doing so a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.
- System leaders must address and create the required culture to support service interagency collaboration and service integration.
- The older people's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the older people's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.
- System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.
- System leaders must evaluate their winter plans and pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand.
- System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.
- System leaders must implement the STP's joint workforce strategy and work with the full range of care providers to support a competent, capable and sustainable workforce.

Operational priorities

- System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.
- System leaders should ensure that housing support services are included within

multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.

- System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure resources are used effectively.
- System leaders should review methods used to identify carers eligible for support so that they are assured that carers are receiving the necessary support and have access to services.
- System leaders should ensure that better advice, information and guidance is offered to people funding their own care.
- Continue to embed the trusted assessor model.

Engagement priorities

- System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.
- Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.



Oxford University Hospitals
NHS Foundation Trust



OXFORDSHIRE
COUNTY COUNCIL

CARE QUALITY COMMISSION
OXFORDSHIRE LOCAL SYSTEM REVIEW
(November 2017)

ACTION PLAN



Oxfordshire
Clinical Commissioning Group



Oxford Health
NHS Foundation Trust

Background

Following the announcement in the Spring Budget 2017 that councils would receive an additional £2 billion to support adult social care needs, reduce pressure on the NHS and stabilise the care provider market, the CQC were asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 20 local authority areas. The onsite review of the Oxfordshire Health and Social Care system took place between 27 November and 1 December 2017 with inspectors interviewing senior system leaders, holding focus groups with frontline staff and making visits to several health and social care services.

On 29 January 2018 system leaders from across Oxfordshire County Council (OCC), Oxford University Hospital Foundation Trust (OUHFT), Oxford Health Foundation Trust (OHFT), South Central Ambulance Service (SCAS) and GP Federations, and major local stakeholders came together with CQC inspectors and representatives from the Department for Health, Social Care Institute for Excellence and NHS England to discuss the findings of the report and agree actions that would be taken in response. This action plan was developed following those initial discussions and describes the actions that will be taken by the system in response to the areas for improvement identified in the CQC report.

Oxfordshire System Leaders have approached this System review and the development of the action plan as a real opportunity to galvanise, improve and enhance system working. The review has reflected back to the system the challenges which are well understood locally, such as workforce, it has provided the catalyst for finalising the single vision for health and social care in Oxfordshire and challenged the system to progress further and faster with an integrated offer to our population. System Leaders were supported in developing the plan by Deborah Rozansky from the Social Care Institute for Excellence.

Action Plan

This action plan contains high-level actions and should be read in conjunction with the Accident and Emergency Delivery Board (AEDB) Improvement Plan (see embedded document below). The AEDB Plan describes the tactical and operational priorities for a specific area of the system (A&E performance and hospital flow).



AEDB Improvement
Plan.pdf

The Action Plan will be approved by the Oxfordshire Health and Wellbeing Board, which will be responsible for assuring its delivery.

Key to initials used in the action plan:

Initials	Name	Role	Organisation
BH	Bruno Holthof	Chief Executive Officer Chair of Accident and Emergency Delivery Board	Oxford University Hospitals NHS Foundation Trust (OUHFT)
BL	Benedict Leigh	Deputy Director Joint Commissioning	Oxfordshire County Council (OCC)
DHa	Dominic Hardisty	Chief Operating Officer	Oxford Health NHS Foundation Trust (OHFT)
DHe	Diane Hedges	Deputy Chief Executive Officer	Oxfordshire Clinical Commissioning Group (OCCG)
JMW	Dr Jonathan McWilliam	Strategic Director for People	Oxfordshire County Council (OCC)
IH	Cllr Ian Hudspeth	Leader of the Council Chair of Health & Wellbeing Board (HWB)	Oxfordshire County Council (OCC)
KC	Dr Kiren Collison	Clinical Chair Vice Chair of Health & Wellbeing Board (HWB)	Oxfordshire Clinical Commissioning Group (OCCG)
KT	Kate Terroni	Director for Adult Services	Oxfordshire County Council (OCC)
LP	Louise Patten	Chief Executive Officer	Oxfordshire Clinical Commissioning Group (OCCG)
PB	Pauline Brown	Local Director	Health Education Thames Valley (HETV)
SF	Sam Foster	Director for Nursing	Oxford University Hospitals NHS Foundation Trust (OUHFT)
SW	Sula Wiltshire	Director of Quality	Oxfordshire Clinical Commissioning Group (OCCG)
TB	Tim Boylin	Director for Human Resources	Oxford Health NHS Foundation Trust (OHFT)

Strategic Priority	Key actions	Accountable	Responsible	Completion date	Current progress
A) System leaders must improve how they work together to plan and deliver	A1) Agree the refreshed vision for Health & Wellbeing in Oxfordshire	IH / KC	JMW / LP	31/05/18	Paper in development for March Health & Wellbeing Board. Meeting with OCC co-production board to discuss approach to strategy development.

health and social care services for older people in Oxfordshire. Whilst doing so a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.	A2) Review and revise the Oxfordshire Health & Wellbeing strategy to ensure that is co-produced and owned by all key stakeholders and aligned with individual organisational strategies and informed by evidence and best practice	IH / KC	JMW / LP	19/07/18 (HWB)	As above
	A3) Develop a co-produced older people's strategy that delivers the Oxfordshire Health & Wellbeing vision and strategy and which is owned by all key stakeholders and aligned with individual organisational strategies (see C) for detailed actions)	IH / KC	KT / LP	15/11/18 (HWB)	As above
	A4) Review and simplify the system governance structure to clarify accountability and reduce overlap i. Full review (membership, frequency, Terms of Reference etc.) of Health & Wellbeing Board ii. Redesign of system programmes/boards to ensure delivery of Health & Wellbeing, refreshed strategic objectives to consider the development of an	IH / KC	JMW / KT / LP	22/03/18 (draft for HWB) May 2018 (final)	Engagement with stakeholders carried out by Chair and Vice-Chair during February 2018.

	integrated care system for older people in Oxfordshire				
	A5) Review impact of changes to strategy and accountability within 12 months of implementation to ensure maximum effectiveness	IH / KC	JMW / KT / LP	July 2019	
B) System leaders must address and create the required culture to support service interagency collaboration and service integration.	B1) Review the relational audit carried out by CQC and invest in organisational development to address specific issues	Chief Executives	Chief Executives	30/04/18	Five senior commissioners from OCC and OCCG to jointly attend the NHSE commissioning capability programme
	B2) Establish a set of principles, behaviours and narrative to support shared purpose around the needs of the individual and delivery of strategy	Chief Executives	Chief Executives	30/04/18	Initial principles agreed 26/1/18
	B3) Agree a shared accountability framework.	Chief Executives	Chief Executives	30/09/18	
	B4) Develop a major programme of substantial inter-organisational activities to cascade, embed and monitor impact of these principles and behaviours in delivery of our strategy	Chief Executives	Chief Executives	30/09/18	Early Stage Quick Wins The New Team Hunter project: Inter-organisational approach to “Home First” and right destination first time – OCC, OH and Age UK are embedded on short stay wards at John Radcliffe Hospital to improve flow. At midway review this was showing positive

					impact and there is continued commitment to the project. • There is a dedicated Emergency Department worker from OCC to gather early intelligence and reduce admissions where possible. • Creation of a number of joint commissioning posts between OCC and OCCG - Childrens Lead - Care Home Commissioner - Home Care Innovation Officer
The Older People's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the Older People's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.	C1) Develop a co-produced older people's strategy that delivers the Oxfordshire Health & Wellbeing vision and strategy and which is owned by all key stakeholders and aligned with individual organisational strategies - The development of strategy will build upon current diagnostics - It will be co-produced and be based on a review of older people's experiences including what people say about the services they currently receive	IH / KC	KT / LP KT / LP KT / LP	15/11/18	Paper on scope and process for development of Older People's Strategy to go to March 18 HWB. Joint Strategic Needs Assessment (JSNA) has been refreshed and is going to HWB 22.03.2018 Older Peoples specific JSNA currently in development Meeting held with OCC Co-Production Board (TeamUp) to inform design of co-production model for strategy development.

	iii. A whole system approach will be taken in developing a frailty pathway that will be tested, implemented and evaluated iv. The development of the strategy will be used to refresh JSNA for 2019-20		DHa / BL / DHe JMW	November 2018 March 2019 (HWB)	Draft frailty pathway in place – the actions in this section will build on the work already undertaken in this area
D) System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.	D1) Agree and implement an effective escalation framework and protocols so partners can prioritise activity and make a single consistent set of deployment resource decisions during escalations. It will include the ability of the system to prioritise activity and capacity at times of pressure across different providers to maximise flow. i. Share learning within system partners and implement change accordingly ii. Develop a mechanism to collate learning from work carried out during escalations iii. 6 monthly system wide review meetings, supported by the STP Urgent Emergency Care group, for mop-up and future plan adjustment	BH	System Flow Executive	AEDB April 18	Escalation processes reviewed by System Flow Executive as part of reflection on the deployment of the winter plan and in the development of the Easter Plan which was agreed on 02/03/18. This will be consolidated into the winter plan 2018/19 which will be completed by 30/4/2018.

E) System leaders must evaluate its winter plans and demand pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand.	E1) Implement the Oxfordshire AEDB Urgent Care Improvement Plan (appended). Plan is monitored monthly at AEDB and has been developed in response to external analysis commissioned by NHSE/I.	BH	System Flow Executive	See AEDB Plan appended.	The AEDB Urgent Care Improvement Plan to be finalised at AEDB March 2018. Easter plan agreed 02/03/18. Plan focuses on ensuring improved access to GP appts and adequate Out of Hour, Community and Social Care capacity. In addition, the plan includes short term actions to improve out of hospital flow and is looking at reviewing smaller care packages, improved flow through the Hub and Community Hospitals.
	E2) Agree and implement effective reporting and oversight of the AEDB plan at HWB to assure system accountability for the delivery of these plans	IH / KC	JMW	22/03/18	
	E3) Evaluate the current plan to identify and implement any changes and lessons learned at system level and incorporate any changes into 2018/19 plans i. Review access to capacity during high demand periods ii. Review constraints in Hospital Discharge and Reablement Pathway	BH	System Flow Executive	30/4/18 (NHSE ops planning)	Learning from 2017/18 plan and subsequent holiday surge escalation to be written into 2018/19 winter plan which will be developed by 30/04/18.

	iii. Home needs in relation to admission and discharge identified at an early stage, allowing referrals to be made promptly iv. Ensure CHC process is as streamlined as possible v. Implement all whole system agreed recommendations of Carnall Farrar and Hunter reports vi. Review current approach to primary prevention vii. Review current approach to secondary prevention				Discussion on priorities for future work in primary prevention scheduled at Health Improvement Board in May 2018
F) System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of	F1) We will develop a system wide approach to provider market management, including non-commissioned services such as voluntary and charitable services	IH / KC	KT / LP	19/7/18	OCC-OCCG joint Care Home commissioner post commenced March 18. Care Home review commissioned from external agency to report back March 18
	F2) We will engage our market in developing a shared understanding of system needs and market capacity and capability.	IH / KC	KT / LP	15/11/18	Paper in development for March HWB. Meeting with OCC co-production board to discuss approach to strategy development.

domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.	F3) We will develop commissioning intentions with providers in a co-produced model to create a sustainable market with the capacity and capability that is aligned to the Health & Wellbeing and Older People's strategy. i. We will deploy a Provider Collaborative framework for CCG commissioned services to be agreed at CCG Board and shared with OCC commissioners ii. Review market position statements in conjunction with providers, ensuring they set out a clear forward vision. iii. Review all potential bed capacity across the system and work with providers to develop a solution for escalation	IH / KC	KT / LP	15/11/18	Older People's Strategy will reflect the demand and capacity work phase 2 commissioned by NHS England Mar-June 2018
G) System leaders must implement the STP's joint workforce strategy and work with the full range of care providers to support a	G1) Set up a Local Workforce Action Board (System Workforce Action Board) which is aligned to the BOB STP workforce strategy reporting through the HWB governance structure.	IH / KC	SW	April 2018	Paper on recommendation for System Workforce Action Board was approved by System Flow Executive and then submitted to CEO's for final sign off – Dec 2017 First meeting of System Workforce Action Board held – Feb 2018

competent, capable
and sustainable
workforce.

This work will link to the existing
Oxfordshire Training Network

Action Plan agreed Jan 2018

G2) Agree Oxfordshire System Unregistered Workforce – Action Plan – Key actions:

IH / KC

- i. Complete the first phase and evaluate the joint recruitment campaign
- ii. Develop a joint identity and brand for the sectors unregistered workforce
- iii. Introduce a range of 'valuing staff' initiatives, exploring options for staff incentives
- iv. Investigate whether Home Share/Shared Lives schemes present an opportunity to link care staff with lower cost accommodation
- v. Identify further innovations to increase home care capacity – exploring personal health/social budgets and micro providers, creation of local social capital and maximising the use of technology

KT

March 2018

First phase of the joint recruitment campaign completed and reviewed the impact

KT

September 2019

TB

March 2019

BL

March 2019

BL

August 2018

Commencing May 2018, a 12-month Wellbeing teams pilot to explore different ways of employing home care staff.

	vi. Deliver a skills and leadership development programme for care providers		PB	March 2019	
	vii. Shape a career pathway for unregistered care workers		SF	March 2019	Initial Non-Registered System Workforce Workshop held 30/1/18
	G3) Develop and improve workforce links with provider forums – help to live at home, care homes, supported living, CCG mental health and Extra Care Housing	IH / KC	BL / DHe	November 2018	Engagement with providers started Feb 2018
	G4) Review provider relationships in relation to workforce nationally to learn from best practice	IH / KC	BL / DHe	July 2018	
	G5) Evaluate and build on work already carried out with ADASS and Skills for Care on Value Based Recruitments	IH / KC	BL	December 2018	Evaluation of the impact on practice and the return on investment of this work is ongoing. Engaging with other Local Authorities in the South East via ADASS Workforce Group Further meetings set-up for May and June 2018.
	G6) Review of Log on to care	IH / KC	BL	March 2019	Analysis completed in Jan 2018

	Look at next steps to encourage providers to use this tool and link this to the care certificate.				
	G7) Work with Skills for care/providers and contract managers to obtain better representative data across the sector, e.g. Turnover, retention, qualifications, sickness, demography	IH / KC	BL	March 2019	Joint initial workshops in 2017 to encourage and support an increased response rate. Discussions have taken place with Skills for Care to provide additional workshops and support. Contracts now specify National Minimum Dataset (NMDs) data to be completed for domestic care providers. Consulted with providers (as part of the annual rates review - Feb 2018) on how we could facilitate increased response. Learning expected March 2018 and will be incorporated into future plans.
H) System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well	H1) Implement the Oxfordshire AEDB Urgent Care Improvement Plan to improve system flow to be monitored monthly at AEDB. The AEDB Plan (appended) has been developed in response to external analysis commissioned by NHSE/I.	BH	System Flow Executive	As per AEDB implementation plan	NHSE commissioned demand and capacity work to be delivered by June 18. Pathway mapping for key services to be completed by 23/03/18.
	H2) In addition to the tactical priorities identified in the AEDB improvement plan we will undertake a comprehensive co-produced	BH	System Flow Executive	In-line with frailty pathway	See AEDB Plan

defined, communicated and understood across the system.	review of all pathways with patients, users, clinicians and voluntary and community services into and out of the health and social care system to identify streamlined processes that: i. keep people at home living as independently as possible for as long as possible ii. provide timely response to people at risk of admission iii. ensure that people who are in hospital return home when they are well enough to do so				
	H3) We will create a series of priorities from the review that will identify how we will measure and monitor improvement.	BH	System Flow Executive	TBC subject to completion of review	See AEDB Plan
	H4) We will strengthen the reporting and oversight of the AEDB plan at HWB to assure system accountability for the delivery of these plans.	IH / KC	JMW	22/03/18	See AEDB Plan
I) System leaders should ensure that housing support services	I1) Appoint dedicated social care and community health staff to identify and manage housing related issues in community hospitals.	System Flow Executive	System Flow Executive	Nov 2017	In place Nov 17

are included within multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals	i. Work with Oxford City Council to deliver the Trailblazer initiative which is working into OUH, supporting Emergency Department and discharge teams with dedicated advice and support from housing professionals ii. Age UK to support Short Stay wards as part of a Home First initiative in OUH which is flagging housing needs earlier in the discharge planning process.			Jan 2018 Jan 2018	In place Jan 18 Pilot in place Jan 18
	I2) Hold a series of strategic housing workshops.	IH / KC	KT	August 2018	First meeting held December 2017 (Next meeting May) One on one meetings with districts Jan 2018
	I3) Use key findings from Oxon health and social care working and living survey to inform the outcomes within the business case to identify sustainable solutions to the housing challenges	IH / KC	KT	December 2017	Survey completed in Sept 17 – reported in Dec 17
	I4) Get feedback from ADASS Working Group Network Enquiry	IH / KC	KT	May 2018	Completed March 2018

	and put into summary report. Use it to inform business case and discuss further at May workshop				
	I5) Meet with district council to discuss key workers housing data, key findings and agree next steps.		KT	August 2018	Held initial group meeting – Dec 17 Further one on one meeting to take place – Jan – Mar 18 Further meetings option following May workshop.
Page 102 System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure	J1) A review of commissioned services considering their design, delivery and outcomes will be carried out to improve their effectiveness, and reduce and avoid duplication	IH / KC	BL / DHe	November 2018	Supporting People to Live at Home board (OCC, OCCG, and VCS reps, inc. Healthwatch) met 23rd January. Covering research and innovation around home care, wellbeing pilots, home care strategy and market stabilisation. Meetings occur bi-monthly Joint appointment of Care Homes Commissioner for OCC & OCCG, March 2018. System review of discharge-to-assess, post hospital reablement and community reablement (HART) reporting 23rd March to System Flow Executive. Shared market position statements to be reviewed under the management of the pooled budget officers group to start April 2018.

resources are used effectively.	J2) As part of the system flow work in (h) we will review the way in which we carry out assessments. This will include reviewing the progress of our Trusted Assessor Model to ensure this is fully implemented and confirm that it follows patients through their journey.	KT	System Flow Executive	September 2018	Pilot of Trusted Assessors in intermediate care beds is ongoing. Training for home support providers in new delegated health tasks, with plans to extend this to other provider organisations
K) System leaders should review methods used to identify carers' eligibility for support so that they are assured that carers are receiving the necessary support and have access to services.	K1) We will work with carers and carer organisations in a review of how we identify carers using national standards and best practice across health and social care organisations.	Chief Executives	KT/LP	15/11/18	Paper in development for March HWB. Meeting with OCC co-production board March 18 to discuss approach to strategy development. Carers' needs highlighted by board.
	K2) As part of the development of the older people's strategy we will ensure we have a variety of mechanisms in place to assist carers in how to find and access services. We will co-produce these with carers to ensure they are appropriate and provides them with the information they need.	IH / KC	KT/LP	15/11/18	As above

L) System leaders should ensure that better advice to access information and guidance is offered to people funding their own care.	L1) System wide agreement on roles and responsibility to support people who fund their own care	IH / KC	Chief Executives	May 2018	
	L2) As part of the review of assessment processes set out in (j) we will ensure we identify a person's funding status at an early stage and that the appropriate information is available to them to support a timely decision around next steps. i. Creation of brokerage service for self-funders ii. Review the information currently being provided to self-funders	IH / KC	KT/LP	15/11/18 January 2019 April 2018	Creation of a brokerage and care support team delivering to self-funders and organisations including Adult Social Care from 1st April 2018, this is the first stage of developing the offer. Planned system review of support to self-funders to come to SFE for June 2018 Review of information on the OCC public website underway January 2018
M) Continue to embed the trusted assessor model.	M1) As set out in (j) - We will review the way in which we carry out assessments and identify opportunities to move towards a	BH	System Flow Executive	As per AEDB implementation plan	Pilot of Trusted Assessors in intermediate care beds is ongoing.

	comprehensive trusted assessment model which follows patients through their journey.				Training for home support providers in new delegated health tasks, with plans to extend this to other provider organisations
N) System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced	N1) We will commit to develop and implement a best practice model of continuous co-production across commissioner and provider organisations. We will scope the potential to develop established bodies that can inform this process.	IH / KC	KT	19/7/18 (HWB strategy)	Co-production champion training with SCIE advertised and due to take place 5 th /6 th June - this is the first step in creating a whole system champions network.
	N2) This model will ensure service users, patients, their families and carers are engaged from inception and throughout the development and implementation process when reviewing strategies, integrated systems and structures using co-production principles.	IH / KC	KT	19/7/18 (HWB strategy)	
	N3) This approach will be deployed in the development of the Health & Wellbeing and Older People's strategy and in the development of accountability structures set out in this plan. i. As part of this work we will establish a process to identify and take proactive measures to	IH / KC	JMW / KT / LP	19/7/18 (HWB strategy) 15/11/18 (OP strategy)	

	engage with under-represented groups in society.				
O) Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation. Page 466	O1) Map the current role and impact of voluntary sector and local communities within Oxfordshire's services and in support of strategic development.	IH / KC	KT	19/7/18	
	O2) In all pathway redesign and strategy development we will value and draw in the expertise in the Voluntary sector, providers and Districts. Co-designing in our provision the knowledge and connection of the local areas in Oxfordshire to offer solutions to gaps - especially care at home – working together to maximise social capital	IH / KC	BL / DHe	November 2018	An LGA Peer Review of the work carried out with the Voluntary Sector is planned to take place 20 - 22 March 2018
	O3) Review and develop activities to strengthen the capability and capacity of the voluntary sector and local communities as part of the Health & Wellbeing accountability structures, involvement in strategic planning and delivery of support to people as part of the Health & Wellbeing and Older Person's Strategy.	IH / KC	KT / LP	15/11/18	

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Health & Wellbeing Board – March 22nd 2018

Older People – A Joint Strategy for the Future

Report by the Director of Adult Services and Chief Executive of Oxfordshire Clinical Commissioning Group

Summary

1. Oxfordshire has an existing Older People's Joint Commissioning Strategy which ran from 2013-16. This strategy was developed in conjunction with Oxfordshire's residents and reflected their priorities and needs. Whilst we believe that many of the principles and values within this strategy remain relevant in 2018, it is right that our approach is reviewed and updated.
2. A review of Oxfordshire's Older People's strategy was one of a number of related recommendations made by the Care Quality Commission following the recent system review, listed as Annex 1 to this document. Reviewing this strategy is a key part in renewing and developing system partnerships, and agreeing a shared vision for Oxfordshire in the future.
3. Whilst we recognise that principles and values from our previous strategy remain relevant in 2018, this is a genuine opportunity to take a fresh look at our priorities and approach, taking into account the changing population and health & social care landscape.
4. This strategy will be developed by all system partners, it is not the intention of this paper to pre-suppose the outcome of this work, but to outline the proposed scope and approach.

Recommendations

5. This paper seeks approval from the Health & Wellbeing Board for the proposed approach in relation to
 - i. The scope of the strategy and the questions it must address
 - ii. Development approach
 - iii. The role of external support in delivering this strategy

Proposed Scope of the strategy

6. The Oxfordshire Older People's Strategy will form the policy document that describes the strategy and vision for meeting the needs of older people and the outcomes that we agree should be achieved. This will drive the system's response to the needs of our older population over the next 5 years.
7. The strategy must describe how the needs of our older population will develop and change over the next 5 years and must identify the challenges for commissioners, and health & social care providers. It needs to set out the outcomes we must deliver which will meet these challenges.

8. The Older People's Strategy will sit within the context of Oxfordshire's overarching Health & Wellbeing Strategy; and must reflect the emerging frailty pathway and acknowledge where these areas of work overlap.
9. In addition to describing the agreed vision and outcomes, the strategy must create a framework and identify priorities for implementation and how these outcomes will be delivered. These priorities will be agreed by system partners and stakeholders in more detail but will include:
 - i. How Oxfordshire supports older people to age well: maximising health and wellbeing; preventing limiting long term conditions; enabling older people to manage their own health; and supporting people and communities in a sustainable way. This will consider the provision of information and advice; formal care; community support; and the management of the diseases of aging until end of life.
 - ii. How we will help older people at times of urgent need: how we will build on current practice to design and mobilise services that can respond in a timely way to support people who are frail to help them remain at home and/or return home after a hospital episode.
 - iii. How people and communities can shape the design and delivery of their health and social care services.
 - iv. How people and communities can develop and maintain the resilience to help themselves.
 - v. How we will match resources to the delivery of outcomes both in health and social care for all older people, including those in receipt of financial support from Adult Social Care and those funding their own care.
 - vi. How we mobilise other resources such as planning, transport, employers, training providers, and the wider population in achieving the delivery of the strategy.
 - vii. How we will deploy new ways of working including an innovative approach to service design and the use of technology.
 - viii. How we will measure success.
 - ix. How we will agree key priorities for the next 5 years, and how the strategy and implementation plan will enable us to deliver against these priorities.

Development of the revised strategy

The strategy will be jointly led by Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford Health NHS FT, Oxford University Hospitals NHS FT and Oxfordshire's GP Federations with full involvement from other stakeholders in the statutory, voluntary and private sector. This aligns with the current work regarding reshaping the Health & Wellbeing Board.

10. Principles of co-production will be embedded in our approach to working together as system stakeholders. This approach is necessary to ensure that there is shared ownership of the vision, of the outcomes we need to achieve, the priorities for delivery and agreement around how we might address the system challenges.

11. We recognise the skills and willingness within our population to engage in a productive conversation about system challenges and it is therefore expected that the views of older people, carers and communities will be integral to this work. The co-production approach must deliver the requirements set out in paragraph 9 above. We need to set a high bar in terms of our ambition to assure that we develop the strategy that will be able to deliver the outcomes.
12. Our approach to co-production will follow the principles outline by the Social Care Institute of Excellence¹
 - ✓ Equality – all stakeholders’ contributions are considered equally
 - ✓ Diversity – we will seek a range of contributions, including those from groups that are hard to reach
 - ✓ Accessibility – we will engage with people using a range of means
 - ✓ Reciprocity – people will feel supported in our approach and recognise the value in their contributions
13. An approach which follows these principles requires a thorough and at times patient approach. We need to invest time in reaching our stakeholders and hearing their views and find ways to reflect and accommodate differing perspectives. Both formal and informal structures will need to be established to assure the delivery of the strategy in the required time frame. We have engaged with the OCC Co-production Board in the development of this paper, and they have agreed to identify good practice in the delivery of co-produced strategy, and in principle to support the development of this work.
14. In the light of the vital importance of this strategy and the need to develop a clear and co-produced vision, the Health & Wellbeing Board is asked to consider potential external support for this work using one of the following models:
 - i. Support from an external agency with the expertise and credibility to drive our system towards an effective co-produced strategy
 - ii. Expert advice and support to internal leadership
 - iii. Dedicated programme support to appointed internal leadership

Timescales

15. Work has begun with Oxfordshire’s co production board to plan our approach to the development of this strategy. This board is convened by the County Council and includes representation from service users. Conversations with this board are at an early stage but indicate that there is an enthusiasm to undertake this work in a co-produced way.
16. Going forward, we anticipate that this board can provide guidance regarding the approach, but wider networks of stakeholder representatives will be integral and work is required to map and plan the approach in more detail.

¹ <https://www.scie.org.uk/publications/guides/guide51/what-is-coproduct/index.asp>

17. It is anticipated that this work will take place in Spring and Summer 2018, with final production of this strategy in Autumn 2018. This timescale aligns with the key dates within the CQC system wide action plan.
18. An update will be brought to future Health & Wellbeing Board meetings with anticipated sign off of the strategy taking place in November 2018. More details regarding timescales will be presented once further work has been undertaken with stakeholders.

Rachel Pirie OCC
Ian Bottomley OCCG

Annex 1 – Requirements from CQC System Review

- iv. System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. ***Whilst doing so a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery***
- v. System leaders ***must address and create the required culture*** to support service interagency collaboration and service integration
- vi. ***The Older Person's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment.*** As part of the Older Person's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.
- vii. System leaders ***must implement the STP's joint workforce strategy*** and work with the full range of care providers to support a competent, capable and sustainable workforce
- viii. System leaders ***must review how people flow through the health and social care system*** including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.
- ix. System leaders should ensure that housing support services are included within multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.
- x. System leader should review methods used to identify carers' eligible for support so that they are assured that carers are receiving the necessary support and have access to services.
- xi. System leaders should ensure that better advice to access information and guidance is offered to people funding their own care.
- xii. ***System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.***
- xiii. Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.

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Health and Wellbeing Board Review: Update, Emerging Issues and Findings and Next Steps.

1. Introduction

At its last meeting the Health and Wellbeing board (HAWB) agreed to a review of its functions, structure and governance.

Following the urgent concerns of the CQC, the Chair and Vice-Chair undertook an extensive process of review through interviewing key stakeholders and inviting written views. The meetings were informal and the views expressed non-attributable.

The following programme of interviews was undertaken:

Date	Stakeholder Group	Invitees
1st February 2018	County Council and CCG Senior Officers	Catherine Mountford Jonathan McWilliam Kate Terroni Lucy Butler Peter Clark
1st February 2018	County Council Cabinet Members. All current members of the HWB	Cllr Lawrie Stratford Cllr Hilary Hibbert-Biles Cllr Steve Harrod
15th February 2018	Chair and Chief Executive, Oxford University Hospital NHS Foundation Trust	Dame Fiona Caldicott Bruno Holthof
15th February 2018	Chair and Chief Executive, Oxford Health NHS Foundation Trust	Martin Howell Stuart Bell
15th February 2018	GP Federation Chairs and Chief Executives	Helen Shute; Ben Riley; Andrew Elphick, John Harrison Mark Bish. David Ridgway
15th February 2018	Chairs of CCG Locality Patient Fora	Helen van Oss Anita Higham Graham Shelton Jeremy Hutchins Tracey Rees Shelagh Garvey
15th February 2018	Chair and Director, Oxfordshire Healthwatch	Prof George Smith Rosalind Pearce
15th February 2018	Chair and Chief Executive, South Central Ambulance Trust	James Underhay (Dep CEO) Lena Samuels (Chair) Will Hancock (CEO)
20th February 2018	Social Care Provider organisations	Chris Ingram (Style Acre) George Tuthill (Oxon Carehomes Assoc) Charles Taylor (Oxon Carehomes Assoc Chair elect) Eddy McDowell (Oxon Assoc Care

		Providers) Trish O'Leary (Vale House); Dan Hayes (Order of St John)
20th February 2018	Chair and Vice Chair of Health Improvement Board	Cllr Anna Badcock Cllr Marie Tidball
21 st February 2018	Chief Executive, Oxfordshire Clinical Commissioning Group	Lou Patten
1st March 2018	Medical Directors and Lead Nurses, OUHFT, OHFT, SCAS	Tony Berendt Sam Foster Ros Alstead / Pete McGrane Mark Hancock John Black
1st March 2018	Carers and Patient Advocacy Organisations	Dan Knowles (Mind) Kay Francis (Carers Oxon) Penny Thewlis (Age UK Oxon) Angela Cristofoli (OCVA) Kathy Shaw (OCVA) Bryan Mitchell (My Life My Choice)
1st March 2018	NHS England	David Radbourne Ruth Williams (Director of Nursing) Anne Eden

Written views were invited from all those interviewed, District Councils and the Police and Crime Commissioner. Written views were received from:

- 1 Councillor Jeanette Baker, West Oxfordshire District Council
- 2 Councillor Hilary Hibbert-Biles, Oxfordshire County Council
- 3 Helen Shute, Oxfed
- 4 Dan Knowles, Oxfordshire Mind
- 5 Cherwell District Council
- 6 Oxford City Council

The views of MPs were sought in one to one discussion.

In addition, Healthwatch agreed to seek and represent views from the wider Voluntary sector through their network.

The full recent report of the Care Quality Commission (CQC) appears elsewhere on this meeting's agenda and comments in detail on the current working of the HAWB. A precis of the CQC's views regarding the HAWB is given below:

Summary

- *The Oxfordshire Health and Wellbeing board (HWB) did not have a clear role in influencing and supporting a strategic approach to support the joined-up delivery of services.*
- *There was recognition that the HWB required reconfiguration and a stronger sense of purpose.*

- *The chair and vice chair had a clear view for the development of the HWB and were keen to enact changes that would make it more effective and improve engagement with providers including the VSCE sector.*
- *There was a strong demonstration of commitment in respect of the HWB and it was expected that once this had undergone reconfiguration it would become more effective in its role*

Benefits of the review of the HWB cited by the CQC

- *The planned HWB review presented an opportunity for:*
 - *improved coproduction bringing together a full range of providers, and holding them to account for the delivery of the transformation programme, as well as providing clarity in respect of the interface with the wider STP.*
 - *It was anticipated that the restructure of the HWB would provide the vision for integrated systems and structures*
 - *The review should focus on setting a shared vision for the system and the relationship between the HWB, the Oxfordshire Transformation Programme and the STP. This is particularly important if the HWB is to become the locus for the journey towards an Accountable Care System.*
 - *Given its statutory role for system leadership the HWB is the right place to set, agree and lead this vision, linked also to the STP*

Other issues to be addressed:

- *there was recognition amongst system leaders that the most likely route to resolving recruitment and retention issues was through joint working across the system, and through the Oxfordshire Transformation Programme aligned with the STP and the HWB*
- *the HWB did not fully set out the strategic ambition of system integration, including integrated commissioning*
- *It was not evident that identified priorities from the JSNA were aligned with the STP and BCF priorities*

This paper summarises the views expressed to the Chair and Vice Chair; sets out key areas of consensus and areas where views differed; sets out the emerging consensus view for discussion; seeks the views of the HAWB on all of these matters and proposes the next steps.

The document sent to stakeholders to request views is included at Annex 1.

Annex 2 contains a summary of the role and powers of the HAWB as expressed in statute.

2. Report on Views and Issues Expressed by Stakeholders

2.1 Status of the HAWB

There was wide consensus that the HAWB, as set out in statute, should be the premier oversight body for a very wide range of health and wellbeing issues in the County.

2.2 Profile of the HAWB

There was wide consensus that the profile was currently too low and needed to be higher.

Many of those interviewed did not know of the work of the Board.

2.3 Functions of the HAWB

Those who knew of the work of the Board felt that it did cover a wide range of health and wellbeing issues, particularly through its three sub-groups.

The breadth of coverage could be further extended to cover issues such as housing, but respondents understood that the two-tier nature of Local Government presented practical problems in achieving this. There was a general consensus that the HAWB should have more formal links with the Growth Board, but no clear view on how this might be achieved.

The HAWB should be seen to exercise authority over a wide range of health and wellbeing issues.

It was acknowledged that there were areas of overlap function with Partnerships such as the Community Safety Partnerships.

There was wide consensus that a single authoritative HAWB Strategy which was agreed by all would be a major step forward. The HAWB should hold partners to account for delivery of this strategy.

There was a clear view, in agreement with the CQC's view, that the Board should have a more active oversight of issues of 'system flow' involving the NHS and Adult Social Care.

The sub-groups called the Children's Trust and Health Improvement Board were generally seen to be functioning well over a wide range of topics.

The two Joint Management Groups covering adult's issues were felt to be functioning well, but there was a need for the HAWB to cover a wider range of strategic topics around health and social care services for adults as follows:

- The HAWB is one of a range of groups partially overseeing similar topics for adult's services. This needs to be streamlined so that there are fewer groups.
- The 'health and social care system' does not have a single place where strategic priorities are clearly set or where overall transformational change is agreed. This should be overseen by the HAWB and its subgroups.
- There is duplication of membership and scope with groups such as the A and E Delivery Board and the Transformation Board.
- Decision making is confused and insufficiently transparent.
- There is a lack of clarity regarding 'commissioner' and 'provider' bodies and their respective roles. Clearly commissioners and providers need to come together to agree strategic priorities, yet we also need a mechanism to avoid conflict of interest, at least in the short term, while 'whole system working' matures.
- There is no single agreed 'envelope of money' within which decisions can be taken.
- If the 'health and adult social care system' moves towards an Integrated Care System (ICS), the majority view was that this should be overseen by the HAWB. It was acknowledged that there may need to be a number of transitional steps before this can be achieved in full.

- the current existing groups and Boards working on NHS and adult social care issues across the County should be rationalised and simplified.

2.4 Structure and sub-groups of the HAWB

There was wide consensus that sub-groups were necessary given the breadth and complexity of the business.

There was wide consensus that the current division into 3 functional topics (i.e children's issues, health improvement issues and adult health and social care issues) was useful.

The sub-groups also allow for a wider range of welcome participation in the work of the overall Board.

Comments about the functions of individual subgroups have been covered above.

2.5 Membership of the HAWB

There was wide consensus that the core membership should be small (various numbers were suggested, generally around 10-12 as a maximum).

However, many respondents felt that they should have a 'seat' which would exceed this number.

Some respondents felt that a 'seat' would not be helpful as their primary engagement was elsewhere in the 'system', particularly on the sub-groups or via a reference group. This was the consensus view from the Voluntary Sector and of patient group representatives.

The majority felt the Chief Executives of the larger statutory organisations should sit on the HAWB so as to facilitate decision making, although the valuable role of Chairs and Non-Executive Directors was also acknowledged.

There was overall support for the current 'chairing' arrangements.

The balance of view was that major 'service providers' should be members as this was the clear direction of the NHS, while others felt this was a conflict of interest. Major service providers were felt to include Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust. South Central Ambulance Service NHS Foundation Trust would have a greater impact through representation in the subgroups, as would the Federations.

As stated above, the consensus voluntary and community sector view expressed was that input would be better focussed through subgroups or through a reference group.

The statutory mandatory composition of the Board was felt to be restrictive and tended to put too much emphasis on County Council membership.

MPs were felt by all to be important stakeholders who needed to be constructively engaged. There was no clear consensus on how they might be systematically engaged.

Various solutions were proposed to resolve these issues e.g.:

- Members might be of two groups, voting members and advisory members (as per the CCG Board).
- there might be wider representation on subgroups

- standing reference groups of various kinds could be set up or periodic 'big tent' events could be held
- inviting people with subject-specific expertise to give views on specific topics
- regular and focussed written updates from specific sectors and groups
- more creative ways might be sought of involving the mandatory statutory officers which would still meet statutory requirements.

2.6 Decision-making powers of the HAWB

There was wide consensus that the HAWB should be decision-making, but differing views as to the scope and nature of the decision-making.

It was noted that the HAWB is already decision-making over a range of issues: a Joint Health and wellbeing Strategy, the JSNA, the Better Care Fund agreement etc. This was supported.

Almost all of the debate around decision making centred on the 'NHS and Adult Social Care' subgroup. The consensus was that clear and binding decisions were needed in this area.

Decision making in the Children's and Health Improvement subgroup attracted little comment or was felt to be satisfactory.

Some Statutory Bodies were willing to devolve further decisions and some were not. As devolving decisions to the HAWB is discretionary this cannot be a matter of compulsion and has implications for the future functioning of the Board.

Some favoured HAWB decision-making over a fairly detailed strategy and holding bodies to account for delivery of that strategy as set out in performance indicators, financial targets and outcome measures.

Regarding the future 'adult's subgroup(s)', some favoured a process of 'sign off' in individual organisations before coming to the adult's subgroup or HAWB for decision making.

Regarding the future 'adult's subgroup(s)', the majority felt that decision-making of some kind was essential, with these decisions receiving final approval from the HAWB. There was concern that a decision-making process involving, in sequence, NHS Boards, the 'adult's subgroup' and then the HAWB was far too slow and cumbersome to be effective.

2.7 Relationship of the HAWB to other Partnerships, Groups and Boards

This is covered above. There majority view was that this was a complex topic.

There was consensus that 'system transformation' of health and social care should be part of the HAWB mechanism and should be overseen within the revised 'adult's subgroup(s)', and that if properly assimilated would obviate the need for a parallel Transformation Board.

However, the wider representation and ensuing debate at the Transformation Board was valued and should be retained.

Relationships with the Community Safety Partnership and Growth Board were satisfactory but should be more active as stated above so that these 3 partnerships together could cover a very wide range of interlocking issues across the County.

2.8 Designing a Health and Wellbeing Board that meets current national direction of health care organisations and emerging governance models

The national policy governing NHS and Adult Social Care Services direction favours the creation of Integrated Care Systems. The consensus was that the potential for an ICS in Oxfordshire should be built into the design of a revised Adult's Sub-group or sub-groups

2.9 Style of the HAWB meetings

The consensus view was that the meetings 'feel too much like County Council Committee meetings rather than meetings of equal partners'. Meetings should feel inclusive. A move away from County Hall as the permanent venue would assist.

2.10 Frequency of the HAWB

The current schedule of 4 monthly meetings was felt to be too infrequent. Various proposals were made from quarterly to monthly, the majority favoured quarterly meetings provided that the sub-groups were active and able to make decisions.

These meetings might be supplemented by special 'deep dive' sessions and/or Board development sessions.

3. Summary of the key emerging findings to date:

1. The HAWB should be one of 3 senior decision-making partnerships in the County alongside the Growth Board and the Community Safety Partnership.
2. It should continue to take a broad overview of health and wellbeing issues.
3. It should agree an overarching health and wellbeing strategy and hold organisations to account in delivering it.
4. The Board's membership should be reviewed to ensure that its membership will deliver its agreed function; this should include representatives from OUHFT and OHFT.
5. The HAWB or its 'adults' subgroup(s) should be decision making where possible over NHS and Adult Social Care issues.
6. The overall structure of topics areas covered by the current sub-groups (eg adult health and social care, children and health improvement) should be retained.
7. The areas in most urgent need of review are: membership and decision making of the HAWB itself and the work of the adults' subgroup(s) and its decision making.
8. The adult's subgroup(s) should have oversight of service transformation and should subsume the current service transformation role of the Transformation Board. However, the wider debate which takes place in the Transformation Board with patient representative and voluntary and community organisations is valued and needs to be retained in some form

9. Voluntary organisations and patient representative groups have a key role to play, but may wish to input via sub-groups or via reference groups or through contribution to debate on specific issues.
10. Regular communication with MPs should be built into the work of the Board.

4. Next Steps

Following discussion at the HAWB the Chair and Vice-Chair propose to continue discussions with relevant parties and to bring a final proposal to a specially constituted HAWB on the 10th May 2018 to ensure that pace of change is maintained.

5. Recommendation

The HAWB is asked to note and discuss the emerging findings and approve the proposed next steps.

Cllr Ian Hudspeth, Leader OCC and Chair Oxon HAWB

Dr Kiren Collison, Chair of OCCG and Vice Chair Oxon HAWB

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Review of Oxfordshire's Health and Wellbeing Board:

Gathering Stakeholder Views

This briefing note sets out proposals for engaging with stakeholders to gather initial views which will be used to inform the review of Oxfordshire's Health and Wellbeing Board (HAWB) as agreed by the Board on 9/11/2017. A summary of the statutory role and duties of Health and Wellbeing Boards are appended for your reference.

The Board felt that it was timely to review the Board's role and governance arrangements for the following reasons:

1. The NHS's priority as stated in the 'Five Year Forward View' and subsequent documents is to move to Accountable Care Systems (ACS) and a number of these have been established. The Health and Wellbeing Board agreed to explore its role in the development of an ACS as part of this review.
2. The NHS has also moved to an emphasis on 'whole system working' as opposed to a clear-cut distinction between commissioners and providers. The previous governance model was based on this distinction and thus the Board's membership was based on service commissioners rather than on service providers. This therefore currently precludes the involvement of NHS trusts who are clearly integral to 'whole system working' and the involvement of the Voluntary Sector for example.
3. The Oxfordshire Transformation Board continues to work on practical issues of service transformation in the County and, although there is a strong synergy and an overlapping membership between it and the Health and Wellbeing Board, the Governance links between the two would benefit from clearer definition.
4. Over the years the Health and Wellbeing Board has received requests to expand its membership and the way it engages with a wide range of organisations. These have come from many sectors, including patient groups and advocacy groups, the voluntary and community sector, cultural and arts organisations, the police and the military. Our initial thinking was to avoid a Board which would be too large to be effective and so we decided to be guided by the statutory membership. It is now timely to review the membership of the Board again.
5. Since the Board met, we have also received verbal feedback from the Care Quality Commission regarding one aspect of the Board's work – that it should more actively oversee 'system flow' i.e. movement of people through primary care to hospital and through to discharge. This is likely to become a formal recommendation of the CQC and will be taken into account in the review.

It is therefore proposed that the Chair and Vice-chair of the Health and Wellbeing Board begin an engagement exercise early in the New Year by gathering the views of key stakeholders which will inform discussion at the next HAWB. This will take the shape of individual meetings and group events during early 2018, the detail of which will be advised in due course.

The following questions will guide the review:

1. What should the functions of the HAWB be?
2. What should its role be in any emerging proposals to form an Accountable Care System?
3. How should the Board balance its role in coordinating a wide range of wellbeing issues with the specific needs to oversee 'system flow'?
4. How should it carry out these functions?
5. The HAWB is currently advisory rather than decision-making, is this sufficient?
6. What governance arrangements are needed to make this effective?
7. What powers should organisations delegate to the Board to make it effective?
8. What should its relationship be with bodies with a similar remit e.g. the Bucks Oxon Berks STP Executive and the Oxfordshire Transformation Board.
9. How should the public/ patient voice be engaged?
10. Should the current HAWB sub-groups be changed?
11. How should statutory organisations be represented and with what authority?
12. How should a potentially wide range of other organisations and stakeholders (e.g. the voluntary sector) be engaged?
13. What barriers might get in the way and how can they be removed?

The arrangements of other HAWBs elsewhere will also be analysed as part of the review.

Stakeholders to be contacted as part of this engagement exercise will include:

- Organisations currently represented on the Health and Wellbeing Board (Oxfordshire County Council, Oxfordshire Clinical Commissioning Group, NHS England, Healthwatch, District and City Council representatives)
- NHS Foundation Trusts
- NHS GP Federations
- Other providers of health and social care services
- Voluntary Sector Organisations
- Representatives of Patients' and Service Users' Groups

Next steps

We are planning to invite stakeholders to a series of informal discussions with us during February. Written views will also be welcome.

This will assist us in shaping the Terms of Reference for the review which will be presented to the Health and Wellbeing Board on 22nd March 2018

Annex 2 . Health and Wellbeing Boards: Roles, Powers and Responsibilities

A. Purpose, powers and responsibilities - summary

The Health and Social Care Act 2012 established HWBs as statutory committees of all upper-tier local authorities to act as a forum for key leaders from the local health and care system to jointly work to:

- improve the health and wellbeing of the people in their area,
- reduce health inequalities, and
- promote the integration of services.

Local Government Association summarised the functions as follows:

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and Clinical Commissioning Groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and / or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.
- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services
- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and / or functions relating to the joint commissioning of service and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

B. The sections of the Health and Social Care Act 2012 gave the following detail regarding the establishment and membership of Health and Wellbeing Boards

S194 Establishment of Health and Wellbeing Boards

- (1) A local authority must establish a Health and Wellbeing Board for its area.
- (2) The Health and Wellbeing Board is to consist of—
 - (a) subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),
 - (b) the director of adult social services for the local authority,
 - (c) the director of children's services for the local authority,
 - (d) the director of public health for the local authority,
 - (e) a representative of the Local Healthwatch organisation for the area of the local authority,
 - (f) a representative of each relevant clinical commissioning group, and
 - (g) such other persons, or representatives of such other persons, as the local authority thinks appropriate.
- (3) A nomination for the purposes of subsection (2)(a) must be made—
 - (a) in the case of a local authority operating executive arrangements, by the elected mayor or the executive leader of the local authority;
 - (b) in any other case, by the local authority.
- (4) In the case of a local authority operating executive arrangements, the elected mayor or the executive leader of the local authority may, instead of or in addition to making a nomination under subsection (2)(a), be a member of the Board.
- (5) The Local Healthwatch organisation for the area of the local authority must appoint one person to represent it on the Health and Wellbeing Board.
- (6) A relevant clinical commissioning group must appoint a person to represent it on the Health and Wellbeing Board.
- (7) A person may, with the agreement of the Health and Wellbeing Board, represent more than one clinical commissioning group on the Board.
- (8) The Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.
- (9) At any time after a Health and Wellbeing Board is established, a local authority must, before appointing another person to be a member of the Board under subsection (2)(g), consult the Health and Wellbeing Board.
- (10) A relevant clinical commissioning group must co-operate with the Health and Wellbeing Board in the exercise of the functions of the Board.
- (11) A Health and Wellbeing Board is a committee of the local authority which established it and, for the purposes of any enactment, is to be treated as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972.

- (12) But regulations may provide that any enactment relating to a committee appointed under section 102 of that Act of 1972—
- (a) does not apply in relation to a Health and Wellbeing Board, or
 - (b) applies in relation to it with such modifications as may be prescribed in the regulations.

C. Health and Social Care Act 2012 – duty to encourage integrated working

S195 Duty to encourage integrated working

(1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

(2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

(3) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health and Wellbeing Board.

(4) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

(5) Any reference in this section to the area of a Health and Wellbeing Board is a reference to the area of the local authority that established it.

(6) In this section—

- “the health service” has the same meaning as in the National Health Service Act 2006;
- “health services” means services that are provided as part of the health service in England;
- “health-related services” means services that may have an effect on the health of individuals but are not health services or social care services;
- “social care services” means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).

D. Health and Social Care Act 2012 – other functions of Health and Wellbeing Boards

S196 Other functions of Health and Wellbeing Boards

(1) The functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in

Health Act 2007 (“the 2007 Act”) are to be exercised by the Health and Wellbeing Board established by the local authority.

(2) A local authority may arrange for a Health and Wellbeing Board established by it to exercise any functions that are exercisable by the authority.

(3) A Health and Wellbeing Board may give the local authority that established it its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act.

(4) The power conferred by subsection (2) does not apply to the functions of the authority by virtue of section 244 of the National Health Service Act 2006.

E. Health and Social Care Act 2012 – participation of NHS Commissioning Board

S197 Participation of NHS Commissioning Board

(1) Subsection (2) applies where a Health and Wellbeing Board is (by virtue of section 196(1)) preparing—

- (a) an assessment of relevant needs under section 116 of the Local Government and Public Involvement in Health Act 2007, or
- (b) a strategy under section 116A of that Act.

(2) The National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its preparation of the assessment or (as the case may be) the strategy.

(3) Subsection (4) applies where a Health and Wellbeing Board is considering a matter that relates to the exercise or proposed exercise of the commissioning functions of the National Health Service Commissioning Board in relation to the area of the authority that established the Health and Wellbeing Board.

(4) If the Health and Wellbeing Board so requests, the National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its consideration of the matter.

(5) The person appointed under subsection (2) or (4) may, with the agreement of the Health and Wellbeing Board, be a person who is not a member or employee of the National Health Service Commissioning Board.

(6) In this section—

- “commissioning functions”, in relation to the National Health Service Commissioning Board, means the functions of the Board in arranging for the provision of services as part of the health service in England;
- “the health service” has the same meaning as in the National Health Service Act 2006

F. Health and Social Care Act 2012 – discharge of functions of Health and Wellbeing Boards

S198 Discharge of functions of Health and Wellbeing Boards

Two or more Health and Wellbeing Boards may make arrangements for—

- (a) any of their functions to be exercisable jointly;
- (b) any of their functions to be exercisable by a joint sub-committee of the Boards;
- (c) a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions.

G. Health and Social Care Act 2012 – supply of information to Health and Wellbeing Boards

S199 Supply of information to Health and Wellbeing Boards

(1) A Health and Wellbeing Board may, for the purpose of enabling or assisting it to perform its functions, request any of the following persons to supply it with such information as may be specified in the request—

- (a) the local authority that established the Health and Wellbeing Board;
- (b) any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8);
- (c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

(2) A person who is requested to supply information under subsection (1) must comply with the request.

(3) Information supplied to a Health and Wellbeing Board under this section may be used by the Board only for the purpose of enabling or assisting it to perform its functions.

(4) Information requested under subsection (1) must be information that relates to—

- (a) a function of the person to whom the request is made, or
- (b) a person in respect of whom a function is exercisable by that person

References:

[House of Commons Library – Health and Wellbeing Boards](#)

[Local Government Association](#)

[Health and Social Care Act 2012](#)

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