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NHS Oxfordshire Clinical Commissioning Group | OXFORDSHIRE COUNTY COUNCIL | healthwatch Oxfordshire

To: Members of the Health Improvement Partnership Board

Notice of a Meeting of the Health Improvement Partnership Board

Thursday, 23 April 2015 at 2.00 pm

Town Hall, Oxford

Peter G. Clark
County Solicitor

16 April 2015

Contact Officer: ***Katie Read, Policy & Partnership Officer***
Tel: (01865) 328272; Email: katie.read@oxfordshire.gov.uk

Membership

Chairman – District Councillor Mark Booty
Vice Chairman - City Councillor Ed Turner

Board Members:

Ian Davies	Cherwell & South Northants District Council
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Voluntary Sector
Paul McGough	Public Involvement Network
Dr Jonathan McWilliam	Director of Public Health
Cllr Judith Nimmo Smith	South Oxfordshire District Council
Dr Paul Park	Oxfordshire Clinical Commissioning Group
Cllr G.A. Reynolds	Cherwell District Council
Aziza Shafique	Public Involvement Network
Cllr Alison Thomson	Vale of White Horse District Council
Jackie Wilderspin	Public Health Specialist

Notes:

- ***Date of next meeting: 2 July 2015***

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on (01865) 815270 or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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

AGENDA

1. Welcome by Chairman, District Councillor Mark Booty

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Minutes of Last Meeting (Pages 1 - 8)

2:05pm
5 minutes

To approve the minutes of the meeting held on 2 February 2015 and to receive information arising from them.

6. Public Involvement Network Final Report (Pages 9 - 18)

2:15pm
20 minutes

Report presented by: Paul McGough and Aziza Shafique, Public Involvement Network Representatives

A report to summarise the Public Involvement Network Representatives' perspective of their 18 month tenure in support of the Health Improvement Board, and the activities and work undertaken whilst in this role.

Verbal update from: Rachel Coney, Healthwatch Oxfordshire

A verbal update to the Health Improvement Board on the recruitment of a Healthwatch Ambassador to be a lay representative on the Board.

7. Performance Report (Pages 19 - 48)

2:35pm
45 minutes

People responsible: Members of the Health Improvement Board

Performance Report presented by: Jonathan McWilliam, Oxfordshire County Council

Immunisation Report Card presented by: Sally Bradshaw, NHS England

Treatment of Opiate and Non-opiate Users Report Card presented by: Jackie Wilderspin and Jo Melling, Oxfordshire County Council

Annual Report on the Basket of Housing and Health Indicators presented by: Dave Scholes, Oxford City Council

A report on progress against the targets of the Health Improvement Board, to include two report cards on immunisation and the treatment of opiate and non-opiate drug users, and an annual report on the housing indicators under priority 10 including suggested revisions to housing indicators for the year ahead.

8. Health Improvement Board Priorities 2015-16 (Pages 49 - 160)

3:20pm
15 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jackie Wilderspin, Oxfordshire County Council

Background Paper: Oxfordshire Joint Strategic Needs Assessment Annual Summary Report, March 2015

A discussion paper to set the context for deciding the Health Improvement Board priorities for 2015-16.

9. Domestic Abuse Support Services Review

3:35pm
10 minutes

Verbal update from: Natalia Lachkou, Oxfordshire County Council

A verbal update to the Health Improvement Board on the review of domestic abuse support services.

10. Oral Health Promotion Update (Pages 161 - 170)

3:45pm
10 minutes

Report presented by: Eunan O'Neill, Oxfordshire County Council

A report to update the Health Improvement Board on the oral health of Oxfordshire's local population and to outline the statutory responsibilities of the County Council in relation to oral health.

11. Oxford University Hospitals Trust and Oxfordshire County Council Joint Public Health Strategy (Pages 171 - 180)

3:55pm
10 minutes

Report presented by: Andrew Stevens and Behrooz Behbod, Oxford University Hospitals NHS Trust.

A report to update the Health Improvement Board on progress achieved against the Joint Public Health Strategy Action Plan for 2014/15, and to set out priorities for 2015/16.

The Health Improvement Board is recommended to approve the public health priorities for 2015/16 and note the 2014/15 annual report.

12. Health Improvement Board Terms of Reference (Pages 181 - 182)

4:05pm
5 minutes

Presented by: Jackie Wilderspin, Oxfordshire County Council

An update to the Health Improvement Board terms of reference, namely the membership of the Board.

13. Forward Plan (Pages 183 - 184)

4:10pm
5 minutes

Presented by: Councillor Mark Booty, Chairman

A discussion of the forward plan for the Health Improvement Board.

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HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Monday 2 February commencing at 1.00 pm and finishing at 4.00 pm.

Present:

Board Members:	Councillor Ed Turner (Vice Chairman), Oxford City Council – in the chair
	Councillor Hilary Hibbert-Biles, Oxfordshire County Council, Cabinet Member for Public Health & Voluntary Sector Councillor Alison Thomson, Vale of White Horse District Council Jackie Wilderspin, Public Health Specialist Dr Jonathan McWilliam, Director of Public Health Ian Bottomley, Oxfordshire Clinical Commissioning Group (substitution for Dr Paul Park) Ian Davies, Cherwell and South Northants District Council
Officers:	
Whole of meeting	Sophie Kendall, Oxfordshire County Council Katie Read, Oxfordshire County Council
Part of meeting Agenda item 7	Natalia Lachkou, Oxfordshire County Council
Agenda item 9	Eunan O'Neill, Oxfordshire County Council Stephen Pinel, Oxfordshire County Council Paula Jackson, NHS England David Munday, NHS England
Agenda Items 9 & 11	Kate Eveleigh, Oxfordshire County Council
Agenda Item 11	Dale Hoyland, Affordable Warmth Network
Agenda item 12	Shaibur Rahman, Oxford City Council

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

If you have a query please contact Katie Read (Tel 01865 328272; Email: katie.read@oxfordshire.gov.uk)

ITEM	ACTION
1. Welcome The Vice-Chairman, City Councillor Ed Turner, welcomed all to the meeting.	
2. Apologies for Absence and Temporary Appointments Apologies have been received from: Councillor Mark Booty, Councillor George Reynolds, Councillor Judith Nimmo-Smith, Aziza Shafique, Paul McGough, Val Johnson. Ian Bottomley was present as substitute for Dr Paul Park, Oxfordshire Clinical Commissioning Group.	
3. Declaration of Interest No declarations were received.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Minutes of 25 September Meeting The minutes of the September meeting were approved.	
6. Minutes of Last Meeting The minutes of the September meeting were approved.	
7. Housing Related Support Update Natalia Lachkou introduced a report on the progress of implementing changes to housing related support services. Oxfordshire's Health and Wellbeing Board and Oxfordshire County Council's Cabinet considered suggestions at their latest meetings and approved the plan. This decision will be made formal on 4th February if there are no objections. New short term (11-12 months) contracts will be signed in February to cover the period 2015-16, whilst re-commissioning of the new pathway is underway, ready for April 2016. The Housing Support Advisory Group was asked to consider what indicators should be used to monitor the interim contracts. The Group reviewed the current basket of housing indicators, but wanted to see the shape of new services before making suggestions. **Suggestions for housing indicators are to be presented at the next Board meeting.** More detail was requested on the new contractual arrangements. **Natalia Lachkou will circulate this later in February, after new contracts have been signed.**	**NL/HSAG chairman** **NL**

The tabled housing performance data was discussed during this item: Jackie Wilderspin highlighted two new pieces of data under indicators 10.1 and 10.5; the number of households in temporary accommodation housed in bed and breakfast accommodation, and the number of people estimated to be sleeping rough. Concern was expressed at how high the result in West Oxfordshire is for households in temporary bed and breakfast accommodation, at 50% though the number of cases was still very low compared to other districts. **This figure will be queried with West Oxfordshire District Council for further explanation.** It was clarified that bed and breakfast figures cover accommodation with shared facilities, so the figures would not include "nightly charged" temporary accommodation. **Future performance reports should include a clarification of terms.**	**KR** **KR**
8. Public Involvement Network Update Jackie Wilderspin updated the Board on the status of the PIN representatives – their tenure is ending and their duties are transferring to Healthwatch. The Board is in a position to determine the roles and responsibilities of the new Healthwatch Ambassador representatives, including how many are invited to sit on the Board. The chair thanked Aziza Shafique and Paul McGough in their absence for their dedicated and highly productive contribution to the Board as PIN representatives, and proposed sending a letter of thanks on behalf of the Board. **A letter will be sent to the PIN representatives.**	**KR & MB**
9. Performance Report Jonathan McWilliam presented the performance report and preceded it with a reminder that expectations and targets were set high to push standards up. At 8.1 – the Board should recognise that the geographical area of the NHS area team has recently grown and it needs to ensure that Oxfordshire is receiving its fair share of resources. At 8.2 - The quarter 2 'actual' figure was corrected from 6.4% to 11.6%, making the RAG rating green. **A report card on opiate and non-opiate users (8.5 & 8.6) was requested for the Board's next meeting.** At 9.3 – The source of the data for Didcot at 9.3 is to be further understood before quoting again**. An email update is to be sent to the Board if necessary.**	**JW** **JW**

Ed Turner reported that Oxford City Council has embraced breastfeeding at their public facilities and they are looking into encouraging food establishments to support breastfeeding on their premises through environmental health inspections. He requested **an update on what all members have done and plan to do to encourage breastfeeding.**	**District councillors /KR**
At 11 – Immunisation activities are still part of the remit of the larger NHS area team. There was discussion about reduced uptake of MMR immunisations and **a report card on immunisation was requested for the Board's next meeting.**	**PJ**
The Board agreed that **a letter should to be sent to NHS England about addressing the falling immunisation numbers in Oxfordshire.**	**JMc**
Paula Jackson provided a short update on immunisation activities. NHS England is looking to commission a small number of outreach immunisation nurses per practice to address the remaining small percentage who are not being successfully immunised. <u>Report card 1 – NHS Health Checks</u> Eunan O'Neill and Stephen Pinel expanded on the report card. Referring to invitations sent, there are now only three providers who have not yet sent official invitations to clients, rather than the six reported. **Cllr Hibbert-Biles requested for detail to be sent to her on those three providers.**	**SP**
Eunan O'Neill reported that management of the Health checks contract has improved - Stephen Pinel has already done the following: • started discussions with providers about sharing resources, • created performance dashboards to display missed opportunities for individual providers, and • undertaken a number of quality assurance activities. Although it was recognised that GPs are under pressure, a tougher contract management approach was recommended to drive up results. <u>Report card 2 – Bowel screening</u> David Mundy and Paula Jackson presented the report card. Oxfordshire has better rates of uptake for bowel screening than the national average – between 3,000 and 4,000 postal tests are sent to patients each month. David Mundy expanded on the actions and initiatives currently	

underway to raise awareness of bowel screening and encourage uptake, including work with GPs, BME communities and new trials. Paula Jackson advised that the area team is waiting for the new, simpler 'Fit test' to be signed off nationally before it can be rolled out locally. The Board discussed the difficulties of engaging the relevant section of the population about bowel screening, particularly men aged 60 or older. There is no prominent national campaign or publicity on bowel screening because of the legal implications of 'informed choice'. It was suggested that older people's groups known to district authorities could be used to promote screening and provisions could be included in mental health contracts. **Paula Jackson and her team to make suggestions to the Public Health Protection Forum about how they can best contribute to activities that will help increase the uptake of bowel screening.** <u>Report card 3 – Smoking cessation</u> The report card was presented by Kate Eveleigh who explained that a new provider of smoking cessation services will be in place from 1 April 2015 and the drop off in quit rates is reflected nationally, not just locally.	**PJ**
10. Draft Alcohol and Drugs Partnership Strategy Jackie Wilderspin introduced the strategy. The strategy is a statutory requirement for the Safer Communities Partnership, but is also to be governed through the Health Improvement Board. An assessment of need highlighted that alcohol related hospital admissions are high in Oxfordshire and there is a high level of binge drinking in Oxford City. There is also a growing threat from legal highs and a high number who are starting treatment, but not completing it. The Children's Trust has been approached about monitoring the targets for children and young people in the strategy. Action planning has already started with partners; working groups will be developing plans and meeting once a year as a partnership. Reports will be presented to the Board on the progress of work. It was highlighted that there is an opportunity for overlap between mental health services and drug and alcohol services using Turning Point. There could also be opportunities to work with the licencing authority around prohibiting legal highs at festivals and other licensed events. <u>The Board agreed the strategy.</u>	

11. Fuel Poverty and Affordable Warmth Network Update Kate Eveleigh and Dale Hoyland presented the report explaining that the reported figures are high, but a high proportion were enquiries about increasing income from benefit entitlements. Dale Hoyland reported that encouraging take up of the Green Deal has been difficult because of people's resistance to taking on debt. This reflects the national picture. Locally a fuel poverty grant is held where small fixes are needed, amounting to a few hundred pounds per property. The need for district authorities to continue liaising with others was emphasised – particularly with GPs in terms of targeting relevant people.	
12. Making Every Adult Matter Pilot Progress Report Shaibur Rahman provided an update on the MEAM pilot, starting with a summary of the initiative and Oxfordshire's approach to it. He reported that support workers have found the 'MEAM status' is already opening doors and impacting on the flexibility of services. Shaibur confirmed that Turning Point have been involved in the project, as it is about identifying where services are seeing the same people and having a joined up approach to support. The pilot has been extended until August 2015. Shaibur confirmed that the MEAM status is retained by individuals if they 'disappear' and return later on. The Board welcomed the update and recognised the good work of the project so far.	
13. Public Health Campaigns Report Cllr Hibbert-Biles updated the Board on the major Public Health campaigns undertaken in 2014 and set out plans for campaigns in 2015-16. The Board discussed ways to join up campaigns. The Board acknowledged and supported the plans for public health campaigns in 2015-16.	
14. Forward Plan No items on the forward plan were discussed. From the meeting, the following items will be added: • **Report on revised housing indicators.**	**KR**

• **A performance report card on opiate and non-opiate users.** • **A performance report card on immunisation.**	
The meeting closed at 3.40pm	

..... in the Chair

Date of signing .....

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Health Improvement Partnership Board

Date of Meeting: Thursday 23rd April 2015

Title of Report:

Final Public Involvement Network Lay Representative Report

Is this paper for:	**Discussion**	**Decision**	**Information**
			X

Purpose of Report: To summarise Public Involvement Network Lay Representatives' perspective of their 18 month tenure, in support of the Health Improvement Board.

Action Required:

Consider in relation to new Healthwatch Oxfordshire Ambassador responsibilities and priorities.

Impact on users and carers:

Assure continued public representation on Health Improvement Board, public engagement, involvement, feedback and scrutiny across Oxfordshire health and social care priorities.

Author/s: Paul McGough and Aziza Shafique

Executive Summary:

This is not intended as comprehensive analysis – it is an overview of the main highlights and conclusions of Public Involvement Network Lay representatives', Aziza Shafique and Paul McGough, time supporting the Health Improvement Board – from end September 2013 until end March 2015. The paper is our personal independent view of the 18 month period. Not that of Healthwatch Oxfordshire or any other organisation.

During our induction we met Public Involvement Network Lay Representatives from the preceding year, plus the newly recruited peer Representatives from the Children and Young People's Partnership Board and the Adult Health and Social Care Partnership Board. Early on we met Healthwatch Oxfordshire colleagues too. It was a helpful and motivational introduction to our role. We attended our first Core Public Involvement Network Group meeting in October 2013, read many documents, discussed and defined our focus with County Council engagement officers in relation to the Board's priorities. By early December 2013 we had written and circulated our plan, setting out 6 one year goals:

1. Devise and deliver an effective Public engagement and involvement plan targeting Asian Community and focusing on Oxford University Hospital (OUH) Trust staff, members, patients and other priority groups.
2. Attend Public and Patient meetings and consultation forums
3. Build effective networks to seek views on specific Health Improvement Board priorities
4. Feedback Public views and themes to Health Improvement Board - and as appropriate to any partner organisations (Anonymously respecting Patient and Public confidentiality).
5. Develop core questions and questionnaire templates
6. Support Outcomes Based Commissioning approaches

Our remit was centred on the Health Improvement Board priorities – focusing on preventive health and wellbeing – however in view of the health and social care reform changes, we opportunistically drew on our related acute sector interaction and experience – as acute hospitals are in transition, shifting their emphasis towards more rapid assessment, diagnosis and community centred home based care and preventive health strategies.

The chart .1 below summarises our activities in priority areas covering these six goals. Our overview does not attempt to evaluate our contribution.

Chart 1

Health Improvement Board Priorities:	**Main Public Involvement Network - Plus associated activities:**
Priority 8: Preventing early death and improving quality of life in later years	**Asian Women's Group Project:** (refer to highlight section) **Outcomes Based Commissioning of services**, focusing on the new models of care – to address the challenges facing primary and community care; contributed to public engagement consultations on maternity services and new approaches to diabetes care. Sat on evaluation panel for Outcomes Based Commissioning Most Capable Provider selection for Older People services across Oxfordshire; took part in **Oxford University Hospitals Patient and Staff Peer review assurance programme** – focused on whether services are safe, effective, responsive caring and well led. Took part as trained member the Patient-Staff Peer review team. Also took part in **Healthwatch Oxfordshire Enter and View visits**, to gain insight into the patient hospital discharge process in acute and community hospitals. **Contributed to various locality Group and other consultations**. Working Group on Friends and Family Test system procurement, as well as participating in Public engagement with the **Academic Health Science network.** And took part in **NHS England Clinical Commissioning Group Assurance,** as Lay Leaders and Lay Advisory Panel members to Thames Valley Team Patient Strategy Group. **Workshop: Muslim Faith & Wellbeing Workshop 29th April 2014.** Led by Faith & Community elders. **Older People's Partnership Board Open Meeting June 3rd 2014** – presentation and working groups session with carers and people. **Public Forum consultation meeting:** Public, Patients and Carers to a discuss **dementia service awareness and mental health services in North Oxfordshire.** The North Oxfordshire Locality Group (Chipping Norton) 18th June 2014**.**

	National Workshop: - NHS England 'Improving Experience of Care Through People' 13th Nov 2014. **Workshop:** on **strategy to promote mental wellbeing** and prevent mental ill health in Oxfordshire. 27th Nov 2014 **Workshop: on Medicines Optimisation** (last meeting this morning 23rd April 2015) – about the safe and effective use of medicines to enable the best possible outcome. *(*Academic Health Science Network)
Priority 9: Preventing chronic disease through tackling obesity	**Workshop: Healthy Weight** to develop the action plan for the healthy weight strategy 2nd July 2014.
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness.	**In response to national budget cuts, and Oxfordshire County Council's proposed 38% budget cuts on Housing related support,** Public Involvement Network Lay representatives collaborated to produce a letter and paper to express public concern about potential impact. This was sent to the Oxfordshire County Council Director for Social and Community Services and Health Improvement Board and other stakeholders. The paper and subsequent correspondence highlighted the difficulties faced by vulnerable groups; people with disabilities and long term health issues – including mental health and wellbeing - and on the impact of housing support cuts, for example on people with learning disabilities and victims of domestic abuse. This initiative was lead by lay representative Marie Tidball from the Adult and Social Care Board, in close liaison Health Improvement Board lay representatives. The aim was to raise the profile of key issues and called for robust impact assessment of any cuts on at risk groups. **Workshop - Health Improvement Board - on Housing-Related Support Proposals**, attended on 29th May 2014. **Conference - attended on Domestic Abuse Awareness in the Community** 18th October 2014 Oxford pastors Forum - in partnership with Oxfordshire County Council Social Services, Thames Valley Police, NHS, Oxfordshire Safeguarding Board and various organisations that work

	with victims of domestic abuse.
Priority 11: Preventing infectious diseases through immunisation.	**Antibiotic microbial resistance Health Protection Research Unit research projects Working Group.** Patient and Public Involvement Group representative. (Research centres on whole genome and antibiotic resistance - not immunisation per se).

Highlights:

Much of our efforts centred on attending public meetings and making contributions to Clinical Commissioning Group Strategic and Locality Group forums, GP Patient Participation Group meetings, Public Involvement Network Core Group Bubbling up sessions, Health Improvement Board meetings and various workshops (see chart 1) to help understand public issues and themes, and to give ongoing feedback to the Health Improvement Board.

A particularly significant contribution was the Asian Women's Well-being research project. Researched and report written by Aziza Shafique and published June 2014.

The research was sponsored and supported by Healthwatch Oxfordshire and The Asian Women's Group, who decided that a research project engaging with Asian women - to probe their experiences and attitudes around three areas - access to GP services, domiciliary care, and mental health was a priority.

The research drew attention to the specific health risks and health needs of the Asian community and examined cultural barriers surrounding these three areas.

http://www.healthwatchoxfordshire.co.uk/sites/default/files/asian_womens_group_-_health_watch_final_report_19_9_14_rc_0.pdf

We focused for a period on NHS Healthcheck – in 40-74 year old men and women without pre-diagnosed medical conditions and upon their uptake of this free screening service and the barriers to update; amongst minority ethnic groups in Oxford City; Polish (mixed gender) and Asian men and women – engagement was carried out separately.

We were pleased to have been invited to contribute to the development of the OUH-OCC Joint Public Health plan and to start to see its implementation through the Public Health Steering Committee – and especially to see the innovative work that is happening in Oxford University Hospital and being planned for the wider community.

What we would have liked to have done:

Had we had the time and the resource – to ensure wider social engagement - and had there been more of us:

- **Street level** (Supermarket, Shopping precincts, coffee shops)
- Elderly Lunch clubs as a forum to seek views on Health and wellbeing matters
- **Local companies** (Corporate sector) including manual public services through to "blue chip" companies – i.e. to broadly reflect social groups
- **Key influencer organisations** (more with Faith Groups, Men's and Women's Groups and clubs - Oxfordshire Community Sports and Social clubs, and health activity promoting organisations)
- **Grass roots research** - working collaboratively with other organisations and health and social care professionals on specific intervention - collaborating with Community Dieticians targeting healthier eating cooking demonstrations – linked to healthy weight and exercise - particularly at risk ethnic minority groups.
- **Attend hobby / interest / community and home based activity events** to target predetermined age, gender and ethnic groups in health-social profile (refer to Aziza Shafique's work on how and where she engaged in different ways to reach out to Asian women, through the Asian Women's Group).

Biggest disappointments:

Public not being able to stave off planned cuts of £133K in 2016/17 on Domestic Abuse services budget - on a budget of £331K. We believe these costs will, in reality, not turn into real savings, but will be transferred and picked up by other parts of the social care, emergency services and health care system – we feel these savings are not savings, but merely regrettable cost shifts.

Not being able to take forward the issue of Asian community need to have an URDU speaking General practitioner in Oxford City (particularly for the elderly), plus greater access to other face-to-face language support (as oppose to remote translation services). This issue was seen to be outside of the remit of the Public Involvement Lay Representative per se, however we decided to take this forward independently ourselves. Meetings were held with NHS England and the relevant GP Practice and a commitment was made in June 2014 to run a workshop about Rose Hill Community centre GP practice possible development - to engage with the public about this. Nearly a year later this has not materialised nor followed through by commissioners.

Conclusions:

1. A key issue we identified early on was the scope of the role and the demands on the Public Involvement Lay Representative (a voluntary part time role suggested to be around 10 hours a week commitment). In relation to our ability to reach out across Oxfordshire in the defined Health Improvement Board priority areas, across a wide geographic region, with only two part time voluntary Lay

Representatives – this was, in reality, not possible. We did strive to attend meetings in Oxfordshire localities and take part in bubbling up and large group events – however we have to be upfront and declare that there were inherent limitations on the coverage and face to face public engagement and involvement opportunities we could create in the time available, with only two part time voluntary Lay reps.

2. That said, we felt energised and wholly committed – so we set our agenda, wrote and circulated our plan, and opportunistically targeted our time and own resources where we felt we could add some value and have impact - in consultation with County Council colleagues. We cannot claim it was representative of the Oxfordshire region, but it was based on the priorities set by the Health Improvement Board. We drove our own activity agenda with the four priorities and our six one year goals in mind. In practice we put many more hours in than 10 per week, to create public involvement and engagement opportunities. There were no tangible resources we could call upon - not even a display stand – we had to buy our own flip chart stand and paper for one meeting outside a mosque because no exhibition stand was available.

3. On the basis of our experiences and voluntary contributions over 18 months we believe it is important to reaffirm, from our perspective, the need to have independent appropriately supported Public representation on the Health Improvement Board. Maintaining 'arms length' independence was, we feel, essential to the success of the role; as it was also vital to have the support of Health Improvement Board members throughout our tenure. This was appreciated and helped us to keep going.

4. Occasionally it was a challenge to balance our Public Involvement Representative roles, to seek views and to scrutinise on behalf of the public whilst at the same time holding to an official corporate strategy. At a personal level we felt we were well supported by County Council engagement officers, particularly in our early months in post, as we navigated through some of these issues and the impact of national political decisions. Throughout we were well supported too by Healthwatch Oxfordshire and the County Council Public Health team. We too had some very positive collaboration with peer Public Involvement Network Representatives on the other partnership Boards – especially Adult Health and Social Care on the issue of Housing support.

5. We believe that coming from non-mainstream NHS or local government backgrounds made it easier for us to ask the questions the public were asking, or wanted us to ask, as their representatives. Aziza in particular was able to utilise her strong Asian community connections opportunistically and proactively diffuse health and social care system changes, on occasion. This was outside of the remit of the role, but sensible in the circumstances, to fill occasional communication void.

6. Whilst throughout we remained wholeheartedly committed to the Health Improvement Board's priorities, goals and ambitions, the general public and community were sometimes understandably at variance with the national decision to cut local government expenditure, due to its impact on health and social care budgets. In this regard, occasionally we felt the need to voice public concerns and not infrequently we found ourselves having to make it clear that we were not representing the Health Improvement Board itself when expressing opinions or highlighting issues to the public, or to other health or social care provider organisations. We sometimes had to identify 'which hat we were wearing'. We tried to be constructive and pragmatic to safeguard public interest where we could.

7. When we were in doubt about the extent of our remit in voicing public views and concerns, as well as taking advice from the engagement team - we took as our overriding guidance; 'The seven principles of public life' on how to view or role and how to act. (Appendix 1: The Committee on Standards in Public Life. January 2013, Fourteenth report Cm 8519.) These principles we feel remain fundamental and should be embedded in the new Healthwatch Ambassador role – as indeed in all public life roles – and be kept in mind at all times.

8. During the few occasions when there were complexities and differences of perspective, we appreciated the Board's understanding and acceptance of this dissonance, indeed we saw this as a 'litmus test' of the healthy Public-Professional partnership we felt existed on the Health Improvement Board.

9. We would like to independently state - as Public Involvement Network Lay Representatives that we felt we had sufficient freedom to fulfil our brief to the public and had the full support from the Board to do so. We couldn't change everything we wanted to, but we felt we had some influence on health and social care strategy focused on health improvement, as a result of feeding back Public views and contributing to performance reviews and other agenda items.

10. Finally we would like to say - time restriction was a major constraint, as were resources. We were self-motivated, largely self-supporting and self-sustaining volunteers who supported each other well, playing to each other's' strengths. In practice we gave up to two or three days of our time regularly each week for periods on Public Involvement Network (including associated related voluntary work). Going forward, wholly relying on such volunteers alone we believe would limit community outreach and public engagement and impact. We believe as well as the new Healthwatch post-holders having sufficient time and commitment - importantly sufficient budget will be required to take Public representation to the next level in the area of Health Improvement. This is the challenge for the CEO of Healthwatch Oxfordshire and County Council and Clinical Commissioning Group colleagues, to determine what vision, priorities, scope, requirements and importantly resources they can allocate to support the new Healthwatch

Ambassador roles, in order to take the role to the next higher level of Public Involvement and influence on decision making.

Acknowledgements:

We would like to formally thank the Board for embracing our commitment, for supporting our independence and our personal style and passion, in the way that Board members did. It was greatly appreciated by both of us, as was the support of Healthwatch Oxfordshire colleagues and Public Involvement Lay Representatives on the other Partnership Boards. Aziza and I enjoyed working together, supporting the Health Improvement Board. Indeed, it was a privilege for us to represent the public voice, to take an active part in the health and wellbeing improvement evaluations and scrutiny on a wide range of health improvement initiatives in Oxfordshire.

With best wishes and thanks to all our colleagues – it was a pleasure working together with you.

Paul McGough and Aziza Shafique April 23rd 2015

Public Involvement Network Lay Representatives Health Improvement Board.

APPENDIX 1.

The seven principles of Public Life*

- ***Selflessness***... 'act solely in terms of public interest...'
- ***Integrity*** *(in this particular context of the lay role and public life in general, we feel it legitimate and appropriate to broaden the word integrity to also mean 'Independence')*...This sits well with the stated principle ... 'freedom from obligation to people or organisations that might try inappropriately to influence them in their work...' For example to not allow political pressure to mute public voice, nor suppress public interest or public representation. (also refer to Openness)
- ***Objectivity***...'act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias...'
- ***Accountability***...'act and take decisions impartially, fairly, and on merit, using the best evidence and without discrimination and bias
- ***Openness***... 'act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.'
- ***Honesty***...'be truthful'
- ***Leadership***...'exhibit these behaviours in their own behaviour ...and actively promote and robustly support the principles and be willing to challenge poor behaviour when it occurs.'

*Standards Matter; A Review of Best practice in promoting good behaviour in public life; Committee on Standards in Public Life, January 2013, Fourteenth report Cm 8519.

Updated: 15th April 2015

Health Improvement Board
23rd April 2015

Q3 Performance Report

Background

1. The Health Improvement Board is expected to have oversight and of performance on four priorities within Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, and ensure appropriate action is taken by partner organisations to deliver the priorities and measures, on behalf of the Health and Wellbeing Board.

2. The four priorities the Board has responsibility for are:

   Priority 8: Preventing early death and improving quality of life in later years
   Priority 9: Preventing chronic disease through tackling obesity
   Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
   Priority 11: Preventing infectious disease through immunisation

Current Performance

3. A table showing the agreed measures under each priority, expected performance and current performance is attached as appendix A.

4. There are 5 indicators that are only reported on an annual basis and these will be reported in future reports following the release of the data.

5. For the 13 indicators that can be regularly reported on, current performance can be summarised as follows:

   4 indicators are Green.
   3 indicators are Amber (defined as within 5% of target).
   4 indicators are Red
   2 indicators does not yet have information available for Q3 – these are indicators 8.5 (opiate users successfully leaving treatment) and 8.6 (non-opiate users successfully leaving treatment). These indicators were both rated as Red at the end of Q2. These should be available for the next meeting.

6. Three of the indicators rated Red at the end of Q3 are within Priority 8. These are:
   a. 8.1 At least 60% of those (aged 60-74 years old) sent bowel screening packs will complete and return them. This had reduced slightly to 57.0% at the end of Q3.
   b. 8.3 At least 66% of those invited for NHS Health Checks (aged 40-74 years old) will attend. At the end of Q3 this figure was 48.3% and has been Red throughout the year. A report card relating to this indicator was discussed at the January meeting.
   c. 8.4 At least 3800 people will quit smoking for at least 4 weeks. At the end of Q3 this figure was 1633.
   d. 9.1 – Obesity level in Year 6 children is also rated Red. This was reported in the January report.

7. Report cards have been produced for indicators 8.5 and 8.6 – opiate and non-opiate users successfully leaving treatment as well as indicator 11.1 – at least 95% of children receive dose 1 of MMR.

   Alison Wallis
   Performance & Information Manager, Joint Commissioning
   15/04/2015

Updated: 15th April 2015

Oxfordshire Health and Wellbeing Board
Performance Report

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
Priority 8: Preventing early death and improving quality of life in later years											
8.1	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	**Expected** 60%		**Expected** 60%		**Expected** 60%		**Expected** 60%			Indicator was previously separated into 60-69 and 70-74 age groups, however from Q2 these are no longer reported separately. Q3 data updated
NHS England		**Actual**	R	**Actual** **57.3%**	A	**Actual** **57.0%**	R	**Actual**			
8.2	Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%	**Expected** 3.75%		**Expected** 7.5%		**Expected** 11.25%		**Expected** 15%		Q3 - All localities on target to achieve 15%. Only Oxford City and West localities at risk of not achieving the aspired 20%.	
OCC		**Actual** 5.4%	G	**Actual** 11.6%	G	**Actual** **16.9%**	G	**Actual**			
8.3	At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)	**Expected** 46%		**Expected** 50%		**Expected** 58%		**Expected** 66%		Q3 - Two CCG localities currently over 50% (West and North). All others below 50%. Lowest South East at 40.6%.	
OCC		**Actual** 41.5%	R	**Actual** 43.1%	R	**Actual** **48.3**	R	**Actual**			
8.4	At least 3800 people will quit smoking for at least 4 weeks (Baseline 3622 in 13/14) Baseline women smoking in	**Expected** 868	R	**Expected** 1672	R	**Expected** 2574	R	**Expected** 3800			Women smoking in pregnancy – 8%

OCC	pregnancy (%) – 9% (Q4 1314)	**Actual** 626 Women smoking in pregnancy – 8%		**Actual** 1133		**Actual** **1633**		**Actual**			
8.5	8.6% of opiate users successfully leaving treatment by the end of 14/15 (baseline 6.5% 2013/14)	**Expected** 7.0%	G	**Expected** 7.5%	R	**Expected** 8.0%		**Expected** 8.6%			The number of non-opiates users successfully completing treatment is below the set target. Through the introduction of the Public Health Outcome Framework the performance measure has changed from counting drug users safely supported in services to counting those who successfully complete treatment. Current performance is being addressed with a comprehensive recovery plan with Public Health England support to develop and implement system wide action plans.
OCC		**Actual** 7.1%		**Actual** 6.9%		**Actual** **nya**		**Actual**			
8.6	38.2% of non-opiate users successfully leaving treatment by the end of 14/15 (baseline 15.5% 2013/14)	**Expected** **21.2%**	R	**Expected** **26.9%**	R	**Expected** **32.6%**		**Expected** **38.2%**			
OCC		**Actual** 14.5%		**Actual** 17.7%		**Actual** nya		**Actual**			
Priority 9: Preventing chronic disease through tackling obesity											
9.1	Ensure that the obesity level in Year 6 children is held at no more than 15% and no district population should record more than 19% (Baseline 15.2% in 2013)			**Expected** 14.9% or less	R					Oxford City – 21% Is the only locality above 19%. South Oxfordshire has the lowest obesity level – 15.2%	
OCC				**Actual** **16.9%**							

9.2	Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 22.2% against 28.5% nationally, 2013-14 Active People Survey)							**Expected** **21.2%**			
District council								**Actual**			
9.3	63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual health visitor locality should have a rate of less than 50%	**Expected** 63%		**Expected** 63%		**Expected** 63%		**Expected** 63%		Q3. Banbury locality is 45.3%	
NHS England & CCG		**Actual** 60.3%	**A**	**Actual** 60.5%	**A**	**Actual** **59.7%**	**A**	**Actual**			

Updated: 15th April 2015

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness											
10.1 District Councils	The number of households in temporary accommodation as at 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire)							**Expected** 197 or less **Actual**			
10.2 OCC	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 83.9% in 13/14)	**Expected** 75% **Actual** 91%	G	**Expected** 75% **Actual** 91%	G	**Expected** 75% **Actual** **91%**	G	**Expected** 75% **Actual**		The majority of people receive a service from a county wide service which means it isn't possible to accurately provide data on a locality basis	
10.3 District Councils	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 81% in 2013- 2014 when there were 2837 households known to services)	**Expected** 80% **Actual** 82%	G	**Expected** 80% **Actual** 86%	G	**Expected** 80% **Actual** 84%	G	**Expected** 80% **Actual**		Varies from 80.7% in West Oxfordshire to 92.9% in South Oxfordshire	
10.4	Establish a baseline of the number of households in Oxfordshire who have received significant increases in the				G			**Expected** 550			Data provided is for Q1 and Q2 and has already exceeded the target set for the year.

Updated: 15th April 2015

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Affordable Warmth Network	energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners. It is hoped that an aspirational baseline target of 550 households will be reached			**Actual** 712				**Actual**			
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 74 in 2013-14							**Target** < 74			
District Councils								**Actual**			

Updated: 15th April 2015

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 11: Preventing infectious disease through immunisation											
11.1	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.8%) and no CCG locality should perform below 94%	**Expected** 95%	G	**Expected** 95%	A	**Expected** 95%	A	**Expected** 95%		Two localities fall below the expected 94% target - Oxford City 93.2% (an increase from 92.8% in Q1) South East 93.6%. Highest – West Oxfordshire – 96.7%	Indicator not rated Green as Oxford City is below the 94% threshold.
NHS England		**Actual** 95.2%		**Actual** 94.6%		**Actual** **95.2%**		**Actual**			
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 93.7%) and no CCG locality should perform below 94%	**Expected** 95%	R	**Expected** 95%	R	**Expected** 95%	A	**Expected** 95%		Only 2 localities (North East and South East) perform above the 94%. Lowest – Oxford City – 88.5%	
NHS England		**Actual** 92.6%		**Actual** 91.9		**Actual** **92.5%**		**Actual**			
11.3	At least 60% of people aged under 65 in "risk groups" receive flu vaccination (baseline 55% 13/14)							**Expected** 55%			
NHS England								**Actual**			
11.4	At least 90% of young women will receive both doses of HPV vaccination. (baseline to be confirmed)							**Expected** Over 90%			
NHS England								**Actual**			

Housing data collection, for performance reporting to Health Improvement Board in 2014-15

Regular Performance reporting – outcomes for 2014-15 on priority 10 in the Joint Health and Wellbeing Strategy 2014-16:
Tackling the broader determinants of health through better housing and preventing homelessness

Measure 10.1

10.1	The number of households in temporary accommodation on 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire in 2013-14) ***Responsible Organisation: District Councils*** **Proposal agreed:** **Separate out the number in bed and breakfast accommodation** **Six monthly instead of annually**	6-monthly Quarter 2 Quarter 4	Housing Support Advisory Group District representatives Collated by the Chairman of the Housing Support Advisory Group (rotates amongst Districts each year) Dave Scholes, Oxford City Council (via Katie Read)

Quarter: 4 Jan – March 15

Data:

		Cherwell	City	South	Vale	West	Total
1	The number of households in temporary accommodation	34	107	21	18	12	**192**
2	The number of households in temporary accommodation, housed in bed and breakfast accommodation	0	1	3	2	2	**8**

For 10.1 - bed and breakfast figures cover accommodation with shared facilities; therefore the figures would not include “nightly charged” temporary accommodation.

Measure 10.3

10.3	At least **80% of households** presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 81% in 2013 - 2014 when there were 2837 households known to services). ***Responsible Organisation: District Councils***	Quarterly	Housing Support Advisory Group District representatives Collated by the Chairman of HSAG Dave Scholes, Oxford City Council (via Katie Read)

Quarter 3: Oct – Dec 14

Data:

			Cherwell	City	South	Vale	West	Total
1 (E1)	Total number of applicant households who were homeless as defined by the Housing Act 1996, comprising the following categories	**A**	39	63	6	12	27	**147**
1a (E1,1)	Eligible, unintentionally homeless and in priority need		24	35	2	6	27	**94**
1b (E1,2)	Eligible, homeless and in priority need but intentionally so		6	19	1	5	0	**31**
1c (E1,3)	Eligible, homeless and not in priority need		9	9	3	1	0	**22**
2 (E,10,1)	Total number of cases where positive action was successful in preventing homelessness of which	**B**	189	306	79	83	113	**770**
	The Measure		82.9 %	82.9%	92.9%	87.4%	80.7%	**84.0%**

References are to P1E return
Outcome indicator is calculated by expressing B as a percentage of A + B

Measure 10.3

10.3	At least **80% of households** presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 81% in 2013 - 2014 when there were 2837 households known to services). ***Responsible Organisation: District Councils***	Quarterly	Housing Support Advisory Group District representatives Collated by the Chairman of HSAG Dave Scholes, Oxford City Council (via Katie Read)

Quarter 4: Jan - March 15

Data:

			Cherwell	City	South	Vale	West	Total
1 (E1)	Total number of applicant households who were homeless as defined by the Housing Act 1996, comprising the following categories	**A**	37	47	10	12	14	120
1a (E1,1)	Eligible, unintentionally homeless and in priority need		18	30	7	8	11	74
1b (E1,2)	Eligible, homeless and in priority need but intentionally so		10	9	3	1	3	26
1c (E1,3)	Eligible, homeless and not in priority need		9	8	0	2	0	19
2 (E,10,1)	Total number of cases where positive action was successful in preventing homelessness of which	**B**	Not yet available	333	65	94	20	
	The Measure		Not yet available	87.6%	86.7%	88.7%	58.8%	

References are to P1E return
Outcome indicator is calculated by expressing B as a percentage of A + B

Measure 10.5

10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2013-14 (baseline: 74) ***Responsible Organisation: District Councils***	Annually Quarter 3 (November)	Housing Support Advisory Group District representatives Collated by the Chairman of HSAG Dave Scholes, Oxford City Council (via Katie Read)

Quarter 3

Data:

		Cherwell	**City**	**South**	**Vale**	**West**	**Total**
1	The number of people estimated to be sleeping rough	14	Estimate 43 Count 26	3	5	3	68

For 10.5 - from November 2014, all Districts will report their November estimate (according to the methodology set out by Homeless Link – so Oxford City will do an estimate according to this methodology, as well as their count).

Oxfordshire Health and Wellbeing Board
Detailed performance report – April 2015

1. Details

Strategic Priority: *Preventing infectious disease through immunisation*

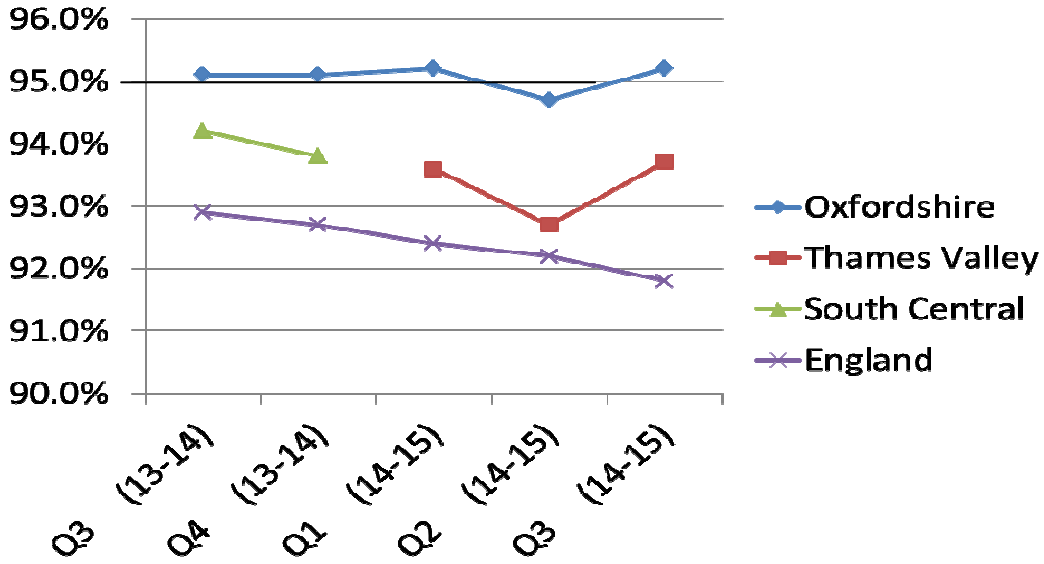
Strategic Lead: *Sally Bradshaw (Consultant in Public Health)* **Last updated**:

PROGRESS MEASURE: *At least 95% children receive dose 1 of MMR (measles, mumps and rubella) vaccination by age 2*

Current indicator RAG Rating Green

2. Trend Data

Uptake of MMR dose 1 Oxfordshire CCG October 2013 to March 2015



3. What is the story behind this trend? - Analysis of Performance

- The MMR vaccine, given as part of the routine childhood vaccination schedule protects against measles, mumps and rubella. Two doses of MMR vaccine are required to provide satisfactory protection. The first dose should be given between 12 to 13 months of age with a second dose at 3 years 4 months of age (or soon after)
- Call and recall for MMR vaccination is by letter to the child's home address from the Child Health Information Service (CHIS)
- Parents/Carers are invited to contact their GP surgery to arrange vaccination
- A maximum of 3 reminders are sent by CHIS to the child's home address in the event of vaccination not being given and where there is no documented evidence of refusal
- Data on MMR vaccination uptake is collected by CHIS, shared with the local NHS England Area Team and reported quarterly as part of the national COVER data collection
- **Uptake of MMR dose 1 in Oxfordshire is consistently higher than regional and national averages and prior to Quarter 2 (2014-15) exceeded the national target of 95%**
- During Quarter 2 (2014-15) uptake of MMR dose 1 fell below the national target of 95%
- **During Quarter 3 (2014-15) uptake of MMR dose 1 exceeded the national target of 95%**

4. What is being done? - Current initiatives and actions

Actions	Commentary
¤ **Identifying anomalies in the data** GP practices with data anomalies are identified by the CHIS team	• GP practices with data anomalies have been contacted to ascertain the accuracy of the data
¤ **Identifying variations in uptake** Vaccination uptake is monitored at practice level and is scrutinised quarterly by NHS England Screening and Immunisation team to identify practices with low uptake rates	• GP practices with low uptake have been identified
¤ **Providing support to practices** GP practices with low uptake rates are contacted by a member of the NHS England Screening and Immunisation team and offered support	• Screening and Immunisation Coordinators offer practice visits and resources to raise awareness of vaccination with patients and staff

5. What needs to be done now? - New initiatives and actions

Action	By Whom & By When
¤ Continue to check provisional data for anomalies and follow up with GP practice to improve data accuracy	CHIS - ongoing
¤ Continue to monitor practice level data and scrutinise quarterly to identify practices with low uptake rates and offer appropriate support	Screening and Immunisation team - ongoing
¤ Explore the feasibility of funding to the community trust to develop a clinical post offering childhood immunisation (0-5 years) promotion and, if necessary, community based immunisation across Oxfordshire. The focus of this project/post will be on health inequalities including hard-to-reach groups / geographies / populations in order to achieve 95% uptake of the 0-5 year childhood immunisation programme.	NHS England (South Central) - TBC

Report card: Successful Completions of treatment for opiate and non-opiate use.

Oxfordshire Health and Wellbeing Board
Detailed performance report

1. Details

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

Strategic Lead: *Jackie Wilderspin, Jo Melling*

PROGRESS MEASURE:

8.5 Percentage of opiate users successfully leaving treatment by the end of 14/15
8.6 Percentage of non- opiate users successfully leaving treatment by end of 14/15

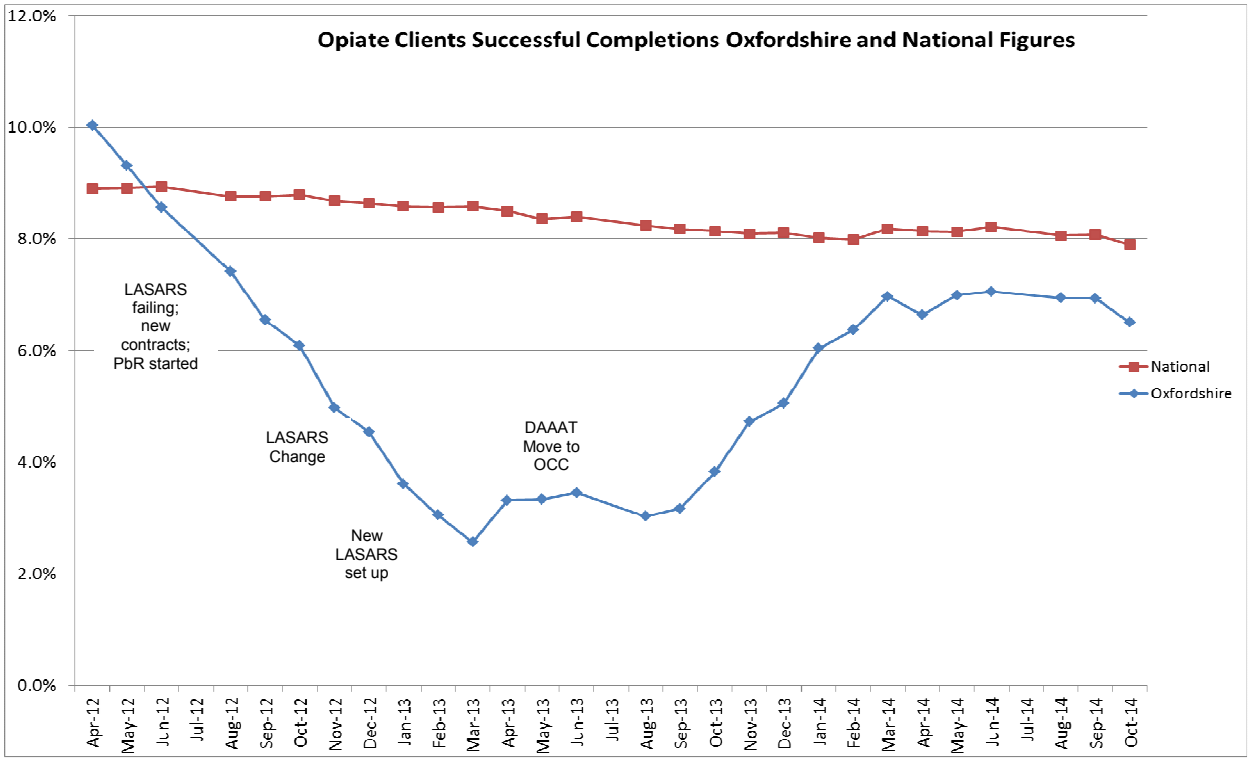
NOTE: The National Drugs Treatment Monitoring System, run by Public Health England to collate all performance data, has been out of service for several months and has only recently come back into use. This means that performance reports have not been available since October 2014.

Current indicator RAG Rating Red

2. Trend Data

Outcome no 8.5 'Opiate' Service Users

An opiate service user is any service user citing at least one primary, secondary or tertiary problem in the list of Opiates.

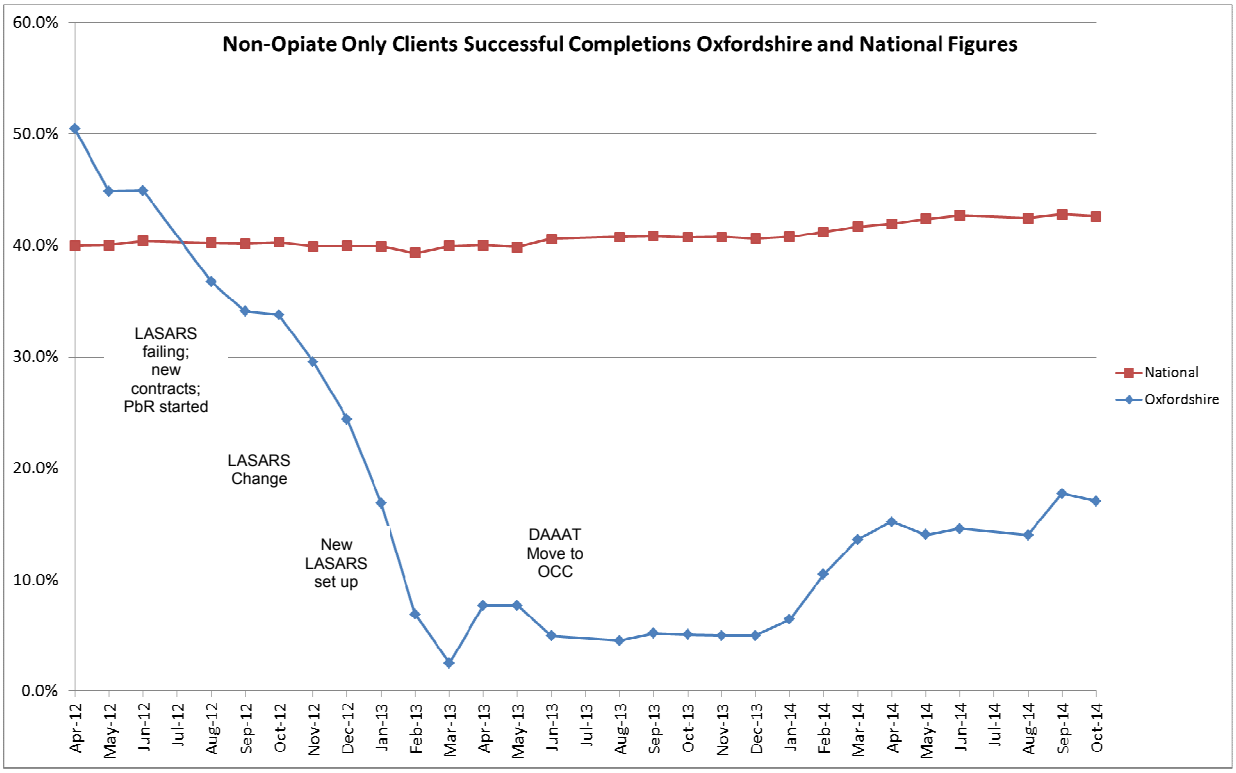


Report card: Successful Completions of treatment for opiate and non-opiate use.

	Opiate						
	Mar-14	Apr-14	May-14	Jun-14	Aug-14	Sep-14	Oct-14
Numbers in treatment - rolling 12 months	1592	1597	1602	1601	1584	1571	1553
Total completions - rolling 12 months	111	106	112	113	110	109	101
Successful completions as a proportion of number in treatment - rolling 12 months	7.0%	6.6%	7.0%	7.1%	6.9%	6.9%	6.5%
Direction of Travel From Previous Period	-	↓	↑	↑	↓	-	↓
NATIONAL	8.2%	8.1%	8.1%	8.2%	8.1%	8.1%	7.9%
Oxfordshire compared to National	-1.21%	-1.50%	-1.14%	-1.16%	-1.12%	-1.14%	-1.39%

Outcome no. 8.6 'Non-Opiate Only' Service Users

A non-opiate service user is any service user citing a primary problem substance of non-opiate, and no secondary or tertiary problem in the list of Opiates or Alcohol.



	Non-Opiate Only						
	Mar-14	Apr-14	May-14	Jun-14	Aug-14	Sep-14	Oct-14
Numbers in treatment - rolling 12 months	103	112	114	110	100	96	88
Total completions - rolling 12 months	14	17	16	16	14	17	15
Successful completions as a proportion of number in treatment - rolling 12 months	13.6%	15.2%	14.0%	14.5%	14.0%	17.7%	17.0%
Direction of Travel From Previous Period	-	↑	↓	↑	↓	↑	↓
NATIONAL	41.7%	41.9%	42.4%	42.7%	42.4%	42.8%	42.6%
Oxfordshire compared to National	-28.08%	-26.75%	-28.32%	-28.13%	-28.42%	-25.07%	-25.52%

3. What is the story behind this trend? - Analysis of Performance

- The Public Health Outcomes Framework includes performance measures for people completing courses of treatment for drugs and alcohol use. These measures indicate the number of people who successfully complete treatment and don't re-enter services for 6 months. The outcomes are reported by the type of substance for which treatment was received (opiates, non-opiates and alcohol).

- Performance in Oxfordshire treatment services has been poor for some time and a recovery plan has been in place for over a year. This poor performance originated soon after the current contractors were engaged in 2012, prior to the transfer of the commissioning function to the County Council in April 2013. The previous commissioning arrangements were governed by the DAAT Board and carried out by the DAAT Team. Historically the treatment services were designed to retain people in treatment and Oxfordshire was very successful at this. A change in national strategy meant a shift in emphasis to moving people through treatment to abstinence. This proved more difficult to manage through the new contracts from 2012.

- The work to improve performance on these new targets began soon after the function shifted to the County Council. Since the Council has been managing the contracts there have been some improvements, but performance is still below national averages.

- Public Health England officers have been supporting this recovery plan since October 2013 and work is on-going with all current contractors. Regular reports have been made to the Public Health Governance, Quality and Performance Group and to the Performance Scrutiny Committee. More details of the actions being taken are set out below.

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4. What is being done? - Current initiatives and actions

A recovery plan to improve performance was drawn up in partnership with Public Health England and all the contractors in the autumn of 2013 and implemented immediately. Preparation included extensive engagement with staff as well as with service users and their carers and relatives. .

The recovery plan was revised in October 2014 and now being implemented alongside the plan for transition to the new treatment service provider. The new service provider, Turning Point, has taken on the contract for treatment services from 1st April 2015. This is the result of a major procurement exercise in 2014 which used learning from the poor performance of earlier contracts and set out a specification for a single provider to run a comprehensive service. This contract incorporates prevention, harm reduction and treatment services and support for abstinence based recovery. This new contract will reduce the difficulty in navigating the system and will mean service users can access a wide range of treatment options all provided through one contract.

The specific actions set out in the recovery plan are summarised in the table below:

Report card: Successful Completions of treatment for opiate and non-opiate use.

Actions	Commentary
¤ Recovery plan drawn up in Oct 2013 built on consultation with service providers and clients. Actions included improving data quality, timely recording and reporting of progress, staff training, service user engagement, access to a range of psycho-social treatment options and communication to ensure that referrals into the service were easy to make.	• Some improvements in performance were noted throughout 2014 as a result of this action. • Providers under contract from 2012-15 were not awarded the new contract and transition to the new contractor began in December 2014. A new recovery plan was agreed in the light of this.
¤ A revised plan to Improve Successful Completions was agreed. It includes the following areas of action: 1. Improving referrals into Treatment Services 2. Communications 3. Service user involvement 4. Performance Management 5. Workforce development 6. Improved interventions offered to Shared Care users	The plan was agreed by all providers of services, including the new contractor. Progress included • Ongoing training of staff to ensure accurate and timely recording of data about client progress. • An audit of all clients in treatment through shared care, to improve understanding of their prescriptions and options for psycho social treatment. • Following up clients who drop out of treatment in early stages
¤ The new contractor for treatment services, Turning Point, began their contract in December 2014 to ensure good transition to being fully operational by April 2015. Monthly meetings of an Implementation Steering Group have been held, including partners from mental health, primary care and housing support services. The actions from the recovery plan have been incorporated into this transition work and will continue to be monitored through Contract Management meetings	There has been some progress with the processes set out in the recovery plan but the lack of performance reporting since October 2014 means the impact of transition cannot be seen yet. Progress has included • Set up of good referral systems into treatment from primary care, the criminal justice system, hospitals and others. • Regular and informative newsletters to staff, clients, GPs and other stakeholders • Successful recruitment of new staff alongside TUPE of staff from previous contractors. • Training needs assessment of all staff and a comprehensive training plan • Clinical transfer of all clients to the new provider • Continuation of shared care and recruitment of new nurses to support GP led care.

Report card: Successful Completions of treatment for opiate and non-opiate use.

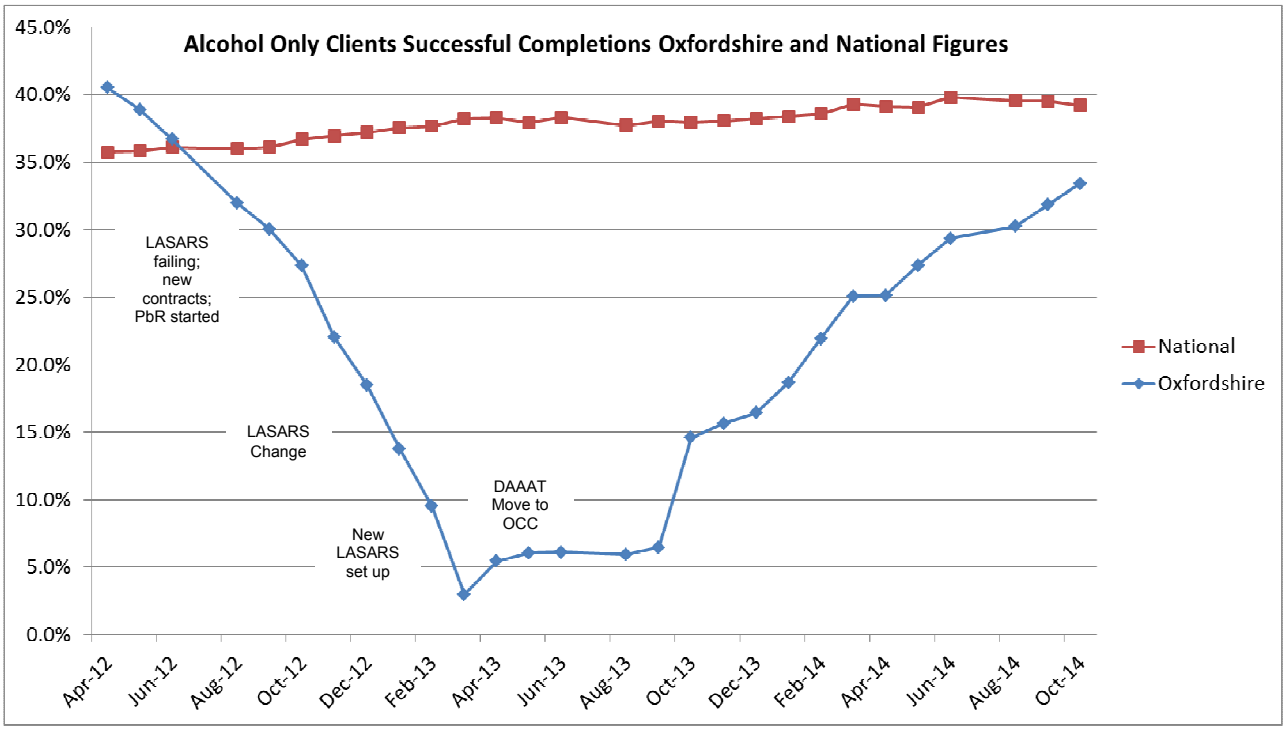
5. What needs to be done now? - New initiatives and actions

Action	By Whom & By When
¤ Further revision of the recovery plan in the light of new contract arrangements. This will be done in collaboration with PHE	OCC and PHE June 2015
¤ Performance reporting from NDTMS to monitor the impact of transition on the overall performance	PHE As soon as the system is running
¤ Regular contract management meetings to ensure all actions in the recovery plan are being prioritised	OCC monthly
¤ Continuation of the Transition Steering Group for at least 3 months to ensure partner organisations continue to be engaged and informed and clients have a good experience of services	OCC and Turning Point April – July 2015
¤ Successful induction and training of all staff employed by Turning Point – both new recruits and those transferring from previous providers of the service	Turning Point June 2015

Appendix: Related performance data on people in treatment for Alcohol and Alcohol/Non-opiate use

'Alcohol Only' Service Users

An alcohol service user is any service user citing a primary problem substance in the list of Alcohol substances and no secondary or tertiary problem in the list of Opiates or Non-Opiates.

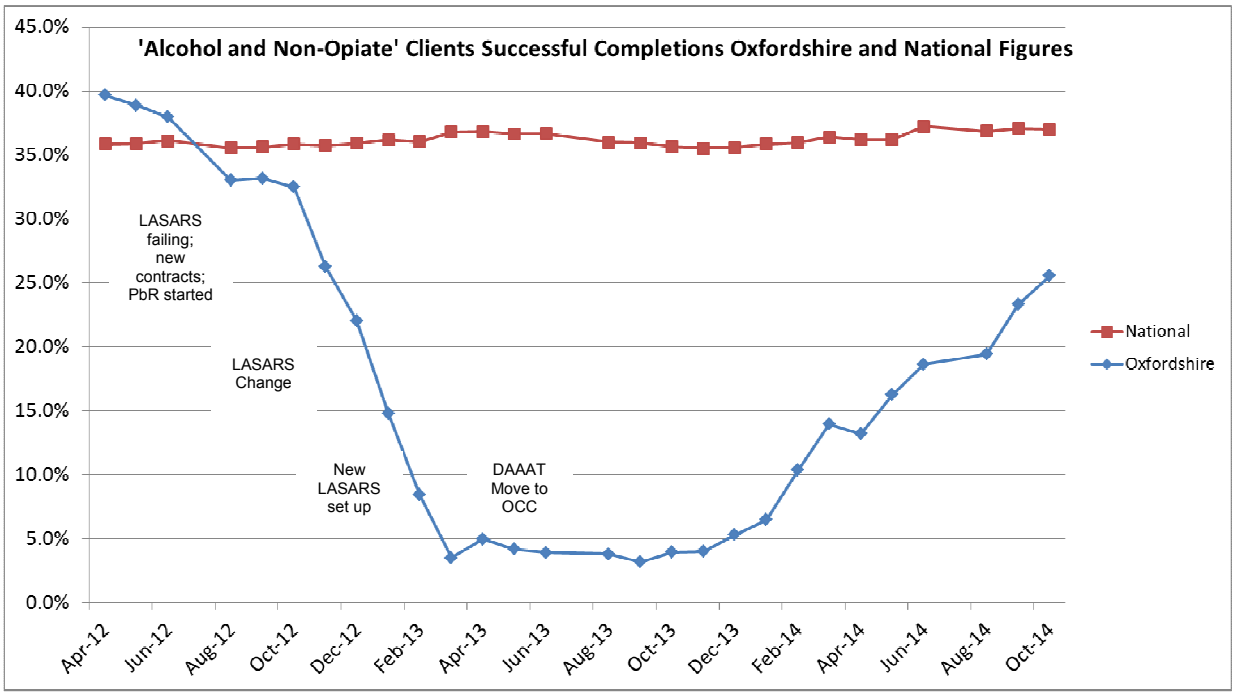


	Alcohol Only						
	Mar-14	Apr-14	May-14	Jun-14	Aug-14	Sep-14	Oct-14
Numbers in treatment - rolling 12 months	602	645	636	627	549	540	512
Total completions - rolling 12 months	151	162	174	184	166	172	171
Successful completions as a proportion of number in treatment - rolling 12 months	25.1%	25.1%	27.4%	29.3%	30.2%	31.9%	33.4%
Direction of Travel From Previous Period	-	-	↑	↑	↑	↑	↑
NATIONAL	39.3%	39.1%	39.1%	39.8%	39.6%	39.5%	39.2%
Oxfordshire compared to National	-14.22%	-13.99%	-11.71%	-10.44%	-9.32%	-7.68%	-5.79%

Report card: Successful Completions of treatment for opiate and non-opiate use.

'Alcohol & Non-Opiate' Service Users

An 'Alcohol & Non-Opiate' service user is any service user citing at least one substance in the list of alcohol substances and at least one substance from the list of Non-Opiate substances, but citing no Opiate use.



	Alcohol & Non-Opiate						
	Mar-14	Apr-14	May-14	Jun-14	Aug-14	Sep-14	Oct-14
Numbers in treatment - rolling 12 months	208	235	234	231	237	236	227
Total completions - rolling 12 months	29	31	38	43	46	55	58
Successful completions as a proportion of number in treatment - rolling 12 months	13.9%	13.2%	16.2%	18.6%	19.4%	23.3%	25.6%
Direction of Travel From Previous Period	-	↓	↑	↑	↑	↑	↑
NATIONAL	36.4%	36.2%	36.2%	37.2%	36.9%	37.1%	37.0%
Oxfordshire compared to National	-22.48%	-23.02%	-19.97%	-18.63%	-17.45%	-13.77%	-11.49%

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Health Improvement Board
Basket of Indicators for Housing and Health
Annual Report 2014-15

One of the Joint Health and Wellbeing Strategy Priorities the Health Improvement Board has responsibility for is "Tackling the broader determinants of health through better housing and preventing homelessness" (Priority 10).

At the May 2013 Health Improvement Board, the 'basket of housing indicators' that would be reported annually to the Board meeting were agreed. These were then amended and updated slightly at the May 2014 meeting, which agreed the following measures.

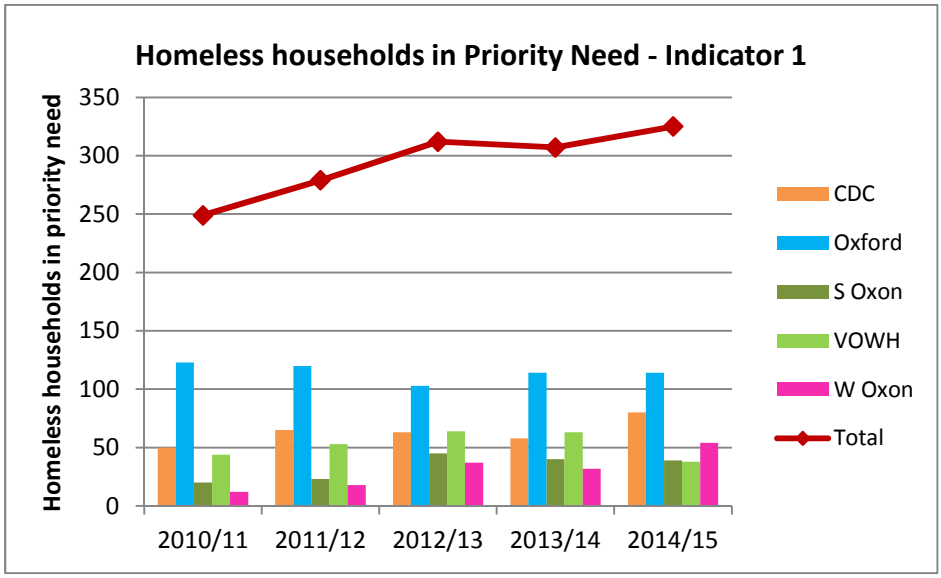
The full dataset of statistics for 2014-15, and the previous two years, are shown on the last page of this report.

Key:

CDC	Cherwell District Council
Oxford	Oxford City Council
S Oxon	South Oxfordshire District Council
VOWH	Vale of White Horse District Council
W Oxon	West Oxfordshire District Council

Homelessness Presentations (Indicator 1)
There has been an upward trend in people presenting as homeless*, over the whole County, in the past five years, rising from 411 in 2010/11 to 498 in 2014/15, although the total fell slightly from 517 the previous year. The situation differs across Districts, with some experiencing greater volumes of presentations and some less, over this five year period.

There has been an increase in people who are accepted as statutorily homelessness and are in **priority need** in the County since 2010/11 to 2014/15 (249 to 325 households). There are differences between Districts however. Over the past year, two Councils have seen significant rises (Cherwell and West Oxfordshire); two broad stability (Oxford City and South Oxfordshire); and one with a reduction (Vale of White Horse).



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

The numbers of people found to be **intentionally homeless** is broadly static, having risen in 2013/14, but is now at 12/13 levels (111 households deemed intentional in 14/15).

The numbers of people presenting as homeless but **not in priority need*** are relatively low. Over the County as a whole, the numbers have increased from 50 in 2011/12 to 69 in 2013/14, then to 62 in 2014/15. As in previous years, there are considerable variations between the Districts with most cases recorded in either Cherwell or Oxford City (23 and 29 households respectively).

** Local housing authorities have a duty to secure accommodation for households who are in priority need under homelessness legislation. Categories of priority need are pregnancy, dependent children, vulnerable as a result of old age, mental illness or handicap, or physical disability or other special reason, homeless as a result of an emergency such as fire or flood, a child aged 16 or 17, vulnerable as a result of having been looked after, accommodated or fostered, as a result of serving in the armed forces or having been imprisoned or ceasing to occupy accommodation because of actual or threatened violence.*

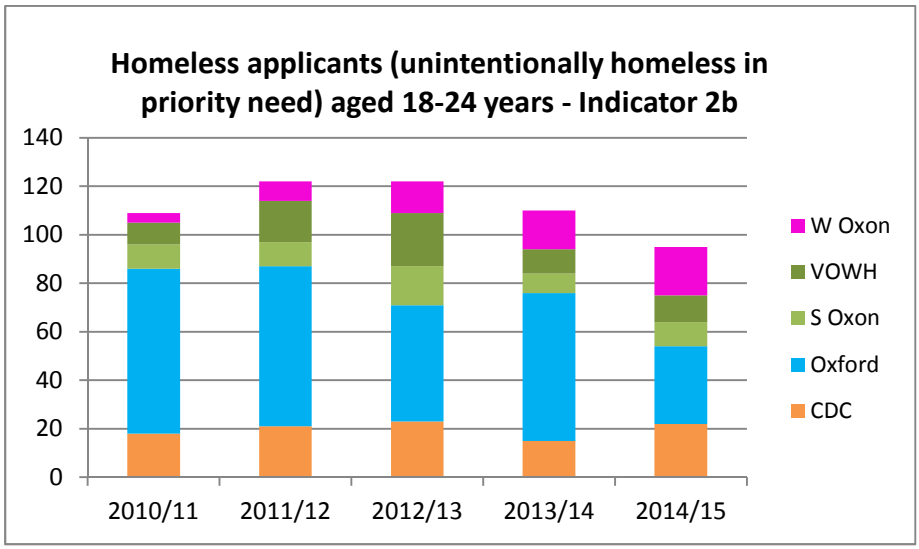
People found to be homeless expressed as a percentage of the number of people of cases where positive action was successful in preventing homelessness was 83%*. This is above the target (10.3) of 'at least 80%' and an improvement on the 13/14 figure of 81%.
(2498 preventions/ 2952 homeless applications plus preventions)*

Homeless applicants who were unintentionally homeless and in priority need (Indicator 2)

In 13/14, 116 people aged 16 -24 were accepted as homeless in Oxfordshire. There were 6 people aged 16 or 17 and 110 between 18 and 24 years. In 14/15 that figure fell to 95, the lowest recorded in the past 4 years, with no 16/17 year olds accepted, which must reflect the effective joint work through the Joint Housing Team with Childrens Services.

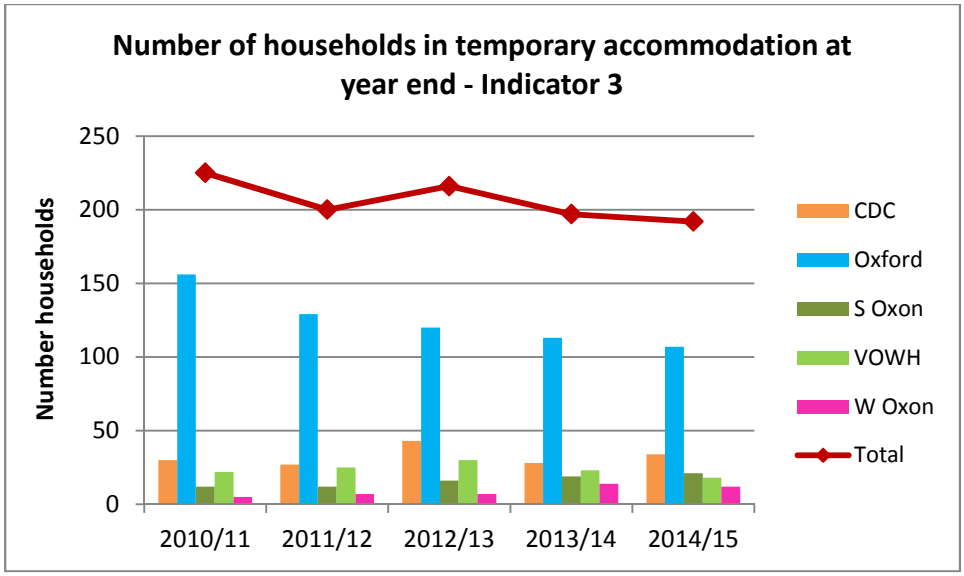
The number of households who are in priority need because of physical disability or mental illness remains moderately low. In 2014/15, there were 15 homeless households where a member had a physical disability and 22 because of mental health.

In 13/14, an increase in the number of households accepted as homeless with the main reason being due to rent arrears, was reported, although the number was low (19 households). This has dropped to 12 households in 2014/15.



Number of households in Temporary Accommodation (Indicator 3)

There were 192 households in temporary accommodation at the end of the financial year 2014/15, a reduction of 5 from the previous year (exceeding target 10.1). There are some local variations within Districts – although these are small when considered annually.

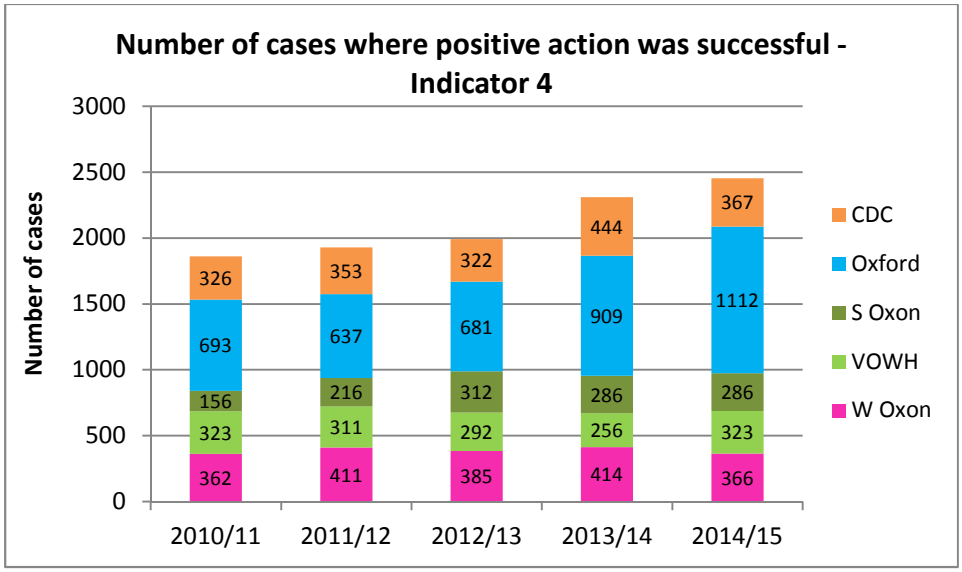


Number of households in Bed and Breakfast accommodation (New indicator request)

As at the 31st March 2015, 8 households in Oxfordshire, out of the 192 indicated above, were in bed and breakfast (non-self-contained style) accommodation.

Positive action preventing homelessness (Indicator 4)

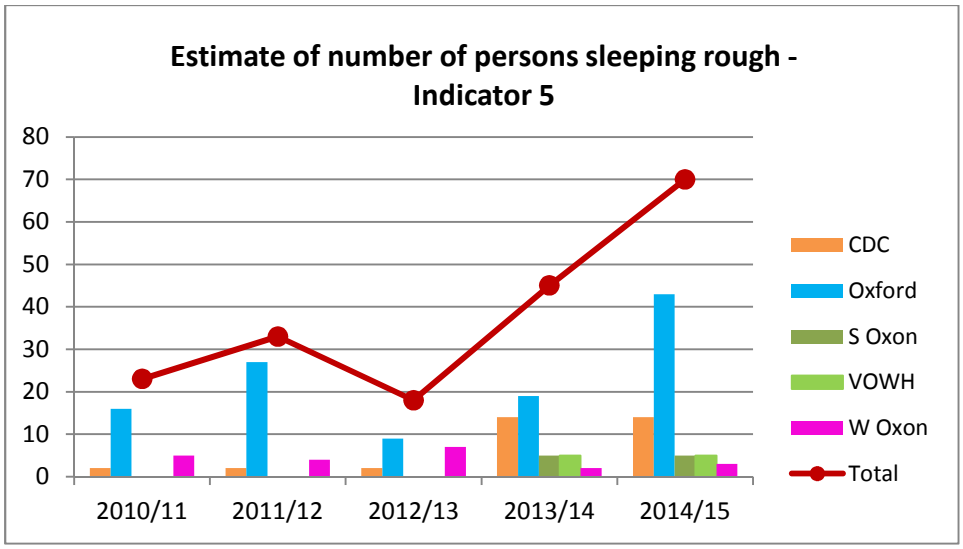
There were 2,454 cases recorded where positive action prevented homelessness, compared to 1992 in 2012/13. Positive action covers securing accommodation with a housing association or in the private rented sector as well as a result of the provision of advice, support or other intervention.



Rough-Sleeping (Indicator 5)

The estimated number of people rough sleeping is 70, showing a substantial increase from 45 persons in 13/14, although it should be noted that up to 14/15, Oxford City Council recorded the actual figure from quarterly street counts, while due to the nature of the other districts, a count was not practicable and an estimate was made by the Council using intelligence from partner agencies. The autumn count and estimates were reported to Central Government.

Whilst Oxford City still undertakes quarterly street counts, it has been agreed that it will conduct an estimate (using the same approved and verified methodology as the Districts) annually in the autumn, and report this figure into the HIB. The makes the data comparable across all the District Councils in Oxfordshire. The result of this change is that the recorded figure for Oxford City has more than doubled, and the recorded change is due to this. The estimates in Cherwell, South Oxfordshire, Vale of White Horse and West Oxfordshire are based on better information arising from the commissioning of an Outreach team from 13/14 on, but are broadly stable from that year to 14/15.



Removal of Spare Room Subsidy

Full data on the number of Housing Association and Council tenancies affected by the Removal of Spare Room Subsidy** was not available in 13/14, but 2,084 were reported in the County excluding West Oxfordshire. These households have found that their housing benefit has been reduced because of the introduction of the Social Sector size criteria.

That number is now recorded as 2,304 across all Oxfordshire, but this increase is due to the inclusion of data from West Oxfordshire, and has generally fallen from 13/14.

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

- *each adult couple*
- *any other person aged 16 or over*
- *two children of the same sex under the age of 16*
- *two children under the age of 10 regardless of their sex*
- *any other child*

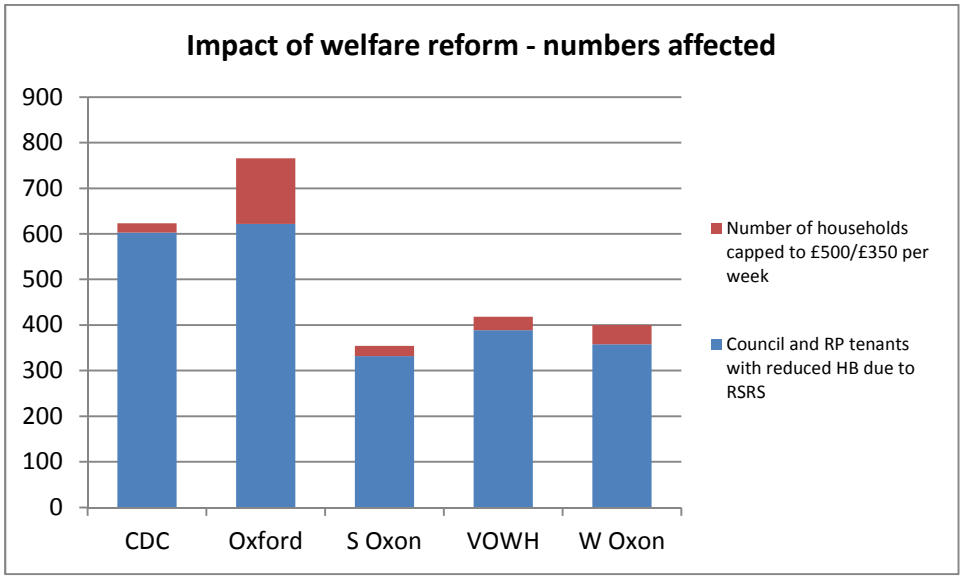
- *a carer (who does not normally live with the tenant) if the tenant or their partner needs overnight care.*

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

Benefit Cap
257 households in the County are affected by the Benefit Cap***.

Overall this is static, but the recorded numbers have tended to fall in most districts, whereas West Oxfordshire has seen a significant increase.

****£350 per week maximum of benefits covered for single adults who don't have children or whose children don't live with them and £500 per week maximum for couples (with or without children living with them) and £500 a week for single parents whose children live with them.*



Joint Working in 2014/15

There have been a number of areas of joint working over the 14/15 year, between the County Council, District Councils, and other statutory partners such as the Oxfordshire Clinical Commissioning Group and health. This has included:

- Continued engagement with the Health Notification protocol for homeless families placed in temporary accommodation
- Successful joint commissioning of the young person pathway (new contracts live from 1st April 2015)
- Continued joint engagement in the commissioning of the adult homeless pathway following the budget reductions to this (preparing for new contracts in Feb 2016)
- A successful bid for two year funding to central government (lead by Cherwell DC) to undertake new initiatives working with offenders
- A health round-table event in Oxford City that can be used to improve communications and develop better linkages with regard to some hospital discharges

Going Forward – Opportunities for joint working in 2015/16

It is hoped that this work will be further developed and built on going forward in 2015/16. Areas of joint work already identified include:

- Continued engagement with the commissioning of the Adult Homeless pathway
- A review of the impact of cuts to the Floating Support service (one year review)
- Review of the Domestic Abuse services
- Developing work and initiatives in relation to Complex Needs

Recommendations for indicator changes in 2015/16

It is recommended that the existing indicators are retained, plus the additional information regarding households in B&B accommodation (requested in May 14 for April 15 on), as well as total households in temporary accommodation.

No additional indicators are proposed for the forthcoming year, however, the Housing Support Advisory Group proposes that it develops some key indicators in relation to the contract management and performance outcomes of the following service areas, and monitors these. It proposes that it will report any issues in relation to these, to the Health Improvement Board, going forward, on an exception basis, where performance is not meeting targets by more than a 5% margin (i.e. flagged Red in RAG status reports).

It is proposed that this could include the following service areas:

- Adult Homeless Pathway
- Young Persons Pathway
- Floating Support
- Domestic Abuse
- Substance Misuse (Housing Related Support)

Annual 'Housing Basket of Indicators' report, for end of year Health Improvement Board

	2012/13						2013/14						2014/15					
	CDC	Oxford	S Oxon	VOWH	W Oxon	**Total**	CDC	Oxford	S Oxon	VOWH	W Oxon	**Total**	CDC	Oxford	S Oxon	VOWH	W Oxon	**Total**
Indicator 1 Homeless households																		
(1a) in priority need	63	103	45	64	37	**312**	58	114	40	63	32	**307**	80	114	39	38	54	**325**
(1b) intentionally homeless	30	46	13	15	9	**113**	34	67	13	14	13	**141**	25	51	13	11	11	**111**
(1c) no priority need	11	26	7	6	1	**51**	24	23	11	11	0	**69**	23	29	2	5	3	**62**
Total	104	175	65	85	47	**476**	116	204	64	88	45	**517**	128	194	54	54	68	**498**
Indicator 2 Homeless applicants who were unintentionally homeless and in priority need who were/had																		
(2a) aged 16/17yrs	2	0	0	1	3	**6**	0	0	0	1	5	**6**	0	0	0	0	0	**0**
(2b) aged 18 to 24	23	48	16	22	13	**122**	15	61	8	10	16	**110**	22	32	10	11	20	**95**
(2c) physical disability	3	3	3	1	3	**13**	3	3	2	6	1	**15**	2	7	1	3	2	**15**
(2d) mental illness	2	4	5	6	2	**19**	1	5	7	5	0	**18**	2	7	5	6	2	**22**
(2e) rent arrears	1	3	2	2	0	**8**	0	15	0	2	2	**19**	0	7	2	1	2	**12**
Indicator 3 Number of households in temporary accommodation at end of year (10.1 in JHWS)																		
Households in Temp Accom.	43	120	16	30	7	**216**	28	113	19	23	14	**197**	34	107	21	18	12	**192**
Indicator 4 Number of households where positive action was successful in preventing homelessness																		
Homeless Preventions	322	681	312	292	385	**1992**	444	916	268	256	414	**2298**	367	1112	286	323	366	**2454**
Indicator 5 Number of Persons Rough Sleeping (10.5 in JHWS)																		
Estimate/count of persons sleeping rough	2	12*	0	0	7	**21**	14	19*	5	5	2	**45**	14	43	5	5	3	**70**
Impact of Welfare Reform																		
Council & RP tenants with reduced HB due to RSRS							633	694	332	425	N/A	**2084**	603	622	332	389	358	**2304**
Number of households capped to £500/£350 pw							33	155 *	30	43	24	**255**	20	144	22	29	42	**257**

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Priorities for the Health Improvement Board
A discussion based on outcomes for 2014-15 and the findings of the Joint Strategic Needs Assessment.

April 2015

1. Introduction

The Joint Health and Wellbeing Strategy (JHWBS) for Oxfordshire includes 11 priority areas of work. Four of these priorities have been set by the Health Improvement Board (HIB). These are

Priority 8: Preventing early death and improving quality of life in later years
Priority 9: Preventing chronic disease through tackling obesity
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
Priority 11: Preventing infectious disease through immunisation

Work to monitor health improvement in each of these areas is measured through the use of a small number of outcomes for each priority. An aspirational target was set at the beginning of the year for each of these indicators. Progress against the outcomes set for 2014-15 has been monitored at each meeting of the Board. In the last year it has also been possible to report the variation in outcomes for some of these indicators, with the areas or groups showing the worst and best results being named.

The JHWBS is revised annually and this provides an opportunity for the Health Improvement Board members to consider priorities for the year ahead. In order to facilitate that discussion this paper sets out a summary of performance on the priorities agreed for 2014-15 and outlines some of the issues identified in the Joint Strategic Needs Assessment. Members of the Board will be aware of other issues and concerns which they will want to bring to the discussion.

2. Summary of performance on current priorities

A detailed performance report will be presented to the Health Improvement Board elsewhere on the agenda and is summarised in Appendix 1. The following issues are emerging from the performance reports

2.1 Many of the targets set for 2014-15 were “aspirational” and have not been achieved. However, the levels of achievement in Oxfordshire may still compare well with other parts of the country– breastfeeding rates, for example, are higher than the national rates, even though the aspirational target was not met. The monitoring of outcomes by the HIB has kept a spotlight on these areas of work even though the overall outcomes were not achieved. This is true of the uptake of NHS Health Checks, the breastfeeding rates and the uptake of the bowel screening programme.

2.2 The commissioning or contracts for some areas of work has changed over the last 2 years and it has been important to keep track of performance during that time to ensure that change has not led to poorer outcomes. This is true of the

immunisation and screening targets. Contracts for smoking cessation and drugs treatment services have also be re-procured in the last few months and this may account for some difficulties in performance.

2.3 Some inequalities in outcomes have been reported in the last year as data has been made available on the variation in performance in different areas of the county. For example, the percentage of children who are overweight or obese varies from 15.2% in South Oxfordshire to 21% in Oxford City. The addition of figures to show the range of outcomes has been welcomed by members of the Board as it gives useful detail.

3. Issues highlighted in the annual report of the Joint Strategic Needs Assessment (JSNA)

The Annual report of the JSNA has also been circulated to members of the Health Improvement Board at this meeting. Some of the trends that are reported which are of relevance to the work of this Board may include

3.1 The population is growing as a result of migration and is also ageing. Life expectancy has continued to increase for both men and women. Pressure on services seems likely to increase, particularly where demand is more highly concentrated among older people. As the proportion of older people increases this pressure can only be reduced through preventing long term conditions and promoting healthy lifestyles.

3.2 There are some localities or communities with poorer outcomes for many of the indicators listed. Some of these are linked to social deprivation such as rates of smoking, obesity, physical activity and preventable / premature deaths. Access to services also varies, with some people living in rural areas being more disadvantaged. Overall obesity rates are lower than national rates for both adults and children and participation in physical activity is higher than the national rates but there are variations across the county. Alcohol related hospital admissions are higher in the City.

3.3 The proportion of households in private rented accommodation has risen slightly in recent years. The percentage of people living in fuel poverty is below the national average but higher in the City. Rates of homelessness and families in temporary accommodation have remained at similar levels for the last few years.

3.4 Diagnosis of long term conditions shows that 5% adults have diabetes in Oxfordshire. The diagnosis of cancer continues to increase, though mortality figures are not increasing - this may indicate early diagnosis through screening programmes and general awareness.

3.5 In general the population report good levels of wellbeing. Indications of depression and anxiety affect women slightly more than men and are also highest in 25-44 year olds. Suicide rates are similar to national figures.

3.6 The proportion of five year old children with some tooth decay in Oxfordshire has increased in the last few years. It was higher than the proportion for England overall.

Other considerations

It is likely that pressure on health and social care services will continue to increase at the same time as greater efficiency is demanded. The need for self-care and prevention of long term conditions is still paramount. The factors which are most influential in determining health outcomes remain

- Smoking status
- High blood pressure and high blood cholesterol levels
- Body mass index – a factor of diet and physical activity
- Alcohol consumption

In addition to this the influence of living and working conditions is also important. These include housing, income, educational attainment, employment, air quality and community safety.

4. Recommendations

It is recommended that

1 The Health Improvement Board maintain their focus on the 4 priorities listed above

2 The Board should continue to receive performance reports that include the best and worst performance by locality or group. Where possible each outcome should be set to include a reduction in the inequality of outcomes. This will mean work has to be focussed on the groups with worse outcomes in order for the overall target to be reached.

3 Consideration is given to adding indicators for the following issues
- Young people who are vulnerably housed
- Smoking in pregnancy

Jackie Wilderspin, April 2015

Appendix 1 Summary of performance reported in March 2015

1. The following outcomes set for 2014-15 are currently rated "green"
   - Number of invitations for NHS Health Checks sent out
   - Number of people receiving housing related support will depart services to take up independent living
   - Number of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies who are prevented from becoming homeless
   - number of households in Oxfordshire who have received significant increases in the energy efficiency of their homes or their ability to afford adequate heating.

2. Some indicators were rated "amber" at the latest reporting period which means they were within 5% of achieving the target set
   - Percentage of babies are breastfed at 6-8 weeks of age
   - Percentage of children receiving dose 1 of MMR (measles, mumps, rubella) vaccination by age 2

3. Other indicators were rated "red" and have not achieved the targets set by the latest reporting period
   - At least 60% of those sent bowel screening packs complete and return them (ages 60-69 and ages 70-74)
   - At least 66% of those invited for NHS Health Checks attend (ages 40-74)
   - At least 3800 people quit smoking for at least 4 weeks
   - 8.6% of opiate users successfully leaving treatment by the end of 14/15
   - 38.2% of non-opiate users successfully leaving treatment by the end of 14/15
   - Ensure that the obesity level in Year 6 children is held at no more than 15%
   - At least 95% children receive dose 2 of MMR vaccination by age 5

4. There are some indicators for which reports have not yet been received
   - Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week
   - Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 74 in 2013-14
   - At least 60% of people aged under 65 in "risk groups" receive flu vaccination
   - At least 90% of young women will receive both doses of HPV vaccination.

Joint Strategic Needs Assessment Annual Summary Report 2015

Introduction

The Joint Strategic Needs Assessment (JSNA) monitors trends in the health and wellbeing of Oxfordshire's population and assesses changing patterns of need and demand for services across the county. This year's JSNA looks at a wide range of data across the topics of:

- Population
- Population groups
- Wider determinants of health
- Morbidity and mortality
- Lifestyles
- Service demand
- Quality of services

New for this update of the Oxfordshire JSNA are locally-produced datasets and analysis including:

- Oxfordshire County Council's population projections
- Analysis of mental health service use data
- Further analysis of Census data
- Analysis of national research studies, with results extrapolated to Oxfordshire

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

- The Director of Public Health's Annual Report
- Health and Wellbeing Board performance reports
- The Pharmaceutical Needs Assessment
- Market Position Statements on Care Homes, Extra Care Housing, and Home Support Services
- The Strategic Intelligence Assessment for Oxfordshire

For a detailed look at the data which informs this report, go to http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment. The website includes:

- Data Directory, with links to key datasets to explore
- Publications Directory, containing publications related to the JSNA
- Bespoke enquiries or data requests, to ask us about the JSNA data

Contents

Table of Figures

1. Executive Summary[1]

Oxfordshire's population is growing, and growing older. In mid-2013 the population was estimated to be 666,100, having risen by about 10% since 2001. The number of people aged 65 and over was 112,400, an increase of around 28% over the same period.

The changes can be attributed to increased inward migration, particularly to the urban hubs of Oxford and Banbury, and the increasing life expectancy of the existing population, particularly in the rural areas of the county. Following a rise in births over the first ten years of the century, fertility rates in Oxfordshire are now expected to remain stable at 2010 levels.

Oxfordshire remains the most rural county in the South East of England. Meanwhile, its population is becoming more diverse. Between the 2001 and 2011 Census surveys the proportion of people identifying as black and ethnic minorities almost doubled, from 4.9% to 9.2% of the population.

Overall, Oxfordshire is prosperous, with a strong economy and a comparatively affluent population. In 2010 it was ranked the twelfth least deprived upper tier local authority out of 152 in England. However, there are pockets of social deprivation, with 18 local areas in the most deprived 20% nationally. These areas tend to show poorer levels of health and wellbeing across a range of indicators.

Oxfordshire's population is also relatively healthy, and the county performs better than regional and national averages on many indicators. Fewer people report being limited in their daily activities and increases in healthy life expectancy mean that people are living in good health for longer. Meanwhile, healthier behaviours are more prevalent, with higher than average levels of physical activity, fewer people overweight or obese and relatively low levels of smoking. However, poor lifestyle choices are an important source of health and wellbeing needs.

There are some particular challenges facing the county's health and wellbeing. For example, Oxfordshire has higher than average rates of people being killed or seriously injured on the roads. Meanwhile, diagnoses of some health conditions, including dementia, are thought to lag well behind actual prevalence. There is also considerable variation across the county on many of the health and wellbeing indicators, as well as inequalities across different population groups.

Over the coming years Oxfordshire's resident population is expected to continue growing and ageing. Under Oxfordshire County Council's principal projection scenario, which assumes a medium level of housing growth, the population is set to grow by 11% in the next ten years. The same scenario sees the number of those aged 65 and over increasing by 23%.

[1] The executive summary draws out key headlines from the rest of the report. Sources for data are not given here but are specified in footnotes throughout the main report.

The changing population profile of the county brings with it significant implications for health and wellbeing. Pressure on services seems likely to increase, particularly where demand is more highly concentrated among older people. Some services are already seeing significant challenges in meeting demand. This can be seen in the proportions of A&E waits which take more than four hours, as well as delays in people leaving hospital beds (which were almost three times the national rate in 2013/14). In addition, demand for both children's and adult's social care has been growing at an even faster rate than would be expected by population growth, suggesting that previously unmet need is coming forward. Meanwhile, because the population is increasingly diverse, needs may differ from locality to locality.

1.1. Limitations of the Data

In many cases up-to-date data are not available on the topics covered in the report. Therefore, older data, proxy measures and extrapolations are sometimes used. However, these may yield less accurate figures.

Projections should also be treated with caution and not treated 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 more significantly, where confidence levels are wider. 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, and highlights where confidence intervals are particularly wide.[2]

It is not always possible to provide subgroup breakdowns, for example by district, age, 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.

1.2. Geographic Boundaries

The administrative boundaries of Oxfordshire and its five districts are only partly coterminous with those of Oxfordshire Clinical Commissioning Group (CCG) and its localities: There are small areas in the East of the county (around Thame and Chinnor) and in the South West, which do not fall within the CCG area. The figure

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

below maps district boundaries (shown with thick black lines) against CCG localities (shaded).

Figure 1: Boundary map for Oxfordshire County Council and Clinical Commissioning Group

Source: Oxfordshire Clinical Commissioning Group

Unless otherwise stated, data presented in the report are for the county rather than the CCG area.

1.3. Areas for Future Development

In 2014 Oxfordshire County Council's Research and Intelligence Team published an in-depth analysis of the needs of children. The Team plans to publish further in-depth analyses of working age adults (in 2015) and older people (in 2016) to supplement the JSNA.

Other possible areas for future development include:

- Combining health and social care records to improve understanding of patient pathways and service users with complex needs
- Mapping data between Oxfordshire administrative geographies and CCG geographies
- Continue improving understandings of the relationships between population subgroups and health outcomes; and wider determinants of health and health outcomes

2. Population

This section describes the changing size and profile of Oxfordshire's population, and levels of deprivation in the country.

2.1. Population Size

In June 2014 the Office for National Statistics (ONS) released population estimates for mid-2013.[3] These put Oxfordshire's population at 666,100[4], continuing a trend of growth that has seen the county's population rise by 9.7% since 2001. This increase in the population is similar to the level seen in the South East (9.6%) but higher than for England overall (8.9%).

Within Oxfordshire, population growth between 2001 and 2013 has been highest in Oxford (14.2%) and West Oxfordshire (12.8%); it has been lower in Cherwell (8.8%), Vale of White Horse (6.8%) and South Oxfordshire (6%).

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, with significant housing growth expected over the coming years.

In October 2014 Oxfordshire County Council published population projections for the period to 2052, based on five growth scenarios.[5] The population projections represent the range of variation considered feasible for changes in life expectancy, fertility, migration, and housing growth. Unlike the Council's small area population forecasts, these are independent of district local plans.[6] More details of the methodology used can be found in Appendix A.

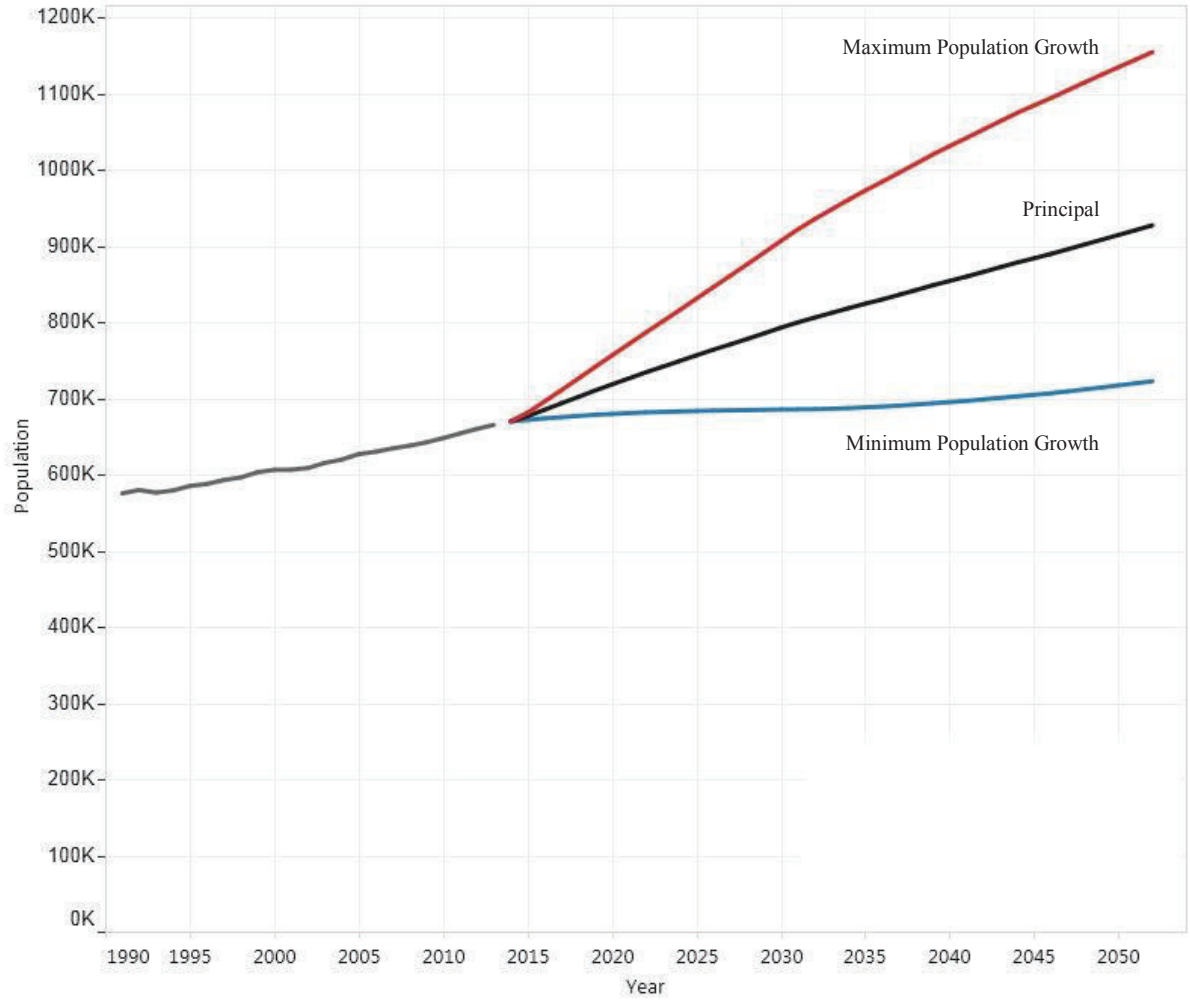
Figure 2: Population Change

[3] ONS population estimates for mid-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

[4] At the time of the 2011 Census, Oxfordshire's population numbered 653,800 residents

[5] Population Projections Summary Report: http://insight.oxfordshire.gov.uk/cms/long-range-population-projections-summary-report-autumn-2014

[6] Population Forecasts: http://insight.oxfordshire.gov.uk/cms/population-0.



Source: Oxfordshire Insight, data taken from ONS Population Estimates for mid-2013 and Oxfordshire County Council Research & Intelligence Population Projections (autumn 2014)

You can explore the data using the interactive population projection dashboards on the Insight website: https://public.tableausoftware.com/views/Summer14ProjectionsDashboard/Dashboard1?:embed=y&:showVizHome=no

The five city and district authorities in Oxfordshire are currently revising their local plans in light of the Strategic Housing Market Assessment (SHMA).[7] The SHMA concluded that up to 93,560-106,560 additional homes would be needed across Oxfordshire for the period 2011-2031.

Existing district plans anticipate 19,536 new homes being built between April 2014 and March 2019 (5,332 in Cherwell, 4,545 in Vale of White Horse, 3,595 in Oxford, 3,366 in South Oxfordshire and 2,698 in West Oxfordshire).

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

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.

2.2. Life Expectancy

2.2.1. Overall Life Expectancy

Life expectancy at birth predicts the average number of years a person born today could expect to live if they were to experience that area's age-specific mortality rates (although, 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 for some time.

In Oxfordshire, the 3-year rolling average life expectancy at birth for 2011-2013 was 80.8 (male) and 84 (female).[8] Overall, this continues a trend of increasing life expectancy, contributing to the growth in the number of older people in the county. This is discussed further under 2.3.1 Older People.

Life expectancy in Oxfordshire continues to exceed the England average (79.4 for boys and 83.1 for girls, over the same period). Life expectancy in Oxfordshire was similar to the South East average (80.4 for male children and 83.9 for female children).

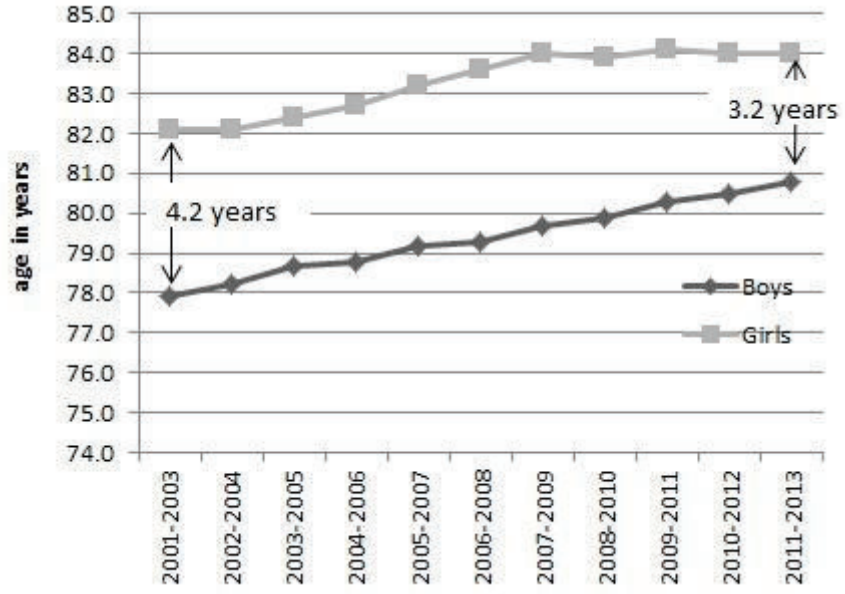
There was some variation in life expectancy across the county. Male life expectancy was lower in Oxford (79) than in the other districts: 81.5 in South Oxfordshire, 81.2 in Vale of White Horse, 80.9 in West Oxfordshire and 80.7 in Cherwell. Female life expectancy was more consistent across different parts of the county.

You can explore the data using the Public Health Surveillance dashboards (various indicators under Demography) on the Insight website:
http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

The gap between male and female life expectancy in Oxfordshire has reduced in recent years (this difference is statistically significant). The change is due to male life expectancy increasing at a faster rate.

Figure 3: Male and female life expectancy at birth in Oxfordshire

[8] Public Health Outcomes Framework, indicator 0.1ii: http://www.phoutcomes.info/



Source: Office for National Statistics life expectancy statistics

2.2.2. Disability-free Life Expectancy

The Office for National Statistics publishes three-year rolling estimates of disability free life expectancy at national, regional and county levels.[9] Disability free life expectancy 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.

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. 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.

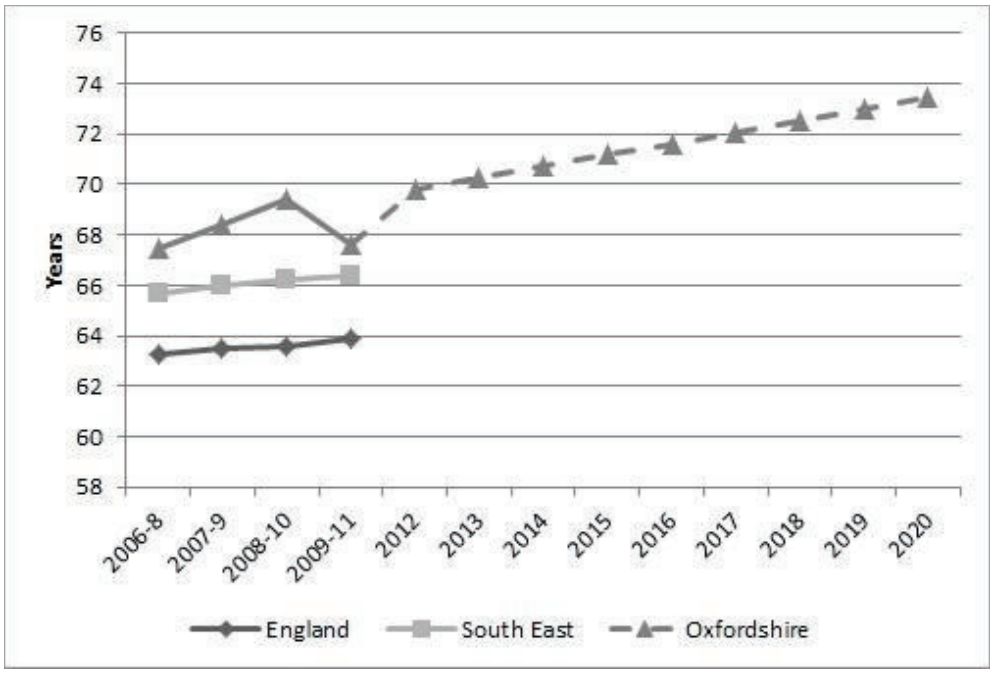
Disability free life expectancy in Oxfordshire remains significantly above the national average. Male disability free life expectancy has consistently been in the top 10% of the 150 upper tier local authorities in England since 2006-8. Female life expectancy has been in the top 20%.

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.[10]

[9] ONS subnational health expectancies: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Subnational+Health+Expectancies

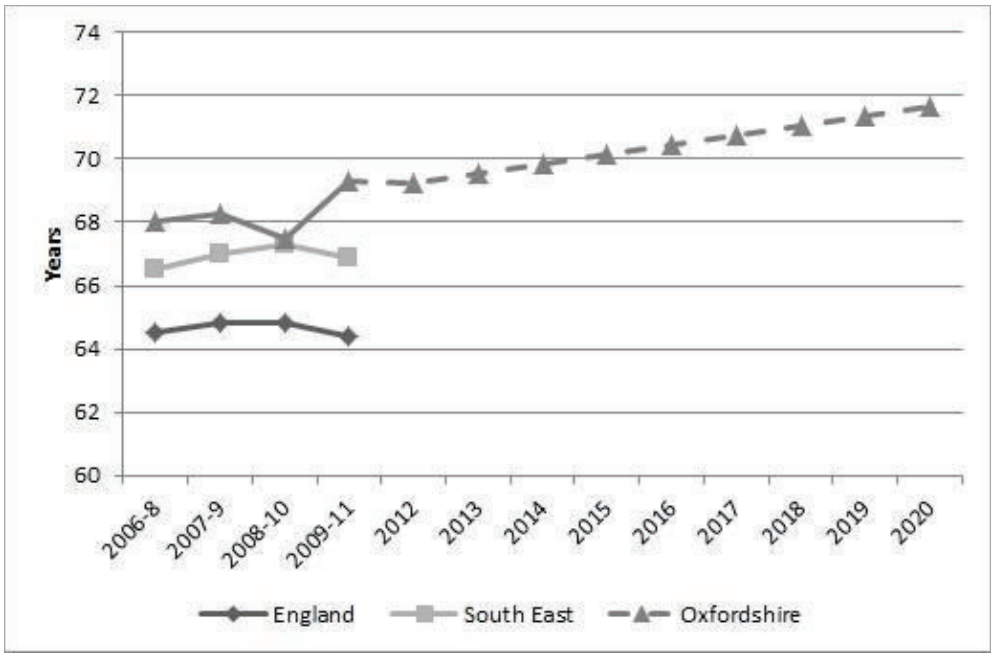
[10] Projections for disability free life expectancy use Oxfordshire County Council's Research and Intelligence team's overall life expectancy projections and apply trends in disability free life expectancy from the period 2006-2008 to 2009-2011, based on ONS estimates. The changing ratios between overall 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

Figure 4: Male Disability Free Life Expectancy



Source: ONS subnational health expectancies/ OCC projections

Figure 5: Female Disability Free Life Expectancy



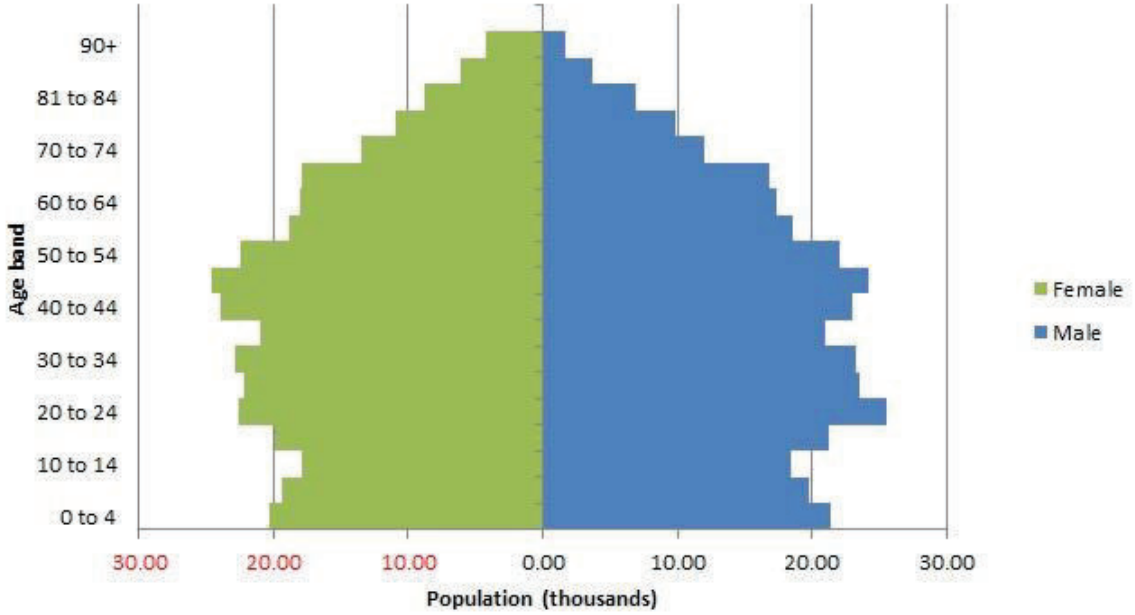
Source: ONS subnational health expectancies/ OCC projections

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.

2.3. Population Profile

Figure 6 shows the population profile of Oxfordshire, by age and sex, in mid-2013.

Figure 6: Population profile



Source: ONS Mid-2013 Population Estimate

You can explore the population profile for Oxfordshire, Cherwell and Oxford using the Public Health Surveillance dashboard (population pyramids under Demography) on the Insight website: http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

The number of people in Oxfordshire grew across all age groups between 2001 and 2013. As shown in Figure 7 below, the largest proportionate increase was among older people, followed by babies and young children. [11]

Figure 7: Oxfordshire's Population by Age Group

Age group	Number in 2001	Number in 2013
0-3	28,600	33,600 *(+17.6%)*
4-15	89,700	91,200 *(+1.6%)*
16-64	400,900	428,900 *(+7%)*
65+	88,100	112,400 *(+27.6%)*
85+	11,300	15,700 *(+38.6%)*
Total	607,300	666,100 *(+9.7%)*

Source: ONS Mid-2013 Population Estimate

[11] 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. Percentages are based on raw ONS figures rather than the rounded figures included in the JSNA.

2.3.1. Older People

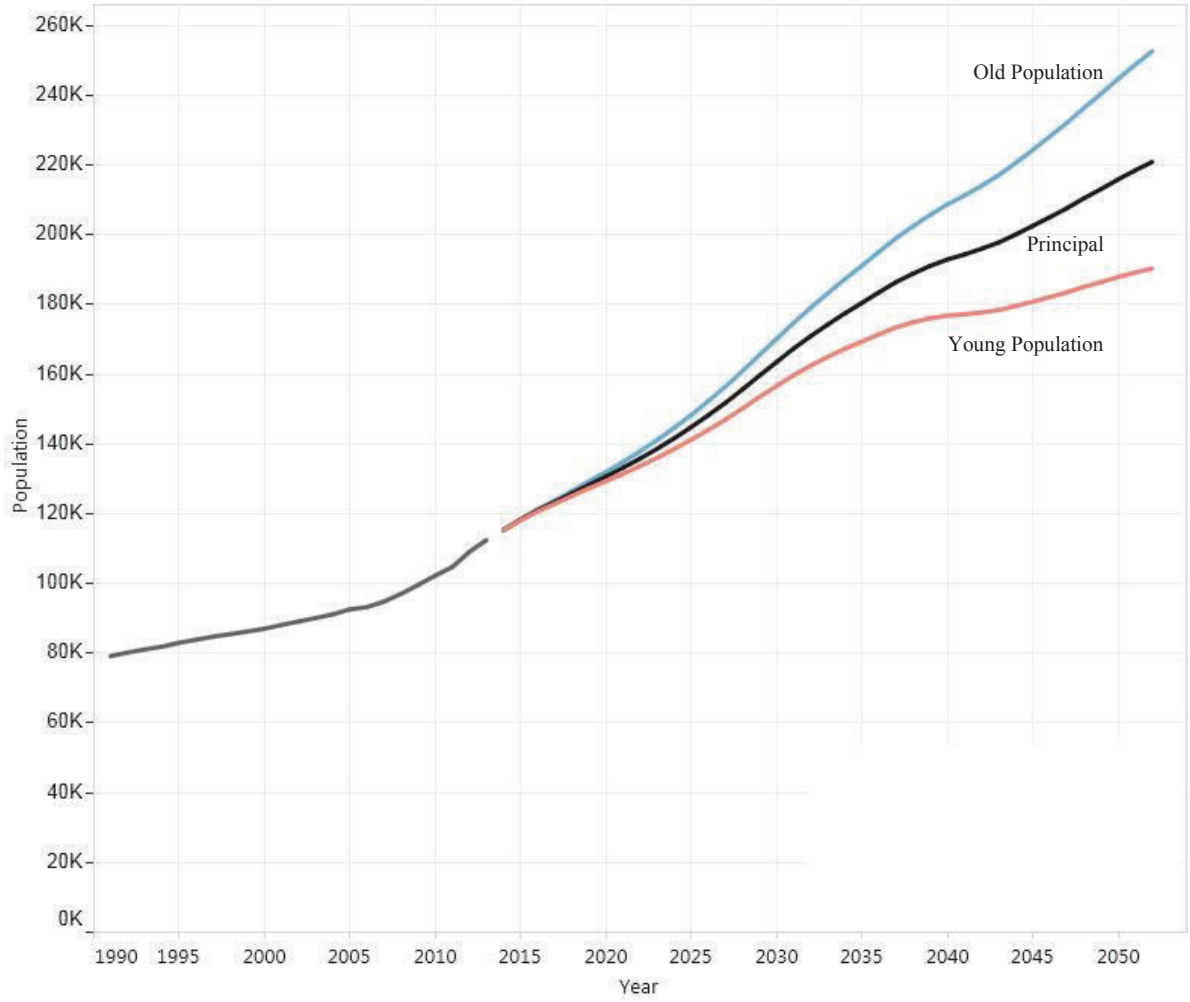
In 2013 there were 112,400 people aged 65 and over, representing an increase of 27.6% since 2001. Within this group, the number of people aged 85 and over increased by 38.6%, to 15,700 in 2013.

In 2013 those aged 65 and over made up 16.9% of the county's population (up from 14.5% in 2001); 85 and overs made up 2.4% (up from 1.9% in 2001). These proportions were slightly lower than in the South East (where 65 and overs comprised 18.3% of the population and 85 and overs 2.6%). They were similar to England overall (17.3% and 2.3%, respectively).

The proportion of older people was higher in South Oxfordshire (19.5% 65 and over; 2.7% 85 and over), West Oxfordshire (19.4% 65 and over; 2.7% 85 and over) and Vale of White Horse (19.1% 65 and over; 2.6% 85 and over). Cherwell was similar to the county average with 16.6% aged 65 and over, and 2.1% aged 85 and over. The proportion of older people was lower in Oxford, where just 11.2% of the population was aged 65 and over, with 1.8% aged 85 and over. Oxford's population is skewed towards younger adults, probably because of the presence of two large universities in the city.

The proportion of older people in the county is projected to continue increasing, under each of Oxfordshire County Council's population projection scenarios. More information about the projection scenarios, and how they were generated, are available in Appendix A.

Figure 8: Oxfordshire's 65+ population



Source: Oxfordshire Insight, data taken from ONS Population Estimates for mid-2013 and Oxfordshire County Council Research & Intelligence Population Projections (autumn 2014)

The growing number of older people in the county is likely to affect health and wellbeing needs significantly. Older people are more likely to experience certain health conditions (see, for example sections 3.8 Disability and 5.1 Morbidity) and to be users of many health and social care services (see section 7 Service Demand).

2.3.2. Babies and Infants

In 2013 there were 33,600 infants aged 0-3 in Oxfordshire. The number of 0-3 year-olds grew by 17.6% in the period since 2001, increasing the relative size of this age group from 4.7% to 5% of the population. The proportion of 0-3 year-olds in Oxfordshire was similar to that in the South East (5%) and England overall (5.1%); it was also similar across each district (within half a percentage point either way).

The growth in the number of children aged 0-3 can be explained in part by rising fertility rates across England throughout the 2000s.[12] Meanwhile, international migration into Oxfordshire has increased the number of women of childbearing age: in 2010 a quarter of live births in Oxfordshire were to mothers born outside the UK

[12] Fertility rates measure the average number of children born to a woman over a whole lifetime.

(25.6%).[13] The latest ONS assumptions anticipate national fertility rates remaining stable between now and the mid-2030s. This is a change from previous ONS assumptions which anticipated fertility rates reaching a 40-year high-point in 2013 and falling thereafter.[14]

2.3.3. Children

There were 91,200 children aged 4-15 in Oxfordshire in 2013. Although the absolute number of children aged 4-15 increased by 1.6% between 2001 and 2011, the proportion of 4-15 year olds in the population fell from 14.8% to 13.7% over the same period. The proportion of 4-15 year-olds in Oxfordshire was a little lower than in the South East (14.1%) but similar to England overall (13.9%). There was a smaller proportion of 4-15 year olds in Oxford (12.1%) than in the other districts: 14.5% in Cherwell, 14.3% in South Oxfordshire, 14.1% in Vale of White Horse and 13.6% in West Oxfordshire.

2.3.4. Adults

There were 428,900 adults aged 16-64 in Oxfordshire in 2013, representing an increase of 7% among this group since 2001. The proportion of 16-64 year olds in the population fell slightly, from 66% of the population in 2001 to 64.4% in 2013. This was a little above the proportions seen in England (63.8%) and the South East (62.7%). Across the county there were proportionately more 16-64 year olds in Oxford (71.6%) than other districts: 63.5% in Cherwell, 62% in West Oxfordshire, 61.9% in Vale of White Horse and 61.3% in South Oxfordshire. Again, this is likely to be linked to the presence of two large universities in the Oxford.

2.3.5. Sex

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

In 2013 49.6% of Oxfordshire's population was male and 50.4% was female.[15] 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 had a slightly higher proportion of males (50.2%). The relative proportions of men and women in the county have remained stable over time.

[13] Parents' Country of Birth, England and Wales, 2010: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-223048. You can explore the data using the dashboard on the Insight website: http://insight.oxfordshire.gov.uk/cms/mothers-country-birth-dashboard

[14] More information is available from Oxfordshire County Council's Research & Intelligence Team's newsletter (August 2014): http://insight.oxfordshire.gov.uk/cms/august-newsletter

[15] 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

2.4. Affluence and Deprivation

The Indices of Multiple Deprivation (IMD) measure relative levels of deprivation across England.[16] They combine a number of indicators into a single deprivation score for each small area of the country (known as 'Lower Super Output Areas', or LSOAs). The indicators are chosen to cover a range of economic, social and housing issues.

Overall, Oxfordshire is an affluent and prosperous county. According to the 2010 IMD, Oxfordshire ranked as the twelfth least deprived upper tier local authority out of 152 in England.[17] 102 of Oxfordshire's 404 LSOAs in 2010 ranked among the 10% least deprived nationally; 183 ranked among the 20% least deprived.[18] In population terms, around a quarter of the county's population is estimated to live in areas that were ranked among the 10% least deprived in England. Over two fifths live in areas ranked among the 20% least deprived.

One of Oxfordshire's LSOAs ranked among the 10% most deprived in England, and 18 ranked among the 20% most deprived. In population terms, just under 5% of the county's population is estimated to live in areas that were ranked among the 20% most deprived nationally.

Relatively deprived areas in the county include parts of South East Oxford, Abingdon, and Banbury[19]. These areas are shaded in dark blue on the map in Figure 9 below. Deprivation is consistently linked to poorer health and wellbeing outcomes.[20]

Figure 9: Map of deprivation in Oxfordshire

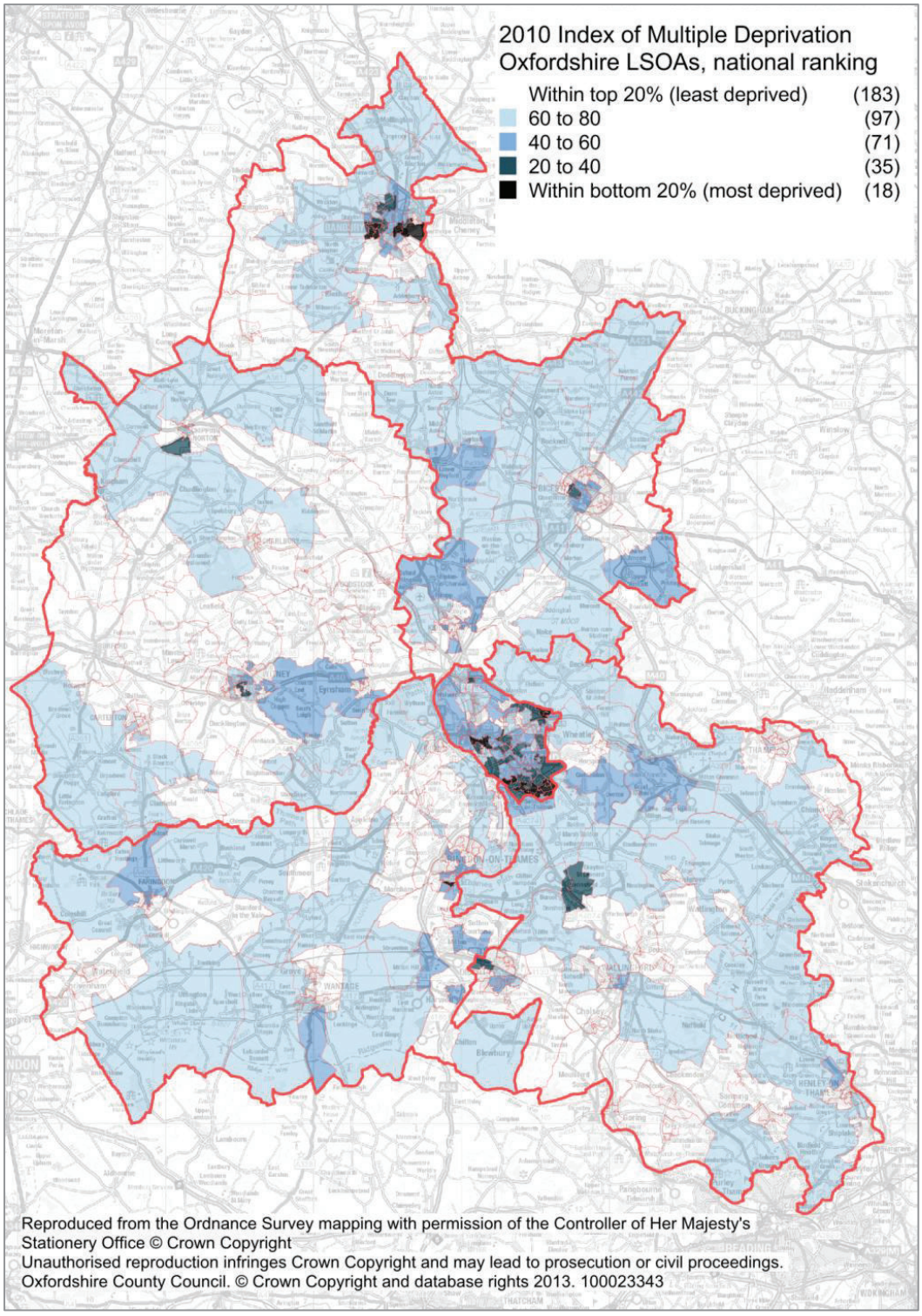
[16] English indices of deprivation: https://www.gov.uk/government/collections/english-indices-of-deprivation

[17] The 2010 Indices of Multiple Deprivation are available from the GOV.UK website: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010.

[18] In total there were 32,376 LSOAs across England in 2010.

[19] LSOAs in the following wards - Northfield Brook, Rose Hill and Iffley, Blackbird Leys, Barton and Sandhills, Banbury Ruscote, Banbury Grimsbury and Castle, Littlemore, Holywell, Abingdon Caldecott.

[20] See, for example, the 2010 report: *Fair Society, Healthy Lives* (also known as the Marmot Review): http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review



Source: Oxfordshire Insight, data taken from 2010 Index of Multiple Deprivation, DCLG.

In the 2010 IMD four of the 38 indicators measured health deprivation and disability[21]. Across the four indicators in the health deprivation and disability domain, 193 Oxfordshire LSOAs ranked in the top 20% nationally. However, 18 ranked among the 20% most deprived.

[21] These were: years of potential life lost; comparative illness and disability ratio; measures of acute morbidity; and the proportion of adults under 60 suffering from mood or anxiety disorders.

It is notable that Oxfordshire contained relatively high levels of deprivation on the geographic barriers index, which assesses the average road distance to key services such as hospitals and schools. 139 LSOAs in the county were among the 20% most deprived nationwide in this respect. The majority of these areas are in Cherwell, South Oxfordshire, Vale of White Horse, and West Oxfordshire and are predominantly rural. Rurality and isolation are discussed separately in sections 3.4 Rurality and 4.8 Isolation and Loneliness.

The Department for Communities and Local Government is currently updating the indices of deprivation, for publication in summer 2015. The new data will feed into future iterations of the Oxfordshire JSNA.

2.5. Further Information

Further information relating to the Population chapter is available from the JSNA data directory at the following link: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

3. Population Groups

This section provides data on particular subsets of Oxfordshire's population, including those with legally protected characteristics[22] and those identified as being potentially vulnerable.[23] For the most part it is not currently possible to analyse health outcomes specifically for people in these subgroups. However, available data have been referenced where appropriate.

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%).[24] 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 the data using the interactive ethnicity dashboard on the Insight website: http://insight.oxfordshire.gov.uk/cms/ethnicity-0

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.[25] 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

[22] The Equality Act 2010 identifies nine protected characteristics: age (covered in the previous chapter 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. Due to lack of data, this report does not cover gender reassignment. However, the ONS published a position paper on trans data in 2009: http://www.ons.gov.uk/ons/guide-method/measuring-equality/equality/equality-data-review/trans-data-position-paper.pdf

[23] Other potentially vulnerable groups are identified in Oxfordshire's equalities briefing: http://insight.oxfordshire.gov.uk/cms/equalities-briefing-november-2014.

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

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

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).

3.1.3. Black and Minority Ethnic (BME)

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.

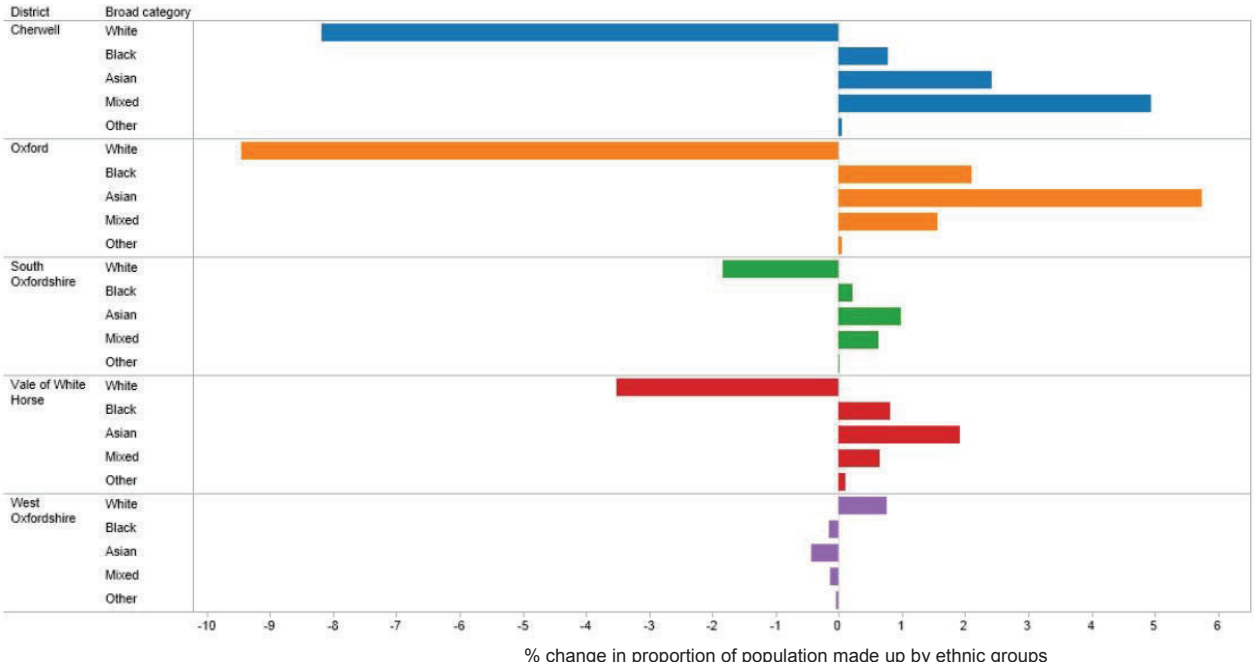
People from Asian backgrounds constituted the largest BME group, numbering 31,700, or 4.8% of the county's population (up from 2.4% in 2001). Most came from Indian backgrounds (1.3% of the population) or Pakistani backgrounds (1.2%).

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 Figure 10 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 10: Change in the proportion of the population made up by ethnic groups



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

3.2. 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).[26] 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%).

[26] Census 2011, table KS209EW; Census 2001, table S103: https://www.nomisweb.co.uk

3.3. Language

Proficiency in English could potentially affect residents' access to health and social care services.

At the time of the 2011 Census, 93.1% of people aged three and over in Oxfordshire spoke English as their main language.[27] 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, 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%).[28] 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.

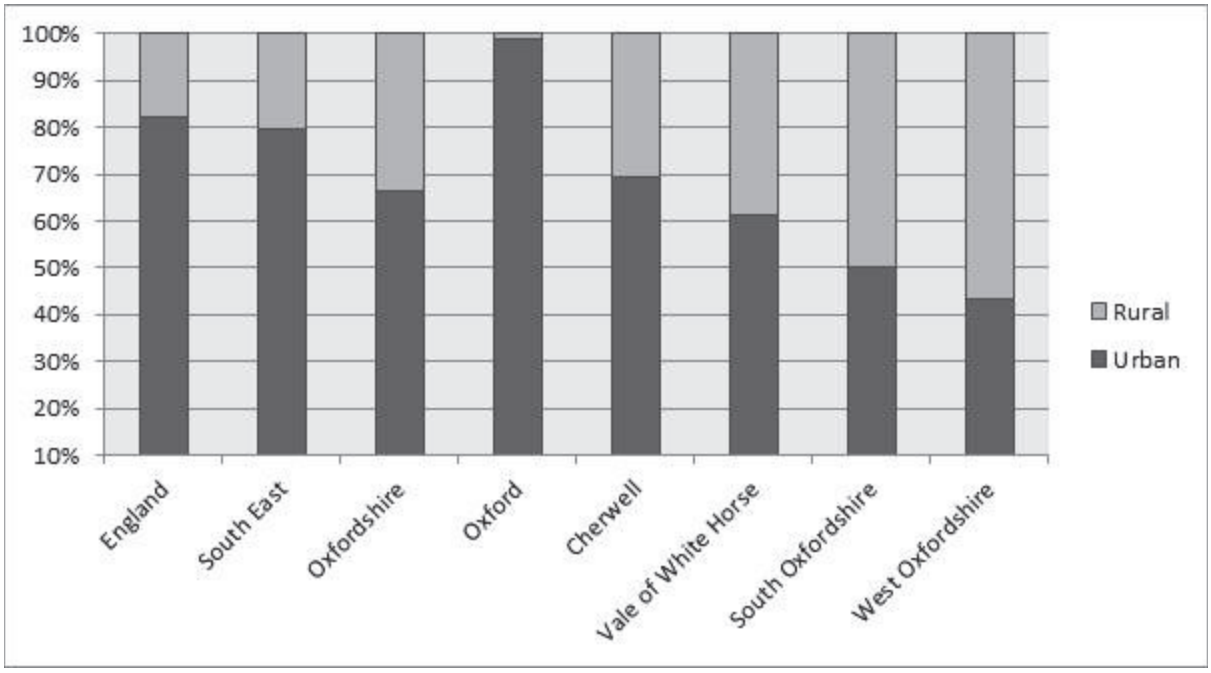
3.4. Rurality

Oxfordshire remains the most rural county in the South East of England: 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%).[29] This compares to proportionately larger urban populations in the South East (79.6% of the total population) and England overall (82.4%).

[27] Census 2011, table QS204EW: https://www.nomisweb.co.uk
[28] Census 2011, table QS205EW: https://www.nomisweb.co.uk
[29] 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.

There was considerable variation across the different parts of the county, as shown in Figure 11 below: whereas Oxford was 98.8% urban, a majority of residents in West Oxfordshire lived in rural areas (56.6%).

Figure 11: Percentage of urban and rural residents



Source: ONS 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.[30] 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%). These population profiles may have a bearing on issues of isolation and loneliness, discussed further in section 4.8 Isolation and Loneliness.

3.5. Sexual Orientation

[30] 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

Reliable figures on the number of lesbian, gay, or bisexual people in the county are still difficult to obtain. The Census did not include questions on sexual identity or 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.

Experimental statistics from the ONS's 'Integrated Household Survey' suggested that the proportion of people identifying as gay, lesbian or bisexual in 2013 was 1.3% in the South East, against a figure for England of 1.9%.[31]

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%).[32] 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.

3.7. Pregnancy and Maternity

[31] ONS Integrated Household Survey, January to December 2013: http://www.ons.gov.uk/ons/rel/integrated-household-survey/integrated-household-survey/january-to-december-2013/index.html

[32] 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.

3.7.1. Conceptions

In 2012 there were 9,500 conceptions in Oxfordshire, reflecting a rate of 71.4 conceptions per 1,000 women aged 15-44.[33] This rate was fairly consistent with data for the previous three years (within three per 1,000 women). It was below the rates seen in the South East (76.4) and England overall (78.8).

In Oxfordshire 17.2% of conceptions led to therapeutic abortion in 2012, a similar proportion as in the previous three years (within three percentage points).[34] The proportion of abortions was lower than in the South East (19.7%) and England overall (20.9%).

3.7.2. Teenage Conception

The latest 3-year rolling data for 2010-12 indicates that in Oxfordshire there were 22 conceptions per 1,000 females aged 15-17 years.[35] Teenage conceptions have fallen in Oxfordshire, and the current rate is lower than in the South East (26 per 1,000 females aged 15-17 years) and England (31). Across the county, higher rates in Oxford have reduced and now remain lower than the national average.

You can explore the data using the public health surveillance dashboard (indicator under Healthy Lifestyles) on the Insight website:
http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

Some wards in Oxfordshire continue to have higher rates of teenage conceptions. These are predominantly in Cherwell (Banbury Grimsbury & Castle and Banbury Ruscote) and Oxford City (Northfield Brook, St. Mary's, Iffley Fields, Blackbird Leys, Rose Hill & Iffley and Barton & Sandhills). Wards in South Oxfordshire (Didcot Northbourne and Didcot All Saints) and Vale of White Horse (Abingdon Abbey & Barton and Abingdon Caldecott) have had high rates too but not consistently so.

3.7.3. Births

In 2012 there were 8,200 live births to Oxfordshire mothers.[36] Almost a quarter of these were born to mothers from Oxford (24.4%) with a similar proportion to mothers from Cherwell (23%). Smaller proportions of the mothers were from South Oxfordshire (18.8%) Vale of White Horse (17.8%) and West Oxfordshire (16%). In the same year there were 31 still births in the county.[37]

3.7.4. Breastfeeding

Breastfeeding gives a baby the best possible nutrition, protects against disease and future obesity and encourages a strong bond between mother and baby.

[33] ONS Conception Statistics: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-332828
[34] This figure includes legal abortions under the Abortion Act 1967. It does not include miscarriages or illegal abortions.
[35] ONS Conceptions Statistics: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Conceptions
[36] ONS Live Births Statistics: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Live+Births
[37] Health & Social Care Information Centre still births data: https://indicators.ic.nhs.uk/webview/

In 2013/14 60% of infants in Oxfordshire were being breastfed at 6-8 weeks. [38] This was significantly higher than the proportion in the South East (50%) and England (46%). However there were differences across the county: the highest proportions of breastfeeding were seen in Oxford (68%) and the lowest in Cherwell (53%). This further conceals varying degrees of breastfeeding within districts, for example there are some GP practices within Oxford with very high levels of breastfeeding and some with very low levels.[39]

You can explore the data using the public health surveillance dashboard (Indicator under Preventing Ill Health) on the Insight website:
http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

3.8. Disability

Disability is defined under the Equality Act 2010 as having a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on one's ability to do normal daily activities. 'Substantial' means more than minor or trivial; for example, it takes much longer than it usually would to complete a daily task like getting dressed. 'Long-term' means for 12 months or more.

This subsection provides an overview of disability in Oxfordshire, drawing on a range of data from national and local sources. The Morbidity and Mortality chapter discusses other specific long-term physical and mental conditions.

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%).[40] 94.3% of these were living at home.

You can explore the data using the interactive health and disability dashboards on the Insight website:
http://public.tableausoftware.com/views/CaringHealthandDisabilityinOxfordshire/Introduction?:showVizHome=no

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

[38] Public Health Outcomes Framework, indicator 2.02ii: http://www.phoutcomes.info/
[39] GP-level data provided by Oxford Health
[40] Census 2011, table QS303EW: https://www.nomisweb.co.uk.

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.

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.

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.

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.[41] Over half of these were female (57%) and two in five lived alone (40%).

3.8.2. Family Resources Survey Disability Data

The Family Resources Survey for 2012/13 found that around 19% of the UK's population was disabled, experiencing physical, mental, cognitive, learning, social, behavioural or other types of impairments.[42] The proportion in the South East was a little lower, at 16%.

Applying the rate for the South East to the 2013 population estimate for Oxfordshire suggests that there could be around 106,600 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 2012/13. However, this group increased in number over the same period due to population growth, from 10.8 million to 12.2 million. Whilst 7% of children (0.9 million) were disabled, 16% of those of working age (6.1 million) were disabled and 43% of adults over State Pension Age (5.1 million) were disabled.[43][44] A slightly

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

[42] Family Resources Survey (FRS): https://www.gov.uk/government/statistics/family-resources-survey-2012-to-2013. 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.

[43] 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.

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 Figure 12 below.[45]

Figure 12: Disability prevalence disaggregated by impairment type in the United Kingdom

	2012/13	
Impairment type	**Millions**	**Percentage**
Mobility	6.9	57%
Stamina/ breathing/ fatigue	4.6	38%
Dexterity	3.4	28%
Mental health	1.9	16%
Memory	1.8	15%
Hearing	1.8	14%
Vision	1.6	13%
Learning	1.4	12%
Socially/ behaviourally	0.8	6%
Other	2.5	20%

Source: Family and Resources Survey

Applying these rates to Oxfordshire (using the above estimate of 106,600 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 13: Extrapolated impairment type figures for Oxfordshire

Impairment type	**Extrapolated number with impairment**
Mobility	60,700
Stamina/ breathing/ fatigue	40,500
Dexterity	29,800
Mental health	17,000
Memory	16,000
Hearing	14,900
Vision	13,900
Learning	12,800
Social/ behavioural	6,400
Other	21,300

Source: Extrapolation from Family and Resources Survey

[44] The FRS does not record information on individuals in nursing or retirement homes. This means that figures relating to older people may not be representative of the United Kingdom population, as many older people may have moved into homes where they can receive more frequent help. Therefore it is likely that disability prevalence for older people is higher than estimated from the FRS.
[45] Family Resources Survey: https://www.gov.uk/government/statistics/family-resources-survey-2012-to-2013. The total will sum to more than 100% as respondents can be affected (and can report) more than one impairment type and the denominator is the number of disabled people.

At a national level, the FRS data show that disabled people of State Pension age were more likely than those 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 than those of State Pension age 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.[46] The number with a serious physical disability has been estimated at over 9,000.

3.8.4. Sight Loss

At the end of March 2014 3,095 people were registered blind or partially sighted in Oxfordshire (1,675 and 1,410 respectively).[47] More than three quarters of these were aged 65 or over. Two thirds were also recorded as having an additional disability.

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).[48] RNIB projects that these figures could increase by almost 25 per cent to over 23,000 affected by sight loss 2020, nearly 3,000 of whom will have severe sight loss (blindness).[49] 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.[50] It is also linked to obesity[51] and is influenced by health inequalities, including deprivation, ethnicity and age.[52]

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[46] 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.

[47] 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

[48] RNIB Sight Loss Data Tool: 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 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

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

[50] 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

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.[53] These indicators show that in 2012/13 the rate of sight loss due to glaucoma in Oxfordshire was 9.3 people aged 40 and over per 100,000 in the population. The rate of sight loss due to diabetic eye disease was 3.5 people aged 12 and over per 100,000 in the population. These rates were similar to those for England overall.[54] However, Oxfordshire had a lower rate of sight loss certifications than England (35.3 per 100,000 people, compared with 42.3 for England overall).

Sight loss can have wider implications for health and wellbeing. For example, a recent evidence review found that almost half (47%) of all falls sustained by blind and partially sighted people were directly attributable to their sight loss[55] 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.[56] [57]

3.8.5. Deafness

Data on people registered as deaf or hard of hearing were collected every three years up to 2010.[58] 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.

3.8.6. Learning Disability

Adults with Learning Disability

In 2010 it was estimated that around 900,000 (2% of) adults aged 18 and over in England had a learning disability, of whom 191,000 (21%) were known to learning disabilities services.[59] At this time Oxfordshire was home to around 1.2% of

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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.

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

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

[53] 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

[54] It should be noted that there are relatively wide confidence intervals for the county-level figures.

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

[56] 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

[57] 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;

[58] 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

[59] *People with Learning Disabilities in England*: http://www.improvinghealthandlives.org.uk/uploads/doc/vid_9244_IHAL2011-02PWLD2010.pdf

England's adults aged 18 and over. On a proportionate basis, this suggests that around 11,100 adults in the county might have had a learning disability.

Separate estimates for 2014 put the number of 18-64 year olds in Oxfordshire with a learning disability at around 10,000.[60] Just under a quarter of these are estimated to have a moderate or severe learning disability.

In 2013/14 around 2,200 patients aged 18 and over of GP surgeries in the Oxfordshire Clinical Commissioning Group area were recorded as having a learning disability.[61] This was equivalent to 0.4% of registered patients. The proportion was similar to the previous year and the Thames Valley area overall. It was slightly lower than for England (0.5%).

Children with Learning Disability

In 2010 it was estimated that around 298,000 children aged 0-17 in England had a learning disability.[62] In 2010 Oxfordshire was home to around 1.2% of England's children aged 0-17. On a proportionate basis, this suggests that around 3,600 children in the country might have had a learning disability at that time.

In 2014 around 2,300 (2.1% of) pupils in Oxfordshire schools had statements of special educational needs (SEN).[63] 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 16,700 (15.7% of) pupils in Oxfordshire schools were recorded as having SEN but not having statements. Again, this proportion remained broadly similar in the years since 2007, and was slightly above the rates for the South East and England overall (15.1% for both).

3.8.7. Disability Benefits

[60] 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.
[61] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof. 83 GP practices in Oxfordshire participated in the QOF 2013/14. It should be noted that people registered with GPs in Oxfordshire are not all necessarily resident in Oxfordshire; and not all residents of Oxfordshire are registered with a GP within the county. Learning disability is defined as the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning) which started before adulthood (18 years), with lasting effect on development. The definition encompasses people with a broad range of disabilities but does not include all those people who have a "learning difficulty".
[62] *People with Learning Disabilities in England:* http://www.improvinghealthandlives.org.uk/uploads/doc/vid_9244_IHAL2011-02PWLD2010.pdf
[63] 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.

The Department for Work and Pensions provides statistics on disability-related benefits.[64] Key data for Oxfordshire are set out below:

- Around 20,200 people in Oxfordshire were claiming Disability Living Allowance in May 2014 (this has now been phased out for new claimants)[65]
- According to official experimental statistics, between June and October 2014 there were 3,650 Personal Independence Payment claims.[66] As of 1 October 2014 decisions had been made on 1,860 of these, with 52% being awarded.
- Around 13,400 people were claiming Attendance Allowance in May 2014[67]
- Around 13,200 people were claiming Employment and Support Allowance in May 2014[68]
- Around 1,800 people were claiming Incapacity Benefit or Severe Disablement Allowance (both of which have now been phased out for new claimants).

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. Armed Forces Personnel

3.9.1. 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.[69] (It should be noted, though, that an expansion of activities at RAF Brize Norton in West Oxfordshire, during

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

[65] 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 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.

[66] Personal Independence Payment (PIP) was introduced in Oxfordshire on 10 June 2014. It replaces Disability Living Allowance for people aged 16-64. Data are available from the Department for Work and Pensions: https://www.gov.uk/government/collections/personal-independence-payment-statistics

[67] 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.

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

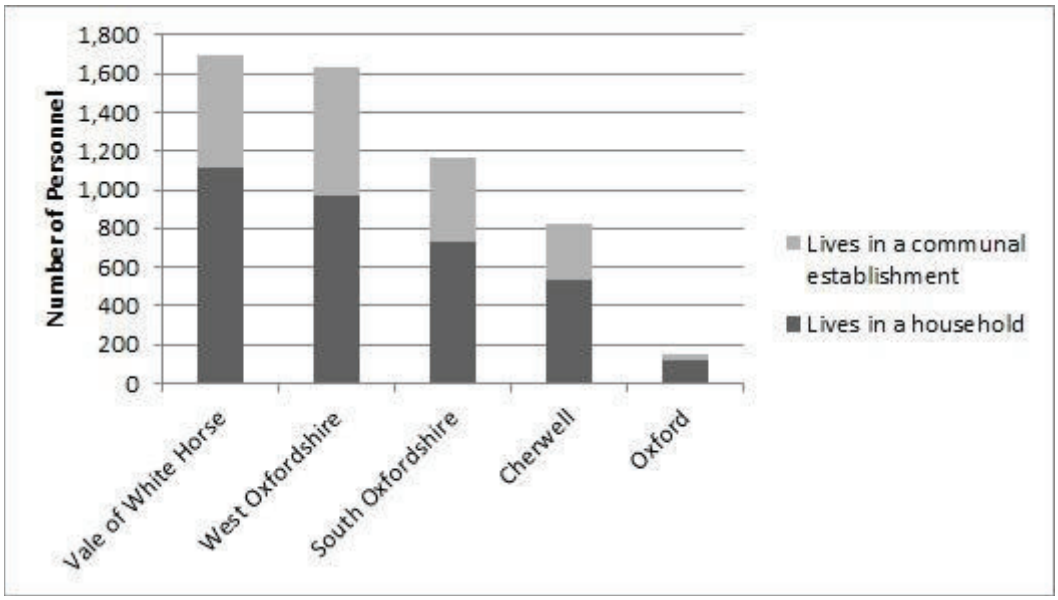
[69] Census 2011, table QS121EW: https://www.nomisweb.co.uk. Regular Armed Forces personnel receive all their primary care from Defence Medical Services (DMS) GPs, not the NHS, although secondary care is accessed via the NHS. DMS Medical Centres at RAF Brize Norton and RAF Benson also provide GP care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

2011/12, saw an increase of several hundred resident personnel there.[70]) The proportion of regular armed forces personnel in Oxfordshire was higher than for the South East (0.4%) and England overall (0.3%).

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 14: Armed Forces personnel



Source: ONS 2011 Census

In October 2014 around 10,000 regular armed forces personnel were stationed in Oxfordshire (although not all necessarily reside in the county).[71] This number has declined slightly in the years since 2011, from over 11,000. The majority of armed forces personnel stationed in Oxfordshire were military personnel (85%) with a minority being civilians (15%). A little under half were stationed in West Oxfordshire (45%) with around two in ten in each of Vale of White Horse (22%) and South Oxfordshire (20%). 11% were in Cherwell (and were predominantly civilians) with less than 1% in Oxford.

3.9.2. Veterans

A number of local authorities and Clinical Commissioning Groups (CCGs), in conjunction with their Public Health departments, have undertaken military veterans'

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

[71] Ministry of Defence Quarterly Location Statistics: https://www.gov.uk/government/statistics/location-of-uk-regular-service-and-civilian-personnel-quarterly-statistics-2014

health needs assessments. In reviewing a cross-section of these health needs assessments in February 2014 Lord Ashcroft noted that the reports all highlight 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.[72] 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 communities.

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 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.

3.10. Carers

3.10.1. Numbers 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

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

county's population (up from 8.8% in 2001).[73] 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 Insight website: http://public.tableausoftware.com/views/CaringHealthandDisabilityinOxfordshire/Introduction?:showVizHome=no

In May 2014, around 6,300 people in Oxfordshire claimed Carers Allowance.[74]

3.10.2. Needs of Carers

In 2012/13 over half of adult carers reported having some kind of impairment themselves. More than two in ten had a long-standing illness (21.7%). Similar proportions had a physical impairment or disability (20.4%) or sight or hearing loss (20.4%).[75]

[73] Census 2011, table LC3304EW: https://www.nomisweb.co.uk

[74] Department for Work and Pensions tabulation tool: http://tabulation-tool.dwp.gov.uk/100pc/tabtool.html Carer's Allowance (CA) is a non-contributory benefit for people aged 16 or over:

- who look after a severely disabled person for at least 35 hours a week
- who are not gainfully employed (i.e. not earning more than £95 per week after certain deductions) and
- who are not in full-time education.

[75] Survey of Adult Carers in England 2012-13: http://www.hscic.gov.uk/searchcatalogue?productid=13851&topics=1%2fSocial+care%2fUser+experience&sort=Relevance&size=10&page=1#top

In 2012/13 around four in ten adult carers in Oxfordshire said they had as much social contact as they would like (41.6%).[76] This was similar to the proportions saying this in the South East (40.2%) and England overall (41.3%). The finding suggests that a majority of adult carers are suffering from some degree of isolation (isolation and loneliness are discussed in more detail in section 4.8 Isolation and Loneliness).

As part of the Adult Carers in England survey (2012/13) six in ten carers in Oxfordshire said they were satisfied with the support or services they and the person they cared for received from Social Services in the previous 12 months (61%).[77] This was significantly lower than satisfaction level among *users* of adult social care services (see section 8.1 Adult Social Care User Survey). Most carers wanted more time to do what they wanted, more control, support and social contact; and to be fully involved in decisions about those they care for. Carers also stated that they find it hard to access the information they want, though when they find it they are usually satisfied.

3.11. Further Information

Further information relating to the Population Groups chapter is available from the JSNA data directory at the following link: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

[76] Public Health Outcomes Framework, indicator 1.18ii: http://www.phoutcomes.info/
[77] Survey of Adult Carers in England: https://nascis.hscic.gov.uk

4. Wider Determinants of Health

This section considers wider economic, social and environmental factors affecting health and wellbeing.[78]

4.1. Housing and Homelessness

4.1.1. Housing and Homelessness Overview

Although the relationship between housing and health is difficult to assess precisely, it has been found that bad housing conditions – including homelessness, temporary accommodation, overcrowding, insecurity, and housing in poor physical condition – constitute a risk to health.[79] Research suggests that poor housing, which presents certain structural or environmental hazards to inhabitants, is associated with increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety.[80]

4.1.2. 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%).[81] 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.

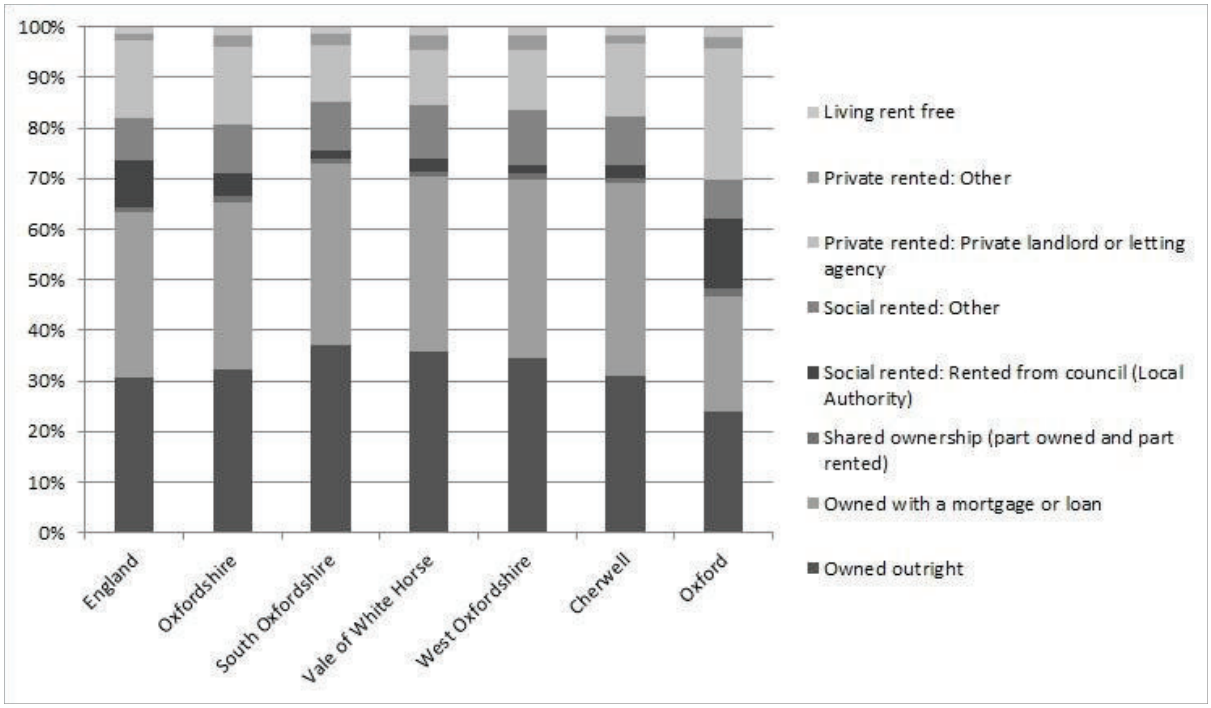
Figure 15: Households by tenure type

[78] 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

[79] The Marmot Review: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[80] Housing and Health Post Note, January 2011: http://www.parliament.uk/documents/post/postpn_371-housing_health_h.pdf

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



Source: ONS 2011 Census

Figure 15 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%).

4.1.3. 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%).[82] 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.

4.1.4. Fuel Poverty

Cold homes are linked to increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. [83] The elderly have been found to be particularly likely to suffer ill health in a cold home.[84]

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

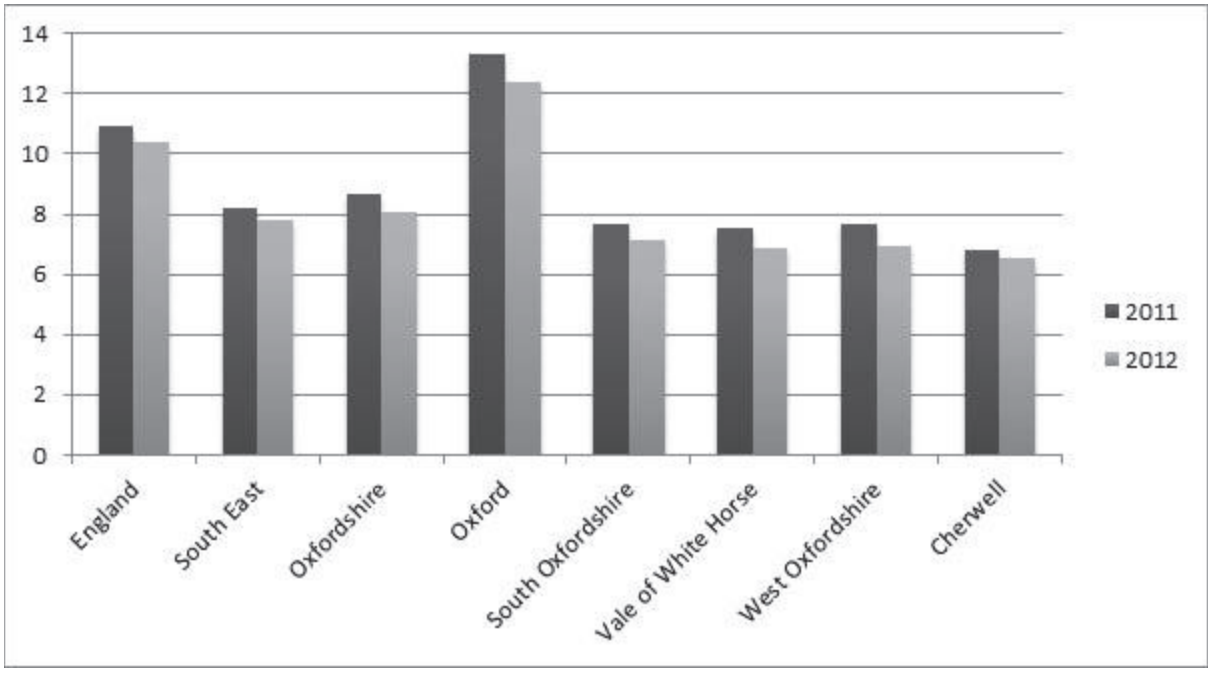
[82] Census 2011, table QS414EW**:** https://www.nomisweb.co.uk
[83] Housing and Health Postnote 371 (January 2011): http://www.parliament.uk/documents/post/postpn_371-housing_health_h.pdf
[84] *IBID*

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 2012 8% of Oxfordshire's population was living in fuel poverty (down slightly from 8.7% in 2011).[85] This was similar to the proportion seen in the South East (7.8%) and below that in England overall (10.4%).

Oxford had proportionately more people living in fuel poverty (12.4% or around one in eight people). For the other districts, fuel poverty affected around 7% of people (approximately one in fourteen).

Figure 16: Percentage of people in fuel poverty (2011 and 2012)



Source: Public Health England

A more detailed map of fuel poverty in the county is available on the Insight website: http://insight.oxfordshire.gov.uk/cms/fuel-poverty-map-pdf-format

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.

In 2011 there were an estimated 45,900 households in Oxfordshire not connected to the gas network.[86] Across the county, proportionately more households were unconnected in West Oxfordshire (24%), Cherwell (22%) and South Oxfordshire (19%) than in Vale of White Horse (15%) and Oxford (10%).

[85] Public Health Outcomes Framework, indicator 1.7: http://www.phoutcomes.info/ .
[86] 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

A more detailed map of households not connected to the gas network in Oxfordshire is available on the Insight website: http://insight.oxfordshire.gov.uk/cms/map-households-not-connected-gas-network-png-format

4.1.5. Homelessness

Homelessness is associated with adverse health.[87] 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.

In 2013/14 the rate of homelessness acceptances in Oxfordshire was 1.2 households per 1,000 (the same as in 2012/13 but up from 0.98 since 2010/11).[88] This rate was lower than for the South East (1.7) and England (2.3).

The rate of households in temporary accommodation in Oxfordshire in 2012/13 was 0.7 households per 1,000 (broadly similar to rates for the previous three years).[89] Again, this was lower than for the South East (1.4) and England (2.6).

Across the county, Oxford had higher rates of both kinds of statutory homelessness than Oxfordshire overall. This is could in part be related to the presence of homeless facilities in the city.

Estimated numbers of people sleeping rough in Oxfordshire in 2013/14 are shown in Figure 17 below, based on calculated estimates (for all districts) and counts (conducted in Oxford only).[90]

Figure 17: Estimates of rough sleeping (2013/14)

Area	Number sleeping rough (estimate)	Number sleeping rough (count)
Cherwell	14	*N/A*
Oxford	45	19
South Oxfordshire	5	*N/A*
Vale of White Horse	5	*N/A*
West Oxfordshire	2	*N/A*

Source: Data provided by District Councils

[87] Public Health England Outcomes Framework: http://www.phoutcomes.info/
[88] Public Health England Outcomes Framework, indicator 1.15i: http://www.phoutcomes.info/
[89] Public Health England Outcomes Framework, indicator 1.15ii: http://www.phoutcomes.info/
[90] Data provided by District Councils, January 2015. Trends have not been analysed due to small numbers.

4.2. Education

Inequalities in educational attainment have been linked with health inequalities including, for example, being overweight, smoking and developing lung cancer and other limiting illnesses.[91] International research has found that the most consistent predictor of the likelihood of death in any given year is level of education.[92]

4.2.1. 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%).

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 Insight website:
http://public.tableausoftware.com/profile/graham.occ#!/vizhome/qualifications/Qualifications

4.2.2. 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 2014 78% of pupils in Oxfordshire achieved level 4 or above in reading, writing and maths.[93] This represents a drop below the England average (79%) for the first time in a number of years.

Across the county only one district – West Oxfordshire – was in the top 25% of districts nationally (compared to four Oxfordshire districts in 2013). The performance of pupils resident in Oxford has increased slightly in 2014, but Oxford continues to rank in the bottom 25% of districts nationally.

[91] *Fair Society, Healthy Lives: The Marmot Review:* http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/Marmot/MarmotIndicators2014.aspx
[92] 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
[93] DfE Statistical First Release - *National Curriculum Assessments Key Stage 2 in England 2013/14 (revised)* published December 2014: https://www.gov.uk/government/collections/statistics-key-stage-2

However, progress between Key Stage 1 and Key Stage 2 was higher across all subjects in Oxfordshire than the national average, with at least a 1% increase in each subject being reported in 2014.

In 2014 pupils known to be eligible for free school meals in Oxfordshire were 23 percentage points less likely to achieve level 4 or above in reading, writing and maths than those who were ineligible. This attainment gap remains larger than the national average (18%).

4.2.3. 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 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). For this reason previous years' results cannot be directly compared.[94]

In 2014 59.4% of pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE, including English and maths.[95] This was above the England average of 56.8%. Across the county, Oxford schools have moved out of the bottom quartile in national GCSE rankings for the first time in a number of years.[96]

In 2014 the proportion of pupils at schools in Oxfordshire making the expected progress in English and mathematics (of three whole levels between Key Stages 2 and 4) was higher than the national average.

Pupils known to be eligible for free school meals in Oxfordshire schools were 34 percentage points less likely to achieve five or more A*-C GCSE grades including England and maths than those who were ineligible. This attainment gap remains larger than the national average (27%).

4.3. Employment

Correlations have been found between being in good quality employment and better health; conversely, unemployment is linked to poorer health.[97]

4.3.1. Economic activity

In the financial year 2013/14 there were 355,000 economically active people in Oxfordshire.[98] This was equivalent to 80.1% of people aged 16-64. The rate of

[94] Although it is not possible to compare results, it is still possible to compare national rankings.
[95] DfE Statistical First Release - *GCSE and Equivalent Results in England, 2013-14* published Dec 2014: https://www.gov.uk/government/collections/statistics-gcses-key-stage-4
[96] DfE GCSE Statistics by pupil characteristics: https://www.gov.uk/government/statistics/gcse-and-equivalent-attainment-by-pupil-characteristics-2014
[97] *Fair Society, Healthy Lives: The Marmot Review:* http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/Marmot/MarmotIndicators2014.aspx
[98] Official labour market statistics: https://www.nomisweb.co.uk.

economically active people was higher than for the South East (79.9%) and England (77.5%). It was higher among men (85.5%) than women (74.4%).

In Oxfordshire 76.8% of people aged 16-64 were in employment (64.6% were employees; 11.9% were self-employed).[99] This proportion has remained fairly stable (within two percentage points) over the last five years, having peaked at around 80% in 2006. The proportion employed was higher in Oxfordshire than in the South East (75.5%) and England (71.9%). As a percentage of the economically active population, 95.9% were in employment (79.3% were employed; 16.2% were self-employed).

In 2013/14 3.4% of people aged 16-64 in Oxfordshire were unemployed. This figure represented a reduction from a nine-year high of 6.5% in 2012/13.[100] As a proportion of the economically active population, 4.1% were unemployed. The rate in Oxfordshire was lower than for the South East (5.4%) and England (7.3%).

Employment rates were similar across different parts of the county (unemployment rates are difficult to compare at district level, due to small sample sizes).

In November 2014 0.7% of people aged 16-64 in Oxfordshire claimed Job Seekers Allowance (JSA).[101] This continued a declining trend since February 2013, when the claimant rate was 1.7%. The rate for Oxfordshire remains lower than for the South East (1.2%) and Great Britain (2%).

You can explore the data using the interactive unemployment dashboard on the Insight website:
http://insight.oxfordshire.gov.uk/cms/unemployment-dashboard

4.3.2. Workplace Health and Wellbeing

Between 2010 and 2012, an average of 1.7% of working days were lost due to sickness absence in Oxfordshire.[102] 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.

[99] 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 (eg, 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%).
[100] 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.
[101] Official labour market statistics: https://www.nomisweb.co.uk. People claiming JSA must declare that they are out of work, capable of, available for and actively seeking work during the week in which the claim is made.
[102] Public Health Outcomes Framework, indicator 1.09ii: http://www.phoutcomes.info/

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%).[103] 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.

4.4. Crime

4.4.1. Overall Levels of Crime

In the 12 months leading up to 30 September 2014 there were 33,228 crimes recorded by the police in Oxfordshire.[104] This represents a fall of 8.5% (or 3,077 crimes) from the previous 12 month period. Crime fell across all categories except sexual offences (which increased by 19.7%), theft from the person (which increased by 3.8%) and violence with injury (which increased by 2.3%).

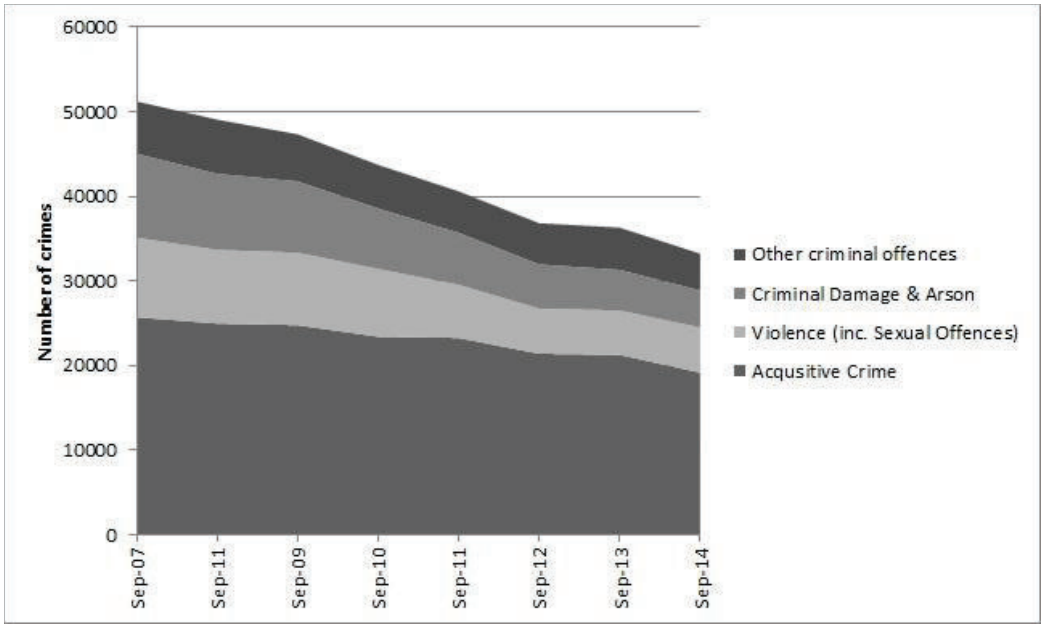
Over the longer term recorded crime has fallen by 18.2% over the last three years, and by 35.1% over the last seven years (see figure below).

Figure 18: Long term crime trends in Oxfordshire, broken down by category[105]

[103] ONS Sickness Absence in the Labour Market data: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-351500

[104] ONS Police Recorded Crime Statistics (published January 2015): http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/index.html

[105] Acquisitive crime includes robbery, burglary, vehicle offences, theft from the person, bicycle theft, shoplifting and all other theft offences. Violence includes homicide, violence with injury, violence without injury and sexual offences.



Source: ONS Police Recorded Crime Statistics (January 2015)

The figure below presents numbers and rates (per 1,000 people) of different categories of crime recorded in Oxfordshire in 2013/14.

Figure 19: Numbers and rates of crime in Oxfordshire and its districts, broken down by category (1 October 2013 to 30 September 2014)

	Oxfordshire		Cherwell		Oxford		South Oxfordshire		Vale of White Horse		West Oxfordshire	
	Number of crimes	Rate per 1,000 people	Number of crimes	Rate per 1,000 people	Number of crimes	Rate per 1,000 people	Number of crimes	Rate per 1,000 people	Number of crimes	Rate per 1,000 people	Number of crimes	Rate per 1,000 people
VICTIM BASED CRIME	28,888	*43.4*	5,946	*41.4*	12,515	*80.9*	4,048	*29.8*	3,453	*27.9*	2,926	*27.1*
Violence against the person offences	**4,568**	*6.9*	**1,030**	*7.2*	**1,693**	*10.9*	**649**	*4.8*	**635**	*5.1*	**561**	*5.2*
Homicide	4	*0.0*	2	*0.0*	2	*0.0*	0	*0.0*	0	*0.0*	0	*0.0*
Violence with injury	1,841	*2.8*	437	*3.0*	662	*4.3*	257	*1.9*	253	*2.0*	232	*2.1*
Violence without injury	2,723	*4.1*	591	*4.1*	1,029	*6.6*	392	*2.9*	382	*3.1*	329	*3.0*
Sexual offences	**771**	*1.2*	**175**	*1.2*	**285**	*1.8*	**86**	*0.6*	**125**	*1.0*	**100**	*0.9*
Robbery	**172**	*0.3*	**28**	*0.2*	**111**	*0.7*	**15**	*0.1*	**13**	*0.1*	**5**	*0.0*
Theft offences	**19,001**	*28.5*	**3,853**	*26.8*	**8,949**	*57.8*	**2,577**	*18.9*	**1,942**	*15.7*	**1,680**	*15.6*
Burglary, including:	**2,763**	*4.1*	**567**	*3.9*	**815**	*5.3*	**657**	*4.8*	**423**	*3.4*	**301**	*2.8*
-Domestic burglary	991	*1.5*	215	*1.5*	421	*2.7*	207	*1.5*	86	*0.7*	62	*0.6*
-Non-domestic burglary	1,772	*2.7*	352	*2.5*	394	*2.5*	450	*3.3*	337	*2.7*	239	*2.2*
Vehicle offences	2,612	*3.9*	600	*4.2*	903	*5.8*	502	*3.7*	324	*2.6*	283	*2.6*
Theft from the person	1,053	*1.6*	151	*1.1*	758	*4.9*	54	*0.4*	43	*0.3*	47	*0.4*
Bicycle theft	2,377	*3.6*	191	*1.3*	1,818	*11.7*	103	*0.8*	180	*1.5*	85	*0.8*
Shoplifting	3,793	*5.7*	1,084	*7.5*	1,600	*10.3*	397	*2.9*	375	*3.0*	337	*3.1*
All other theft offences	6,403	*9.6*	1,260	*8.8*	3,055	*19.7*	864	*6.4*	597	*4.8*	627	*5.8*
Criminal damage and arson	**4,376**	*6.6*	**860**	*6.0*	**1,477**	*9.5*	**721**	*5.3*	**738**	*6.0*	**580**	*5.4*
OTHER CRIMES AGAINST SOCIETY	4,340	*6.5*	1,132	*7.9*	1,749	*11.3*	484	*3.6*	566	*4.6*	409	*3.8*
Drug offences	2,140	*3.2*	587	*4.1*	829	*5.4*	245	*1.8*	297	*2.4*	182	*1.7*
Possession of weapons offences	197	*0.3*	58	*0.4*	76	*0.5*	21	*0.2*	25	*0.2*	17	*0.2*
Public order offences	1,577	*2.4*	341	*2.4*	716	*4.6*	152	*1.1*	202	*1.6*	166	*1.5*
Miscellaneous crimes against society	426	*0.6*	146	*1.0*	128	*0.8*	66	*0.5*	42	*0.3*	44	*0.4*
TOTAL	**33,228**	***49.9***	**7,078**	***49.3***	**14,264**	***92.2***	**4,532**	***33.3***	**4,019**	***32.5***	**3,335**	***30.9***

Source: ONS Police Recorded Crime Statistics (January 2015)

More detailed data on crime in Oxfordshire are available from the Oxfordshire Safer Communities Partnership Strategic Intelligence Assessment: http://insight.oxfordshire.gov.uk/cms/community-safety-0.

4.4.2. Offenders and detainees

Nationally, offending is known to be linked to heightened prevalence of substance misuse, mental ill health and suicide.[106]

In Oxfordshire, there are two category C prisons (HMP Bullingdon, holding up to 1114 male prisoners, and HMP Huntercombe, holding up to 430 male prisoners).

[106] See, for example, Thames Valley Local Criminal Justice Board Needs Assessment Report 2014: http://insight.oxfordshire.gov.uk/cms/thames-valley-lcjb-needs-assessment-report-2014; *Public Health and Criminal Justice: Promoting and protecting offenders' mental health and wellbeing* (Centre for Mental Health, 2010): http://www.centreformentalhealth.org.uk/pdfs/Public_health_and_criminal_justice.pdf and *Gender differences in substance misuse and mental health amongst prisoners* (Ministry of Justice, 2013): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf

There is also an immigration removal centre (IRC Campsfield, holding up to 276 male detainees).

4.5. Abuse and Exploitation

4.5.1. 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.

Using data from the crime survey for England and Wales and population data from the Census 2011 survey it is estimated that there are 22,200 people aged 65 and under in Oxfordshire likely to have been victims of domestic abuse.[107]

In the period from April 2014 to December 2014 Thames Valley Police recorded 6,319 domestic abuse incidents which were not recordable as crimes.[108] Over the same period there were 1,684 domestic abuse incidents which were recorded as crimes. Whilst the number of domestic abuse incidents not recordable as crimes has continued to increase, the number of recorded crimes has continued to fall. Across the county, rates of domestic abuse crimes and incidents have historically tended to be higher in Oxford and Cherwell than in the other districts.

In 2013/14 3,072 victims of domestic abuse in Oxfordshire accessed dedicated support services, including:

- The Oxfordshire Domestic Abuse Service (offering refuge, outreach and resettlement)
- Independent Domestic Violence Advisors

[107] Crime survey for England and Wales appendix table 4.09: http://www.crimesurvey.co.uk/; Census 2011 table LC1108: https://www.nomisweb.co.uk

[108] Data provided by Thames Valley Police for inclusion in Oxfordshire's Strategic Intelligence Assessment

- Parents and Children Together outreach services.[109]

4.5.2. Female Genital Mutilation (FGM)

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.[110] 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. [111] 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 by October 2014 over 200 women in the South of England had been identified by acute hospital providers as having undergone FGM at some previous point in their lives.[112] However, no figure is presented for the total population (children and women) who may have been affected by FGM.

4.5.3. Forced Marriage

In 2013 the UK Forced Marriage Unit gave advice or support related to a possible forced marriage in 1302 cases nationwide. [113] This was down from 1485 in 2012. 9.9% of these were in the South East, compared with 11% in 2012.

4.5.4. 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.[114]

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[109] Annual Performance report to OSCP Business Group, June 2014: http://insight.oxfordshire.gov.uk/cms/oscp-performance-and-monitoring-bi-annual-report-nov-2013

[110] Health and Social Care Information Centre Female Genital Mutilation Dataset: http://www.hscic.gov.uk/fgm

[111] 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

[112] Health and Social Care Information Centre Female Genital Mutilation Dataset: http://www.hscic.gov.uk/fgm

[113] Forced marriage information: https://www.gov.uk/forced-marriage

CSE is a form of child sexual abuse. Victims of CSE can experience severe and enduring consequences on their physical and mental health.[115] The prevalence of CSE has been an emerging national issue of concern over recent years.

Since 2011, when Operation Bullfinch commenced, there have been a number of successful convictions, as set out below.

Operation Bullfinch:	6 victim witnesses, 9 defendants,	7 men convicted, sentenced to a total of 95 years
Operation Bullfinch - Additional Perpetrator:	3 victim witnesses, 1 defendant	Found guilty of 5/8 offences and awaiting sentence
Ongoing operation:	8 victim witnesses, 7 defendants,	Currently in court – to update on conclusion of the trial
Lone perpetrator:	7 victim witnesses, 1 defendant, pleaded guilty	Found guilty, sentenced to 10 years in prison
Lone perpetrator:	2 victim witnesses, 1 defendant	Found guilty, sentenced to 54 months in prison
Lone perpetrator:	1 male victim witness	Found guilty, 32 month imprisonment
Lone perpetrator:	2 victim witnesses	Found guilty, Six years in prison
Group of three perpetrators:	1 victim witness	Found guilty, 27 month sentences
Lone perpetrator:	4 victim witnesses	Found guilty, 3 year sentence
Lone perpetrator:	1 victim witness	Found guilty, 6 weeks in prison and financial compensation

[114] 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

[115] These are discussed in more detail in the Health Working Group Report on Child Sexual Exploitation (2014): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279189/Child_Sexual_Exploitation_accessible_version.pdf and in *Estimating the costs of child sexual abuse* (NSPCC, 2014) http://www.nspcc.org.uk/globalassets/documents/research-reports/estimating-costs-child-sexual-abuse-uk.pdf

In November 2012, Thames Valley Police and Oxfordshire County Council established a joint team called 'Kingfisher', with support from the local health service, education professionals, and other partners including Oxford City Council. Based at Cowley Police Station, a team of around 20 work together to safeguard children who are being sexually exploited or are considered to be at risk of sexual exploitation. Since 2012 the Kingfisher team has worked with 255 young people at risk of exploitation.[116] The majority of these were female and aged between 13 and 17.

Factors linked to heightened risk of CSE include children going missing, children with a history of abuse and children in care.[117] During the first half of 2014/15 over 400 children went missing in Oxfordshire, with around 15% of those going missing on more than two occasions. Information on numbers of children in care is provided in section 7.8 Social Care Services for Children.

The Oxfordshire Safeguarding Children Board has a CSE strategy and action plan which is managed through a dedicated CSE sub-group with wide partnership representation.

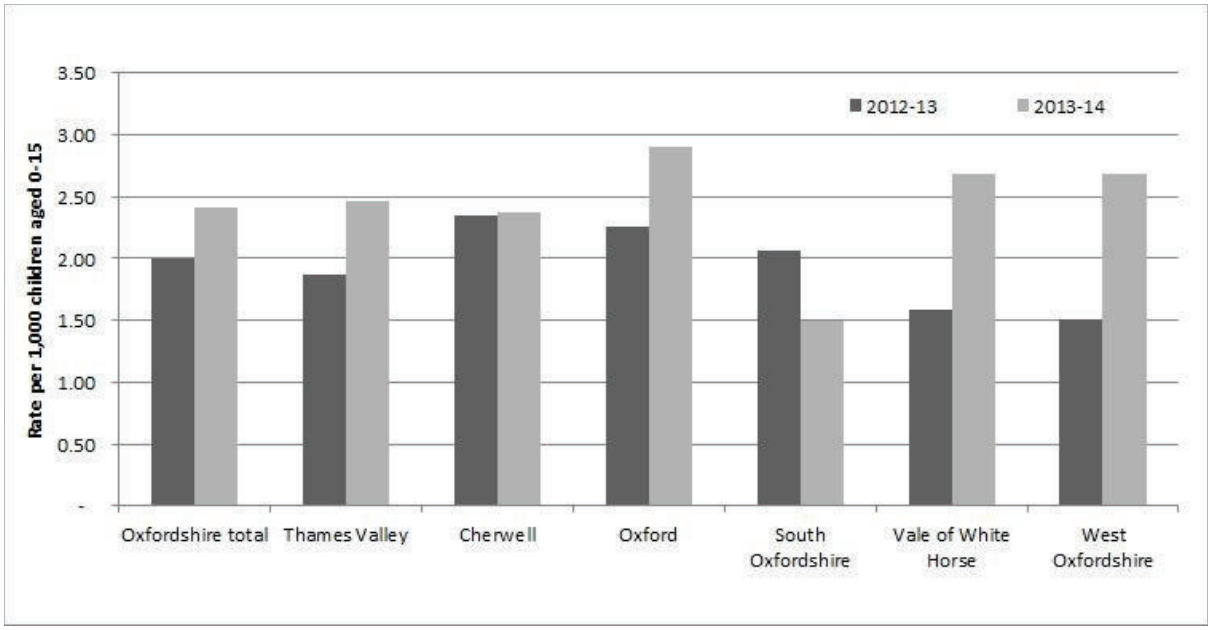
4.5.5. Abuse and Sexual Offences involving Children

Police recorded crime data measure rates of abuse and sexual offences involving children, including: abuse of children through prostitution and pornography; abuse of a position of trust of a sexual nature; rape of a child; sexual activity involving a child; sexual assault on a child; and sexual grooming.

The rate of recorded abuse and sexual offences involving children in Oxfordshire that involve children increased between 2012/13 and 2013/14, from 2 offences per 1,000 children aged 0-15 to 2.4.[118] The wider Thames Valley area saw an even greater increase over the same period.

Figure 20: Police Recorded Abuse and Sexual Offences involving Children (rate per 1,000 children)

[116] Data provided by the Kingfisher team to Oxfordshire County Council
[117] Health Working Group Report on Child Sexual Exploitation (2014): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279189/Child_Sexual_Exploitation_accessible_version.pdf
[118] Home Office police recorded crime open data tables: https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables



Source: Home Office

4.5.6. Human Trafficking

At national level, in 2013 the UK National Referral Mechanism received 1556 referrals of potential victims of trafficking first encountered in England; this represents a 49% increase on 2012 referral totals.[119]

4.6. Thriving Families

Oxfordshire's Thriving Families programme supports families identified as being among the most in need of help, based on national criteria around poor school attendance and behaviour, anti-social and criminal behaviour, youth offending and adults out of work.

As of the end of September 2014 810 troubled families had been identified in Oxfordshire, and were being worked with to improve outcomes across employment, education, offending and anti-social behaviour.[120]

4.7. Environmental Quality

4.7.1. Air Quality

Air Quality Monitoring and Management

[119] National referral mechanism statistics 2013: http://www.nationalcrimeagency.gov.uk/publications/national-referral-mechanism-statistics/139-national-referral-mechanism-statistics-2013

[120] Data provided by Oxfordshire County Council Joint Commissioning Team. As of the end of October 2014 774 of these families had been 'turned around', based on their achievement of national employment, education, offending and anti-social behaviour outcomes. The number and proportion was the highest in the Thames Valley and put Oxfordshire 15th out of 152 local authorities in England.

Air quality across Oxfordshire is considered to be generally good. However, there are some areas where traffic, in particular, can lead to increased levels of air pollution.

Air quality is regularly monitored at many locations across Oxfordshire.[121] Where national air quality objectives are judged unlikely to be achieved, an Air Quality Management Area (AQMA) must be declared and an action plan produced. There are currently 11 AQMAs in Oxfordshire, where the annual mean objective for nitrogen dioxide is being exceeded (three in Cherwell, one covering the whole of Oxford, three in South Oxfordshire, two in Vale of White Horse and two in West Oxfordshire).[122] A new AQMA in Vale of White Horse is currently being consulted on.

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 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.[123] 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 2012 it was estimated that 5.1% of all-cause mortality among people aged 30 and over in Oxfordshire was attributable to particulate air pollution from man-made sources.[124] Again, it should be noted that there remains considerable uncertainty about the relationship between particulate air pollution from man-made sources and mortality, meaning that the figure should be treated with caution. Focusing on trends over time and comparisons with other areas is therefore more likely to be useful.

[121] More information about monitoring is available through district council websites:
- 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/

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

[123] *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

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

Calculated mortality attributable to man-made, particulate air pollution in Oxfordshire decreased from 5.6% in 2010 and from 5.5% in 2011. In 2012 it was at the same level as in the South East and England as a whole. The proportion of mortality attributable to man-made air pollution was 5.5% in Oxford, 5.2% in Cherwell, 5.1% in both South Oxfordshire and Vale of White Horse and 4.8% in West Oxfordshire.

4.7.2. Outdoor space

Green spaces have been found to have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage.[125]

In 2012/13 it was estimated that 19.4% of people in Oxfordshire used outdoor space for exercise or health reasons.[126] This was up from 15.1% in 2011/12. The proportion of people in Oxfordshire using outdoor space was higher than for the South East (15%) and England (15.3%).

4.7.3. 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.[127]

In 2011 Public Health England estimated that 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.[128]

In 2011/12 the rate of complaints about noise in Oxfordshire was 5.8 per 1,000 people in the population.[129] This was the same rate as in the previous year, and was the same as seen in the South East overall. However, across the county there were proportionately more complaints in Oxford (11.1 per 1,000 people in the population) and Cherwell (6.2) than in other districts: 4.3 in Vale of White Horse, 3.5 in South Oxfordshire and 2.4 in West Oxfordshire.

4.8. Isolation and Loneliness

4.8.1. Social Contact

[125] Public Health Outcomes Framework: http://www.phoutcomes.info/.
[126] 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 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.
[127] Public Health Outcomes Framework, indicator 1.14ii: http://www.phoutcomes.info/.
[128] Public Health Outcomes Framework, indicator 1.14iii: http://www.phoutcomes.info/.
[129] Public Health Outcomes Framework, indicator 1.14i: http://www.phoutcomes.info/.

Various national and international research studies have linked social isolation and loneliness with adverse health outcomes, including higher mortality rates.[130] Social engagement has also been found to be a driver of quality of life.[131]

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.[132] 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.

Social Contact among Older People

There is evidence to suggest that older people can be more susceptible to social isolation and loneliness.[133] Analysis conducted in 2013 found that 25% of people aged 52 and over in England sometimes felt lonely, with 9% saying they often did.[134] Proportionately more of those aged 80 and over felt lonely sometimes or often (46%, compared to an average of 34% of those aged 52 and over). This figure was around three in five for people who lived alone (see section 4.8.2 Living Alone).

Self-reported loneliness was more prevalent among those who had been widowed, separated or divorced, or were in poor health. A strong association was also found between loneliness and reported limitations in performing daily activities (discussed under section 3.8.1 Census Data on Limitations to Daily Activities).

In another 2013 study of people aged 55 and over in Great Britain, 15% reported often feeling lonely.[135] Moreover, 57% experienced at least half of the symptoms

[130] 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 S.L. Syme. (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.

[131] 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*.

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

[133] Clifton, J. (2009). *Ageing and Well-being in an International Context. Politics of Ageing Working Paper no 3*: Institute for Public Policy Research. IPPR. Available: http://www.ippr.org/images/media/files/publication/2011/05/ageing_international_context_1732.pdf

[134] Measuring National Well-being - Older people and loneliness, 2013: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/older-people-and-loneliness/art-measuring-national-well-being--older-people-and-loneliness.html#tab-Key-points. Further data on the extent of loneliness can be found through: Evangelical Alliance: http://www.eauk.org/culture/statistics/how-lonely-are-we.cfm; Campaign to End Loneliness: http://www.campaigntoendloneliness.org/loneliness-research/; Royal Voluntary Service: http://www.royalvoluntaryservice.org.uk/news-and-events/news/loneliness-rife-among-older-men; Age UK: http://www.ageuk.org.uk/professional-resources-home/knowledge-hub-evidence-statistics/research-community/social-inclusion-and-loneliness-research/

[135] ComRes and The Silver Line Loneliness Study, 2013: https://www.thesilverline.org.uk/wp-content/uploads/2013/11/The-Silver-Line-Loneliness-Survey-FULL-FINDINGS-1.pdf

identified by academics as being associated with loneliness (the gap between these figures could be ascribed to the stigma of loneliness). The same study found that around a third of people aged 55 and over 'never' or 'not very often' met up for an outing with friends or family (34%) and a quarter 'never' or 'not very often' had a chat on the phone (25%).

Social Contact among Social Care Users

In 2013/14 half of social care users in Oxfordshire said they had as much social contact as they would like (49.7%).[136] This continues an improving trend since 2011/12 (when 41.5% said they had as much social contact as they would like). The proportion of Oxfordshire social care users satisfied with the amount of social contact they had was higher than for England overall (44.2%).

More than eight in ten social care users in Oxfordshire said they had at least an adequate amount of social contact (82%). This was higher than the proportion saying this in England overall (78%) although not significantly so.

Social contact for carers is discussed under section 3.10.2 Needs of Carers.

4.8.2. Living Alone

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.[137] Social support (discussed in section 4.8.1 Social Contact) has been shown to affect the extent to which people recover from the transition to 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).[138] 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).[139]

[136] Adult Social Care User Survey: http://www.hscic.gov.uk/socialcare/usersurveys
[137] 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
[138] Census 2011, table KS105EW and KS102EW; Census 2001, table T08: https://www.nomisweb.co.uk
[139] 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)

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).[140] 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.

4.9. Further Information

Further information relating to the Wider Determinants of Health chapter is available from the JSNA data directory at the following link:
http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

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.

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

5. Morbidity and Mortality

This section covers the prevalence of illnesses and diseases in Oxfordshire (morbidity) and causes of deaths (mortality).

5.1. Morbidity

5.1.1. Diabetes

Diabetes mellitus affects 2.9 million people in the UK with a further million people likely to have the condition but not be aware of it. The majority of these will have Type 2 diabetes.

The Quality and Outcomes Framework (QOF) shows that in 2013/14 there were over 27,000 people aged 17 years and over diagnosed with Diabetes across GP practices in the Oxfordshire Clinical Commissioning Group area. This represents almost 5% of registered patients in that age group.[141] This was a similar proportion to the previous year. Oxfordshire percentages were lower than in the Thames Valley and England overall. This may be due to lower prevalence or low recording at GP practices.

5.1.2. Cancer

The incidence of detected cancers has been increasing across all areas in people under the age of 75. This shows that Oxfordshire has a higher rate of incidence than the South East and England in both men and women, although 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. (Incidence of oral cancer is discussed separately, in section 6.7.2.)

You can explore the data using the interactive public health surveillance dashboard (indicators under Preventing Ill Health) on the Insight website: http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

5.1.3. Circulatory Diseases

True prevalence of coronary heart disease and stroke are difficult to obtain but GP-recorded diagnoses provide a good estimate.[142] Within the GP-registered population in the Oxfordshire Clinical Commissioning Group area 2.6% have a recorded diagnosis of coronary heart disease (CHD) and 1.6% are recorded as having had a stroke or transient ischaemic attack (TIA) in 2013/14.[143] These proportions are similar to, or higher than, in the Thames Valley area, but significantly lower than in England overall.

[141] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof.
[142] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof.
[143] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof.

You can explore the data using the interactive public health surveillance dashboard (indicators under Preventing Ill Health) on the Insight website: http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

5.1.4. Mental Health

This section considers the prevalence of mental health problems and self-harm among adults and children. Suicide is discussed in section 5.2.7 Suicide.

Personal Wellbeing (Annual Population Survey)

The Office for National Statistics (ONS) began measuring personal wellbeing in April 2011, through the Annual Population Survey (APS). [144] Since then, the APS has included four questions which are used to monitor personal well-being 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?

People are asked to give their answers on a scale of 0 to 10, where 0 is 'not at all' and 10 is 'completely'. The average ratings for Oxfordshire in 2013/14 broadly reflect the regional and national picture, as shown in Figure 21 below. Similar ratings were seen across different parts of the county.

Figure 21: Average ratings of personal well-being 2013/14

	Life satisfaction	Worthwhile	Happiness	Anxiety
United Kingdom	7.51	7.74	7.38	2.93
England	7.49	7.73	7.37	2.94
South East	7.59	7.8	7.46	2.88
Oxfordshire	7.59	7.81	7.36	2.88

Source: ONS Personal Wellbeing in the UK 2013/14

Indications of Depression and Anxiety (Understanding Society)

[144] ONS Personal Wellbeing in the UK 2013/14: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2013-14/index.html. The APS includes responses from 165,000 people nationwide. Unlike other questions on the APS, people are asked the personal wellbeing questions directly and no one else in the household is allowed to respond on their behalf. The APS is a household survey, and after weighting, the APS Personal Wellbeing dataset provides a representative sample of adults (aged 16 and over) living in residential households in the UK.

Understanding Society, a nationwide survey, estimated that in 2011/12 around one in five (18.6%) people aged 16 and over in the UK showed some indications of depression or anxiety.[145] Although, there was no significant difference from the previous year's figure there has been an increase since 2009/10, when 18% showed indications of depression or anxiety. The proportion was similar to that seen in the South East overall (18.2%).

Indications of depression or anxiety were higher among women (21.6%) than men (15.5%). Higher rates were also seen among people aged between 25-44 (21.3%) and 16-24 (19.9%).

Adult Psychiatric Morbidity

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 Figure 22 below.[146]

Figure 22: 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

[145] Measuring National Wellbeing, Domains and Measures – September 2013 (ONS): http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/domains-and-measures---september-2014/index.html. It should be noted that not everybody showing some indications of depression or anxiety would describe their condition in this way, and some problems are likely to be short term

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

Source: Adult psychiatric morbidity in England, 2007
* Differences calculated for 16-74 year olds.
** Alcohol and drug misuse is discussed further in sections 6.3 Alcohol and 6.4 Drugs.

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.

Mental Health Diagnoses (GP Quality and Outcomes Framework)

According to the Quality and Outcomes Framework, in 2013/14 around 37,000 (6.6% of) patients aged 18 and over registered with GPs in the Oxfordshire Clinical Commissioning Group area had an unresolved diagnosis of depression.[147] The figure was up slightly from 6% in 2012/13. This was similar to the proportion in England overall (6.5%) and slightly above that for the Thames Valley area (6.1%).

In 2013/14 around 5,300 (0.8% of) patients of all ages had a record of serious mental illness, such as schizophrenia, bipolar affective disorder or other psychoses.[148] This was similar to the proportion in 2012/13 and those for the Thames Valley area and England overall (0.7% and 0.9%, respectively).

Section 136 Detentions

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.

In 2013/14 Thames Valley Police made 347 Section 136 detentions across Oxfordshire.[149] This represented an increase of 19% from the previous year. During the first eight months of the 2014/15 financial year there were 187 detentions.[150]

Across the county 44% of the detentions made between April 2012 and November 2014 were in Oxford. 36% were in Cherwell or West Oxfordshire. The remaining 20% were in South Oxfordshire or Vale of White Horse.

[147] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof. This covers all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.
[148] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof.
[149] Data provided by Thames Valley Police in December 2014 from Thames Valley Police Crime Recording Systems CEDAR and NICHE. Other detentions may have been carried out by British Transport Police in Oxfordshire, which are not included in these numbers.
[150] Assuming similar numbers of detentions in each month, this gives a projected number of detentions for 2014/15 of about 280.

For detentions where information about age is available (just under 95% of the total) over four in ten were among those aged 25-44 (42%). Just under a quarter of the detentions were among those aged 18-24 (23.6%) similar to the proportion among the 45-64 age group (23.2%). 4.7% were detentions of under 18s, with 1.2% among 65 and overs.

For detentions where information about sex is available (representing 96% of all detentions) three in five were female and two in five were male.

Mental Health in Children

There are relatively few data about prevalence rates for mental health disorders in pre-school age children.[151] 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%.[152]

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).[153] 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%).

Analysis of national surveys suggests that peak onset of mental ill health is 8-15 years and half of lifetime mental ill health starts by age 14.[154]

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.[155]

5.1.5. Self-harm

Self-harm results in 98,000 inpatient admissions in England per year and 99% of these are emergency admissions.[156] In 2012/13 the rate of emergency hospital

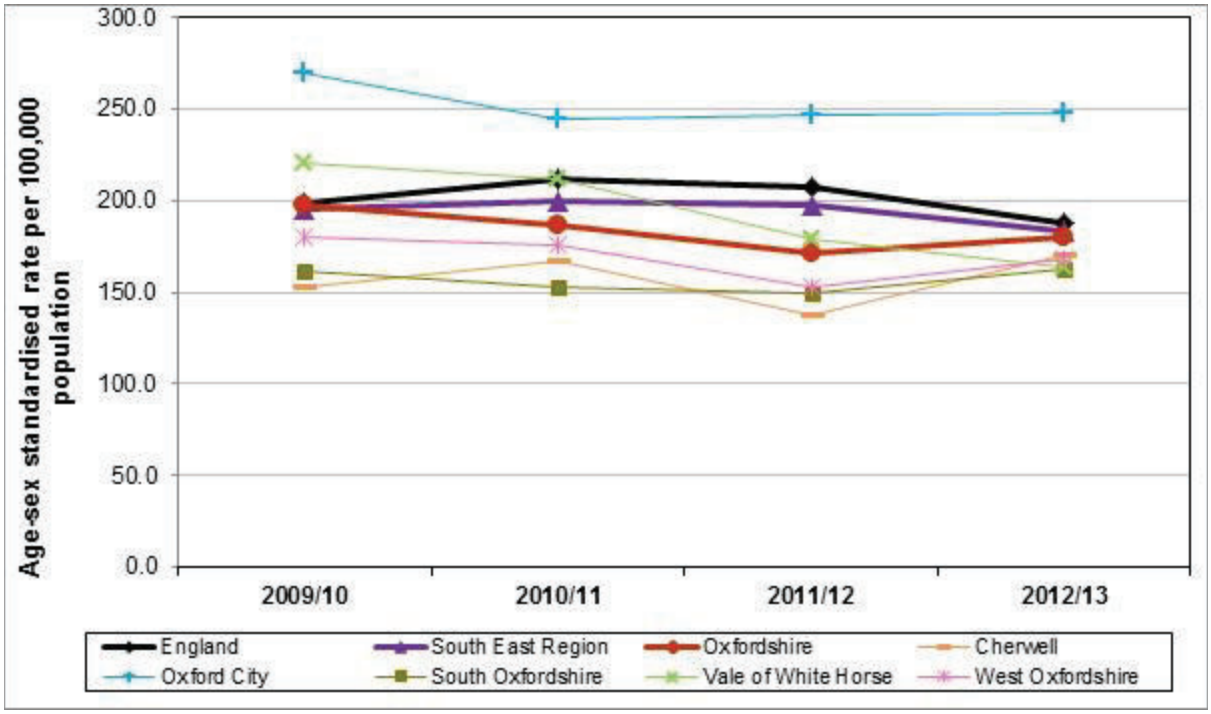
[151] CAMHS Needs Assessment: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34
[152] Egger, H. L. and Angold, A. (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. Journal of Child Psychology and Psychiatry, 47 (3-4), 313–37.
[153] 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.
[154] House of Commons Health Committee's third report of the 2014-15 session: *Children's and adolescents' mental health and CAMHS:*
http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf
[155] CAHMS Needs Assessment: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34
[156] Health and Social Care Information Centre Hospital Episode Statistics:
http://www.hscic.gov.uk/hes

admissions for intentional self-harm Oxfordshire was 180 per 100,000 people.[157] This represents a slight increase on the previous year (171.7 people per 100,000). The figure was similar to rates in the South East (183) and England overall (187).

Across the county, the rate of emergency hospital admissions for intentional self-harm was higher in Oxford than in other districts (248 per 100,000 people, significantly worse than the rate for England).

Rates of emergency hospital admission in Oxford are significantly higher than Oxfordshire as a whole. The data in Figure 23 below do not include patients who attended Accident and Emergency (A&E) or Minor Injury Unit (MIU) but were not admitted to hospital; they are therefore likely to be an underestimate of the true rate of self-harm in the population.

Figure 23: Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 people (2009/10-2012/13)[158]



Source: Public Health England

5.1.6. Dementia

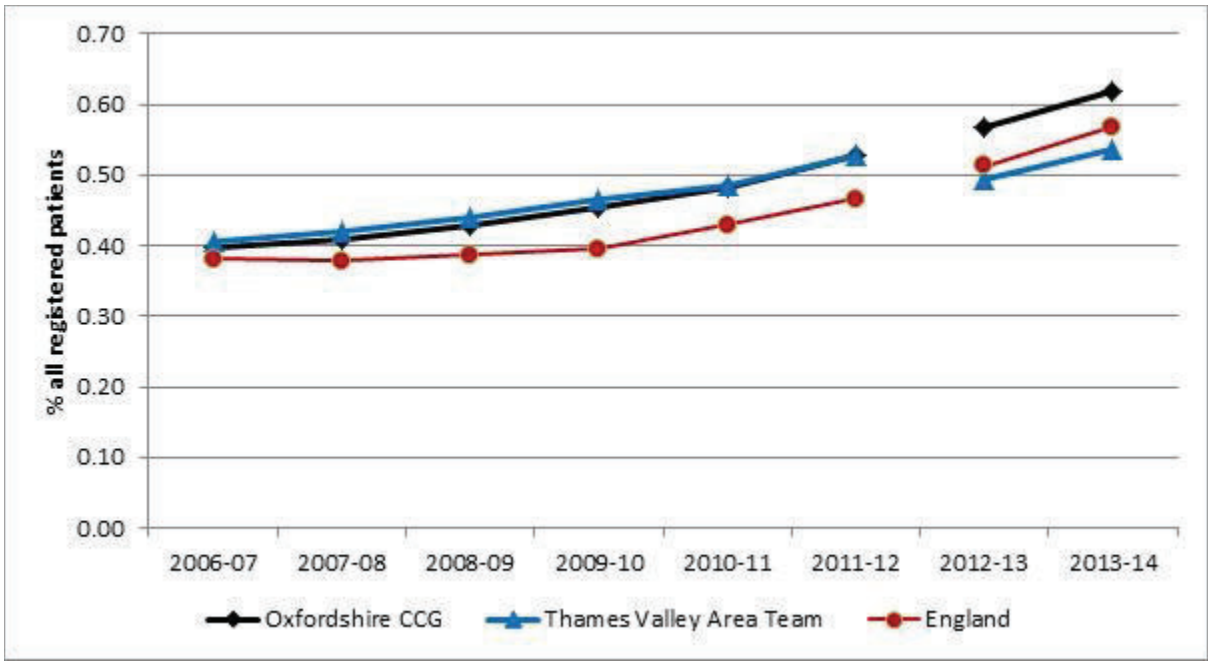
As of Autumn 2014, there were an estimated 8,300 people with dementia in Oxfordshire.[159]

[157] Public Health England Health Profiles: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES.
[158] This rate is calculated in relation to a hypothetical population, with a specified age and sex profile, to facilitate comparisons over time.
[159] Data provided by Oxfordshire Clinical Commissioning Group

Data in support of the Dementia Strategy and the Dementia Challenge are taken from Quality and Outcomes Framework (QOF) and are being collected on a monthly basis to support the Prime Minister's Dementia Challenge, which includes an ambition to improve the national diagnosis rate of dementia.

In 2013/14 the recorded prevalence of dementia stood at 0.6% of people registered with GPs in the Oxfordshire Clinical Commissioning Group area.[160] This was similar to the proportion in the Thames Valley area and in England overall. As shown in Figure 24 below, there has been a steady increase in recorded dementia diagnoses across all geographic areas.

Figure 24: Dementia diagnoses recorded by GPs in the Oxfordshire Clinical Commissioning Group area, Thames Valley and England (2006-07 to 2013-14)[161]



Source: Quality and Outcomes Framework

You can explore the data using the interactive public health surveillance dashboard (indicator under Preventing Ill Health) on the Insight website: http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

Monthly data for April to August 2014 show that dementia diagnoses remained fairly static across this short time period, either showing no change or a slight decrease in numbers.

5.1.7. Other Conditions

Epilepsy

[160] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof.
[161] Prior to 2012 data are for the Oxfordshire Primary Care Trust and South Central Strategic Health Authority, hence the break in the trend line.

In 2013/14 around 3,800 patients aged 18 and over of GP practices in the Oxfordshire Clinical Commissioning Group area were receiving drug treatment for epilepsy (representing 0.7% of GP patients in that age group).[162] This proportion was consistent with the previous year, and close to that for the Thames Valley area (0.7%) and England overall (0.8%).

Asthma

In 2013/14 around 40,700 patients of GP practices in the Oxfordshire Clinical Commissioning Group area were registered as having asthma (representing 5.8% of GP patients).[163] The proportion was very slightly down from 6% in the previous year. It was similar to recorded prevalence in the Thames Valley (5.9%) and England overall (5.9%).

Hypertension

In 2013/14 around 84,200 patients of GP practices in the Oxfordshire Clinical Commissioning Group area were recorded as having hypertension (representing 12% of GP patients).[164] The proportion was similar to the previous year and the Thames Valley area (12.1%). It was lower than recorded prevalence in England overall (13.7%).

Chronic Obstructive Pulmonary Disease (COPD)

In 2013/14 around 8,800 patients of GP practices in the Oxfordshire Clinical Commissioning Group area were recorded as having COPD (representing 1.3% of GP patients).[165] The proportion was similar to the previous year and the Thames Valley area. It was lower than recorded prevalence in England overall (1.8%).

Tuberculosis (TB)

Levels of TB in the UK have stabilised over the past 7-8 years. Despite considerable efforts to improve TB prevention, treatment and control, the incidence of TB in the UK is higher compared to most Western European countries.[166]

The rate of TB in Oxfordshire was 13 cases per 100,000 people in the period 2010-12. This remains lower than the averages for England and the region covering Oxfordshire, Buckinghamshire and Berkshire.[167] In the UK the majority of cases

[162] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof
[163] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof. This excludes patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months.
[164] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof
[165] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof
[166] Given the importance of TB as a public health issue, it is one of the key priorities of Public Health England who are working to support local clinical, preventative and social care systems in the NHS, local government and wider health and social care systems to address TB in Oxfordshire.
[167] Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance https://www.gov.uk/government/collections/tuberculosis-and-other-mycobacterial-diseases-diagnosis-screening-management-and-data

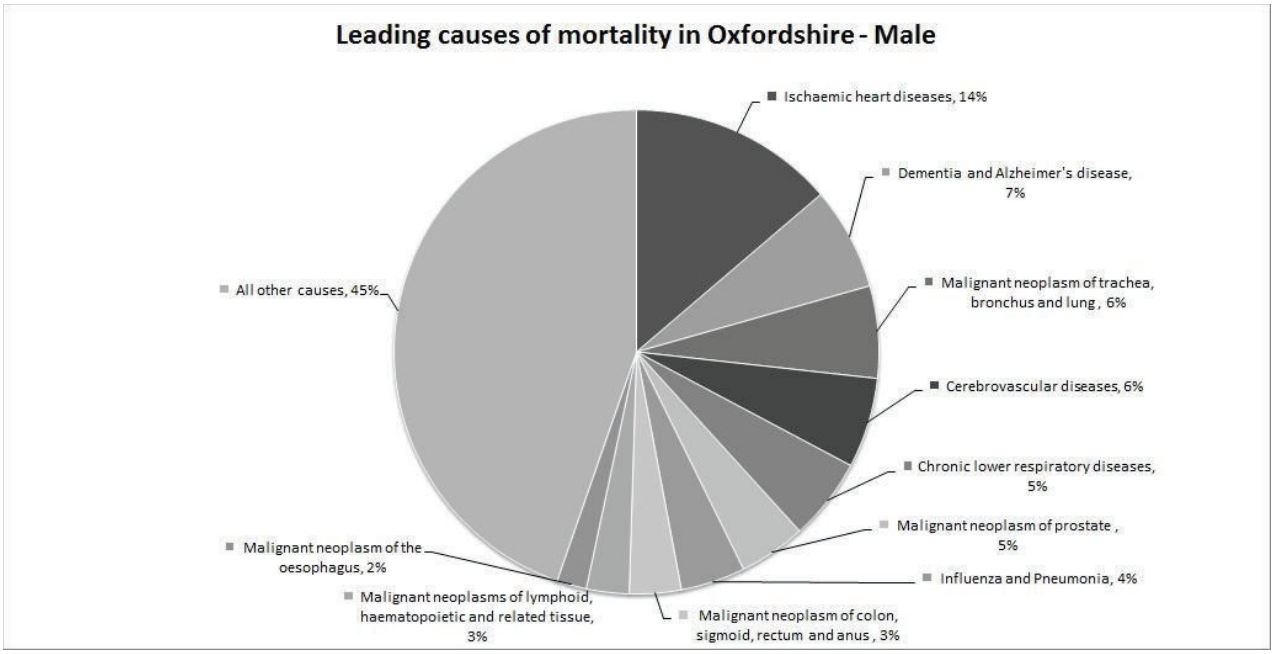
occur in urban areas amongst young adults, those coming in from countries with high TB burdens and those with a social risk of TB. This is reflected in the higher rate of TB in Oxford compared to other districts in the county.

You can explore the data using the interactive public health surveillance dashboard (indicator under Health Protection) on the Insight website: http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

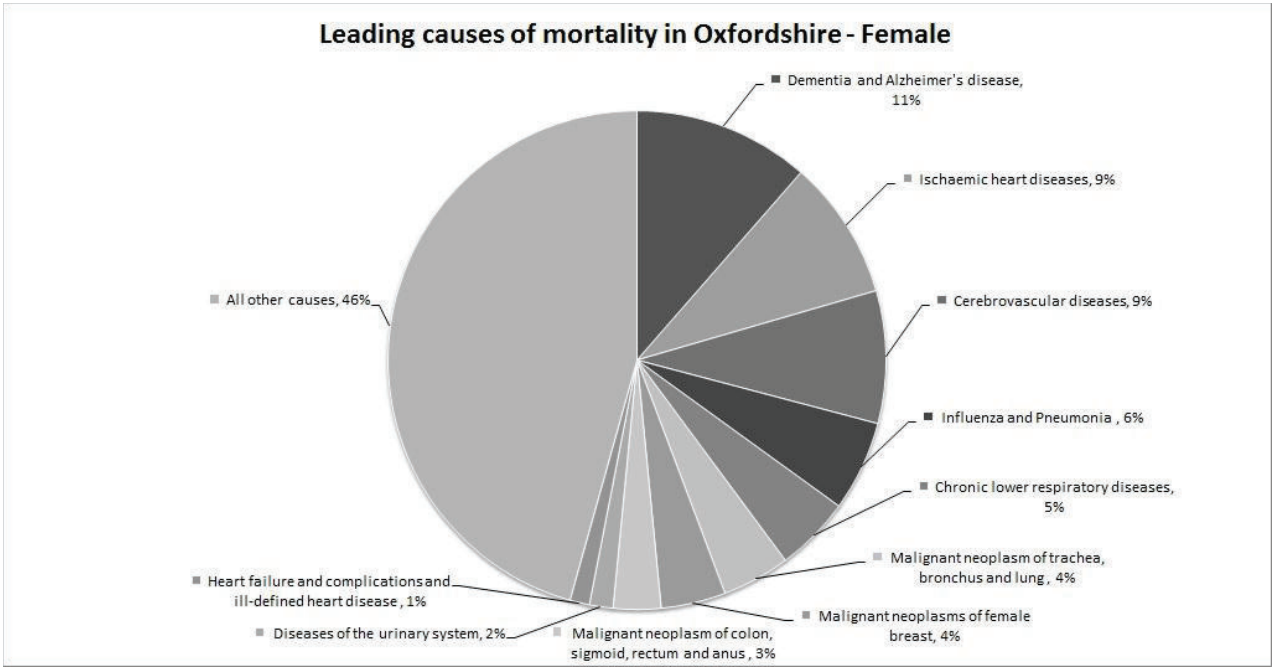
5.2. Mortality

Oxfordshire does not differ from the national picture in terms of leading causes of death in males and females.[168]

Figure 25: Main causes of mortality in Oxfordshire (male and female)



[168] ONS mortality data: http://ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates



Source: Office for National Statistics mortality statistics

5.2.1. Cancer

In 2010-2012 there were over 2,000 deaths in Oxfordshire from all types of cancer in people under the age of 75 years.[169] For male residents the cancer mortality rate for this age group was 109.8 deaths per 100,000 men and boys under the age of 75. This rate remains significantly lower than the England average (117.3). In female residents the mortality rate was 92.6. It is no longer significantly lower than the England average (97) and data for 2010-12 indicate a slight upward turn.

Across all age groups, cancers of the lung, bowel, breast and prostate accounted for almost half (46%) of all cancer deaths in the UK in 2012.[170] The proportion was slightly lower in Oxfordshire at 43% but these remain the major causes of cancer mortality in the county.[171]

5.2.2. Circulatory Diseases

The main cause of male mortality in Oxfordshire is Ischaemic Heart Disease (IHD) representing almost 14% of all male deaths in 2010-2012 (slightly lower than the proportion for England overall, of 16%).[172] For women IHD is the second leading cause of death, representing approximately 9% of all female deaths (the same proportion as in England overall).

Cerebrovascular diseases accounted for significant minorities of all deaths in 2010-2012: 6% of all male deaths and 8% of all female deaths, numbering almost 1,200 in total. These proportions were the same as those in England overall.

[169] ONS mortality data: http://ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates
[170] Cancer Research UK: http://www.cancerresearchuk.org/cancer-info/cancerstats/mortality/
[171] Health & Social Care Information Centre (H&SCIC): https://indicators.ic.nhs.uk/webview/
[172] ONS mortality data: http://ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates

5.2.3. Dementia

For women the leading cause of death was Dementia and Alzheimer's disease representing just over 11% of female deaths in 2010-12.[173] For men, it was the second leading cause of death, representing just under 7% of all deaths in 2010-12.

5.2.4. Smoking attributable mortality

Smoking remains the biggest single cause of preventable mortality and morbidity in the world.[174] It was estimated in 2013 that smoking accounted for 1 in 6 of all deaths in England.[175]

Because of the significant inequalities in smoking related deaths, smoking attributable mortality figures are included in the Local Tobacco Profiles produced by Public Health England (PHE). The latest figures (based on 2011-13) 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.

You can explore the data using the interactive public health surveillance dashboard (indicator under Mortality) on the Insight website:
http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

5.2.5. 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.[176] Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population.

For the three-year period from August 2009 to July 2012, there were an estimated 938 excess winter deaths in Oxfordshire.[177] This was similar to surrounding areas in the South East region and the national average.

5.2.6. Killed and Seriously Injured

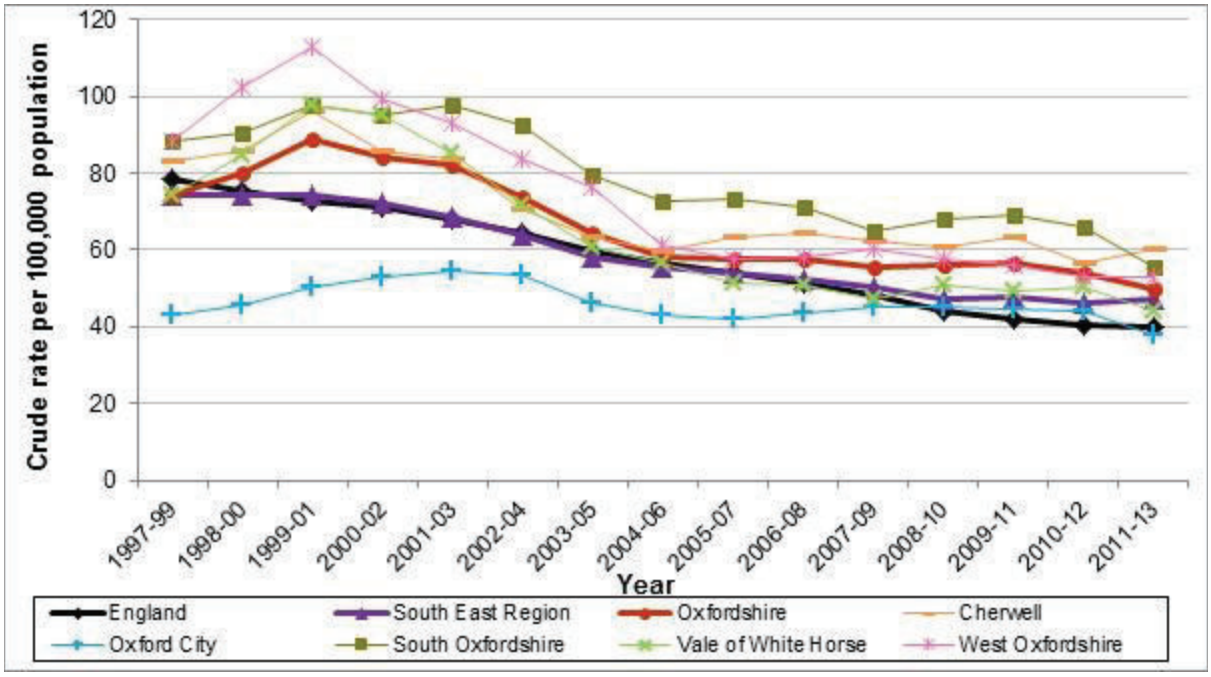
The latest 3-year rolling data for 2011-2013 show a rate of 49.9 people per 100,000 being killed and seriously injured on Oxfordshire roads[178] Despite a downward trend in the number of people killed or seriously injured on Oxfordshire's roads since the

[173] ONS mortality data: http://ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates
[174] World Health Organisation report on Global Tobacco Epidemic 2009
[175] Health and Social Care Information Centre Statistics on Smoking 2013: http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf
[176] Public Health Outcomes Framework: http://www.phoutcomes.info/
[177] Public Health Outcomes Framework, indicator 4.15iii: 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.
[178] Public Health England Outcomes Framework, indicator 1.10: http://www.phoutcomes.info/ . These data report accidents by place; the people involved will often not be Oxfordshire residents. The data do not differentiate between deaths and serious injuries.

turn of the century, the county has a significantly higher rate than in the South East (47) and England overall (39.7). This is shown in

Figure 26 below. It is due to relatively high rates in Cherwell, South Oxfordshire and West Oxfordshire, reflecting the nature of roads in these parts of the county.[179]

Figure 26: Crude rate per 100,000 people of people killed or seriously injured on the roads (1997-2013 3-year rolling data)



Source: Public Health England

Further information obtained from Oxfordshire County Council road traffic accident casualty data shows that in 2013:

- The number of fatal accidents was 19, lower than in 2012 (28). The majority of these (14) were to motorcycle or car drivers. Three were car passengers, one was a pedestrian, and one was a cyclist.
- The number of people seriously injured was slightly higher in 2013 than in 2012 (308 in 2013, 279 in 2012).
- Both serious and slight injuries among children were lower than previous years but one child was killed on Oxfordshire roads in 2013.[180]

5.2.7. Suicide

[179] Since motorways and major trunk roads in these districts are used by drivers from all over the country, and the data show injuries and deaths on these roads for all road users and pedestrians, higher rates are not thought to be related to the behaviour of the resident population.
[180] Oxfordshire County Council road casualties statistics: https://www.oxfordshire.gov.uk/cms/content/road-casualties

In 2010-12 the rate of suicide in Oxfordshire was 8.5 people per 100,000.[181] This was similar to rates seen across the South East (8.4) and England overall (8.5). The number of suicides reduced to 47 in 2012 from 55 in 2011.

The suicide rate in men is three times that in women, similar to the national picture. In Oxfordshire the suicide rate in men is comparable to surrounding areas and the national rate. Generally, rates in younger people have decreased and rates in older people have increased. The highest risk group is men aged 45-59.

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.

5.3. Further Information

Further information relating to the Morbidity and Mortality chapter is available from the JSNA data directory at the following link:
http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

[181] Public Health Outcomes Framework, indicator 4.10: http://www.phoutcomes.info/

6. Lifestyles

This section presents data on lifestyle factors affecting the health and wellbeing of people in Oxfordshire.

6.1. Excess Weight and Obesity

6.1.1. 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.[182]

Self-reported data for 2012 indicated that almost 61% of Oxfordshire's adult population were overweight or obese. This was significantly lower than the national average (64%). Data for the districts indicated similar levels except in Oxford where the proportion is slightly lower at 55%.

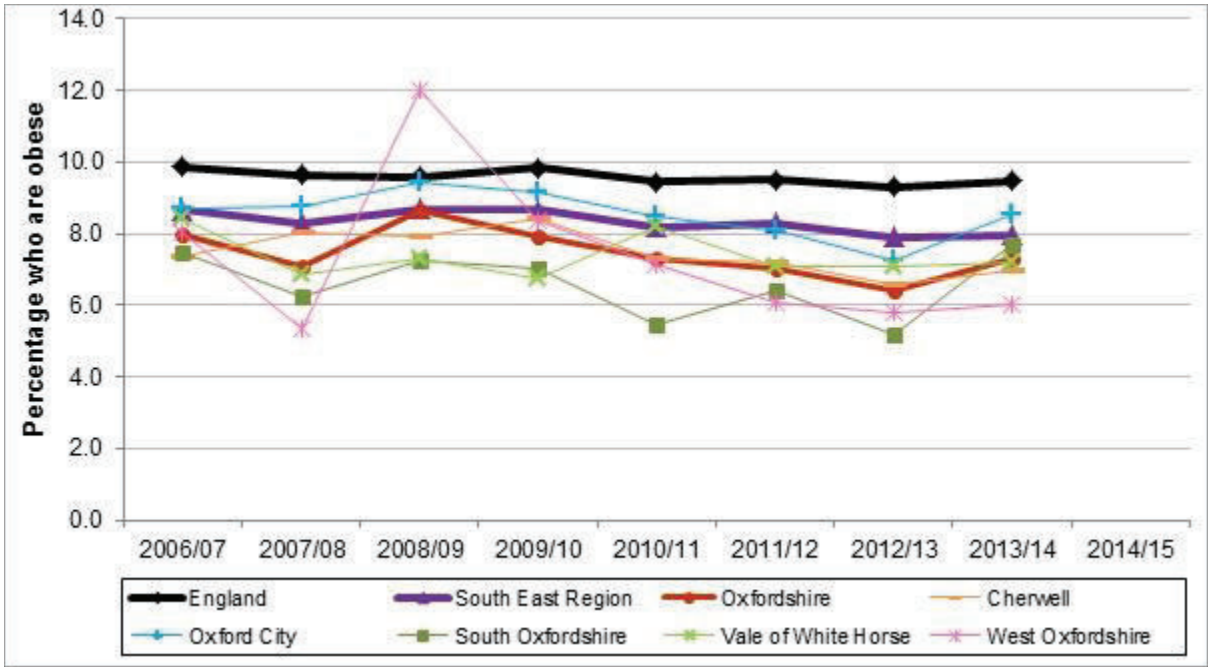
6.1.2. Obesity in Children

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 2013/14.[183]

Prevalence of obesity among children in Reception Year has remained fairly stable, with some fluctuation at a district level. Oxfordshire has a significantly lower rate of obesity among reception-age school-children than England overall.

Figure 27: Obesity among Children in Reception year

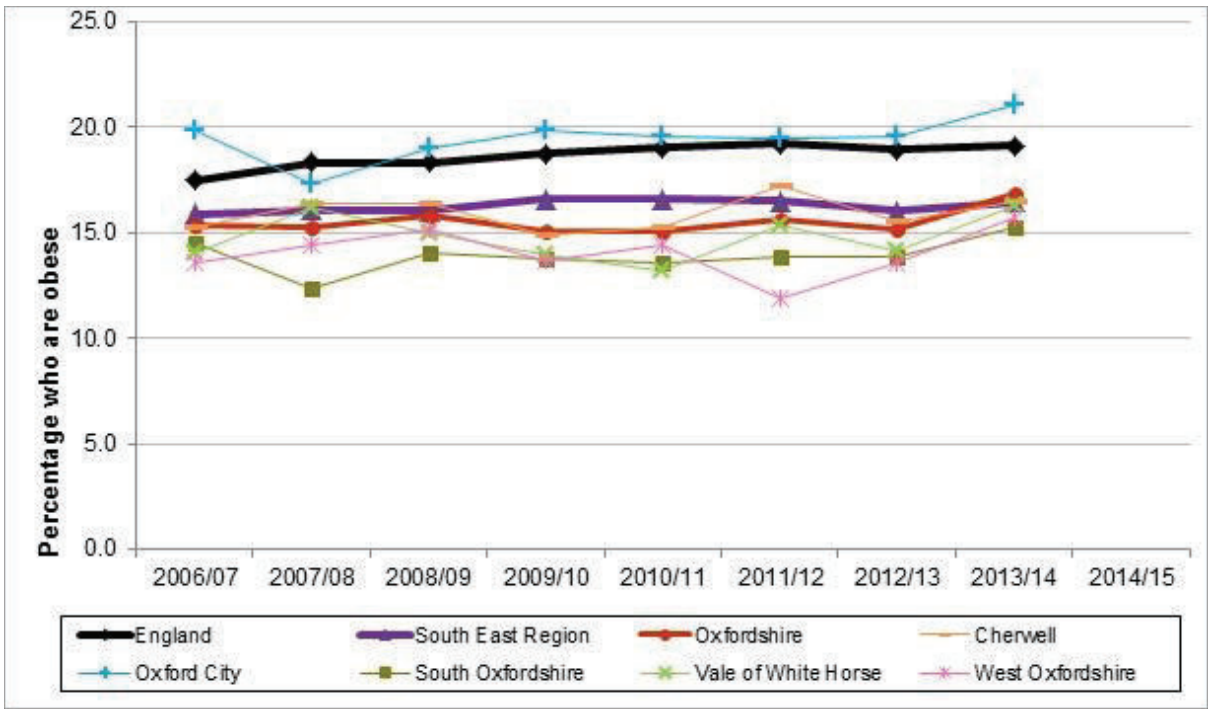
[182] Public Health Outcomes Framework, indicator 2.12: http://www.phoutcomes.info/. Adults are defined as overweight (including obese) if their body mass Index (BMI) is greater than or equal to 25kg/m^2. As this is the first year of recorded data it is not possible to examine trends.
[183] National Child Measurement Programme: http://www.hscic.gov.uk/ncmp



Source: National Child Measurement Programme

Children in Year 6 have a higher prevalence of obesity than those in Reception year. Trends for children in Year 6 indicate that prevalence of childhood obesity is rising nationally. The trend for Oxfordshire was steady until recently: data for 2013/14 indicates an increase but it is too early to know if this reflects a new trend. The current level of obesity among this age group remains lower in Oxfordshire than in England. However, there is some fluctuation across the districts, and Oxford has a significantly higher obesity rate in Year 6 children than the county as a whole.

Figure 28: Obesity among Year 6 children



Source: National Child Measurement Programme

As in previous years, a strong positive relationship exists nationally between deprivation and obesity prevalence for children in each school year. The obesity prevalence among Reception Year children attending schools in areas in the most deprived decile was 12% compared with 6.6% among those attending schools in areas in the least deprived decile.

The NCMP also reveals substantial variation in childhood obesity prevalence between ethnic groups at a national level. Obesity prevalence was significantly higher than national average for children in both school years in ethnic groups 'Asian or Asian British', 'Any Other Ethnic Group', 'Black or Black British' and for the 'Mixed' ethnic group. Obesity prevalence was significantly lower than the national average for children in both Reception and Year 6 in the 'White' ethnic group and for 'Chinese' in Reception.

6.1.3. 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.[184] Physical inactivity has been linked to a range of other health conditions, including diabetes and some cancers; it is estimated to be responsible for a significant proportion of premature all-cause mortality.[185] 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 2013 62% of those aged 16 years and over in Oxfordshire achieved at least 150 minutes of physical activity per week.[186] This was similar to the level for the previous year (60%). The proportion was similar to the South East (58%) and significantly higher than in England overall (56%).

Across the county, proportions varied from 59% in West Oxfordshire to 66% in Vale of White Horse. However, these differences from the county average were not statistically significant.

Those who do less than 30 minutes of at least moderate intensity physical activity per week are classed as 'physically inactive'. In 2013 23% of people aged 16 years and over in Oxfordshire were physically inactive. This was similar to the previous year (22%). The proportion was significantly lower than in the South East (27%) and

[184] Public Health Outcomes Framework: http://www.phoutcomes.info/.
[185] 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
[186] 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.

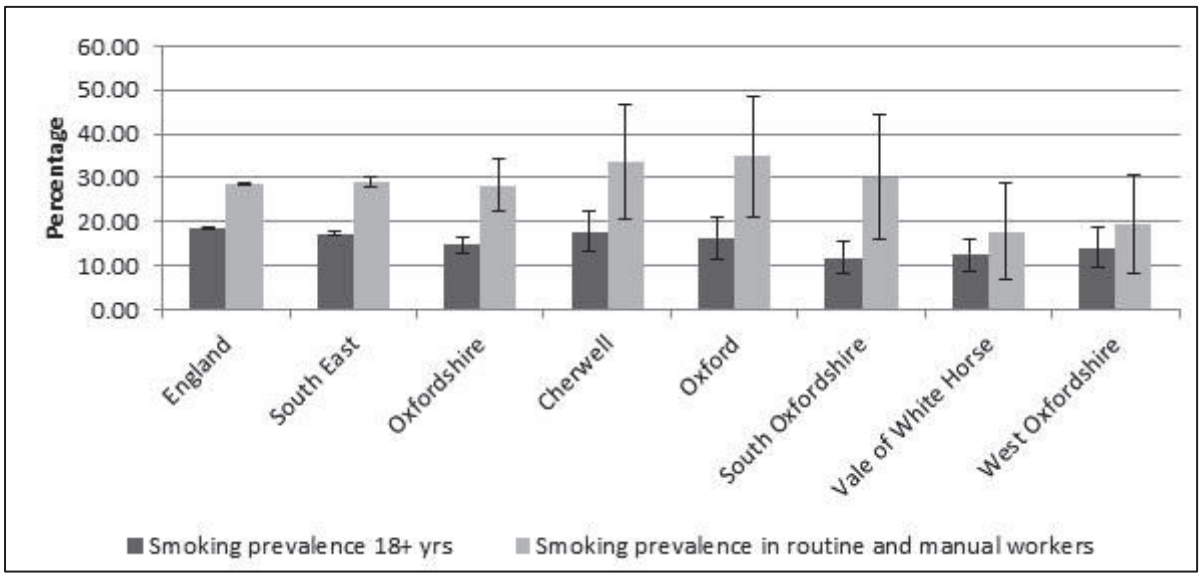
England overall (29%). According to the publication "Turning the Tide of Inactivity" Oxfordshire has the 9th lowest level of inactivity of 150 local authorities.[187]

6.2. Smoking

Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease.

In 2013 smoking prevalence in Oxfordshire was estimated to be 14.7%.[188] This has been declining since 2010 (when it was 18.5%). Prevalence in Oxfordshire was significantly lower than in the South East (17.2%) and England overall (18.4%). However, prevalence among those in routine and manual employment was much higher at 28% (similar to the average for England).

Figure 29: Smoking prevalence



Source: Public Health England

The ONS Opinions and Lifestyle, Smoking Habits Amongst Adults Survey (2013) found that, across England, adult smokers were more likely to be unmarried, unemployed, working in routine and manual occupations, or have lower level educational qualifications[189]

Children

[187] Turning the Tide of Inactivity (2014): http://www.ukactive.com/turningthetide/
[188] Public Health Outcomes Framework, indicator 2.14: http://www.phoutcomes.info/
[189] Opinions and Lifestyle, Smoking Habits Amongst Adults Survey 2013 carried out by the Office for National Statistics: http://www.ons.gov.uk/ons/rel/ghs/opinions-and-lifestyle-survey/adult-smoking-habits-in-great-britain--2013/stb-opn-smoking-2013.html

In 2012 less than a quarter of 11-15 year old pupils reported that they had tried smoking at least once.[190] At 22% this is lowest level recorded since data were first collected in 1982, and continues a decline seen since 2003, when 42% of pupils had tried smoking.

Mothers

In 2013/14 9.3% of mothers in Oxfordshire were recorded as smokers at the time of delivery.[191] This was significantly lower than the proportion in 2012/13 (12.7%) and continues a steady year-on-year declining trend. It was also lower than the equivalent proportion in England (12%).

6.3. Alcohol

6.3.1. Alcohol Consumption

The health harms associated with alcohol consumption are widespread, with around 9 million adults in England drinking at levels that pose some risk to their health.[192]

Public Health England produces local alcohol profiles for lower tier local authorities in England.[193] In 2012/13 the directly age-standardised rates for alcohol-specific hospital admissions in both male and female residents were relatively high in Oxford: 654.5 male admissions per 100,000 in the population; and 286.2 female admissions. These were significantly above the rates for the Thames Valley area and England. All other districts of the county had similar or, in many cases, significantly lower, rates relative to the regional and national averages.

In three of the districts (Cherwell, South Oxfordshire and West Oxfordshire) there has been a declining trend in under 18 alcohol-specific hospital admissions over the four years from 2008/9 to 2012/13. In Oxford and Vale of White Horse numbers have remained fairly stable over the period.

6.3.2. Alcohol Treatment

The National Drug Treatment Monitoring System includes information on individuals who were in treatment during 2013/14 and who cited alcohol as their primary problematic substance.[194]

Structured alcohol treatment mostly takes place in the community, near to users' families and support networks. However, a stay in residential rehabilitation is

[190] Smoking, Drinking and Drug Use among Young People Survey 2013: http://www.hscic.gov.uk/catalogue/PUB14579
[191] Public Health Outcomes Framework, indicator 2.03: http://www.phoutcomes.info/
[192] Local Alcohol Profiles for England: http://www.lape.org.uk/
[193] Local Alcohol Profiles for England: http://www.lape.org.uk/. Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases (100%) of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis.
[194] National Drug Treatment Monitoring System: https://www.ndtms.net/WhatWeAre.aspx

appropriate for the most serious cases. In Oxfordshire 9% of adults within treatment had attended residential rehab during their latest period of treatment (compared to 4% in England).

Keeping waiting times low is thought to play a vital role in supporting recovery from alcohol dependency. 96% of individuals waited under three weeks to start treatment in Oxfordshire compared to 93% in England.

6.4. Drugs

Drugs are known to have a variety of damaging effects on both physical and mental health and wellbeing.[195] In 2012/13 there were around 1,700 people aged 18 and over in drug treatment in Oxfordshire.[196] According to the latest estimates (for 2011/12) around half of opiate and crack users in the county are in treatment.[197]

6.5. Drug and Alcohol Use among Young People

The Young People's Drug and Alcohol Service provides treatment and support for young people aged up to 19 across Oxfordshire, as well as supporting those affected by their parent's or family member's substance misuse.

In 2013/14 there were 68 young people in specialist substance misuse services, 43 of whom were new presentations during the year.[198] As mentioned above, not all of these will be substance users themselves, but may instead have parents or family members who are.

Cannabis was the main substance involved (cited for 59 individuals) with alcohol next (39 individuals). 29 individuals cited both cannabis and alcohol.

In terms of completion, 78% were planned exits (compared to 79% nationally). This is broken down further into two categories:

- treatment completed - drug free (36% in Oxfordshire, compared to 33% nationally)
- treatment completed - occasional user (42% in Oxfordshire, compared to 45% nationally)

[195] 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

[196] National Drug Treatment Monitoring System: https://www.ndtms.net/WhatWeAre.aspx

[197] Public Health England prevalence estimates for opiate and/ or crack cocaine use: http://www.nta.nhs.uk/facts-prevalence.aspx

[198] Data extracted from Public Health England's Activity Report, Q4 2013/14

6.6. New Psychoactive Substances

The Office for National Statistics published numbers of deaths in the UK which involved new psychoactive substances (so called 'legal highs') in the period from 2011 to 2013.[199] Nationally, deaths increased from 29 in 2011 to 52 in 2012, and again to 60 in 2013. These figures indicate the risks of new psychoactive substances.

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 81 in 2013.[200]

6.7. Oral Health

6.7.1. Tooth Decay

Poor oral health can have important physical and psychological effects for both children and adults, including pain, sleeplessness and poor dietary intake.[201] 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%.[202] 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.

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%

[199] Deaths Related to Drug Poisoning in England and Wales (ONS, 2013): http://www.ons.gov.uk/ons/dcp171778_375498.pdf

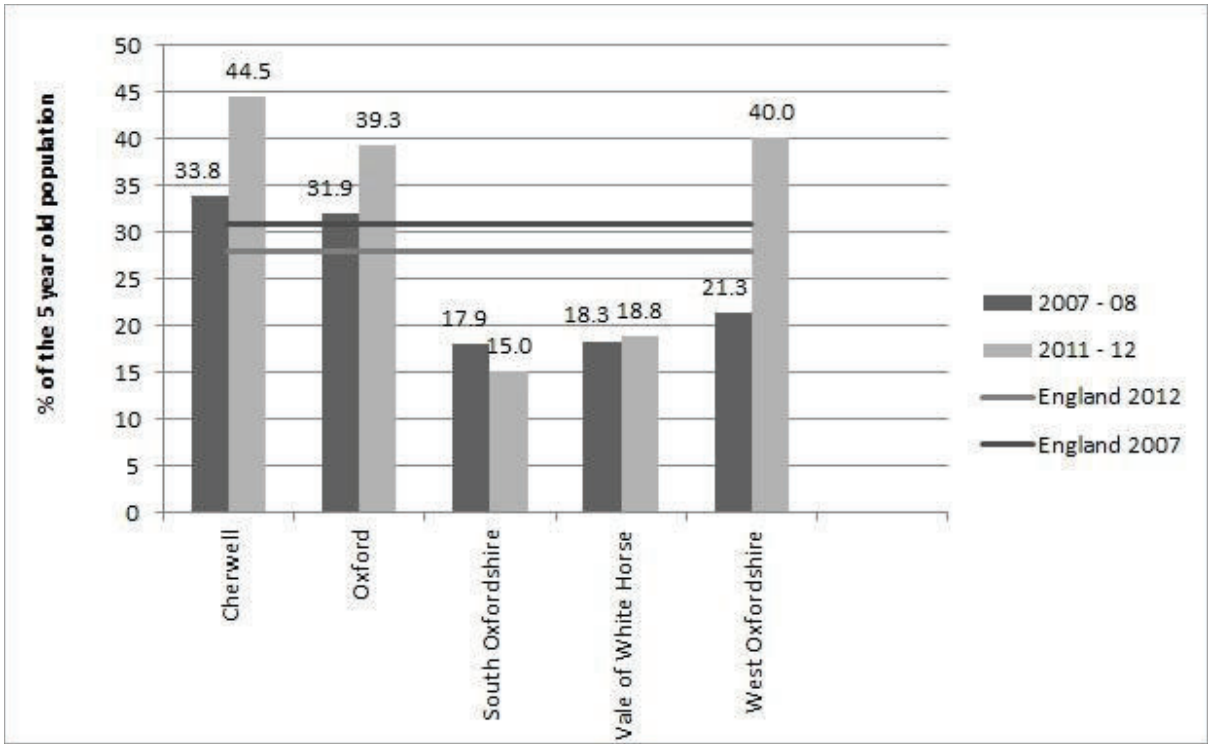
[200] EMCDDA-Europol 2013 Annual Report on the implementation of Council Decision 2005/387/JHA: http://www.emcdda.europa.eu/publications/implementation-reports/2013

[201] Data and analysis in this section have been provided by Public Health England.

[202] 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.

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 30: 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 backgrounds experience higher levels of decay than those from managerial and professional 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 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

6.7.2. Oral Cancer

Oral cancer rates are rising. There were less than 4000 cases in England in 2012 but this is increasing. Oral cancer is more common in men but differences are reducing as lifestyles of men and women become more similar.

6.8. Sexually Transmitted Infections (STIs)

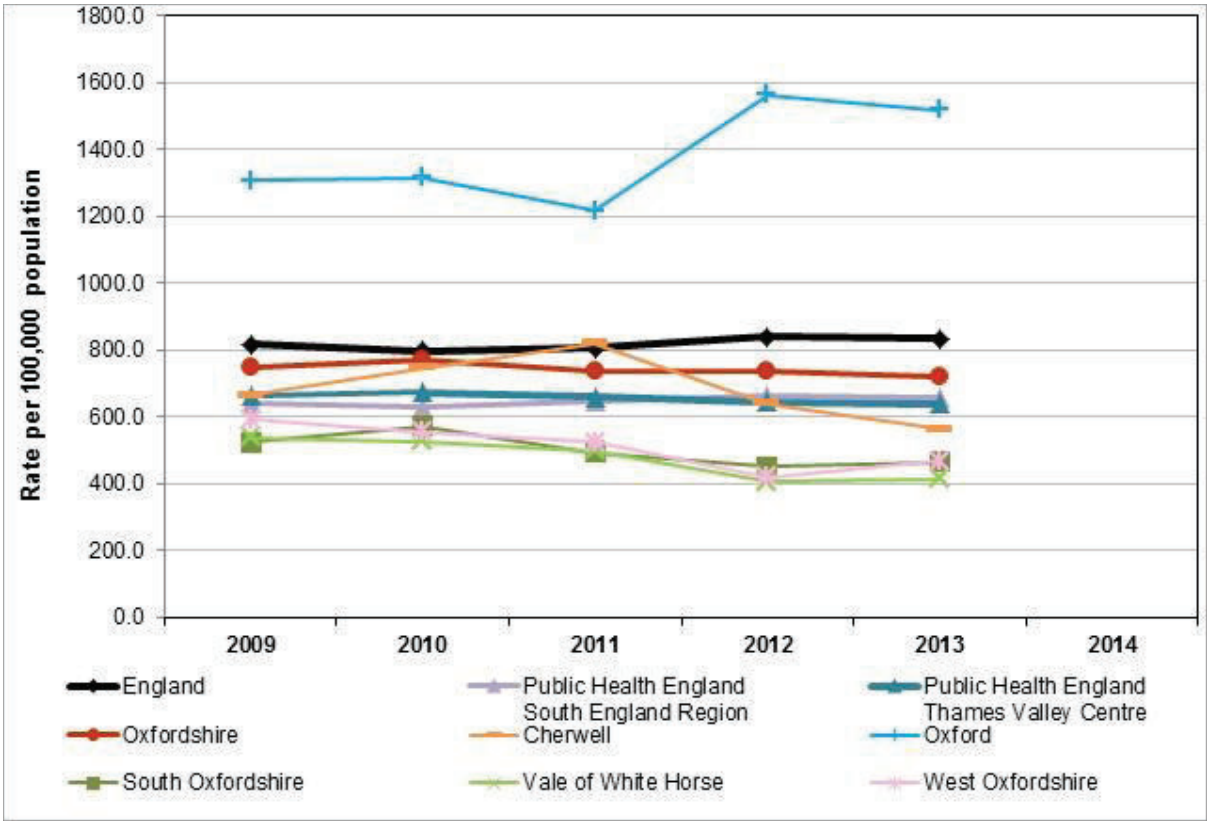
In 2013 Oxfordshire had a rate of 720.8 STIs per 100,000 people. [203] This was below the rate for England (834.2) but significantly higher rate than in the Thames Valley area (640.5).

Below county level it can be seen that the high rate is driven by Oxford. The reasons for this are complex and are currently being investigated. It may be influenced by the proportionally larger younger population in Oxford, given that younger people tend to have riskier sexual behaviour. In addition, individuals who do not provide their residential postcode are allocated the postcode of the GUM clinic they attend, which would either be in Oxford or Banbury.

Figure 31: Rate of diagnosis of acute sexually transmitted infections (STIs) per 100,000 people (2009 to 2013)[204]

[203] Public Health England STI Statistics: https://www.gov.uk/government/collections/sexually-transmitted-infections-stis-surveillance-data-screening-and-management

[204] All acute STIs include chlamydia infection. Chlamydia diagnoses from GUM services that were reported as previously diagnosed at another service have been excluded from data from 2012. These diagnoses have been reported via Chlamydia Testing Activity Dataset and are already included in the community services' chlamydia data. As a result, GUM services' chlamydia data from 2012 are not comparable to data from previous years. Data are shown for trend purposes only.



Source: Public Health England

From the chart it is not possible to see which STIs or population groups may be causing the rate to be high. However, nationally the most commonly diagnosed STI in 2013 was chlamydia. The impact of STIs remains greatest in young heterosexuals under the age of 25 years and in men who have sex with men (MSM).

Gonorrhoea diagnoses increased in 2013. This may be due in part to the introduction of the new test for gonorrhoea in August 2012, which has increased case finding in MSM. On-going high levels of unsafe sexual behaviour probably also contribute to this rise.

You can explore the data using the interactive public health surveillance dashboard (indicator under Healthy Lifestyles) on the Insight website: http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

6.9. HIV

Human Immunodeficiency Virus (HIV) attacks the immune system, and weakens the ability to fight infections and disease. It 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. It is one of the most important communicable diseases in the UK and is associated with serious morbidity, high costs of treatment and care, significant mortality and a high number of potential years of life lost.

The prevalence of people living with a diagnosis of HIV has been increasing across all geographic areas over the past 12 years. Individuals who are diagnosed 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".

The prevalence of HIV in Oxfordshire (1.3 people per 1,000 15-59 year olds in 2012) remains significantly lower than the average across England (2.1).[205] However the prevalence rate in Oxford (2.4 in 2012) is significantly higher than the national average. This is likely to be due to the diverse population including more young people and proportionately more people from ethnic minority groups: HIV is more prevalent in Black African communities and Oxford has a relatively high proportion of Black ethnic minorities.

You can explore the data using the interactive public health surveillance dashboard (indicator under Healthy Lifestyles) on the Insight website: http://insight.oxfordshire.gov.uk/cms/public-health-surveillance-dashboard

6.10. Further Information

Further information relating to the Lifestyles chapter is available from the JSNA data directory at the following link: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

[205] Public Health England Sexual and Reproductive Health Profiles.
(previously sourced from Survey of Prevalent HIV Infections Diagnosed (SOPHID))
http://fingertips.phe.org.uk/profile/sexualhealth

7. Service Demand

This section sets out the changing demand for health and social care services across Oxfordshire.

7.1. Primary Health Care Services

7.1.1. GP Practice Population

In 2013/14 there were 83 GP practices in the Oxfordshire Clinical Commissioning Group area, with a total registered population of 700,500.[206] The number of patients was up from 693,500 in 2012/13 and has increased by nearly 4% over the past five years.[207]

In September 2013 there was an estimated rate of 74.8 GPs per 100,000 people in the area.[208] This was a little below the previous year's rate of 78. However, it was higher than the rate in England overall (66.9 GPs per 100,000 people).

In 2014 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 (54%).[209] Seven in ten said they had done so within the last six months (71%).

7.1.2. Out of Hours GP Services

In 2013/14 there were 97,800 out of hours GP service consultations in the Oxfordshire Clinical Commissioning Group area.[210] This was lower than the figure for 2012/13 of 112,200. Around six in ten consultations involved patients attending primary care centres (61%). Three in ten finished with telephone advice (31%). One in ten involved patients being seen at home (11%).[211]

7.2. Planned Secondary Health Care Services

Across the range of planned secondary health care services commissioned by Oxfordshire Clinical Commissioning Group, the CCG expects demand to rise at a

[206] Quality and Outcomes Framework: http://www.hscic.gov.uk/qof. The number of practices has fallen slightly since then, due to a few GP practices merging.
[207] This number is likely to include the records of people who remain registered despite leaving the area, as well as people who live in neighbouring counties but are registered with GPs in Oxfordshire. This explains the fact that the GP-registered population is larger than the county's population.
[208] Health and Social Care Information Centre: https://indicators.ic.nhs.uk/webview/
[209] GP Patient Survey (January 2015 release): https://gp-patient.co.uk/. NHS England GP Patient Survey analysis: http://www.england.nhs.uk/statistics/2014/07/03/gp-patient-survey-2013-14/
[210] Data provided by Oxfordshire Clinical Commissioning Group
[211] These proportions do not add to 100% because a single consultation (taking place over the course of a single day) may involve more than one type of interaction between GP and patient.

faster rate than average population growth, due principally to the changing (ageing) profile of the population.[212]

7.2.1. Outpatient Appointments

Outpatients are those referred to attend short appointments in hospital.

First Attendances

During the first seven months of 2014/15 there were 101,900 first outpatient attendances among registered GP patients in the Oxfordshire Clinical Commissioning Group area.[213] The CCG expects total first attendances to reach around 172,300 by the end of the financial year. (The number of residents attending outpatient appointments is likely to be lower, due to some attending more than one appointment.) Just over half of these appointments are the result of referrals from a GP.

Age data were recorded in over 99% of outpatient attendances taking place in the first seven months of 2014/15. Nearly half were among those aged 18-59 (48.2%) whilst four in ten were among the 60 and over age group (39.8%). The under-18 age group comprised a much smaller proportion (12%).

Follow-up Appointments

During the first seven months of 2014/15 there were 155,000 follow-up outpatient attendances among patients registered with GPs in the Oxfordshire Clinical Commissioning Group area. Around four in ten were referrals from GPs (41.8%).

Of follow-up attendances where age data were recorded (98% of the total attendances) half were among those aged 60 and over (50.3%) and over four in ten were among the 18-59 age group (41.5%). The under-18 age group again comprised a much smaller proportion (8.2%).

Attended outpatient appointments for mental health services are discussed in more detail in section 5.1.4 Mental Health.

Community hospitals

During the first half of 2014/15 there were 1,300 community hospital admissions among patients registered with GPs in the Oxfordshire Clinical Commissioning Group area.[214]

[212] Information about expected changes in service demand has been provided by the Oxfordshire Clinical Commissioning Group and has been produced with reference to Oxfordshire County Council's population projections (principle scenario).
[213] Data provided by Oxfordshire Clinical Commissioning Group. This covers appointments provided by Oxford University Hospitals NHS Trust, Royal Berkshire NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust, and Heatherwood & Wexham Park Hospitals NHS Foundation Trust.
[214] Data provided by Oxfordshire Clinical Commissioning Group (December 2014).

7.2.2. Elective Admissions

Elective admissions are planned admissions to hospital, for stays of one or more nights.

In the first seven months of the 2014/15 financial year there were 5,000 elective admissions among Oxfordshire residents.[215] The CCG expects total elective admissions to reach around 8,100 by the end of the financial year. (The number of residents admitted is likely to be lower, due to some being admitted more than once.)

Of elective admissions where age data were recorded (94% of the total admissions) over half were among those aged 60 and over (52.3%). A little under half were among those aged 18-59 (45.9%). Just 1.8% were among the under 18 age group.

7.2.3. Day Case Admissions

Day care admissions are planned admissions to hospital, where patients do not need to stay overnight.

In the first seven months of 2014/15 there were 25,800 day cases among patients registered with GPs in the Oxfordshire Clinical Commissioning Group area.[216] The CCG expects total day case admissions to reach around 43,800 by the end of the financial year. (The number of residents admitted is likely to be lower, due to some being admitted more than once.)

Of day case admissions where age data were recorded (99% of the total admissions) over half were among those aged 60 and over (53.3%) with 44% among those aged 18-59. Just 2.8% were among the under 18 age group.

7.2.4. District Nursing

In the first half of 2014/15 there were 134,300 district nursing attended contacts with Oxfordshire residents. [217]

7.3. Emergency Care

Across the range of emergency care services commissioned by Oxfordshire Clinical Commissioning Group, the CCG expects demand to rise at a faster rate than average population growth, due principally to the changing (ageing) profile of the

[215] Data provided by Oxfordshire Clinical Commissioning Group. This covers appointments provided by Oxford University Hospitals NHS Trust, Royal Berkshire NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust, and Heatherwood & Wexham Park Hospitals NHS Foundation Trust.
[216] Data provided by Oxfordshire Clinical Commissioning Group. This covers appointments provided by Oxford University Hospitals NHS Trust, Royal Berkshire NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust, and Heatherwood & Wexham Park Hospitals NHS Foundation Trust.
[217] Data provided by Oxfordshire Clinical Commissioning Group.

population.[218] For the same reason, it expects admissions to involve longer average stays in hospital.

7.3.1. Accident and Emergency

A&E Attendance

In 2013/14 there were 119,100 A&E attendances among patients registered with GPs in the Oxfordshire Clinical Commissioning Group area.[219] For the first seven months of the 2014/15 financial year the figure was 73,200. This represents a 4.8% increase compared to the first seven months of the previous year. The CCG expects total A&E attendances to reach around 124,800 by the end of the financial year.

The number of residents admitted is likely to be lower than the number of admissions, due to some people being admitted more than once. To give an indication, in the first half of the 2014/15 financial year 15% of patients accounted for 30% of A&E attendances at Oxford University Hospitals NHS Trust.[220]

Of A&E attendances where age data were recorded (over 99% of the total attendances for 2014/15) half were among those aged 18-59 (49.9%) with around a quarter from each of the other age groups (26.3% aged 60 and over; 23.7% aged under 18).

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).

During the first eight months of 2014/15 waiting times at OUHT were within four hours 92% of the time. At RBFT they were within four hours 96% of the time. These figures compare with an England average of 95%.

Emergency Services

In 2013/14 there were 92,900 calls made to '999' for ambulances from patients registered with GPs in the Oxfordshire Clinical Commissioning Group area.[221] This was up 5.6% on the previous year. During the first six months of 2014/15 there were 48,900 calls, up 7.6% on the same period for the previous year.

[218] Information about expected changes in service demand has been provided by the Oxfordshire Clinical Commissioning Group and has been produced with reference to Oxfordshire County Council's population projections (principle scenario).
[219] Data provided by Oxfordshire Clinical Commissioning Group. This covers appointments provided by Oxford University Hospitals NHS Trust, Royal Berkshire NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust, and Heatherwood & Wexham Park Hospitals NHS Foundation Trust.
[220] Data provided by Oxfordshire Clinical Commissioning Group
[221] Data provided by Oxfordshire Clinical Commissioning Group.

Overall, around half of total calls result in patients being conveyed to emergency departments, compared with a little over a third being treated at the scene.

In 2013/14 211,800 calls made to '111' from patients registered with GPs in the Oxfordshire Clinical Commissioning Group area were connected to provider switchboards.[222] Around a third of 111 calls answered resulted in callers being recommended to contact (face to face) primary and community care, with a further one in ten recommended to speak to primary and community care. About a quarter did not need to be triaged.

7.3.2. Emergency Hospital Admissions

In the first seven months of 2014/15 there were 29,300 emergency hospital admissions among patients registered with GPs in the Oxfordshire Clinical Commissioning Group area.[223] The CCG expects total emergency admissions to reach around 49,600 by the end of the financial year.

The number of residents admitted is likely to be lower than this figure, due to some being admitted more than once. To give a sense of this, in the first half of the 2014/15 financial year 18% of patients accounted for 35% of non-elective (emergency) admissions to Oxford University Hospitals NHS Trust.[224]

Of emergency admissions where age data were recorded (over 98% of the total admissions) almost half were among those aged 60 and over (49.2%) with over a third among those aged 18-59 (37.9%). Around one in eight were among those aged under 18 (12.8%). Around a quarter of emergency admissions were admitted from GPs (24.7%).

Public Health England suggests that higher percentages of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions.[225] In 2013 there was a higher proportion of emergency hospital admissions among people of Black and Asian ethnicities than overall in Oxfordshire (48.9% and 45.8% of hospital admissions of people of Black and Asian ethnicities, respectively, compared with 41.6% overall).[226]

7.3.3. 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 due to non-clinical reasons, for example because the patient is awaiting a care package in their own home, or further non-acute care.

[222] Data provided by Oxfordshire Clinical Commissioning Group.
[223] Data provided by Oxfordshire Clinical Commissioning Group. This covers appointments provided by Oxford University Hospitals NHS Trust, Royal Berkshire NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust, and Heatherwood & Wexham Park Hospitals NHS Foundation Trust.
[224] Data provided by Oxfordshire Clinical Commissioning Group
[225] Public Health England Profiles: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES.
[226] Public Health England Profiles: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES.

In 2013/14 the average daily rate of delayed transfers of care within Oxfordshire was 27 people aged 18 and over per 100,000.[227] This was similar to the figure for the previous year; it was down from 30.6 in 2011/12. It was significantly higher than the England average rate of 9.6 per 100,000 people.

7.4. Physical Disability

In March 2014 Oxfordshire County Council was supporting 792 adults aged 18-64 with a physical disability.[228] Proportionately fewer adults with a physical disability were being supported in Oxfordshire (1.8 people per 1,000 18-64 year olds) than in the South East (2.2) and England (2.3).

At this time nearly nine in ten supported adults with a physical disability were supported at home (88%, numbering 704). The remainder were in care homes (numbering 88). The proportions were similar to those for the South East and England overall.

7.5. Learning Disability

In March 2014 Oxfordshire County Council was supporting 2,028 adults aged 18-64 with a learning disability.[229] Proportionately more adults with a learning disability were being supported in Oxfordshire (4.4 people per 1,000 18-64 year olds) than in the South East (4) and England (3.9).

At this time over eight in ten supported adults with a learning disability were supported at home (83%, numbering 1673) which was higher than levels in the South East (71%) and England overall (76%). Of the remainder 14% were supported in care homes (numbering 279) and 4% were supported in shared lives schemes (numbering 76).

7.6. Mental Health

7.6.1. Oxford Health Mental Health Referrals

In 2013/14 around 11,000 Oxfordshire residents were referred to Oxford Health mental health services and seen at least once.[230] This represents an increase of around a thousand from the previous two years.

[227] NHS Delayed Transfers of Care Statistics: http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
[228] Referrals, Assessments and Packages of Care/ Adult Social Care Combined Activity Return: https://nascis.hscic.gov.uk/
[229] Referrals, Assessments and Packages of Care/ Adult Social Care Combined Activity Return: https://nascis.hscic.gov.uk/
[230] Data provided by Oxford Health

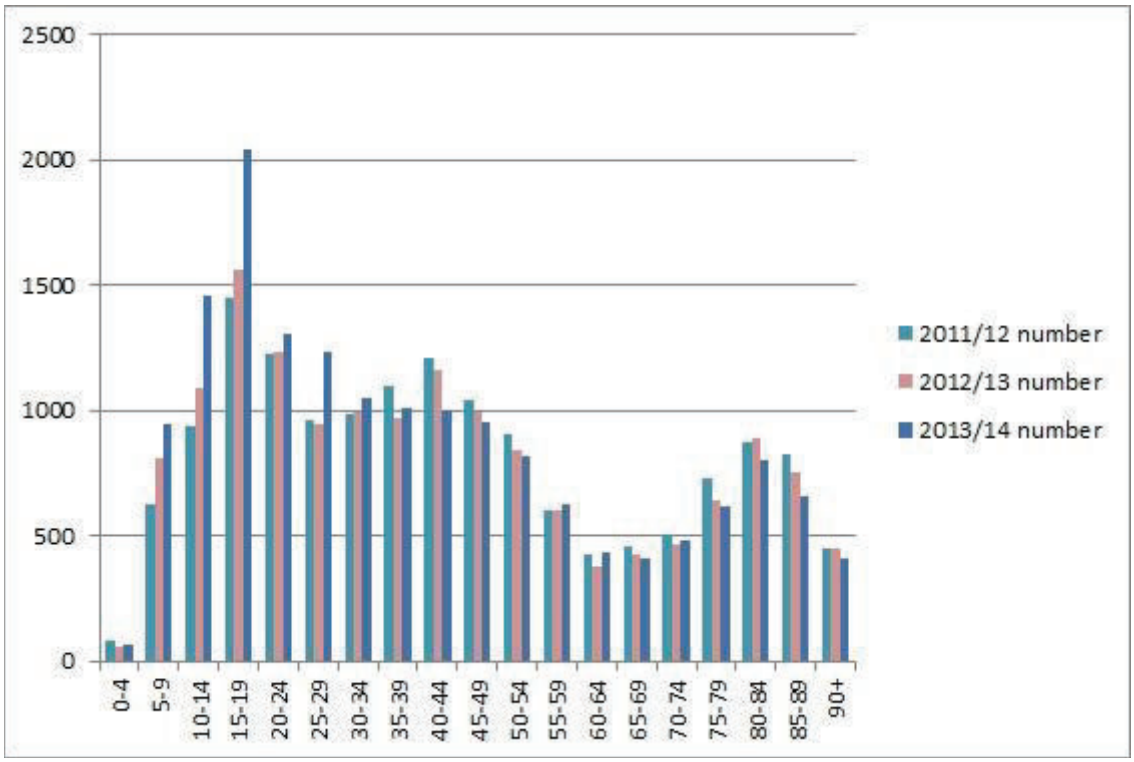
More female than male residents were referred, making up 56% of the service users, compared with 44% male. This ratio has remained consistent over the last three years.

Nine in ten Oxfordshire service users for whom ethnicity data have been recorded were from White British backgrounds (90%), with 4% from Other White backgrounds, 2% from Mixed backgrounds, 2% from Asian or Asian British backgrounds and 1% from Black or Black British backgrounds.[231] Again, these proportions have remained consistent over the last three years.

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 (10-15 service users per 1,000 people from these backgrounds in the population). There were lower rates of service use among people from Black or Black British backgrounds (7-8 service users per 1,000 population) and Asian or Asian British backgrounds (5-6 service users per 1,000 population).

Of the total number of referrals for Oxford Health mental health services, the largest proportion were among people aged 15-19 (12.5%), followed by those aged 10-14 (8.9%), those aged 20-24 (8%) and those aged 25-29 (7.6%).[232]

Figure 32: Oxford Health mental health services referrals by age



[231] NB in this dataset the figure for Asian or Asian British service users does not include people from Chinese backgrounds.
[232] Since some Oxfordshire residents were referred to mental health services more than once during the year, the total number of referrals was over 15,000, compared to around 11,000 people referred.

Source: Oxford Health

Almost half of the referrals were for Oxfordshire Adult Mental Health Services (47%). Around a quarter were for Children and Adolescent Mental Health Services (24%) and nearly two in ten were to the Oxfordshire Older Adult Mental Health Services (18%). Significant minorities of referrals were for Oxfordshire Psychological Services (8%) and Eating Disorders Oxfordshire (2%). The remaining referrals were to one of 14 other mental health services.

7.6.2. Oxfordshire Mind Wellbeing Service

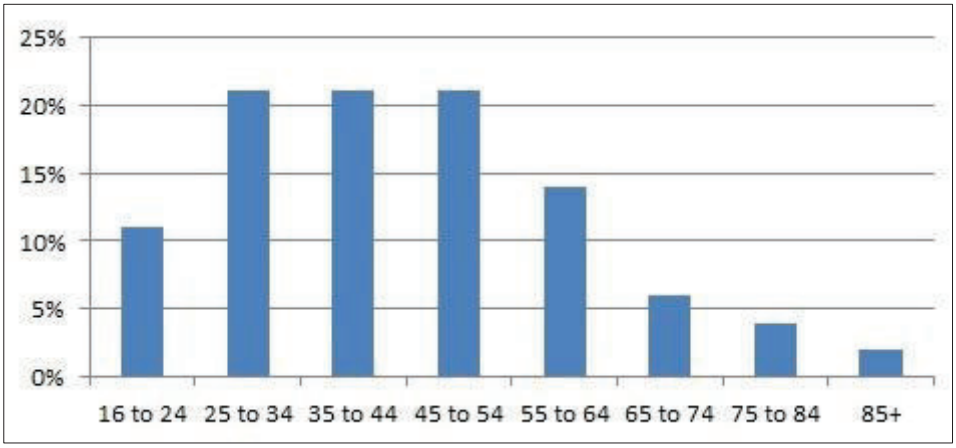
The Wellbeing Service delivered by Oxfordshire Mind is to enable the residents of Oxfordshire to better manage and sustain their mental health and wellbeing.[233]

Between April 2011 and March 2014 the Wellbeing Service reached the following numbers of residents through its activities:[234]

- 20,428 residents were reached through Public Wellbeing events and activities
- 24,153 residents were reached through provision of information and options
- 1,559 residents were reached through short course provision
- 2,236 were reached through peer support groups
- 420 were reached through 1-to-1 recovery support

3,656 unique individuals used the most intensive services, i.e. information and options; short courses; peer support groups; and 1-1 recovery support. Of these, over a third were from Cherwell or West Oxfordshire (35%) whilst 29% were from South Oxfordshire and 27% were from Oxford (for 9% the area of residence was unknown). 60% were men and 40% were women. Nearly two thirds were aged 25-54, as shown in Figure 33 below.

Figure 33: Oxfordshire Mind Wellbeing Service most intensive users by age



[233] More information on the service is available at the following link: http://www.oxfordshire-mind.org.uk/help/wellbeingservice/aboutws

[234] Data provided by Oxfordshire Mind: http://www.oxfordshire-mind.org.uk/. Some residents will have participated in more than one of these activities.

Source: Oxfordshire Mind Wellbeing Service Data

Nearly nine in ten users of the most intensive services were from White backgrounds (87%, slightly below the proportion of Oxfordshire's population from White backgrounds, which stood at 90.9% in 2011[235]). 2% were from Asian or Asian British backgrounds, the same proportion as were from Black or Black British backgrounds (2%) and Mixed backgrounds (2%). A further 7% were recorded as being from Chinese or Other ethnic backgrounds.

Among the 3,656 users of the most intensive services, peer support had the largest take-up (62%), followed by short courses (43%), information and options (22%) and 1-to-1 recovery support (12%). Over a third of users participated in two or more services (36%). Peer support and short courses were the most common combination of services.

There was considerable variation in the time period over which individuals chose to use the Wellbeing Service: the most common length of interaction was a week or less (28%). However, a similar proportion of users were supported for a year or more (27%).

7.6.3. TalkingSpace Oxfordshire

TalkingSpace is a service co-delivered by Oxfordshire Mind and Oxford Health, which offers a range of psychological therapies for the treatment of common mental health depression and anxiety.[236] It follows a stepped care approach, according to the need of the patient. In 2013/14 the service had 7,569 referrals and supported 5,607 patients at step 2 and step 3 (step 2 includes courses, groups to treat insomnia, computerised Cognitive Behavioural Therapy and self-help with guidance from a member of the team; step 3 includes group Cognitive Behavioural Therapy, mindfulness groups and individual therapy).[237]

7.7. Social Care Services for Older People

7.7.1. Demand for Older People's Care Services

Nationally, it has been estimated that over a quarter of people aged 65 and over in England who lived at home in 2012/13 received some form of care (27.6%).[238] This could be paid care (including self-funded and local authority-funded care), unpaid ('informal') care, or both.

[235] Census 2011, table QS201EW: https://www.nomisweb.co.uk
[236] More information is available from the following link: http://www.talkingspaceoxfordshire.org/about-us/
[237] TalkingSpace Oxfordshire Annual Report 2013/14
[238] The Bigger Picture: Understanding disability and care in England's older population: http://strategicsociety.org.uk/bigger-picture-understanding-disability-care-englands-older-population/

Of those receiving care, around nine in ten received unpaid care, comprising 24% of the total older population. Over a third received some form of paid care or help, making up 10% of the total older population. However, 6.9% reported only sometimes or hardly ever having their needs met by the care and support they received. The same study estimates that 70,000 older people in England who have difficulty with three or more activities of daily living are not receiving any care at all.

Direct extrapolation to Oxfordshire's older population yield the following care estimates:

- 31,000 people aged 65+ receiving some form of care
- 27,000 people aged 65+ receiving unpaid care
- 11,200 people aged 65+ receiving paid care
- 7,800 people aged 65+ only sometimes/ hardly ever having needs met by care and support received
- 800 people aged 65+ not receiving any care at all

These figures should be treated with caution, given that Oxfordshire is unlikely to reflect exactly the national picture of needs.

As of March 2014 Oxfordshire County Council was supporting 4,935 older people.[239] The rate of older people being supported in Oxfordshire in 2013/14 was 39.9 per 1,000 people aged 65 and over. This was higher than the rate for the South East (37.8) but lower than the England average (46).

Nearly two thirds of older people were supported at home (64%, numbering 3,100). This was higher than proportions in the South East (57%) and England (59%). The remainder were supported in care homes (numbering 1,835).

As of 1 April 2014 1,791 older people were receiving 18,434 hours of care per week at an average of 10.3 hours per person.[240]

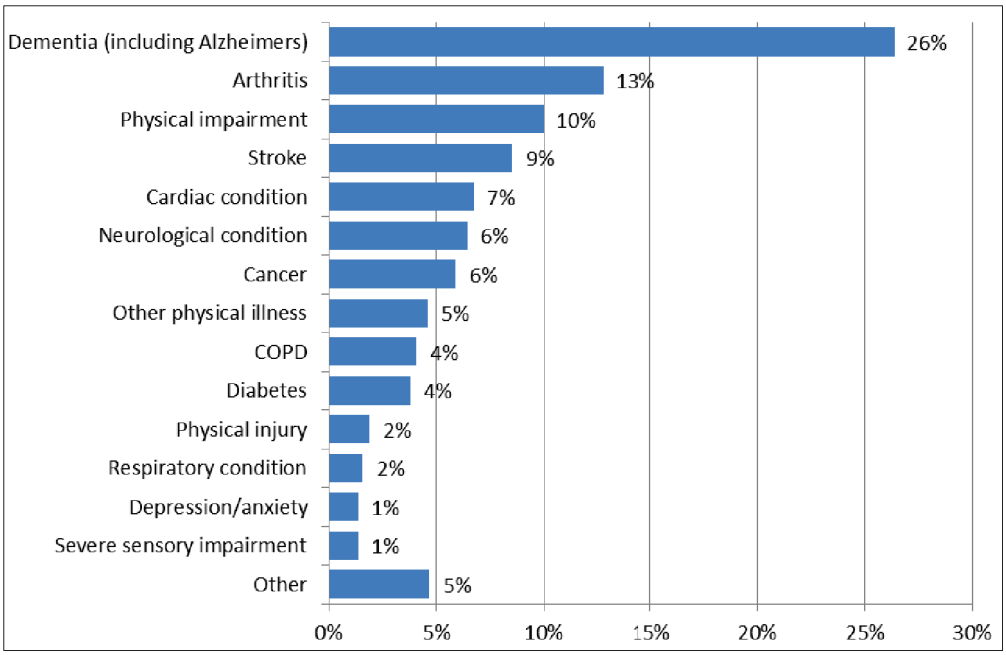
7.7.2. Health Conditions Affecting Older People

Analysis of assessment data offers further texture to the types of needs people have when entering the social care system. A sample of assessment forms for 1500 Self Directed Support service users over the period of October 2011 to July 2013 suggests that the condition most affecting the activities of daily living for older people presenting to social services is dementia, which affected 26% of the sample (a further 6% recorded dementia as their secondary condition). Other common conditions included Arthritis (13%), Physical impairment (10%), Stroke (9%), Cardiac conditions (7%), Neurological conditions (6%), and Cancers (6%).

Figure 34: Percentage of self-directed support service users over 65 by primary disabling condition at time of first assessment

[239] Referrals, Assessments and Packages of Care/ Adult Social Care Combined Activity Return: https://nascis.hscic.gov.uk/

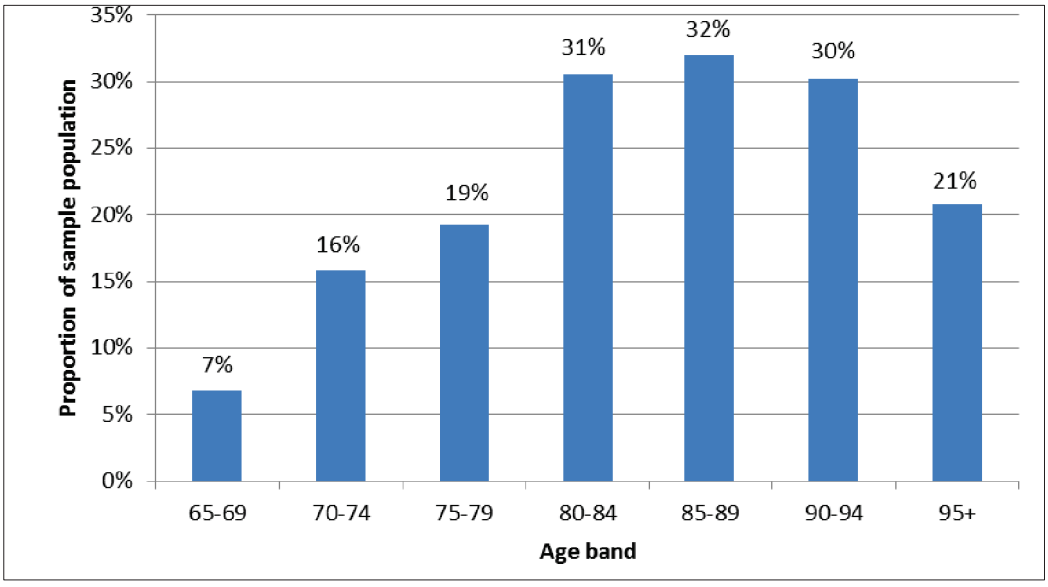
[240] Data provided by Oxfordshire County Council



Source: FACE Needs Profile Database, Oxfordshire County Council

The same data suggest that the likelihood of a client presenting with dementia increases with age, with 7% of people aged 65 to 69 presenting with dementia as a primary disabling condition, compared to 32% for people aged 85 to 89, as shown in Figure 35.

Figure 35: SDS Service users with dementia at time of first assessment, by age band (October 2011-June 2013)



Source: FACE Needs Profile Database, Oxfordshire County Council.

For those over the age of 95, the most common condition affecting activities of daily living was arthritis, which affected 26% of this age group.

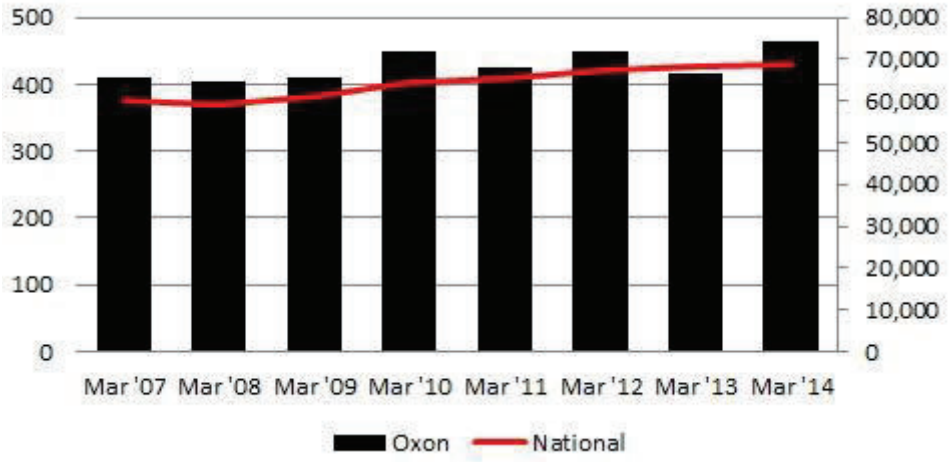
Feedback from older people in Oxfordshire cited three key things as contributors to quality of life: health, control over daily living, and social contact.

Service users have highlighted the fact that good, up-to-date, accessible information and advice underpins people's ability to be more independent, have more control and make better choices. It needs to be jargon free, accessible in a variety of formats and channels, up-to-date and simple.

7.8. Social Care Services for Children

As of March 2014 there were 465 children in care (or 'looked after children') in Oxfordshire.[241] This represents an increase of 13% since March 2007, broadly reflecting patterns across England.

Figure 36: Looked After Children in England and Oxfordshire

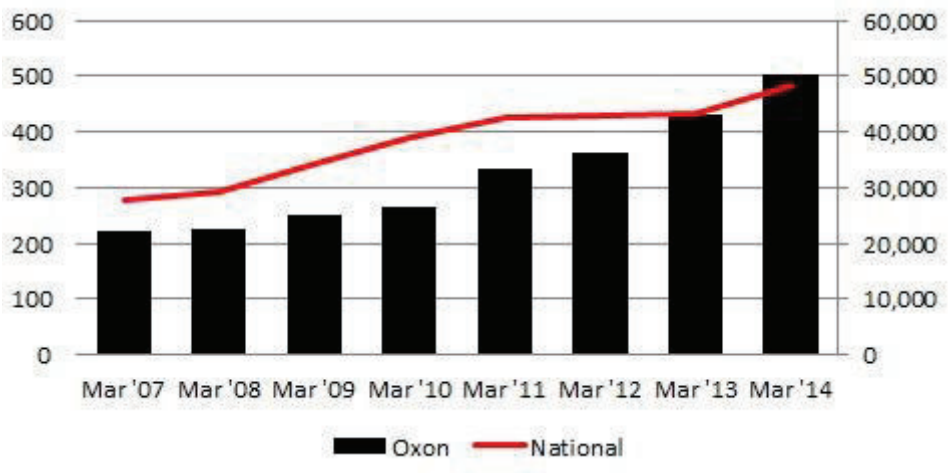


Source: Department for Education

As of March 2014 there were 504 children on protection plans in Oxfordshire.[242] This figure has more than doubled since March 2007, rising by 129%. The increase was much higher in Oxfordshire than in England overall (73% over the same period).

Figure 37: Children on Protection Plans in England and Oxfordshire

[241] Department for Education statistics: https://www.gov.uk/government/collections/statistics-looked-after-children#history
[242] Department for Education statistics: https://www.gov.uk/government/collections/statistics-children-in-need



Source: Department for Education

In a Survey of Looked After Children in December 2013, 85% stated that they were happy with their social workers.[243] 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.

7.9. 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 2013/14, approximately 110,000 NHS-funded journeys were booked for patients registered with a GP in the Oxfordshire Clinical Commissioning Group area.[244] Three quarters of these were aged 65 and over (75%).

Changes to the eligibility criteria for NEPTS were implemented in October 2014 in the context of growing demand for the more complex elements of the service. [245] Under the new criteria, patients capable of walking and getting in and out of vehicles unaided, and patients who can walk but require minimal assistance from a single ambulance crew member to get in and out of a vehicle, are no longer eligible for patient transport. It is considered that these are people who can use the equivalent of a friend's or relative's car, taxi, public or voluntary transport. As a result, around

[243] Data provided by Oxfordshire County Council's Joint Commissioning Team
[244] Clinical Commissioning Group Governing Body meeting paper 14.82 (September 2014): http://www.oxfordshireccg.nhs.uk/get-involved/board-meetings/papers-for-september-2014/
[245] Clinical Commissioning Group Governing Body meeting paper 14.82 (September 2014): http://www.oxfordshireccg.nhs.uk/get-involved/board-meetings/papers-for-september-2014/

31,200 of the journeys provided in 2013/14 (to convey around 6,200 patients) would no longer be available.

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.)

There are 47 volunteer car schemes in Oxfordshire with just under 1100 volunteer drivers.[246] Overall, these schemes provide an estimated 58,000 journeys per year, the majority of which are for health-related purposes.

There is anecdotal evidence that schemes have been under pressure, both with the increase in demand for non-emergency patient transport, and because of journey requests for early morning or weekend appointments, or cancellations at short notice. Demand for volunteer driver schemes is expected to increase further as more people are now ineligible for NEPTS.

Demand for transport services may also be affected by the rural nature of Oxfordshire (see sections 3.4 Rurality and 2.4 Affluence and Deprivation) and the ageing population (see section 2.3 Population Profile).

7.10. Further Information

Further information relating to the Service Demand chapter is available from the JSNA data directory at the following link: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

[246] Data provided by Oxfordshire Rural Community Council, December 2014

8. Quality of Services

This section brings together further data on patient experience of health and social care services.

8.1. Adult Social Care User Survey

For the last four years councils have surveyed users of social care aged 18 and over as part of a national survey.[247] 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 2013/14, 7,190 people in Oxfordshire were eligible for the survey, 1,614 were sent forms and 489 replied.

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 and 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. Over the last four years Oxfordshire's composite score has consistently improved. In 2013/14 Oxfordshire ranked 21st out of 152 local authorities in the country.

In 2013/14 nine in ten social care users were satisfied with the care and support received was (89.3%). Nearly two thirds said they were very satisfied (64.5%). These results were similar to previous years, and to satisfaction levels for England.

8.2. Friends and Family Test

In September 2014 87% of respondents at Oxford University Health Trust A&E departments said they would recommend it to friends and family, if they needed similar care or treatment.[248] 7% said they would not. These advocacy levels were very similar to those for the Thames Valley area and England overall.

In the same month 95% of the Trust's inpatient respondents said they would recommend the service to friends and family. 2% said they would not. Again, advocacy levels were very similar to those for the Thames Valley area and England overall.

[247] Adult Social Care User Survey: http://www.hscic.gov.uk/socialcare/usersurveys
[248] Friends and Family Test: http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/

Over nine in ten women said they would recommend antenatal, birth, post-natal ward and post-natal community services at Oxford University Health Trust (94%, 96%, 93% and 95% respectively). 3% or less would not recommend these services. The results were broadly similar (within one or two percentage points) to those for the Thames Valley area and England overall.

8.3. 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.[249]

In 2014 nine in ten patients of GPs in the Oxfordshire Clinical Commissioning Group area rated their GP surgery as (very or fairly) good (89%).[250] 83% said they would (definitely or probably) recommend the surgery to someone who has just moved into the local area. These findings were consistent with results for 2013 and 2012.

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.

8.4. Further Information

Further information relating to the Quality of Services chapter is available from the JSNA data directory at the following link: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

[249] GP Patient Survey (January 2015 release): https://gp-patient.co.uk/. NHS England GP Patient Survey analysis: http://www.england.nhs.uk/statistics/2014/07/03/gp-patient-survey-2013-14/
[250] *Ibid*

9. 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 Data Directory points users to further data and tools available, whilst the JSNA Publications Directory contains relevant research reports, to supplement those cited throughout this report. The Oxfordshire Insight website also contains a wealth of further information about the county and its population.

We anticipate continuing to refresh the JSNA report annually. However, data and publications will be added to the appropriate directories on an on-going basis. If you have enquiries, suggestions or would like to get involved with the JSNA development, please email the Research and Intelligence Team: JSNA@Oxfordshire.gov.uk.

Appendix A: Population Projections

In autumn 2014 Oxfordshire County Council's Research and Intelligence Unit produced long-range projections (to 2052) of population or household growth. They complement the Unit's population and household forecast work, rather than replacing or being an alternative to forecasts. They have been produced to:

- Provide a long-term indication of likely changes in the population (up to 2052 in this release), far beyond the period usually identified in district local plans, upon which forecasts are based.
- Document the upper and lower limits of population change that is feasible and which Oxfordshire and its districts may experience in coming years – to support planning for the longer-term.
- Interpret national-level uncertainty about how the population's overall size and age-distribution may change (uncertainty nationally about future fertility, migration, life expectancy, and the economy) by showing how different outcomes in each area would affect the population of Oxfordshire and its districts.

It is important to understand the differences between the projections and forecasts produced by the Research and Intelligence Unit. Neither provides a crystal-ball, nor a time machine (the future is always subject to uncertainty and change), but they provide the best evidence available about how the population is likely to change. Our projections and forecasting both make statements about the future population, but with crucial differences:

- Research and Intelligence Unit forecasts are based on published district local plans (the best evidence at any point in time of how housing stock will change over the short-medium term). They are a single set of population data, representing a single scenario for changes in life expectancy, fertility, migration, household formation, and housing stock changes;
- Research and Intelligence Unit projections are independent of district local plans. They are a series of population data, representing the range of variation considered feasible for changes in life expectancy, fertility, migration, and housing growth.

The Unit has produced a series of variant population projections, in a manner similar to the England wide long-term projections produced by the ONS. Each variant shows how the population would change if the individual factors that affect population change occur in a particular combination, within the range that's considered feasible. E.g. it is expected that life expectancy will continue to increase, but it is unclear by how much: there is a range within which experts think future life expectancy will lie. We don't know which point in the range is "right" (there is no crystal ball) but we can explore what will happen if the highest or lowest points in the range occur in the coming years. The five variant scenarios are:

1. “Principal”: a projection of the population with each variable set to the middle of the “possible” range for each individual variable. Principal uses the middle-of-the-range value for each factor that can influence how the population changes.

2. “Maximum”: a projection of the population with each variable set to the combination in which the population growth is maximised, within the ‘possible’ range for each individual variable.

3. “Minimum”: a projection of the population with each variable set to the combination in which the population growth is minimised, within the ‘possible’ range for each individual variable.

4. “Old”: a projection of the population with mid-level housing growth and each demographic variable set to the combination in which a large older population and a small child population occurs, within the ‘possible’ range for each individual variable.

5. “Young”: a projection of the population with mid-level housing growth and each demographic variable set to the combination in which a large child population and a small older population occurs, within the ‘possible’ range for each individual variable.

The table below sets out the detailed variables for each projection scenario.

Projection name	Fertility	Life expectancy	International migration	Internal migration	Housing growth / economic growth
Principal (middle setting for all variables)	ONS **mid** assumption, used to modify recent historic district Age-Specific Fertility Rates observed in each district **50%** of recent "slippage" behind national fertility in Oxford City continues	ONS **mid** mortality trajectory, used to modify recent historic district Age-Specific Mortality Rates s	ONS **mid** assumption, used to modify recent historic district age/gender totals.	Existing recent historic rates – except fixed-flows for student ages in Oxford City.	**Mid** -point between historic lowest 5 year period level of housing delivery since mid-1990s, and highest level ("SHMA max" totals)
Maximum	ONS **high** assumption, used to modify recent historic district ASFRs **Zero** on-going "slippage" behind national fertility for Oxford City	ONS **high** trajectory, used to modify recent historic district ASMRs (higher mortality in upper age groups, younger population profile, higher occupancy rating, more people overall living in each area)	ONS **high** assumption, used to modify recent historic district age/gender totals.	Existing recent historic rates – except fixed-flows for student ages in Oxford City.	**Max** housing growth ("SHMA max" to 2031, plus continued level of SHMA-upper delivery/max economic growth after 2031, aside from "catch-up" addition (Figs 2, 11 of SHMA report)
Minimum	ONS **low** assumption, used to modify recent historic district ASFRs Recent "slippage" behind national fertility for Oxford City continues	ONS **low** trajectory, used to modify recent historic district ASMRs	ONS **low** assumption, used to modify recent historic district age/gender totals.	Existing recent historic rates – except fixed-flows for student ages in Oxford City.	**Min** lowest 5 year period level of housing delivery since mid-1990s, continued 2012-2052

Projection name	Fertility	Life expectancy	International migration	Internal migration	Housing growth / economic growth
Old	ONS low assumption, used to modify recent historic district ASFRs Recent "slippage" behind national fertility for Oxford City continues	ONS LOW mortality trajectory, used to modify recent historic district ASMRs	ONS low assumption, used to modify recent historic district age/gender totals.	Existing recent historic rates – except fixed-flows for student ages in Oxford City.	**Mid -**point between historic lowest 5 year period level of housing delivery since mid-1990s, and highest level (SHMA max totals)
Young	ONS high assumption, used to modify recent historic district ASFRs Zero on-going "slippage" behind national fertility for Oxford City	ONS high mortality trajectory, used to modify recent historic district ASMRs	ONS high assumption, used to modify recent historic district age/gender totals.	Existing recent historic rates – except fixed-flows for student ages in Oxford City.	**Mid -**point between historic lowest 5 year period level of housing delivery since mid-1990s, and highest level (SHMA max totals)

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Oral Health in Oxfordshire

A report to the Health Improvement Partnership Board

Thursday 23 April 2015

Eunan O'Neill, Consultant in Public Health. Public Health Directorate

This paper will discuss the oral health of the local population in Oxfordshire and outline the statutory responsibilities of the Oxfordshire County Council in relation to oral health services.

1. Introduction

1.1 Having a healthy mouth promotes a healthy body by helping us enjoy a variety of foods. Good oral health promotes wellbeing by enabling us speak, communicate and so participate in society. A healthy mouth helps our children learn, thrive and develop. Our ability to have a healthy mouth is disturbed by oral diseases, including tooth decay, gum disease and oral cancers. Oral diseases are largely preventable but are still among the most commonly found chronic diseases.

1.2 Whilst nationally the oral health of the population has continued to improve over the past few decades, oral diseases remain a common problem. There has been a change in the pattern of oral disease from being common through all sections of the population to one of being more prevalent in smaller groups of the population. This has been supported with epidemiological data and there are oral health inequalities experienced with disadvantaged and vulnerable groups, similar to wider health inequalities.

1.3 Though there are significant improvements in the oral health of the population, dental disease can still have a significant impact on both children and adults who can suffer pain and poor self-esteem as a consequence.

1.4 Oral health is an integral part of overall health. A significant proportion of the population in England experience very good levels of oral health. Successive oral surveys have shown that child and adult oral health has been improving over the past 30 years. However, the vulnerable, disadvantaged and socially excluded groups are at greater risk of oral diseases affecting their teeth, gums, supporting bone, and soft tissues of their mouth, tongue and lips.

2. Oral Health Services in Oxfordshire

2.1 Since the transition of Public Health to Local Authorities in April 2013 as a consequence of the Health & Social Care Act (2012), there has been a statutory responsibility for Oxfordshire County Council to commission a range of oral health services. The County Council is however not the only

commissioner of oral health services as the Health & Social Care Act (2012) divided the responsibility for the commissioning oral health services was divided between different organisations. The service needs of the individual may result in overlap of responsibility of organisations to meet these needs (figure1).

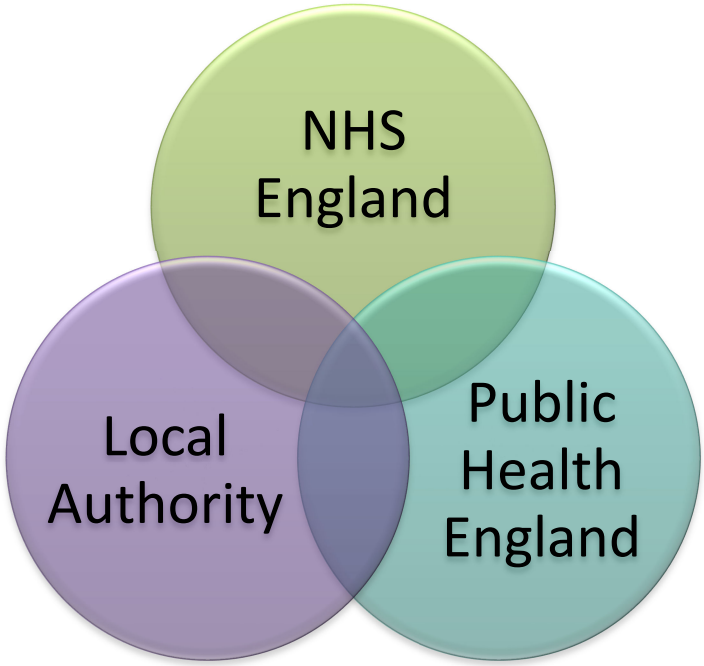

Figure1. Commissioning arrangements for oral health services

Role of NHS England in oral health services

2.2 NHS England Area Team is responsible for the commissioning and management of most dental services that are used by the public:

- General dental services
  - High street dental practices which treat a range of patients
- Salaried dental services
  - Community dental services which mainly treat people who find it difficult to access care from a general practice because of their additional needs e.g. people with a learning disability or severe dental phobia.
- Urgent care dental services
  - Services commissioned to provide care for people with urgent dental need. This includes services provided outside of normal working hours
- Secondary and Tertiary Specialist services
  - Specialist dental services for complex dental treatments

Role of Local Authority in oral health services

2.3 Oxfordshire County Council is responsible for commissioning and management of the following oral health services:

- Dental Epidemiology
  - The conducting of oral health surveys
- Oral Health Promotion
  - Support delivery of preventive programmes including providing advice on oral health for the wider population

Role of Public Health England in Oral Surveys

2.4 Public Health England (PHE) provides Specialist Dental Public Health advice and a leadership role in the provision of oral health locally and nationally. PHE also provide dental intelligence support through the Dental Public Health Intelligence Programme (DPHIP).

3. Oral Health Services Commissioned by Oxfordshire County Council

3.1 On 1st April 2013 the statutory responsibility for the commissioning of dental public health functions transferred from the NHS to local government.

3.2 The dental public health functions of Local Authorities include a statutory requirement to provide or secure provision of oral surveys. The statutory instrument states that:

A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area—
Oral health surveys to facilitate—

i. *the assessment and monitoring of oral health needs,*
ii. *the planning and evaluation of oral health promotion programmes,*
iii. *the planning and evaluation of the arrangements for provision of dental services as part of the health service, and*
iv. *where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.*
v. *The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc.) so far as that survey is conducted within the authority's area.*

3.3 Domain 4 (Healthcare public health and preventing premature mortality) of the Public Health Outcomes Framework (PHOF) includes and indicator relating to "tooth decay in children aged 5." Continued local dental epidemiology survey provision will be required for the monitoring of this indicator.

3.4 The delivery of dental epidemiology and oral health promotion services were delivered by Oxford Health Community Dental Services as part of a block contract with NHS England until 31 March 2015 who managed these under a Memorandum of Understanding (MoU) with the County Council.

3.5 The natural end point of the previous contact provided an opportunity to develop a service that would meet the statutory responsibility of the Local Authority and also meet the need to provide oral health promotion at a population level for Oxfordshire.

3.6 The newly commissioned services are a contracted value of £124k per year for three years with an option to extend for one year. The contract commenced on 1 April 2015 and is provided by Community Dental Services CIC.

Dental Epidemiology

3.7.1 The service aims to deliver the collection of dental as part of the Dental Public Health Intelligence Programme (DHIP) to provide data which will aid the understanding of local oral health needs and inform commissioning of services.

3.7.2 As the oral health of five year old children is a Public Health Outcome Framework these children are examined every other year. In the interim years there is an opportunity to examine other population groups. The planned population group for 2015/16 is older adults in assisted living.

3.7.3 The provider ensures that all staff are suitably trained and calibrated and collect the oral health survey in accordance with national protocols to ensure comparability with local and national data.

Oral Health Promotion

3.8.1 Oral disease is an easily preventable and cumulative disease. By implementing simple oral hygiene habits and informed lifestyle choices an individual can reduce their oral disease risk. Therefore improving oral health is more than providing a single intervention but encouraging a “whole life approach” to provide the wider population with the knowledge and skills to achieve improved oral health practices.

3.8.2 In commissioning an oral health promotion service it was important that the services offered are complimentary to the individual oral health promotion delivered by dental professionals. Using a “whole system approach” in designing a service aimed to deliver health promotion at several points in the system. Creating healthier public policies, supportive environments, strengthening community action, developing personal skills and reorienting health services towards prevention will improve children’s oral health. These “upstream” actions should be complemented by specific “downstream” interventions to effectively prevent oral disease as shown in the model below (figure 2).

3.8.3 The service aims to achieve the following local outcomes;

- Improved knowledge of how to access NHS dental services
- Improved oral health for the local population;
- Reduced health inequalities relating to dental care, with a priority focus on children, older people and vulnerable groups;
- Achieve best value and make best use of the dental public health budgets and make the case for future investment;
- Development of oral health promotion services to meet best practices and population needs

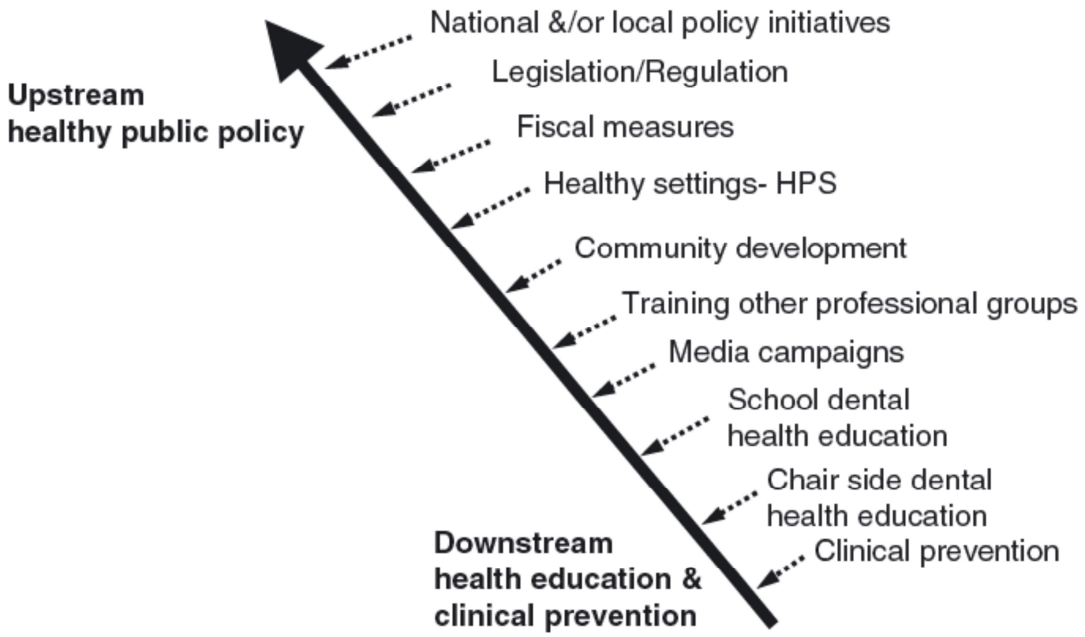

Figure2. Upstream/ Downstream: options for oral disease prevention. Source: Watt RG. From victim blaming to upstream action: tackling the social determinants of oral health inequalities. Community Dent Oral Epidemiol 2007; 35: 1–11

3.8.4 The specification for the service is designed to engage with children and adults using the following approach to embed oral health in the wider community.

<u>Oral health promotion interventions aimed at children</u>

3.9 The service will improve the oral health of children by implementing the following actions:

- Accredit preschool settings as oral health promoting settings for early years and primary school children.
- Train health and non-health professionals who work with children about the importance and promotion of oral health.
- Advocate integration of oral health into targeted home visits by health/social care workers.

- Provide oral health information and advice through early years (children aged 0-5 years) services, whilst providing tailored information and advice in areas where there is a higher risk of poor oral health.
- Promote supervised tooth brushing schemes in early year settings and primary schools based in areas where children are at higher risk of poor oral health.
- Promote oral health in the primary and secondary school curricula.
- Promote a 'whole-school' approach to oral health in primary education, such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting evidence-based, age-appropriate, oral health information for parents, carers and children, including details on how to access local dental services.

Oral health promotion interventions aimed at adults

3.10 The service will improve the oral health of the adult population by implementing the following actions:

- Promote oral health in the workplace.
- Deliver targeted services for adults at higher risk of poor oral health, including peer (lay) support groups or peer oral health workers.
- Train health and non-health professionals who work with adults from deprived populations and those who do not attend dentist regularly, as well as adults with additional needs (i.e., adults who rely on others for care), about the importance and promotion of oral health.
- Provide information about what services are available to the public and how to access them.
- Work with partners to promote oral health and oral health services in residential care homes.

4. Addressing oral health inequalities in Oxfordshire

4.1 Commissioners of oral health services will aim to reduce oral health inequalities by

- Targeted communications signposting the population to dental services and encouraging a relationship with a local dentist
- Working with NHS England to ensure that there is adequate access to services for vulnerable groups and deprived communities
- Ensuring that our provider of oral health promotion targets the following groups
    - Children in deprived areas
    - Older people
    - Rural populations
    - Ethnic minorities
    - Vulnerable groups such as people with learning disabilities
    - Drug and alcohol mis-users

5. Commissioner Priorities 2015/16

5.1 The commissioning team have the following priorities for Oral Health in 2015/15

- Successful implementation of the new contract
- Continued communications about oral health
- Delivery of the oral health survey for 2015/16
- Training of school health nurses in priority area schools in oral health
- Further development of the accreditation scheme of preschool settings
- Training of non-health professionals working with vulnerable groups and deprived communities in oral health messages

6. Oral Health in Oxfordshire

Oral Health of Children in Oxfordshire

6.1 The oral health surveys are carried out as part of the Public Health England (PHE) dental public health intelligence programme (DPHIP) (formerly known as the national dental epidemiology programme). Surveys are conducted annually, usually over academic years. They are carried out on randomised stratified samples although the commissioning bodies can opt to commission wider surveys e.g. census surveys. Locally the level of information for oral health in children is at the district level. The surveys are co-ordinated and supported by a team from Public Health England (previously the Dental Observatory which was part of the North West Health Observatory). This team develops the survey protocols, delivers examiner training and collates and disseminates the data.

6.2 The most recent data relating to children in Oxfordshire is for 3 year old children (conducted in 2013) and 5 year old children (conducted in 2011/12).

Three Year Old Children

6.3.1 In Oxfordshire 10.3% of the three-year-old children examined had decay experience. This was lower than the proportion for England (11.7%) and Thames Valley (11.2%) although the difference is not statistically significant. The proportion of the three year old population with decay experience varied between the lower tier local authorities in the county. The lowest proportion of three-year-olds with decay experience was seen in Vale of White Horse (6.37%). The greatest proportion was seen in South Oxfordshire (15.32%). It should be noted that only the difference in proportion with decay experience between the Vale of White Horse and South Oxfordshire is statistically significant.

6.3.2 Severity of decay in three year old children was measured using the average number of teeth per child affected by decay (decayed, missing or filled teeth

(d3mft)). In Oxfordshire, the average number of teeth per child affected by decay (decayed, missing or filled teeth (d3mft) was 0.28. This is lower than the England (0.36) or Thames Valley (0.38) mean.

6.3.3 Within Oxfordshire there was variation in the severity of decay experience (mean number of teeth affected by decay) across the lower tier local authorities. The lowest mean was found in West Oxfordshire (0.18) and the highest in South Oxfordshire (0.42). Only in West Oxfordshire was the mean lower than the Thames Valley (0.38) and England (0.36) mean at a value which was statistically significant. There were no statistically significant differences between the mean for the lower tier local authorities within Oxfordshire.

6.3.4 For the first time, this survey provides data that show the wide variation in the prevalence and severity of dental decay experienced by three-year-old children living in different parts of the country. This, and the polarisation of disease into a minority of children, suggests inequalities are being experienced within both Thames Valley and Oxfordshire. Results show that there was greater polarisation of caries in this age group than has been typically seen among five-year olds.

6.3.5 Variation and inequalities in dental decay experience are commonly attributed to an association with deprivation. This association is well established and has been widely described in relation to other children and adult age groups. In the most recent survey of five-year-olds in England, for example, the correlation between poor oral health and deprivation (using the index of multiple deprivation9) was strong, with 44% of the variation in decay levels in local authorities being explained by differences in deprivation.

6.3.6 Data analysis suggests that the correlation seen between deprivation and tooth decay in five-year-olds is less obvious in three-year-olds. A correlation analysis by PHE using the current survey data at a national level shows a far weaker association between decay and deprivation than was seen for the five-year-old survey in 2012.

6.3.7 Nationally, the strength of association between caries prevalence at age three and age five at lower-tier local authority level was moderate (R2=0.48). Only 19% of the DPHEP 3-year-old survey data, Oxfordshire summary September 2014 prevalence and 25% of the severity was thought to be explained by deprivation in the 2013 survey.

Five year old children

6.4.1 The latest survey of 5-year-old children, for which full results are available, was carried out in 2011/12. In the 2011/12 survey of 5 year old children the primary sampling unit was the district authority.

6.4.2 Tooth decay (dental caries) is the most important oral disease in children. Dental caries is commonly measured using the dmft index, which is a record of the number of decayed (d), missing (m) and filled (f) teeth (t). Data are

usually expressed as d3mft where a tooth is considered as decayed when there is obvious decay into the dentine of the tooth.

6.4.3 The Oxfordshire data for mean d3mft for the 2011/12 surveys the average number of decayed, missing and filled teeth (d3mft) for 5yr old children in Oxfordshire was 0.98, which overall is statistically similar than national levels (d3mft = 0.94).

6.4.4 The mean number of 5yr olds with decayed, missing or filled teeth in Oxfordshire has increased slightly in 2011/12, however is this based on a smaller sample size (approximately 26% of all 5yr olds).

6.4.5 Cherwell and Oxford City continue to have higher than the national average in terms of numbers of decayed, missing and filled teeth for 5yr olds (d3mft= 1.34 and 1.3 respectively).

6.4.6 The rate of decay in 5yr old children in West Oxfordshire (d3mft = 1.17) increased since the last survey. It is thought that this increase is likely due to a statistical anomaly created by the sampling methods used for surveying the children.

6.4.7 The mean for South Oxfordshire (d3mft= 0.41) and the Vale of the White Horse (d3mft= 0.55) is lower than England.

Adult oral health

6.5.1 The last national oral health survey of adults was conducted in 2009. The survey revealed that oral health is improving with more people having a functional dentition and keeping their natural teeth for life.

- The proportion of adults in South central with decay is 29% with an average of 2.7 decayed teeth each. More tooth decay occurs in adults than in children with 25-34 year olds and 75+ year olds having most disease
- 6% of the population in South Central suffer from severe gum disease putting them at high risk of tooth loss
- 31% adults in South Central reported impacts on their daily lives from oral problems. 41% reported poor oral health. 27% adults in south Central experienced dental pain in the last year
- Urgent dental problems are more likely to be experienced by older people, irregular attenders, smokers, people with dental anxiety, people from lower socio-economic groups
- Complex oral health needs requiring advanced restorative care are increasing, particularly in older adults, and a small proportion of young and middle aged adults
- Oral cancer incidence rates are rapidly rising
- Inequalities in oral health are consistently seen: tooth decay, gum disease, and oral cancer varies with age, geography and socioeconomic status

- People from deprived areas are more likely to suffer from decayed teeth, no teeth, gum disease, oral cancer, urgent dental problems, impacts on their daily life

6.5.2 Reasons for improvement in oral health in adults are thought to be:

- Changes in social norms and behaviours, including body hygiene, smoking rates, use of fluoride toothpaste, increasing public engagement in oral health and rising expectations Oral hygiene behaviours have substantially improved: 75% reported brushing twice daily in the most recent adult survey and levels of plaque and calculus have steadily improved over the last 40 years.55
- Changes in diagnosis and treatment of oral diseases mean that dentists are more likely to restore teeth than in the past where full dental clearances were commonplace.

6.5.3 While oral health has improved generally, it is not all good news. Population averages for adults hide oral health inequalities and a 'social gradient' exists whereby higher levels of disease can be seen at each lower level of the social hierarchy. Data shows that adults from the most deprived areas, in most age groups, are more likely to have:

- Decayed teeth
- No teeth
- Gum disease
- Oral cancer
- Suffer from urgent conditions6

6.5.4 It is well established that absolute deprivation has a significant impact on health status but the social gradient illustrates the importance of relative deprivation.56 This is significant for Thames Valley where there are pockets of deprivation in a broadly affluent area.

Oxford University Hospitals NHS
NHS Trust

A Joint Public Health Strategy for Oxford University Hospitals NHS Trust: Annual report and 2015/16 priorities

Executive Summary

1. The OUH Board and the Health Improvement Board approved the Public Health Strategy for OUH in March 2014, together with a 2014/15 Action Plan. The strategy sets out the approach OUH is taking to improve and maintain good health in the population it serves, and is jointly held with Oxfordshire County Council, the responsible body for public health in Oxfordshire.
2. This report describes progress achieved between 1 April 2014, the date the strategy came into operation, and 31 March 2015. It also sets out priorities for action against the strategy during 2015/16 in the three priority themes: (i) Building capacity to promote healthy lifestyles to all patients, visitors, and staff (ii) Developing a health promoting environment (iii) Embedding population health approaches within OUH
3. This has been a productive and exciting first year in developing a population health approach for OUH. The Public Health Steering Committee met in July 2014, November 2014, and March 2015, to oversee and develop the work. This Committee includes representatives from across OUH and from a broad range of partner organisations.
4. Highlights include the success of and securing substantive funding for the Health Improvement Advice Centre, and the development of close links with local partner organisations. This population approach by OUH has been widely welcomed by these organisations, as well as nationally by the Chief Executive of Public Health England and the Director of Nursing at the Department of Health.
5. Recommendation: The Board is asked to approve the public health priorities for 2015/16 and to note the annual report.

1. Purpose

1.1. The purpose of this paper is to update the Board on progress achieved against the OUH Public Health Strategy Action Plan for 2014/15, and to set out priorities for 2015/16 for the approval of the Board.

1.2. This paper documents progress achieved between 1 April 2014, the date the strategy came into operation, and 31 March 2015. It also sets out priorities for action against the strategy during 2015/16. These build on progress to date and incorporate emerging priorities and opportunities. Consultation on future priorities has been carried out among OUH staff, foundation trust members, and stakeholder organisations.

2. Background

2.1. The strategy is held jointly with Oxfordshire County Council (OCC), the responsible body for public health in Oxfordshire. The strategy and its 2014/15 action plan were approved by the OUH Board and the Oxfordshire Health Improvement Board (on behalf of Oxfordshire Health and Wellbeing Board) in March 2014.

2.2. The rationale for the strategy is that while OUH is the primary provider of acute health care services in Oxfordshire, it has the potential to play a much broader role in improving and maintaining the health of the entire population it serves, including those who are currently well. This population health approach will contribute to addressing the current rising rates of demand on OUH services.

2.3. The three overarching aims of the strategy are to:

(i) Build capacity to promote healthy lifestyles to patients, visitors, and staff at all opportunities;

(ii) Develop a hospital environment that enables and promotes healthy behaviours;

(iii) Embed population health approaches within OUH.

3. Here for Health 2015/16: What Oxford University Hospitals is doing to improve the health of the population we serve

3.1. Oxford University Hospitals is committed not just to treating disease, but to improving people's health across Oxfordshire. Every year, we have a million 'patient contacts' with people across the county – that's a million chances to help people change their lifestyle in ways that could reduce their chances of becoming ill. Plus, every time we talk to our patients, we can get the message out to their families, friends and carers as well.

3.2. It isn't only our patients' health that's important to us. We have 11,500 staff members who we would like to keep healthy as well – and we know that looking after our staff, both physically and mentally, helps them to look after their patients even better.

3.3. We can't do this alone, which is why Oxford University Hospitals is working with Oxfordshire County Council, and other local groups and organisations that share our goal of promoting health to our patients, visitors and staff.

3.4. Here, we set out what we plan to do during 2015/16 to achieve this goal.

We will promote healthy lifestyles to our patients, visitors and staff

3.5. During 2014/15, we launched an exciting new drop-in centre providing health improvement advice for patients, staff and visitors – The Here for Health Centre – at the John Radcliffe Hospital. We also trained staff across our hospitals in how to give brief health improvement advice to their patients and colleagues.

3.6. During 2015/16, we will:

- Increase access to the health improvement advice centre, including by:

  - 'pop-up' centres at our other hospital sites;

  - going into the community in partnership with other organisations;

  - seeking ways to expand the service to meet demand from all hospital sites.

- Train more of our staff in physical and mental health promotion and giving brief advice by:

  - inclusion in induction/ training courses/ group meetings for some key staff groups;

  - offering the opportunity for all staff who want to be trained to become 'health champions';

  - becoming an accredited site to deliver externally developed and recognised training in this area.

- Help our patients, visitors and staff to access specialist support for alcohol and drug misuse, smoking cessation, maintaining a healthy weight, and mental wellbeing.

- Increase the provision of physical and mental health improvement information across all hospital sites, including through information boards at all sites.

We will create a hospital environment that promotes health

3.7. During 2014/15, our staff told us they wanted to be able to buy healthier food and drink options at our hospitals. We worked with food providers to achieve this and there are now greater numbers of healthy choices during main meal times. We also looked at our hospital sites to find ways that we could increase opportunities for people to be more physically active.

3.8. During 2015/16, we will:

- Make changes to our hospital sites to make healthier choices the easier choices, including by:

- developing and agreeing a food and drink strategy, in line with national guidance;

- increasing access to healthier food and drink options at all of our sites, 24 hours a day, 7 days a week;

- promoting and increasing opportunities for active travel and other physical activity.

- Promote and support mental wellbeing in our staff.
- Curtail exposure of patients, staff and visitors to second-hand smoke on our hospital sites

We will make population health integral to what we do

3.9. During 2014/15, we set up a Public Health Steering Committee to guide and oversee our work in this area, including representatives from across our staff groups and divisions, and from other important organisations such as Oxford City Council and Oxford Academic Health Science Network,. In addition, each of our clinical divisions identified and committed to their own public health objectives.

3.10. During 2015/16, we will:

- Develop a substantive public health function within the Trust with a defined set of responsibilities to improve the health of the population we serve.
- Make sure the health of the population becomes part of our core business, through inclusion of population health priorities in the organisation's business plan.
- Develop ways to ensure that the broad impact of everything we do on the population's health is considered and maximised.

Our guiding principles

3.11. Four guiding principles will apply across all of the work proposed here:

- **Equity** will be considered in all public health policies and interventions, and all will aim to reduce inequities in disease burden, disease risk factors, and access to services.
- **A holistic approach to physical and mental health and wellbeing** – we will take a holistic approach to health promotion, and consider physical and mental health jointly and in equal esteem in all public health policies and interventions.
- **Sustainability of resources** – including environmental resources, will be considered in all public health policies and interventions.
- **Community development** – we will look for opportunities to develop better links to benefit the wider community, and we will make sure that all public health policies and interventions are consistent with, and linked to, other initiatives across the county.

3.12. We will keep listening to feedback and checking regularly to see if what we're doing is making an impact. We will also continue to find out what more we can do to support our patients, visitors and staff to make healthier choices.

3.13. For more information: please visit our website www.ouh.nhs.uk/HereforHealth; or email public.health@ouh.nhs.uk

For our employees to find out more about staff health and wellbeing: visit the staff intranet ouh.oxnet.nhs.uk/HealthandWellbeing or NHS Employers http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing; or email staff.wellbeing@ouh.nhs.uk

4. Annual report: 1 April 2014 to 31 March 2015

(i) Building capacity to promote healthy lifestyles to all patients, visitors, and staff

Training staff to deliver brief health promotion advice

4.1. Valuable lessons have been learnt from evaluation of a Thames Valley-wide pilot to train staff in public service organisations to promote health to members of the public they are in contact with. These have shaped the approach taken to training OUH staff.

4.2. The OUH Occupational Health and Wellbeing Promotion Specialist has continued to recruit staff 'Health Champions' and train them in brief health improvement advice.

4.2.1. Discussions are underway to expand training in brief health improvement advice in the OUH Community Paediatrics department, and to recruit more health champions from the department.

4.3. OUH is considering applying to become a training centre for delivery of Royal Society of Public Health 'Understanding Health Improvement' training. This will enable us to deliver externally-recognised training to OUH staff, and to those from other organisations.

4.4. The public health team and The Centre for Occupational Health and Wellbeing have identified existing fora for extending delivery of brief advice training. Opportunities have been identified through Band 5 and 6 preceptorship and leadership courses, and through inductions for Clinical Support Workers and apprentices. The intention is for sessions to be developed for delivery by the current course organisers, thereby ensuring future sustainability.

Providing information and support on improving health to patients, visitors, and staff

4.5. The innovative OUH '*Here for Health'* Health Improvement Advice Centre was launched on 27 August, following recruitment of two members of staff. A 1-year pilot has been jointly funded by the Oxford Radcliffe Charitable Fund and through the NHS England Area Team CQUIN. Substantive funding for continuation of the centre at the John Radcliffe hospital has now been secured. The service is subject to on-going evaluation and ethical approval is being

sought for permission to follow up service users for more detailed evaluative research.

4.6. The public health team and the centre staff have engaged widely across OUH and community services, developing links for referrals to and onward from the service, and identifying opportunities for synergy and consistency in health promotion locally. The Health Improvement Advice Centre has been included in the care pathway of patients in the gastroenterology and ophthalmology departments. Good links have also been made with other departments, including paediatrics, with arrangements being made for referral or for centre staff holding sessions within certain clinics. The staff also now hold a bleep enabling contact from wards for patients unable to attend the centre.

4.7. The possibility of offering opportunities for work experience and projects for students at Oxford Brookes University and Oxford University are being explored.

4.8. Between 27 August 2014 and 25 March 2015, 1073 (32% male; 68% female) individuals accessed the centre. Of these, 47% were staff, 22% patients, and 30% visitors to the hospital. The most frequent reasons for consultation have been for weight management (39%) and physical activity (26%). Feedback to date has been highly positive from service users, referring clinicians, and external organisations.

Expand alcohol and smoking cessation services for patients

4.9. A discussion paper on reducing alcohol-related harm and service burden at OUH has been produced for presentation to the Clinical Governance Committee. Links have been made between the *Here for Health* Centre and the Emergency Department Community Safety Practitioner to ensure consistent advice and referral pathways.

4.10. The public health team and the Hospital Smoking Cessation Specialist are exploring increasing provision of information and nicotine-replacement therapy (NRT) to patients. An audit survey has been prepared to determine how widely inpatients are provided with information and offered NRT prior to and following admission. Promising discussions have been held, and a written proposal submitted to Oxford County Council for the funding a trial of provision of NRT for 50 service users through the Health Improvement Advice Centre.

Estimate the baseline burden of unhealthy behaviours in OUH staff, patients and visitors

4.11. Work has commenced using hospital and routine data to calculate the estimated prevalence of various lifestyle risk factors among OUH staff, patients and visitors.

(ii) Developing a health promoting environment

Enable healthier food choices and physical activity for staff, patients and visitors

4.12. The Centre for Occupational Health and Wellbeing with the public health team surveyed staff about food provision at OUH. The survey received 2,355 responses, and identified clear demand for increased availability of healthier food choices, particularly outside core meal times and in locations not well served by restaurants. The results were presented to providers, who identified some simple changes they could make in line with demand expressed, some of which have since been enacted and others are in progress

4.13. Consistent with the Department of Health Hospital Food Standards Report, a food strategy covering the provision staff/visitor catering, retail and patient food and hydration is being developed for OUH. The national standard requirements are being discussed with providers through the OUH Food Group, which includes representatives from all providers plus Occupational Health, Public Health, and Facilities.

4.14. The indoor and outdoor environment at OUH was evaluated at all 4 sites, to assess opportunities for active travel and physical activity. The report and its recommendations will be discussed by the Public Health Steering Committee and the OUH Health and Wellbeing Strategy Group for approval.

4.15. The public health team are exploring with Oxford City Council the possibility of developing an outdoor gym at the JR site. Charitable funding is being sought.

Improving staff mental wellbeing

4.16. The Centre for Occupational Health and Wellbeing has convened a working group to develop a Trust policy on stress and mental wellbeing. This group includes Divisional Representatives and the public health team.

4.17. A comprehensive training programme embedding mental health training across the Trust has been developed by the Centre for Occupational Health and Wellbeing. The Trust has signed a memorandum of understanding with NHS employers to train 100 managers during 2015 in Mentally Healthy workplace. The package is being delivered by the Centre for Occupational Health and Wellbeing and evaluated by NHS employers.

(iii) Embedding population health approaches within OUH

4.18. A Public Health Steering Committee has been established to oversee the delivery of the strategy and to guide development of work in this area. This is a sub-committee of the Trust Management Executive. It includes representation from across divisions and staff groups at OUH, as well as key partner organisations, including Oxfordshire County Council, Oxford City Council, Oxfordshire Clinical Commissioning Group, Oxford Health NHSFT, the Academic Health Science Network, and University of Oxford.

4.19. Three productive and stimulating meetings were held in July and November 2014, and March 2015, identifying synergies and opportunities for joint working across organisations to improve the health of the population, as well as developing the future priorities. An Executive Working Group comprising the public health team, Occupational Health and Wellbeing, and Oxfordshire

County Council meets in the interims between Committee meetings. The Smart City concept is concerned with the variety of ways in which the management of urban environments is assisted by information technology. This Smart City proposal will be presented at the Steering Committee meeting in March 2015 for discussion of opportunities for incorporating population health.

4.20. All OUH divisions identified their own public health objectives in their business plans for the first time in 2014/15. The key strategic and operational aim for 2015 is to develop a mentally healthy workplace and encourage a culture of managing stress, building resilience and promoting mental wellbeing within the OUHT community:

4.20.1. *This division is committed to releasing 15 relevant managerial staff to attend the NHE employers "mentally healthy workplace" day's training delivered on site from April 15 – July 2015 offered by Centre for Occupational Health and Wellbeing.*

4.20.2. *This division is committed to building resilience within the division and will release both managers to be trained as trainers or / and staff to attend building resilience workshops to be offered internally during 2015 by each division through their trained representative supported by the Centre for Occupational Health and Wellbeing*

4.20.3. *This division is committed to developing a culture of health and wellbeing and will support and enable a staff member from every work area within the division to be released for a day's training to become a health champion during 2015-16. This aim is to build up an activist group focused on developing a community approach within each division.*

4.21. Work is underway to establish an internal OUH population health function, as to date this work has been led by public health specialty registrars on placement from the Oxford Deanery.

5. Conclusion

5.1. This has been a productive and exciting first year in developing a population health approach for OUH. Highlights include the success of and securing substantive funding for the Health Improvement Advice Centre, and the development of strong links with local partner organisations. Close working links have also been developed between the public health team and the Centre for Occupational Health and Wellbeing, to ensure synergy and consistency of work. It is anticipated that these links will be further strengthened and consolidated moving forward.

5.2. The work has been presented to the Chief Executive of Public Health England during a visit to Oxfordshire County Council, who praised the Trust for its innovation in this area. The Director of Nursing for the Department of Health and Public Health England has also recently visited OUH to find out about the programme of work by the public health team and the Centre for Occupational Health and Wellbeing, including a visit to the Health Improvement Advice

Centre. A blog about the work was published on her website (https://vivbennett.blog.gov.uk/2015/03/17/improving-population-health-at-ouh-aine-lyng/). .

5.3. Over the coming months, priorities (as set out in section 3) will include furthering implementation of brief advice training, identification and development of opportunities to enhance the hospital environment to better promote health, and seeking a Public Health Consultant post to lead the internal population health function for OUH.

6. Recommendation to the Board

6.1. The Board is asked to approve the population health priorities for OUH for the year 2015/16 and to note the 2014/15 annual report.

Dr Louise Marshall, Public Health Specialty Registrar
Dr Behrooz Behbod, Public Health Specialty Registrar
Dr Adam Briggs, Public Health Specialty Registrar
Ms Anna Hinton, Health and Wellbeing Promotion Specialist, Centre for Occupational Health and Wellbeing
Mr Andrew Stevens, Director for Planning and Information

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Oxfordshire Health and Wellbeing Board

Health Improvement Partnership Board

Terms of Reference

Purpose

The Oxfordshire Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

The Health Improvement Partnership Board exists to support the Health and Wellbeing Board in this purpose by delivering service change and improved outcomes through partnership working.

Responsibilities

To achieve its purpose, the Health Improvement Partnership Board has the following responsibilities:

- To demonstrate effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources
- To deliver the priorities and objectives arising from the Joint Health and Wellbeing Needs Assessment (JSNA) for Oxfordshire,
- In particular to:
    - *Bring a coordinated and coherent approach to influencing a broad range of determinants of health to bring about health improvement*
    - *Work together to recommend priority areas to improve health in order to make a real and measurable difference to outcomes*
    - *Recommend actions and responsibilities to make that improvement a reality*
    - *Hold each other to account for making the agreed change and for reporting progress*
- To meet the performance measures agreed by the Health and Wellbeing Board.

Membership

The core membership of the Health Improvement Partnership Board is:

- Five district/city councillors – one of whom will be Chairman and another Vice-Chairman
- County Council Cabinet Member for Public Health and Voluntary Sector
- Clinical Commissioning Group representative
- Director of Public Health for Oxfordshire
- Public Health Specialist
- District Council officer representative

- Healthwatch Ambassador

In attendance
- District Councils' officer for partnership development

It is proposed that a wide range of stakeholders can be invited to Board meetings at the discretion of the Chairman. They may attend as expert witnesses and to report on implementation of plans.

Governance

The meetings of the Health Improvement Partnership Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and the Access to Information Procedure Rules, insofar as these are applicable to the Partnership Board.

The Health Improvement Partnership Board will also be subject to existing scrutiny arrangements with the Oxfordshire Joint Health Overview and Scrutiny Committee providing the lead role.

Members of the Group will be subject to the Code of Conduct applicable to the body which they represent.

The Partnership Board will meet at least once a year in public. Dates, times and places of meeting will be determined by the Chairman of the Partnership Board.

The County Council's Joint Commissioning Team will service meetings of the Partnership Board including the preparation and circulation of agendas and minutes.

The Health and Wellbeing Board will agree terms of reference and membership for the Partnership Board. It will also agree its priorities, proposed outcomes and performance measures. The Partnership Board will review the terms of reference on an annual basis.

Peter Clark
County Solicitor and Monitoring Officer

April 2015

Health Improvement Partnership Board
Forward Plan 2015-16

Date	Item
Thu 2 July 2015 2-4pm Oxford Town Hall	• Re-commissioning of housing-related support • Healthy Weight Action Plan update • Young People's Housing Support
Thu 29 Oct / 19 Nov 2015 (tbc)	• Re-commissioning of housing related support • Healthwatch Report, including update on Asian Women's Wellbeing project
Thu 11 / 18 Feb 2015 (tbc)	
Standing items:	
• Minutes of the last meeting and any matters arising • Healthwatch Ambassadors' Report • Performance Report (including any report cards) • Forward Plan	
Proposals/periodically:	
To be kept under regular review: • Re-commissioning of housing-related support • Welfare reform • Oxford City Council Housing Strategy (for information) • Healthy Weight Action Plan • Oxfordshire Sports Partnership • Mental Wellbeing Strategy • Children and Young People's Plan 2015-2018	

15 April 2015

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