Joint Strategic Needs Assessment Annual Report 2016

Introduction

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

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

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

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

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

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

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

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

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

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

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1. Executive Summary

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

Population

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

Population Groups

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

Wider Determinants of Health

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

Morbidity and Mortality

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

Lifestyles

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

Service Demand

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

Limitations of the Data

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

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

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

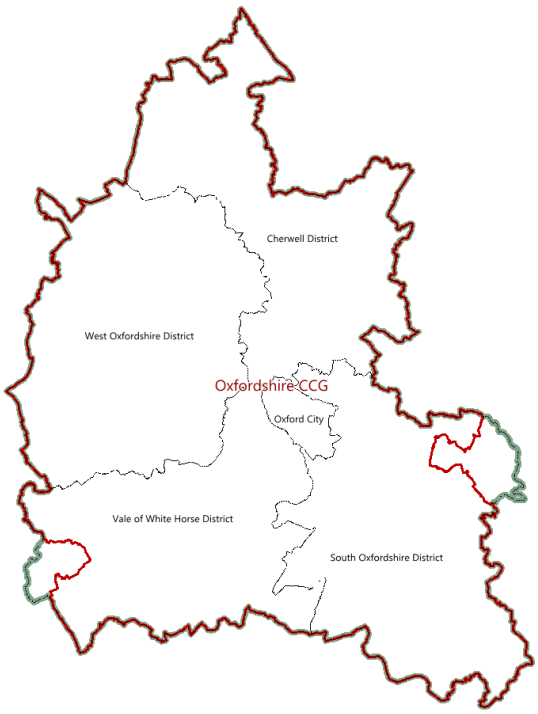
Throughout the report figures are often rounded to the nearest 100 (and percentages to one decimal place) to avoid giving a false sense of accuracy. Discussion focuses on differences that are statistically significant (the term 'significant' is used in this technical sense throughout the report).

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

Geographical Boundaries

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

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



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

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

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

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

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

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

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

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

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

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

Areas for Future Development

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

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

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

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

2. Population

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

2.1. Population Size

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

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

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

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

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

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

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

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

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

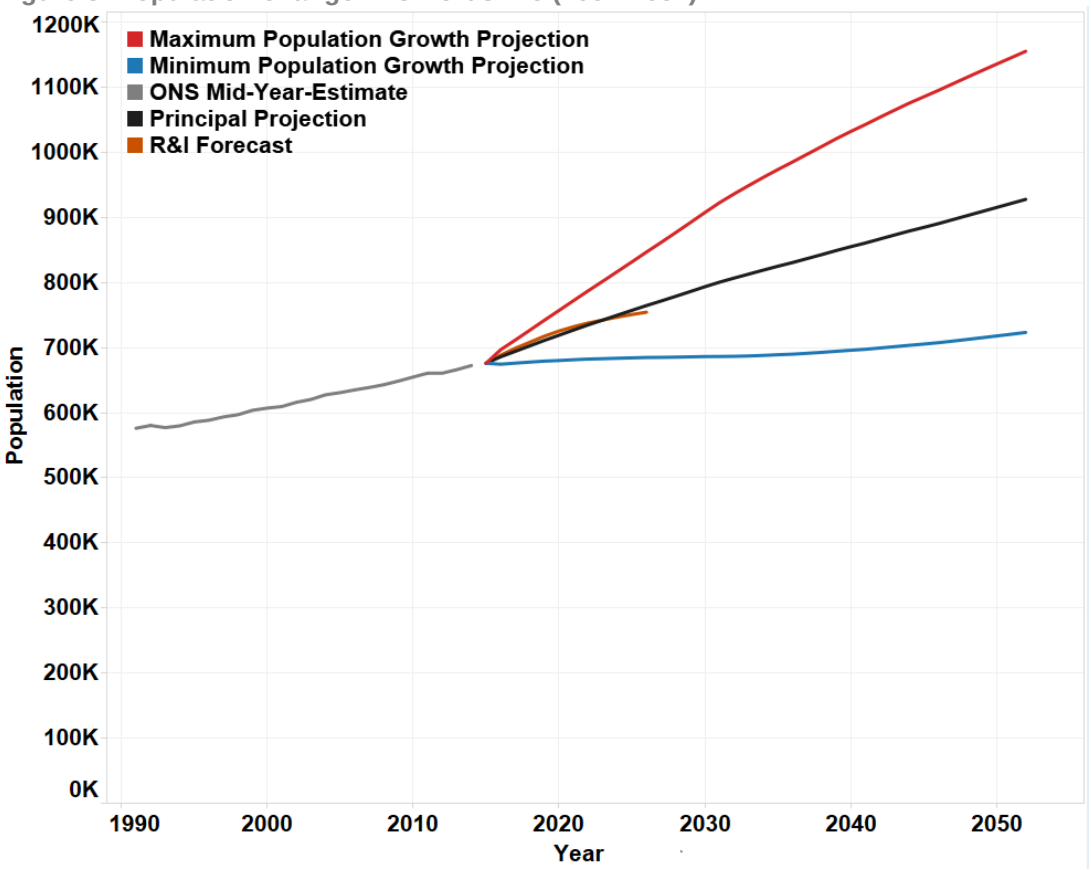
[5] ONS population estimates for mid-2014: http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2014/mid-year-population-estimates-for-the-uk-2014.html. Percentages are based on raw ONS figures rather than the rounded figures included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

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

- The **long range population projections**[7] take into account ambitions for 93,560-106,560 new homes between 2011 and 2031, as set out in Oxfordshire's Strategic Housing Market Assessment.[8] The projections cover the period up to 2052, based on five growth scenarios. They represent the range of variation considered feasible for changes in life expectancy, fertility, migration, and housing growth. Unlike the population forecasts, these are independent of district local plans. More details of the methodology used can be found in the population projections report.

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

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



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

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

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

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

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

2.2. Life Expectancy

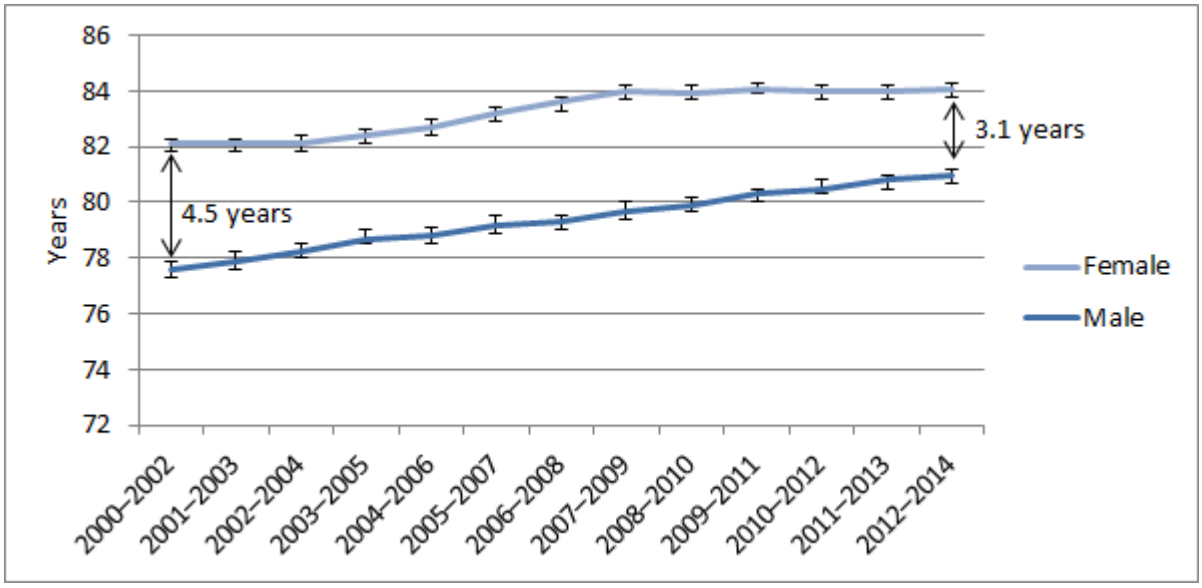
2.2.1. Overall Life Expectancy

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

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

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

Figure 4: Male and female life expectancy at birth in Oxfordshire, 3-year rolling data for 2000-02 to 2012-14



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

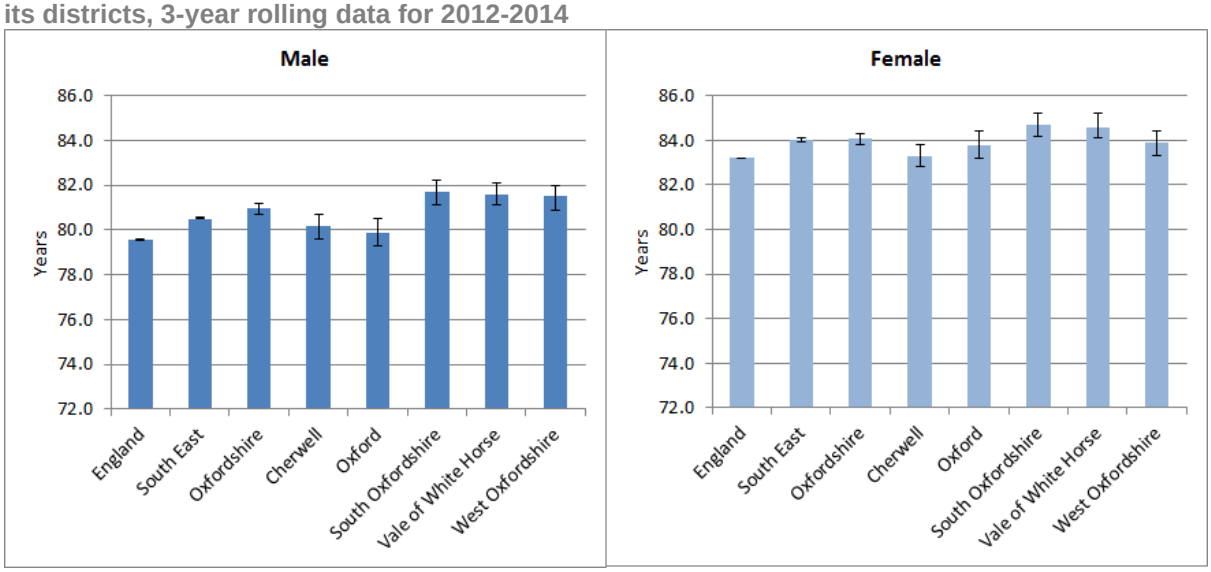
For the 2012-14 period, life expectancy for both sexes was higher in Oxfordshire than the national average. *Male* life expectancy was also higher than the regional average (whereas *female* life expectancy was similar to the regional average).

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

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

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

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



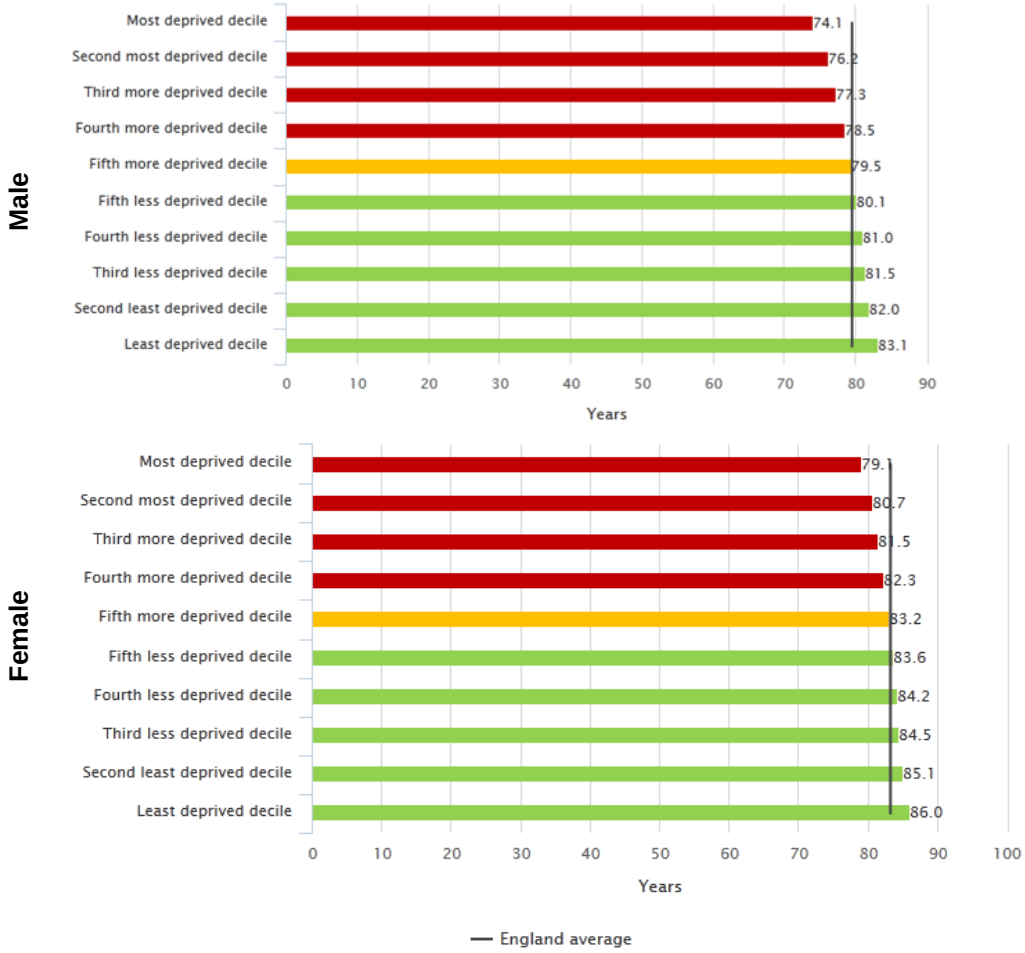
Source: Office for National Statistics. *NB the vertical axis starts at 72 years, not 0 years.*

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

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

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

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



Source: Public Health England

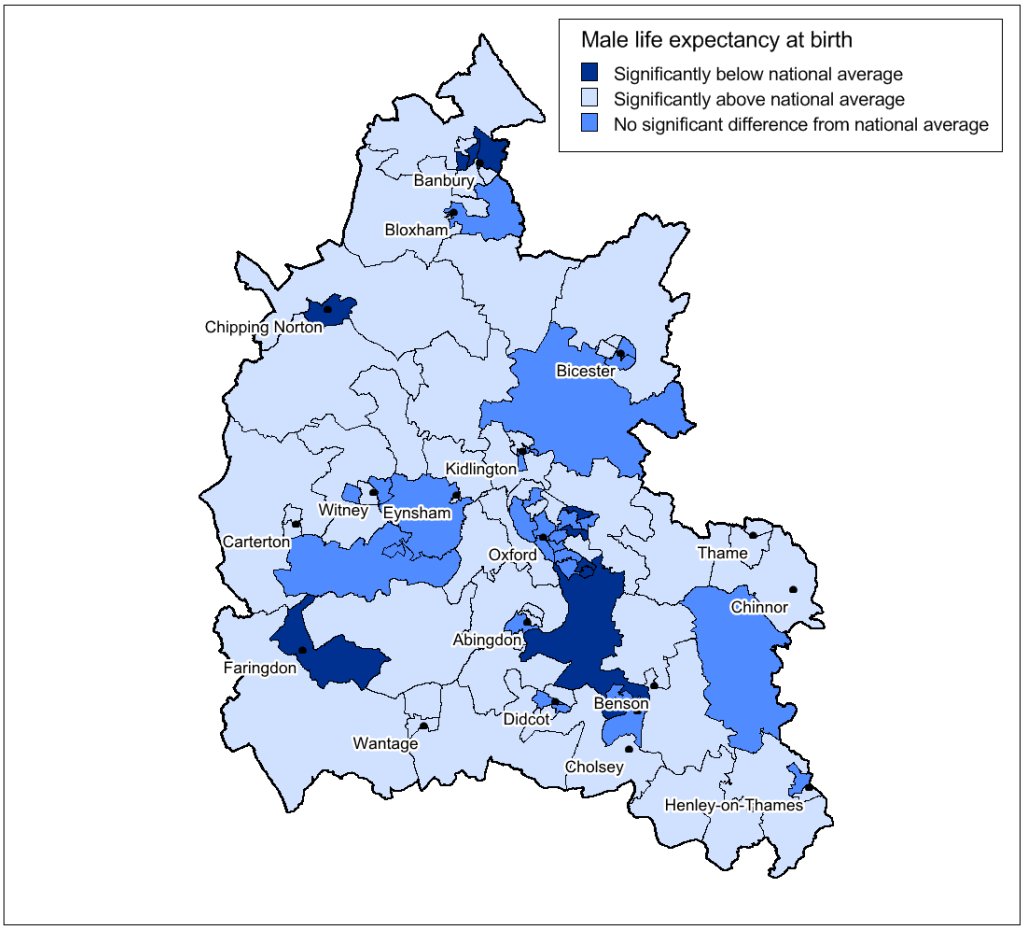
In Oxfordshire, pooled data for the period 2009-2013 show that male life expectancy at birth was estimated to differ by 5.6 years between those living in the most and least deprived areas of the county.[12] The confidence level for this figure is 95% within the range 4.4-6.9 years. The level of inequality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

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

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

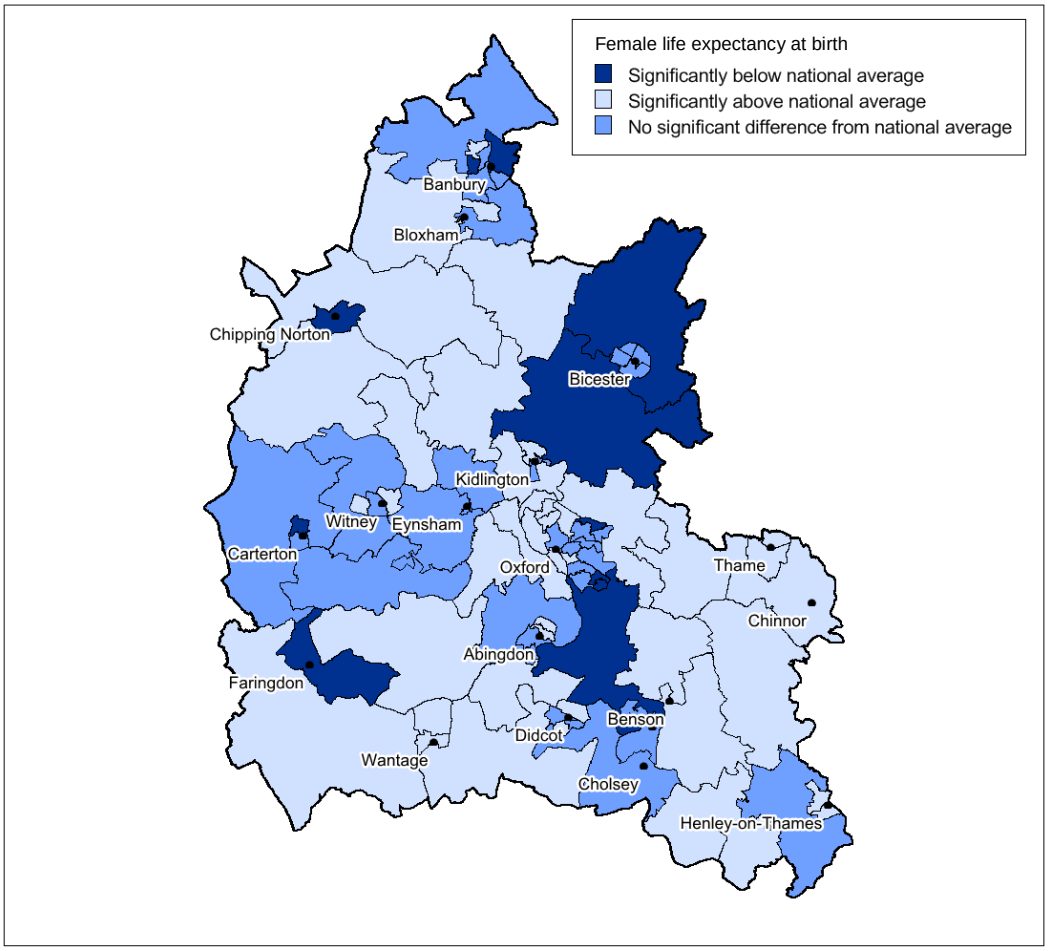
[12] Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within upper Tier Local Authorities: 2009-2013 (ONS, November 2015): http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/inequality-in-health-expectancies-us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

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



Source: Office for National Statistics

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



Source: Office for National Statistics

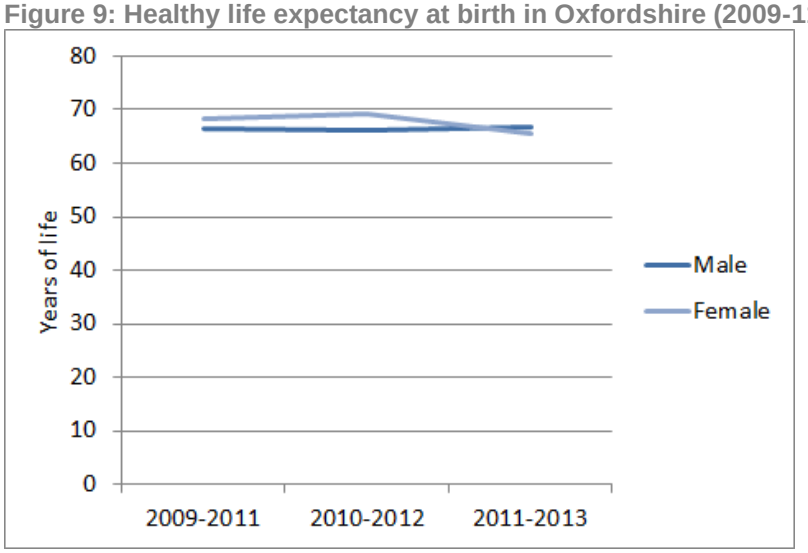
2.2.2. Healthy Life Expectancy

The Office for National Statistics publishes three-year rolling estimates of healthy life expectancy (the number of years of life a person spends in good health) at national, regional and county levels.[13] Nationally, overall life expectancy has been increasing faster than healthy life expectancy in recent years; this means people may have *more* years living in ill-health in the future.[14]

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

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

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



Source: Office for National Statistics subnational health expectancies

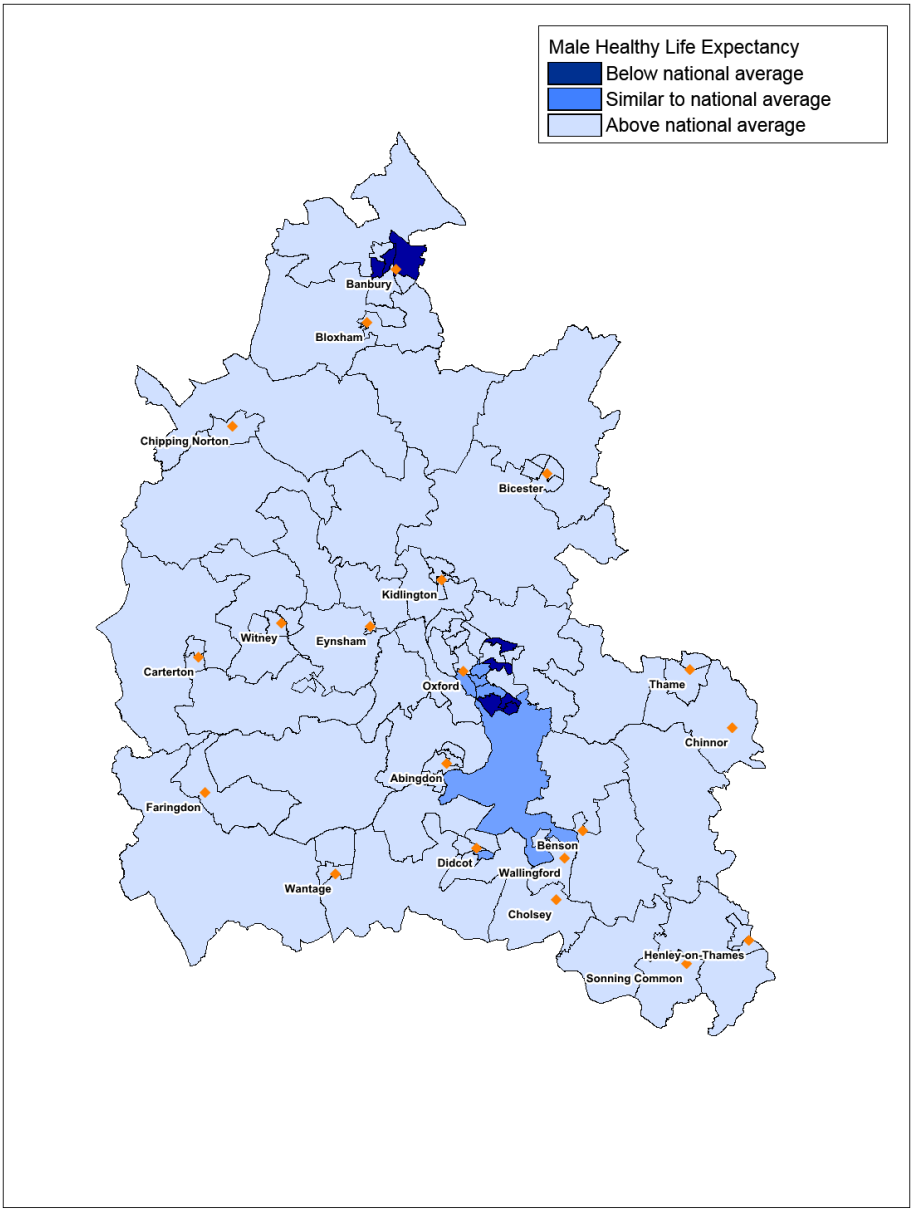
Healthy life expectancy in Oxfordshire is above the national average: for the period 2011-2013 the average healthy life expectancy for a boy born in England was 63.3; for a girl it was 63.9.[15] Healthy life expectancy in Oxfordshire is statistically similar to the South East average (65.6 for a boy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

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

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

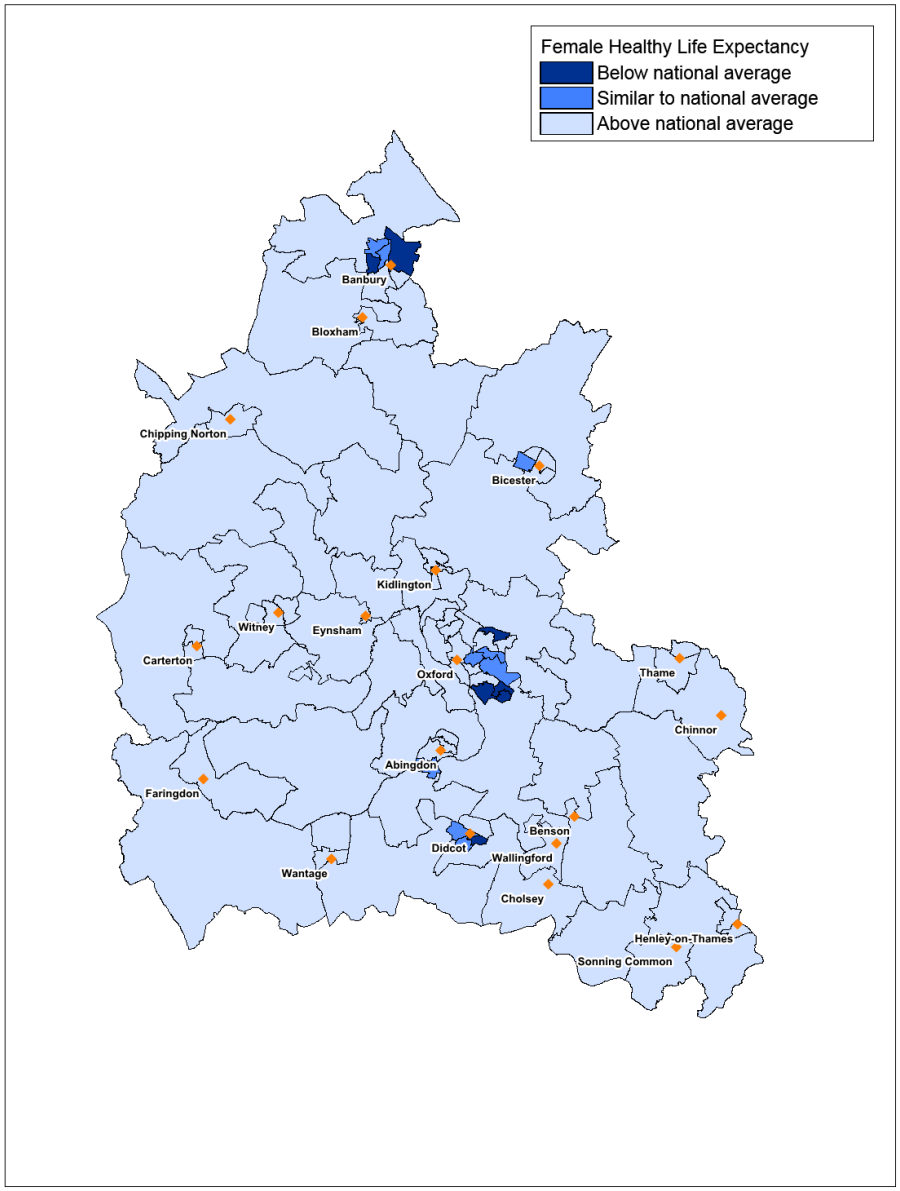
[16] ONS Health Expectancies at Birth for Middle Layer Super Output Areas (MSOAs), England, 2009-2013: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/2009-2013/index.html

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



Source: Office for National Statistics health expectancies statistics

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



Source: Office for National Statistics health expectancies statistics

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

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

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

2.2.3. Disability-Free Life Expectancy

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

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

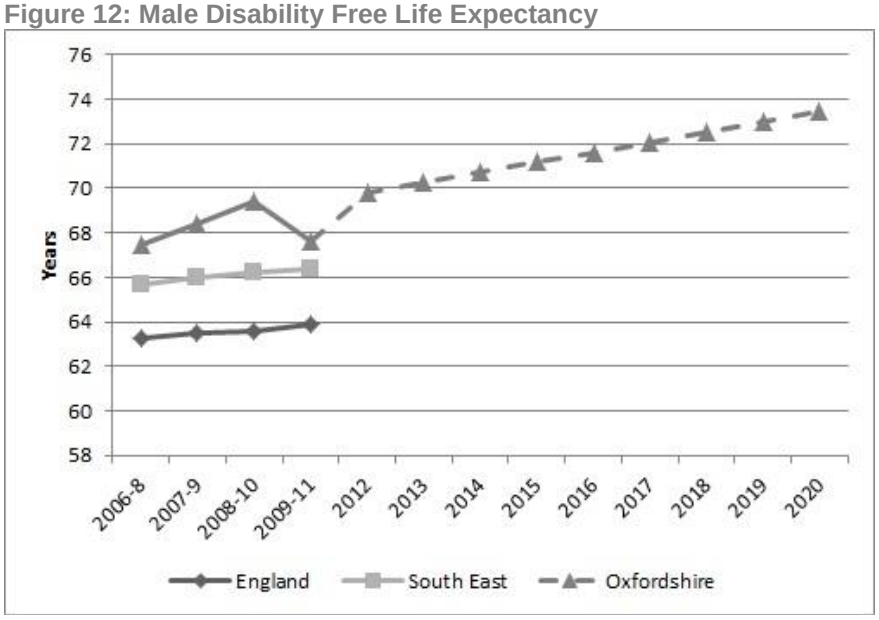
Disability free life expectancy in Oxfordshire remains significantly above the national average. Male disability free life expectancy has consistently been in the top 10% of the 150 upper tier local authorities in England since 2006-8. Female disability-free life expectancy has been in the top 20%.If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

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

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

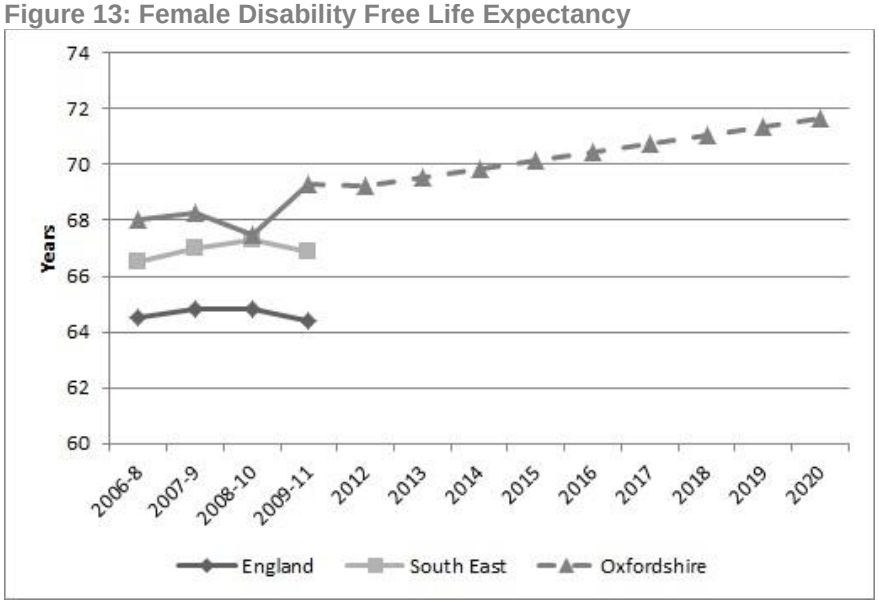
[20] Projections for disability free life expectancy use Oxfordshire County Council's Research and Intelligence team's overall life expectancy projections and apply trends in disability free life expectancy from the period 2006-2008 to 2009-2011, based on ONS estimates. The changing ratios between overall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

Figure 12: Male Disability Free Life Expectancy



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

Figure 13: Female Disability Free Life Expectancy

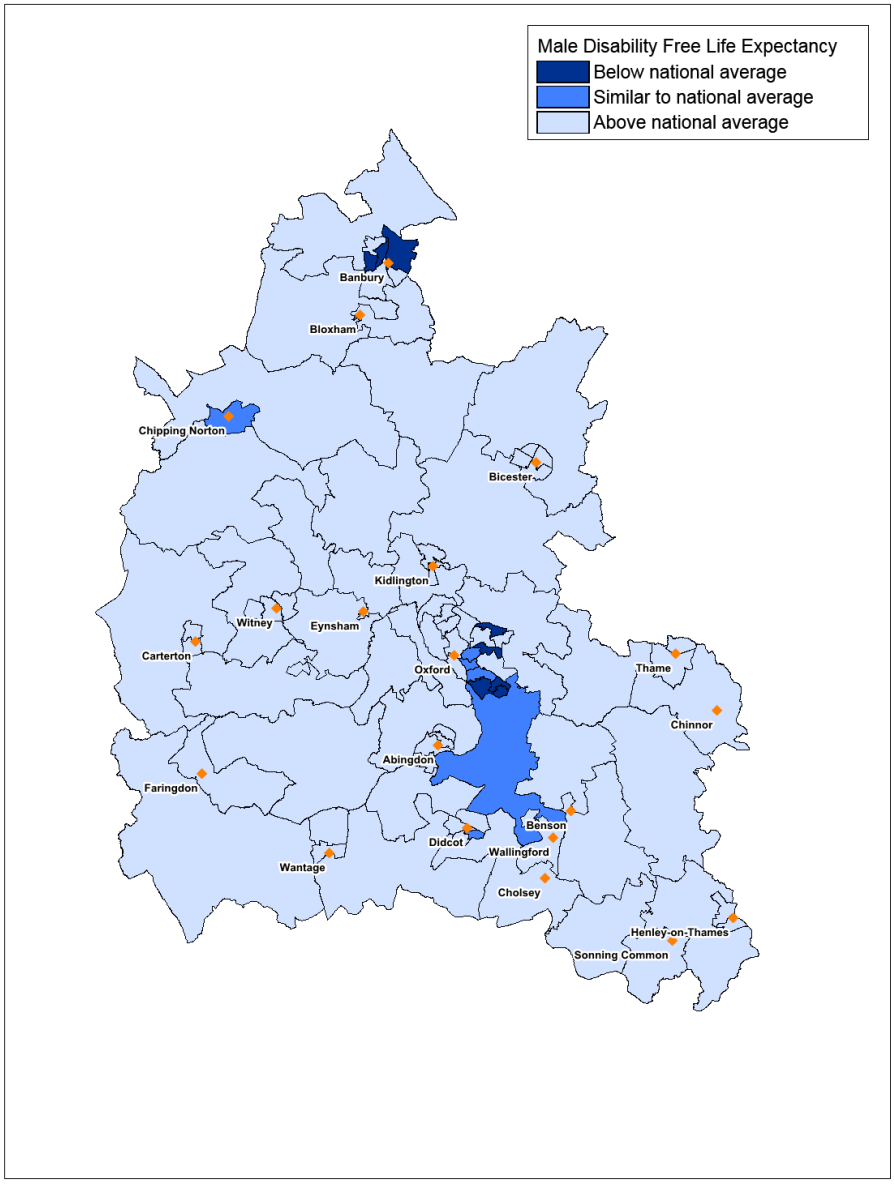


Source: Office for National Statistics subnational health expectancies/ OCC projections

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

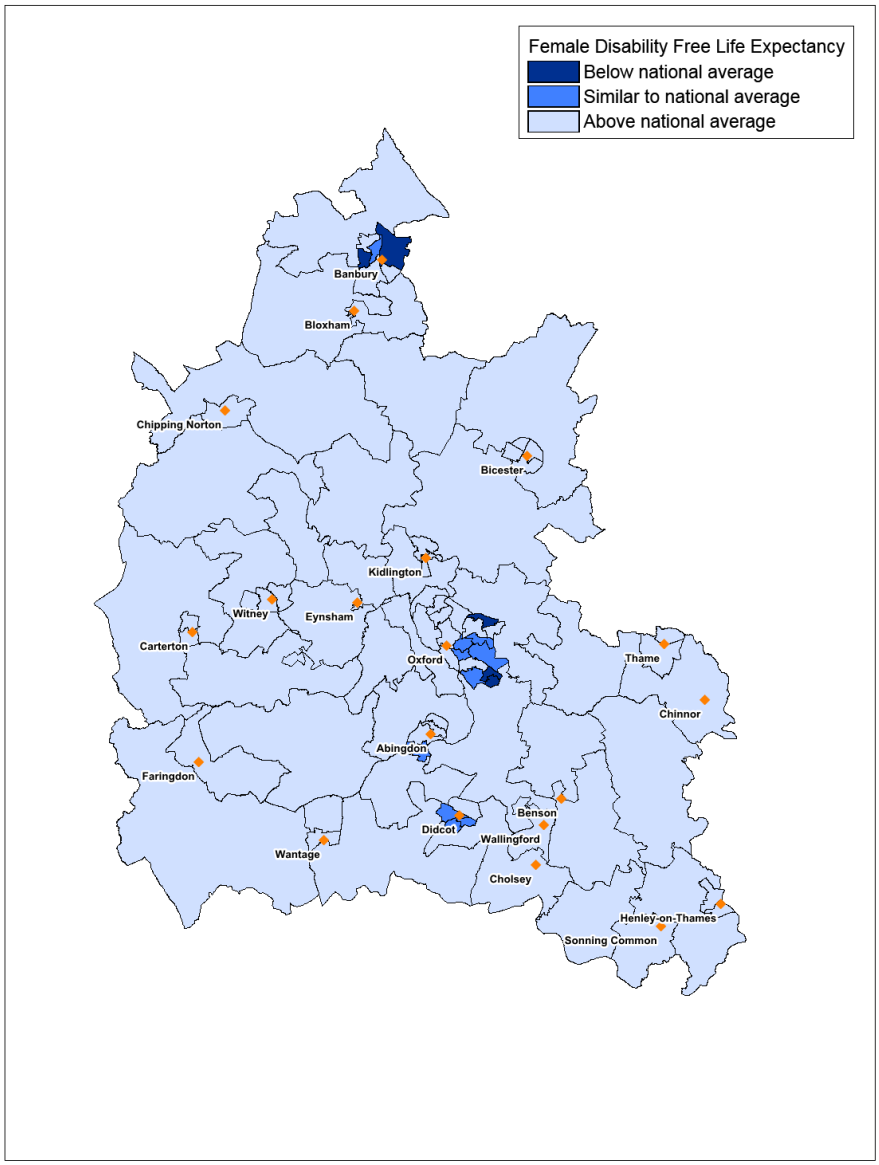
[21] ONS Health Expectancies at Birth for Middle Layer Super Output Areas (MSOAs), England, 2009-2013: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/2009-2013/index.html

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



Source: Office for National Statistics health expectancies statistics

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



Source: Office for National Statistics health expectancies statistics

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

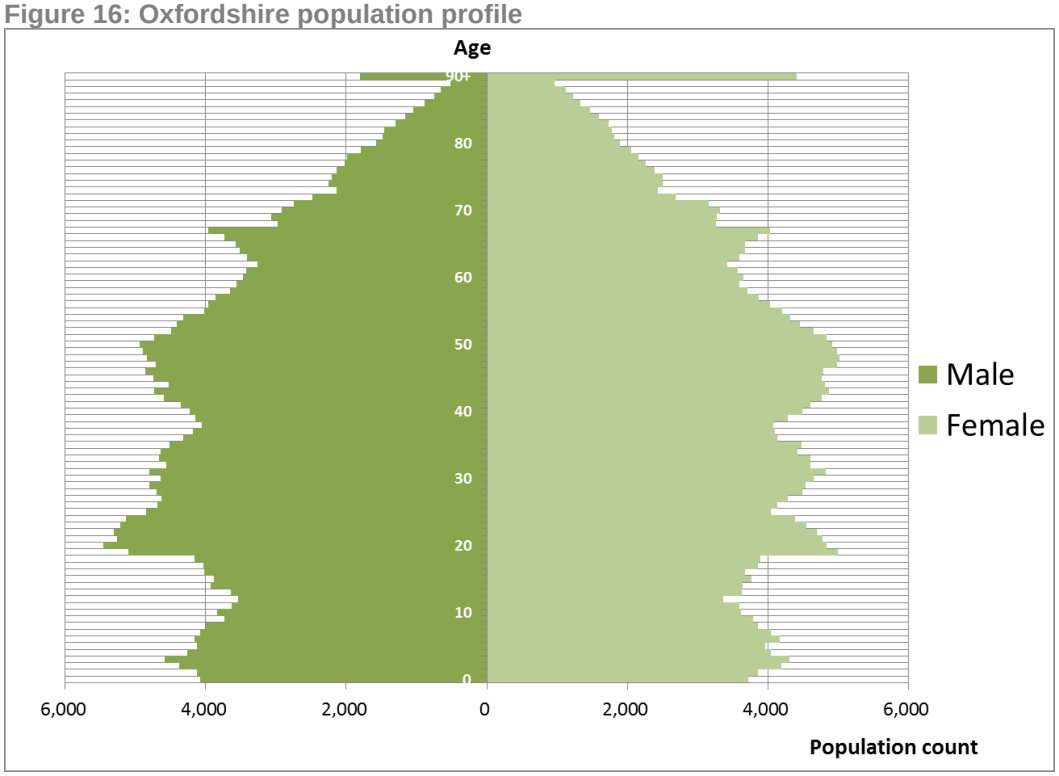
Meanwhile, the inequality in female DLE at birth was estimated at 7.3 years, with 95% confidence within the range 5.8-8.8 years. Again, this was significantly better than the national average.

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

2.3. Population by Sex and Age

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

Figure 16: Oxfordshire population profile



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

2.3.1. Sex

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

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

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

2.3.2. Age

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

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

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

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

Figure 17: Oxfordshire's population by age group

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

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

Older People

In 2014 there were an estimated 115,600 people aged 65 and over, representing an increase of 11.4% since 2011. Within this group, the number of people aged 85 and over was estimated to have increased by 10.3%, to 16,200.

In 2014 those aged 65 and over made up an estimated 17.2% of the county's population (up from 15.9% in 2011); 85 and overs made up 2.4% (up from 2.2% in 2011). These proportions were slightly lower than in the South East (where 65 and overs comprised 18.6% of the population and 85 and overs 2.6%). They were similar to England overall (17.6% and 2.3%, respectively).

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

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

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

Source: Office for National Statistics Mid-2014 Population Estimate

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

Babies and Infants

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

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

Children and Young People

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

Working Age Adults

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

3. Population Groups

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

3.1. Race and Ethnicity

3.1.1. White British and Irish

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

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

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

3.1.2. Other White

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

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

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

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

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

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

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

3.1.3. Black and Minority Ethnic

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

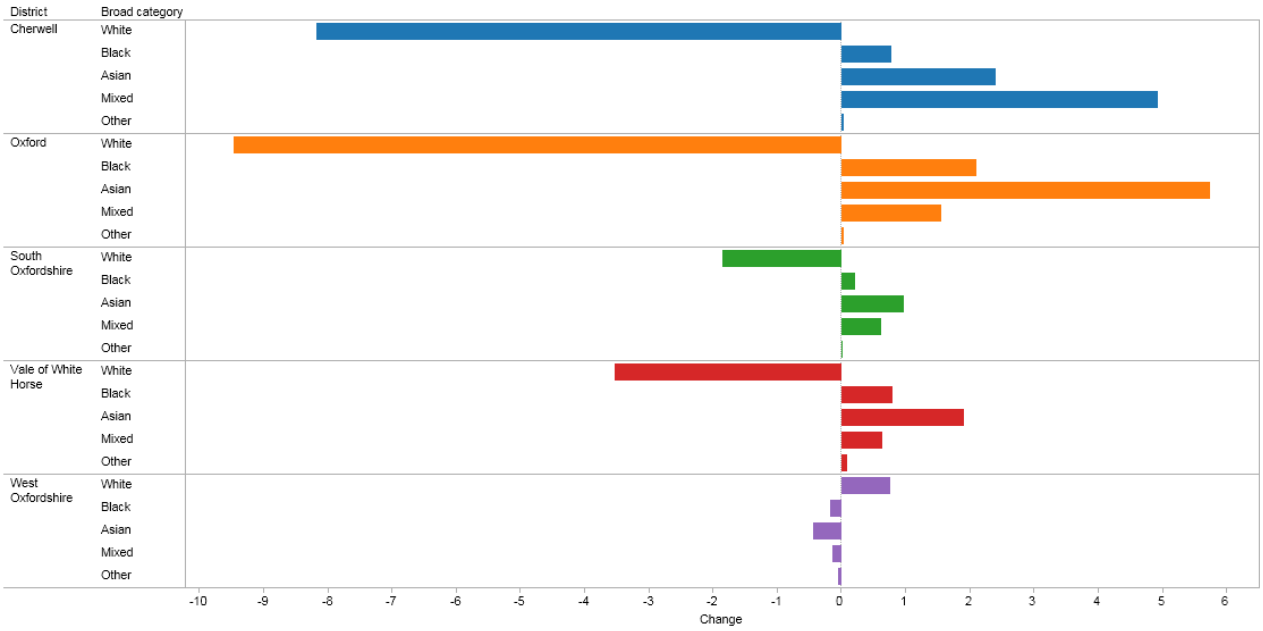
People from Asian backgrounds constituted the largest BME group, numbering 31,700, or 4.8% of the county's population (up from 2.4% in 2001). Most came from Indian backgrounds (1.3% of the population) or Pakistani backgrounds (1.2%).

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

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

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

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



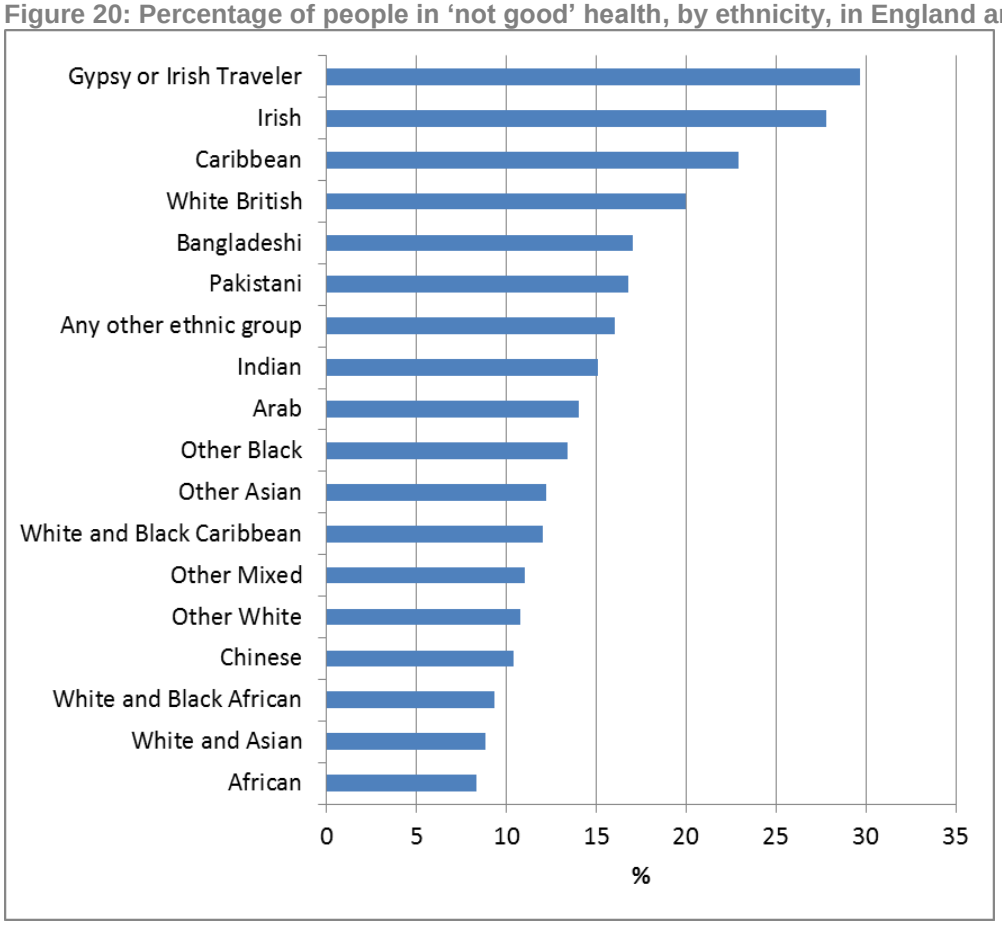
Source: Oxfordshire Insight, data taken from 2001 and 2011 ONS Census surveys

3.1.4. Ethnicity and Health

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

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

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



Source: Office for National Statistics

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

3.2. Language

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

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

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

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

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

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

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

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

3.3. Religion and Belief

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

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

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

3.4. Sexual Orientation

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

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

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

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

3.5. Gender Reassignment

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

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

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

3.6. Marriage and Civil Partnership

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

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

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

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

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

3.7. Pregnancy and Maternity

3.7.1. Conceptions

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

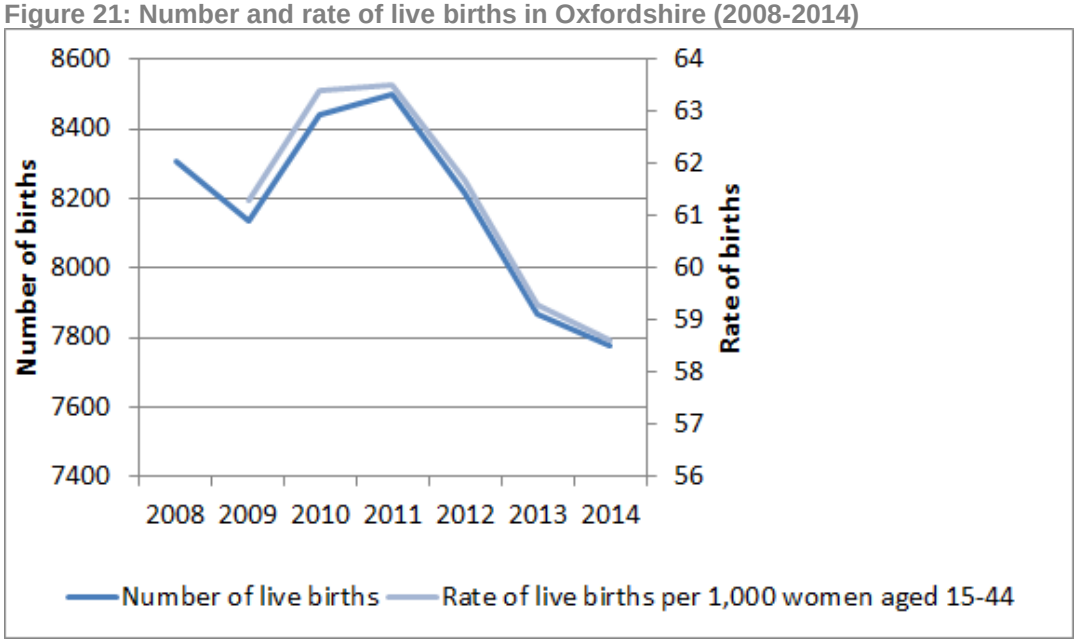
In Oxfordshire 17.6% of conceptions led to therapeutic abortion in 2012, a similar proportion as in the previous three years (within three percentage points).[42] The proportion of abortions was lower than in the South East (19.7%) and England overall (21.2%).

Teenage conceptions are discussed in chapter 6: Lifestyles.

3.7.2. Births

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

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



Source: Office for National Statistics Birth Statistics

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

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

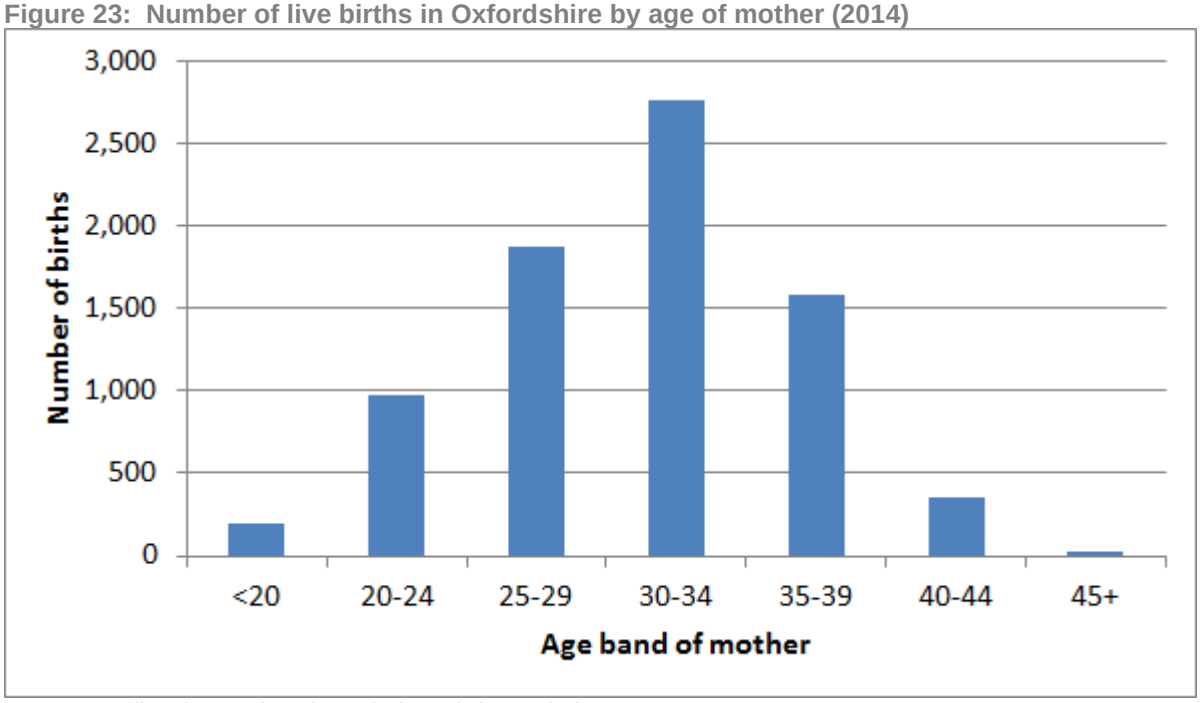
Figure 22: Number and rate of live births in Oxfordshire's Districts (2014)

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

Source: Office for National Statistics Birth Statistics

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

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



Source: Office for National Statistics Birth Statistics

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

3.8. Disability

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

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

3.8.1. Census Data on Limitations to Daily Activities

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

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

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

On average, Oxfordshire's people were less limited in their daily activities than in the wider South East, where 15.7% reported this. Levels across England were higher again, with 17.6% saying they were limited.

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

Around two fifths of the people in Oxfordshire who were limited in their daily activities, said they were limited a lot (numbering 37,600, 5.8% of the county's population). Again, this was lower than the proportions seen in the South East (6.9%) and England (8.3%). There was little variation across the county, with the city and districts within half of one percent of the county average.

Limitations by Sex

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

Limitations by Ethnicity

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

Limitations by Age

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

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

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

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

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

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

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

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

3.8.2. Family Resources Survey Disability Data (National Data)

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

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

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

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

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

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

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

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

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

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

Source: Family Resources Survey, 2013/14

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

Figure 25: Extrapolated impairment type figures for Oxfordshire

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

Source: Extrapolation from Family Resources Survey, 2013/14

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

3.8.3. Physical Disability

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

3.8.4. Sight Loss

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

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

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

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

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

People Registered Blind or Partially Sighted

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

Sight Loss Prevalence

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

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

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

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

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

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

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

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

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

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

Preventable Sight Loss

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

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

3.8.5. Hearing Loss

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

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

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

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

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

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

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

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

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

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

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

3.8.6. Learning Disability

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

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

Adults with Learning Disability

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

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

3.8.7. Children with Statements of Educational Needs

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

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

3.8.8. Disability Benefits

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

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

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

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

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

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

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

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

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

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

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

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

3.9. Rural Population

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

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

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

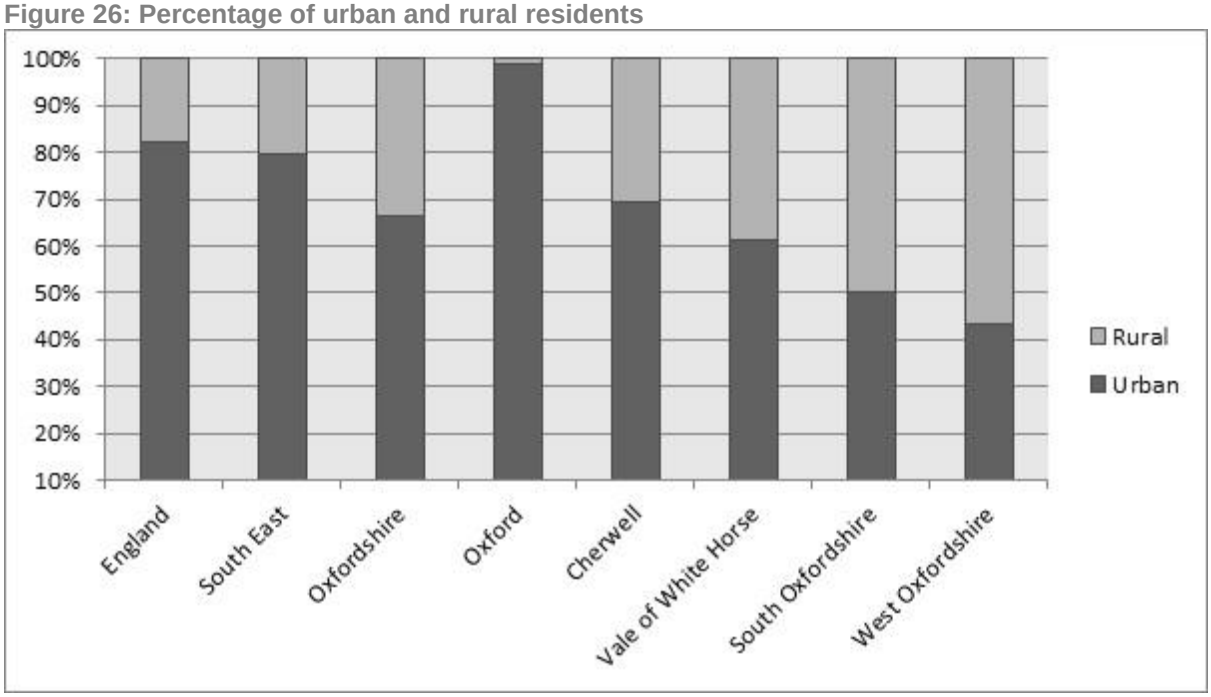
[73] Department for Work and Pensions StatXplore tool: https://stat-xplore.dwp.gov.uk/ Personal Independence Payment (PIP) helps with some of the extra costs caused by long-term ill-health or a disability if you're aged 16 to 64. PIP started to replace Disability Living Allowance (DLA) for people aged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

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

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

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

Figure 26: Percentage of urban and rural residents



Source: Office for National Statistics 2011 Census

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

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

3.10. Armed Forces Personnel

3.10.1. Regular Armed Forces Personnel

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

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

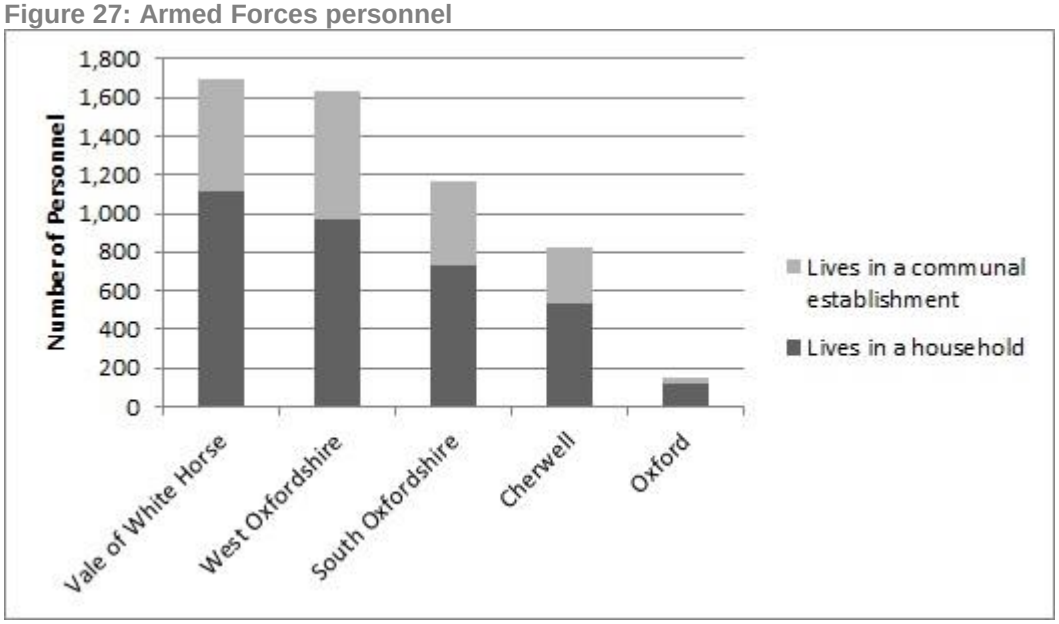
[78] Census 2011, table QS121EW: https://www.nomisweb.co.uk. Regular Armed Forces personnel receive all their primary care from Defence Medical Services (DMS) GPs, not the NHS, although secondary care is accessed via the NHS. DMS Medical Centres at RAF Brize Norton and RAF Benson also provide GP care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

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

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

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

Figure 27: Armed Forces personnel



Source: Office for National Statistics 2011 Census

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

3.10.2. Veterans

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

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

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

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

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

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

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

3.11. Carers

3.11.1. Number of Carers

At the time of the 2011 Census, around 61,100 people in Oxfordshire said they provided some level of informal care to a relative or friend, representing 9.4% of the county's population (up from 8.8% in 2001).[82] This proportion was slightly lower than in the South East (10.2%) and England overall (9.8%).

Across the county, there were proportionately fewer carers in Oxford (7.7%) than in other districts: 10.3% in Vale of White Horse, 9.9% in both South and West Oxfordshire and 9.4% in Cherwell.

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

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

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

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

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

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

3.11.2. Carers' Needs and Outcomes

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

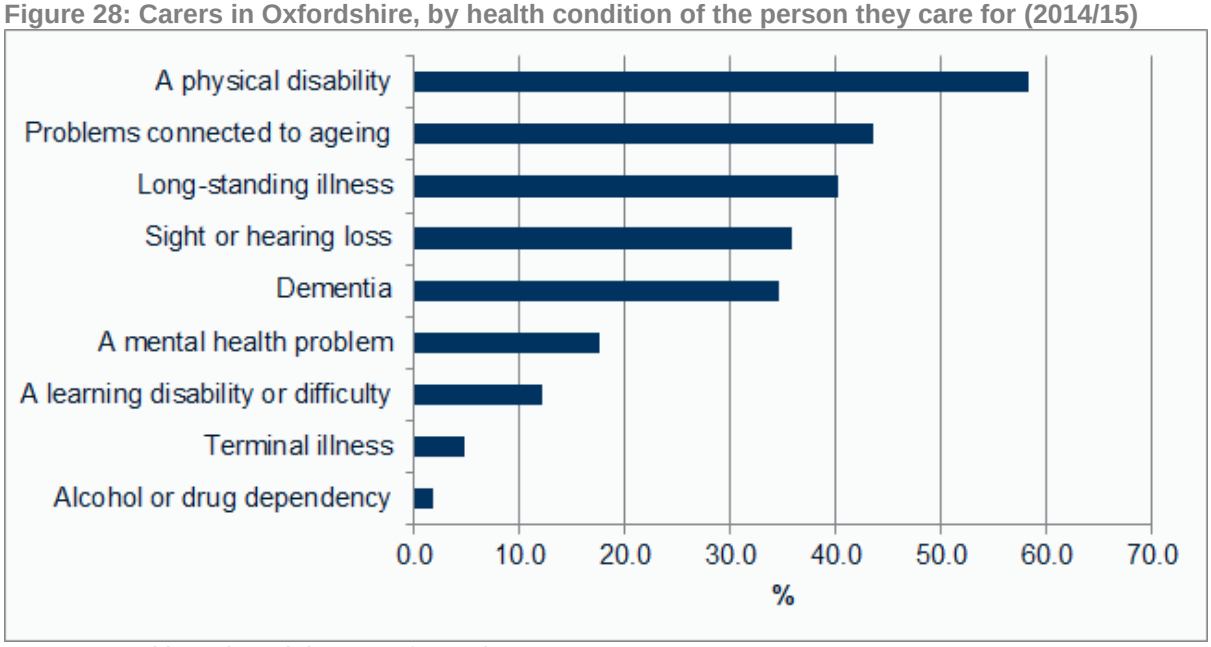
715 carers in Oxfordshire responded to the survey in 2014/15. The following analysis highlights where the survey results for Oxfordshire differed significantly from national averages; otherwise they can be assumed to be similar. Due to relatively wide confidence intervals around the local figures, it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

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

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

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

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



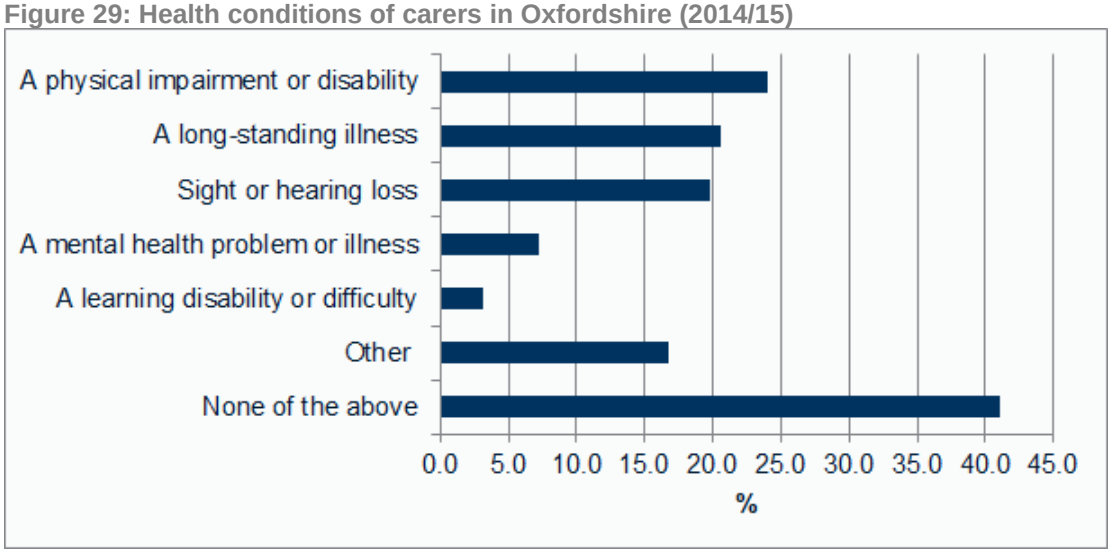
Source: Health and Social Care Information Centre

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

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

Over half of the carers surveyed reported having a health problem themselves, commonly a physical impairment or disability, a long standing illness, and/ or loss of sight or hearing.

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



Source: Health and Social Care Information Centre

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

Only one in five respondents to the survey in Oxfordshire said they were able to spend their time as they wanted, doing things they value or enjoy. Most said they were able to do some of these things but not enough (65.8%). 14.3% said they didn't do anything they value or enjoy. The pattern of responses did not differ significantly from the national picture.

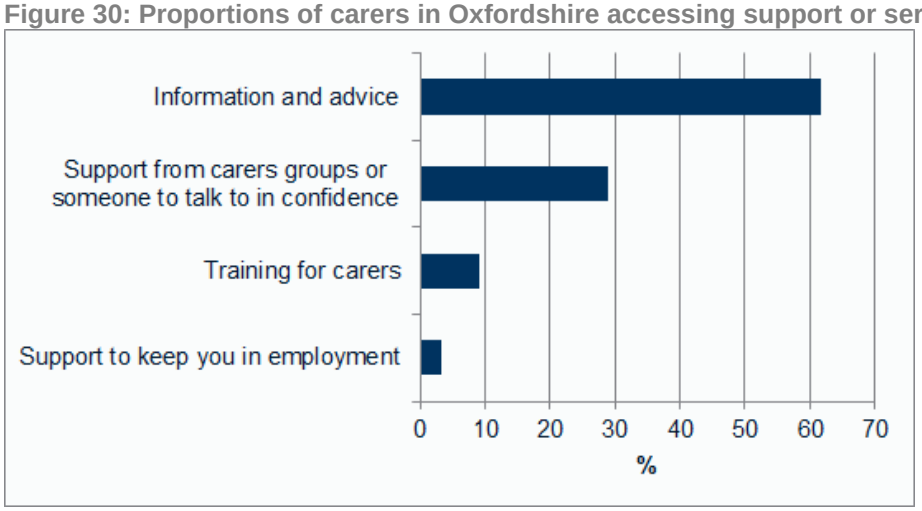
Likewise, over seven in ten respondents said they did not have as much control over their daily life as they want. Some of these said they had *no* control (making up 12.4% of all respondents). The pattern of responses did not differ significantly from the national picture.

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

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

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

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



Source: Health and Social Care Information Centre

Most respondents said they had found it (very or fairly) easy to find information and advice about support, services and benefits. Nearly 90% had found the information and advice they had received (very or quite) helpful.

More than three quarters of carers who had received support or services from Social Services said they were satisfied with what they had received. A little under half said they were very or extremely satisfied. These satisfaction levels were broadly similar to regional and national averages, and to the results of the previous survey in Oxfordshire in 2012/13.

4. Wider Determinants of Health

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

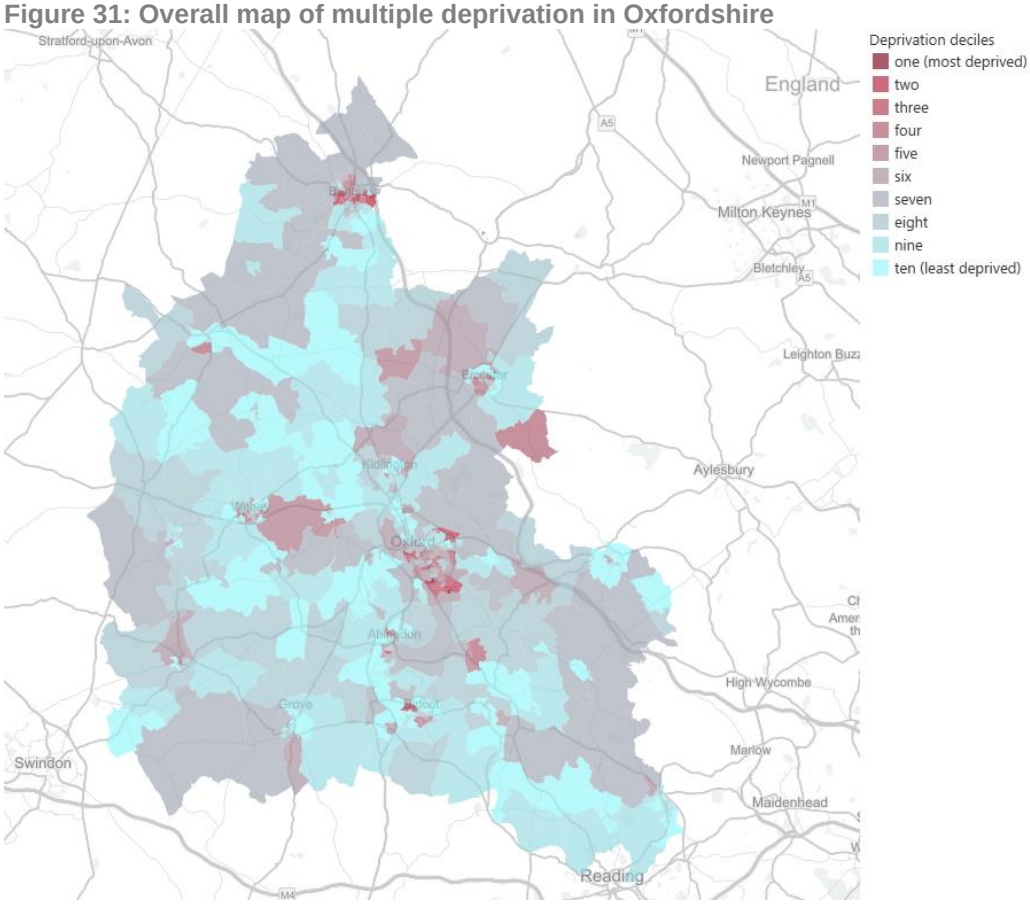
4.1. Affluence and Deprivation

4.1.1. Overall Index of Multiple Deprivation

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

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

Figure 31: Overall map of multiple deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

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

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

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

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

On the other hand, two LSOAs are among the 10% most deprived in England. These are in Oxford City, in parts of Rose Hill and Iffley ward, and Northfield Brook ward. In 2010 only the latter of these was among the 10% most deprived areas. A further 13 LSOAs are among the 10-20% most deprived (down from 17 in 2010). These are concentrated in parts of Oxford City, Banbury, and Abingdon.

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

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

Source: DCLG English Indices of Deprivation 2015

In general, the areas of Oxfordshire that were identified as the most deprived in 2010 remain the most deprived. However, in Oxford City, one LSOA in Holywell ward, and another in Littlemore, have moved out of the 10-20% most deprived. However, one in Rose Hill has moved *into* the 10-20% category.

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

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

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

4.1.2. Index of Income Deprivation

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

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

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

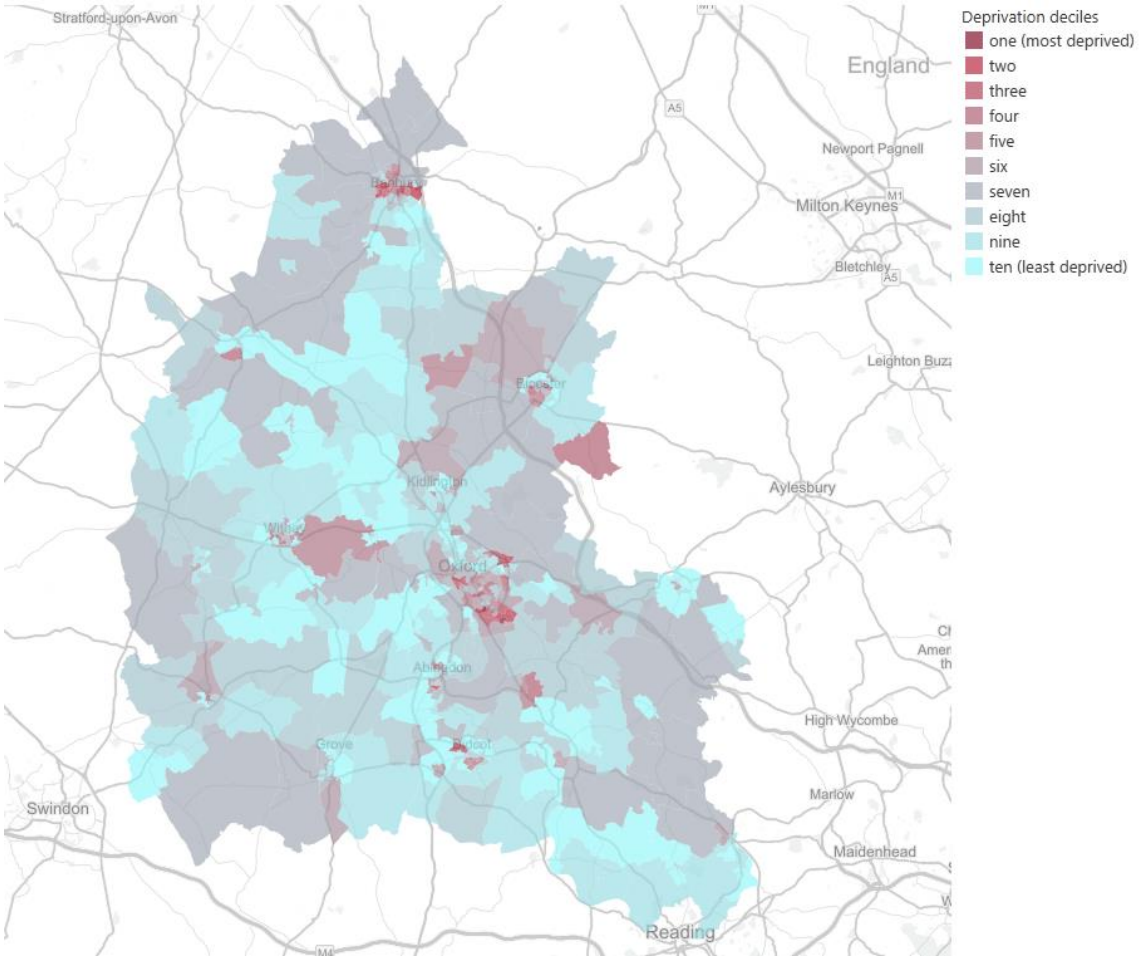
The map below shows the pattern of income deprivation across Oxfordshire.

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

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

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

Figure 33: Map of income deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

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

4.1.3. Levels of Income

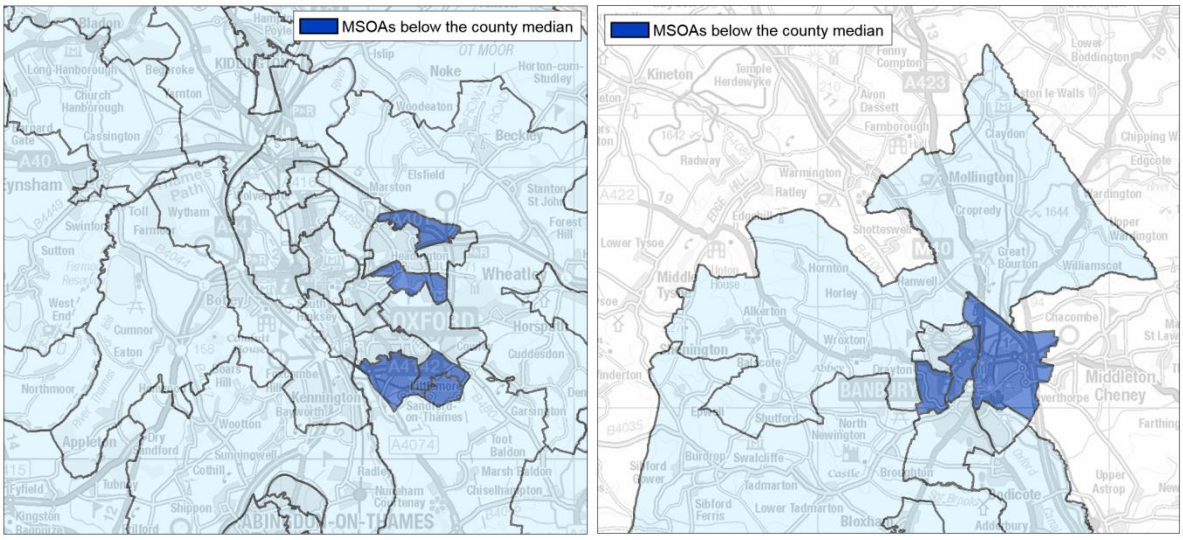
Estimates have been produced of the mean net weekly household income for each medium-sized area in England and Wales (technically known as middle-layer super output areas, or MSOAs).[91]

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

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

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

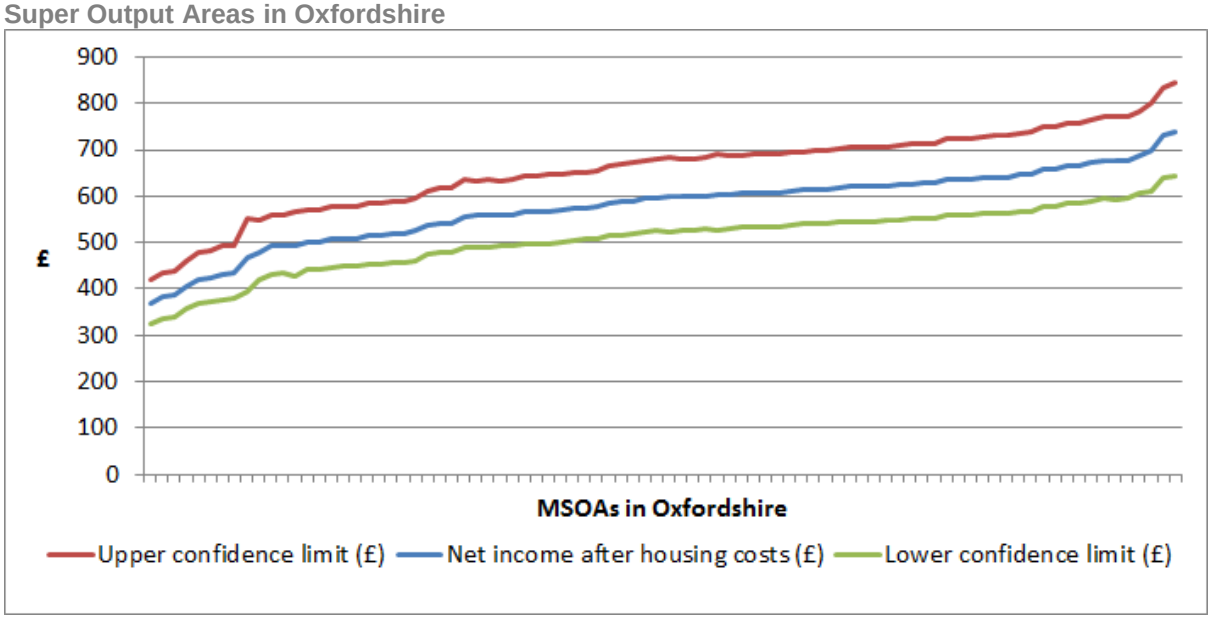
Figure 34: Map of areas in Oxford and Banbury with low mean net weekly household income



Source: Office for National Statistics

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

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



Source: Office for National Statistics

4.2. Housing and Homelessness

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

4.2.1. Tenure

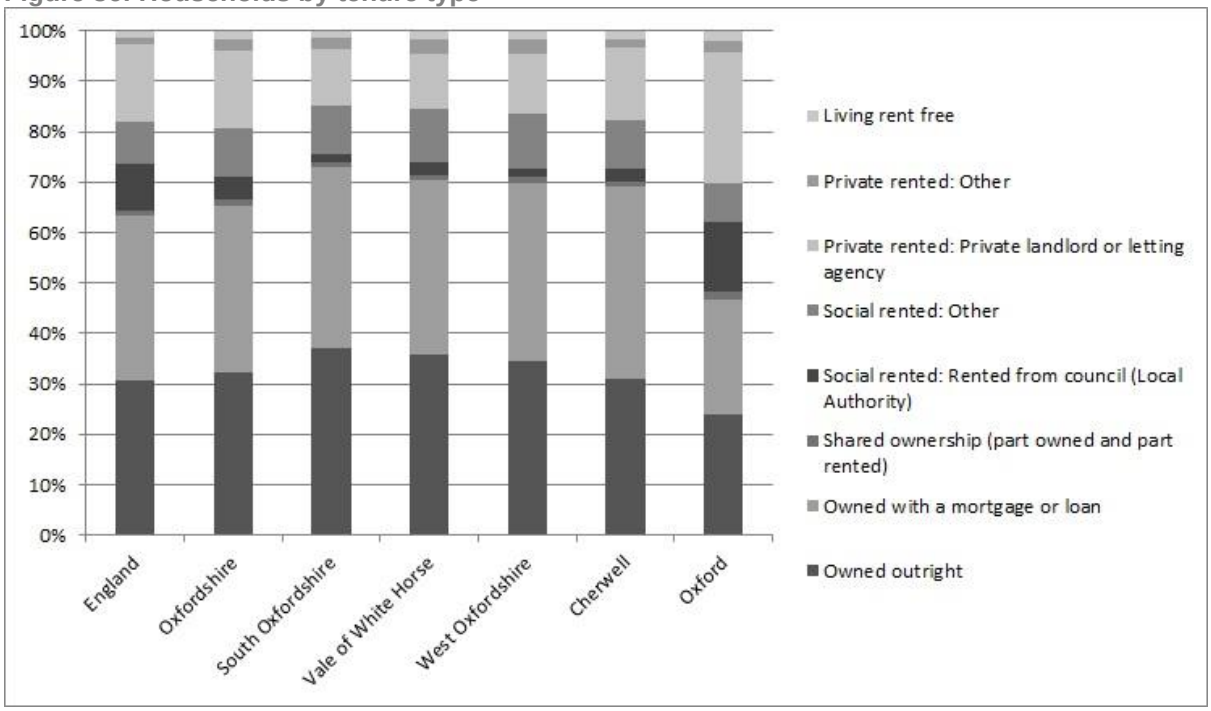
At the time of the 2011 Census, there were 258,900 households in Oxfordshire. Around two thirds lived in housing they owned, either outright (32.3%) or with a mortgage or loan

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

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

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

Figure 36: Households by tenure type



Source: Office for National Statistics 2011 Census

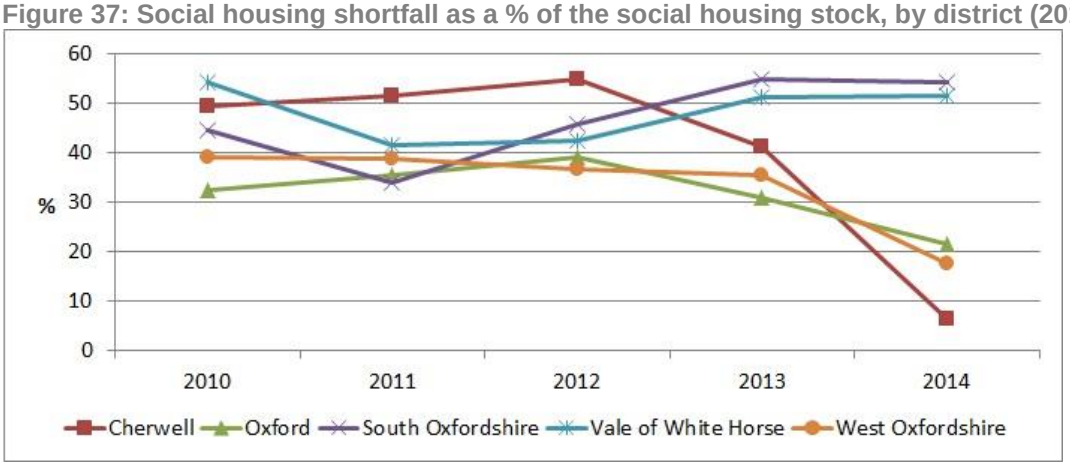
The figure above demonstrates considerable variation in tenure patterns across different parts of the county. Most notably, the proportion of Oxford's households in local authority social housing was about three times higher than for Oxfordshire overall (13.6%, compared with 4.6%).

4.2.2. Availability of Social Housing

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

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

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



Source: Office for National Statistics Housing Statistics

4.2.3. Barriers to Housing

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

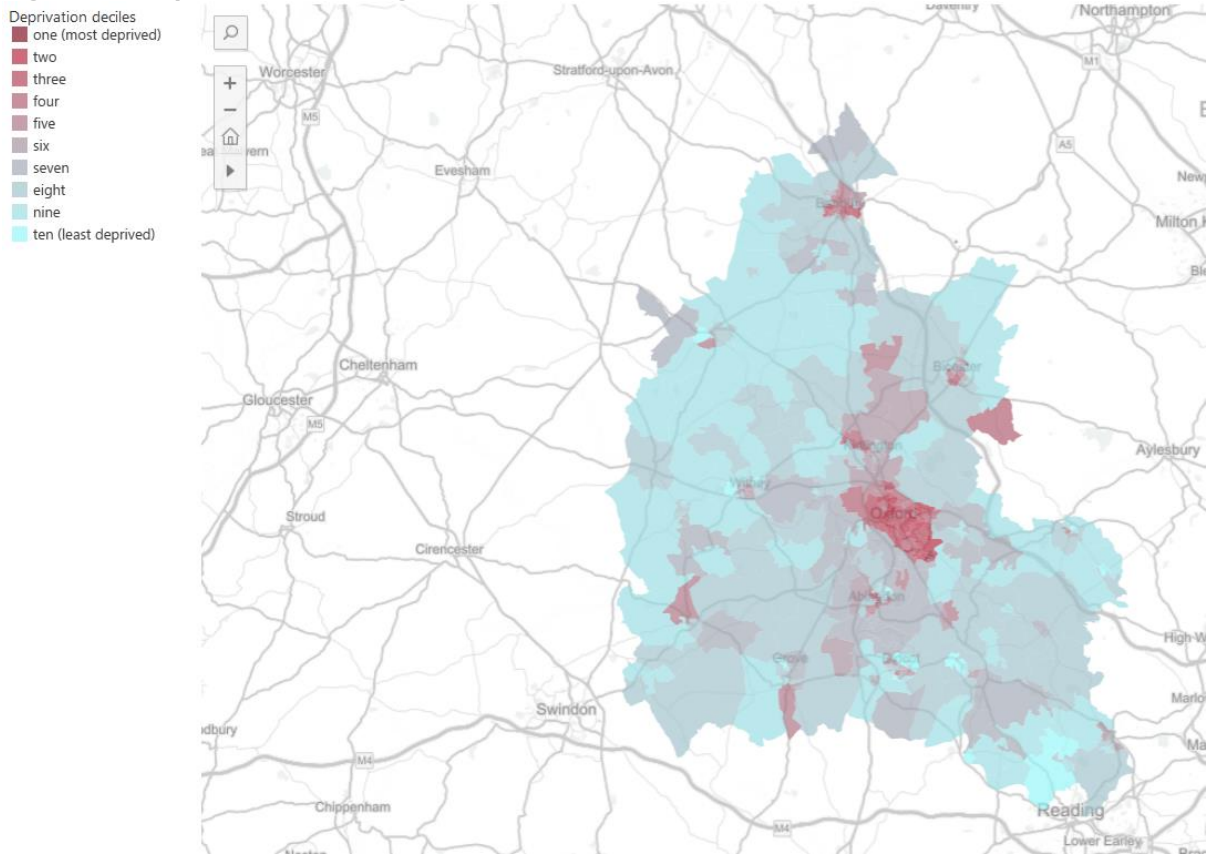
In terms of wider barriers to housing, most of Oxfordshire's 407 small areas (technically known as lower layer super output areas, or LSOAs) are *less* deprived than the national average. 93 are in the 20% *least* deprived of 32,844 small areas in England.

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

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

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

Figure 38: Map of wider housing barriers in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

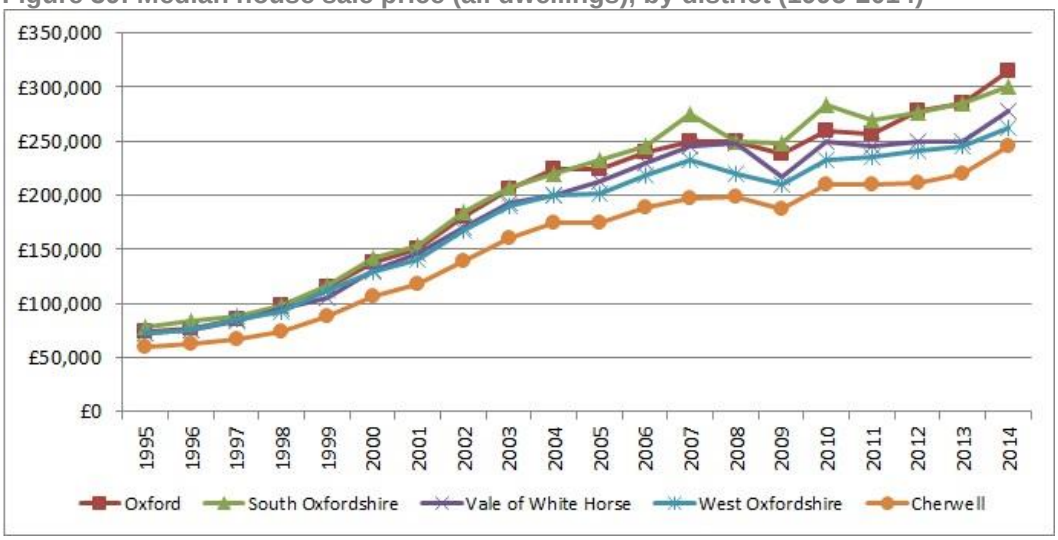
4.2.4. Housing Affordability

House Prices

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

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

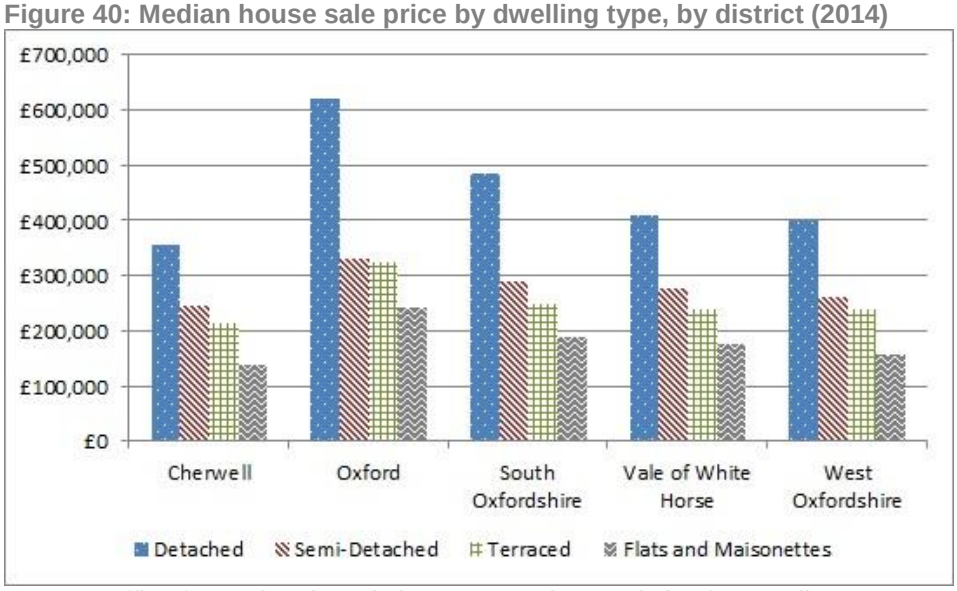
Figure 39: Median house sale price (all dwellings), by district (1995-2014)[95]



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

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

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

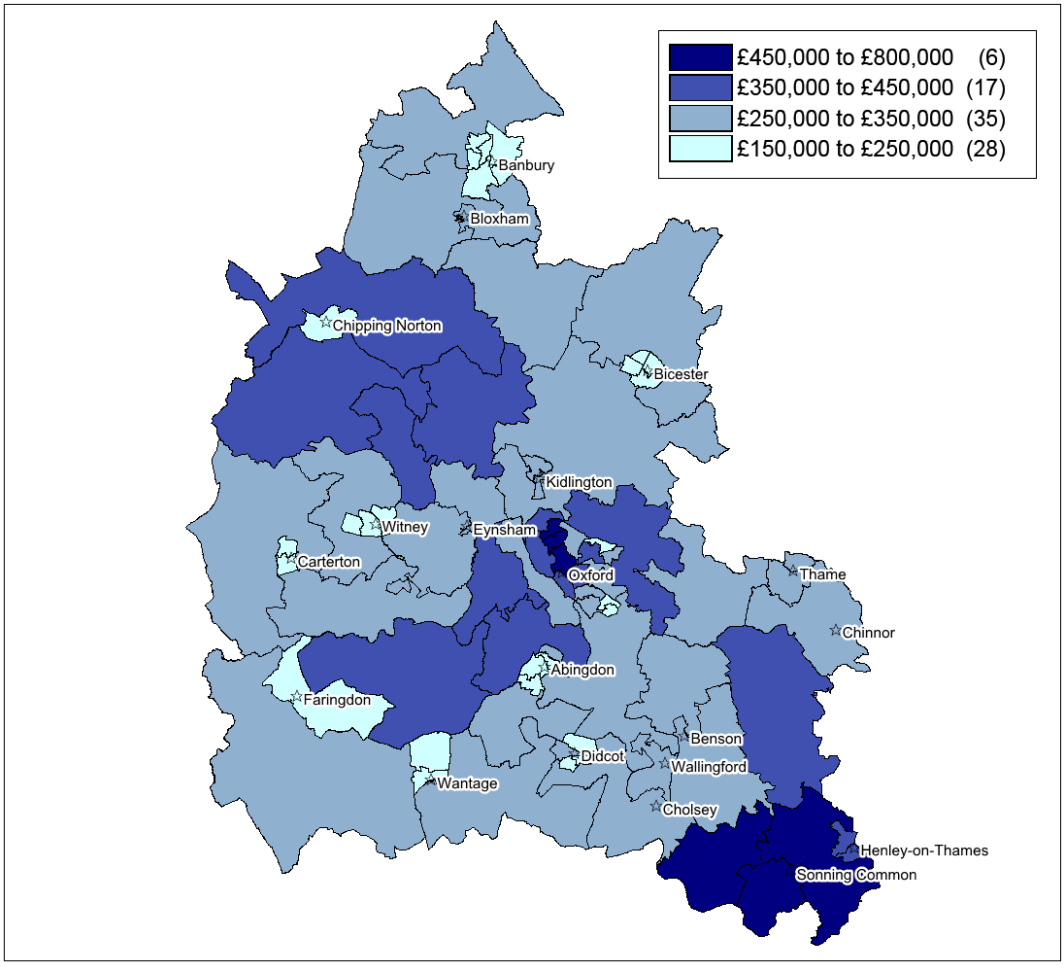


Source: Office for National Statistics House Price Statistics for Small Areas

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

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

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



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

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

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

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

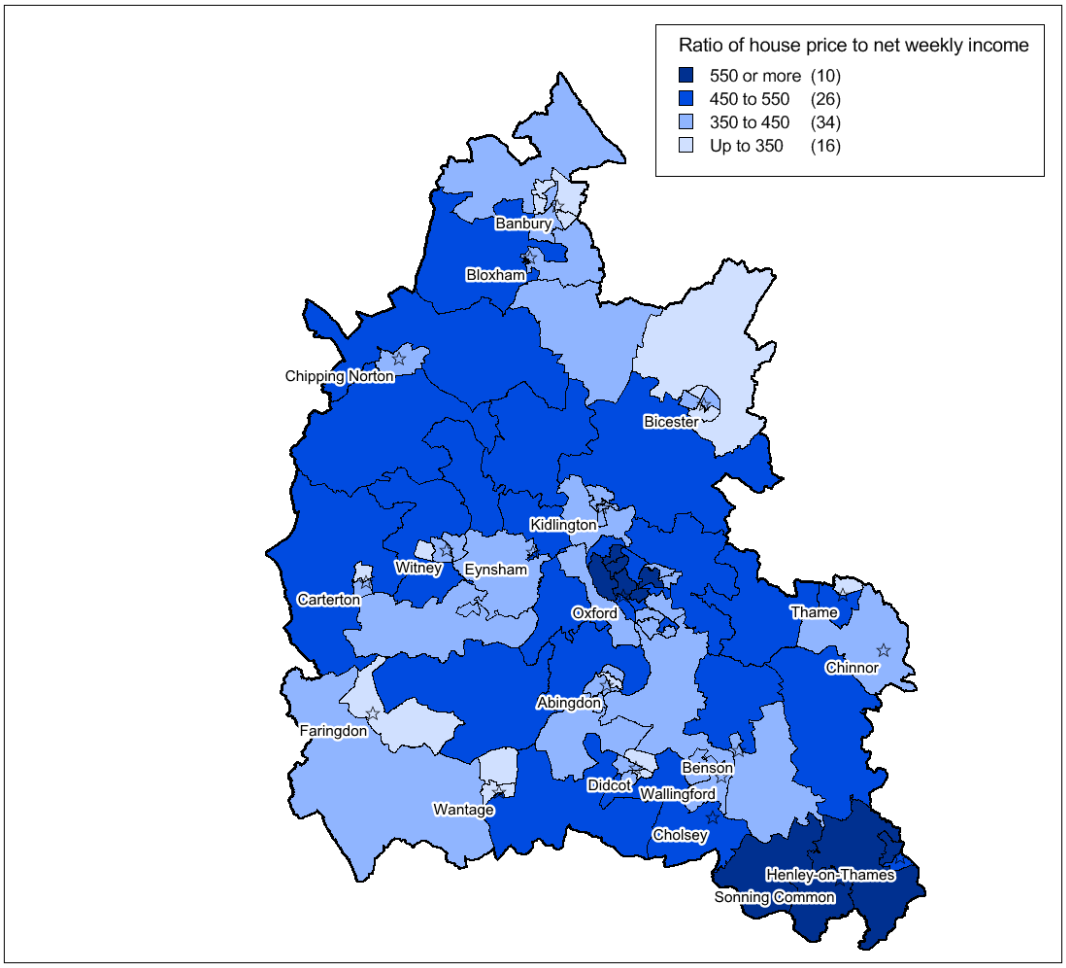
Source: Office for National Statistics House Price Statistics for Small Areas/ Annual Survey of Hours and Earnings

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

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

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

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



Source: Office for National Statistics

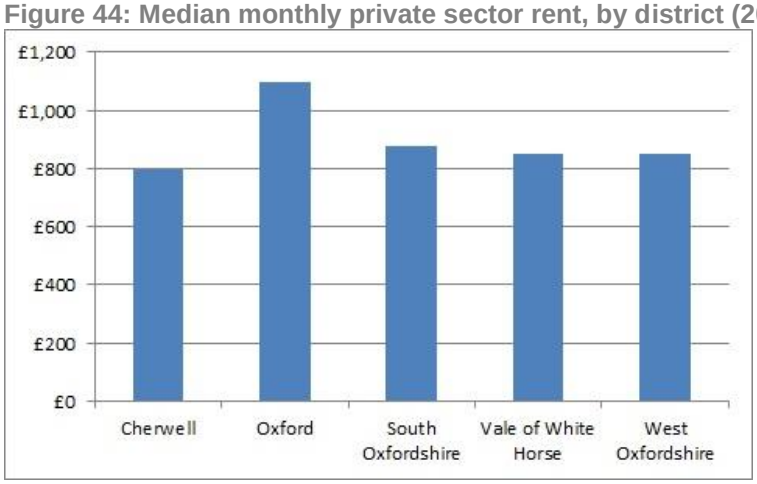
Private Sector Rents

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

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

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

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



Source: Office for National Statistics Housing Statistics

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

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

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

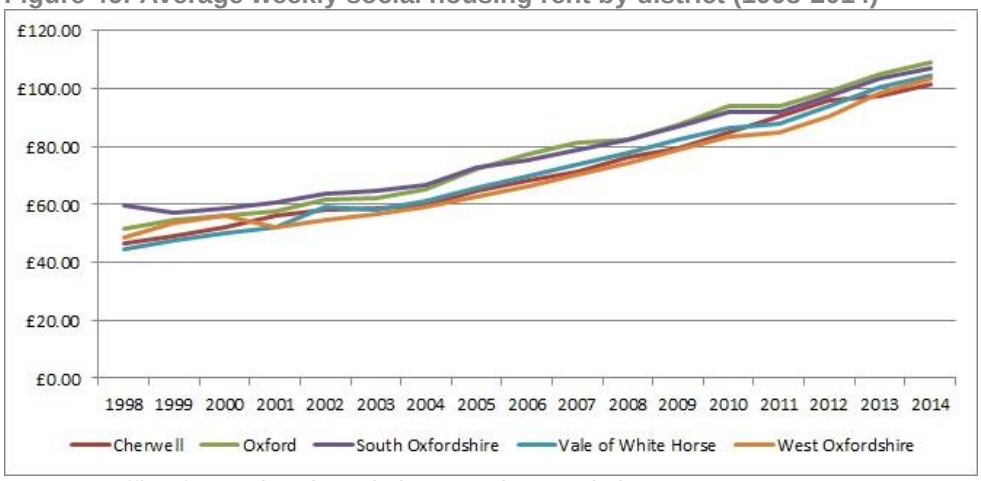
Source: Office for National Statistics Housing Statistics/ Annual Survey of Hours and Earnings

Social Housing Rents

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

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

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



Source: Office for National Statistics Housing Statistics

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

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

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

Source: Office for National Statistics Housing Statistics

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

4.2.5. Housing Conditions

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

Indoor Living Environment

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

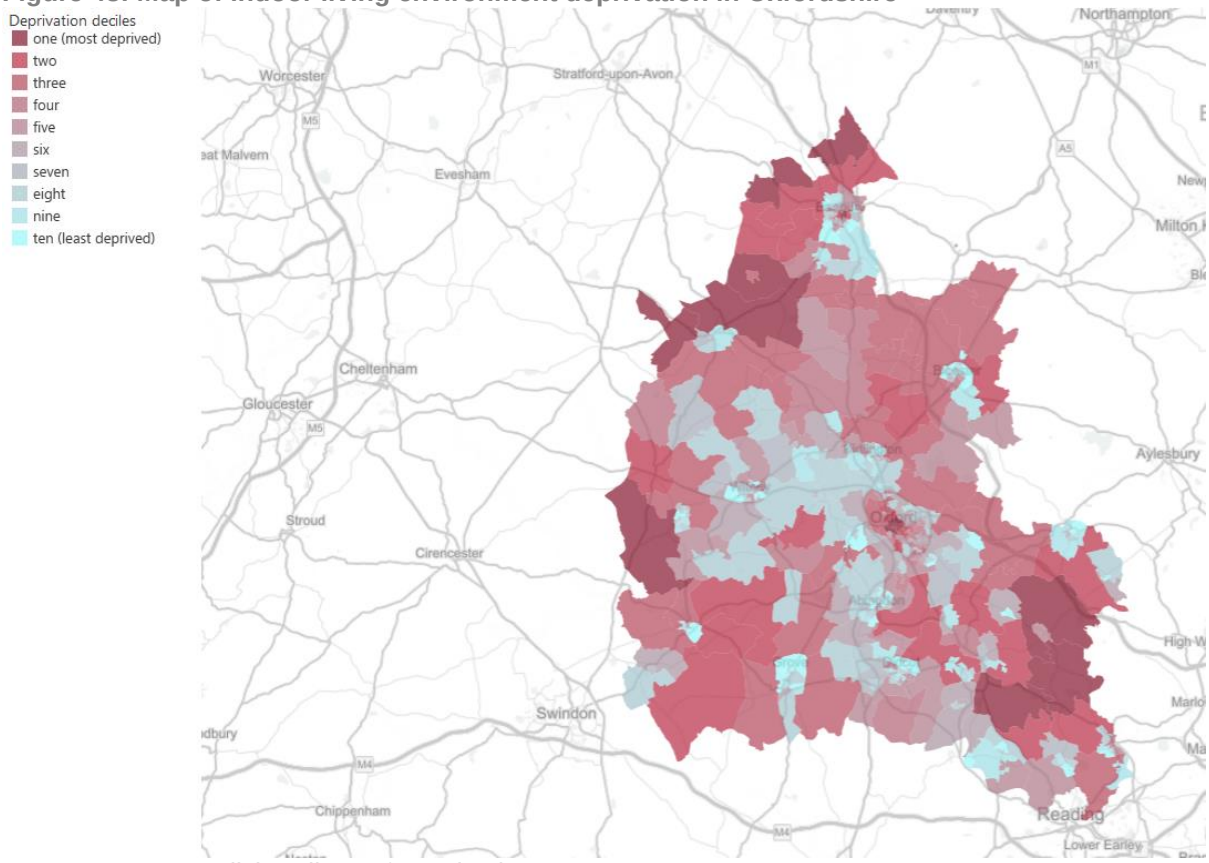
[103] The data cover larger private registered providers of social housing only
[104] The figures do not take account of other sources of income or financial support.
[105] The Marmot Review: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review; Chartered Institute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

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

However, 12 of Oxfordshire's small areas are among the 10% *most* deprived nationally. These are located towards the northern, north-western, western, and south-eastern edges of the county, as well as in parts of Oxford City. A further 28 small areas are in the 10-20% *most* deprived nationally and are similarly spread around different parts of the county.

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

Figure 48: Map of indoor living environment deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

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

Overcrowding

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

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

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

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

Fuel Poverty

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

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

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

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

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

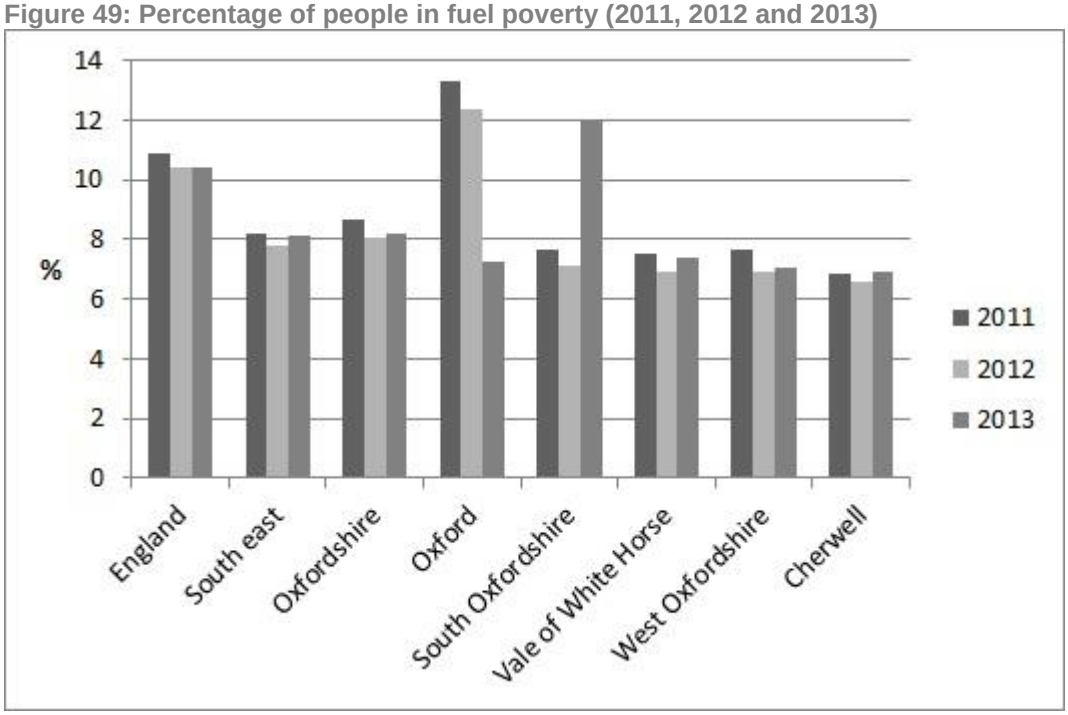
[109] ONS Census 2011 analysis of health in England and Wales (July 2015): http://visual.ons.gov.uk/health-census/

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

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

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

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



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

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

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

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

4.2.6. Homelessness

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

Statutory Homelessness

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

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

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

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

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

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

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

Rough sleeping

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

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

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

Source: Oxfordshire Health Improvement Board/ DCLG

4.3. Education and Qualifications

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

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

4.3.1. Early Years

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

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

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

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

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

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

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

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

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

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

4.3.3. Pupil Attainment at Key Stage 4 (GCSE)

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

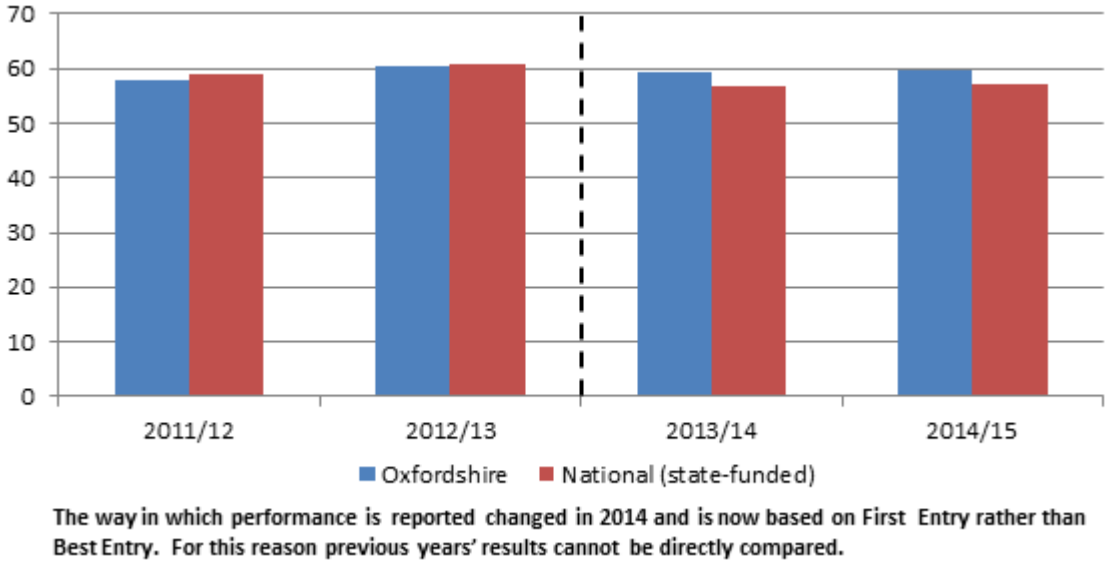
[120] Department for Education statistics on early years foundation stage profile assessments: https://www.gov.uk/government/collections/statistics-early-years-foundation-stage-profile; Public Health England Children and Young People's Health Benchmarking Tool: http://fingertips.phe.org.uk/profile/cyphof

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

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

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

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



Source: Department for Education

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

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

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

4.3.4. Qualifications

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

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

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

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

4.3.5. Education and Deprivation

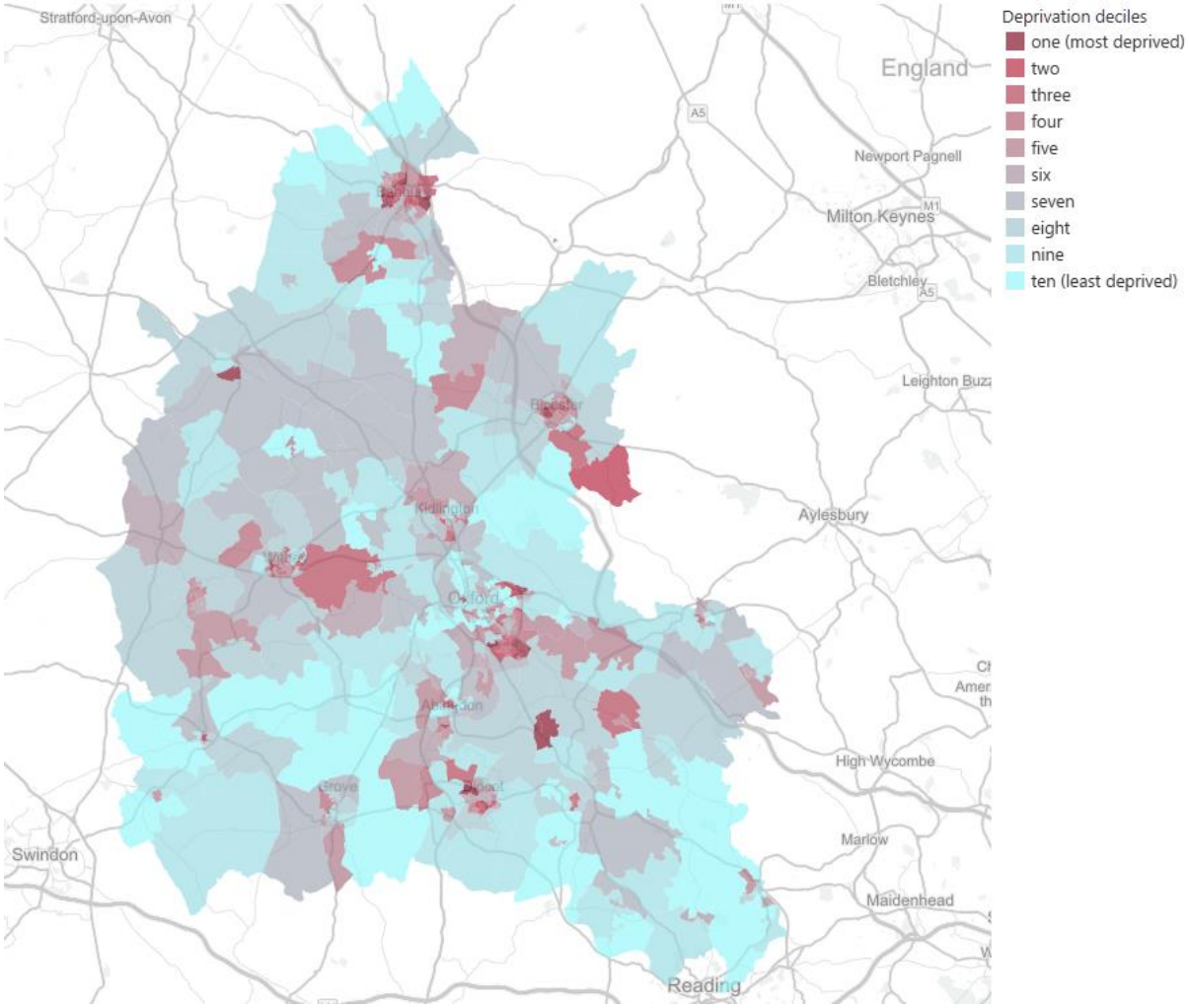
An index of deprivation relating to education, skills and training was published as part of the English Indices of Deprivation 2015.[123] This index covers two sub-domains relating to children's and young people's attainment, on one hand, and adult skills and qualifications on the other.

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

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

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

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



Source: DCLG English Indices of Deprivation 2015

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

4.3.6. Young People Not in Education, Employment or Training

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

4.4. Work and Earnings

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

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

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

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

4.4.1. Economic Activity

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

4.4.2. Employment

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

Employment rates remain similar across different parts of the county.

4.4.3. Unemployment

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

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

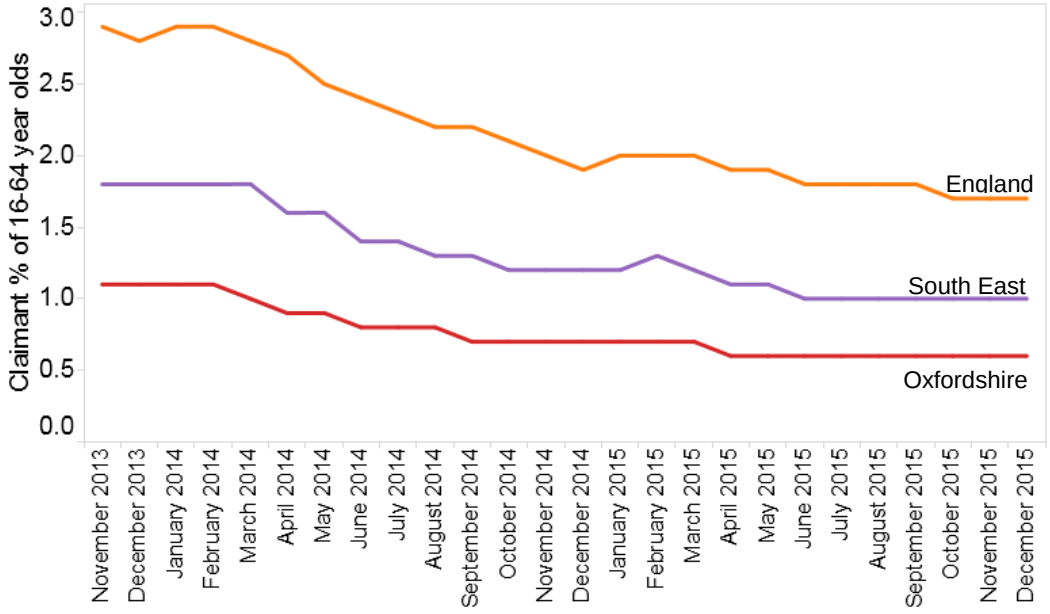
Experimental statistics show that in December 2015 there were 2,490 people aged 16 and over in Oxfordshire who were out of work and were either claiming Jobseeker's Allowance or were claiming Universal Credit.[130] (Ideally only those Universal Credit claimants who are out of work and required to seek work should be included in the claimant count, but it is not currently possible to produce estimates on this basis. The claimant count therefore currently includes some out of work claimants of Universal Credit who are not required to look for work; for example, due to illness or disability.)

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

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

[127] Official labour market statistics: https://www.nomisweb.co.uk.
[128] Those counted as being in employment include people who did some paid work in the survey reference week (whether as an employee or self-employed); those who had a job that they were temporarily away from (e.g. on holiday); those on government-supported training and employment programmes; and those doing unpaid family work. Of the 19.9% of 16-64 year olds who were not economically active, over a third were studying (35.1%) and over a quarter were looking after the family or home (27.4%). Smaller numbers were retired (15%) and long-term sick (14.2%).
[129] Those counted as being unemployed include people without a job who were available to start work in the two weeks following their interview and who had either looked for work in the four weeks prior to interview or were waiting to start a job they had already obtained.
[130] Official Claimant Count data, downloaded from Nomis: https://www.nomisweb.co.uk/

Figure 53: Claimant count, 2013-2015



Source: Nomis

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

4.4.4. Employment Deprivation

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

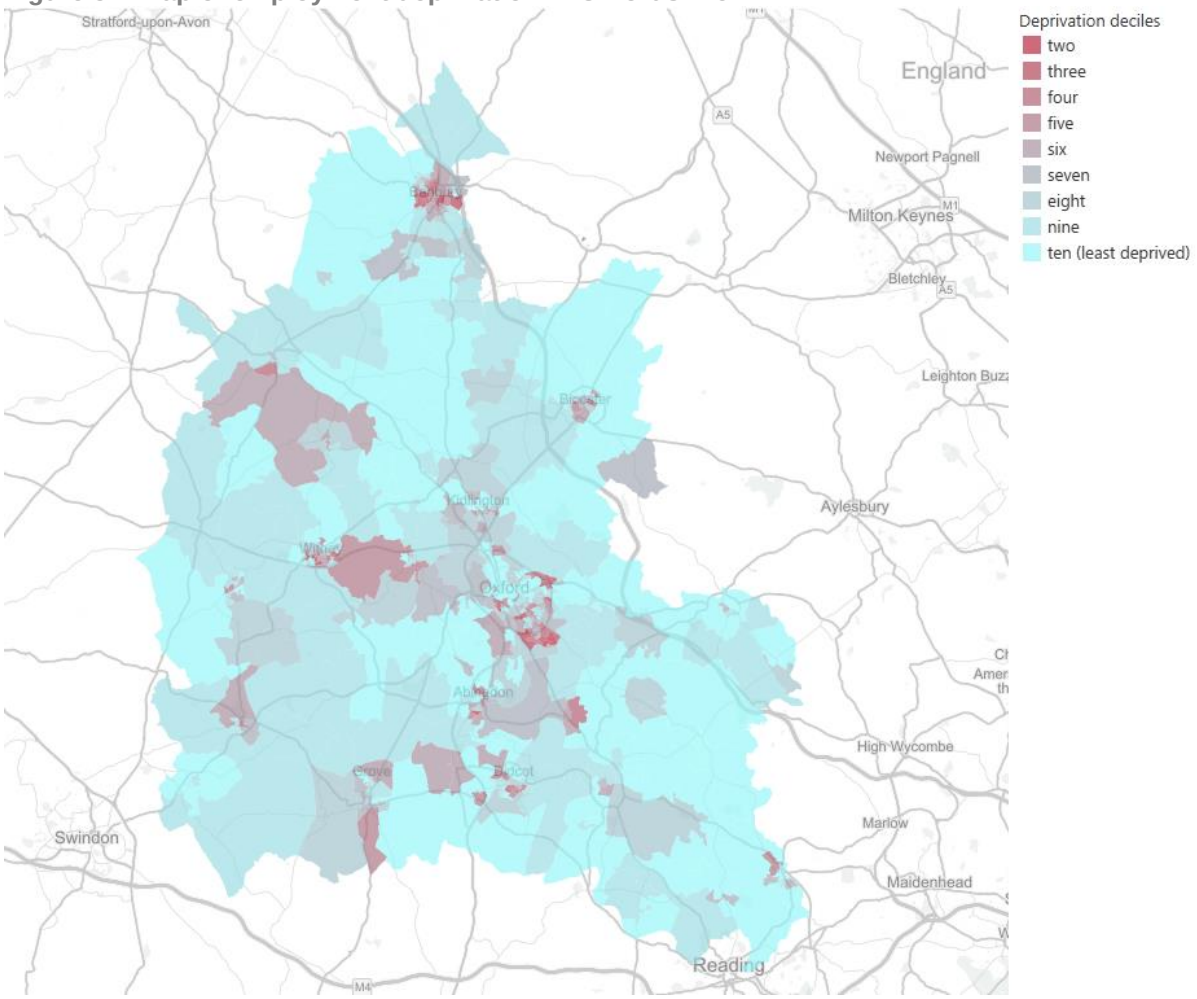
Oxfordshire has relatively low levels of employment deprivation: it is the 9th *least* deprived of 152 upper tier local authorities in England. Most of the 407 small areas in Oxfordshire are *less* deprived than the national average. 224 are in the 20% *least* deprived nationally.

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

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

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

Figure 54: Map of employment deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

4.4.5. Earnings

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

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

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

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

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

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

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

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

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

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

4.4.6. Workplace Health and Wellbeing

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

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

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

4.5. Crime

4.5.1. Crime Deprivation

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

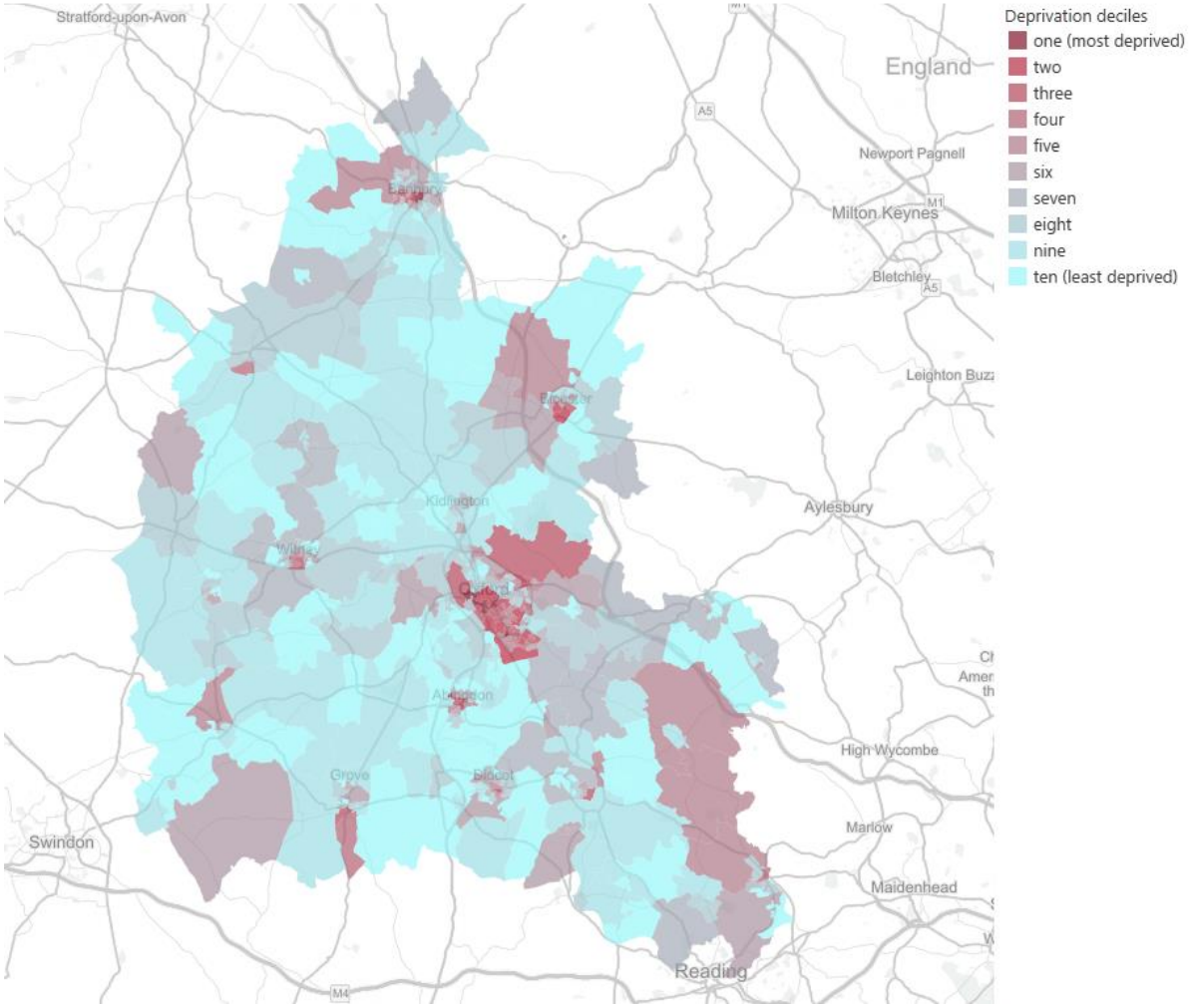
Oxfordshire has relatively low levels of crime deprivation: it is the 16th *least* deprived of 152 upper tier local authorities in England. Most of the 407 small areas in Oxfordshire are *less* deprived than the national average. 167 are in the 20% *least* deprived nationally.

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

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

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

Figure 55: Map of crime deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

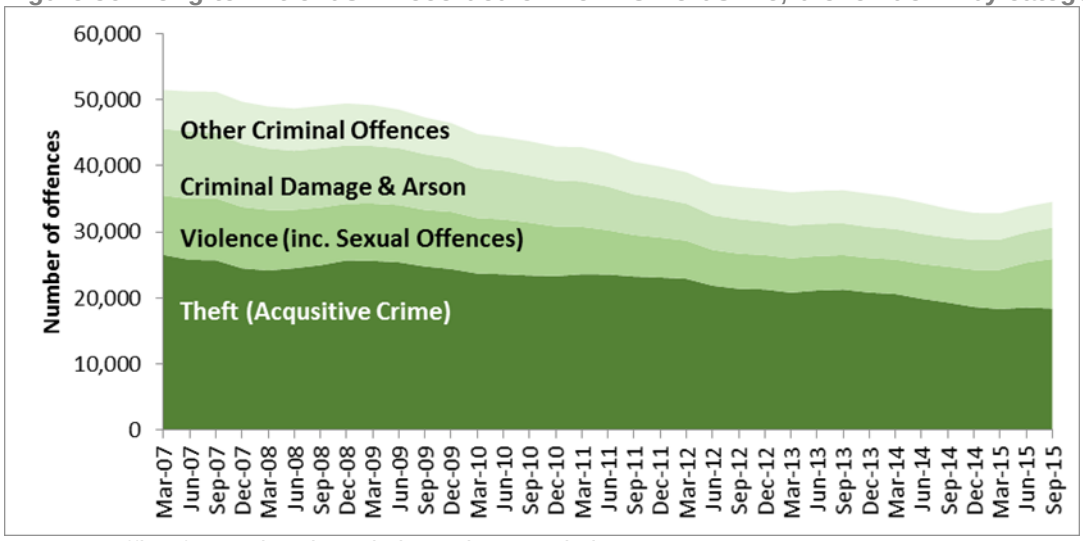
4.5.2. Crime Trends

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

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

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

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



Source: Office for National Statistics Crime Statistics

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

4.6. Abuse and Exploitation

4.6.1. Domestic Violence and Abuse

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

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

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

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

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

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

4.6.2. Female Genital Mutilation

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

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

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

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

4.6.3. Forced Marriage

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

4.6.4. Child Sexual Exploitation

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

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

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

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

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

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

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

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

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

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

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

4.6.5. Human Trafficking

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

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

4.7. Troubled Families

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

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

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

4.8. Environmental Quality

4.8.1. Outdoor Environment

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

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

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

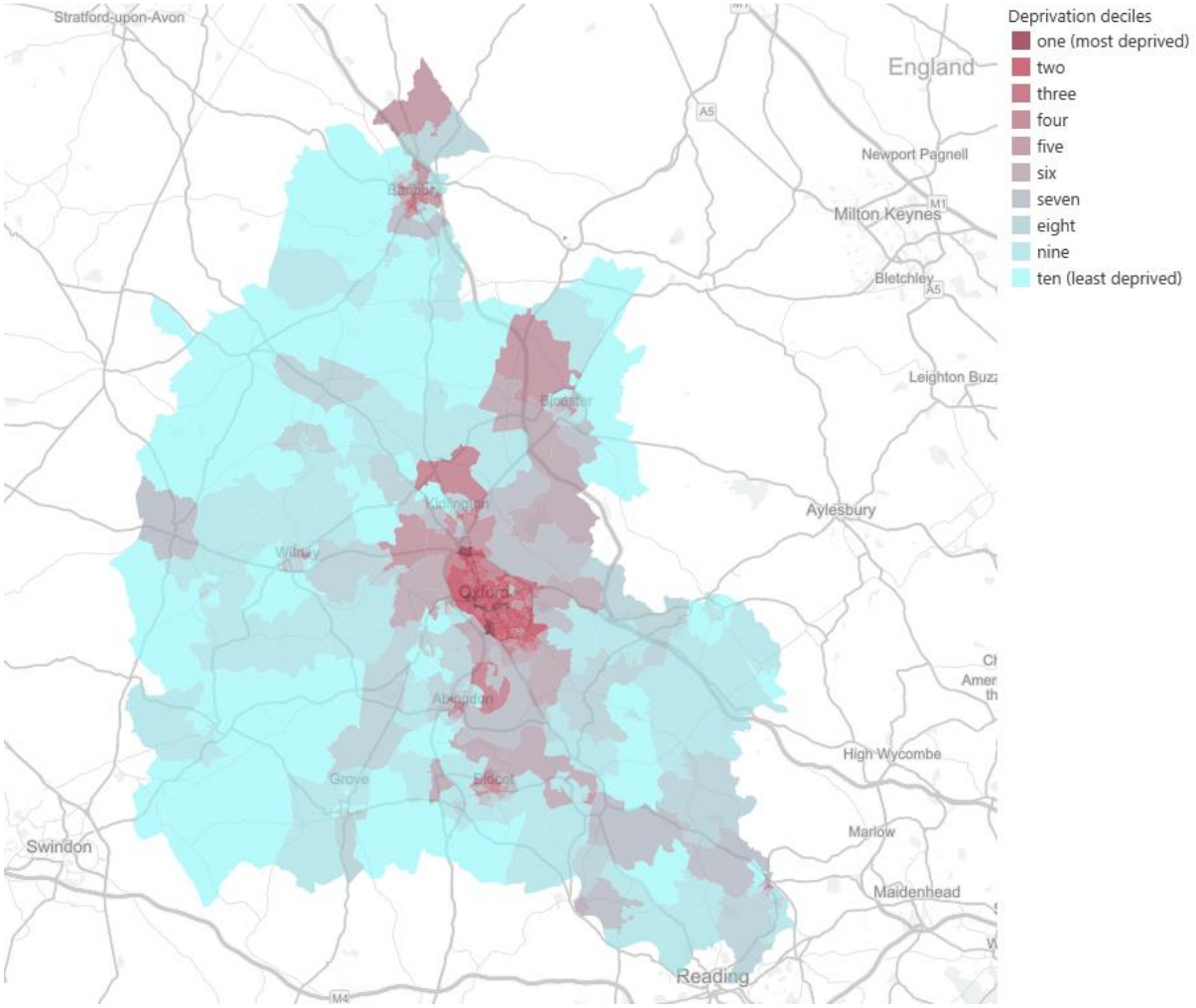
The map below shows the pattern of living environment deprivation in Oxfordshire.

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

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

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

Figure 57: Map of outdoor environment deprivation in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

4.8.2. Air Quality

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

Air Quality Monitoring and Management

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

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

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

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

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

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

Air Quality and Mortality Estimates

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

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

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

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

4.8.3. Use of Outdoor Space

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

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

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

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

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

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

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

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

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

4.8.4. Noise

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

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

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

4.9. Isolation, and Loneliness

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

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

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

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

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

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

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

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

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

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

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

4.9.1. Social Contact

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

4.9.2. Living Alone

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

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

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

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

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

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

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

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

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

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

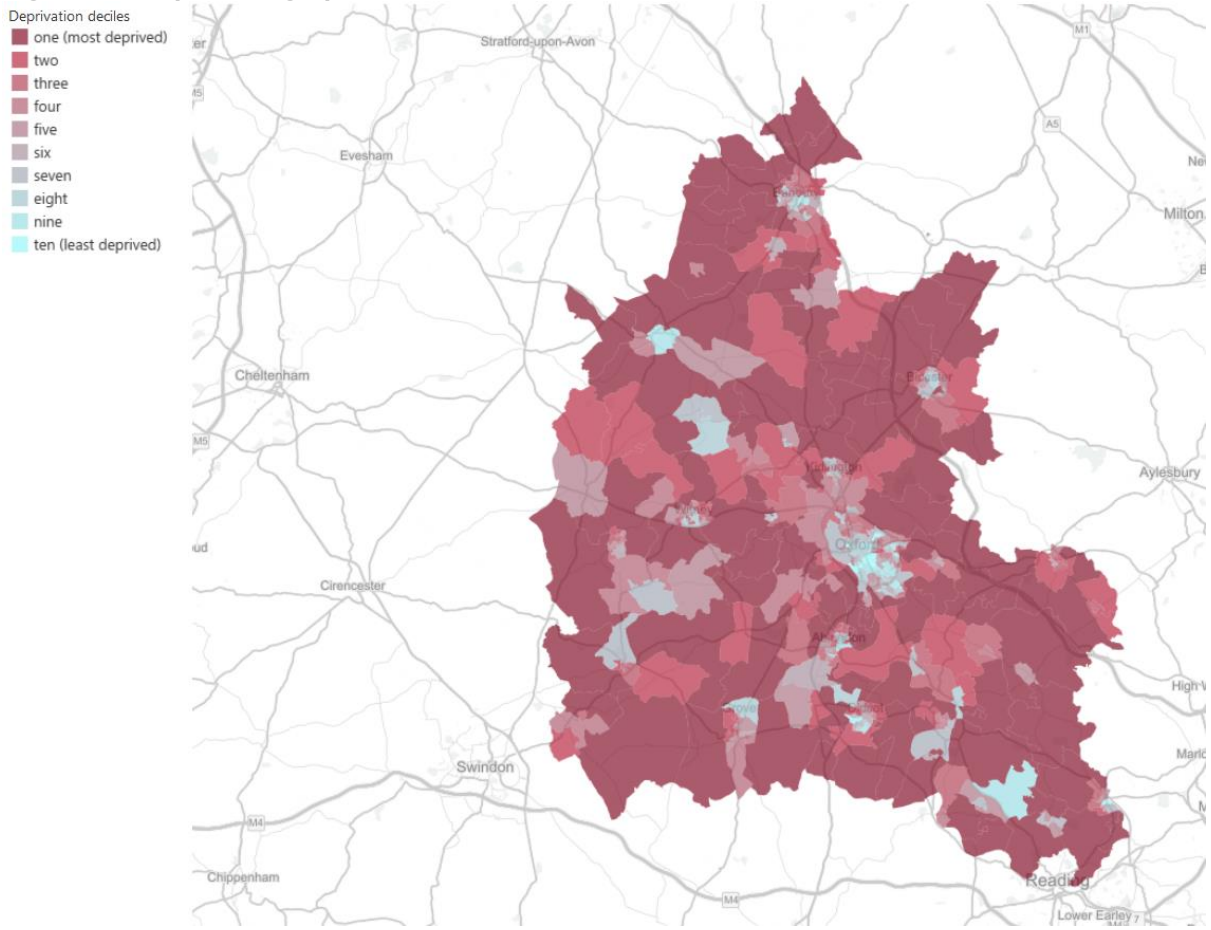
[168] Living alone in later life and its psychological impacts – the significance of the means of transition into living alone: http://ageing.oxfordjournals.org/content/42/3/366.full.pdf+html

4.9.3. Geographical Barriers

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

In terms of geographical barriers, the majority of Oxfordshire's 407 small areas (technically known as lower layer super output areas, or LSOAs) are *more* deprived than the national average. 85 are among the 10% *most* deprived nationally and are concentrated outside the main urban centres. A further 60 small areas are in the 10-20% *most* deprived nationally. The map below shows the pattern of geographical barriers in Oxfordshire.

Figure 58: Map of Geographical Barriers in Oxfordshire



Source: DCLG English Indices of Deprivation 2015

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

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

5. Morbidity and Mortality

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

5.1. Health Deprivation and Disability

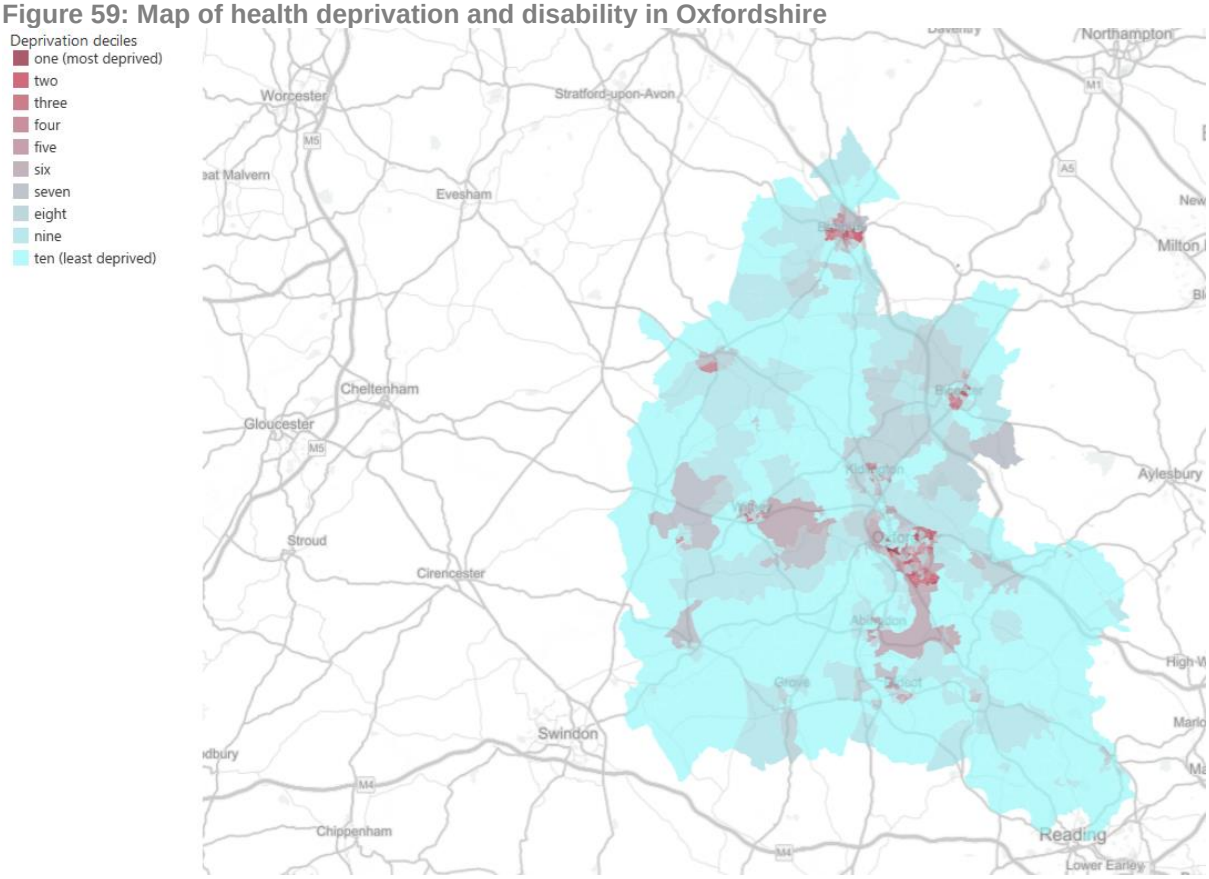
An index of health deprivation and disability was published as part of the English Indices of Deprivation 2015.[170] This combines indicators about premature death, illness, disability, and hospital use. Oxfordshire is the 16th *least* deprived upper tier local authority in terms of health and disability.

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

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

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

Figure 59: Map of health deprivation and disability in Oxfordshire



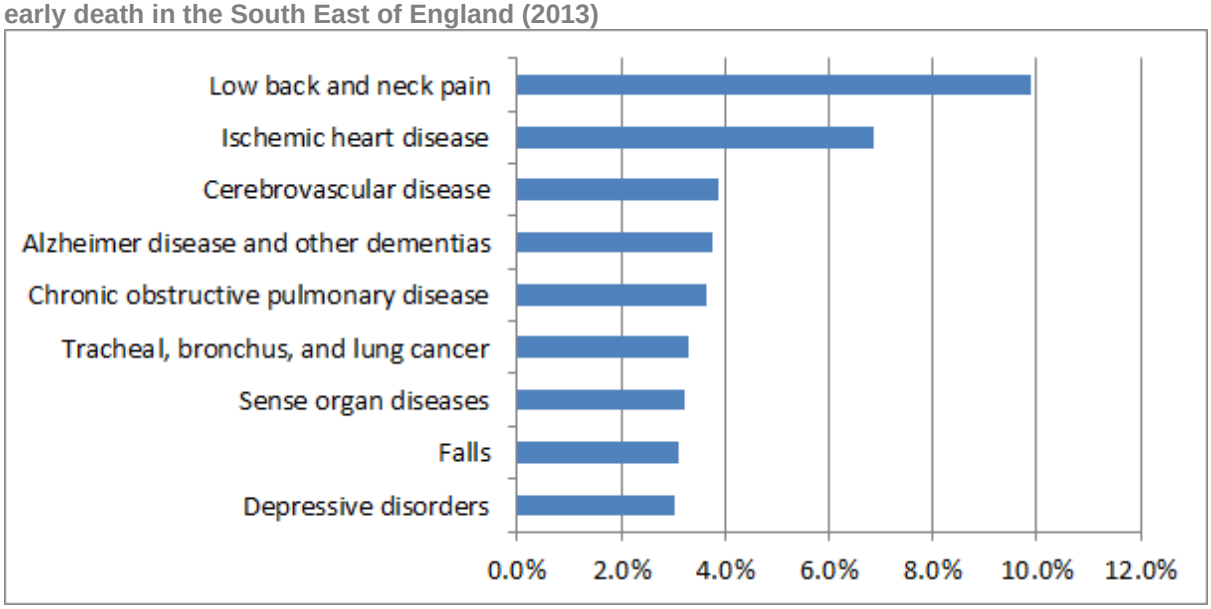
Source: DCLG English Indices of Deprivation 2015

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

5.2. Global Burden of Disease

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

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



Source: Institute for Health Metrics and Evaluation

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

5.3. Morbidity

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

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

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

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

The health and care needs of patients include:

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

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

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

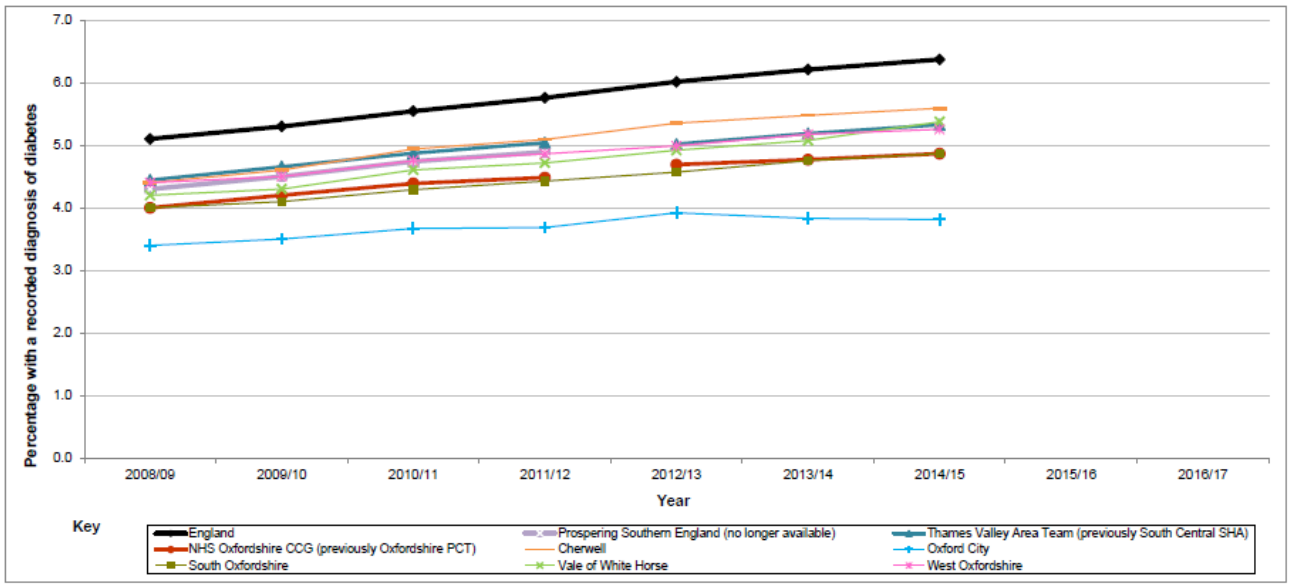
5.3.1. Diabetes

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

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

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

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



Source: Quality and Outcomes Framework

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

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

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

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

Raised blood glucose levels

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

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

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

5.3.2. Cancer

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

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

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

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

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

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

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

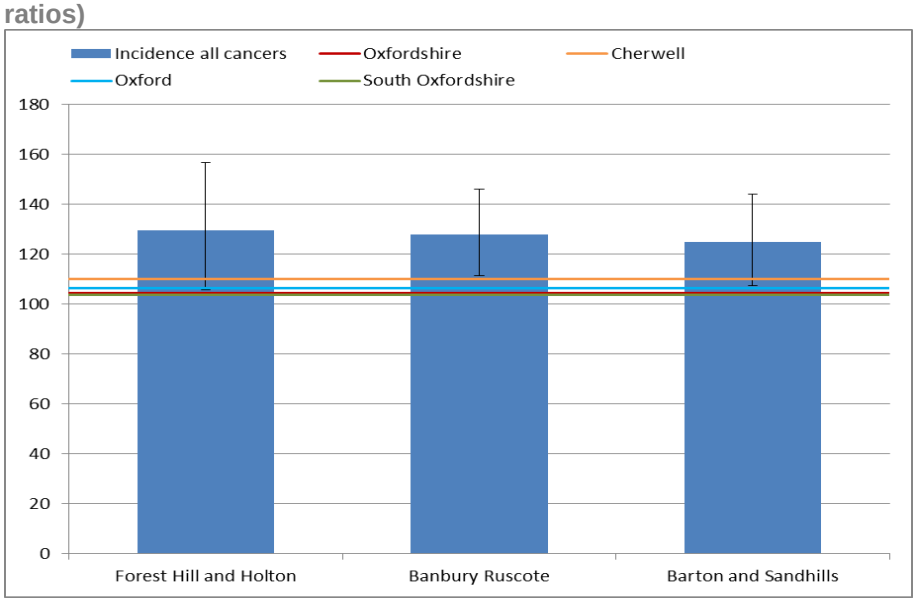
Figure 63: Oxfordshire GP practices with the highest rates of cancer diagnosis

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

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

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

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



Source: Public Health England

Breast Cancer

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

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

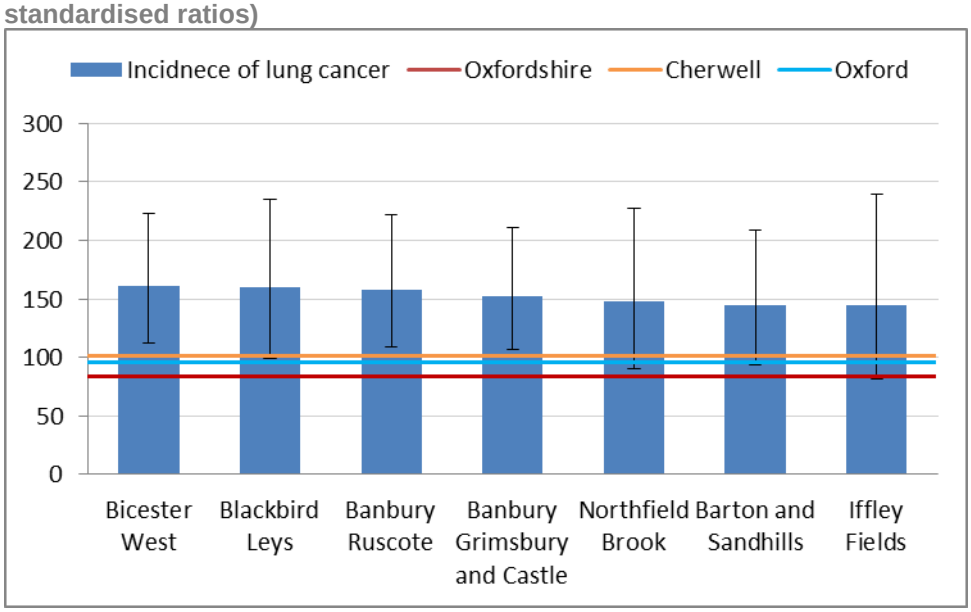
and to take hormone replacement therapy, all of which are associated with increased breast cancer incidence.[182]

Lung Cancer

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

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

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



Source: Public Health England

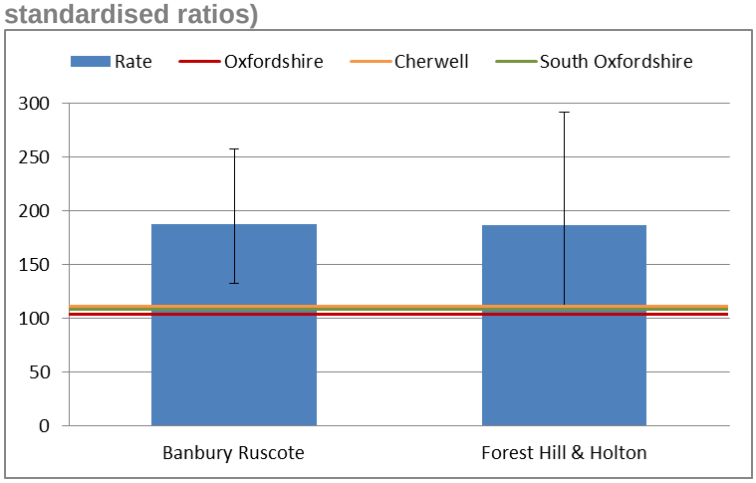
Bowel Cancer

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

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

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

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



Source: Public Health England

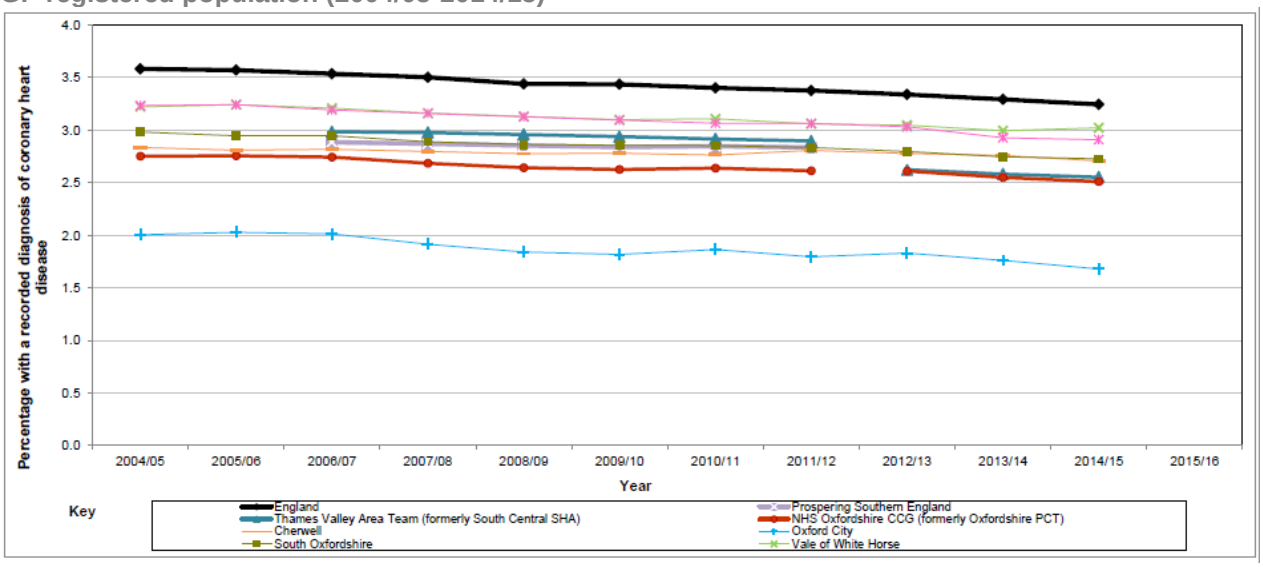
5.3.3. Circulatory Diseases

Coronary Heart Disease (CHD)

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

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

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



Source: Quality and Outcomes Framework

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

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

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

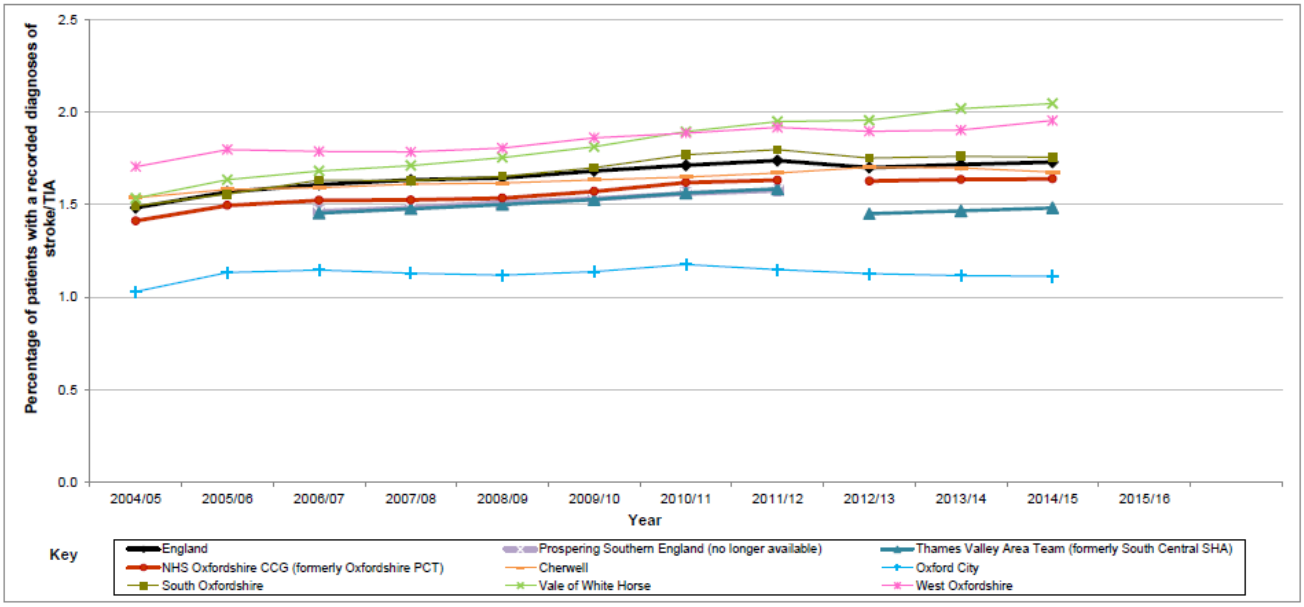
Practice Name	Ward*	District*	CHD prevalence
Bampton Surgery	Bampton and Clanfield	West Oxfordshire	3.9%
Sibford Surgery	Sibford	Cherwell	3.9%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	3.8%
Kennington Health Centre	Kennington and South Hinksey	Vale of White Horse	3.8%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

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

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

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

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



Source: Quality and Outcomes Framework

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

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

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

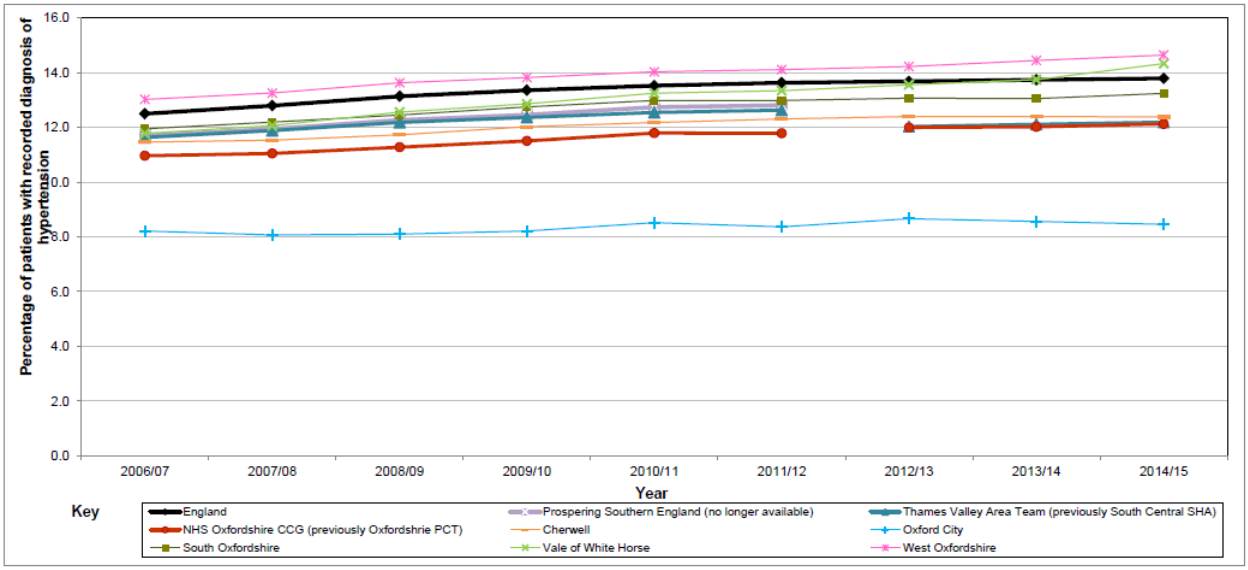
Practice Name	Ward*	District*	Stroke/ TIA prevalence
Berinsfield Health Centre	Berinsfield	South Oxfordshire	3.1%
The Malthouse Surgery	Abingdon Abbey and Barton	Vale of White Horse	2.7%
Exeter Surgery	Kidlington South	Cherwell	2.6%
Kennington Health Centre	Kennington and South Hinksey	Vale of White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

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

5.3.4. Hypertension (High Blood Pressure)

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

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



Source: Quality and Outcomes Framework

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

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

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

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

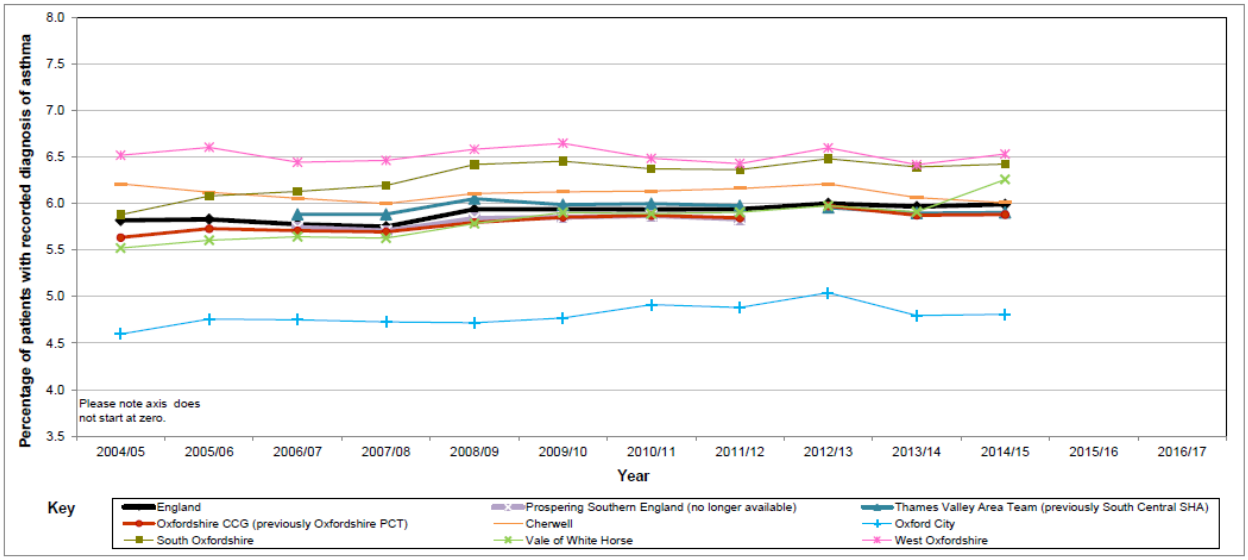
*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

5.3.5. Asthma

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

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

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



Source: Quality and Outcomes Framework

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

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

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

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

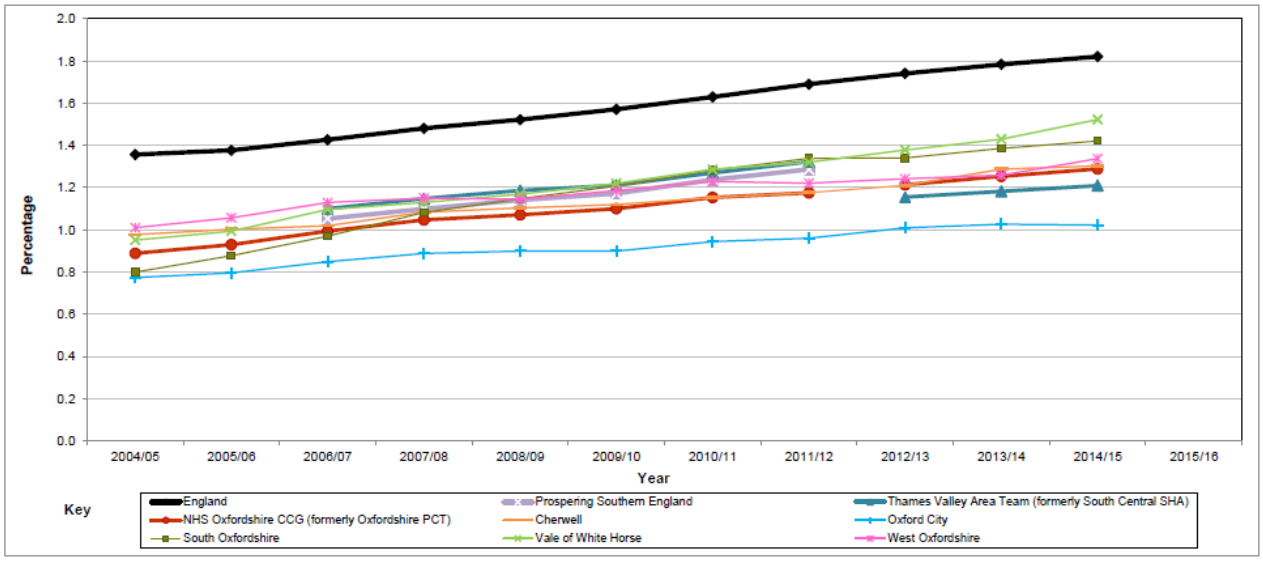
*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

5.3.6. Chronic Obstructive Pulmonary Disease (COPD)

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

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

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



Source: Quality and Outcomes Framework

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

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

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

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

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

5.3.7. Dementia

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

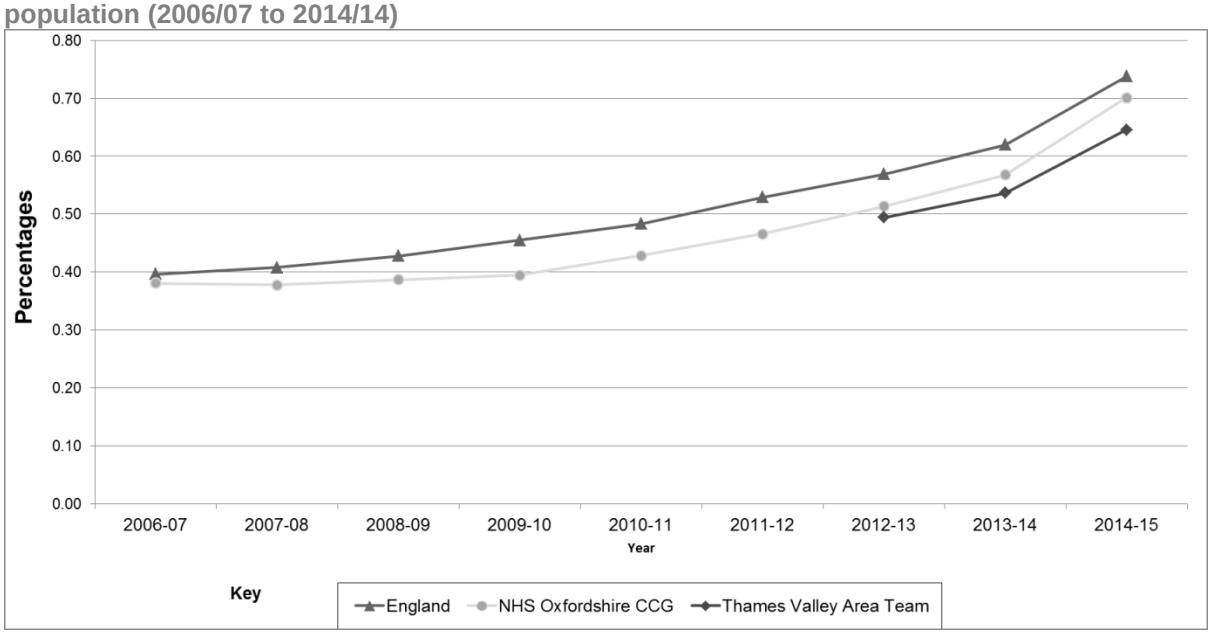
In 2015/16 the estimated number of people aged 65 and over in the Oxfordshire Clinical Commissioning Group area who have dementia is 7,641.[196] It is thought that nearly 3,000 of these are as yet undiagnosed.

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

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

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

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



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

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

Figure 78: Oxfordshire GP practices with the highest rates of Dementia

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

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

Source: Quality and Outcomes Framework

5.3.8. Epilepsy

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

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

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

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

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

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

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

5.3.9. Autistic Spectrum Disorder

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

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

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

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

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

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

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

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

5.3.10. Mental Health

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

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

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

Adult Wellbeing

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

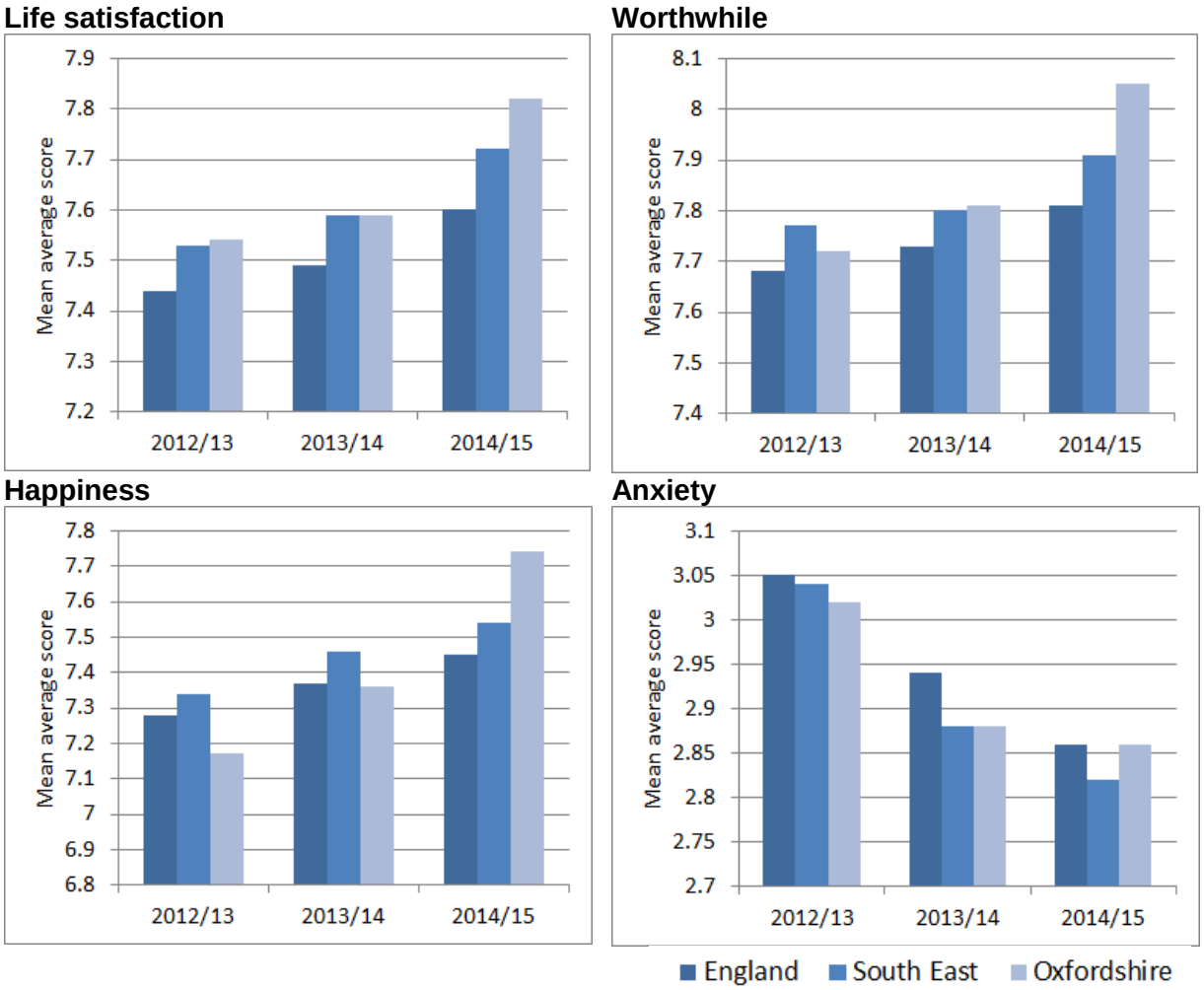
- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

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

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

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

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



Source: Office for National Statistics Personal Wellbeing Statistics

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

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

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

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

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

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

Child Wellbeing (National Data)

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

Mental Disorders

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

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

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

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

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

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

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

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

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

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

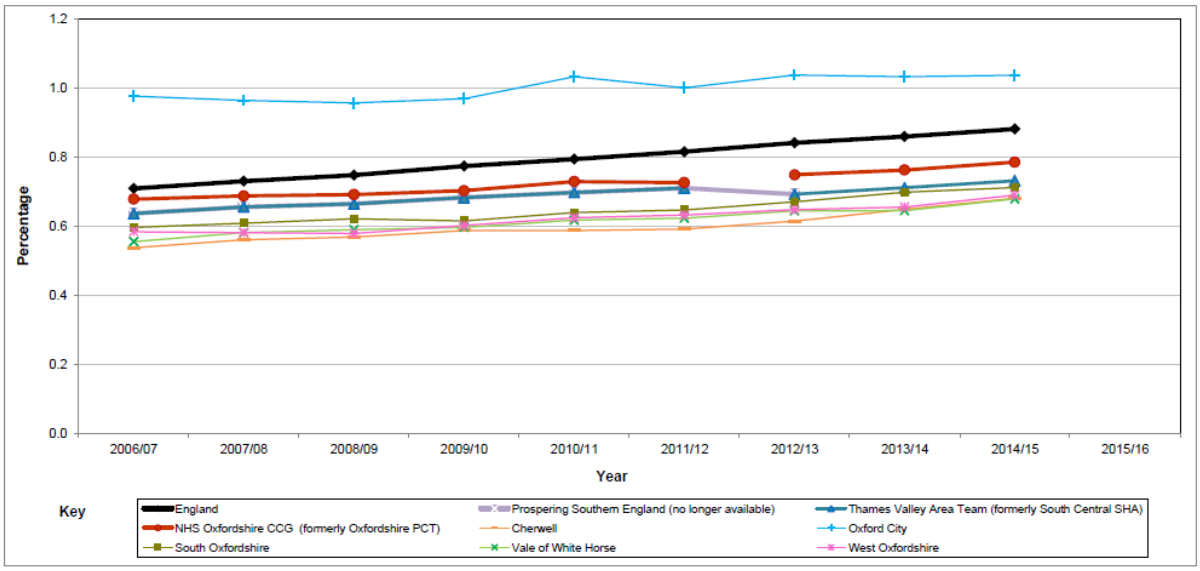
Practice Name	Ward*	District*	Rate of diagnosed depression
Oak Tree Health Centre	Didcot Ladygrove	South Oxfordshire	17.3%
Broadshires Health Centre	Carterton North East	West Oxfordshire	16.3%
Langford Medical Practice	Bicester South	Cherwell	13.7%
Didcot Health Centre Practice	Didcot All Saints	South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

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

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

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

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



Source: Quality and Outcomes Framework

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

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

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

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

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

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

Figure 84: Rates of mental disorder in England

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

Source: Adult psychiatric morbidity in England, 2007
* Differences calculated for 16-74 year olds
** Alcohol and drug misuse is discussed further in chapter 6: Lifestyles.

Just under a quarter of adults in England screened positive for at least one of the conditions included in the study. Of those with at least one condition 68.7% met the criteria for *only* one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions. Numbers of identified conditions were not significantly different for men and women.

[215] *Adult psychiatric morbidity in England, 2007:* http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

Detentions under Section 136

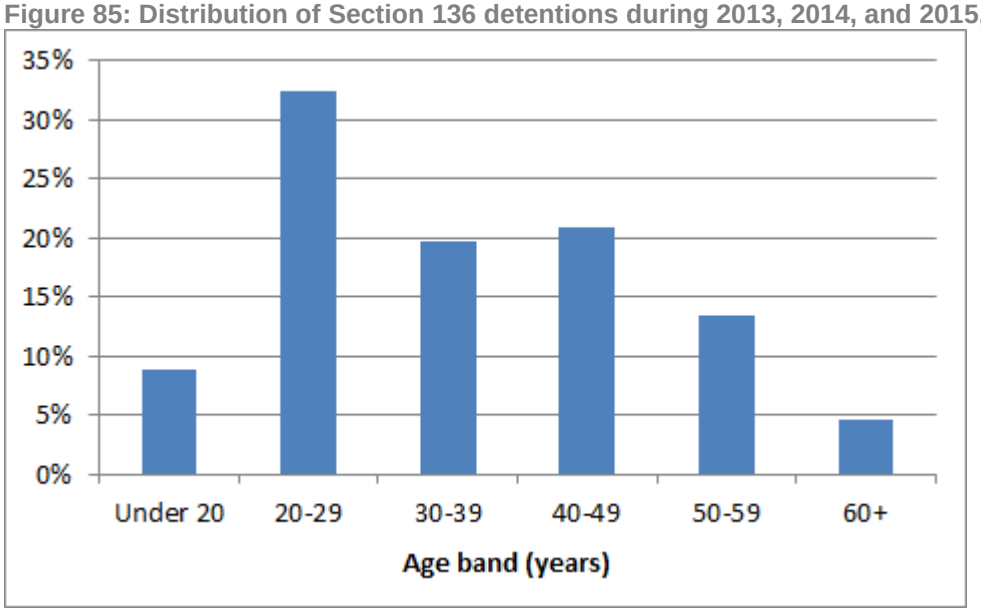
Section 136 of the Mental Health Act enables the police to act if they believe that someone is suffering from a mental illness and is in need of immediate treatment or care. The police may take that person from a public place to a place of safety, either for their own protection or for the protection of others. This is known as a Section 136 detention.

During the three calendar years 2013-2015, there were 891 Section 136 detentions in Oxfordshire.[216] Around 40% of these (358) were during 2013, with around 30% in each of 2014 and 2015 (266 and 267 detentions, respectively).

Over the full three-year period, around 45% of the detentions were made in Oxford, whilst around 35% were in Cherwell and West Oxfordshire, and around 21% were in South Oxfordshire and Vale of White Horse.

A majority of the detainees were male (around 59%). The chart below shows the age distribution, with those aged 20-29 making up the largest group of people detained.

Figure 85: Distribution of Section 136 detentions during 2013, 2014, and 2015, by age band



Source: Thames Valley Police

Mental Health in Children

It has been estimated that 50% of adult mental illness starts before the age of 15 and more than 75% by the age of 18.[217] However, there is limited information available on the prevalence of mental ill health in children.

There are relatively few data about prevalence rates for mental health disorders in pre-school age children.[218] A 2006 literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6%.[219]

[216] Data provided by Thames Valley Police, January 2016.
[217] Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Arch Gen Psychiatry*. 2003 Jul;60(7):709-17
[218] CAMHS Needs Assessment: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34
[219] Egger, H. L. and Angold, A. (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. Journal of Child Psychology and Psychiatry, 47 (3-4), 313–37.

General prevalence estimates for mental health disorders in children aged five to 16 years have been estimated in a report by Green et al (2004).[220] Prevalence was found to vary by age and sex, with boys more likely to have experienced or be experiencing a mental health problem than girls (11.4% compared with 7.8%). Children aged 11 to 16 years were also found to be more likely than 5 to 10 year olds to experience mental health problems (11.5% compared with 7.7%).

The more recent 'What About YOUth' survey showed that mental wellbeing among children aged 15 in England was better among those who were:[221]

- living in less deprived areas
- had a more positive perception of their body-image
- had high life satisfaction
- were in better health
- consumed more fruit and vegetables
- exercised more

The same study found that a majority of children aged 15 in England reported having high or very high life satisfaction. On average, boys reported higher life satisfaction than girls. Young people from Black and Minority Ethnic (BME) backgrounds reported lower levels of life satisfaction than those from a White background. Poorer life satisfaction was also seen among young people who were living in more deprived areas, who were in worse health, or who had experienced bullying.

Separate national-level research indicates higher incidence of mental health problems among children and young people with learning disabilities, looked after children, and children who are homeless or sleeping rough.[222]

Children and young people with poor mental health are more likely to have poor educational attainment and employment prospects, social relationship difficulties, physical ill health and substance misuse problems, and to become involved in offending.[223]

Self-Harm (Hospitalisation)

Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves, irrespective of the purpose of the act. There is a significant and persistent risk of future suicide following an episode of self-harm.[224]

During 2013/14 the number of emergency hospital admissions for intentional self-harm in Oxfordshire was 1,421.[225] The rate of hospital admissions for intentional self-harm is rising in Oxfordshire, similarly to the regional and national picture.

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[220] Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004. Office for National Statistics. London, HMSO. Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life.

[221] Health and Wellbeing of 15 year olds in England: Findings from the What About YOUth? Survey 2014 (HSCIC/ Ipsos MORI, December 2015): http://www.hscic.gov.uk/catalogue/PUB19244/what-about-youth-eng-2014-rep.PDF

[222] CAHMS Needs Assessment: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34

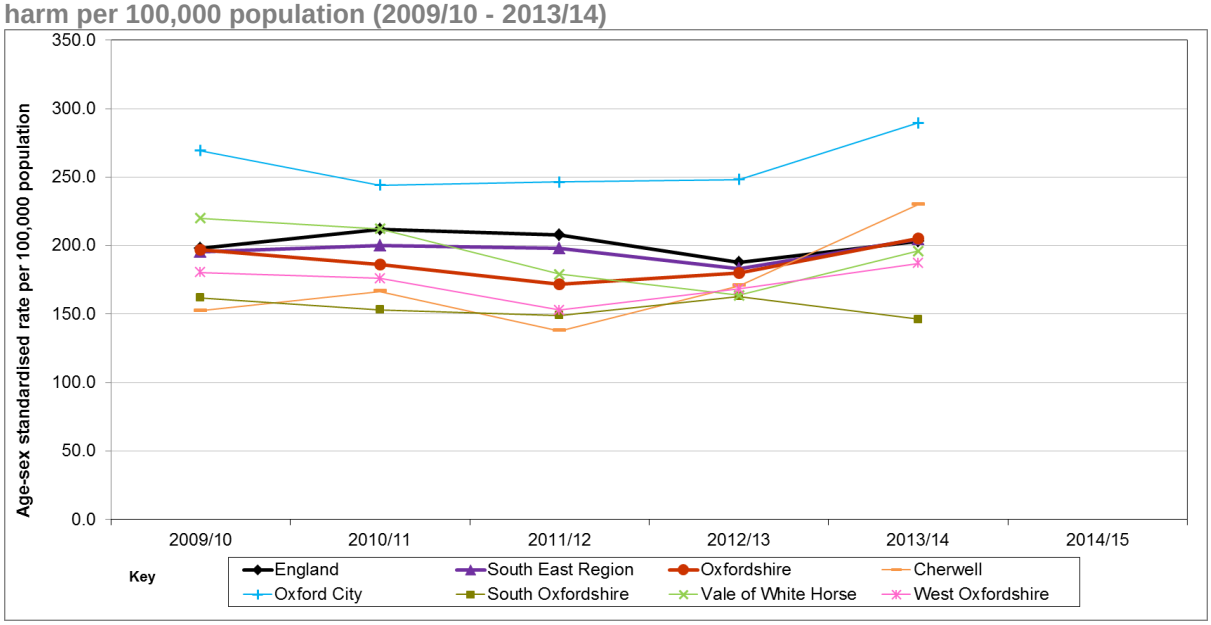
[223] Annual Report of the Chief Medical Officer 2013: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

[224] Public Health England Local Health tool: http://www.localhealth.org.uk/#v=map4;l=en

[225] Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

The data in the chart below will not include patients who attended Accident and Emergency (A&E) or Minor Injury Unit (MIU) who were not admitted to hospital; it is likely to be an underestimate of the true rate of self-harm in our population.

Figure 86: Age/ sex-standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population (2009/10 - 2013/14)



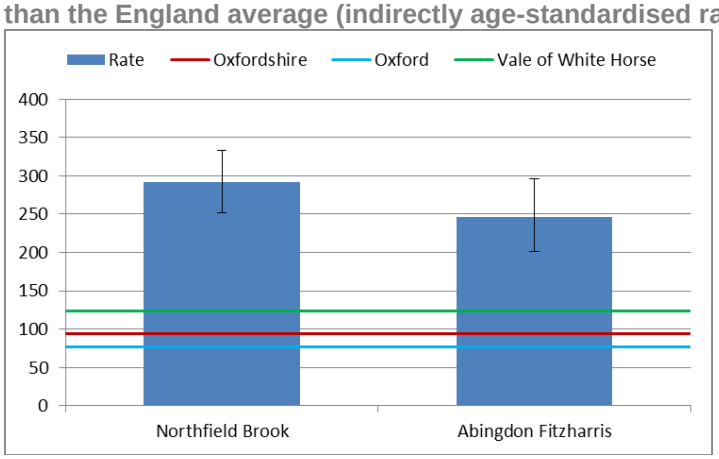
Source: Local Authority Health Profiles

Within the county, the rate of emergency hospital admissions for intentional self-harm is higher in Oxford than in other districts. Elsewhere in the county, South Oxfordshire shows a decline in rates of emergency admissions for self-harm.

Pooled data for the years 2008/09 to 2012/13 show that two wards in Oxfordshire had higher rates of hospital stays for self-harm than the district, county, and national averages.[226] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

[226] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at smaller geographies will be relatively low and confidence intervals will therefore be wide.

Figure 87: Oxfordshire wards with rates of hospital stays for self-harm significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

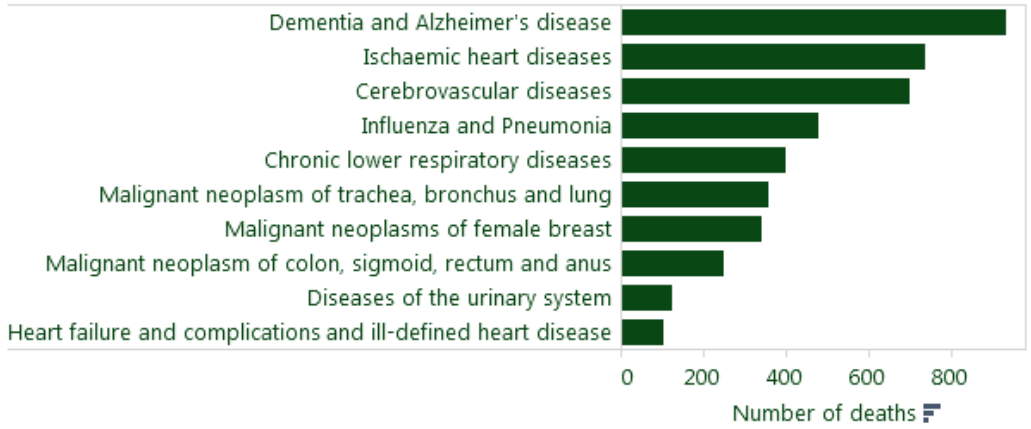
5.4. Mortality

This section covers some of the main causes of death in Oxfordshire.

5.4.1. Overview

Oxfordshire is similar to the national picture in terms of leading causes of death in males and females.[227] Analysis of male and female mortality data for the three-year period 2011-13 is presented in the charts below.[228] Where possible, mortality data in the rest of this section is for the period 2012-14. However, in some cases data for this time period is not yet available.

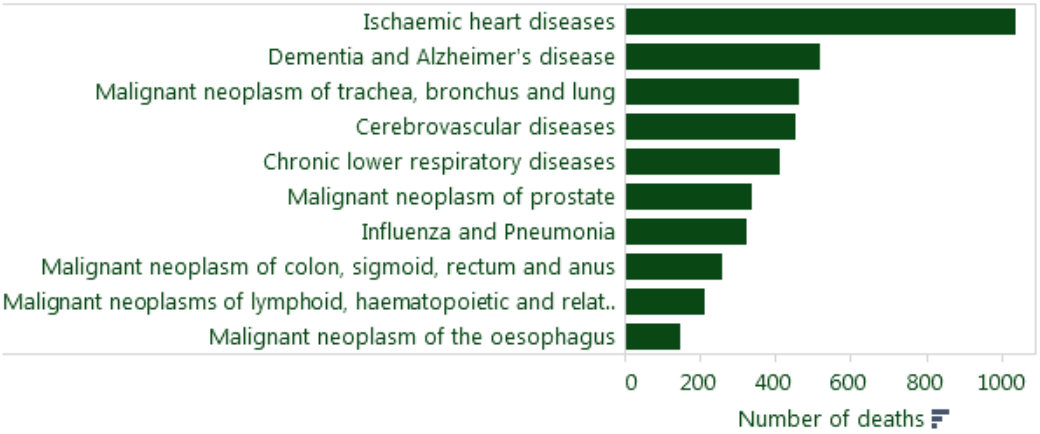
Figure 88: Leading causes of female mortality in Oxfordshire (2011-2013)



Source: Office for National Statistics/ Public Health England

[227] ONS mortality data: http://ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates
[228] Analysis provided by Public Health England

Figure 89: Leading causes of male mortality in Oxfordshire (2011-2013)



Source: Office for National Statistics/ Public Health England

Methodological Note

Mortality outputs are based on rates that are directly age-standardised using the European Standard Population (ESP). The ESP in use was introduced in 1976 and is an accepted methodological standard in health statistics in the UK and the rest of Europe.

At the end of 2012 Eurostat decided to bring this population structure up to date. For both sexes, mortality rates for all causes of death registered in 2012 were significantly higher when calculated using the 2013 ESP compared with the 1976 ESP. This is to be expected as deaths predominantly occur at older ages and the larger number of older people in the 2013 ESP wields more influence on these summary figures. This affects three year pooled data for 2010-12 onwards.[229]

This methodological revision will also affect some other age-standardised rates, such as cancer incidence rates.

The Office for National Statistics has produced an interactive map of age-standardised mortality rates in English and Welsh local authorities.

5.4.2. Cancer

Early mortality from cancer is a direct measure of health care need, as public health interventions for prevention, early diagnosis and effective treatment can all reduce the burden of cancer morbidity and mortality.

In 2012-14 there were less than 2,000 deaths in Oxfordshire from all types of cancer in people under the age of 75 years.[230] For male residents the cancer mortality rate was 133 deaths per 100,000 under the age of 75 years. This rate remains significantly lower than the England average (157.7). In female residents the mortality rate was 115.8, also significantly lower than the England average (126.6).

More than one in five of all cancer deaths in the UK are from lung cancer. Lung, bowel, breast and prostate cancers together accounted for almost half (46%) of all cancer deaths in

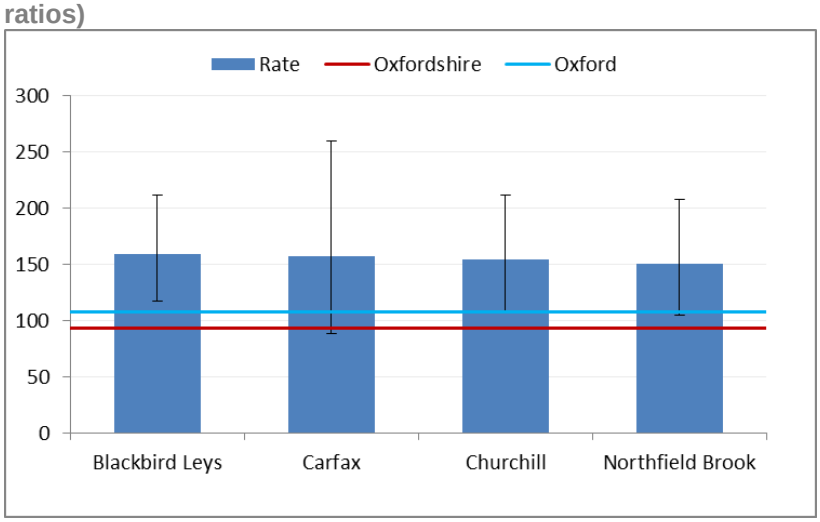
[229] For more information, see: http://www.ons.gov.uk/ons/rel/subnational-health2/european-standard-population/effect-on-uk-official-statistics/sty-revision-of-esp.html

[230] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/

the UK in 2012[231]. The proportion was slightly lower in Oxfordshire at 43% but these remain the major causes of cancer mortality in the county.[232]

Pooled data for the period from 2008 to 2012 show that the four Oxfordshire wards with the highest death rates from cancer were all in Oxford City, and two of these were significantly above the district and county averages.[233] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 90: Oxfordshire wards with the highest cancer mortality (indirectly age-standardised ratios)



Source: Public Health England

5.4.3. Circulatory Diseases

Pooled data for 2012-14 shows that the mortality rate from cardiovascular disease among male residents of Oxfordshire aged under 75 was 80.6 deaths per 100,000 population.[234] This rate was significantly lower than in England (106.2) and the South East region (90.7). The equivalent female mortality rate was 33.4 per 100,000 population (less than half that for men) and was also significantly lower than the rates for England (46.9) and the South East region (38.9).

5.4.4. Respiratory Diseases

Two of the main respiratory diseases are chronic obstructive pulmonary disease (COPD) and asthma.

The most common cause of COPD is smoking. Over the 2012-14 three-year period, the rate of mortality from COPD in male residents of Oxfordshire aged under 75 was 12.6 deaths per 100,000 population.[235] In female residents it was 11.4. Both rates were significantly lower than in England overall, which had a male mortality rate of 19.9 and a female mortality rate of 15.6. However, Oxford City had a significantly higher male mortality rate from COPD. As

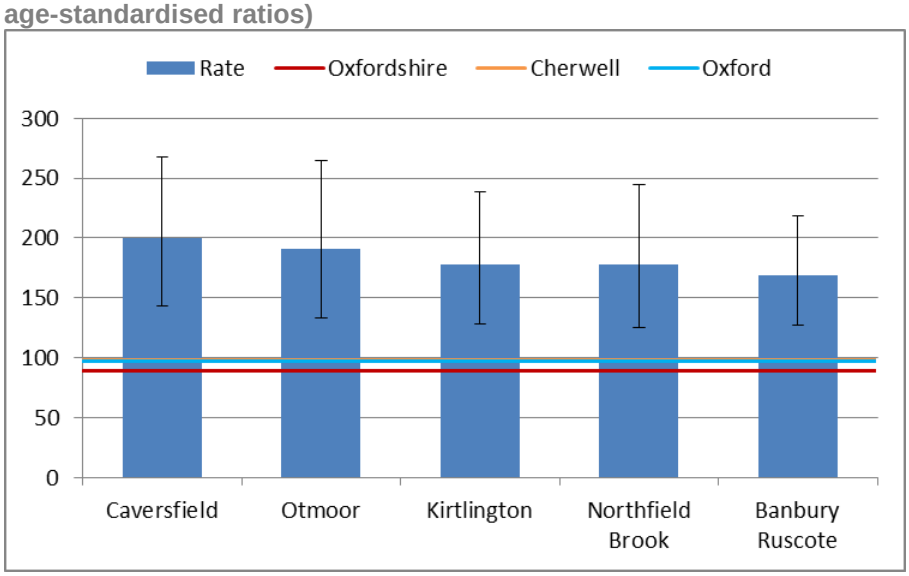
[231] Cancer mortality statistics: http://www.cancerresearchuk.org/content/cancer-mortality-statistics#heading-One
[232] Health and Social Care Information Centre: https://indicators.ic.nhs.uk/webview/
[233] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at smaller geographies will be relatively low and confidence intervals will therefore be wide.
[234] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/
[235] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/

there is a correlation between smoking prevalence and deprivation this may account for the higher rates in Oxford City.

Generally speaking Oxfordshire's mortality rates from asthma (for all ages and both genders) have decreased, and although there has been some variation over the last few years, the number of deaths from asthma remains fairly static.[236]

Pooled data for the period from 2008 to 2012 show that five Oxfordshire wards had higher death rates from respiratory diseases, compared with the county average.[237] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 91: Oxfordshire wards with the highest mortality from respiratory diseases (indirectly age-standardised ratios)



Source: Public Health England

5.4.5. Deaths Caused by Smoking

Smoking is the biggest single preventable cause of disease and premature death in the UK.[238] One in two regular smokers is killed by tobacco - half dying before the age of 70, losing an average of 21 years of life. Preventing people from starting smoking is key to reducing the health harms and inequalities associated with tobacco use.

The latest available figures (for the 2011-13 period) indicate that Oxfordshire had a significantly lower mortality rate than the national average, with a directly standardised rate of 230.7 per 100,000, compared to 288.7 for England. However the rate in Oxford was higher than the rest of Oxfordshire.

[236] Health and Social Care Information Centre Compendium of Population Health Indicators: https://indicators.ic.nhs.uk/webview/

[237] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

[238] Action on Smoking and Health smoking statistics (November 2014): http://ash.org.uk/files/documents/ASH_107.pdf

5.4.6. Deaths Caused by Alcohol

The harmful use of alcohol results in 3.3 million deaths globally each year.[239] In England there were 18,100 deaths in the three-year period 2011-13 (12,325 males, 5,775 females) which were due to alcohol-specific conditions.[240] In Oxfordshire, alcohol-specific mortality accounted for 142 deaths in the same three-year period (85 male, 57 female).

For both men and women in Oxfordshire, alcohol-specific mortality has remained fairly steady. The mortality rate for males in 2011-13 was significantly lower than England. For females, although lower than England, it was not significantly so. Most Oxfordshire districts have low numbers of deaths among men caused directly by alcohol consumption and are significantly lower than for England.[241]

In 2012-14 Oxfordshire's overall mortality rate from liver disease in people under 75 years was significantly lower than England (7.4 and 10.8 per 100,000 population, respectively)[242]. Data split by gender shows that liver disease mortality in males is significantly better than England (17.4 and 23.4 per 100,000 male population, respectively) but in females it is similar to England (12.9 and 12.4 per 100,000 female population respectively).

5.4.7. Excess Winter Deaths

The number of excess winter deaths depends on the temperature and the level of disease in the population as well as other factors, such as how well equipped people are to cope with the drop in temperature.[243] Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population.

Three-year rolling data for the period August 2010-July 2013 shows that there were an estimated 1,034 excess winter deaths in Oxfordshire (around half of which were among those aged 85 and over). This represented a ratio of extra deaths to expected deaths (based on the average of the number of non-winter deaths) of 21.2.[244] This was similar to surrounding areas in the South East region and the national average.

A majority of the excess winter deaths between 2010 and 2013 were among women. In Oxfordshire, the ratio of extra female deaths to expected female deaths was worse than the national average (at 25.3 compared with 19.3). This appears to be driven by above average rates in Oxford and South Oxfordshire.

For more analysis of excess winter deaths in Oxfordshire, see the District Data Service chart of the month from August 2015.

[239] World Health Organisation (WHO) Facts and Figures: http://www.who.int/substance_abuse/facts/en/
[240] Conditions included are only those wholly attributable (100%) to alcohol (2014 version): http://www.cph.org.uk/publication/updating-england-specific-alcohol-attributable-fractions/
[241] Public Health England Local Alcohol Profiles for England: http://fingertips.phe.org.uk/profile/local-alcohol-profiles
[242] Health & Social Care, Compendium of Health Indicators: https://indicators.ic.nhs.uk/webview/
[243] Public Health Outcomes Framework, indicators 4.15i-iv : http://www.phoutcomes.info/
[244] Public Health Outcomes Framework, indicators 4.15i – 4.15iv: http://www.phoutcomes.info/: The Excess Winter Deaths (EWD) Index expresses the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths based on the average of the number of non-winter deaths.

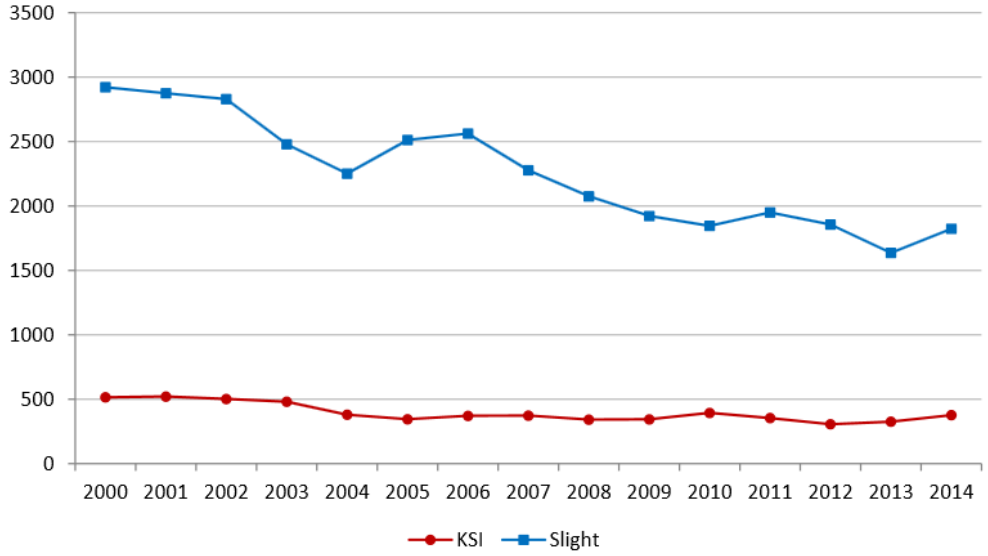
5.4.8. Road Casualties

378 people were reported to the police as killed and seriously injured (KSI) on Oxfordshire's roads in 2014.[245] Of these, 26 were killed (including three children) and 352 were seriously injured (including 19 children). A further 1,824 slight injuries were reported to the police.

Car drivers made up the largest group of road casualties in 2014 (accounting for two fifths of the total) followed by cyclists (who made up 16.4%) and car passengers (who made up 15.5%). Motorcyclists and pedestrians each made up just under 10% of the total casualties.

The charts below show key trends since the turn of the century. Most of the main road user groups have seen a fall in the number of casualties over this period. However, injuries among pedal cyclists have shown a rising trend (as has also been reported nationally) which appears to be due at least in part to increased levels of cycling.

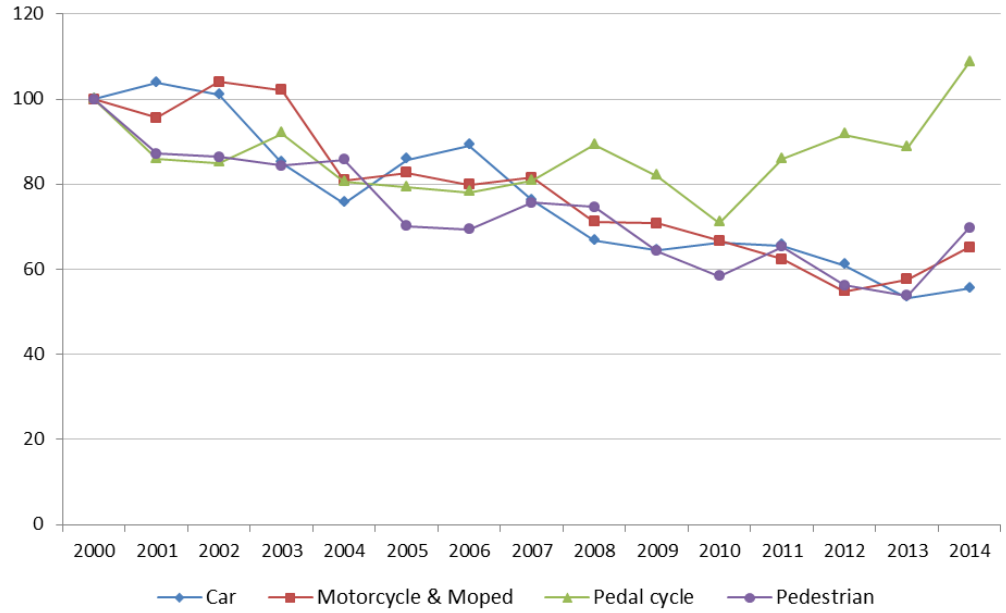
Figure 92: Number of police-reported road casualties in Oxfordshire (2000-2014)



Source: Oxfordshire County Council

[245] Oxfordshire County Council's road casualties statistics: https://www.oxfordshire.gov.uk/cms/content/road-casualties

Figure 93: Indexed comparison of police-reported road casualties in Oxfordshire (2000-2014) by specific road user-group (where casualty numbers in 2000 = 100)

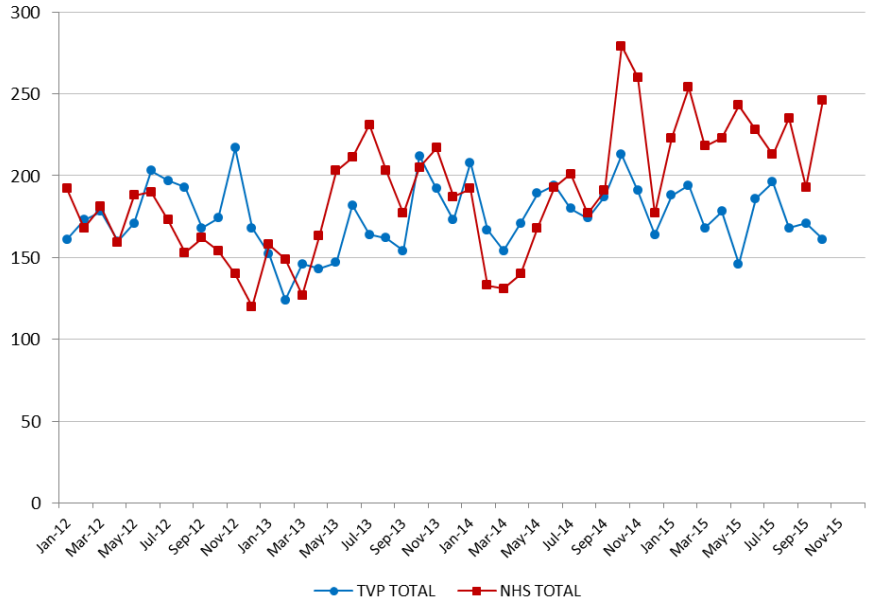


Source: Oxfordshire County Council

Men are slightly more likely than women to be killed or injured on the roads; they made up 57.7% of total casualties in 2014.

Police-reported casualty statistics are likely to underestimate the true number, as a substantial number of accidents – particularly those involving minor injuries – are not reported to the police. Some of these may, however, be reported to the health service, when casualties attend hospital Accident and Emergency (A&E) departments. The chart below compares the number of road casualties reported to police and recorded in Oxfordshire's A&E departments.

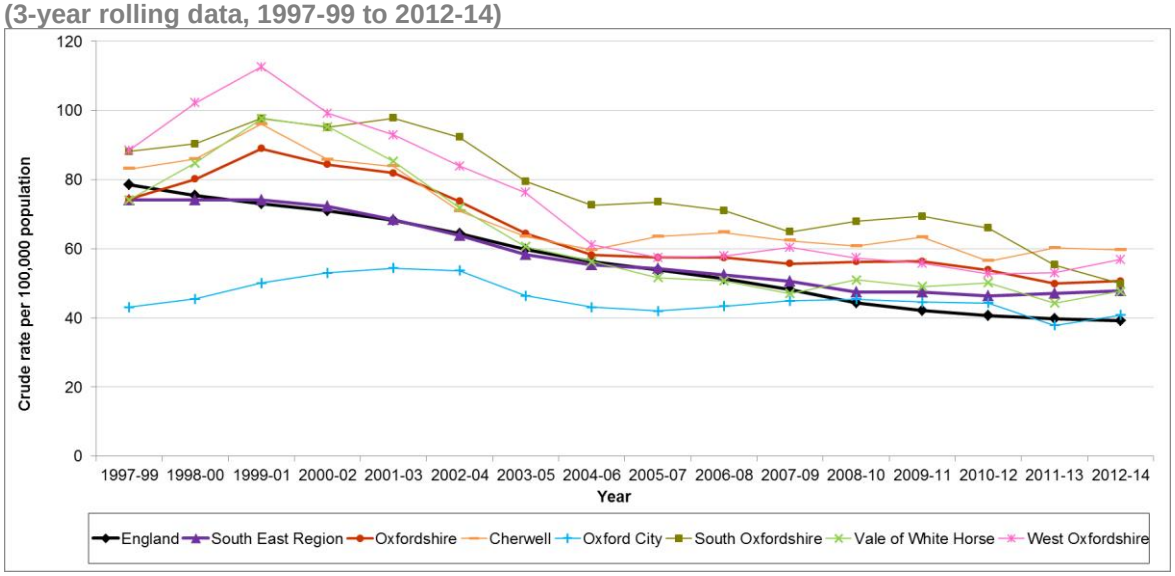
Figure 94: Number of police-reported and A&E admitted casualties in Oxfordshire (Jan 2012 - Oct 2015)



Sources: Oxfordshire County Council / Oxford University Hospitals NHS Foundation Trust

The latest 3-year rolling data for people reported to the police as killed and seriously injured (KSI) on the roads in Oxfordshire covers the period 2012-2014.[246] These statistics show a KSI rate of 50.6 people per 100,000 in the population. Since the turn of the century, there has been a general downward trend in the rate of people killed or seriously injured on Oxfordshire's roads.

Figure 95: Crude rate per 100,000 population of people killed or seriously injured on the roads (3-year rolling data, 1997-99 to 2012-14)



Sources: Department for Transport / Oxfordshire County Council

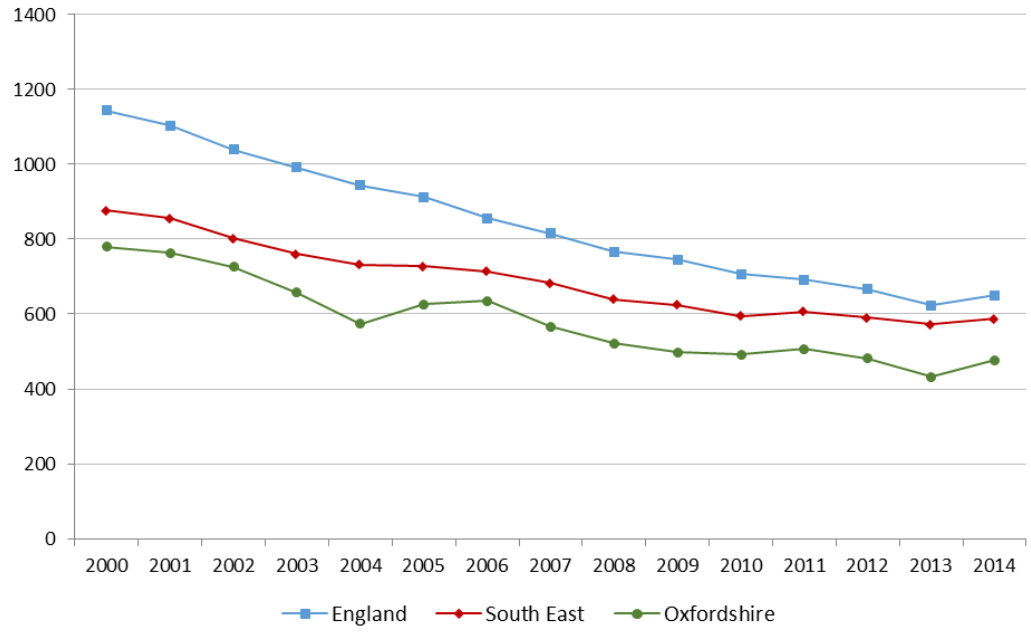
Oxfordshire continues to have a significantly higher rate of KSI per head of population (50.6 in 2012-14) than in the South East (47.9) and England overall (39.3). Across all districts except Oxford, rates exceeded the national average. Rates in Cherwell and South Oxfordshire also exceeded the regional average, whereas Oxford had a significantly lower rate than in the South East overall. When compared to its statistical neighbours on this measure, Oxfordshire's performance continues to be relatively poor.

However, a more detailed analysis of the casualty data, taking account of traffic flows by the main user groups, and the character of the roads where the casualties were sustained (whether higher speed rural environments or lower speed urban/ village settings), suggests that the actual risks faced by road users in Oxfordshire are very similar to, or lower than, those in other parts of the country. [247]

The chart below, comparing casualty rates per billion vehicle miles, shows that Oxfordshire's casualty rate has been consistently below the national and regional averages, and has fallen at a similar pace.

[246] Public Health Outcomes Framework, indicator 1.10: http://www.phoutcomes.info/
[247] Oxfordshire County Council analysis

Figure 96: Total casualty rate per billion vehicle miles (2000-2014)



Sources: Department for Transport/ Oxfordshire County Council

In summary, compared to other parts of the country, Oxfordshire has relatively more and busier rural roads but fewer residents so, whilst the population-based casualty rate is higher than average, the traffic-based rate is lower.

For more detailed information, including comparisons with Oxfordshire's statistical neighbours, see the Oxfordshire County Council Road Traffic Accident Casualty Data Summary 2014.

5.4.9. Suicide

In 2012-14 the rate of suicide and undetermined injury in Oxfordshire was 9.7 people per 100,000.[248] This was lower (although not significantly so) than rates seen across the South East (10.7) and England overall (10.6). The number of suicides in 2014 was 54, compared to 58 in 2013. In Oxfordshire, the suicide rate in men is around three times the rate in women, in line with the national picture.

Because of the small numbers involved, it is difficult to establish clear patterns in suicide rates over time or across different parts of the county.

[248] Health and Social Care Information Centre Compendium of Population Health Indicators: http://www.hscic.gov.uk/

6. Lifestyles

This section presents data on lifestyle factors that affect health and wellbeing, such as smoking, drinking, drugs, weight, and exercise. Further resources are available online, by visiting the JSNA – Lifestyles webpage.

6.1. Overview of Risk Factors

New national research estimates that dietary risks are the single largest risk factor for health, accounting for around one tenth of the total burden of ill health, disability, and early death in the South East of England in 2013.[249] These were closely followed by tobacco smoke and having a high body-mass index, which each account for around 9% of the burden. Other important behavioural risk factors included alcohol and drug use, accounting for 5.5% and low physical activity, accounting for 2.7%.

6.2. Excess Weight and Obesity

There is now a considerable amount of evidence linking obesity with a wide range of health issues.[250] Compared with a non-obese man, an obese man is five times more likely to develop Type 2 Diabetes, three times more likely to develop cancer of the colon and more than two and half times more likely to develop high blood pressure (a major risk of stroke and heart disease). An obese woman, compared with a non-obese woman, is almost thirteen times more likely to develop Type 2 diabetes, more than four times more likely to develop high blood pressure and more than three times likely to have a heart attack. Risks of other diseases, including angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke, are also increased.

A complex range of factors are linked to obesity, including poverty and deprivation, parental weight, and access to green spaces.[251]

6.2.1. Excess Weight in Adults

Excess weight in adults is recognised as a major determinant of premature mortality and avoidable ill health. The Active People Survey began including questions on height and weight for the first time from January 2012 to enable the monitoring of excess weight in adults at a local level.[252] An indicator measuring excess weight in adults is now calculated from three years of Active People Survey (APS) data combined, rather than a single year as previously used (i.e. for 2012). This means that trend data are not available.

The latest 3-year rolling data for Oxfordshire on excess weight in adults covers the period 2012-2014.[253] This estimates that 60.9% of those aged 16 and over are classified as overweight or obese. This is lower than both the average for England (64.6%) and the average for the South East (63.4%). Adults in Oxford were less likely to be overweight than in other districts; this may relate in part to its younger age profile.

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[249] Institute for Health Metrics and Evaluation (IHME). **GBD Compare - Public Health England**. Seattle, WA: IHME, University of Washington, 2015. Available from http://vizhub.healthdata.org/gbd-compare. (Accessed November 2015)

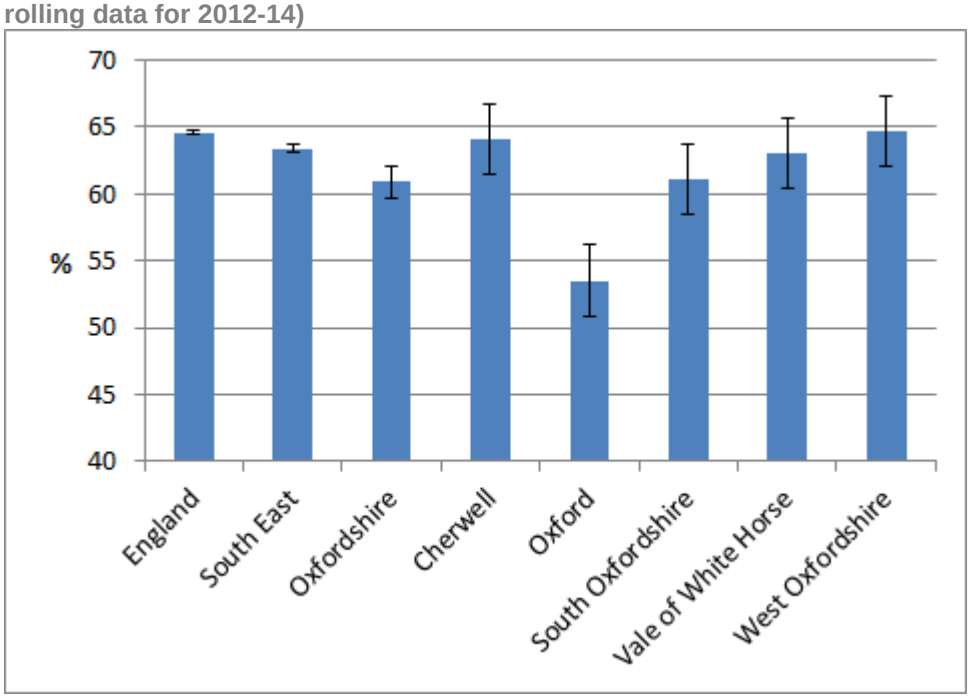
[250] Data in this paragraph are from Public Health England web resources on health risks (accessed November 2015): http://www.noo.org.uk/NOO_about_obesity/adult_obesity/Health_risks

[251] Parkhurst, A. (2014). Fat Chance? Exploring the evidence on who becomes obese: http://www.2020health.org/2020health/Publications/Publications-2015/Fat-chance.html

[252] Public Health Outcomes Framework, indicator 2.12: http://www.phoutcomes.info/. Adults are defined as overweight (including obese) if their body mass Index (BMI) is greater than or equal to 25kg/m^2. As this is the first year of recorded data it is not possible to examine trends.

[253] Public Health Outcomes Framework, indicator 2.12: http://www.phoutcomes.info/

Figure 97: Excess weight in adults in England, South East, Oxfordshire and its districts (3-year rolling data for 2012-14)



Source: Public Health Outcomes Framework/ Active People Survey, Sport England. *NB The vertical axis starts at 40% not 0%.*

GP practices maintain a register of patients aged 16 or over who have been recorded as having a body mass index (BMI) of 30 or above during the preceding 12 months. The quality of the data is dependent on recording within practices.

In 2014/15 there were around **43,000 GP-registered patients aged 16 and over** in the Oxfordshire Clinical Commissioning Group area who were recorded as being obese in the previous 12 months.[254] This number has fallen by around 1,500 since 2013/14. The prevalence rate of obesity likewise fell from 7.7% to 7.4% of patients aged 16 and over. This is in line with national trends. The rate for Oxfordshire remains below the averages for England (9.0%) and the South (8.2%).

The table below shows the 5 Oxfordshire GP practices with the highest recorded rates for obesity. It is important to remember that rates have not been standardised by age or sex, and will be affected by the underlying social and demographic characteristics of each practice's patient population. The quality of the data is also dependent on diagnosis and recording within practices. However, the figures give a snapshot of where health needs relating to excess weight may be the greatest.

[254] Quality and Outcomes Framework 2014/15: http://www.hscic.gov.uk/catalogue/PUB18887. Obesity is defined as having a body mass index (BMI) of 30 or above.

Figure 98: Oxfordshire GP practices with the highest recorded rates of obesity

Practice Name	Ward*	District*	Obesity rate
Nettlebed Surgery	Watlington	South Oxfordshire	16.2%
Broadshires Health Centre	Carterton North East	West Oxfordshire	13.6%
North Bicester Surgery	Bicester North	Cherwell	12.1%
Berinsfield Health Centre	Berinsfield	South Oxfordshire	12.0%
White Horse Medical Practice	Faringdon and the Coxwells	Vale of White Horse	11.9%

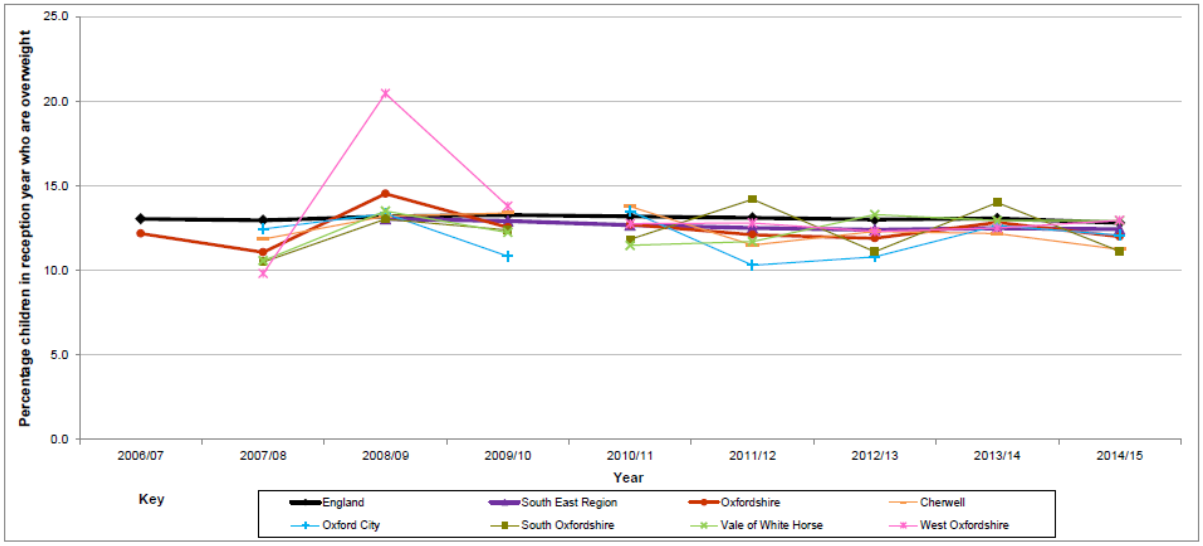
*These are the ward and district in which the practice is located. However, many of the patients may live elsewhere
Source: Quality and Outcomes Framework

6.2.2. Excess Weight in Children

Being obese or overweight can increase the risk of developing a range of serious diseases in later life. Children in Reception year and Year 6 have been measured in schools since 2006/7 under the National Child Measurement Programme (NCMP). The latest data available are for the school year 2014/15.[255]

Prevalence of excess weight among children has remained fairly stable, with some fluctuation at district level. The data for 2014/15 show that 11.9% of reception-age children were overweight and a further 6.6% were obese.

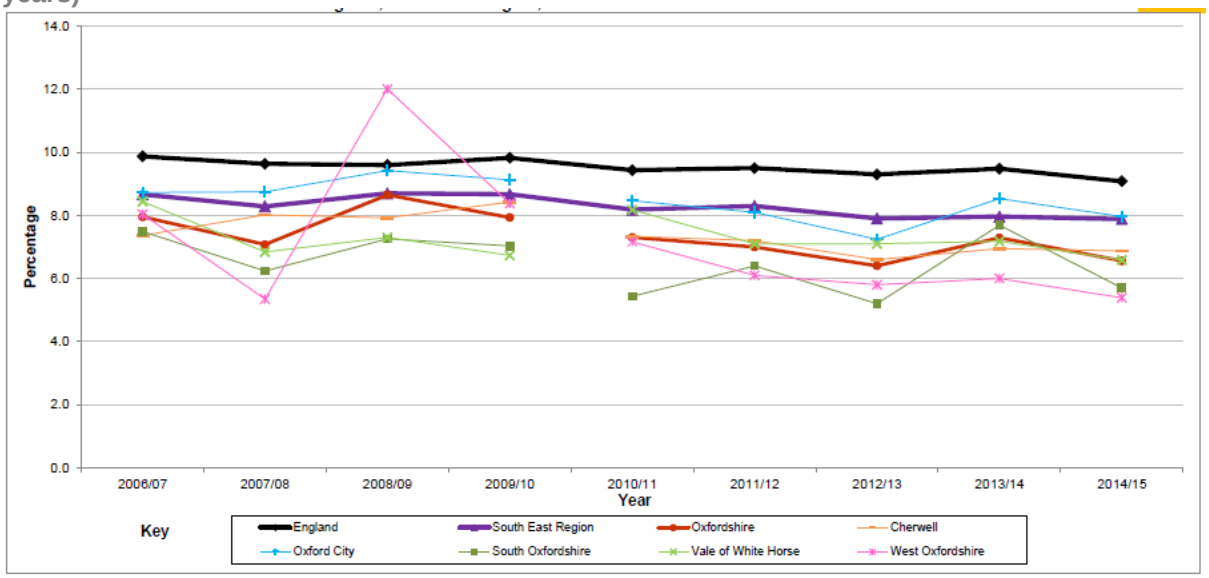
Figure 99: Percentage of Reception Year children who are overweight (2006/07-2014/15 academic years)[256]



Source: National Child Measurement Programme

[255] National Child Measurement Programme: http://www.hscic.gov.uk/ncmp
[256] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

Figure 100: Percentage of Reception Year children who are obese (2006/07-2014/15 academic years)[257]

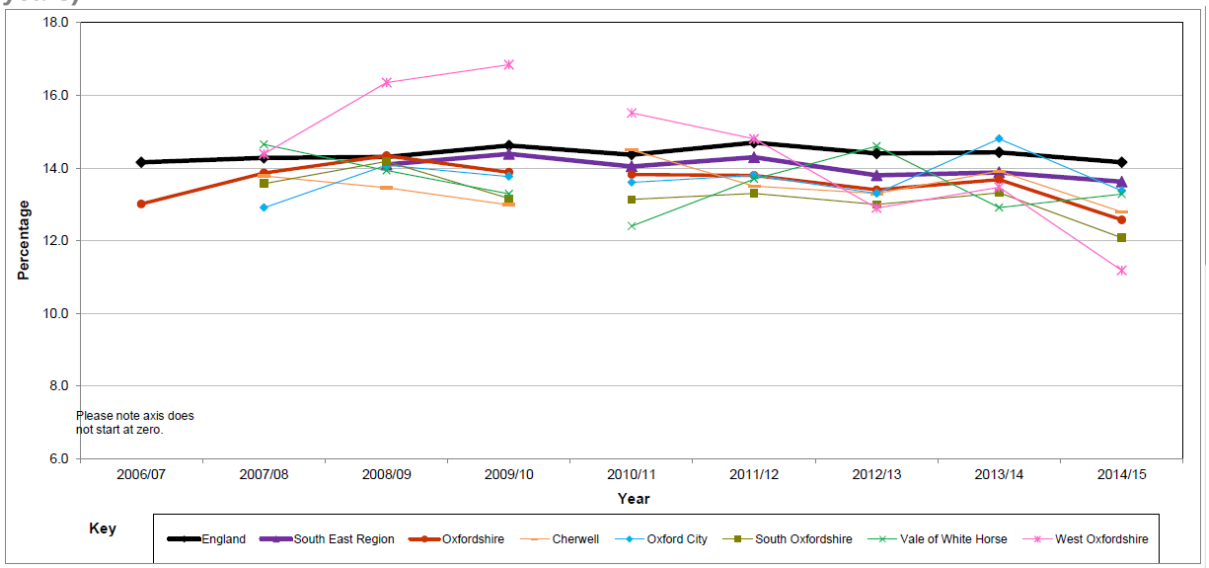


Source: National Child Measurement Programme

For Year 6 children, 12.6% were overweight and another 16.2% were obese. These rates were significantly lower than in England overall. Three of Oxfordshire's districts (West Oxfordshire, Vale of White Horse, and South Oxfordshire) continue to have lower levels of childhood excess weight than the national average. However, Cherwell has moved closer to the national average in 2014/15 and its Year 6 obesity rate is no longer better than the national average.

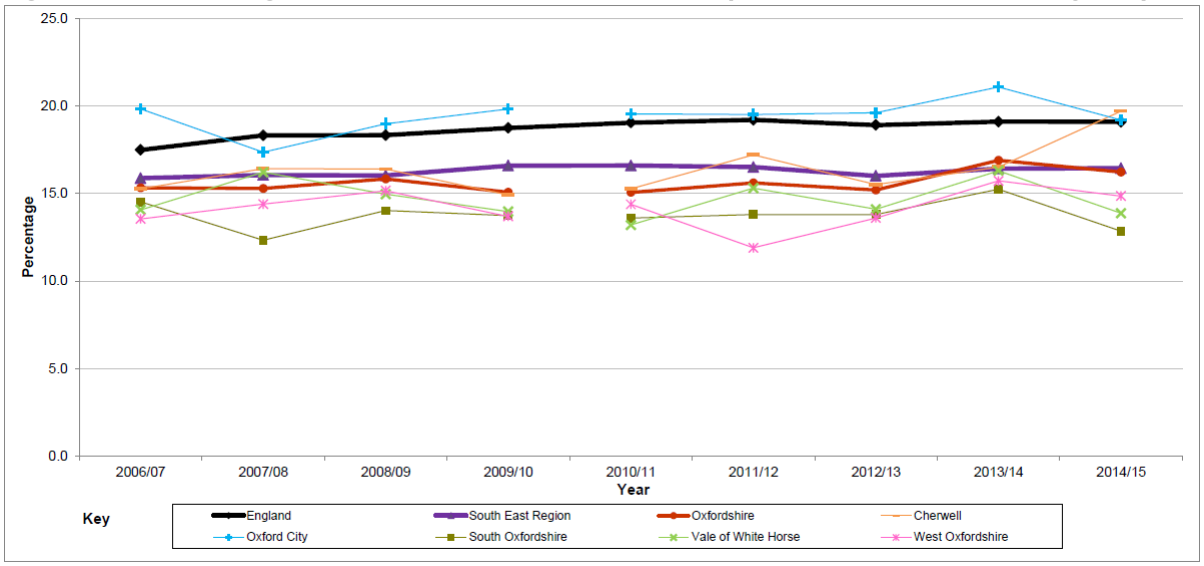
[257] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

Figure 101: Percentage of Year 6 children who are overweight (2006/07-2014/15 academic years)[258]



Source: National Child Measurement Programme

Figure 102: Percentage of Year 6 children who are obese (2006/07-2014/15 academic years)[259]



Source: National Child Measurement Programme

6.3. Physical Activity

People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared with those who have a sedentary lifestyle.[260] Meanwhile, physical inactivity has been linked to a range of other health

[258] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

[259] Data from 2010/11 are derived from the postcode of the child for Oxfordshire and districts within Oxfordshire. Prior to that year data were based on postcode of the school. Although in general these two sets of figures are quite similar, there is a notable impact in areas where high concentrations of pupils attend a school located in a local authority different to their home authority.

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

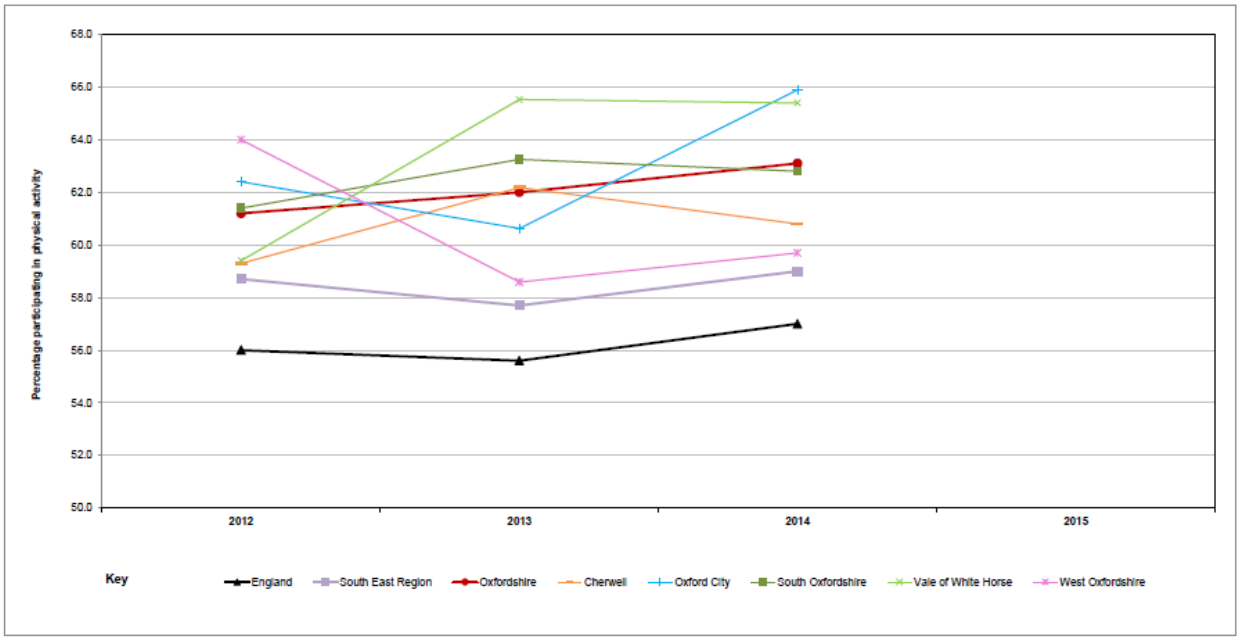
conditions, including diabetes and some cancers; it is estimated to be responsible for a significant proportion of premature all-cause mortality.[261]

The Chief Medical Officer currently recommends that adults undertake 150 minutes (2.5 hours) of moderate activity per week in stints of 10 minutes or more.

In 2014 an estimated 63.1% of those aged 16 years and over in Oxfordshire achieved at least 150 minutes of physical activity per week.[262] This was similar to the level for the previous two years year (60%) and higher than the averages in the South East (59%) and England overall (57%).

Across the county, estimates varied from 59.7% in West Oxfordshire to 65.9% in Oxford. However, these differences were not statistically significant, due to wide confidence levels.

Figure 103: Percentage of adults aged 16+ participating in sport and recreational activity (2012-2014)



Source: Sport England Active People Survey

Those who do less than 30 minutes of at least moderate intensity physical activity per week are classed as 'physically inactive'.[263] In 2014 an estimated 21.9% of people aged 16 years and over in Oxfordshire were physically inactive. This was similar to previous years (23% in 2013 and 22% in 2012). The proportion was significantly lower than in the South East (25.4%) and England overall (27.7%). According to the publication "Turning the Tide of Inactivity" Oxfordshire has the 9th lowest level of inactivity of 150 local authorities.[264]

[261] See, for example, Ekelund et al. (2015). Physical activity and all-cause mortality across levels of overall and abdominal adiposity in European men and women: the European Prospective Investigation into Cancer and Nutrition Study (EPIC). *American Journal of Clinical Nutrition:* http://ajcn.nutrition.org/content/early/2015/01/14/ajcn.114.100065.full.pdf+html; *Making the Case for Physical Activity:* (British Heart Foundation National Centre, 2013): http://www.bhfactive.org.uk/resources-and-publications-item/40/419/index.html

[262] Public Health Outcomes Framework, indicator 2.13i: http://www.phoutcomes.info/. Until more years of data become available it is not possible to say whether or not physical activity participation is increasing.

[263] Public Health Outcomes Framework, indicator 2.13ii: http://www.phoutcomes.info/

[264] Turning the Tide of Inactivity (2014): http://www.ukactive.com/turningthetide/

6.4. Smoking

Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease.

In 2014 an estimated 13.6% of adults in Oxfordshire were smokers.[265] This figure has fallen over the past five years, from 18.5% in 2010. It is now significantly lower than both the national and regional averages (18.0% and 16.6%, respectively). However among routine and manual workers there is no significant difference (29.3% in Oxfordshire, 28.0% in England).

Smoking prevalence in all of Oxfordshire's districts was either below, or similar to, national and regional averages. Modelled synthetic estimates of smoking prevalence at ward-level indicate that levels of smoking may be above the national average in five wards in Oxfordshire, all of which are concentrated in Oxford and Banbury: Blackbird Leys, Banbury Ruscote, Banbury Neithrop, Northfield Brook, and Banbury Grimsbury and Castle.[266]

6.4.1. Smoking among Children

In 2014/15 an estimated 10.4% of 15 year olds were smokers.[267] This figure was significantly worse than the national average (8.2% in England) and similar to the regional figure for the South East (9.0%).

6.4.2. Smoking in Pregnancy

Smoking in pregnancy increases the risk of miscarriage, complications during pregnancy, low birth weight, congenital defects, stillbirth, or death within the first week of life. The latest figures for Oxfordshire indicate that 8.6% of women were smoking at the time of delivery during 2014/15.[268] This was significantly lower than the national average (11.4%).

6.5. Alcohol Consumption

The health harms associated with alcohol consumption are widespread. Around 9 million adults in England drinking at levels that pose some risk to their health.[269] Drinking may also harm other people.[270] Statistics on people in alcohol treatment in Oxfordshire can be found in section 7.6 below. More information about chronic alcohol use among homeless patients who present at Oxford's Luther Street Medical Centre is provided above, under section 5.3: Morbidity.

6.5.1. Alcohol-Related Hospital Admissions

The acute or long term effects of excessive alcohol consumption are a major cause of avoidable hospital admissions.[271]

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[265] Integrated Household Survey, analysed by Public Health England for the Local Tobacco Profiles, 2015: http://www.tobaccoprofiles.info/

[266] Public Health England's Tobacco Control JSNA Support Pack for Oxfordshire: http://insight.oxfordshire.gov.uk/cms/system/files/documents/20151019%20South%20East%20-%20Oxfordshire%20-%20Tobacco%20Data%20-%20JSNA%20Support%20Pack%20V3.pdf

[267] What About YOUth (WAY) survey, data available through the Public Health England Local Tobacco Profiles, 2015: http://www.tobaccoprofiles.info/

[268] Calculated by Public Health England from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD), available from the Public Health Outcomes Framework, indicator 2.03: http://www.phoutcomes.info/

[269] Local Alcohol Profiles for England: http://www.lape.org.uk/

[270] See for example, *Alcohol's Harm to Others* (Institute of Alcohol Studies, July 2015): http://www.ias.org.uk/News/2015/13-July-2015-Majority-of-Brits-harmed-by-other-peoples-drinking.aspx

[271]

In 2013/14 the directly age-standardised rate of hospital admissions for alcohol-specific conditions in Oxfordshire was 284 per 100,000 people.[272] These conditions are a direct result of alcohol consumption and are often related to high consumption levels, defined as harmful drinking, including alcohol dependency ("alcoholism").

The rate of alcohol-specific hospital admissions in Oxfordshire has remained broadly stable over the last five years. In 2013/14 it was also similar to the South East average (295) but lower than the England rate (374). The rate was higher among male residents of the county (370) than female residents (203). In absolute numbers, 1,165 men in Oxfordshire were admitted to hospital with alcohol-specific conditions, compared with 670 women.

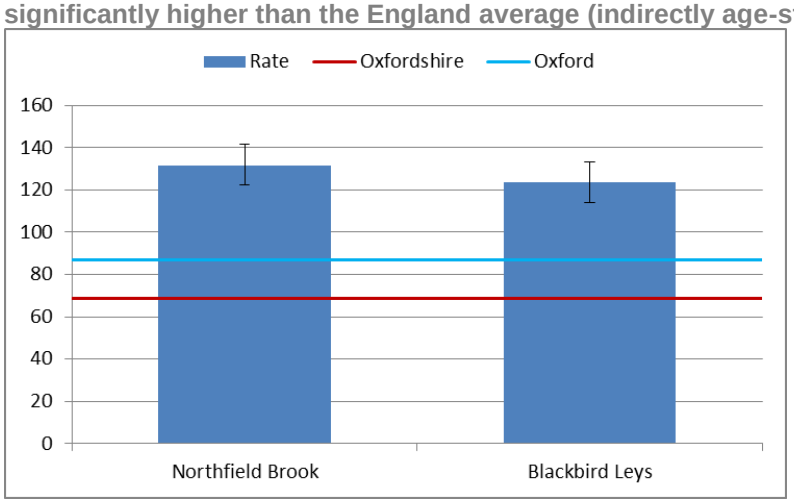
Rates of alcohol-specific admissions in Oxford were above county and national averages (estimated at 453 per 100,000 people). This was driven in particular by the high male rate in the city (estimated at 644). All other districts of the county had similar or, in many cases, significantly lower, rates relative to the regional and national averages.

Three-year rolling data for the period 2011/12-2013/14 shows that the rate of alcohol-specific hospital admissions among under 18 year olds in Oxfordshire was 41.9 per 100,000 in the population. This was statistically similar to proportions in the South East (35.6) and England overall (40.1). However, again it was higher in Oxford (72.8 per 100,000 under 18s) whilst other districts had rates similar to or lower than the national average.

Oxfordshire had relatively low rates of alcohol-*related* (as opposed to alcohol-*specific*) hospital admissions, as well as admissions for alcohol-related conditions.

Pooled data for the years 2008/09 to 2012/13 show that two wards in Oxfordshire had higher rates of hospital stays for alcohol-attributed conditions than the district, county, and national averages.[273] This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 104: Oxfordshire wards with rates of hospital stays for alcohol-attributable conditions significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

[272] Public Health England Local Alcohol Profiles for England: http://fingertips.phe.org.uk/profile/local-alcohol-profiles

[273] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

6.6. Drugs

Drugs are known to have a variety of damaging effects on both physical and mental health and wellbeing.[274] Statistics on people in drug treatment in Oxfordshire can be found in section 7.6. More information about substance abuse among homeless patients who present at Oxford's Luther Street Medical Centre is provided above, under section 5.3: Morbidity.

A 2014 study indicates that the percentage of 15 year olds who have ever tried cannabis in Oxfordshire is approximately 13.8%, compared to an England average of 10.7%.[275] However the proportion who have taken drugs (excluding cannabis) in the last month is less than 1% (similar to England average).

6.6.1. New Psychoactive Substances ('Legal Highs')

The number of deaths involving new psychoactive substances (NPS) is low compared with the number of deaths involving heroin/ morphine, other opiates, or cocaine. However, over the past few years there has been a rise in NPS deaths in England, with 67 deaths registered in 2014 (up from 60 deaths in 2013).[276]

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol implemented an early warning system across Europe in 1997 to facilitate the sharing of information about new substances between EU countries. Since 2007 growing numbers of new psychoactive substances have been discovered and reported each year, from 15 in 2007 to 101 in 2014.[277]

The Psychoactive Substances Act received Royal Assent in January 2016 and is expected to come into force on 6 April 2016.

6.7. Oral Health

Poor oral health can have important physical and psychological effects for both children and adults, including pain, sleeplessness and poor dietary intake.[278] Population groups at high risk of oral diseases include:

- Older people
- People with mental illness
- Prisoners
- Homeless people
- People with drug and alcohol problems
- People with learning disabilities
- People who use tobacco

In 2011/12 the proportion of five year old children with some tooth decay experience in Oxfordshire was 32.9%.[279] This represented an increase from 25.7% in 2007/8. It was higher than the proportion for England overall (27.9%) but similar to that for the Thames Valley.

[274] This includes, for example, links between injecting drugs and incidence of hepatitis C and bacterial infections, as evidenced in a 2014 report from Public Health England, *Shooting Up: infections among people who inject drugs in the UK* https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk

[275] What About YOUth? Survey (2014): http://www.hscic.gov.uk/article/3742/What-About-Youth-Study)

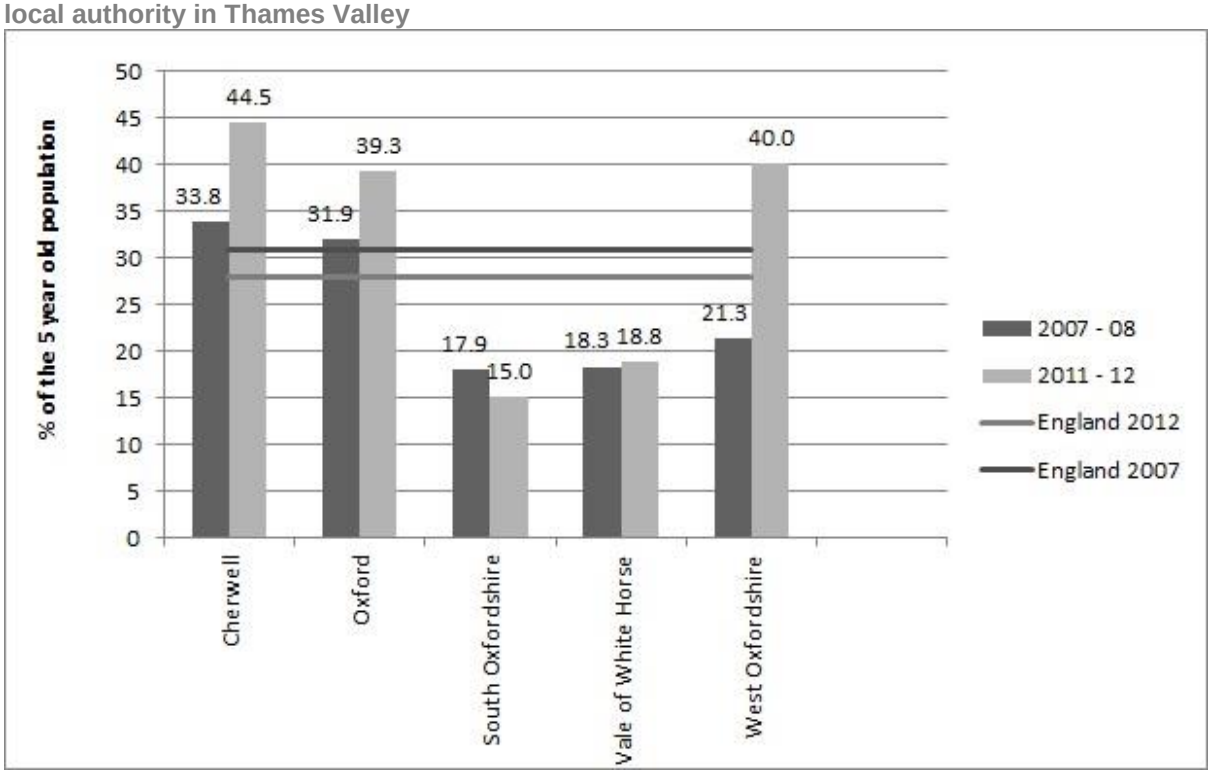
[276] Office for National Statistics: http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2014/deaths-related-to-drug-poisoning-in-england-and-wales--2014-registrations.html

[277] EMCDDA-Europol 2014 Annual Report on the implementation of Council Decision 2005/387/JHA: http://www.emcdda.europa.eu/publications/implementation-reports/2014

[278] All data and analysis on oral health included in this section have been provided by Public Health England.

Across the county fewer than two in ten five year olds in South Oxfordshire and Vale of White Horse had some tooth decay experience in 2011/12 (15% and 19% respectively). However, the proportions in other districts were above the county average: 39% in Oxford, 40% in West Oxfordshire (which saw a significant increase between 2007/8 and 2011/12) and 45% in Cherwell.

Figure 105: Proportion of 5 year olds with some tooth decay experience (d3mft>0) by lower tier local authority in Thames Valley



Source: Public Health England National Dental Epidemiology Oral Health Surveys

Children from routine and manual family backgrounds experience higher levels of decay than those from managerial and professional family backgrounds.

Nationally, rates of tooth decay among adults have fallen from 46% in 1998 to 30% in 2009. However, some adults remain at greater risk of oral disease, including those who are:

- living in deprived conditions
- reliant on others for support/care
- not attending the dentist regularly
- smoking or drinking heavily

More people are keeping their own teeth into old age: the proportion of 65-75 year olds in England with their own teeth increased from 26% in 1979 to 84% in 2009. However, as the older population increases so will the number living with long-term conditions, which can increase their risk of oral diseases. People retaining their own teeth into old age require more complex care to maintain their teeth and oral health.

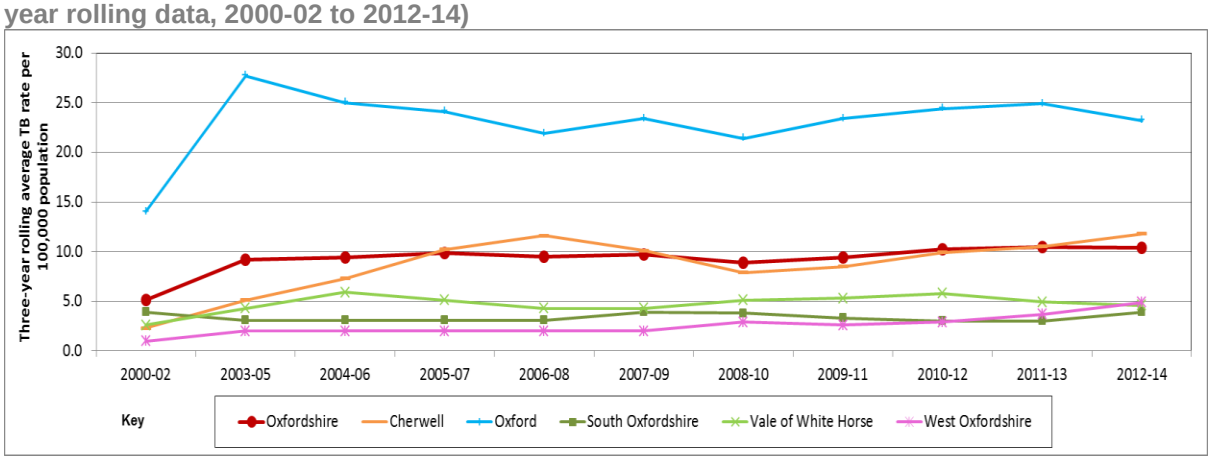
[279] Public Health England National Dental Epidemiology Oral Health Survey, 2012. Since 2007/08 the sample size has been smaller due to a change in the consent method: under positive consent parents are now required to give consent for their child to take part in the survey. If no consent is given the child is not examined.

6.8. Tuberculosis (TB)

In the past three years there has been a year on year decline in the number of tuberculosis (TB) cases in England.[280] The recent reduction is mainly due to a decline in cases in the non-UK born population, which make up nearly three-quarters of all TB cases in England.

The latest three-year rolling data for Oxfordshire, covering the period 2012-14 shows that the incidence rate of TB was 10.4 cases per 100,000 people.[281] This rate has remained stable for the last three years. It is below the national average (13.5 per 100,000 people in England) but above the regional average (8.4 cases per 100,000 people in the South East). Across Oxfordshire's districts, the highest rate is in Oxford (23.2) and this remains above the national average. However, the Oxford rate has fallen slightly in the latest three-year period.

Figure 106: Tuberculosis (TB) rates in Oxfordshire and its districts, per 100,000 population (3-year rolling data, 2000-02 to 2012-14)



Source: Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

6.9. Sexually Transmitted Infections (STIs)

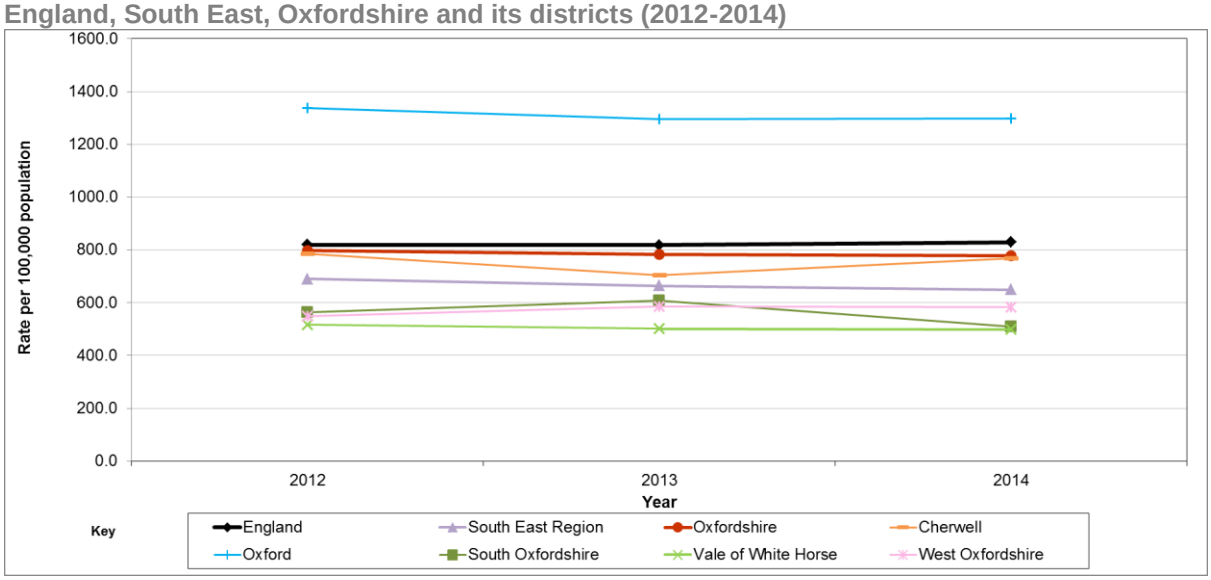
In 2014 the rate of new STI diagnoses in Oxfordshire was 777 per 100,000 people aged 15-64.[282] This was significantly lower than the national average (829). However, in Oxford City the rate (1,298) was significantly higher than the national average.

[280] Tuberculosis in England (Public Health England, 2015): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464914/TB_Annual_Report_2015.pdf

[281] Public Health Outcomes Framework, indicator 3.05ii: http://www.phoutcomes.info/

[282] Data in this section are taken from Public Health England's Sexual and Reproductive Health Profiles: http://fingertips.phe.org.uk/profile/sexualhealth

Figure 107: Rates of new sexually transmitted infections per 100,000 people aged 15-64, in England, South East, Oxfordshire and its districts (2012-2014)



Source: Public Health England

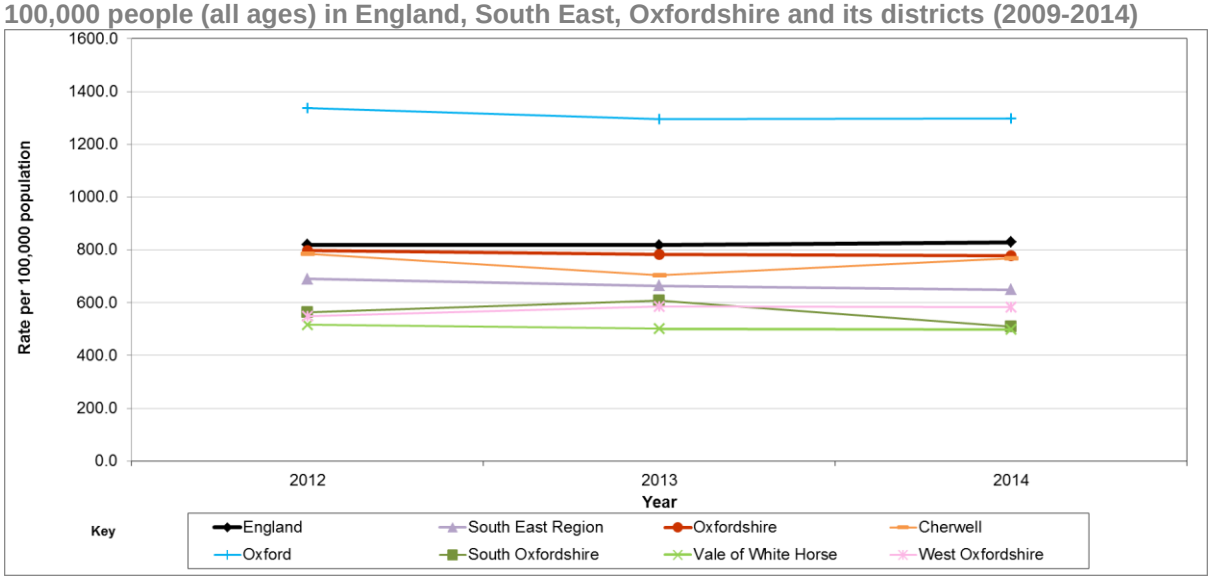
From these data it is not possible to state which STIs or age groups may be causing the rate to be high. However, nationally, the impact of STIs remains greatest in young heterosexuals under the age of 25 years and in men who have sex with men (MSM).

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

6.9.1. Gonorrhoea

Gonorrhoea diagnoses have increased, which may be due in part to the introduction of the new test for gonorrhoea in August 2012. This has greatly improved sensitivity for extra-genital gonococcal infections (throat and rectum) so has increased case finding in MSM.

Figure 108: Rate of diagnoses of gonorrhoea in Genito-urinary Medicine (GUM) clinics per 100,000 people (all ages) in England, South East, Oxfordshire and its districts (2009-2014)

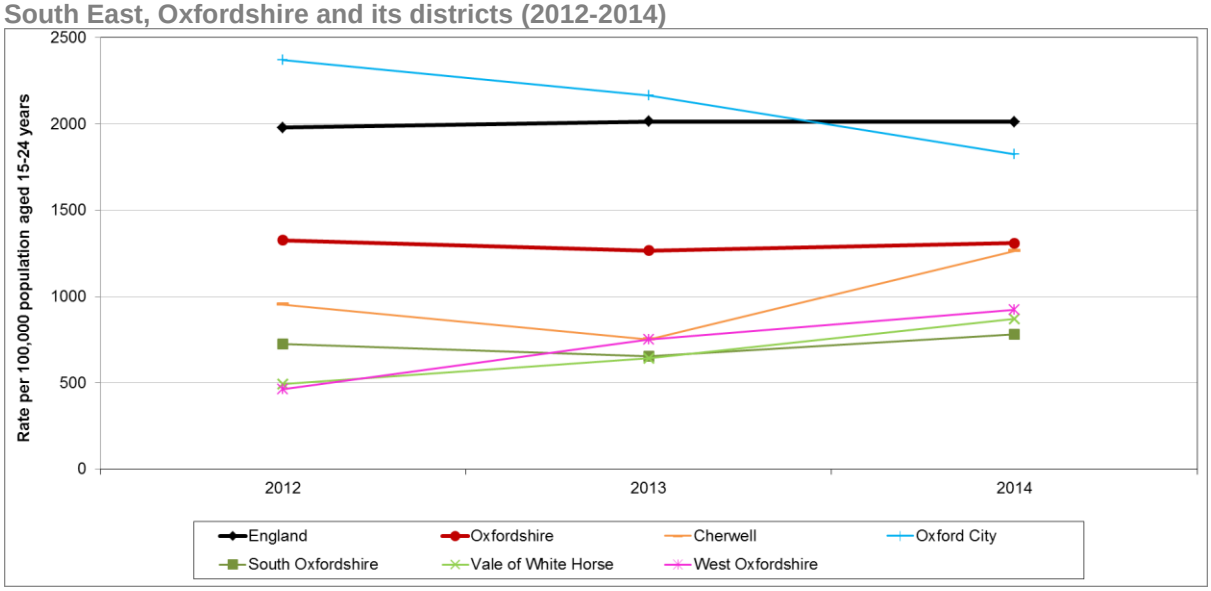


Source: Public Health England

6.9.2. Chlamydia

Chlamydia was the most commonly diagnosed STI in 2014. The detection rate for Chlamydia was set by the Department of Health as a level that would encourage high volume screening in young people under 25 years old.

Figure 109: Rate of diagnoses of chlamydia per 100,000 people aged 15-24 years, in England, South East, Oxfordshire and its districts (2012-2014)



Source: Public Health England

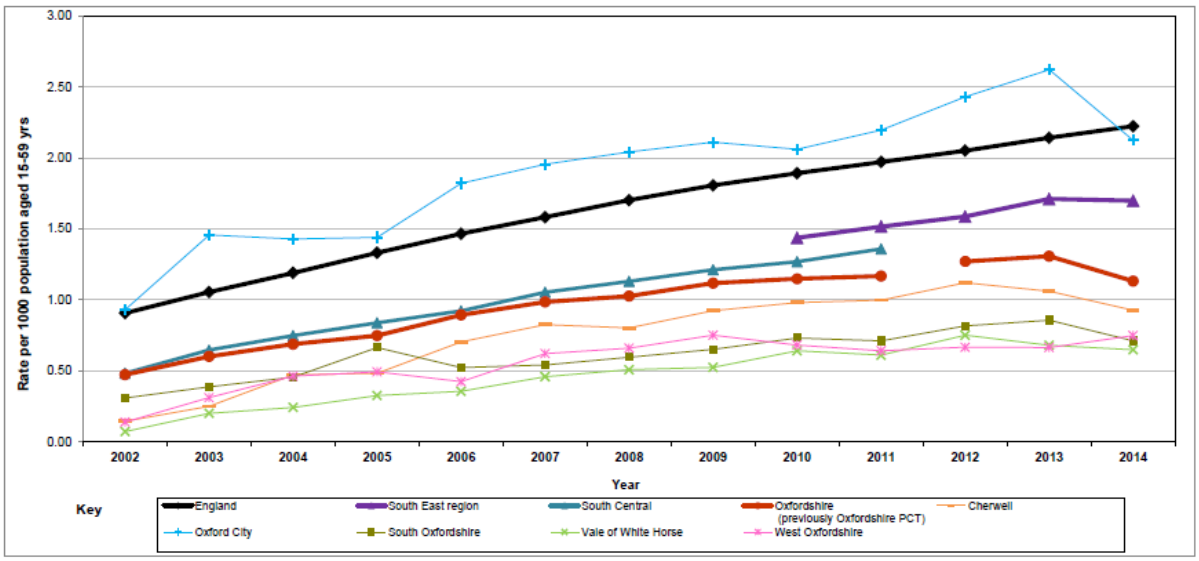
6.9.3. HIV

Human Immunodeficiency Virus (HIV) continues to be one of the most important communicable diseases in the UK. It attacks the immune system, and weakens the ability to fight infections and disease. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost. HIV is most commonly caught by having unprotected sex. It can also be passed on by sharing infected needles and other injecting equipment, and from an HIV-positive mother to her child during pregnancy, birth and breastfeeding.

Individuals who are diagnosed with HIV at early stages in their infections respond well to antiretroviral treatment, have improved health outcomes and are less likely to transmit the virus to others. Because treatment is now provided at an earlier stage in the disease, people who are HIV positive will continue to live longer so the prevalence rate will gradually increase over time i.e. the number of people living with HIV will "accumulate". As a result of this, the prevalence of people living with a diagnosis of HIV has been increasing across all geographical areas over the past 12 years.

Overall in Oxfordshire the prevalence rate of HIV is significantly lower than the national average. However more than half of the people with HIV live in Oxford City which, until recently, has had a significantly higher prevalence rate than England.

Figure 110: Prevalence of diagnosed HIV per 1,000 population aged 15-59 (2002-2014)[283]



Source: Public Health England

6.10. Teenage Conceptions

The latest 3-year rolling data for 2011-2013 indicates that in Oxfordshire there were 19.9 conceptions per 1,000 girls aged 15-17 years.[284] Teenage conceptions have fallen in Oxfordshire, as they have nationally. The current rate for Oxfordshire is lower than that of the South East (23.3) and England (27.6). Across the county, higher rates in Oxford have continued to fall and now remain lower than the national average.

There are some wards in Oxfordshire that continue to have high rates or high numbers of teenage conceptions. These are predominantly in parts of Oxford (including in Iffley Fields, Holywell and St Mary's, Northfield Brook, Rose Hill & Iffley, Barton & Sandhills and Blackbird Leys) and parts of Cherwell (including in Banbury Grimsbury & Castle, Banbury Ruscote and Bicester East).

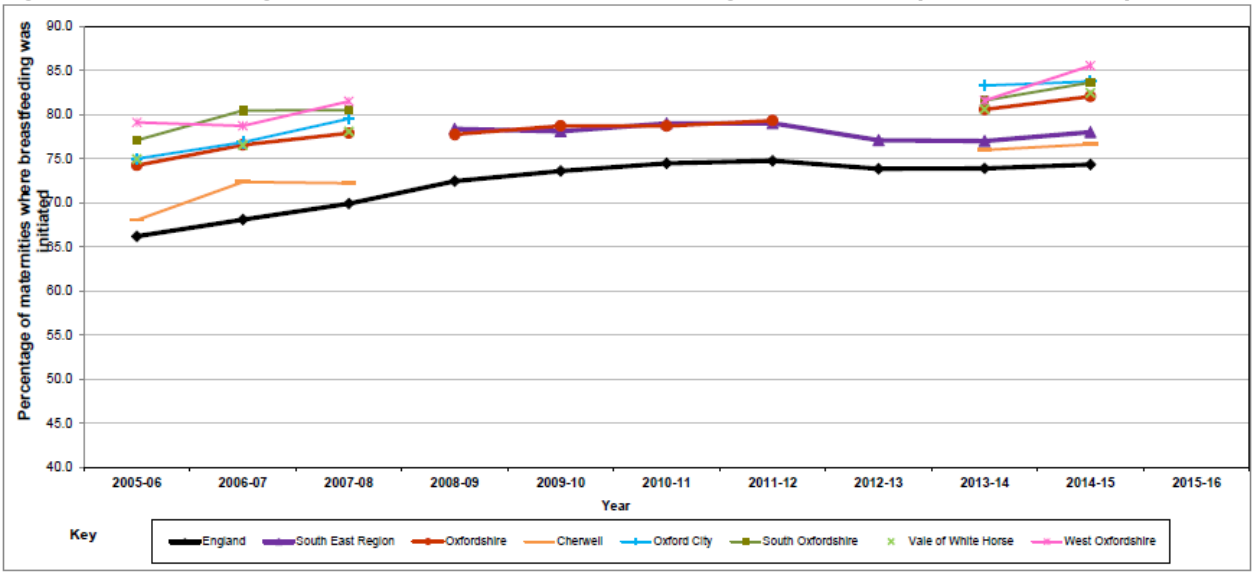
6.11. Breastfeeding

Breastfeeding has been found to give a baby the best possible nutrition, and protect against disease and future obesity, as well as encouraging a strong bond between mother and baby.

[283] Data prior to 2012/13 relate to patients registered with a GP in the Oxfordshire Primary Care Trust; later data relate to patients registered with a GP in the Oxfordshire Clinical Commissioning Group.
[284] ONS Conceptions Statistics: http://www.ons.gov.uk/ons/rel/vsob1/conception-statistics--england-and-wales/2013/index.html

Breastfeeding initiation measures the very first stages of breastfeeding. A mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast or the baby is given any of the mother's breast milk. This is useful but is no guarantee of continued breastfeeding. In 2014/15, 82.1% of mothers in Oxfordshire initiated breastfeeding.[285] This rate is similar to the previous year and is significantly higher than the England average (74.3%) and that for the South East (78.0%).

Figure 111: Percentage of maternities where breastfeeding was initiated (2005/06-2014/15)[286]



Source: Public Health England

The proportion of babies who were being breastfed at 6-8 weeks in 2014/15 was a little lower than initiation, at 62.6%.[287] This rate has been increasing in recent years and it remains significantly higher than in England overall (43.8%).

Rates vary among Oxfordshire districts but all are significantly higher than national averages, both for breastfeeding initiation and at 6-8 weeks.

[285] NHS England data, available through the Public Health Outcomes Framework, indicator 2.02i: http://www.phoutcomes.info/

[286] The gap in trend data between 2007-08 to 2008-09 reflects a methodological change in the way local data were gathered and analysed.

[287] NHS England data, available through the Public Health Outcomes Framework, indicator 2.02ii: http://www.phoutcomes.info/

7. Service Use

This section sets out the changing demand for health and social care services across Oxfordshire. A small amount of summary information is included on the quality of services. Further resources are available online, by visiting the JSNA – Service Use webpage.

The Oxfordshire Clinical Commissioning Group (OCCG) is responsible for commissioning the vast majority of the healthcare provided to patients registered at Oxfordshire-based General Practitioners (GP) practices.

Reports published by Healthwatch Oxfordshire provide more information about the quality of services, from a patient perspective.

7.1. Primary Health Care

7.1.1. GP Practice Population

As of 1st January 2016, there were 77 General Practitioners (GP) practices in the Oxfordshire Clinical Commissioning Group (OCCG) area, with 720,029 registered patients.[288] Across England, demand for general practice is increasing as the population grows in size and ages.[289]

The latest data on GP rates show that in September 2014 there were 75.6 GPs per 100,000 people in the Oxfordshire CCG area.[290] This rate has remained reasonably similar over the past few years. It was above the England average of 66.5.

Nationally, 92% of people live within 2 kilometres of a GP surgery, but there are stark differences between urban and rural areas: only 1% of people in urban areas do not have a GP surgery within 2 kilometres, compared with 37% in rural areas.[291] Deprived areas have also been found to have a lower ration of GPs and nurses to patients.[292]

7.1.2. Contact with GPs

Survey data for 2015 shows that just over half of patients registered with GPs in the Oxfordshire Clinical Commissioning Group area reported having seen or spoken to a GP within the last three months (51%).[293] This compares with 54% in 2014 (although it is not clear whether the difference is statistically significant). Just under seven in ten said they had done so in the last six months (68%). This compares with 71% in 2014, although the difference is not statistically significant. There is also no statistically significant difference from the England average of 70%.

Nationally, patient satisfaction with access to GP appointments is declining and was found to be worse among younger patients and people from Black, Asian and minority ethnic groups.[294]

[288] Health & Social Care Information Centre: http://www.hscic.gov.uk/
[289] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/
[290] Health and Social Care Information Centre LBOI Indicator 8.1: https://indicators.ic.nhs.uk/webview/
[291] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/
[292] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/
[293] GP Patient Survey (January 2016 release): https://gp-patient.co.uk/surveys-and-reports
[294] Stocktake of access to general practice in England (National Audit Office, November 2015): https://www.nao.org.uk/report/stocktake-of-access-to-general-practice-in-england/

7.1.3. Out of Hours GP Services

In the 12 months leading to end of September 2015 OCCG commissioned 106,849 Out-of-Hours contacts. This is a similar level of activity to the previous 12 months. 59,680 of the contacts involved patients attending primary care centres, 34,749 concluded on telephone advice, with the remaining 12,420 involving a patient receiving a visit at their home.

7.1.4. GP Patient Survey

The GP Patient Survey takes place twice a year and asks patients about experiences of their local GP surgery and other local NHS services.[295]

In 2015 just under nine in ten (88% of) patients registered with GPs in the Oxfordshire Clinical Commissioning Group area rated their overall experience of their GP surgery as (very or fairly) good. 82% said they would (definitely or probably) recommend the surgery to someone who has just moved into the local area. These statistics are broadly in line with findings from the previous two years.

Satisfaction and advocacy rates in Oxfordshire were significantly higher than for England overall, where 85% rated their GP surgery as good and 78% said they would recommend it.

In March 2015 Healthwatch published research into people's most common problems with primary care: http://www.healthwatch.co.uk/primarycare

7.2. Secondary Health Care

Nationally, hospital admissions in 2014/15 were up 2.8% on 2013/14 levels, and 31.3% on the levels of ten years ago.[296] The rise in the number of hospital admissions has outpaced population growth, which is likely to be partly to do with the ageing population. However, the length of stay in hospital has been gradually falling over the same period. The Thames Valley has the lowest rate of admissions per head of population of any NHS area team in England.

7.3. Planned Secondary Health Care

The OCCG expects demand to rise at a faster rate than average population growth across the range of planned secondary health care services which they commission, due principally to the changing (ageing) profile of their population.[297]

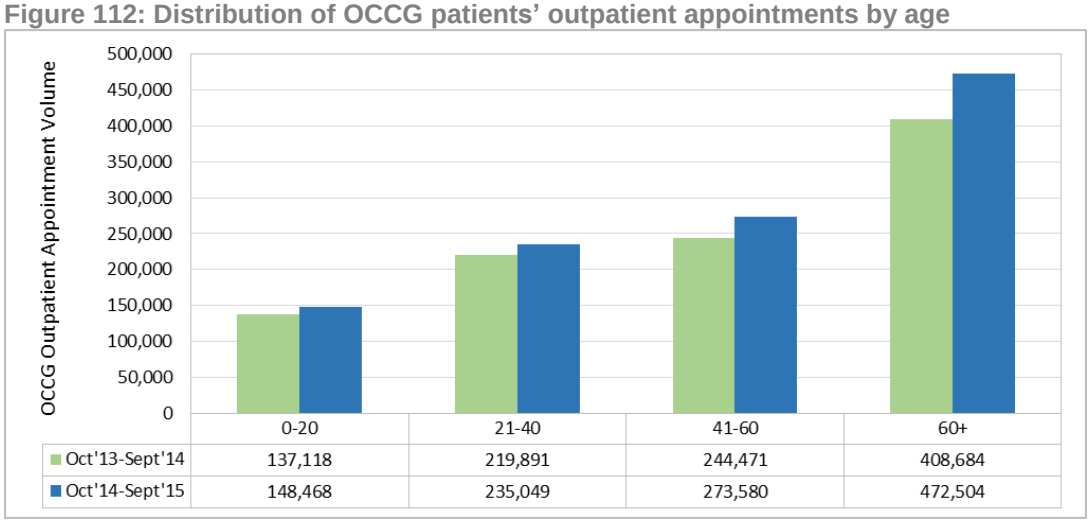
7.3.1. Outpatient Appointments

'Outpatients' are people referred to attend short appointments in hospital.

In the 12 months to the end of September 2015, patients registered with GP practices in the OCCG area scheduled 1,129,601 outpatient appointments. This represents a rise of 10.6% on the previous 12 months' volume of 1,010,164 appointments. 5.1% of scheduled outpatient appointments in this period did not go ahead due to the patient not attending.

[295] GP Patient Survey (January 2016 release): https://gp-patient.co.uk/surveys-and-reports
[296] Hospital Episode Statistics, Admitted Patient Care, England – 2014-15 (Health and Social Care Information Centre, November 2015): http://www.hscic.gov.uk/catalogue/PUB19124
[297] Data in this section, including information about expected changes in service demand, has been provided by the Oxfordshire Clinical Commissioning Group.

Figure 112: Distribution of OCCG patients' outpatient appointments by age



	0-20	21-40	41-60	60+
Oct'13-Sept'14	137,118	219,891	244,471	408,684
Oct'14-Sept'15	148,468	235,049	273,580	472,504

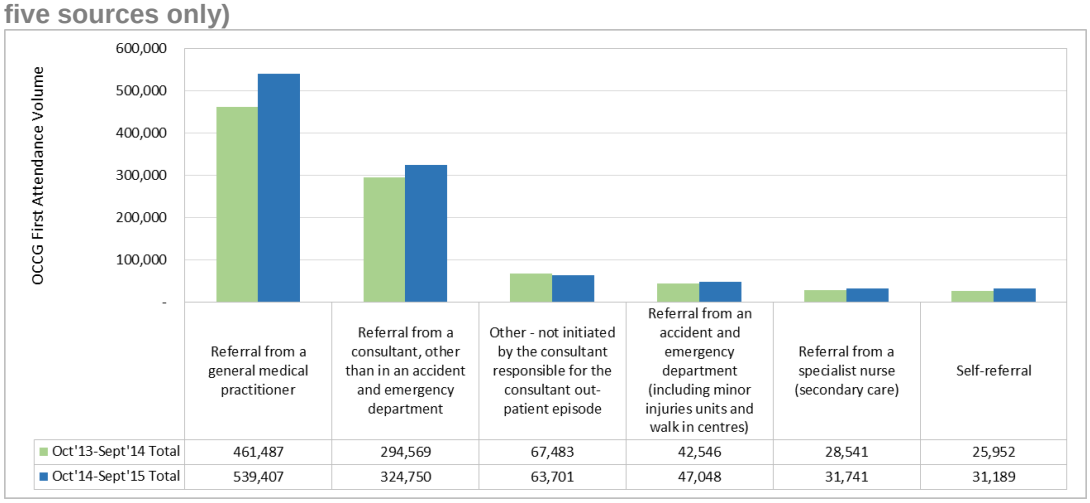
Source: Oxfordshire Clinical Commissioning Group

Around 90% of outpatient appointments can be categorised as 'first attendances' or 'follow-up appointments'. These are discussed in more detail in the next two subsections.

First Attendances

In the 12 months to the end of September 2015, patients registered with GP practices in the OCCG area scheduled 336,180 outpatient first attendances, of which 190,858 (56.8%) resulted from GP referrals. This represents an overall decrease on the previous 12 months, which saw 344,129 attendances, but an increase in GP referrals from 174,414.

Figure 113: Distribution of OCCG patients' first outpatient appointments by referral source (top five sources only)



	Referral from a general medical practitioner	Referral from a consultant, other than in an accident and emergency department	Other - not initiated by the consultant responsible for the consultant out-patient episode	Referral from an accident and emergency department (including minor injuries units and walk in centres)	Referral from a specialist nurse (secondary care)	Self-referral
Oct'13-Sept'14 Total	461,487	294,569	67,483	42,546	28,541	25,952
Oct'14-Sept'15 Total	539,407	324,750	63,701	47,048	31,741	31,189

Source: Oxfordshire Clinical Commissioning Group

Follow-Up Appointments

In the 12 months to the end of September 2015 the number of follow-up outpatient appointments among patients registered with GP practices in the OCCG area was 650,624. This represents an increase on the previous 12 months' figure of 568,559 appointments.

Community Hospital Admissions

During the 12 months to the end of September 2015, OCCG commissioned 2,222 community hospital admissions in Oxford Health Foundation Trust, the OCCG's largest community hospital provider. This is a reduction of 17.4% on the previous 12 months which saw 2,690 admissions.

7.3.2. Elective Admissions

Elective admissions are planned admissions to hospital, for stays of one or more nights.

Elective admissions accounted for 15,423 hospital encounters by patients registered with GPs in the OCCG area in the 12 months to the end of September 2015. This is a 1.0% increase on the previous 12 months, which saw 15,266 admissions. It is likely that some patients experienced multiple admissions, so this figure is not representative of the patient count.

7.3.3. Day Case Admissions

Day case admissions are planned admissions to hospital, where patients do not need to stay overnight. This includes patients who are undertaking a series of planned regular admissions to administer broadly similar treatments (for example, dialysis or chemotherapy).

In the 12 months to the end of September 2015, there were 73,146 day case attendances made by patients registered with GP practices in the OCCG area. This is an increase of 0.2% on the previous 12 months, which saw 73,015 attendances. It is likely that some patients experienced multiple admissions, so this figure is not representative of the patient count.

7.3.4. District Nursing

In the 12 months to the end of September 2015 OCCG commissioned 260,153 district nurse contacts for patients registered with GP practices in the OCCG area. This represents a 3.0% reduction on the previous 12 months' activity of 268,059 contacts.

7.4. Emergency and Unplanned Health Care

Across the range of emergency care services commissioned by Oxfordshire Clinical Commissioning Group (OCCG), the OCCG expects demand to rise at a faster rate than average population growth, due principally to the changing (ageing) profile of the population.[298] For the same reason, it expects admissions to involve longer average stays in hospital.

7.4.1. Accident and Emergency (A&E)

A&E Attendance

Nationally, A&E attendances have been rising every year since 2001/02.[299]

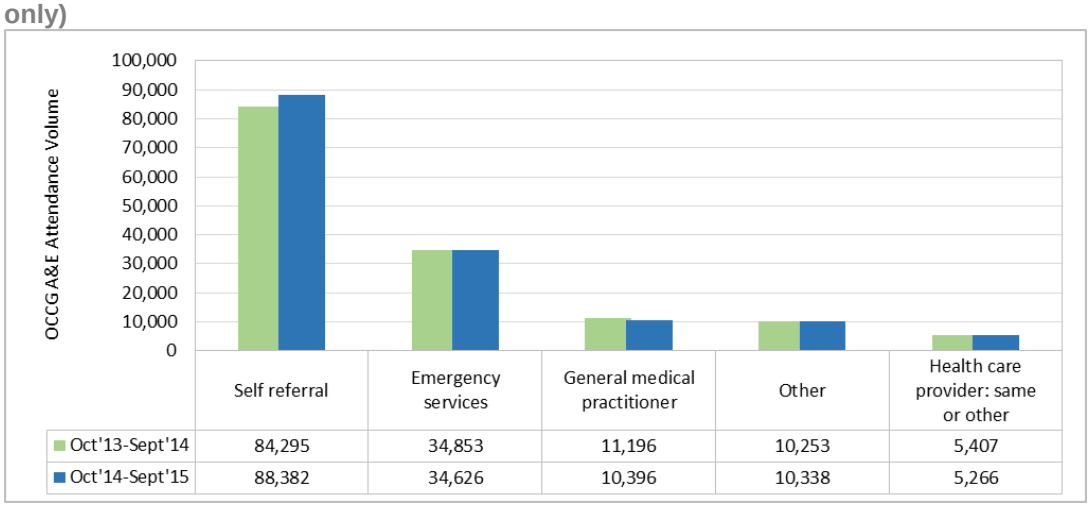
In the 12 months to the end of September 2015, patients registered with GP practices in the OCCG area attended A&E 152,725 times. This represents an increase of 1.4% on the previous 12 months, when attendances totalled 150,661. Attendances among OCCG patients occurred across the country at over 200 providers and hospitals. However, the majority were treated by Oxford University Hospitals NHS Foundation Trust (101,938), Oxford Health NHS Foundation Trust (31,321), and the Royal Berkshire Foundation NHS Trust (5,760).

Of attendances where the referral source was recorded (99.9% of the total) a marginal reduction of 0.5% was observed in the total number of emergency service referrals. However, self-referrals increased by 4.8%.

[298] Data in this section, including information about expected changes in service demand, has been provided by the Oxfordshire Clinical Commissioning Group.

[299] Key facts and trends in acute care (NHS Confederation, November 2015): http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/NHSC%20factsheet%20Nov%20WEB.pdf

Figure 114: Distribution of OCCG patient A&E attendances by referral source (top five sources only)

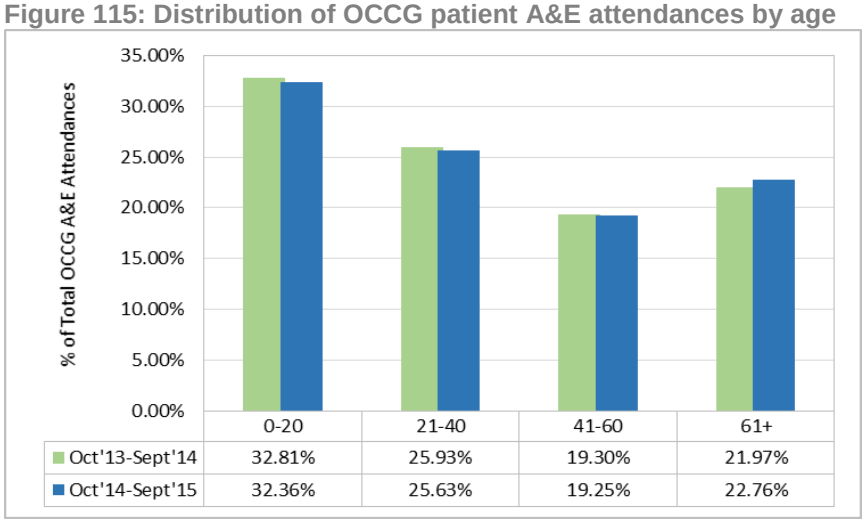


	Self referral	Emergency services	General medical practitioner	Other	Health care provider: same or other
Oct'13-Sept'14	84,295	34,853	11,196	10,253	5,407
Oct'14-Sept'15	88,382	34,626	10,396	10,338	5,266

Source: Oxfordshire Clinical Commissioning Group

The chart below shows the year on year percentage distribution of OCCG patient A&E attendances across age categories.

Figure 115: Distribution of OCCG patient A&E attendances by age

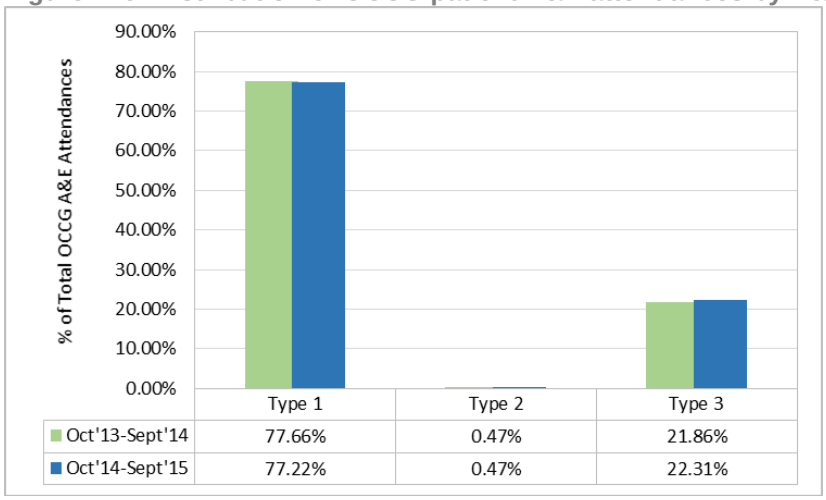


	0-20	21-40	41-60	61+
Oct'13-Sept'14	32.81%	25.93%	19.30%	21.97%
Oct'14-Sept'15	32.36%	25.63%	19.25%	22.76%

Source: Oxfordshire Clinical Commissioning Group

A&E attendance has seen growth across all three department types this year, with the greatest growth seen in Type 3 (Minor Injury Units/Other A&E) which saw an increase of 3.5% from 32,940 attendances to 34,075. Type 1 departments (a consultant-led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients) saw year on year growth of 0.8% (117,009 to 117,928 attendances). Type 2 departments (a consultant-led single speciality accident and emergency service, e.g. ophthalmology, dental, with designated accommodation for the reception of patients) saw year on year growth of 1.4% (712 to 722 attendances).

Figure 116: Distribution of OCCG patient A&E attendances by A&E department type



	Type 1	Type 2	Type 3
Oct'13-Sept'14	77.66%	0.47%	21.86%
Oct'14-Sept'15	77.22%	0.47%	22.31%

Source: Oxfordshire Clinical Commissioning Group

Emergency Department Attendances for Alcohol and Violence

Data gathered from Emergency Departments at the John Radcliffe and Horton General hospitals show that, in the first nine months of the 2015/16 financial year (1st April to 31st December) around 2,000 attendances were recorded as being alcohol-related.[300] They made up around 2.1% of all emergency department attendances. As might be expected, alcohol-related attendances were more likely to occur at the weekend, and also in the early hours of the morning.

The age group experiencing the most alcohol-related attendances were those aged 20-24, making up over one in six of the total number. 63% of attendances were for men or boys, compared with 37% for women or girls. Over 90% of attendances were among people of White ethnicities, broadly in line with the overall make-up of the population.

Meanwhile, slightly over 800 emergency department attendances were recorded as involving assault. Again, they were more likely to occur at the weekend (particularly Sunday) and during the evening/ night.

Again, the age group experiencing the most alcohol-related attendances was those aged 20-24, making up almost a quarter of the total number. Over three quarters of attendances (77%) were for men or boys, compared with 23% for women or girls. Slightly below 90% of attendances were among people of White ethnicities, suggesting that people from Black and Minority Ethnic could be slightly overrepresented in the assault-related attendances figures, compared with the proportion of the overall population they make up.

A little under 200 emergency department attendances were recorded as involving both alcohol *and* assault. These made up around 9% of all alcohol-related attendances, and around 23% of all attendances for assault. However, it is thought that the figures are likely to understate the true extent of alcohol-related violence presenting in A&E.

A&E Waiting Times

The two major A&E departments used by Oxfordshire residents are Oxford University Hospitals NHS Trust (OUHT) and Royal Berkshire Foundation NHS Trust (RBFT).

Of the 139,557 visits made to Oxford University Hospitals Foundation NHS Trust's A&E by the OCCG population in the 12 months to September 2015, 13,442 (9.6%) breached the 4

[300] Data provided by Emergency Department Community Safety Practitioner.

hour waiting time. This is an increase on the previous 12 months which saw 10,016 (7.5%) breaches out of 133,815 visits.

National research by Monitor found that the main reason for more trusts failing to meet the 4-hour emergency standard over the winter of 2014/15 was a reduction in the capacity of inpatient wards to receive admissions from emergency departments.[301]

Emergency Services

The number of 999 calls made for patients registered with GPs in the OCCG area in the 12 months to end of September 2015 totalled 96,368. Around 8,636 came from healthcare professionals, and 38,862 resulted in a patient being conveyed to hospital.

7.4.2. Emergency Hospital Admissions

National analysis suggests that people presenting at A&E increasingly have more serious health issues, which require them to be admitted to hospital.[302] The proportion of A&E attendees admitted into hospital rose from 20.8% in 2004/05 to 27.3% in 2014/15. This is largely driven by the ageing population.

Emergency inpatient admissions, including those of less than 24 hours, for patients registered with GP practices in the OCCG area accounted for 57,474 admissions in the 12 months to the end of September 2015. This was an increase of 2.2% on the previous 12 months' activity level of 56,220 admissions. It is likely that some patients experienced multiple admissions, so this figure is not representative of the patient count

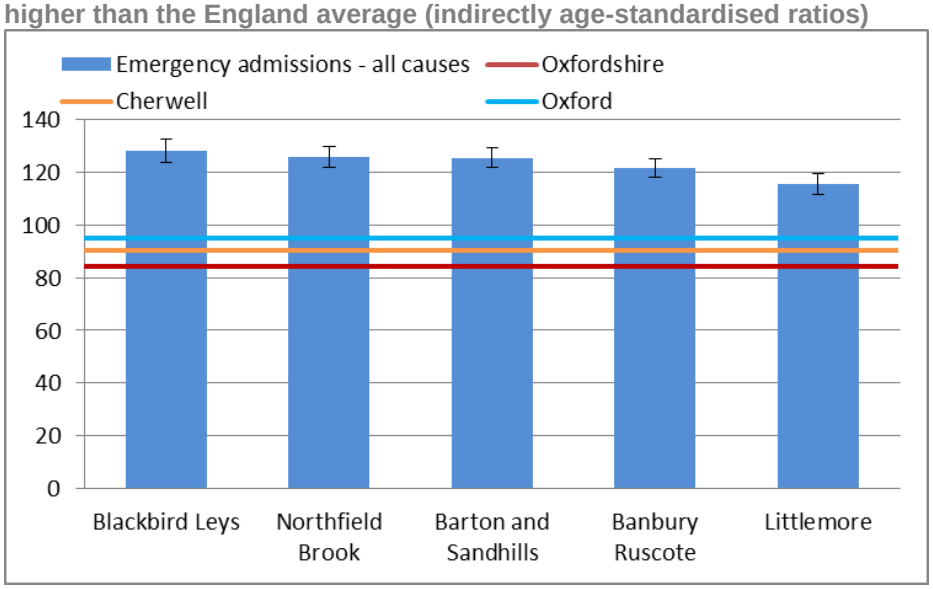
Pooled data for the years 2008/09 to 2012/13 show that Oxfordshire and its five districts had proportionately fewer emergency hospital admissions than nationally.[303] However five wards in Oxford and Banbury have higher rates of emergency hospital admissions for all causes - Blackbird Leys, Northfield Brook, Barton & Sandhills, Littlemore and Banbury Ruscote. This is shown in the chart below, where the England average ratio is standardised to a value of 100.

[301] Improving patient flow: evidence to help local decision-makers (Department of Health, September 2015): https://www.gov.uk/government/publications/improving-patient-flow-evidence-to-help-local-decision-makers/improving-patient-flow-evidence-to-help-local-decision-makers

[302] Key facts and trends in acute care (NHS Confederation, November 2015): http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/NHSC%20factsheet%20Nov%20WEB.pdf

[303] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

Figure 117: Oxfordshire wards with rates of emergency hospital admissions significantly higher than the England average (indirectly age-standardised ratios)

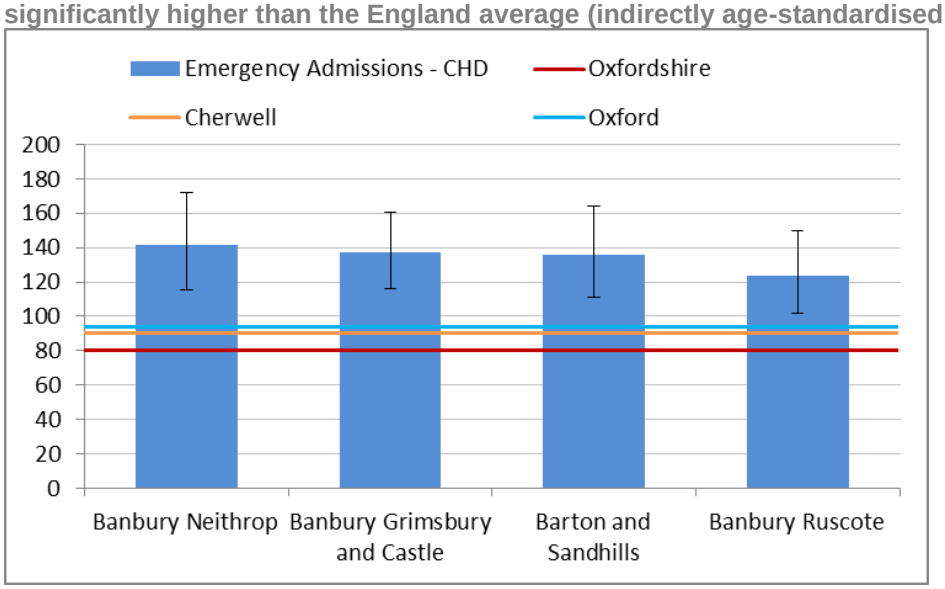


Source: Public Health England

Emergency Hospital Admissions for Coronary Heart Disease

Pooled data for the years 2008/09 to 2012/13 show that Oxfordshire and its five districts had proportionately fewer emergency hospital admissions for coronary heart disease (CHD) than nationally.[304] However, there are four wards within Oxford and Cherwell that have significantly higher rates. This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 118: Oxfordshire wards with rates of emergency hospital admissions for CHD significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

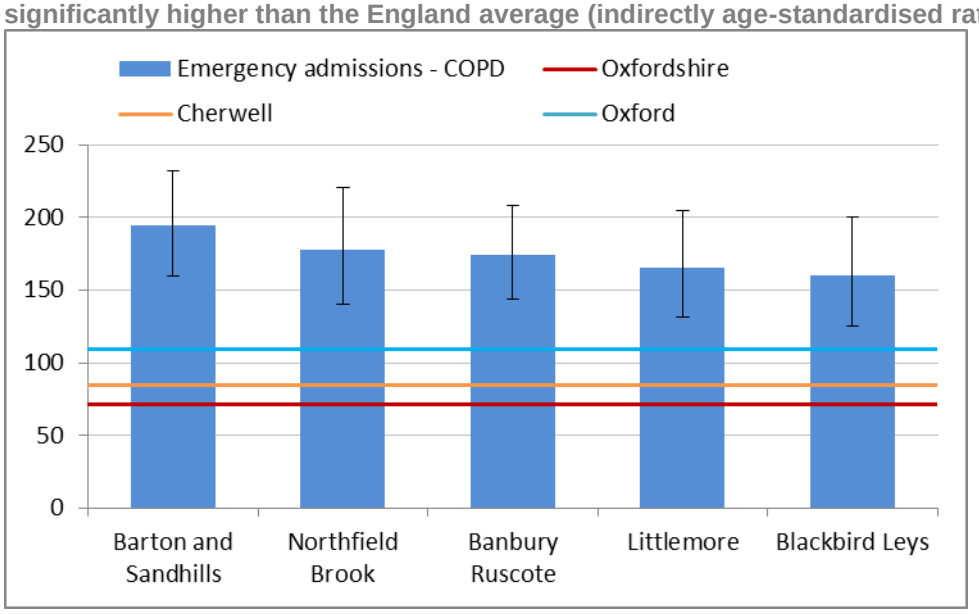
Emergency Hospital Admissions for chronic obstructive pulmonary disease

Pooled data for the years 2008/09 to 2012/13 show that Oxford City was the only district in Oxfordshire that had a higher rate of emergency hospital admissions for chronic obstructive

[304] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

pulmonary disease (COPD) than the national average.[305] However, there were five wards in Oxford and Cherwell that have high rates. This is shown in the chart below, where the England average ratio is standardised to a value of 100.

Figure 119: Oxfordshire wards with rates of emergency hospital admissions for COPD significantly higher than the England average (indirectly age-standardised ratios)



Source: Public Health England

Emergency Hospital Admissions for Dementia

Nationally, there are growing numbers of emergency hospital admissions for people with dementia.[306] This is likely to be due in part to greater awareness and recording of dementia symptoms.

Emergency Hospital Admissions for Head and Brain Injury

Nationally, the rate of hospital admissions for head injury was around 264 per 100,000 people in 2013/14.[307] Applied to Oxfordshire this would give a figure of around 1,800 admissions.[308] However, this figure does not take into account any local differences that may exist in brain injury admission rates

The rate of hospital admissions for acquired brain injury in the UK was 566 per 100,000 people in 2013/14. Applied to Oxfordshire this would give a figure of around 3,800 admissions. Again, this figure does not take into account any local differences that may exist in brain injury admission rates.

7.4.3. Hospital Discharge and Delayed Transfers of Care

A delayed transfer of care occurs when a patient is deemed medically fit to depart from their current care, but is unable to do so because of non-clinical reasons, for example because the patient is awaiting a care package in their own home, or further non-acute care.

[305] Public Health England Local Health tool: http://www.localhealth.org.uk/. The analysis uses indirectly age-standardised ratios, which allow the data at a local level to be compared to those expected given the age structure of local populations. However caution should still be exercised when interpreting the data as numbers at a smaller geographies will be relatively low and confidence intervals will therefore be wide.

[306] *Reasons why people with dementia are admitted to a general hospital in an emergency* (National Mental Health Dementia and Neurology Intelligence Network, March 2015): http://www.yhpho.org.uk/resource/view.aspx?RID=207311

[307] Data in this section comes from Headway statistics (accessed December 2015): https://www.headway.org.uk/about-brain-injury/further-information/statistics/

[308] Calculation based on ONS population estimates for mid-2014.

In 2014/15 the average daily rate of delayed transfers of care within Oxfordshire was 27.5 people aged 18 and over per 100,000.[309] This was similar to the figure for the previous two years; it was down from 30.6 in 2011/12. It was significantly higher than the reported average rate for England, of 11.2 per 100,000 people.

In July 2015 Healthwatch published research into people's experiences of being discharged from hospital, focusing on older people, homeless people, and people with mental health conditions: http://www.healthwatch.co.uk/safely-home

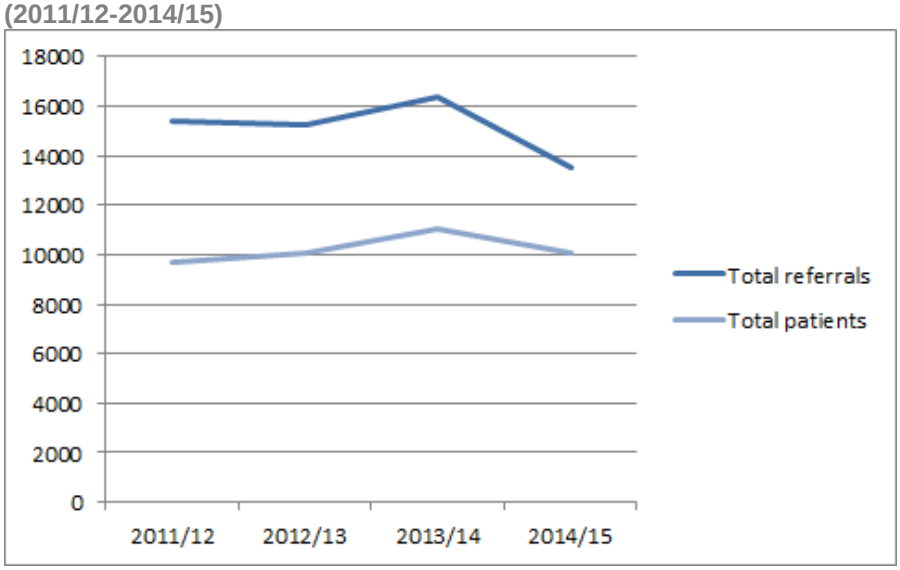
7.5. Mental Health Services

7.5.1. Oxford Health Mental Health Referrals

In 2014/15 slightly over 10,000 Oxfordshire residents were referred to Oxford Health mental health services and seen at least once.[310] This represents a fall of around a thousand since 2013/14, but is similar to the number in the previous two years.

Since some patients were referred more than once during the year, the number of referrals was around 13,500. This number is down on the previous three years.

Figure 120: Number of Oxfordshire residents referred to Oxford Health mental health services (2011/12-2014/15)



Source: Oxford Health

More female than male residents were referred, making up around 58% of the service users, compared with 42% male. This ratio has remained fairly stable over the last three years.

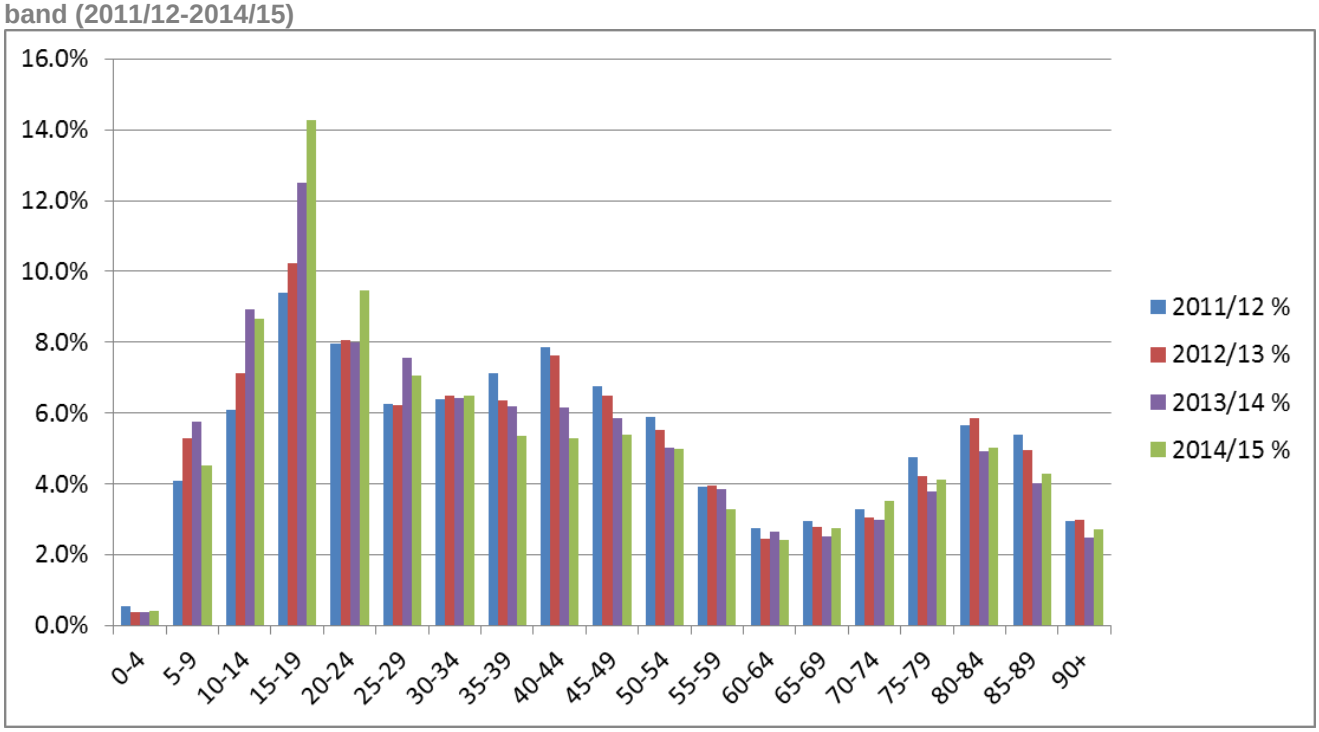
Nine in ten Oxfordshire service users for whom ethnicity data have been recorded were from White British or Irish Backgrounds (90%). Around 4% were from other White backgrounds, 2% were from Mixed ethnic backgrounds, 1% were from Asian or Asian British backgrounds, and 1% were from Black or Black British backgrounds.[311] Again, these proportions have remained fairly stable over the last three years.

[309] NHS Delayed Transfers of Care Statistics: http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
[310] Data in this section has been provided by Oxford Health
[311] NB in this dataset the figure for Asian or Asian British service users does not include people from Chinese backgrounds.

Using population data from the 2011 census, it can be seen that there were higher rates of service use among people from White British and Mixed backgrounds (11-12 service users per 1,000 people from these backgrounds in the population). There were lower rates of service use among people from other White backgrounds (7-8 service users per 1,000 population), Black or Black British backgrounds (6-7 service users per 1,000 population), and Asian or Asian British backgrounds (3-4 service users per 1,000 population).

The 15-19 age group continued to make up the largest proportion of referrals to Oxford Health mental health services in 2014/15. This proportion has been growing in recent years. In general, there has been a shift from older to younger service users, as shown in the chart below.

Figure 121: Oxford Health mental health referrals for Oxfordshire residents, % in each age band (2011/12-2014/15)



Source: Oxford Health

Almost half of the referrals were for Oxfordshire Adult Mental Health Services (47%). Just under a quarter were for Oxfordshire Children and Adolescent Mental Health Services (23%) and one in five were to the Oxfordshire Older Adult Mental Health Services (20%). Significant minorities of referrals were for Oxfordshire Psychological Services (7%) and Eating Disorders Oxfordshire (2%). The remaining referrals were to other mental health services. As would be expected from the changing age profile of service users, the proportion of referrals to the Children and Adolescent Mental Health Services has grown slightly in recent years.

7.5.2. Oxfordshire Mind Wellbeing Service

The Wellbeing Service delivered by Oxfordshire Mind supports the residents of Oxfordshire presenting with a broad range of common mental health and emotional problems.[312]

The Wellbeing Service is open to any one aged 16 or older and acts as a portal for information about mental health services in Oxfordshire. It provides advice, options, signposting, supported onward referrals and appropriate evidence based wellbeing interventions.

[312] More information on the service is available http://www.oxfordshiremind.org.uk/about-us/

In 2014/15 the Wellbeing Service supported 1,914 unique (existing and new) individuals with a range of interventions, including information services and options; educational courses and open peer support groups.[313]

Through its activities the Wellbeing Service reached:[314]

- 8,000 residents through county wider Public Wellbeing events and activities
- 2,000 residents through provision of mental health information and options
- 1,914 residents in educational and coping skills courses, peer support groups and one-to-one support

Of the total individuals accessing the Wellbeing Service in 2014/15, a third (33%) were from Cherwell and West Oxfordshire, whilst 31% were from South Oxfordshire and 31% were from Oxford City. (For 5% the area of residence was unknown).

Within the Wellbeing Service, 58% of service users in 2014/15 were women and 42% were men.

Between April 2014 and March 2015, of those individuals supported, 135 (7%) were in age range 16-24, 1,416 (74%) were in age range 25-59, and 363 (19%) were aged 60 and over.

The ethnicity of individuals using the Wellbeing Service in 2014/15 was predominantly White British (72%). 20% were from non-white British, European, mixed, Chinese, and other ethnic backgrounds , with 8% of individuals preferring not to say.

In addition in 2014/15:

- 200 residents took up a sport or a physical activity as part of joint work between Oxfordshire Mind and the Oxfordshire Sports Partnership
- 688 residents were supported by the 'Benefits for Better Mental Health' project,
- 300 residents were reached through workshops for employers and other community groups
- 120 new volunteers were trained, including 28 'peer support' volunteers who completed our specialist 25-hour training programme

7.5.3. TalkingSpace Oxfordshire

TalkingSpace is a service co-delivered by Oxfordshire Mind and Oxford Health NHS Foundation Trust, which offers a range of psychological (talking) therapies for the treatment of common mental health depression and anxiety. It follows a stepped care approach according to the need of the patient.

TalkingSpace offers evidence-based treatments at Step 2, including short courses, groups to treat insomnia, computerised Cognitive Behavioural Therapy and self-help with guidance from a member of the team. Treatments at Step 3 include group CBT, mindfulness groups and individual therapy.[315]

In 2014/15 the service received 9,000 referrals.[316] It helped support 4,800 patients within Step 2 services, achieving 55% recovery rates, which is above the national average.

[313] Data provided by Oxfordshire Mind.
[314] Oxfordshire Mind Annual Review, 2014/15 http://www.oxfordshiremind.org.uk/about-us/annual-review/
[315] More information is available: http://www.talkingspaceoxfordshire.org/contact-us/
[316] Data provided by Oxfordshire Mind.

7.5.4. Psychological Therapies

In 2014/15 there were 12,045 referrals for psychological therapy services commissioned by the Oxfordshire Clinical Commissioning Group.[317] 8,140 referrals entered treatment, meaning that they had a first treatment appointment in the year (but may have been referred in the previous year). 5,125 referrals finished a course of treatment in the year (following at least two treatment appointments. Again, the referral and appointments may have happened in previous time periods). 60.1% of these showed a reliable improvement, similar to the national average of 60.8%.

Women were over twice as likely as men to use psychological therapy services. Around 2.5% were gay/ lesbian (1.5%) or bisexual (1%).

7.5.5. Child Hospital Admissions for Mental Health

In 2013/14 there were 67 children aged 0-17 in Oxfordshire who were admitted to hospital for mental health conditions.[318] This represents a rate of 47.8 per 100,000 children aged 0-17. The rate has remained broadly similar over the four years from 2010/11, and remains significantly lower than the averages for England (87.2) and the South East (96.1).

7.6. Drug and Alcohol Treatment Services

In 2014/15 there were around 1,800 adults (aged 18 and over) in drug and/ or alcohol treatment in Oxfordshire.[319] The number in treatment for alcohol only was 433, most of whom are considered to be high risk drinkers.

In 2014/15 the number of young people (aged under 18 years) in specialist substance misuse services in Oxfordshire was 58. Most of these (48) started specialist treatment on or after 1 April 2015. Of these:

- 42 began using their main substance before they reached 15 years of age
- 34 were using more than one substance
- 14 reported being affected by others' substance misuse.

Referrals were predominantly from education services, children and family services, or self-referred (including referrals by family and friends).

7.7. Social Care

7.7.1. Adult Social Care

Short-Term Adult Social Care

Older people are the primary users of short-term adult social care services. The figure below shows their use of short-term services in Oxfordshire during 2014/15. The numbers relate to episodes, or contacts, rather than unique individuals: individuals may have accessed multiple services, and may have accessed them more than once. [320]

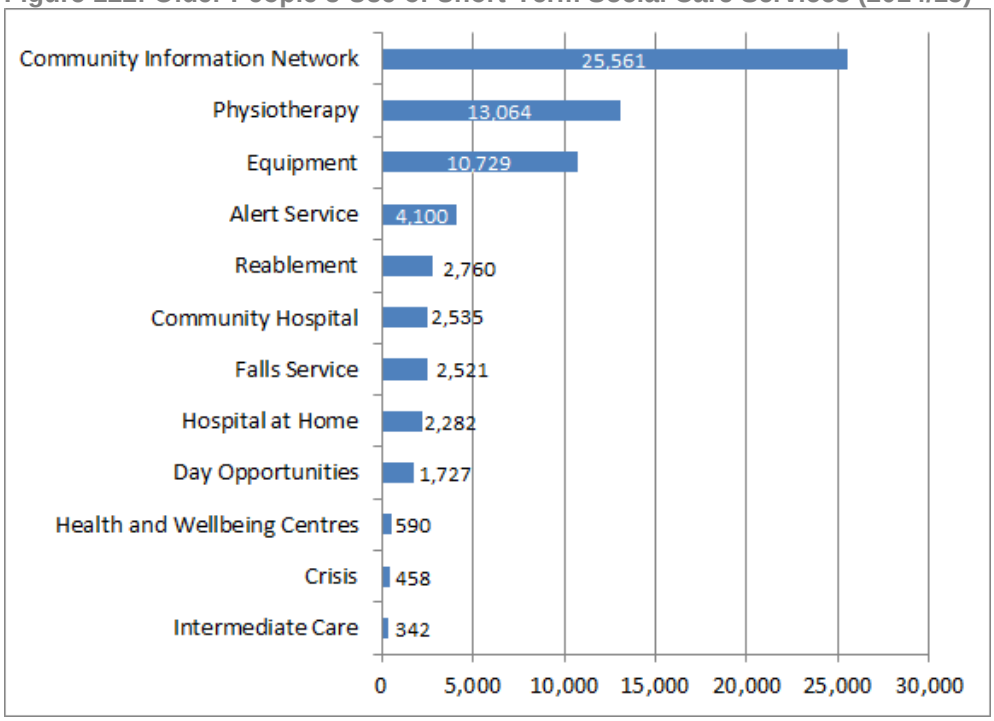
[317] Psychological Therapies, Annual Report on the use of IAPT services – England, 2014-15: http://www.hscic.gov.uk/catalogue/PUB19098

[318] Public Health England's Children and Young People's Health Benchmarking Tool: http://fingertips.phe.org.uk/profile/cyphof

[319] Data in this section come from the National Drug Treatment Monitoring System, and have been provided to Oxfordshire County Council by Public Health England.

[320] Oxfordshire County Council data

Figure 122: Older People's Use of Short-Term Social Care Services (2014/15)



Source: Oxfordshire County Council

'Reablement' is a social care service aimed at supporting people to regain independence that may have been reduced or lost through illness or disability. Guidance from the Department of Health states that a medium-performing reablement service would see between 2-5% of its older population in reablement, and a high performing service over 5%. It is expected that 50% of these would come from hospital and 50% from their own home.

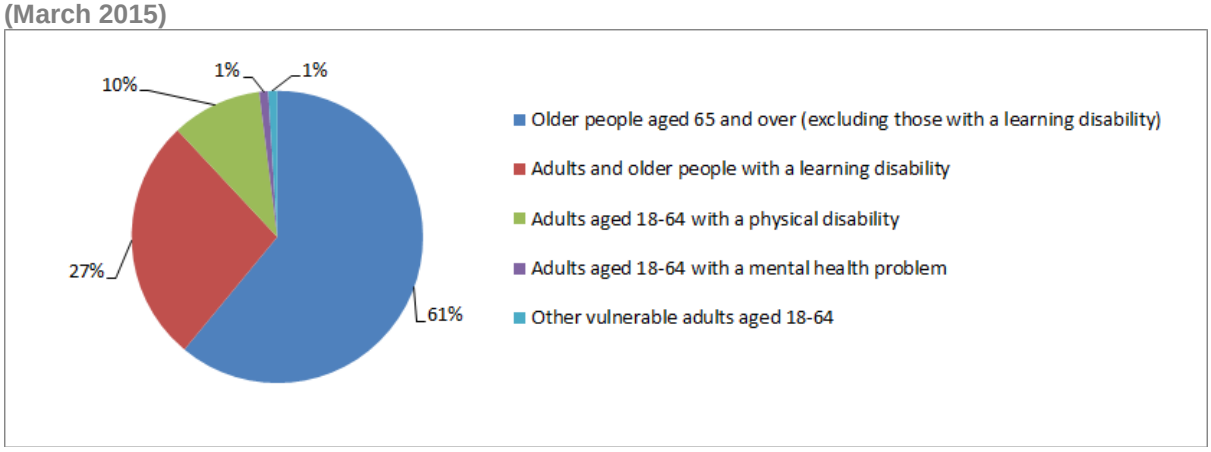
On this basis, a medium-performing reablement service in Oxfordshire could be expected to support just over 4,000 people aged 65 and over, and a high-performing service would support around 6,000 people. As can be seen from the chart above, Oxfordshire's reablement service supports fewer older people than this. However, the number of older people offered reablement services following discharge from *hospital* is similar to what would be expected for a medium-performing service, and reflects national rates. Therefore, the difference relates primarily to older people being offered reablement services from *home*.

Long-Term Adult Social Care

At the end of March 2015 there were 6,494 adults in Oxfordshire receiving long-term social care funded by the county council.[321] A breakdown by client group is presented in the figure below. This shows that the majority of Oxfordshire's social care clients are older people, aged 65 and over.

[321] Oxfordshire County Council data

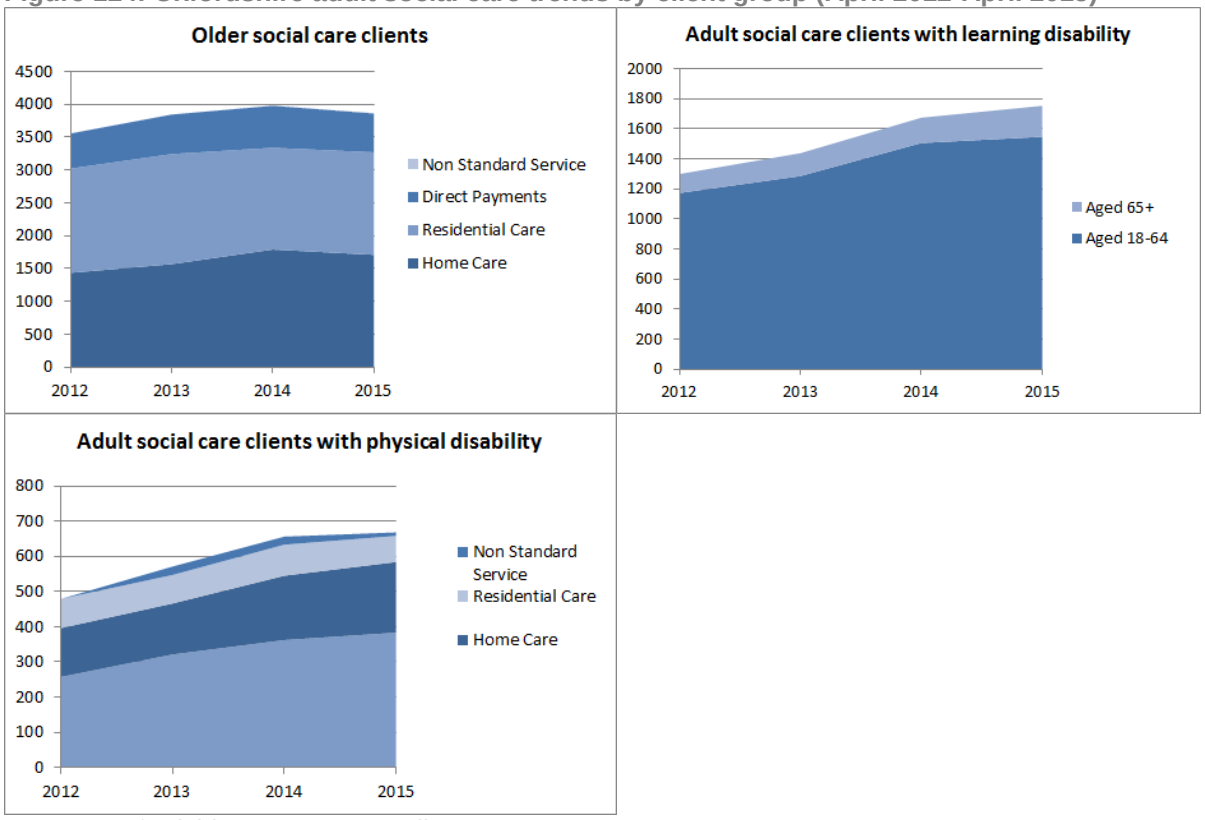
Figure 123: Recipients of local authority funded, long-term, adult social care in Oxfordshire (March 2015)



Source: Oxfordshire County Council

The figures below show trends in the number of social care clients being supported by Oxfordshire County Council as of 1st April in each of the past four years.

Figure 124: Oxfordshire adult social care trends by client group (April 2012-April 2015)



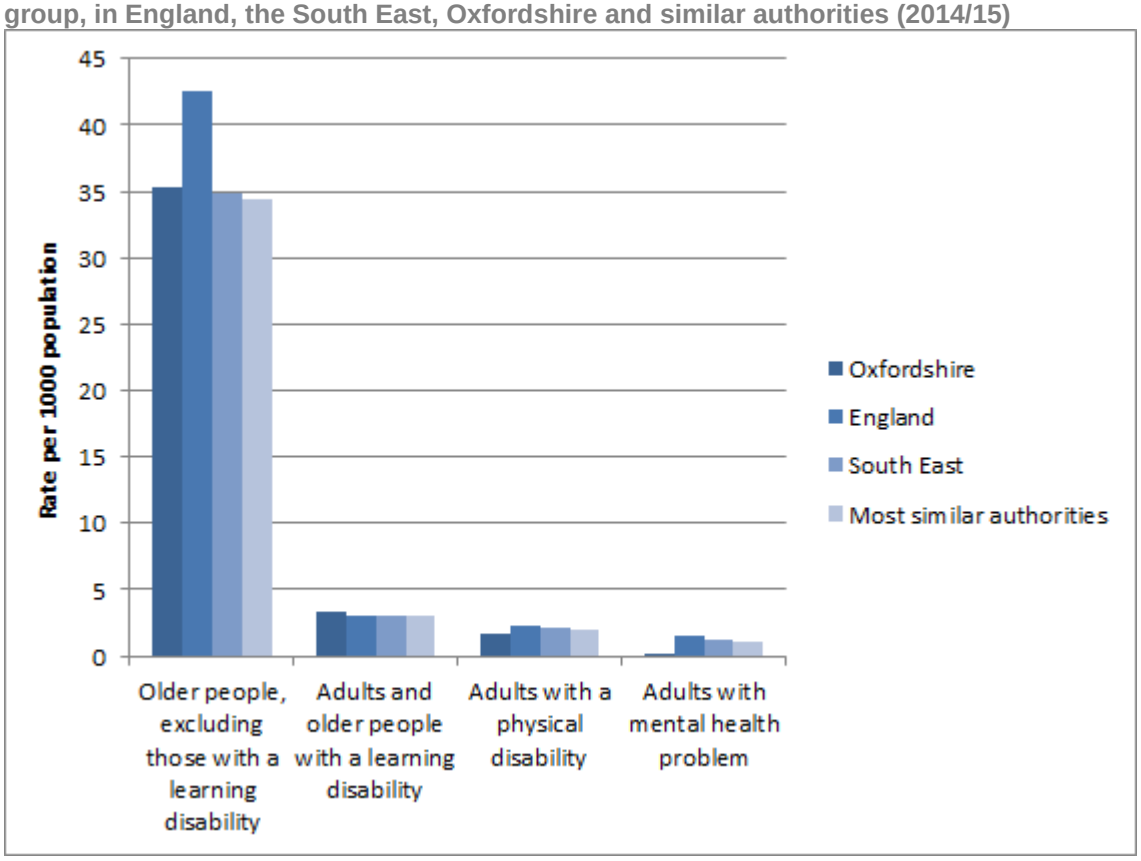
Source: Oxfordshire County Council

The chart below compares rates of local authority funded, long-term adult social care provision in Oxfordshire with the national and regional averages, and a group of the most similar local authorities (our 'statistical neighbours')[322]

[322] The set of local authorities that are Oxfordshire's statistical neighbour authorities for adult social care are: Buckinghamshire, Cambridgeshire, Essex, Gloucestershire, Hampshire, Hertfordshire, Leicestershire, North Yorkshire, Northamptonshire, Somerset, Suffolk, Surrey, Warwickshire, West Sussex, and Worcestershire.

It is important to keep in mind that the way long-term versus short-term support is defined may vary by local authority: support that is considered short-term in Oxfordshire may be classed as long-term elsewhere.

Figure 125: Rates of local authority funded, long-term, adult social care provision, by client group, in England, the South East, Oxfordshire and similar authorities (2014/15)

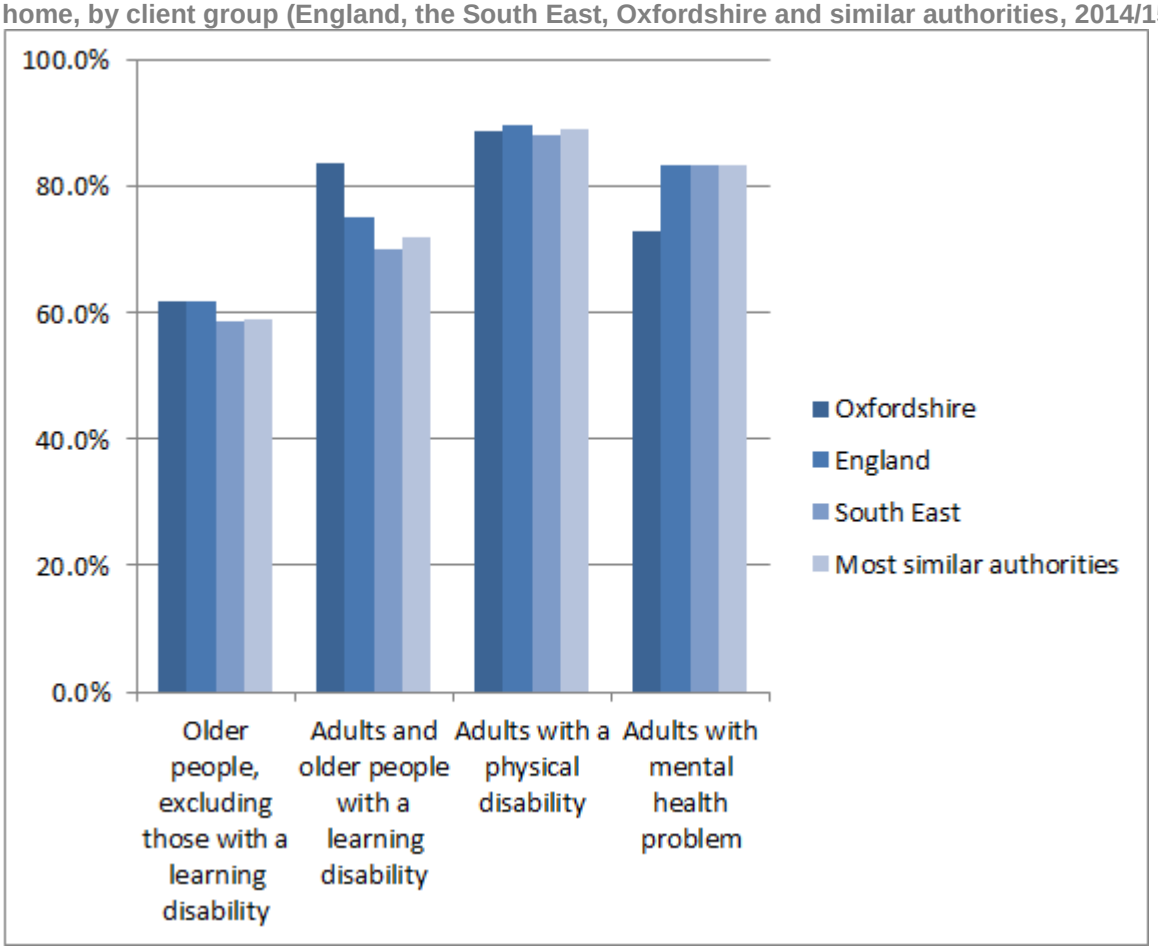


Source: Oxfordshire County Council

The majority of adult social care users are supported at home rather than in a care home. The chart below compares the proportion of adult social care clients in Oxfordshire who are supported at home against national and regional averages, and our statistical neighbours.

Again, it is important to keep in mind that the way long-term versus short-term support is defined may vary by local authority: at-home support that is considered short-term in Oxfordshire may be classed as long-term elsewhere. This may particularly affect the data for clients with physical disabilities and mental health conditions.

Figure 126: Proportion of local authority funded, long-term, adult social care that is provided at home, by client group (England, the South East, Oxfordshire and similar authorities, 2014/15)



Source: Oxfordshire County Council

Adult Social Care Outcomes

For the last five years councils have surveyed users of social care aged 18 and over as part of a national survey.[323] The survey is run each February for people receiving social care funded wholly or in part by councils in the previous September. Its purpose is to learn more about whether or not the services are helping them to live safely and independently in their own home, and to understand the impact on their quality of life. In the 2014/15 survey, 513 adult social care users in Oxfordshire responded.

The headline measure produced by the survey is an overarching view of the 'quality of life for users of social care'. This is a composite measure of eight questions in the survey. The measure identifies whether, after care has been provided, people still have needs in any of the following areas: control over their daily life; being clean and presentable; having enough food and drink; having a clean and comfortable home; feeling safe; having adequate social contact; spending time as they wish and being treated with dignity. In 2014/15, social care-related quality of life in Oxfordshire remained at a similar level to the previous four years. It also remained above the national average, with Oxfordshire ranking 57th of 152 local authorities in England on this measure.

Further analysis of survey responses suggests that Oxfordshire's relatively high quality of life score may be driven by social care users feeling they have control over their lives, feeling safe, and feeling that they have enough social contact.

[323] Adult Social Care User Survey: http://www.hscic.gov.uk/socialcare/usersurveys

In 2014/15, the proportion of care users who were very satisfied with their care and support was 60.6% (although, overall, 90% reported being satisfied). This was down slightly on previous years' results (64.5% in 2013/14 and 62.7% in the two years before that). It was also below the national average, with Oxfordshire ranking 118th of 152 local authorities in England.

The national outcome framework for adult social care brings together data from the adult social care survey and other sources to measure the overall performance of the adult social care system.[324] Oxfordshire performs above average on 74% of the measures in the framework.

To explore the data on adult social care outcomes, visit the interactive health story on Oxfordshire Insight.

Adult Social Care, Sexual Orientation and Gender Identity

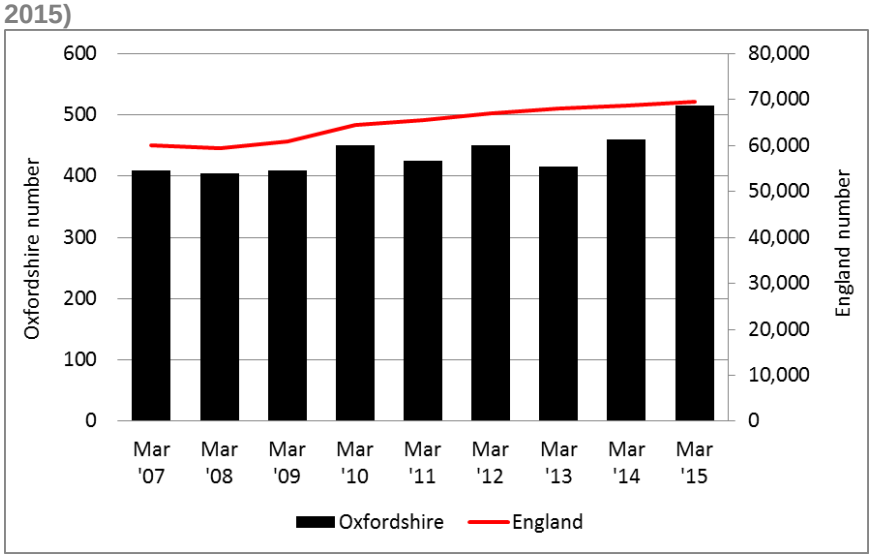
National research has been conducted with adult social care users who are lesbian, gay, bisexual and trans (LGB&T), and their carers.[325] This suggests that these groups may have distinct needs, for example they may be more at risk of social isolation and loneliness; and they may face distinct issues, including discrimination. However, the data on sexual orientation and gender identity of the social care community is currently limited.

7.7.2. Children's Social Care

Looked After Children

As of the end of March 2015 there were 515 children in Oxfordshire who were in care (also known as 'looked after children').[326] The rate of looked after children in Oxfordshire remains below the national average and our statistical neighbours but the number of cases has generally been rising over recent years.

Figure 127: Numbers of looked after children in England and Oxfordshire (March 2007 – March 2015)



Source: Department for Education

[324] Adult Social Care Outcomes Framework: http://www.hscic.gov.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF

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

[326] Department for Education statistics on looked after children (accessed November 2015): https://www.gov.uk/government/collections/statistics-looked-after-children; supporting data provided by Oxfordshire County Council

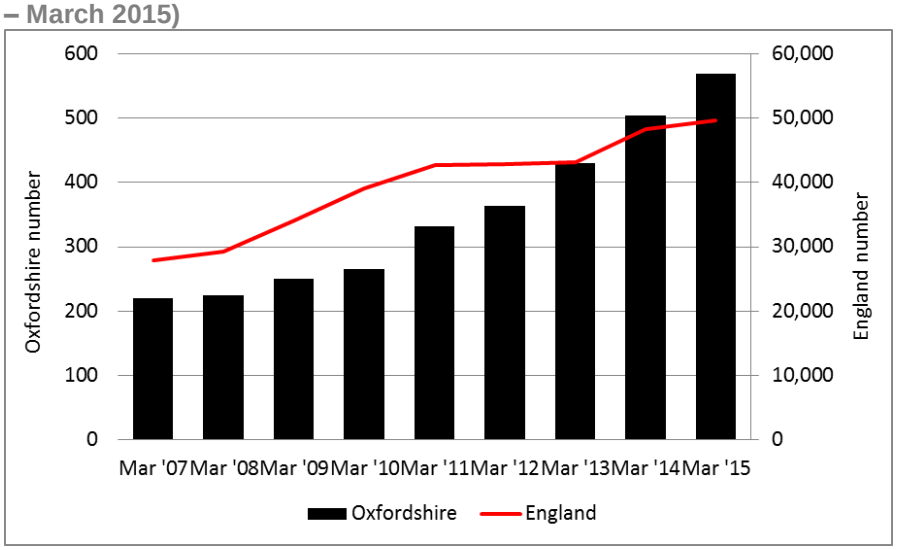
In a Survey of Looked After Children in December 2013, 85% stated that they were happy with their social workers.[327] Further feedback from children and young people has suggested that transition planning and management at key transition points is not always smooth, particularly between children and adult social care and health services, at admission or discharge from hospital, and from primary to secondary school. It was emphasised that communication between professionals and across organisations at transition points is key.

Child Protection Plans

As of the end of March 2015 there were 569 children in Oxfordshire who were the subject of a child protection plan.[328] In slightly over half of cases (56%) this was because of neglect.

Overall, the rate of children on protection plans has tended to be lower locally than nationally but above most of our statistical neighbours. However, the number of children on protection plans in Oxfordshire has been rising in recent years, and it has been rising at a faster rate than in England overall. The biggest increase in the number of protection plans has been among older girls.

Figure 128: Numbers of children on protection plans in England and Oxfordshire (March 2007 – March 2015)



Source: Department for Education

The increase in the number of children on protection plans in Oxfordshire is in line with other areas that have experienced high profile cases of child sexual exploitation. Likewise, other authorities judged 'good' by Ofsted have tended to see a bigger rise in children on protection plans than the national average.

Factors such as parental mental health, drug abuse or domestic violence increase the risk of children becoming subject to a child protection plan.

Care Leavers

Young people leaving care tend to be particularly vulnerable to poor health and wellbeing. For example, national research shows that they are at greater risk of social exclusion, unemployment, health problems, and offending.[329]

[327] Data provided by Oxfordshire County Council's Joint Commissioning Team

[328] Department for Education statistics on children in need and child protection (accessed November 2015): https://www.gov.uk/government/collections/statistics-children-in-need; supporting data provided by Oxfordshire County Council

[329] See, for example, Care leavers' transitions to adulthood: https://www.nao.org.uk/report/care-leavers-transitions-to-adulthood/; *Finding Their Feet: Equipping care leavers to reach their potential*

7.8. Transport Services

Patients with eligible medical needs may access NHS-funded Non-Emergency Patient Transport Service (NEPTS) for non-emergency journeys to and from hospital or acute community healthcare.

During the 2014/15 financial year 102,991 NHS-funded journeys were booked for patients registered with a GP in the Oxfordshire Clinical Commissioning Group area. This represents a reduction from 110,260 in 2013/14. Locally agreed criteria for eligibility have been applied since November 2014.

Patients who are ineligible for NEPTS are signposted to community transport services, provided by voluntary and community organisations. (Alternatively, patients may be able to have their travel costs reimbursed under the NHS Healthcare Travel Cost Scheme; informal lift sharing is also thought to be very common.)
Community transport plays an ever increasing role in transporting people to and from hospitals and other health-related appointments. There has been a slight increase in the number of volunteer car schemes in the county over the past year, from 47 to 49 schemes. They vary in size dramatically, some with 4 volunteer drivers, to others with 50 or more volunteer drivers. There are around 1,100 volunteer car drivers in total and they carry out 59,000 single journeys per year, most of which are health-related. The number of journeys to hospitals has increased, and transport for regular 'wellbeing' appointments has also increased.

Community First Oxfordshire (CFO) provide OCTA badges (hospital parking permits agreed with Oxford University Hospitals NHS Foundation Trust - OUH), which allow volunteers to park in delegated spaces at OUH sites. To evidence the need for OCTA badge spaces, CFO found that the seven main car schemes, between them, carry out 52 return journeys a week to the John Radcliffe hospital alone.

As Oxfordshire is relatively rural, and the subsidies for some bus routes are likely to be withdrawn,[330] it is expected that there will be greater need for community transport in the near future.

Demand for transport services may also be affected by the rural nature of Oxfordshire (see section 3.9: Rural Population and 4.9.3: Geographical Barriers) and the ageing population (see section 2.3.2: Age).

(The Centre for Social Justice, January 2015):
http://www.centreforsocialjustice.org.uk/publications/finding-their-feet

[330] See Oxfordshire County Council Cabinet decision of 10th November 2015:
https://consultations.oxfordshire.gov.uk/consult.ti/stconsultation/consultationHome?utm_source=FURL-1&utm_medium=stconsultation&utm_term=nil&utm_content=&utm_campaign=stconsultation

8. Conclusion

This report summarises key trends affecting the health and wellbeing needs of Oxfordshire's population. It is not intended to be exhaustive. The JSNA webpages on Oxfordshire Insight point users to further data and tools available. Meanwhile, the JSNA Publications Directory contains a number of related documents.

The JSNA summary report is expected to be refreshed annually each spring. However, data and publications will be added to the webpages on an on-going basis.

For any enquiries, suggestions or information about how to get involved with the JSNA development, please email the Research and Intelligence Team: JSNA@Oxfordshire.gov.uk.

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