October 28th 2016

# Recommendations for action on Health Inequalities in Oxfordshire

## Oxfordshire Health Inequalities Commission

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## Acknowledgements

The Commission would like to thank

- The members of the Commission Support Group, convened by the CCG, who gave unstintingly of their expertise and advice, providing useful contacts for the Commission and its secretariat
- The co-opted members of the group, and members of its wider support network, who provided their support and specialist expertise at various stages of the evidence gathering. These include, but are not restricted to Patrick Taylor, Lonah Hebditch, Mandy Rose, Maggie Dent, Emily Phipps and Jackie Wilderspin.
- The members of the public who came along to the evidence sessions to provide their input and views.
- The many people from across the statutory, voluntary and private sectors who produced written submissions, gave oral evidence, and attended the evidence gathering sessions.
- Professor Paul Johnstone, Clare Laurent and her team at PHE, Sir Michael Marmot and Poppy Jaman.
- Allison Thorpe and the secretariat who held the process together

Their support and input were invaluable.

*"Right now, if you're born poor, you will die on average nine years earlier than others. If you're black, you're treated more harshly by the criminal justice system than if you're white. If you're a white, working-class boy, you're less likely than anybody else to go to university."*

*"If you're at a state school, you're less likely to reach the top professions than if you're educated privately. If you're a woman, you still earn less than a man. If you suffer from mental health problems, there's too often not enough help to hand. If you're young, you'll find it harder than ever before to own your own home."*

*Source: Teresa May, Prime Minister*

Poppy Jaman, CEO of Mental Health First Aid England says:

*"I am pleased to endorse the report of the Oxfordshire Commission on Health Inequalities .Mental wellbeing and good health are inextricably linked, and inequalities in socioeconomic conditions will adversely affect the health of the most vulnerable in society. Many people with mental health issues also experience poor physical health and impoverished social conditions. Holistic responses addressing a wide range of socio economic factors such as poor housing, in addition to improved health services , will help address the needs of those with mental health issues and will reduce health inequalities within the county. Implementing the recommendations within this report will be a step forward towards improving the mental wellbeing of Oxfordshire's population."*

Professor Paul Johnstone, Regional Director, Public Health England, says:

*'The report of the Oxfordshire Commission into Inequalities in Health comes at an opportune time .Whilst we are all living longer on average, recent data shows that the gap between the richest and poorest in enjoying a healthier, longer life has not closed and is arguable widening. As this report shows, Oxfordshire is no exception. These inequalities are costly and unsustainable – there is clear evidence that poorer deprived communities depend more on public services including the NHS. The cost of the effects of poverty- which is a big burden on the NHS amongst other services- are nationally estimated at £78bn or 4% GDP. The Brexit vote had many messages and addressing the deep divides in society is now a priority for the Government and must be one for all local areas. The Commission report, which I fully endorse, sets out steps which will address inequalities and I look forward to seeing their implementation'*

## Chairman's Letter

28 October 2016

To the Chairman,
Health and Wellbeing Board

I have pleasure in submitting the report from the Oxfordshire Commission on Health Inequalities. The Commission was established at the request of the Health and Wellbeing Board, recognising that both the human costs and the economic costs of health inequalities to the NHS and to the county are unacceptable. Nationally, an estimated £5.5bn economic loss is associated with health inequalities and due to lost production, higher benefit payments and lost taxes the costs rise to £31-33bn. The county bears its share of these losses and addressing inequalities will strengthen not only the health of its population but also its economic wellbeing.

Informed by the Marmot Review of 2010, the Commission adopted a life course approach, and makes recommendations to reduce local health inequalities across the social gradient as well as at different life stages. In making these recommendations we have drawn upon local experience and sound evidence for effective action, resonating with local, national and international policy directions including the Five Year Forward View and the Sustainability and Transformation processes and we have not repeated the work summarized in the Annual Reports of the Director of Public Health, the Joint Strategic Needs Assessment and other. We also recognise the importance of advocating national solutions in addition to implementing our local recommendations.

During the evidence sessions in different parts of the county we heard about excellent initiatives which target vulnerable populations and were given many examples of current and emerging good practice that can address health inequalities in Oxfordshire.

Our recommendations are made from the perspective of taking local action which can make a difference in the short and medium term. These recommendations will need the guardianship of

the HWB if they are to make a difference to the health of the population of Oxfordshire, particularly its most vulnerable members.

I would like to thank all those who participated in the process of producing this report – most especially the Commissioners and the support team. Without them and the sterling efforts of Allison Thorpe in keeping the show on the road the opportunity to highlight often hidden inequalities might have passed us by.

Professor Sian M Griffiths OBE

## Foreword

The Health Inequalities Commission was convened to gather and review the evidence on inequalities in health in Oxfordshire and, as a contribution to the development of the local strategy for health improvement, to identify areas for policy development likely to reduce these inequalities. We have carried out our task over the last 10 months, drawing on scientific and expert evidence, and peer review.

Throughout the process, we identified that unacceptable inequalities in health persist in Oxfordshire. These inequalities affect the whole of society and they can be identified at all stages of the life course from pregnancy to old age.

The weight of scientific evidence supports a socioeconomic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as to the material environment and lifestyle. It follows that our recommendations have implications across a broad front and reach far beyond the remit of the health services.

We have identified a range of areas for future policy development, judged on the scale of their potential impact on health inequalities, and the weight of evidence. These areas include: poverty, education, housing, transport and access to health and other services. Areas are also identified by the stages of the life course - mothers, children and families; young people and adults of working age; and older people - and by focusing on ethnic and gender inequalities. In our view, these areas offer opportunities over time to improve the health of the less well off. They are not totally inclusive of all possible actions, but reflect what we were told.

**Navigating the Report**

**Section 1: Background to the Review**

**Section 2: The evidence and rationale for recommendations 1-11, which focus on utilizing the Common Principles (Box A) to address inequalities.**

These principles should inform policy, resource allocations and practice across the county if health inequalities are not to become further entrenched or grow:

***Box 1: Common Principles to address health inequalities***

***1. The profound influence and impact of poverty on health needs to be widely recognised and systematically addressed.***

***2.Commitment to prevention needs to be reflected in policies, resources and prioritization***

***3.Resource reallocation will be needed to reduce inequalities***

***4.Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organisations using the Health in All Policies approach***

***5.Data collection and utilisation needs to be improved for effective monitoring of health inequalities***

**Section 3: the evidence and rationale for recommendations 12-40, which focus on common themes across the lifecourse,** drawing together many of the threads common to the other sessions. (figure 1). These recommendations take into account not only geographic communities but also communities of common interest, particularly vulnerable groups most likely to suffer from health inequalities.

**Section 4: the evidence and rationale for recommendations 41-58, which focus on stages of the life course**

- ***Beginning well*** :pre-pregnancy, the antenatal and perinatal period, and childhood,
- ***Living well*** :the middle years
- ***Ageing well*** :the latter years of life.

We hope our report will provide a sound basis for policy development and resource allocations across the Oxfordshire health and social care economy.

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## Section 1 : The Health Inequalities Commission

### 1.1 Introduction

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. But as Sir Michael Marmot has highlighted, health inequalities are not just reflected in poor health for poorer people but affect us all – "it is not about them, the poor, and us the non poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone.'[i] Addressing health inequalities is a priority for the World Health Organisation [ii] and remains central to the UK government's health strategy, the Five Year Forward View [iii], which provides guidance to the NHS.

The open letter from the Secretary of State for Health in February 2016 made it clear that all communities are expected to have plans in place to narrow the gap and reduce overall inequalities in their health. [iv] Local authorities, strengthened by the recent move of public health departments, have inequalities duties – introduced for the first time by the Health and Social Care Act 2012. (see Box 1)

**Box 2: Letter from Secretary of State, February 2016**

To re emphasise the relevance of the need to address the inequality gap, in February 2016, the Secretary of State for Health tasked the NHS to demonstrate:

1. **An evidence-based strategic approach** to reducing health inequalities based on sound governance, accountability and good partnership working, ensuring that reducing inequalities were integral to strategic and business plans.
2. **Systematic focused action** to reduce inequalities in access, outcomes and experience based on a defined and evolving set of metrics.
3. **Evidence of utilisation and development of effective interventions** to reduce health inequalities, doing what is known to be effective, capturing innovation, sharing knowledge about what works and when action will impact.
4. **Improvement in prevention, access, and effective use of services** for Inclusion Health groups and families on the Troubled Families programme.

Source: Letter from Jeremy Hunt (Secretary of State), February 2016, accessed https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/506771/SofS_letter_health_inequalities_acc.pdf

Thus, inequalities have been repeatedly identified as an essential focal point in all work streams, and should therefore be explicitly considered in all policies.

### 1.2 Background to Convening the Commission: Health Inequalities in Oxfordshire

Overall, Oxfordshire is an affluent county with relatively low levels of deprivation[1]. However, there is considerable variation across the county. Two small areas in Oxfordshire are among the 10% most deprived in England[2] and a further 13 areas fall within the 10-20% most deprived in England[3]. People can experience inequalities due to a combination of factors, including their life circumstances and where they live. People experiencing inequalities generally live significantly fewer years than those with less disadvantaged circumstances or those living in more affluent areas. They also generally tend to experience poorer health. Some differences, such as those determined by ethnicity, may require specific interventions. Others are caused by social or geographical factors (also known as 'health inequities') and can be avoided or mitigated. (For an overview of health inequalities issues in Oxfordshire see table 1 and Appendix 2 and 3).

**Table 1: Overview of health inequalities in Oxfordshire**

Source: Emily Phipps, Public Health Team

| Theme | Key Issues | Most Affected |
|---|---|---|
| Beginning Well | - Six Oxfordshire wards are in the top 10% of children in England living in poverty<br>- Families with dependent children still face homelessness despite overall prosperity in the county<br>- There are variations in the number of low birthweight babies born within the county, with deprived areas affected the most<br>- Rising rates of childhood obesity | - Families living in Oxford City and its wards<br>- Families living in Cherwell and its wards |

[1] *110/407 lower super output areas (LSOAs) are in the least deprived 10% nationally (Council, Joint Strategic Needs Assessment, 2016).*

[2] *These are in parts of Rose Hill and Iffley ward, and Northfield Brook ward (Council, Joint Strategic Needs Assessment, 2016). The former has moved into this category since 2010.*

[3] *This is down from 17 in 2010. These are concentrated in parts of Oxford City, Banbury, and Abingdon (Council, Joint Strategic Needs Assessment, 2016).*

| **Table 1: Overview of health inequalities in Oxfordshire**<br>Source: Emily Phipps, Public Health Team | | |
|---|---|---|
| Theme | Key Issues | Most Affected |
| | in some areas<br>- Poor educational attainment amongst children with free school meal status | |
| Living Well | - Highest proportion of long-term unemployed adults live in urban areas<br>- Less people living in deprived areas attending NHS Health Checks<br>- Increasing rates of hospital admissions directly or indirectly related to alcohol<br>- Unpaid caring responsibilities falling on women<br>- Carers from the BAME community less likely to access support<br>- Fuel poverty and overcrowding unequally distributed across the county, mainly affecting urban areas | - Women across Oxfordshire<br>- The BAME community<br>- Adults living in Oxford and Banbury |
| Ageing Well | - Older people in rural areas less able to access services<br>- Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived, despite overall prosperity in the county<br>- Loneliness most affecting older | - Older people living in rural South Oxfordshire<br>- Older people living in rural West Oxfordshire<br>- Older people living in Banbury Grimsbury and Castle<br>- Older people living in Oxford<br>- Older women in Oxfordshire |

| **Table 1: Overview of health inequalities in Oxfordshire**<br>Source: Emily Phipps, Public Health Team | | |
|---|---|---|
| Theme | Key Issues | Most Affected |
| | people living in urban areas<br>- Women in Oxfordshire more likely to require hospital admission due to a fall than men, and more than is seen nationally and regionally | |
| Cross Cutting Themes | - Lack of availability of social housing<br>- Most homeless people are found in Oxford city<br>- A higher number of urban older people and lone parent households are without a car, limiting their access to services<br>- Lack of health needs assessments for minority groups | - Social housing clients in South Oxfordshire and Vale of White Horse<br>- Homeless people living in Oxford<br>- Gypsy and traveller communities<br>- LGBTQ communities<br>- People living on waterways |

National data estimates health inequalities cost £5.5bn nationally, with economic losses associated with health inequalities due to lost production, higher benefit payments and lost taxes estimated at £31-33bn. The economic benefits of addressing inequalities are also substantial. (See Appendix 1).

Against this background, recognising both the human and economic costs of health inequalities, the Oxfordshire Health and Wellbeing Board requested an independent enquiry into health inequalities in Oxfordshire: the Health Inequalities Commission ('the Commission')

### 1.3 The legislative framework for the Enquiry

There are three separate key duties associated with work on equity and health inequalities (see Box 3)

**Box 3: Key legislation for health inequalities**

The Health and Social Care Act 2012 introduced the first legal duties about health inequalities. It included specific duties for health bodies including the Department of Health, Public Health England, Clinical Commissioning Groups, and NHS England which require the bodies to have due regard to reducing health inequalities between the people of England. The Act also brought in changes for local authorities on public health functions.

The Equality Act 2010 established equality duties for all public sector bodies which aim to integrate consideration of the advancement of equality into the day-to-day business of all bodies subject to the duty.

The Social Value Act 2012 requires public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental wellbeing in procurement of services or contracts

The Equality Delivery System 2 (EDS2) supports the evidence base of public sector organisations to demonstrate compliance with the Equality Act 2010 general duty and specific duties, as well as the duty to reduce health inequalities (Health & Social Care Act 2012)

See also: https://www.england.nhs.uk/about/gov/equality-hub/resources/legislation/

The Commission recognises, and has reflected upon, the existing legislative framework for health inequalities as part of its deliberations.

## 1.4 The context of the Commission:

The Commission was established to make recommendations that will reduce health inequalities in Oxfordshire. Informed by the Marmot Review of 2010, it adopted an approach that would enable wide consultation to access evidence, identify risk factors, and support the development of recommendations that would:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities

- Strengthen the role and impact of ill-health prevention

## 1.5 Objectives

The objectives of the Commission were to:

- raise the profile of health inequalities in Oxfordshire
- inform strategic planning and operational delivery by gathering evidence from multiple organisations and individuals in the county by advising on tangible actions
- produce a report for the Oxfordshire Health and Wellbeing Board, to be shared with other relevant bodies, with recommendations for concrete, achievable activities with monitorable expected outcomes.
- ensure the recommendations for action are based on the best available evidence so as to improve the likelihood of reducing health inequalities in Oxfordshire over the next decade.

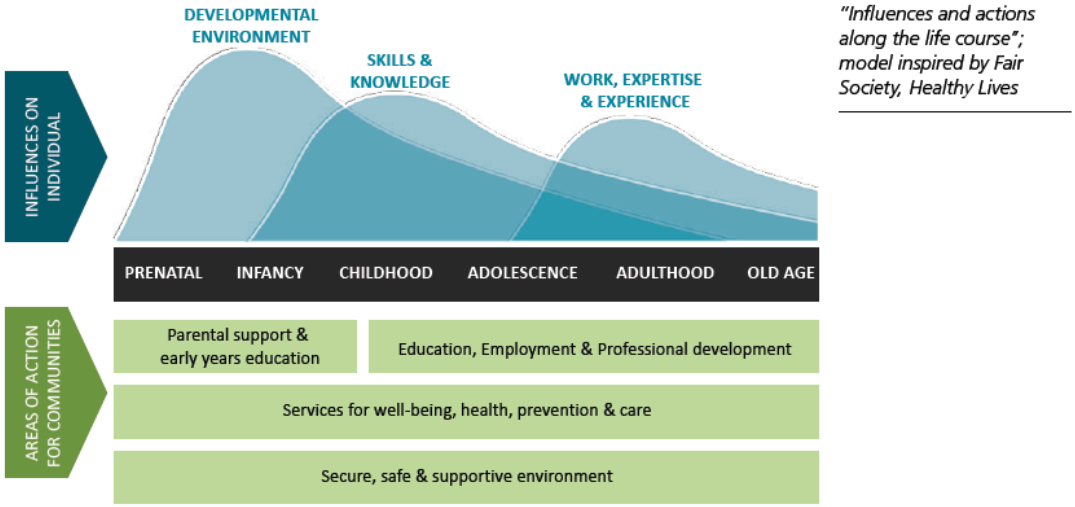
When implemented, these activities are expected to result in Oxfordshire attaining a sustainable reduction of preventable and unjust differences in health.

## 1.6 Scope of the Inquiry and approach

The Commission has considered what is currently being done to identify and tackle health inequalities in Oxfordshire, drawing on documentary and oral evidence provided by statutory, voluntary and charitable organisations and individuals living in Oxfordshire. (Appendix 5 and 6 ). This includes, but was not restricted to, the Annual Reports of the Director of Public Health, the Joint Strategic Needs Assessment, the Sustainability and Transformation Planning process and other reports already in the public domain. The evidence sessions have been held in public, to encourage and enable input from Oxfordshire residents, and to ensure transparency.

Throughout the process, the Commission took account not only of geographic communities but also of communities of common interest, particularly those more vulnerable groups most likely to suffer from health inequalities, using a lifecourse model to inform its deliberations. A lifecourse perspective highlights both critical periods of risk and also the accumulation of risk over an individual's lifetime and directs attention to how health inequalities operate at every level of development – pre conception, childhood, working age, and into the latter years of life.[v.] (see figure 1)

**Figure 1: The lifecourse model**




Source: Google Images

Each consultation session started with a presentation of the available data on health inequalities at a specified stage of the life course :

- ***beginning well*** considered conception and childhood,
- ***living well*** considered the middle years and
- ***ageing well*** considered the latter years of life.

A fourth session considered ***cross cutting themes***, and it was this session that drew together many of the threads from the other sessions.

## Section 2: The Common Principles

*The difference in life expectancy between rich and poor is well known. Perhaps less well known but equally important… is the inequality in the years lived in good health.*

Source: House of Commons Health Committee Report on Public Health, September 2016

Within any geographical area, differences in health can be observed across the population. There are many reasons for this: e.g genetics, biological factors and age. Health inequalities refers to the situation where these differences in health status are consistent and systematic between different groups, and are produced or reinforced by social factors and therefore unfair.

The Commission's overarching assessment of health inequalities in Oxfordshire identified five common principles which need to inform all policy areas and underpin the recommendations of this report. By acting consistently on these principles, the Commission believes we can redress the ***inverse care law*** :[vi].

The **inverse care law** was suggested thirty years ago by Julian Tudor Hart in a paper for The Lancet,[vi] to describe a perverse relationship between the need for health **care** and its actual utilisation. In other words, those who most need medical **care** are least likely to receive it.

### 2.1 Principle 1: The profound influence and impact of poverty on health needs to be widely recognised and systematically addressed.

Mitigating the perverse relationship between poverty and health is essential if we are to address the entrenched inequalities already present within Oxfordshire, and prevent further generations of Oxfordshire residents becoming adversely affected by circumstances beyond their immediate control – the wider determinants of health.

Whilst Oxfordshire is overall a very 'healthy and wealthy' county, there are significant differences in outcomes across health, education and social care for some specific groups. For example:

- Children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in income deprived families
- Between 2014 and 2015, 11.4% of working age adults in Oxfordshire were economically inactive due to long term sick leave. The highest proportion of long term unemployed adults in Oxfordshire live in urban areas
- Fewer people living in deprived areas attend NHS health checks
- Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived in the country, despite the overall prosperity in the county.

Recognising that evidence has shown that poverty and disadvantage lead to poorer health, policy makers at national and local level need to take into consideration how to narrow the gaps and adjust resource allocation across health and social care, and in other areas relevant to the determinants of health, on the principle of budgeting to meet need. The statutory funding bodies will need to work together actively to mitigate the relationship between poverty and health.

*While strong local political leadership can bring enormous benefits for public health, there is also the potential for tension between political priorities and evidence-based decision-making. Clearer standards should be introduced and monitored transparently to improve accountability and to make sure that services to underrepresented or politically unpopular groups are maintained at an appropriate level.*

Source: House of Commons Health Committee, Public Health Report, September 2016

Oxfordshire, through the commissioning of this report, is explicitly accepting the need to address poverty and health inequalities through more investment in prevention, innovation and service design. Many other parts of the country are also focusing on identifying opportunities to prevent problems by improving local conditions and social relationships, for example the Southwark and Lambeth Early Action Commission (Box 4). Much of the learning from these other areas is also relevant to Oxfordshire.

## Box 4: The Southwark and Lambeth Early Action Commission

Source: http://communitysouthwark.org/news-jobs/southwark-early-action-commission

The Southwark and Lambeth Early Action Commission aims to reduce demand for acute services and maintain wellbeing for all residents. Recognising that the underlying causes of most social problems can be traced to the same set of social and economic challenges they have looked for opportunities for local early action to prevent problems by improving local conditions and social relationships. The Commission has identified four goals for early action in Southwark and Lambeth. These are designed to address problems as early on as possible and focus on what can be done locally in the context of extreme budgetary constraints.

- ***Resourceful communities***, where residents and groups are agents of change, ready to shape the course of their own lives. To achieve this people need actual resources (but in the broadest sense), connections, and control.
- ***Preventative places***, where the quality of neighbourhoods has a positive impact on how people feel and enables them to lead fulfilling lives and to help themselves and each other.
- ***Strong, collaborative partnerships***, where organisations work together and share knowledge and power, fostering respectful, high-trust relationships based on a shared purpose.
- ***Systems geared to early action***, where the culture, values, priorities, and practices of local institutions support early action as the new 'normal' way of working.
- To help achieve these goals it will be important to find additional resources.

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***1.*** | Statutory funding bodies need to do more to demonstrate their commitment to reducing inequalities. Their policies and plans should be scrutinized by HWB on an annual basis. | **HWB** |
| ***2.*** | Monitoring of the process of commissioning/service design to ensure it has taken inequalities into account in the design of new models of care and innovations such as vanguards needs to be undertaken regularly. | **CCG/service providers** |
| ***3.*** | Local indicators on progress towards reducing inequalities should be developed, with regular reporting on progress to the Health and Wellbeing Board. This should be in place by the end of 2017 | **PH department in OCC** |

## 2.2. Principle 2: Commitment to prevention needs to be reflected in policies, resources and prioritisation

Recognising budget constraints across the health and social care system, ensuring best value from investment is critical to the health and wellbeing of our population and to the future sustainability of our health and social systems. Numerous studies have shown that investment in primary and preventive care greatly reduces future health care costs, as well as increasing health[vii viii]. Yet investment in prevention is insufficient; with data suggesting that in England, only 4-5% of health spend is focused on prevention activities.[ix] A 2013 report by Monitor suggested that '*A 21st century NHS will need to deliver care that meets the health needs of today and focuses more on preventing illness and supporting individuals in maintaining active and healthy lifestyles.*'[x] Effective prevention strategies benefit the individual, society as a whole, and the health and social care system. (Box 5)

**Box 5: Getting Serious About Prevention: The Five Year Forward View**

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. The warning has not been heeded….(p9)

If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness… (p7)

While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence based intervention strategies. We also need to make different investment decisions…. (p11)

Source: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

It is well recognised that spend on prevention should increase. [ix] Marmot recommends at least 7% of health spend being focused on prevention[4] [i]. Investment in prevention by all agencies is essential if progress in improving the health and wellbeing is to continue and to ensure that existing health inequalities do not grow and become further entrenched.

**Box 6: Health of Oxfordshire residents: examples of potential intervention points for prevention**

- Cherwell, Vale of White Horse and West Oxfordshire have significantly higher percentages of patients recorded as living with diabetes. However, around a quarter of people with type two diabetes are unaware of it, and undiagnosed.
- In Oxfordshire, fewer people living in deprived areas attend health checks
- There are increasing rates of hospital admissions directly or indirectly related to alcohol
- Women in Oxfordshire are more likely to require hospital admission due to a fall than men. The rate of admissions is higher than is seen nationally and regionally.

The evidence presented to the Commission suggests that prevention remains a poor relation in Oxfordshire. More upstream investment in prevention across the health and social care system is

[4] *The Fair Society Health Lives report recommends that overall investment in ill health prevention and health promotion needs to substantially increase to 0.5 per cent of GDP over 20 years.*

needed, if progress in improving the health and wellbeing of Oxfordshire residents is to continue, and to ensure that health inequalities which are already persistent within Oxfordshire (see Box 6 and Appendix 2 and 3) are not exacerbated.

This is not just about investment in essential public health services, but more broadly about ensuring that the prevention agenda is seen as a priority across the whole of the Oxfordshire economy and across all NHS organisations in particular as laid out in the 5 Year Forward View. (Box 5). Part of this will be through enhancing the ability to help people help themselves through consistent good quality advice. It is therefore imperative that every contact matters! Whilst many contributing factors to diseases are beyond the influence of the individual or of health services adopting healthier lifestyles and efficient systems for early detection and screening will promote longer healthier lives.

The Commission calls for a renewed focus on prevention, not just in the NHS, but across the whole of the Oxfordshire economy.

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***4.*** | Greater investment is needed in prevention, innovation and service design both across the health and social care system and more widely to mitigate the impact of poverty and health inequalities. | ***CCG*** |
| | • All NHS partners should state clearly their investment in prevention. | ***NHS*** |
| | • The current level of spending on public health services through the ring fenced budget should be maintained | ***HWB/Councils*** |
| | • The HWB should track increased spending on prevention, [xii] and annually report to the public on progress made and outcomes achieved | ***HWB*** |
| ***5.*** | The needs of disadvantaged groups should be monitored to ensure preventive programmes do not increase the inequalities gap, and that programmes delivered to all raise the health of all, including those who are most disadvantaged[xi]. | ***HWB/STP partners*** |
| ***6.*** | Core preventative services such as Health Visiting, Family Nurse Partnership, School Health Nurses and the Public Health agenda should be maintained and developed | ***CCG*** |

## 2.3 Principle 3: Resource reallocation will be needed to reduce inequalities

*An economic perspective is about more than counting the costs associated with poor health. It is about understanding how economic incentives can influence healthy lifestyle choices in the population.*

Source: http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/promoting-health,-preventing-disease-the-economic-case

*"Cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities. "*

Source: House of Commons Health Committee, Public Health post 2013, Second Report of Session 2016-7[xii]

Ensuring best value from investment is critical to the current and future health and wellbeing of Oxfordshire residents, and the future sustainability of the health and social care system. We heard evidence that budgets need to be allocated to redirect resources for the highest health and wellbeing dividend for the people of Oxfordshire. For example, The Thriving Families Scheme provides intensive support for families with complex social needs. Oxfordshire is an early implementer of the programme, and has demonstrated a cost saving of £3.22 to public services for each pound invested in the project [xiii]

However, the policy of using the resource allocation mechanism to reduce health inequalities is based on the assumption that additional expenditure translates into improved population health outcomes. This clearly depends on the quality and effectiveness of care delivered and whether it explicitly tackles current and future health needs.[xiv] The evidence submitted to this Commission demonstrates that there are unresourced unmet needs in Oxfordshire in addition to areas where reshaping resource allocations could deliver significant benefit in terms of reducing health inequalities (see Appendix 1, 2, 3 and 5). Too often, as Monitor highlighted, the pattern of health and social care expenditure nationally reflects history, rather than an objective assessment of the burden of disease, the 'best value' interventions, and the impact that the interventions can have on reducing health inequalities for our population. Mapping the burden of disease, and using this data to inform commissioning decisions, ensures that resources are focused to effectively respond to current and future population need. (Box 7)

**Box 7: Mapping the distribution of need in Oxfordshire (examples)**

- Whilst there are over 7700 people living with dementia in Oxfordshire, the five GP practices with the highest rates of patients living with the condition are Berinsfield Health Centre, Goring and Woodcote Medical Practice, The Wychwood Surgery, Islip Surgery, and Nuffield Health Centre
- GPs in Vale of White Horse, South Oxfordshire and West Oxfordshire look after a significantly higher proportion of patients with COPD, heart failure and history of stroke or transient ischemic attack (TIA) than GPs in Oxfordshire as a whole
- The current proposal for Syrian Refugee resettlement is that thirty families will be settled in Oxfordshire in the first year (10 in Oxford City, 6 in West Oxfordshire, 6 in Cherwell, 2 in South Oxfordshire, 6 in the Vale of White Horse). These patients can present with complex issues – medical problems that have gone untreated in countries of origin. They may also be suffering the physical and psychological effects of war, trauma, exile, and separation from families.
- The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed are treated in primary care. The most common method of treatment for common mental health disorders in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients. Having a mental health worker attached to or working alongside GP practices improves the knowledge, confidence and capacity of the other primary care professionals in the practice.

Ensuring health spend is adjusted to reflect the burden of disease, areas of deprivation, reverse the inverse care law, and focus resources for better access in higher need areas should be a priority. An audit of NHS spend is required, with the aim of ensuring that resources are allocated to reflect need, not history, and to promote a more holistic population health approach.

| ***Recommendations*** | ***Responsibility*** |
|---|---|
| ***7.*** Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities. | |
| • The CCG should actively consider targeting investment at GP surgeries and primary care to provide better support to deprived groups, to support better access in higher need areas, and specifically address the needs of vulnerable populations.<br>• The CCG should conduct an audit of NHS spend, mapping health spend generally and prevention activity particularly against higher need areas and groups, setting incremental increasing targets and monitoring progress against agreed outcomes.<br>• The ring fenced funding pot for targeted prevention should be expanded in higher need communities, using a systemwide panel of stakeholders to assess evidence and effectiveness, with ongoing independent evaluation of impact, including quantification of impact on other health spend. [5]<br>• An Innovation fund/Community development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations. | ***CCG*** |

## 2.4. Principle 4: Statutory and voluntary agencies need to be better co ordinated to work effectively in partnership organisations using the Health in All Policies approach

Health in all Policies (HiaP), which is supported by central government and WHO, highlights the important links between health and broader economic and social goals in modern societies. It positions improvements in population health and reductions in health inequities as high priority, complex problems that demand an integrated policy response across sectors.

"**Health in All Policies** is an approach to public **policies** across sectors that systematically takes into account the **health** implications of decisions, seeks synergies, and avoids harmful **health** impacts, in order to improve population **health** and **health** equity.

http://www.healthpromotion2013.org/health-promotion/health-in-all-policies

The Commission believes that addressing health inequalities in all policies should be given higher priority in Oxfordshire. In doing so, it believes that explicit consideration should be given to

[5] *This needs to engage people from the community and voluntary sectors, as well as people* working in the statutory sector

ensuring that policies act to level up health status, by ensuring that policy decisions and resource allocations explicitly and effectively:

- ❖ target disadvantaged groups
- ❖ focus on narrowing the health divide, and
- ❖ act to equalize health opportunities across the social spectrum.

Stated policy intentions are not enough. Whilst there was evidence of good partnership work[6] in pockets in Oxfordshire, the Commission was also presented with many examples of where this could be made stronger by adopting a more explicit HIAP approach. In particular:

- ***Better coordination of housing and estate*** generally between local councils and healthcare providers, including consideration of affordability, transport and other infrastructural issues, is needed. The healthy new towns process offers a significant learning opportunity for this. Academic institutes need to be actively involved in the evaluation of the impact of the new towns, ensuring that the learning for new developments and existing developments is captured.
- ***Increased support and coordination for community groups and voluntary groups***. More sustained support for community groups is needed, along with recognition that volunteering has costs and those involved need support to maintain their resilience.
- ***Enabling change, not just signposting-*** the health and social care system, which includes the voluntary sector, needs to know what resources are available and be able to coordinate/signpost services, with sustainable funding. In particular, tasks which require a skilled or qualified professional should not be passed onto a volunteer without adequate training and support (see Box 8).
- Exploring ways of getting **acute expertise delivered into more community settings** so that relevant communities and groups can be targeted (into working better together) .One way to strengthen links would be to review membership of the HWB and increase representation from NHS Trusts as well as voluntary groups such as Age UK

| **Box 8 :Health Champions: Providing support to particularly disadvantaged groups e.g. migrants, particular geographical communities.** |
|---|
| Recruiting paid or voluntary Health Champions in a range of settings – GP practices, leisure or community settings, allied health professionals, pharmacy counter staff or other workers like |

*[6] For example, the Oxfordshire Street Triage Scheme has led to improved experiences and outcomes for people in Oxfordshire experiencing mental health crisis, and has reduced the rising numbers of section 136 detentions seen in previous years (Police)*

Fire and Rescue workers can provide support to people who would otherwise find it difficult to access services. Such programmes can offer personal support to motivated individuals on behaviour change. The Healthy Living Centre model shows the effectiveness of this.

*More information at* **www.altogetherbetter.org.uk**

**Source: Jackie Wilderspin, Public Health Department**

Initiatives, such as the Banbury Bright Futures programme (Box 8), which is in its sixth year provide robust evidence of the progress which can be made by systematic efforts to tackle evidenced disadvantage and health inequality.

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***8.*** | The Health in All Policies approach should be formally adopted and reported on across NHS and Local Authority organisations, engaging with voluntary and business sectors, to ensure the whole community is engaged in promoting health and tackling inequalities. | ***All statutory organisations*** |
| | Regular review of progress should be undertaken by HWB | ***HWB*** |
| ***9.*** | The presence of the NHS and of the voluntary sector should be strengthened on the Health and Well Being Board | ***HWB*** |

**Box 9: The Banbury Brighter Futures programme: Partnership in practice**

Source: evidence provided to Commission by Ian Davies

The Programme has Six Themes to Deliver its Objectives

| Programme Objectives | Theme | Key Priorities |
|---|---|---|
| ➔ improve educational attainment through better numeracy skills and family engagement<br>➔ improve skill levels and educational attainment | Theme 1<br>Early Years, Community Learning and Young Peoples Attainment | Ensuring children get off to the best start in life, that young people, families and communities are supported in their aspirations and educational attainment |
| ➔ improve skill levels and educational attainment<br>➔ improve employability, focusing particularly on young people | Theme 2<br>Employment Support and Skills | Working with local residents and businesses to support skills development, access to training and employment support. |
| ➔ Target specific support to vulnerable people, families and children in need<br>➔ improve employability, focusing particularly on young people | Theme 3<br>Family support and young people not in employment, education or training | Supporting children, young people and families with complex needs. |
| ➔ improve financial situations, addressing debt and financial inclusion<br>➔ good quality mixed housing, affordable and in well managed environments<br>➔ good access to amenities including shops, health centres and leisure facilities | Theme 4<br>Financial Inclusion and Housing | Ensuring there are accessible advisory and support services for those facing challenging financial situations and delivering high quality affordable housing options and opportunities |
| ➔ improve life expectancy with improved overall health and well being<br>➔ reduce the clear inequality gaps with low life expectancy<br>➔ reduce high rates of teenage pregnancy | Theme 5<br>Health and Wellbeing | Improving life expectancy and reducing health inequalities through improved health and well-being |
| ➔ build a safer more connected community where residents feel socially included | Theme 6<br>Safer and Stronger Communities | Reducing crime and anti-social behaviour and ensuring local residents feel safe |

## 2.5. Principle 5: Data collection and utilisation needs to be improved for effective monitoring of health inequalities

*''The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, we are concerned that robust systems to address unacceptable variation are not yet in place. The current system of sector-led improvement needs to be more clearly linked to comparable, comprehensible and transparent information on local priorities and performance on public health.''*
*Source: House of Commons Health Committee Report*

Data collection on health inequalities in the county is patchy and not adequately utilized in policy and resource allocation decisions. During the process of consultation we found it difficult to get good data on Black and Ethnic Minority Communities in the county as well as on other disadvantaged groups[7]:

- National data indicates that gypsy and traveller communities have poorer outcomes in terms of physical health, mental health, education, access to services and mortality. ([xv]) There is very little data available locally on the health of this community.
- Data on age and pregnancy status is more complete and accurate than data on race or religion
- No information was found on people living on waterways

We also failed to fully engage BME communities at the public meetings.

PHE offers access to a rich repository of data. There is a need to ensure that knowledge, understanding and access to this data is broadened, to ensure that policy and resource decisions reflect current and future population trends, rather than historical legacies of action.

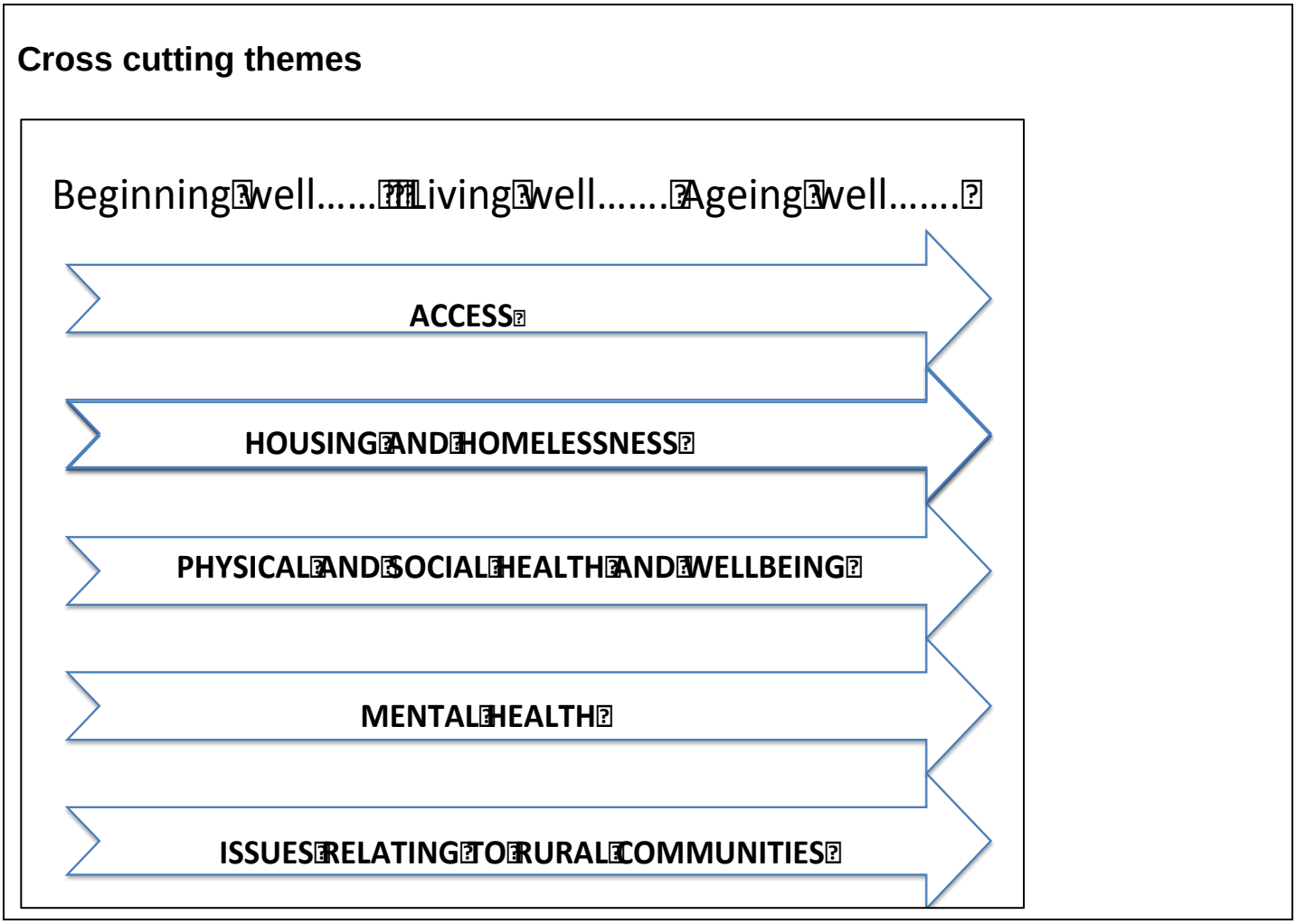
[7] *This is a concern, given that this is one of the protected characteristics covered by the Equality Act. The Commission believe there is a need for focused effort encouraging all public sector organisations (and all organisations & parties who do work on behalf of those organisations) to be fully Equality Act compliant, as this would support good quality data collection that can then be used to inform decision making in a number of areas, including health inequalities*.

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***10*** | The data on health inequalities available through PHE/NHS and other routine sources should be regularly reported to all statutory organisations and made available to the public. | **PH Dept** |
| ***11*** | Gaps in data collection on the health of BME communities, those with learning difficulties and other vulnerable groups at greater risk of poor health should be addressed and data used to inform resource allocation decisions. This includes encouraging all public sector organisations and organisations who do work on behalf of these organisations to be fully Equality Act compliant. | **HWB** |

## Section 3 : Cross- cutting themes from the Evidence Sessions

When considering evidence presented to the Commission, it became apparent that there were a number of common issues which cut across the lifecourse, affecting people's ability to access the services they needed, engage in physical activity and sustain social networks. These factors need to be holistically addressed in efforts to reduce health inequalities. (figure 2)

**FIGURE 2 :**




### 3.1 Access

#### a. Better Access to financial advice:

Encouraging maximisation of benefit is important to all groups in society. Universal benefits, for example Attendance Allowance and rate relief through the Lone Pensioners Allowance, are available to all who qualify, regardless of income or capital. Many people who would benefit from them are not aware of this, and if they do not identify themselves as poor even though on an objective measure they may be so, they do not claim.[xvi] More proactive work to encourage

benefit uptake especially in populations who may not be aware of their rights and entitlements should be undertaken. A number of small-scale initiatives already exist, e.g. Oxfordshire Welfare Rights, Benefits in Practice, and the excellent work done by the CAB. (Appendix 3, 5 and box 10) However, piecemeal funding arrangements hinder progress.

**Box 10 : Benefits in practice**

In addition to their mainstream services, the Citizens Advice Bureaux across the county each run programmes to offer benefits or debt advice locally. Each Bureau has to bid for funding for many of these programmes to run. One example is the Benefits in Practice scheme – a small scale programme which places the CAB advisers into a few GP practices in the City, Banbury and Carterton. The GP practices are selected based on local need and the service is always fully subscribed. Clients can be referred by their GP to get free advice and make their appointments through the Practice Reception. The scheme regularly delivers increases in benefits for clients who are helped to apply for money they are entitled to. Another recent programme in Oxford City has seen the local CAB offering advice on benefits as part of the Better Housing Better Health project, aimed at reducing fuel poverty. This was funded by a grant from the British Gas Energy Trust which was obtained by the Affordable Warmth Network. An early report showed that the CAB worker had been in contact with 73 clients through this scheme and generated £18k worth of benefits for them.

Greater attention needs to be given to the wider arrangements for referring people to benefits advice programmes, as part of a sustained programme of activity which aims to improve financial situations, address debt, and promote financial inclusion across all ages and stages of the lifecourse.

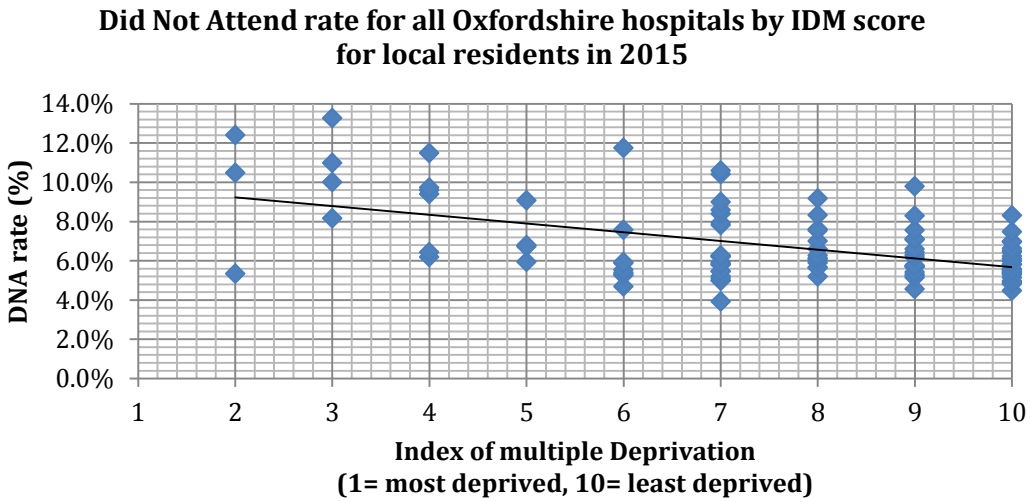
| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***12.*** | Benefits Advice should be available in all health settings, including GPs networked into local areas to support CABs | ***CCG/NHS Partners*** |
| ***13*** | A sub group working on income maximization should be established, and asked to report back to the HWB/CCG within a year | ***HWB*** |
| ***14.*** | District Councils should be approached to seek matched funding, dependent on existing contribution | ***HWB*** |

### b. Better access to services

The pathway redesign work that is being progressed as part of the Oxfordshire transformation programme should be used to develop inclusive and responsive pathways for those groups that have greatest need and/or that traditionally find accessing services difficult. For example, discharge arrangements from NHS care need to be appropriately tailored for people who are homeless.

Analysis of all hospital appointments in 2015 for residents in Oxfordshire by IMD scores suggested that more affluent areas have lower DNA rates compared to more deprived areas of Oxfordshire[8]. (see figure 3 and appendix 3)[9]

## Figure 3:




Source: Bethan MacDonald, Public Health Specialty Registrar, OUHT

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[8] *However, some caution is warranted in the interpretation of these results: In Oxfordshire there are more postcode areas designated as higher IMD scores (least deprived) compared to low IDM score areas; this is reflected in the number of data points for each IDM score shown in the chart below. This is a potential source of bias as fewer data points (as seen for lower IMD scores) gives a less precise estimate of average DNA rates, as indicated by the line of best fit. – see appendix 3*

[9] *For access to acute care, the analysis of Did Not Attend rates correlated to electoral wards that have different characteristics e.g. different socio-economic deprivation scores produced ambiguous results.(see Appendix 9) Other potential measures which could be considered include looking at outcomes and outputs by different population characteristics e.g. % of women from minority ethnic communities who accept invitations to undergo breast screening. It is therefore suggested that there is a need for an exercise to go through relevant indicators in the wider NHS performance framework to determine which can be broken down in this way to yield useful if limited insights into inequalities and provide a metric that can be measured to assess progress in addressing them . In addition, 'softer' measures, such as patient satisfaction should be considered.*

Where patients who are from groups with the greatest need have to attend hospital, all service providers need to ensure that services are as responsive as possible. This could range from ensuring that discharge arrangements from NHS care are appropriately tailored for people who are homeless, through to delivering services that are sensitive to the cultural norms and beliefs of patients from minority ethnic communities.

| ***Recommendation*** | | ***Responsibility*** |
|---|---|---|
| ***15*** | Indicators in the wider NHS performance framework should be utilised as part of routine monitoring for NHS organisations to yield useful, if limited, insights into inequalities and provide a metric that can be measured to assess progress in addressing inequalities. | ***NHS organisations*** |

## 3.2 Housing and health[*xvii*]

### a. Better access to secure, affordable, decent accommodation for Oxfordshire residents

An increasing body of evidence shows a correlation between poor housing and ill health. A Parliamentary Office of Science and Technology report estimated that poor housing conditions cost the NHS at least 600 million per year[xviii.] The quality of the home has a substantial impact on health; a warm, dry and secure home is associated with better health. In addition to basic housing requirements, other factors that help to improve well-being include the neighbourhood, security of tenure and modifications for those with disabilities.[ xix.]

Whilst social housing has generally improved, private rental stock remains a cause for concern both nationally and in Oxfordshire. In terms of the indoor living environment, the JSNA reported that 12 of Oxfordshire's small areas are among the 10% most deprived nationally. These are located towards the northern, north-western, western, and south-eastern edges of the county, as well as in parts of Oxford City. A further 28 small areas are in the 10-20% most deprived nationally and are similarly spread around different parts of the county[xx. Fuel poverty, mould and damp in existing stock and overcrowding all have adverse implications for health and wellbeing. The latest data from 2013 estimates that some 21800 people in Oxfordshire live in fuel poverty, accounting for 8.2% of the total population. (Appendix 3 and JSNA pages 48- 60).

Although shelter is a basic human need, it is clear that Oxfordshire's health inequalities are caused and sustained to a significant degree by the high cost of housing relative to many people's

incomes, and the lack of availability of affordable housing. (see table 1) This also causes major recruitment challenges in the health and social care processes, which in turn has broader implications for supporting people to live longer, healthier lives.

Access to secure, affordable decent accommodation should be a basic human right. However, in Oxfordshire, as Table 1 demonstrates, for many people this is at present an aspiration, rather than a reality. The Commission would like to see this change in Oxfordshire – and calls on all public bodies and Councils to increase the number, affordability and quality of homes, pledging to promote this basic human right. This includes:

- Districts working together to plan for meeting housing need across the County as identified in Oxfordshire's Strategic Housing Market Assessment
- Public agencies, university and health partners working together to developing new models of funding and delivery of affordable homes of a range of tenures to meet the needs of vulnerable people and key workers.
- Public agencies working together to maximise potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing.

**Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture**

| WHO Goal | Oxfordshire |
|---|---|
| Dwellings should provide adequate shelter from natural elements and hazardous substances, be of sound construction and in a reasonable state of report, weatherproof and adequately ventilated. | According to the latest Excess Winter Deaths Index data, South Oxfordshire was one of 4 areas (out of 67) in the South East that had a significantly higher ratio of extra deaths to expected deaths than anticipated (Council, District Data Service Chart of the Month, 2015). Excess winter deaths could be a reflection of fuel poverty or of increasing rates of illness during the winter months, and although is more likely to affect older people, does include data for all ages[10]. |
| Housing ensures personal and household privacy, safety and | There is a wealth of evidence demonstrating the negative effects deprivation has on health and wellbeing. A common measure of deprivation is the Index of Multiple Deprivation, based on over 30 |

[10] Because of this, the Excess Winter Deaths Index can only be used to track trends and should not be used to attribute causation.

| **Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture** | |
|---|---|
| WHO Goal | Oxfordshire |
| security: it should allow individuals to live without fear of intrusion, provide safety and allow safe entry and exit | separate indicators across 7 domains (income; employment; health and disability; education, skills and training; crime; barriers to housing and services; and living environment). Two LSOAs are among the 10% most deprived in England. These are in parts of Rose Hill and Iffley ward, and Northfield Brook ward (Council, Joint Strategic Needs Assessment, 2016). The former has moved in to this category since 2010. A further 13 LSOAs are among the 10-20% most deprived (down from 17 in 2010). These are concentrated in parts of Oxford City, Banbury, and Abingdon (Council, Joint Strategic Needs Assessment, 2016). Whilst this provides information on deprivation, with housing as one of the factors, it is insufficiently targeted to demonstrate whether housing in Oxfordshire achieves the WHO goal. |
| Dwellings should provide space appropriate to household size and composition: this includes space for individual and common purposes within accepted crowding ratios, allowing separation between uses | 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 (Council, Joint Strategic Needs Assessment, 2015). The scarcity of homes means that one in five of Oxford's residents live in a multi-occupation dwelling. High demand and<br>high rental values in Oxford have meant that private landlords can charge high rents and some properties have been poorly managed and badly maintained. Oxford City Council is tackling this through its HMO Licensing Scheme which, since 2011, has seen around 3,000 homes improved by private landlords |
| Reasonable levels of basic services are available at the dwelling, including clean water, sanitation, waste disposal, access infrastructure and power | The latest data from 2013 estimates that 21800 people in Oxfordshire live in fuel poverty, accounting for 8.2% of the total population (Council, Joint Strategic Needs Assessment, 2016) Oxford had proportionately more people living in fuel poverty (12.4% or around one in eight people) (Council, Joint Strategic Needs Assessment, 2015). For the other districts, fuel poverty affected around 7% of people (approximately one in fourteen) (Council, Joint Strategic Needs Assessment, 2015). |

| **Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture** | |
|---|---|
| WHO Goal | Oxfordshire |
| Housing costs are reasonable and affordable, within accepted affordability limits to secure housing for all | Social housing rent in Oxfordshire is rising, and remains higher than in most of the other local authorities in England (Council, Joint Strategic Needs Assessment, 2016). Housing in Oxfordshire is generally expensive. In all districts of the county, median house sale prices are rising and remain higher than most other local authorities (Council, Joint Strategic Needs Assessment, 2016). The ratio of house prices to salaries is high and rising, and Oxfordshire is now one of the most unaffordable places in England to live (Council, Joint Strategic Needs Assessment, 2016). According to the Centre for Cities, Oxford is now the least affordable city for housing with average house prices now 16.2 times average annual salaries[xxii] |
| The location of dwellings allows access to social services, services and space for activities of daily life and economic opportunities, e.g. education, purchasing or growing food, recreation and employment | Car ownership, particularly in rural areas, is an important factor influencing access to services. More people living in rural areas own cars compared to those living in urban areas in Oxfordshire (see tables 2 and 3) (Statistics O. f., 2011). Over half of urban households consisting of a lone older person in Oxfordshire and over a third of urban lone parent households do not have a car (see figure 1) (Statistics O. f., 2011).<br>Access to and use of outdoor green spaces has been demonstrated to have positive impacts on physical health, mental wellbeing and cognitive functioning (Council, Joint Strategic Needs Assessment, 2016). The latest data from March 2013 to February 2014 estimated that the proportion of people in Oxfordshire using outdoor space had fallen from 19.4% (in 2012/13) to 15.7% (Council, Joint Strategic Needs Assessment, 2016) |
| Tenure arrangements ensure reasonable continuity of occupation, providing stability for individuals, households, communities and neighbourhoods | In 2015, the greatest number of families with dependent children requiring support for unintentional homelessness were in Cherwell (47) and Oxford (60) (Government, 2015).<br>Women in contact with secondary mental health services in Oxfordshire are slightly less likely than men to live in stable accommodation (Council, Public Health Surveillance Dashboard, 2015). Women in Oxfordshire in contact with secondary mental health |

| Table 2: Housing: The WHO Eight Goals for Action[xxi]: the Oxfordshire picture | |
|---|---|
| WHO Goal | Oxfordshire |
| | services are also less likely to live in stable accommodation as compared to the national figures, although the significance of this has not been tested (Council, Public Health Surveillance Dashboard, 2015).<br>Female adults with learning disabilities in Oxfordshire are slightly less likely to be in stable accommodation compared to men with learning disabilities, although the difference may not be significant (Council, Public Health Surveillance Dashboard, 2015). |
| Dwellings protect occupants from climate change, and extreme weather events, contributing to the reduction of greenhouse gas emissions | Data recently presented to the Oxfordshire County Council Health Improvement Board indicated that there were 90 rough sleepers in 2015-2016. The majority of these (56) were in Oxford with 21 in Cherwell, 5 in Vale of White Horse and South Oxfordshire and 3 in West Oxfordshire (Lygo, 2016).<br>Living environment deprivation is measured by the Index of Multiple Deprivation and includes indicators such as lack of central heating, poor quality housing, air quality and road traffic accidents (Statistics O. o., 2015). The majority of lower super output areas that are in the top 10-20% most deprived in terms of environment are in Oxford City |

### b. Affordability of Housing

Housing in Oxfordshire is generally expensive. This is as a result of high demand for housing; and a shortage of affordable housing. The Oxfordshire Strategic Housing Market Assessment identifies the need for 100,000 homes between 2011 – 2031. In some areas, such as Oxford City housing supply is constrained by lack of available development land and across the county there is a need to invest in infrastructure to support new housing development. Oxfordshire's councils need to ensure that their joint work through the Oxfordshire Growth Board identify locations for housing and secure funding for infrastructure to sustainably meet housing needs across the County.

The availability of social housing in Oxfordshire varies between districts. In South Oxfordshire and Vale of White Horse in particular, there is demand for over half as much again of social housing

than currently exists (Council, Joint Strategic Needs Assessment, 2016). There are over 3,300 people on Oxford City Council's Housing Register.

But affordable housing does not just mean social housing. Recent changes to government housing policy, such as expansion of Right to buy to Housing Associations, requirements to sell high value council stock and reducing social housing rents will make it harder to invest in housing for social rent. Increasingly, new models of access to the housing market are being developed, which can open up home ownership to broader markets, e.g. shared ownership/rent schemes. There is a need for Oxfordshire to explore this market, and its potential for its residents, in greater detail. The Commission therefore calls on Councils to consider how best to promote access to affordable housing as a cross county priority.

In some areas significant progress has been made (box 11) – but other areas are lagging behind

## Box 11: Delivering affordable housing in Oxford City

Oxford City Council is working in partnership with housing developers to deliver affordable homes; including

- £116 million Council Housing Ambition Programme to build new council homes and improve existing stock
- Substantial long term investment in large scale regeneration projects to deliver 1,700 homes across the city by 2019.
- The council delivered 116 affordable homes in 2014/15 with plans for another 354 to be delivered over the next 5 years
- Over the past decade, private developers and Housing Associations have delivered over 1,600 affordable homes in Oxford for social rent and shared ownership.
- The City Council is directly involved in bringing forward over 80 per cent of all significant housing schemes in the city in the next five years. For example, the City Council has secured funding for new infrastructure for schemes such as Oxpens and the Northern Gateway.
- The City Council has recently created a housing company to deliver new affordable homes, with a range of housing for sale and rent, to help address the city's acute housing need
- The City Council spends about £1.4m every year tackling homelessness, including by funding or providing outreach programmes, day centres, and education, training and employment opportunities.
- The City Council is joint-funding a £10m project with an investment partner and St Mungo's Broadway to buy about 50 homes near Oxford to house homeless families from the city.

## c. Use of public land for affordable and specialist housing

The Commission was told that there are significant holdings in the statutory sector which are underutilized or lying vacant. A strategic review of such assets is needed to determine whether they could be used as part of a more strategic cross sectoral approach to developing affordable and specialist housing across the County.

All public bodies – councils, government departments, health bodies alike – must redouble their efforts to promote the supply of affordable housing. There is the potential to tap into the "One Public Estate" programme to address this. Although action is being taken, for example the review of health estate/creating affordable housing in Cherwell and West, actions tend to be separate activities and we recommend a county wide initiative engaging all sectors is established.

In doing so, recognition must be given that supporting affordable housing, both for social rent and key workers, will affect capital receipts for public asset holders, but that this reflects an important, and fully justified, long-term investment.

## d. Learning from the New Towns

In September 2015, NHS England and Public Health England launched an ambitious new initiative to put health at the heart of new neighbourhoods and towns across the country. They were looking for partners to:

- develop at scale new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent; and
- show what is possible when we radically rethink how health and care services could be delivered.

Oxfordshire has two areas that have been accepted as partners: Barton and Bicester. Learning from the work undertaken in these areas, about what works for shaping new towns, and how to integrate new builds into existing community infrastructure driving positive health benefits for both communities will be essential. It is understood that Oxford Brookes university is already engaged with the Bicester initiative, which will, it is hoped ensure that the learning from this process facilitates future development. (Box 12)

## Box 12: Bicester New Town

Planning of the Healthy New Town programme has taken a holistic approach to improving health and wellbeing by involving a wide spectrum of partners who can impact on all the determinants of health. The partnership group includes not just traditional providers of health and care from the primary, community and acute sector but developers and master planners who can influence how the built environment can influence health, sports agencies and leisure providers that promote active lifestyles, the voluntary sector that can promote community cohesion, and representatives from local patient groups who have identified some of the gaps in health and care that exist in Bicester.

The population based approach that the partnership has adopted means that it has considered how health and wellbeing can be promoted not just in the new housing developments but across the town as a whole; with a view to avoiding an increase in inequalities between existing and new communities. One of the programmes objectives is to ensure that it increase community connections across the town. Finally, the focus on using the programme as a test bed for innovative new approaches to promoting health and wellbeing, including the use of technology to support this, has been assisted by the inclusion of academic partners in the development of the programme to ensure that interventions are evidence based and that learning from the programme is robustly evaluated and disseminated.

This broad partnership of interested agencies has steered the programme to consider the wide range of opportunities to promote health and wellbeing, with a view to achieving an integrated approach to prevention which will involve workplaces, education, housing, planning, the voluntary sector, leisure providers, community groups as well as health and social care providers, in order to build a community where healthy lifestyles can become the norm. This is an approach that reduces the chance of health inequalities at the outset and addresses those which already exist.

The Commission strongly believes that the integration of the academic community into such schemes is essential, if the learning from development is to be applied both to future new developments and more broadly to inform further development and remodelling of existing housing stock and communities.

### e. Social prescribing

In view of the recent national interest in social prescribing, and the encouraging results from Bromley by Bow, the Commission would wish to see consideration given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, and addressing health inequalities in particular. This has, we believe, the potential to become fully integrated as a patient pathway for primary-care practices and to strengthen the links between health-care providers and community, voluntary and local authority services that influence public health, including leisure, welfare, education, culture, employment and the environment (for example, urban parks, green gyms and allotments).

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***16.*** | Public agencies, universities and health partners should work together to develop new models of funding and delivery of affordable homes for a range of tenures to meet the needs of vulnerable people and key workers. | ***Public agencies, universities and health partners*** |
| | Specifically, public agencies should work together to maximise the potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing by undertaking a strategic review of public assets underutilized or lying vacant . | ***Public agencies/HWB*** |
| *17.* | Consideration should given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, addressing health inequalities in particular, and learning from other areas . | ***HWB/CCG*** |

### f. Fuel poverty

'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses. Rates of fuel poverty in Oxfordshire are unacceptably high.

| ***Recommendation*** | | ***Responsibility*** |
|---|---|---|
| ***18*** | In 2014 9.1% of households were fuel poor. This should be reduced in line with the targets set by the Fuel Poverty Regulations of 2014. | ***HWB*** |

### 3.3 Action to reduce the harms of homelessness

Homeless people experience severe health inequalities with an average life expectancy of some 30 years less than the rest of the population [xxiii]. They often suffer from tri-morbidities: the combination of poor physical health, poor mental health and substance misuse, with poor health as both a cause and an outcome of sleeping rough. In general, homeless people experience significant barriers in accessing services to support their health, requiring extra support to access routine and acute services.

Although the County as a whole has a low rate of homelessness, Oxford City consistently has a higher rate than the rest of the county (see Appendix 3 and 5 and box 13). In general, homeless people experience significant barriers in accessing services to support their health, requiring extra support to access routine and acute services.

**Box 13 Homelessness in Oxfordshire:**

Levels of homelessness and rough sleeping are increasing across the country. City and District estimates for rough sleeping for 2015-2016 were as follows:

- City – 56,
- Cherwell – 21 (this is a 40% increase),
- South – 5,
- Vale – 5,
- West – 3.

The Health and Well-being Board's target to not exceed the baseline rough sleeping County-wide estimate (an alternative to street counts) of 68 set in 2014-2015, has been missed in 2015-2016 with an estimated figure of 90.

In November 2015, providers in the homelessness pathway estimated that between 55% and 85% of residents have mental health issues (including undiagnosed) and between 60% and 90% have substance misuse issues.

Phased changes in the funding allocations for housing related support are expected to have a significant impact on the availability of accommodation for single homeless people across the county. We would encourage the District and County Councils to continue to work together to find a solution, which will ensure this already vulnerable population are not further disadvantaged and to regularly report on progress to the Health and Wellbeing Board.

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***19.*** | All public authorities are encouraged to continue their collaboration and invest in supporting rough sleepers into settled accommodation, analysing the best way of investing funding in the future.<br>Homelessness pathways should be adequately resourced and no cut in resources made with all partners at the very least maintaining in real terms the level of dedicated annual budget for housing support. | ***HWB*** |
| ***20.*** | The numbers of people sleeping rough in Oxfordshire should be actively monitored and reduced. | ***HWB*** |

### 3.4 Rurality: reduce the health harms associated with rurality

Oxfordshire is a rural county, with approximately 50% of its population living in small settlements of less than 10,000 people. Health services such as major and community hospitals, out of hours GP services and ambulance services can be more difficult for village based residents to access, with limited or non existent public transport. For older people in particular, with limited access to public transport or poor mobility, rural living can have a negative impact on health and wellbeing. (Box 14) Older people living on low income are at higher risk of experiencing loneliness than those who are better off, with loneliness having been shown to have significant negative impacts on physical and mental health, quality of life and mortality [xxiv] (Appendix 3 and 5).

## Box 14 Rurality and Ageing: Views from Age UK

In a predominantly rural county such as ours, population ageing is more rapid, and the populations of many villages, particularly in Cherwell and West Oxfordshire districts, are becoming rapidly older in age-group composition. This causes increasing demands on health and social care support, at a time where the social care workforce is already under great strain through historic lack of adequate funding. New ways of delivering social care should be investigated so that those who do not have resources to pay for their own care to a desired standard are not disadvantaged further with problems of securing accessible, decent quality care.

We believe that the initiative of some counties in promoting ***Village Companies*** is worth exploring: locally constructed companies and workforces drawn from a narrow geographical area, which may be more economically viable.

For rural communities access is the critical problem, and we see this on two levels:

-**Getting around**. The withdrawal of bus subsidies and reduced funding for community transport has exacerbated existing problems of isolation, exclusion and loneliness. Our perception is that the county has thus far approached the challenge piecemeal, for example with changes to patient transport eligibility taking place in parallel with but separately from other statutory areas of responsibility eg funding for transport to social care, funding of Dial a Ride. In straitened times the only way forward is for a strategic collaboration across the county, and the community needs to step up further to meet this challenge. We believe that the overview and strategy needs to be led at senior level by a community or voluntary sector leader, to knit together the existing patchwork quilt of provision of transport.

**Digital access.** The coverage of superfast broadband is patchy in the extreme. The capability of local communities to exploit the full potential of digital technology is variable, and many groups in society – such as the “older old” – have not yet acquired the skills and confidence to get online and maintain contact with the outside world, for shopping, official transactions, and social contact to maintain friendships and important relationships. This also calls for leadership – perhaps seeking help from the recent Minister for Digital Industries Ed Vaizey MP as a local MP in a rural constituency. It also calls for a more determined programme to help those not online to connect and use digital technology.

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***21.*** | An integrated community transport strategy should be developed[xxv] | ***District and County Councils*** |
| ***22.*** | A digital inclusion strategy, which explicitly targets older people living in rural communities should be developed and the % of older people over 65 with access to on line support regularly reported. | ***STP*** |
| ***23.*** | Reports of isolation and loneliness in older people/people suffering from dementia in rural areas should be collated and monitored on an annual basis with a reduction achieved year on year utilizing advice in http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation . | ***DPH*** |
| ***24.*** | The recommendations from the DPH annual report should be implemented and monitored. | ***DPH*** |

## 3.5 Supporting vulnerable populations

### a. Improving access to services for Refugees and migrant families

Special consideration should be given to the needs of migrant families and refugees. Evidence to the Commission noted that this support needs to be kept under review, recognising that the intensive needs of first generation migrant families for support is unlikely to be required for future generations. (see box 15)

## Box: 15 Oxfordshire Older Chinese People Centre (HAPPY PLACE)

Our Centre was established in 2003 and is located in West Oxford Community Centre. We welcome people who are over 50 years old to join us, particularly older Chinese people in Oxfordshire. Currently we have more than 100 registered members and the average age is around 70.

We aim to reduce isolation, exclusion, loneliness and depression caused by language and cultural barriers, and to promote health and independence amongst older people and carers.

The services and activities the Centre provides are:

- Language support
- Befriending and networking
- Exercise such as table tennis, dance and badminton
- Singing – karaoke
- Hot lunches
- Festival celebrations and day trips
- Health talks, information on social care and safety

**Issues we face**

Our Centre opens 3 hours on Mondays and 2 hours on Thursdays, but we can only afford a paid Co-ordinator for 3 hours a week. The West Oxford Community Centre is intending to increase our rent for hiring the hall too. Although we are funded by the County Council presently, the funding cut may be inevitable in the near future.

Aging is another issue. A lot of the older Chinese people are illiterate and they are very much relying on their family members and our Centre for support. Due to lack of resources, we are unable to provide outreach services for those who are too frail to come to the Centre and are living on their own.

On a positive note, we have one 94 years old lady is still attending our Centre regularly!

See also https://vimeo.com/180749504

A recent report to the OCCG board identified nine different factors, which would need to be considered when working with refugee families. (see Box 16)

## Box:16 Factors to consider when working with refugee families

- Help with registering with general practitioners, dentists and opticians and information about the health care system as refugees will be unfamiliar with UK health care and how things work, and expectations may be different.
- Being aware of cultural factors and cultural adaptation to life in Oxfordshire.
- Country specific health issues – communicable and non-communicable disease.
- Physical and mental health problems arising from past experiences of the conflict in Syria; for example, torture and abuse, war related injuries and psychological trauma, family disappearances and family separation. The need for specialist provision of practitioners experienced in trauma related mental health problems.
- Care of pregnant women, child health, family planning, Immunisations. Primary care services often break down in situations of armed conflict.
- Impact on health of poverty and poor living conditions as refugees.
- The importance of organisations that can provide advocacy and social support.
- Language interpreting. It is important to use qualified interpreters. Family members should not be used.
- Allowing time and confidential space to discuss traumatic events.

Whilst these factors were specifically identified as relevant to the support of Syrian refugees, as part of the Syrian Refugee Vulnerable Persons Resettlement (VPR) programme,(see box 16) many of these factors resonate more broadly for working with ethnic minority and refugee populations, and in the case of Oxfordshire, particularly for working with residents from Campsfield House (see evidence from Ayslum Welcome and Refugee Resource). For example, evidence given to the Commission supported the provision of funding for locally enhanced services for refugees and asylum-seekers to be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers.

## Box 16: The Syrian VPR programme

District Councils are coordinating the Syrian VPR programme in Oxfordshire, on behalf of the Home Office. The resettlement criteria are

- women and girls at risk
- survivors of violence and/or torture
- refugees with legal and/or physical protection needs
- refugees with medical needs or disabilities
- children and adolescents at risk
- persons at risk due to their sexual orientation or gender identity
- refugees with family links in resettlement countries

The resettled refugees are given five years Humanitarian protection status, with permission to work and access public funds and services, including NHS healthcare. At the end of the five years, refuges can apply to settle in the UK, or they may choose to return to Syria.

For the first year Oxfordshire District Councils are currently proposing to integrate thirty families (10 in Oxford City, 6 in West Oxfordshire, 6 in Cherwell, 2 in South Oxfordshire, 6 in the Vale of White Horse).

Source: OCCG July 2016 Briefing Paper: Syrian Vulnerable Persons Resettlement Briefing

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***25.*** | Funding for locally enhanced services for refugees and asylum-seekers should be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers. | ***HWB*** |
| ***26.*** | Outreach work in communities with high numbers of refugees, asylum seekers and migrants, should be actively supported and resources maintained, if not increased, especially to the voluntary sector, to improve access to the NHS, face to face interpretation /advocacy and awareness raising amongst health care professionals | ***HWB*** |

## b. Improving access to Throughcare provision for prisoners

Prisoners, and ex- prisoners are a vulnerable ethnically diverse population, with an increasingly ageing population adding further complexity to ensuring their long term health and wellbeing needs are met. A recent study has suggested that offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. [xxvi]

In Oxfordshire there are three secure establishments: HMP Bullingdon, IRC Campsfield and HMP Huntercombe. Health care provision in each of the prisons and the IRC aims to include primary care and secondary mental health services equivalent to that provided in the community.

Evidence provided to the Commission suggests that prisoners may experience particular challenges with throughcare arrangements – particularly offenders who have received short term custodial sentences, with access to sustainable housing and employment creating a potentially vicious circle. (Box 17)

## Box 17: Offender and detainee health needs

Source: NHS England , Health and Justice Commissioning for Prisons and IRC in Oxford, June 2016 (unless otherwise indicated)

Offenders

- Offenders with addiction or mental health problems are more likely to need support with housing, education or employment to change their lives and prevent future victims, yet at the same time research shows these offenders will find it more difficult to access mainstream help than the general population
- Lifestyle issues:
    - National data suggests that approximately four times as many people smoke in prisons than smoke in the general population. These high rates of smoking damage health, causing marked health inequalities for offenders, and through second hand smoke, is damaging to the health of smoking and non smoking offenders, visitors and staff.[ [xxvii] ] National initiatives are underway to reduce smoking in prisons, including making them a smoke free environment within the next two years .
    - Drug users are estimated to be responsible for between a third and a half of acquisitive crime and treatment can cut the level of crime they commit by about half;
    - Alcohol is a factor in an estimated 53% of violent crime[3] and Accident and Emergency (A&E) data sharing and targeted interventions have been shown to reduce overall A&E violence related attendances in one study by 40%.

Detainees:

- Evidence from Europe and Australia on the health of migrant communities suggests that the most likely health problems will be communicable diseases such as TB, Chicken Pox and HIV.
- There is also evidence to suggest that certain ethnic groups including those most likely to be detained have higher prevalence rates for particular conditions including Asthma, Diabetes and Cardiovascular diseases.
- Certain conditions, including anaemia, dental caries, intestinal parasites, nutritional deficiencies and immunisation irregularities, appear more commonly in newly arrived refugees from developing countries. Also, people with darker skins and those whose mothers lacked adequate nutrition during pregnancy and breast-feeding are known to be at risk of Vitamin D deficiency.
- Mental health issues are reported to be one of the most significant health problems

Prison offers an opportunity for lifestyle advice and guidance however offenders often experience greater barriers to accessing services and ongoing support after release to meet those needs.

| Recommendation | | Responsibility |
|---|---|---|
| ***27*** | Robust pathways to community services for community rehabilitation [including Community Rehabilitation Companies[11]] on release, particularly for short term offenders, need to be developed, | ***HWB*** |

## 3.5 Lifestyle factors : Physical and Social well being :

The importance of lifestyle as a contributor to health is well known, and the Annual Reports of the Director of Public Health have sequentially described trends and targets which will not be repeated in this report [see https://www.oxfordshire.gov.uk/cms/content/oxfordshire-public-health ].

However, we wish to recommend some specific actions:

### a. Physical activity:

The health benefits of physical activity are well documented: for example helping with weight control, reducing the risk of chronic diseases and improving mental health.

The national physical activity recommendations for adults are that they should achieve at least 150 minutes of at least moderate activity over a week. National data, collected through the Health Survey for England 2012, suggests that some 33% of men and 45% of women (over 16) failed to meet these guidelines, with the proportion of people who met the guidelines decreasing with age. National data also demonstrates an inequalities gap: 76% of men and 63% of women in the highest income quintile met the guidelines for aerobic activity, falling to 55% of men and 47% of women in the lowest quintile. [xxviii] In Oxfordshire, some 41.6% of people overall participate in sport at least once a week. [xxix] This varies greatly by demographic group, with disabled people, people over the age of 55 and people from lower socio-economic groups being less likely to participate in sporting activities (see table 3)

[11] ***Community Rehabilitation Company*** *(CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation.*

**Table 3**

Adult (16+) Participation in Sport (at least once a week), by year, and demographic breakdown

| Indicator | Oxfordshire CC | | South East | | England | |
|---|---|---|---|---|---|---|
| | 2005/06 | 2014/15 | 2005/06 | 2014/15 | 2005/06 | 2014/15 |
| Male | 43.9 % | 44.0 % | 41.9 % | 41.8 % | 39.4 % | 40.7 % |
| Female | 33.9 % | 39.3 % | 32.5 % | 33.8 % | 30.1 % | 31.2 % |
| White British | 38.6 % | 41.9 % | 36.8 % | 37.5 % | 34.4 % | 35.5 % |
| BME | 40.2 % | 41.9 % | 39.8 % | 39.0 % | 35.9 % | 37.7 % |
| Disabled | 17.6 % | 24.7 % | 17.5 % | 19.7 % | 15.3 % | 17.2 % |
| Not Disabled | 41.6 % | 44.2 % | 40.1 % | 40.9 % | 38.2 % | 39.6 % |
| 16 to 25 | 59.3 % | 66.0 % | 58.9 % | 59.5 % | 56.2 % | 55.2 % |
| 26 to 34 | 48.7 % | 41.3 % | 48.6 % | 43.5 % | 45.6 % | 44.6 % |
| 35 to 54 | 41.1 % | 47.5 % | 38.9 % | 41.1 % | 35.7 % | 38.2 % |
| 55+ | 20.4 % | 23.5 % | 21.6 % | 23.3 % | 18.9 % | 20.9 % |
| NS-SEC 1&2 | 43.6 % | 45.1 % | 42.0 % | 42.4 % | 40.5 % | 42.9 % |
| NS-SEC 3 | 34.3 % | 34.8 % | 35.0 % | 34.6 % | 32.5 % | 33.1 % |
| NS-SEC 4 | 32.8 % | 33.7 % | 33.7 % | 34.6 % | 32.8 % | 31.8 % |
| NS-SEC 5-8 | 30.7 % | 33.3 % | 29.8 % | 27.5 % | 27.2 % | 25.9 % |

Source: Active People Survey. Measure: Adult (16+) participation in sport (at least once a week) by year and gender, ethnicity, disability, age band and socio-economic class, one session per week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days). Time Period(s): 2005/06, 2014/15

## Box 18 Physical activity

Oxfordshire Sport and Physical Activity (OxSPA) is the strategic partnership for physical activity and sport within Oxfordshire.

Within the partnership, primary schools are supported to deliver Change 4 Life Sports Clubs to those students deemed most in need of a specific intervention. Despite a limited capacity to deliver, all primary schools in Oxfordshire were given access to these clubs. However schools in particularly deprived areas or with concerning National Child Measurement Programme (NCMP) results were specifically targeted. In total, 68 schools have accessed Change 4 Life Sports Club training, with an average of 10 students attending sessions regularly. This means at least 680 of the most at risk children are accessing activity provision in an environment they're comfortable in, with a trained professional who already works at the school.

At present, 9 Oxfordshire secondary schools are taking part in an initiative to address female students' perceptions of physical education and physical activity, and explore how this impacts on whole school life as well as physical activity participation.

Source: OxSPA evidence to Commission

Inactivity increases with age, and this compounds the problem of premature decline in health in a rapidly ageing population. This demonstrates a clear health inequalities challenge. Yet many of the programmes which have been instituted in Oxfordshire suffer from lack of sustainable funding. The Strategic Physical Activity Group does important work, but it needs senior leadership and greater recognition in the health economy. This could be achieved by a prominent and respected figure in the field of physical activity made personally responsible for leading the achievement of the targets, both convening and chairing a new high-level group spanning the statutory sector, leisure and fitness organisations, business and industry, voluntary sector and community interests, represented at senior level. Without decisive, top level leadership it is likely that human and economic costs of inequalities will multiply and health gaps widen. It is crucial that health professionals themselves buy into the need to promote exercise and take opportunities such as prescription and every contact counts to make this happen. Their commitment cannot be taken for granted in this area.

Behaviour change will not occur without much stronger social marketing and awareness-raising. Such campaigns should address new ways of catching imagination and above all reach people through a sense of fun ("health by stealth").

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***28.*** | A set of Oxfordshire-grounded targets for increasing activity should be developed, targeting people living in deprived areas, older people, and vulnerable groups . | ***HWB*** |
| ***29.*** | Continuing investment and coordination of existing initiatives should be maintained supported by social marketing and awareness-raising of the benefits of physical activity to targeted populations. | ***PH Dept*** |
| ***30.*** | The county should :<br>• monitor and increase the number of disabled people participating in regular physical activity<br>• achieve a measurable decrease in inactivity and in parallel an increase in mental well-being measures, measured using the Active People Survey and Health Survey for England datasets<br>• demonstrate and increase a narrowing of the gap between the less socioeconomically privileged groups and the norm . | ***PH Dept*** |

## b. Smoking

Smoking is the single greatest cause of preventable illness and premature death in the UK. It is linked to more than 50 diseases and serious conditions, including cancer, coronary heart disease, stroke, circulatory diseases, chronic obstructive pulmonary disease (COPD) and asthma. According to 2014/15 data, there were some 5212 smoking attributable hospital admissions, with 2314 deaths attributable to smoking in Oxfordshire between 2012 and 2014. (see Figure 3) These figures show that smoking remains an important health issue in Oxfordshire – but they also mask important health inequalities. In Oxfordshire the local figures show a current overall smoking prevalence of 15.5%. For routine and manual groups this rate rises to 30.6. %. These figures are below the national average, but remain a cause for concern. Furthermore the local figures show that 7.9% pregnant women are recorded as smokers at the time they delivered their babies. These figures are slightly lower than those reported on the Tobacco Health Profile site[12].

[12] *Due to ONS announcing it would no longer produce the Integrated Household Survey (IHS) the questions formerly regarded as the IHS core (including smoking prevalence) will continue in the Annual Population Survey (APS). These are National Statistics and provide consistent time series. Local data replaces previously published IHS with APS equivalents. Due to differences in methodology the two "estimates" of smoking prevalence cannot be compared.*

**Figure 3: PHE tobacco control local profile for Oxfordshire (source: http://www.tobaccoprofiles.info/tobacco-control 9 August 2016)**


| Indicator | Period | Oxon | | | Region | England | England | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst | Range | Best |
| Smoking Prevalence in adults - current smokers (APS) | 2015 | – | - | 15.5% | 15.9% | 16.9% | 26.8% | | 9.5% |
| Smoking Prevalence in adult in routine and manual occupations - current smokers (APS) | 2015 | – | - | 30.6% | 26.2% | 26.5% | 36.3% | | 15.8% |
| Successful quitters at 4 weeks | 2014/15 | – | 1,926 | 2,395 | 2,642 | 2,829 | 957 | | 5,741 |
| Smoking status at time of delivery | 2014/15 | – | 634 | 8.6% | 10.3% | 11.4% | 27.2% | | 2.1% |
| Smoking attributable mortality | 2012 - 14 | – | 2,314 | 218.3 | 241.2 | 274.8 | 458.1 | | 184.9 |
| Smoking attributable hospital admissions | 2014/15 | ↑ | 5,212 | 1,457 | 1,301 | 1,671 | 2,835 | | 1,030 |
| Deprivation score (IMD 2010) | 2010 | – | - | 12.3 | - | 21.7 | 5.4 | | 43.4 |

Smoking rates are also likely to be high among people with mental health problems, though no figures are available to verify this[13]. This should be addressed by local data collection.

| ***Recommendation*** | ***Responsibility*** |
|---|---|
| ***31.*** Better data should be collected on smoking rates in different population groups including pregnant women, people with mental health problems, people in manual or routine occupations and other vulnerable groups to ensure that, in addition to lowering the overall rates of smoking ,the inequalities gap between these groups and others is reduced. | ***PH Dept*** |

## c. Alcohol and drugs

### *C1. Alcohol :*

Alcohol is more affordable and available than at any time in recent history. While most people who drink do so without causing harm to themselves or others, there is a strong and growing evidence base for the harmful impact that alcohol misuse can have on individuals, families and communities in Oxfordshire.

13 *For discussion on smoking rates in prisons, see section 3.4c*

The misuse of alcohol impacts on individuals, families and communities in a range of ways. It can be a barrier to achieving the outcomes we wish for Oxfordshire in terms of improved economic performance, reduced worklessness, increased aspiration, reduced health inequalities, improved outcomes for children and families, and reduced crime and disorder. Health, social care services, and criminal justice agencies all have to invest significant amounts of money in providing services to respond to the effects of alcohol misuse.

The local health profile on alcohol suggests that in general Oxfordshire compares favourably with the national averages for alcohol related indicators, although it is slightly higher than the regional and England average for under 18 alcohol related hospital admissions (40.9 (Oxon) to 36.6 (England) and 34.5 (regional). (see figure 4 and appendix 3)

**Figure 4: Alcohol health profile indicators for Oxfordshire**

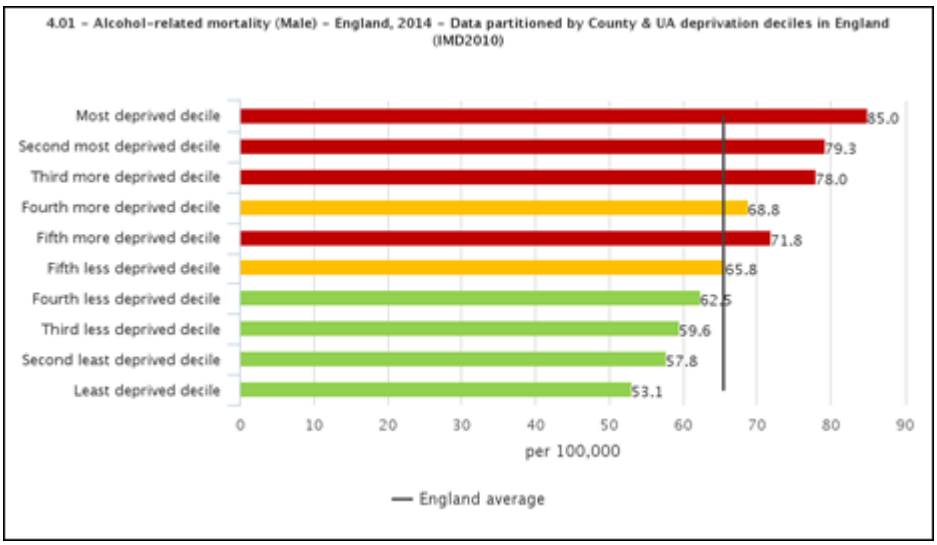
*Compared with benchmark:* Better | Similar | Worse | Lower | Similar | Higher | Not compared

| Indicator | Period | England | South East region | Bracknell Forest | Brighton and Hove | Buckinghamshire | East Sussex | Hampshire | Isle of Wight | Kent | Medway | Milton Keynes | Oxfordshire | Portsmouth | Reading | Slough | Southampton | Surrey | West Berkshire | West Sussex | Windsor and Maidenhead | Wokingham |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.01 - Alcohol-specific mortality | 2012 - 14 | 11.6 | 9.7 | 6.1 | 21.1 | 7.4 | 11.9 | 8.9 | 11.1 | 9.4 | 11.9 | 10.0 | 7.0 | 21.1 | 15.8 | 7.6 | 14.0 | 8.5 | 9.0 | 9.2 | 7.1 | 5.0 |
| 4.01 - Alcohol-related mortality | 2014 | 45.5 | 40.8 | 31.8 | 55.7 | 34.7 | 41.8 | 38.2 | 44.2 | 42.4 | 47.8 | 41.9 | 37.9 | 61.6 | 51.3 | 42.8 | 50.0 | 37.8 | 43.5 | 40.7 | 36.2 | 32.2 |
| 10.01 - Admission episodes for alcohol-related conditions (Narrow) | 2014/15 | 641 | 519 | 459 | 613 | 502 | 571 | 472 | 487 | 526 | 434 | 571 | 572 | 599 | 541 | 625 | 709 | 484 | 424 | 557 | 485 | 379 |
| 9.01 - Admission episodes for alcohol-related conditions (Broad) | 2014/15 | 2139 | 1708 | 1727 | 1815 | 1636 | 1733 | 1605 | 1404 | 1702 | 1730 | 2106 | 1687 | 2021 | 1863 | 2541 | 2284 | 1755 | 1387 | 1695 | 1633 | 1270 |
| 6.01 - Persons admitted to hospital for alcohol-specific conditions | 2014/15 | 364 | 280 | 253 | 485 | 224 | 302 | 260 | 298 | 274 | 220 | 246 | 285 | 509 | 327 | 393 | 494 | 253 | 215 | 284 | 261 | 158 |
| 5.01 - Persons under 18 admitted to hospital for alcohol-specific conditions | 2012/13 -14/15 | 36.6 | 34.5 | 10.9 | 60.0 | 19.5 | 44.4 | 35.9 | 81.6 | 33.5 | 26.4 | 15.6 | 40.9 | 37.3 | 13.3 | 18.8 | 78.0 | 35.7 | 23.4 | 32.6 | 23.1 | 20.1 |

Source: [http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132984/pat/6/par/E12000008/ati/102/are/E10000025](http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132984/pat/6/par/E12000008/ati/102/are/E10000025))

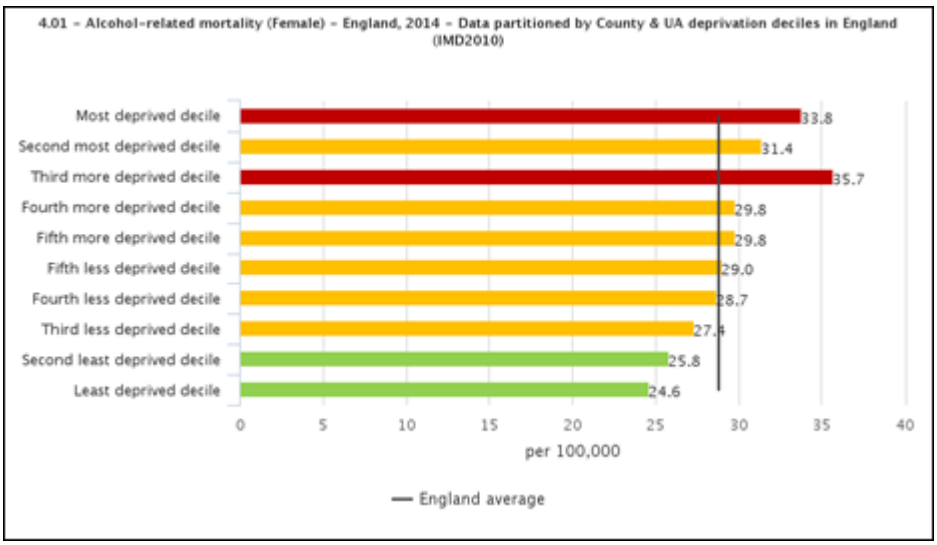
No local data was available for alcohol related deaths or hospital admissions by deprivation.
The Figures below show the alcohol related deaths for England by most/least deprived groups. Men show a greater difference between the best and worst off than for women. (Source: alcohol profile tool) There is no reason to suppose it is not a similar picture locally. (Figure 5)

**Figure 5 :Alcohol related deaths by deprivation - men**




Source: Jackie Wilderspin

**Figure 6: Alcohol related deaths by deprivation - women**

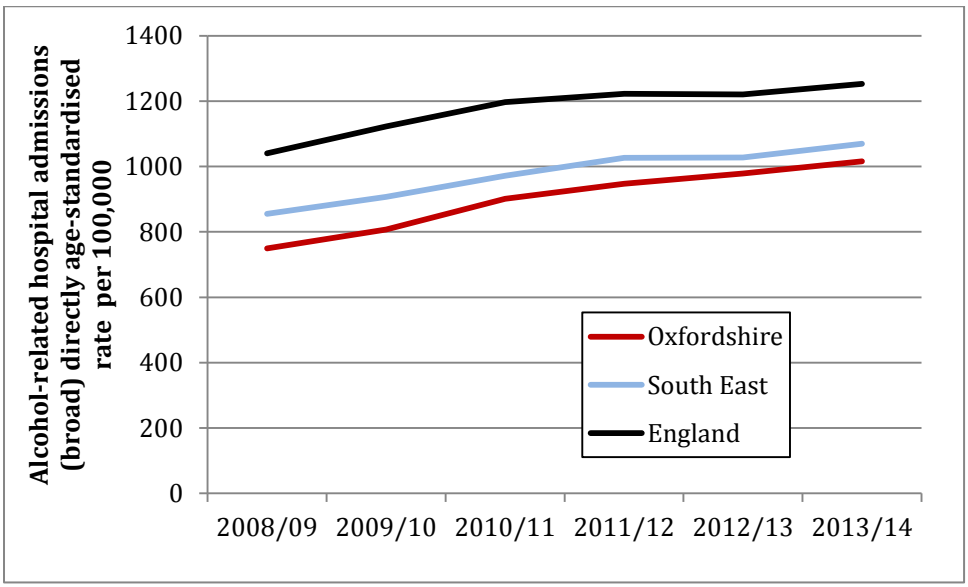



Source: J Wilderspin

In 2013/14 there was a continuing upward trend (3.9% increase on previous year) for **alcohol-related hospital admissions**[14] in England. (Figure 7) The annual increase was greater for women (+4.8%) than men (+3.3%) and it remains the case that rate of admissions among most deprived is 77% higher than rate in least deprived areas.

[14] *Alcohol-related hospital admissions (broad) - Persons admitted to hospital where primary diagnosis or any secondary diagnoses are an alcohol-attributable code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population European standard population.*

**Figure 7 :Alcohol related hospital admissions**




Source: Jackie Wilderspin

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***32.*** | An alcohol liaison service should be developed in the OUHT | ***NHS*** |
| ***33.*** | A project should be developed which aims to reduce drinking in middle aged people living in deprived areas | ***PH Dept*** |
| ***34.*** | Building on experience from Wantage, Community Alcohol Partnerships should be established to address the problems of teenage drinking, particularly in Banbury as A&E data shows high numbers of under 18s attending the Horton ED for alcohol related reasons. [The partnership model brings retailers, schools, youth and other services together to reduce under age sales and drinking.] | ***PH Dept*** |
| ***35.*** | Support and develop schools interventions including support given to school health nurses as well as services such as those run by The Training Effect to increase capacity of young people to choose not to misuse substances. | ***HWB*** |

## *C2 . Drugs*

National data demonstrates that people in deprived circumstances and their families are most likely to suffer from substance misuse, making this a fundamental health inequalities challenge. Yet there is no prevalence data for drug use, as such, as nobody knows exactly how many people are using illegal substances. Local health profiles compiled by PHE suggest that Oxfordshire may have:

- Lower rates of successful completion of drug treatment in non opiate users than both the England and SE England averages (29.9 versus 39.2 and 40.2 respectively – 2014 figures)

- A higher rate than the regional average of parents in drug treatment (99.8 per 100000 children 0-15 versus 78.8 regionally – based on 2011-2 data – but this rate is still below the national average)
- A lower rate of people in substance abuse programmes who inject drugs who have received a hep C test (70.7 versus 81.5 (e) and 85.4 (r) – 2014/5 data).
- A higher rate of children facing a fixed period of exclusion due to drugs/alcohol use ( 0.205 versus 0.1 (e) and 0.115 (r) (2013/4 figures)

**Figure 8: Oxfordshire local health profile (Drugs)**

*Compared with benchmark:* Better | Similar | Worse | Lower | Similar | Higher | Not compared

| Indicator | Period | England | South East region | Bracknell Forest | Brighton and Hove | Buckinghamshire | East Sussex | Hampshire | Isle of Wight | Kent | Medway | Milton Keynes | Oxfordshire | Portsmouth | Reading | Slough | Southampton | Surrey | West Berkshire | West Sussex | Windsor and Maidenhead | Wokingham |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Successful completion of drug treatment - non-opiate users: % who do not re-present within 6 months | 2014 | 39.2 | 40.2 | 54.0 | 38.2 | 43.9 | 35.3 | 44.9 | 54.3 | 41.8 | 31.5 | 32.4 | 29.9 | 37.4 | 44.0 | 52.2 | 49.0 | 44.7 | 34.5 | 28.4 | 33.6 | 35.7 |
| Percentage who have taken drugs (excluding cannabis) in the last month | 2014/15 | 0.9 | 1.0 | 0.2 | 4.2 | 0.6 | 1.2 | 0.4 | 1.2 | 1.3 | 0.9 | 1.6 | 0.9 | 1.1 | 1.6 | 0.7 | 0.7 | 0.9 | 0.7 | 1.3 | 0.8 | 0.3 |
| Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24 | 2012/13 -14/15 | 88.8 | 80.5 | 42.8 | 92.8 | 33.2 | 82.9 | 84.6 | 92.5 | 104.9 | 44.2 | 92.0 | 77.5 | 115.6 | 37.3 | 46.8 | 90.4 | 79.0 | 75.5 | 80.9 | 80.2 | 24.7 |
| 2.16 - People entering prison with substance dependence issues who are previously not known to community treatment | 2012/13 | 46.9 | 53.2 | 36.5 | 51.9 | 51.3 | 52.2 | 52.8 | 38.8 | 57.4 | 44.0 | 53.6 | 47.5 | 53.0 | 54.9 | 50.4 | 52.3 | 55.4 | 55.7 | 60.4 | 32.1 | * |
| Parents in alcohol treatment: rate per 100,000 children 0 - 15 | 2011/12 | 147.2 | 120.0* | 136.8 | 202.2 | 70.5 | 218.4 | * | * | 120.5 | * | 75.5 | 135.7 | * | 92.7 | 103.6 | 55.6 | 124.8 | 125.0 | 101.9 | 108.0 | 63.5 |
| Fixed period exclusion due to drugs/alcohol use: % of school pupils | 2013/14 | 0.100 | 0.115 | 0.077 | 0.179 | 0.131 | 0.153 | 0.122 | 0.053 | 0.142 | 0.074 | 0.102 | 0.205 | 0.037 | 0.087 | * | 0.210 | 0.065 | 0.075 | 0.073 | 0.108 | 0.073 |
| People who inject drugs | 2011/12 | 2.49* | 1.97* | 1.16* | 3.68* | 0.73* | 2.57* | 1.93* | 3.28* | 1.81* | 2.93* | 1.78* | 1.96* | 4.14* | 4.98* | 1.56* | 3.83* | 1.15* | 2.92* | 1.34* | 0.85* | 0.85* |
| Persons in substance misuse treatment who inject drugs - Percentage of eligible persons who have received a hepatitis C test | 2014/15 | 81.5 | 85.4 | 82.4 | 92.6 | 84.5 | 91.9 | 93.5 | 91.3 | 82.4 | 84.2 | 74.7 | 70.7 | 90.6 | 86.3 | 85.3 | 94.7 | 83.9 | 81.3 | 86.8 | 70.9 | 82.3 |
| Percentage with 3 or more risky behaviours | 2014/15 | 15.9 | 17.2 | 13.6 | 23.7 | 13.2 | 22.6 | 16.8 | 18.8 | 18.0 | 18.4 | 15.7 | 19.8 | 16.2 | 14.1 | 6.1 | 17.9 | 17.0 | 14.0 | 17.6 | 15.3 | 11.9 |
| Parents in drug treatment: rate per 100,000 children 0 - 15 | 2011/12 | 110.4 | 78.8* | 76.9 | 150.6 | 71.5 | 59.3 | 54.8 | 84.1 | 106.8 | 115.9 | 84.5 | 99.8 | 124.3 | 72.8 | 71.0 | 132.9 | 59.0 | 70.5 | 35.1 | 101.0 | 50.8 |
| Persons entering substance misuse treatment - Percentage of eligible persons completing a course of hepatitis B vaccination | 2014/15 | 8.7 | 8.4 | 16.7 | 5.6 | 13.4 | 4.1 | 4.8 | 10.5 | 9.2 | 5.1 | 6.9 | 9.5 | 4.4 | 12.5 | 28.8 | 17.5 | 4.5 | 3.3 | 7.2 | 3.4 | 6.7 |
| Adults in treatment at specialist drug misuse services: rate per 1000 population | 2013/14 | 5.0 | 3.1 | 3.2 | 7.6 | 2.4 | 3.6 | 2.2 | 4.1 | 2.7 | 3.5 | 3.1 | 3.7 | 6.1 | 5.4 | 5.4 | 5.5 | 2.4 | 2.5 | 2.4 | 2.8 | 1.8 |
| Adults in treatment at specialist drug misuse services: rate per 1000 population | 2014/15 | 4.8 | 3.0 | 2.8 | 7.5 | 2.3 | 3.7 | 2.0 | 3.5 | 2.9 | 3.9 | 2.7 | 3.4 | 6.1 | 5.4 | 5.1 | 5.2 | 2.4 | 2.6 | 2.2 | 3.1 | 1.8 |
| Adults in treatment at specialist alcohol misuse services: rate per 1000 population | 2014/15 | 2.1 | 1.4 | 2.1 | 2.9 | 1.0 | 1.8 | 1.1 | 1.8 | 1.6 | 1.5 | 0.7 | 0.8 | 5.5 | 0.8 | 1.4 | 2.1 | 1.2 | 0.9 | 1.0 | 1.5 | 1.1 |
| Adults in treatment at specialist alcohol misuse services: rate per 1000 population | 2013/14 | 2.3 | 1.6 | 2.8 | 3.8 | 0.9 | 3.1 | 1.2 | 2.6 | 1.4 | 1.4 | 1.4 | 1.3 | 5.7 | 0.7 | 2.1 | 2.4 | 1.3 | 0.9 | 1.2 | 1.6 | 1.3 |

-

Source: http://fingertips.phe.org.uk/search/drugs#pat/6/ati/102/par/E12000008 9 August 2016

The only robust data is the number of people who were in treatment with local services in March 2016 – for opiates (1550 people), non-opiates (118 people) or alcohol dependency (482 people). These numbers are not a reflection on the numbers of people who may be using these substances in the community as the motivation to enter and remain in treatment is a personal decision.

In addition, there is no reliable data on the use of Novel Psychoactive Substances. Recent investigations by the public health team have identified the use of synthetic cannabinoids in the homeless population as a cause for concern (this is also a problem in prisons). So-called "spice" is linked to very troubling behaviours and possible triggering of psychosis. Furthermore, information from the Forensic Mental health service suggests that there is use of NPS in the secure wards. Whilst the police are actively working to reduce supply, local action is difficult to envisage, given the increasing use of the internet as a source. The evidence collected by the Commission supports the development of a model of care for agencies who work with users of NPS to help them with treatment options, but this is an issue which we believe warrants more in depth exploration.

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***36*** | Resources in the public health budget should be maintained to provide services and support for drug misusers and their families | ***HWB*** |
| ***37.*** | School based initiatives should be promoted for all age groups | ***HWB*** |
| ***38.*** | Policy and action should be targeted to continue to address<br>- the rates of successful completion of drug treatment in non opiate users<br>- the rate of parents in drug treatment<br>- the rate of people in substance abuse programmes who inject drugs who have received a hep C vaccination<br>- the rate of children facing a fixed period of exclusion due to drugs/alcohol use<br>- NPS use | ***HWB*** |

### 3.6 Mental health

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities[xxx.] Many people with mental health problems also suffer poor physical health and impoverished social conditions. Addressing their needs will reduce health inequalities within the county. For example, Oxfordshire has higher than average excess under 75 mortality rates for people with severe mental illness. Recent data published by the Health and Social Care Information Service shows that people with mental health problems have a significantly different level of contact with physical health services compared with other patients.

Whilst this data estimates the mental health needs of UK populations, we have no reason to doubt it is applicable to Oxfordshire.

**Box 19 : Estimated mental health needs of UK populations**

In 2011/12:

- 78% of mental health service users accessed hospital services compared with 48% of non-mental health service users.
- 54% of those arriving at A&E came by ambulance or helicopter compared to 26% of non-mental health service users.
- A higher proportion of these patients were admitted and they stayed in hospital around 30% longer.
- 71% of those admitted were classified as an emergency compared with 40% of non-mental health service users.
- They also had more outpatient appointments.
- The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed are treated in primary care. The most common method of treatment for common mental health disorders in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients. Having a mental health worker attached to or working alongside GP practices improves the knowledge, confidence and capacity of the other primary care professionals in the practice.

Source Dan Leveson

Yet despite such compelling data, years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services. Oxfordshire has one of lowest spends per weighted capita for mental health (FYFV) and did not increase the % allocation of funds to mental health in line with total increased allocation in funding. The degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.

Implementing the 58 recommendations of the National Mental Health Task Force within the local context will help reduce inequalities. In particular, since data shows that Oxfordshire has the lowest spend per weighted population in the region, there is a need to ensure parity of esteem for

mental health in resource allocation. This means not only investing in the delivery of the recommendations from the national taskforce, but also addressing the challenges caused by years of under-investment.

Particular issues arise around access to mental health services. Better ways of tracking and responding to unmet need amongst hard to classify groups with complex individual problems need to be developed to monitor their wellbeing.

| | ***Recommendations*** | ***Responsibility*** |
|---|---|---|
| ***39*** | The under provision of resources for Mental health services should urgently be addressed | ***CCG*** |
| ***40*** | The implementation of the Five Year Forward Strategic View of mental health services for the county should explicitly state how it is addressing health inequalities and how additional resources have been allocated to reduce them. | ***CCG/OH*** |

## Section 4. Life course actions:

In addition to these cross cutting themes we identified actions at different points across the life course:

### 4.1 Beginning well :

Future health inequalities are, to a large extent, determined from a child's earliest years, including its intrauterine development. This is due to biological factors as well as life circumstances. Early responses to what is happening shape future physical and psychological functioning, supporting children to thrive, learn, adapt and form good future relationships. The first few years of life can be critical for readiness to learn, educational achievement and ultimately wealth and economic status, a strong predictor of future health and wellbeing.

#### a. Maternal health

Evidence provided on perinatal mental health highlighted a significant gap: whilst Oxfordshire has a local pathway for mental health services, there is no service or access for women with severe

mental illness and personality disorders as recommended in NICE 192 Antenatal and postnatal mental health (2014)., although such services are being developed in other parts of Thames Valley e.g. Buckinghamshire and Milton Keynes, so there is an inequity between different parts of the region. (see evidence from mental health network). IAPT and IPPS services cannot accept these women. They cannot access preconception care and do not meet the threshold for services if they are in early pregnancy but are well. This is despite the fact that there is a high risk of recurrence postnatally and the issues around continuing, amending, stopping medication are all important.

| | ***Recommendation*** | ***Responsibility*** |
|---|---|---|
| ***41.*** | Perinatal mental health should be a priority with appropriate investment to improve access to perinatal mental health services across Oxfordshire | ***CCG*** |

## b. Children's health and wellbeing

Evidence presented to the commission suggested that more needs to be done to ensure that children are given the best possible start in life, recognising that family circumstances can and do make a difference to health outcomes. Evidence to the Commission noted that Oxfordshire has historically had services for children, with IPPS[15] and OxPIP[16], and the level of primary prevention and early intervention possible through the extensive network of Children's Centres. However this is threatened by proposed cuts to Local Authority services.

Nutrition is an important foundation for good health – and challenges exist in ensuring access to affordable healthy food for all families with young children. Evidence provided to the Commission, which drew on The Trussell Trust's 2016 report data, suggests that food bank use is at a record high across the country**.** We interpolate from national data that 2.5% of the population of Oxfordshire accessed 2 emergency food parcels per person in the last year.

Data for "Children with free school meal status" is collected nationally, and is a good indicator representing children coming from relatively deprived households. In Oxfordshire, the number of

[15] *Infant-Parent Perinatal Service (IPPS) offers support to women who are experiencing or who are at risk of experiencing moderate mental health difficulties such as: parent-infant relationship difficulties; depression and low mood; anxiety and panic attacks; post traumatic stress disorder; obsessive compulsive disorder, and eating disorders*

[16] *Oxford Parent-Infant Project (OxPIP) provides intensive therapeutic support for parents and infants from pregnancy to 2 years who are in need of assistance to establish and build close and nurturing relationships*

children with free school meal status who achieve a good level of development at the end of their reception year is significantly worse than the number over the whole of England at 45.2% compared to 51.2% (England, 2015). We can interpret this as there being a difference in early years development between children coming from richer versus poorer families in Oxfordshire, and that this difference is worse in the county than for the whole country.

**Table 3: Overview of the data for Beginning Well**

Source Emily Phipps

| Theme | Key Issues | Most Affected |
|---|---|---|
| Beginning Well | - Six Oxfordshire wards in the top 10% of children in England living in poverty<br>- Families with dependent children still face homelessness despite overall prosperity in the county<br>- Variation in the number of low birthweight babies born within the county, with deprived areas affected the most<br>- Rising rates of childhood obesity in some areas<br>- Poor educational attainment amongst children with free school meal status<br>- Lack of access to mental health services for pregnant women with severe mental illness and personality disorders<br>- the proportion of children aged 5 years old who are free from dental decay in Oxfordshire was 77.3 (2014/15) increased from 67.1 (2011-12), compared to the England figures which were 75.2 increased from 72.1 | - Families living in Oxford City and its wards<br>- Families living in Cherwell and its wards<br>- pregnant women with severe mental illness and personality disorders<br>- The national report of the survey indicates that decay levels are higher in local authorities where deprivation scores are higher. |

Nationally, there is a robust evidence base showing that children who receive free school meals have lower achievement levels than those who are not eligible for free school meals. As a

county, we need to regularly review educational targets and the associated factors to ensure that progress is being made.

Education is an important factor in future health, and ensuring that children are ready for school entry, are adequately fed during their school days, attend school regularly and their achievement monitored are all important ways in which inequalities can be addressed . We recognise that there is much good work ongoing within the county in these areas. (Box 20)

| **Box 20 Working with the Oxford Academy** |
|---|
| As a result of their presentation at the Health Inequalities Commission hearing, Oxford Academy were invited to participate in any of the health partnership groups in Oxford. They are now a member of the Leys Health & Wellbeing Partnership group |

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***42.*** | Use of food banks needs to be carefully monitored and reported to HWB | ***HWB*** |
| ***43*** | Child Health Profiles and other relevant routine data should routinely be reported from the perspective of addressing factors which could reduce health inequalities, and promote access to health and other services | ***PH Dept*** |
| ***44*** | New and creative ways to work with schools, such as Oxford Academy, should be explored and initiatives funded and evaluated through the proposed CCG fund | ***HWB/CCG*** |
| ***45*** | The current plans for closures of Children's Centres should be reviewed by March 2017 to ensure prioritization of effective evidence-based investment and good practice in early intervention for children and to ensure that the change of investment and resource allocation to young children and their families does not disadvantage their opportunities especially for those children & families from deprived areas and identified disadvantaged groups | ***HWB*** |

### 4.2 Living well :

At every point in the adult's life there is an opportunity to improve health and wellbeing, prevent the development of new conditions, and minimize the impact of pre-existing conditions. (Table 4) Yet at this stage of the lifecourse, engagement with services is often minimal.

| **Table 4: Overview of data on Living Well:**<br>(Source Emily Phipps) | | |
|---|---|---|
| Theme | Key Issues | Most Affected |
| Living Well | - highest proportion of long-term unemployed adults live in urban areas<br>- Less people living in deprived areas attend for NHS Health Checks<br>- Increasing rates of hospital admissions directly or indirectly related to alcohol<br>- Unpaid caring responsibilities falling on women<br>- Carers from the BAME community less likely to access support<br>- Fuel poverty and overcrowding unequally distributed across the county, mainly affecting urban areas | - Women across Oxfordshire<br>- The BAME community<br>- Adults living in Oxford and Banbury |

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***46*** | Resources should be committed to ensure that prevention and lifestyle advice are embedded in all contacts with statutory service providers and the opportunity taken to include advice about healthier lifestyles and signpost support. | ***CCG/NHS/HWB*** |

### a. Workplace health

Being in work is good for health and economic productivity. The health of the workforce is an asset and programmes within workplaces as well as initiatives to reduce worklessness will contribute to reducing inequalities. The Commission heard of good examples both within the NHs and within the local corporate sector.(see Box 21)

**BOX 21: The UNIPART STRATEGIC APPROACH TO WORKPLACE HEALTH AND WELLBEING**

The basis of the UNIPART strategy is to:

- encourage and help all our people take personal responsibility for their own health and wellbeing to improve their quality of life and levels of personal resilience;
- support people, in particular line managers, in understanding the impact of their actions and decisions on the wellbeing of others; and
- identify workplace factors that may negatively impact the health and wellbeing of our people and seek ways to remove or mitigate it


However, some populations are particularly vulnerable. People with learning disabilities, for example, are underserved within the county. There are significant numbers of undeclared learning disabilities, e.g. dyslexia, autism. More needs to be done to support people who are already at a disadvantage with their complex needs as they will have less access to higher paid jobs. Using the Equality Act data and workforce race equality standards can be a useful measure of discrimination, harassment and access to career progression.

| ***Recommendations*** | ***Responsibility*** |
|---|---|
| ***47***. Promoting the health of those in work should be a priority and examples of good practice shared by establishing a county wide network. | ***HWB and partners, e.g. UNIPART*** |
| ***48.*** The NHS workforce should engage in equity audit and race equality standards should be routinely reported | ***NHS/STP*** |
| ***49*** The needs of adults with learning disabilities within the County should be reviewed in 2017 and targets set to reduce their health inequalities . | ***NHS/HWB*** |

## b. Transitions

This report has chosen to use a life course perspective because it highlights the effects of different contexts and influences on stages of development, i.e. childhood, adulthood, and into older age. Transitions between these stages, e.g. from childhood to adulthood, create an important social context which can influence the resources and support available to individuals. Discontinuities in healthcare provision, social support, and access to services can have a profound impact on health and wellbeing, but can also be a determinant of future economic prosperity. [17] For example, becoming a parent can have a profound impact on the financial capabilities of a household – particularly if one parent stays at home to look after the children. This can have an impact throughout the rest of that person's life. Transitional points reflect a juncture of particular vulnerability, where individuals can fall through the gap. The Commission recognised that amongst the adult population some groups were particularly vulnerable to health inequalities, particularly those with learning difficulties. This is an issue that deserves separate consideration, particularly in the absence of affordable life care. The STP and other plans emphasize the move to self care and use of digital technology (i.e. apps). However, this is an approach which needs to be treated with caution, as some people will be left out, which could in turn worsen inequalities.

The evidence provided to the Commission suggests there are a number of areas where improvement can be made. Some of these areas have been considered separately, e.g targeting mental health support to areas of greatest need (see section 3.6)

However, the Commission recognised that amongst the adult population some groups were particularly vulnerable to health inequalities, particularly those with learning difficulties.

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17 *It is understood that the Oxfordshire STP will include a general principle that prevention should be embedded in all clinical contacts.*

### 4.3 Ageing well:

With significant improvements in healthcare and lifestyles, an increasingly large percentage of our population is made up of people aged over 65 years old.[xxxi] Older people are increasingly likely to require support from adult social care and social isolation becomes an important factor in older people's mental health. (Table 5) There is much that can be done to maximise the potential of older adults and enable them to live as independently as possible in their own community, i.e. provision of seasonal flu vaccination, falls prevention activity, tackling fuel poverty, and community development projects to reduce social isolation, particularly for people living in rural communities. More needs to be done to promote integrated health and social care addressing co – morbidities , particularly recognising that depression and low mental health are major predictors of institutionalisation.

**Table 5: Overview of data on Ageing Well**

Source Emily Phipps

| Theme | Key Issues | Most Affected |
|---|---|---|
| Ageing Well | - Older people in rural areas are less able to access services<br>- Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived, despite overall prosperity in the county<br>- Loneliness affects older people living in urban areas most<br>- Women in Oxfordshire more likely to require hospital admission due to a fall than men, and more than is seen nationally and regionally | - Older people living in rural South Oxfordshire<br>- Older people living in rural West Oxfordshire<br>- Older people living in Banbury Grimsbury and Castle<br>- Older people living in Oxford<br>- Older women in Oxfordshire |

#### a. Disjoint between health and social services

One of the key issues highlighted to the Commission was the apparent disjoint between services provided by health and by social care. To respond to this, the Commission would urge the health and social care systems to work together to agree how best to bring together local services to produce a more coherent transition between sectors when addressing inequalities. Whilst shared budgets would appear to be one issue which should be considered, there is a need to think about how this fits with the broader care packages available to older people. For example, looking at

how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers.

There is also a need to protect investment in social care. At present, this is chronically underfunded. There is a need to look at its effectiveness, and ensure effective transitions from health to social care.

Ensuring that services are responsive to the specific needs of older people is essential, recognising that for elderly people this may mean there are issues that could impact access to and benefit from services,

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***50.*** | Health and social care systems should work together to agree how best to bring together local services to produce a more coherent transition between sectors when addressing inequalities, recognising that co-morbidities are common in this age group, and that many older people are acting as carers for their partners and family members. | ***HWB*** |
| ***51.*** | Shared budgets for integrated care should be considered and how this fits with the broader care packages available to older people. For example, looking at how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers. | ***CCG/HWB*** |

### b. Supporting carers

Older carers make it possible for thousands of people to live dignified and fulfilled lives at home, and make a significant and positive contribution to the economy[18]. They deserve to be provided with the very best support to help them both in terms of their caring role, and in maintaining their own health and well-being. Whilst significant progress has been made, sadly, too often, they do not get all of the practical and emotional support they need, and often struggle on their own with the challenges of caring. Health and care professionals need to be guided to consistently respect carers as partners in care, listen to their views and wishes, and recognise and respond to their care and support needs. There is a need to ensure that available resources are maintained to support flexible breaks for carers, personalised to meet their individual needs.

[18] Figures released by Age UK in 2016 revealed that over the past seven years, the number of carers aged 80 and over has rocketed from 301,000 to 417,000 nationally. In Oxfordshire the figure is believed to be between 4,200 and 4,500, with more than half believed to be doing so for more

In his annual report the DPH has highlighted the challenges of the increasingly ageing population in the county and the need to address their needs (Box21).

**Box 21 : Recommendations from DPH annual report on support for the ageing community**

1. Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Adult Social Care Directorate should continue to plan explicitly for services for an increasing population of frail elderly people. Further integration of health and social care services should include this topic as a priority.

2. The Clinical Commissioning Group and NHS England should work with GP services to consider loneliness as a risk factor for disease and consider how affected individuals could be signposted to use local resources such as befriending services and lunch clubs.

3. The Oxfordshire Clinical Commissioning Group should continue to develop improved services for dementia as a priority.

4. Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospitals Trust and Oxford Health Foundation Trust and NHS England should develop, as a priority, their joint work to collaborate in transforming the local health system. This is in order to provide new models of care closer to home, care focussed on prevention and early detection of disease, improved care for carers, prevention of hospital admission and speedy hospital discharge through improved community services, the modernisation of primary care and the funding of primary prevention services by the NHS.

5. Oxfordshire Adult Social Care Directorate should continue to analyse carefully the implementation of the Care Act and feed this information into future service planning.

6. The Director of Public Health should continue to commission NHS Health Checks and ensure that the offering and uptake of these services achieved by local GPs is kept at high levels. Poorly performing practices should be helped to improve the way Health Checks are delivered.

7. Oxfordshire Healthwatch should consider paying particular attention to dementia services and care for carers as part of their forward planning.

8.The Oxfordshire Health Overview and Scrutiny Committee should consider the issues raised in the care closer to home report carefully, and consider the issues raised in the DPH report, to ensure that proposals to re-shape services match demographic need and address health inequalities

| ***Recommendations*** | | ***Responsibility*** |
|---|---|---|
| ***52*** | Support for carers , including their needs for respite care and short breaks , should be supported with resources by all agencies | ***HWB/All agencies*** |
| ***53*** | The recommendations from the 2016 DPH annual report are endorsed and the Commission wishes to ensure they are targeted to reduce health inequalities and progress reviewed by HWB in 2017 | ***DPH*** <br><br> ***HWB/OCC*** |

### c. Addressing isolation

For older people, there is a particular need to provide services to address isolation. Social networks are changing rapidly. Competition for housing and jobs outside local areas has meant that family networks have become dispersed over wide areas, with social repercussions including loneliness at all ages. Alongside this, face to face engagement is being supplemented – and in some cases replaced – by more technological forms of interaction. Evidence presented to the Commission suggested there is a need to provide support services and stimulation to avoid isolation and loneliness especially amongst those with dementia and in rural areas.

Social prescribing is one method that has been used to good effect to encourage positive social interactions, particularly among those who do not enjoy good health. It is a method for the health-care system 'to access pragmatic solutions to meet the growing needs of people living with long-term physical and mental health conditions when medication is not always appropriate or necessary' (Social Prescribing Network 2016), linking patients with medical and non-medical sources of support within the community, such as opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. (see also Section 3.2e)

We would urge the statutory and voluntary sector to work together more. Examples such as VERA (Box 22) show that close working partnerships can have a significant positive impact on older people's lives.

## Box:22 VERA – a good example of statutory services working closely with community groups

Thames Valley Police's Vulnerable Elderly Risk Assessment (VERA) identifies older residents at risk. In a new partnership with Age UK Oxfordshire local Police and Community Support Officers risk assess older people on their patch, using a scoring system which scores more highly for that resident's recent experience of crime or anti-social behaviour, their health needs and degree of mobility, and the availability of nearby family or close friends.

The highest scoring are then referred to the charity Age UK Oxfordshire which is able to connect those residents with services and opportunities that will give them more support from the community, such as befriending, visits, social clubs, classes and exercise opportunities on their doorstep, and access to information which will help them understand and take advantage of benefits and financial entitlements.

**Recommendations**

| | | ***Responsibility*** |
|---|---|---|
| ***54.*** | Support for services and stimulation should be provided to older people, especially those living on their own to avoid isolation and loneliness especially amongst those with dementia and in rural areas | ***CCG/HWB*** |
| ***55.*** | Strategic action should be taken to oversee increased access to support for older people in disadvantaged and remote situations:<br>o physically through a better coordinated approach to transport across NHS, local authority and voluntary/community sectors<br>o digitally through a determined programme to enable the older old in disadvantaged situations to get online<br>o financially, through support to ensure older people, who are often unaware of their financial entitlements, are helped to access the benefits they are entitled to claim. | ***HWB/CCG*** |
| ***56*** | Building on existing experience, support the further development of Alzheimers friendly environments | ***HWB*** |
| ***57.*** | The current gap in provision of support for older people with mental health needs other than dementia needs to be addressed urgently. | ***HWB*** |
| ***58.*** | Promoting general health and wellbeing through a linked all ages approach to physical activity, targeting an increase in activity levels in the over 50s, especially in deprived areas, using innovative motivational approaches such as 'Good Gym' and Generation Games | ***HWB/CCG*** |

## Section 5: Conclusion :

The Commission has reviewed health inequalities in Oxfordshire and the many positive steps already being taken to care for the more vulnerable members of our community. Our objective has been to highlight that inequalities in health are unfair and unjust and that they need to be taken into account and action taken by all concerned with the health of our population.

Whilst it is easy to say that many of the structural elements of poverty and disadvantage are beyond the control of the county and its services it is also true to say that local action can make a difference. It is also easy to discount recommendations on the basis of poor financial data on costs and benefits of the recommendations, but this rigour is not applied to the commissioning of other routine services commissioned on a historical basis. We do know that addressing inequalities will save and improve lives for the most vulnerable in our communities and that gains will accrue over the lifetime of children who benefit from positive interventions .We also know that budgets are constrained, and we need to think creatively about how resources can be allocated or even reallocated.

**Box 23 Useful resources to support action on health inequalities**

The Marmot Review, published in 2010, set out evidence for action across the wider determinants of health to reduce health inequalities. To help turn the Marmot recommendations into practical actions, in September 2014 PHE published the first series of evidence papers on the issue. The commitment to support local action on health inequalities has been continued with new Practice Resource papers that include evidence, information and tips on approaches that local partnerships can adopt on four topic areas:

- Opportunities for using social value act to reduce health inequalities in England
- Promoting good quality jobs to reduce health inequalities
- Reducing social isolation across the life course
- Improving health literacy to reduce health inequalities

The next steps for the Commission will be to promote the findings of this report and discussion of what can be achieved through local action. The areas for action can be reviewed using the tools produced by PHE to support local action (see above). Progress needs to be regularly reported to councils, NHS partners and the local population through the Health and Well Being Board.

| **Overall Recommendations:** | ***Responsibility*** |
|---|---|
| ***59.*** **The suggested actions should be considered by relevant parties and prioritised, with a report on progress to the HWB by mid 2017** | ***HWB*** |
| ***60.*** **The resources produced by PHE to support local action should be used as part of the formal review process. (Box 23)** | ***HWB/all partners*** |

The recommendations from the Commission need to be considered both from a county wide and a local community level, adapted to fit their particular contexts and to be considered by each of the statutory authorities to ensure that they are maximising opportunities to address health inequalities

This should be supported by research from Oxfordshire's extensive research community and the universities fully engaged to support implementation, assessment and evaluation of the recommendations in all sectors.

Monitoring and evaluation, particularly of the suggested new funding, will be needed across the health and social care system and reviewed on a regular basis by the Health and Well Being Board to ensure that there is a reduction in health inequalities in Oxfordshire.

We would like to thank all those who have contributed to the process so far.

October 2016

## Appendices

### Appendix 1: Economic impact estimates to support the business case for investment in the social determinants of health – evidence gathered by the King's Fund

Source: See relevant chapters of www.kingsfund.org.uk/publications/improving-publics-health

| Measure of economic impact | | | |
|---|---|---|---|
| | Cost of illness | Cost-benefit analysis | Social return on investment |
| The best start in life | Each annual cohort of pre- term and low birth weight babies costs an additional £3bn from birth to the age of 18 | Parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested, with savings to the NHS, education and criminal justice systems | |
| Healthy schools and pupils | | Every additional four years of education return £7.20 in the value of health and other outcomes for every £1 spent<br>Anti-bullying programmes can return £15 for every £1 spend in the long-run in terms of higher earnings, productivity and public sector revenue<br>Smoking prevention programmes in schools can recoup as much as £15 for every £1 spent<br>Every £1 spent on contraception to prevent teen pregnancy saves £11 in lower terminations, antenatal and maternity care | |
| Helping people to find good jobs and stay in work | Workplace injuries cost an estimated £13.8bn in 2010-11 and sickness absence contributes to an | Business in the Community estimates its programmes getting disadvantaged groups back into work returns £3 for every £1 spent<br>Employee wellness programmes | |

| Measure of economic impact | | | |
|---|---|---|---|
| | Cost of illness | Cost-benefit analysis | Social return on investment |
| | overall cost of worklessness of £100bn per year | return between £2 and £10 for every £1 spent | |
| Active and safe travel | The overall cost to society of transport-related poor air quality, ill-health and accidents is at least £40bn, with accidents accounting for £9bn | For every £1 spent on cycling provision the NHS saves £4 in health costs<br>Getting one more person to walk to school could pay back £768; and to cycle to work rather than by car between £539 and £641 in terms of NHS savings, productivity improvements and reductions in air pollution and congestion | |
| Warmer and safer homes | Poor housing costs the NHS at least £2.5bn per year due to illnesses related to damp, cold and dangerous homes Treating young people injured by accidents in the home costs almost £150m in A&E treatment Falls and fractures in the over-65s cost £2bn per year | Safety assessments and installation of safety equipment in homes would cost £42,000 for the average local authority and return £80,000 in reduced NHS costs, if 10% of injuries were prevented as a consequence<br>Birmingham City Council's housing programmes (Decent Homes; Supporting People) returned £24m per year for a total outlay of £12m. Quickest paybacks were for reducing cold and reducing falls in elderly people | |
| Access to green and open spaces, and to leisure | Increasing access to parks and open spaces could reduce NHS treatment costs | Birmingham's 'Be Active' programme returned up to £23 in benefits for every £1 spent in terms of quality of life, reduced NHS use, productivity | |

| Measure of economic impact | | | |
|---|---|---|---|
| | Cost of illness | Cost-benefit analysis | Social return on investment |
| services | by £2bn | and other gains to the local authority | |
| Strong communities, well-being and resilience | | Every £1 spent on health volunteering returns between £4 and £10 shared between service users, volunteers and the wider community | An assessment of 15 community health champion projects delivered an SROI of between £1 and £112 for every £1 invested |
| Public protection and regulatory services | In 2002 the average local authority incurred around £18–20m in NHS costs and a further £26–£30m in lost productivity and earnings due to obesity | Investing in a range of practical air quality improvements is likely to return on average a benefit of £620 for every £100 spent | |
| Health and spatial planning | | 'high standard' spatial planning is likely to return £50, £168 and £50 for planning interventions that promote walking, cycling and insulating homes respectively for every £1 spend on the planning process | |

## Appendix 2: Table of Key Health Inequalities issues by thematic area from Emily Phillps, Public Health Department

| Theme | Key Issues | Most Affected |
|---|---|---|
| Beginning Well | - Six Oxfordshire wards in the top 10% of children in England living in poverty<br>- Families with dependent children still face homelessness despite overall prosperity in the county<br>- Variation in the number of low birthweight babies born within the county, with deprived areas affected the most<br>- Rising rates of childhood obesity in some areas<br>- Poor educational attainment amongst children with free school meal status | - Families living in Oxford City and its wards<br>- Families living in Cherwell and its wards |
| Living Well | - highest proportion of long-term unemployed adults living in urban areas<br>- Less people living in deprived areas attending NHS Health Checks<br>- Increasing rates of hospital admissions directly or indirectly related to alcohol<br>- Unpaid caring responsibilities falling on women<br>- Carers from the BAME community less likely to access support<br>- Fuel poverty and overcrowding unequally distributed across the county, mainly affecting urban areas | - Women across Oxfordshire<br>- The BAME community<br>- Adults living in Oxford and Banbury |
| Ageing Well | - Older people in rural areas less able to access services<br>- Older people living in parts of Banbury Grimsby and Castle ward are in the top 10% most deprived, despite overall prosperity in the | - Older people living in rural South Oxfordshire<br>- Older people living in rural West Oxfordshire<br>- Older people living in |

| Theme | Key Issues | Most Affected |
|---|---|---|
| | county<br>- Loneliness most affecting older people living in urban areas<br>- Women in Oxfordshire more likely to require hospital admission due to a fall than men, and more than is seen nationally and regionally | Banbury Grimsbury and Castle<br>- Older people living in Oxford<br>- Older women in Oxfordshire |
| <u>Cross Cutting Themes</u> | - Lack of availability of social housing<br>- Most homeless people are found in Oxford city<br>- A higher number of urban older people and lone parent households are without a car, limiting their access to services<br>- Lack of health needs assessments for minority groups | - Social housing clients in South Oxfordshire and Vale of White Horse<br>- Homeless people living in Oxford<br>- Gypsy and traveller communities<br>- LGBTQ communities<br>- People living on waterways |

## Appendix 3: Data presented at each session

### Beginning Well

### 1. Local Data

#### Poverty

Children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in income deprived families (Statistics O. o., Income Deprivation Affecting Children Index , 2015). The proportion of children living in poverty in the districts of Oxfordshire, the South East and England as a whole, can be found in figure 1 (England, Public Health Outcomes Framework, 2015).

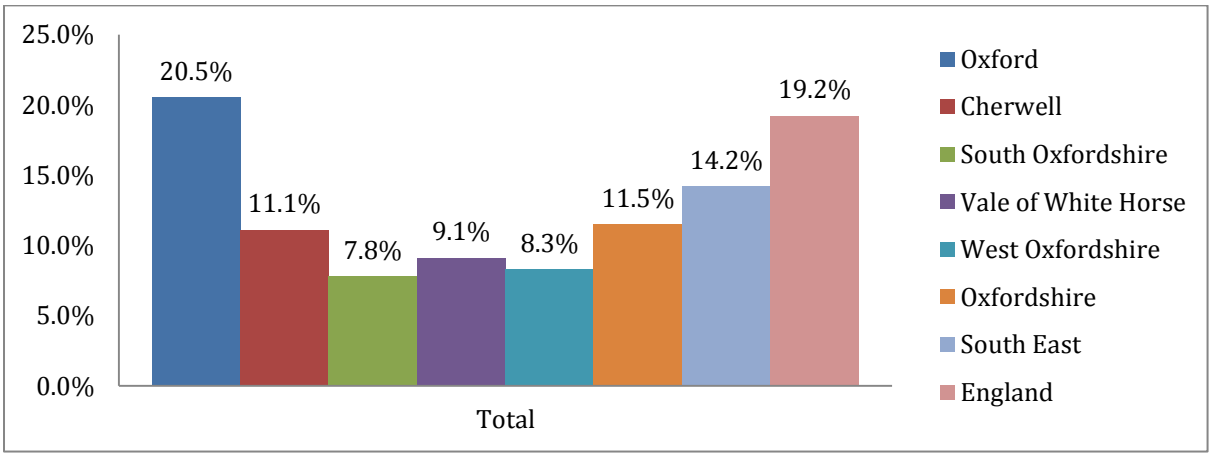


Figure 1 proportion of children living in poverty

#### Homelessness

In 2015, the greatest number of families with dependent children requiring support for unintentional homelessness were in Cherwell (47) and Oxford (60) (Government D. f., 2015). No pregnant women applied for support for unintentional homelessness during 2015 (Government D. f., 2015).

**Conception and Birth**

Obesity, smoking and extremes of maternal age (teenage conception or maternal age greater than 35 years) are all risk factors for poor maternal and infant outcomes. There are known strong links between obesity, smoking, teenage pregnancy and socioeconomic deprivation.

In England, there are 24.3 teenage conceptions for every 1000 girls aged 15 to 17 (England, Public Health Outcomes Framework, 2015). Although on the whole rates in Oxfordshire are below this, the areas with the highest rates of conceptions amongst girls aged 15-17 are in Iffley Fields, Holywell & St Mary's, and Banbury Grimsbury & Castle.

8.6% of mothers in Oxfordshire smoke at the point of delivery, which is better than the overall percantage in England, but is still of concern due to the recognised effects smoking has on foetal growth and child development (England, Public Health Outcomes Framework, 2015). District level data is not available for this indicator; however, we know that there is a strong link between smoking and deprivation (J, 2014), and so could estimate that most of these women are likely to live in the most deprived areas of Oxfordshire (Rose Hill, Blackbird Leys, Northfield Brook, Barton and Sandhills, Banbury Ruscote, Grimsbury and Castle and Banbury Neithrop).
The proportion of babies born with low birthweight in Oxfordshire is below the England average of 2.9% (England, Public Health Outcomes Framework, 2015). However, the areas with the greatest number of babies born with low birthweight are Cherwell (2.6%) and Oxford (2.6%), which are closest to the England average.

The breastfeeding initiation rate for the county is 82.1%, well above the England value of 74.3%. The highest rate of breastfeeding initiation in Oxfordshire is seen in West Oxfordshire (85.6%), which is considerably higher than the lowest rate seen in Cherwell (76.6%) (England, Public Health Outcomes Framework, 2015).

**Infant and Maternal Mortality**

Infant mortality rates (infant deaths under 1 year of age per 1000 live births) in Oxfordshire are not significantly different from the England wide or South East averages, when looking at the most recent crude rates from 2009-2013 (Exchange, 2013). Data is not available for the district levels.

Data on maternal mortality is not available for the county due to the confidential nature in which it is recorded and analysed. The UK Confidential Enquiry in to Maternal Deaths December 2015

report demonstrated no significant difference between the rates of maternal deaths in mothers living in the most deprived versus the least deprived areas of the UK (Marian Knight D. T., 2015). However, a difference had been shown in previous reports, with maternal mortality rates being higher amongst women living in most deprived areas (Marian Knight S. K., 2014). Thinking locally, this may mean that women living in the most deprived areas of Oxfordshire are at greater risk of maternal mortality than those living in the least deprived areas.

**Child and Adolescent Health**

Obesity amongst children in year 6 is rising across the county. The highest rate of obesity in year 6 children is seen in Oxford City, with 19% being obese (Council, Oxfordshire Joint Health and Wellbeing Strategy 2015-2019, 2015).

The number of children at the age of 15 in Oxfordshire who report being a current or occasional smoker is significantly worse than the England average (England, Children and Young People's Health Benchmarking Tool, 2015). The data for this is not available at district level; however, we could reasonably make a cautious assumption that these children are more likely to live in deprived areas, based on the recognised link between smoking and deprivation (J, 2014).

The number of young people hospitalised with injuries from self-harm in the county is rising. In 2015 there were over 100 admissions to the John Radcliffe and Horton hospitals, with most young people coming from the Oxford City, Vale of White Horse and Cherwell districts (Trust O. U., Hospital Episode Data, 2015). The cause for this rise is unclear, and could be due to changes in the way data is collected, increased awareness amongst young people and health care professionals, or the impact of trends such as social media and cyber-bullying.

**Education**

Data for “Children with free school meal status” is collected nationally, and is a good indicator representing children coming from relatively deprived households. In Oxfordshire, the number of children with free school meal status who achieve a good level of development at the end of their reception year is significantly worse than the number over the whole of England at 45.2% compared to 51.2% (England, Children and Young People's Health Benchmarking Tool, 2015). We can interpret this as there being a difference in early years development between children coming from richer versus poorer families in Oxfordshire, and that this difference is worse in the county than for the whole country.

The percentage of children in Oxfordshire achieving over five A* to C grades in English and Maths GCSEs is above the England average (59.4% compared to 56.8%) (Lygo, Educational Attainment Analysis Tables, 2015). However, rates are considerably lower than the England average in the most deprived areas of Oxfordshire. The areas with the lowest achievement are Blackbird Leys (33%) and Rose Hill and Iffley (33.8%) (Lygo, Educational Attainment Analysis Tables, 2015).

## 2. Protected Characteristic Data Sources

Pregnancy and maternity are protected characteristics under the Equality Act 2010. Data on pregnancy is available from Oxford University Hospitals Foundation Trust (OUHFT) from clinical coding. The most up to date data is available from the 2013 Equality Delivery System Monitoring Report for OUHFT, which recorded 14378 episodes of women patients being pregnant. This represents 13% of all female patient episodes and 7% of total episodes (including both male and female) in the trust that year (OUHFT, 2013).

## 3. Local Best Practice

Oxford University Hospitals Foundation Trust has a Public Health Midwifery service for expectant mothers with complex social or mental health issues. Out of all women who booked a pregnancy at the John Radcliffe Hospital in 2015, 926 women were identified as having relevant risk factors. Reasons for referral to the Public Health midwifery team include teenage pregnancy, mental health, domestic violence, drug and alcohol abuse, homelessness and poor social support.

The Thriving Families Scheme provides intensive support for families with complex social needs. Nationally, Oxfordshire is an early implementer of the programme, and has demonstrated a cost saving of £3.22 to public services for each pound invested in the project (Butler, 2015).
Various voluntary organisations provide housing and support services for teenage parents, women at risk of domestic violence and young people at risk (Council, Oxfordshire Directory of Housing Related Support Services, 2012). These services are distributed throughout the county. Oxfordshire County Council provides funding support for the ongoing functioning of these services.

Every secondary school in Oxfordshire has access to a school health nurse. They provide early and individual support to vulnerable children, and build capacity to generally facilitate a healthy lifestyle (both physically and mentally) within the school. Examples of key areas of focus include healthy eating, physical activity, sex education and positive relationships (Council, Oxfordshire Alcohol and Drugs Partnership Strategy 2015, 2015).

## 1. Local Data

### Working age adults

Oxford City has the highest proportion of working age adults that have never worked or are long-term unemployed, and the highest proportion of full-time students (Council, Public Health Surveillance Dashboard, 2015). Although Job Seekers Allowance (JSA) in Oxfordshire as a whole is low, the highest proportion of claimants live Oxford City (NOMIS).

| Area | Economically active % | Unemployed % | JSA claimants % |
|---|---|---|---|
| **Oxford** | 79.1 | 3.6 | 0.6 |
| **Cherwell** | 78.4 | 3.1 | 0.4 |
| **South Oxfordshire** | 86.5 | 2.6 | 0.4 |
| **West Oxfordshire** | 82.1 | 2.7 | 0.4 |
| **Vale of White Horse** | 79.9 | 2.8 | 0.4 |
| **Oxfordshire** | 81.1 | 3.6 | 0.5 |
| **South East** | 80.3 | 4.3 | 1 |
| **England** | 77.7 | 5.4 | 1.5 |

Table 1 Employment and JSA Receipts (NOMIS)

Between 2014 and 2015, 11.4% of working age adults in Oxfordshire were economically inactive due to long term sick leave (NOMIS). This is better than the total value for the whole of the South East of 18.1%. District level data for this is not available due to the small numbers involved.

### Living with chronic disease and disability

GPs in Vale of White Horse, South Oxfordshire and West Oxfordshire look after a significantly higher proportion of patients with COPD, heart failure and history of stroke or transient ischemic attack (TIA) than GPs in Oxfordshire as a whole (Council, Public Health Surveillance Dashboard: COPD, 2016) (Council, Public Health Surveillance Dashboard: Heart Failure, 2015) (Council, Public Health Surveillance Dashboard: Stroke/TIA, 2016).

Cherwell, Vale of White Horse and West Oxfordshire have a significantly higher percentage of patients recorded as living with diabetes than the Oxfordshire average (Council, Public Health

Surveillance Dashboard: Diabetes, 2015). In the 2012 NHS Atlas of Variation for People with Diabetes, no significant relationship was found between type two diabetes and deprivation (NHS, 2012). The number of patients diagnosed with diabetes in general practices in Oxfordshire is also not significantly related to deprivation (England, Public Health Profiles). However, it is important to note that around a quarter of people with type two diabetes are unaware of it and remain undiagnosed, and so are not represented in these statistics (England, Adult Obesity and Type Two Diabetes, 2014). Nationally, risk of type two diabetes increases with age - less than 2% of people aged 16-34 are estimated to have diabetes, compared to 16.5% of those aged over 75 (England, Adult Obesity and Type Two Diabetes, 2014).

Oxford City generally has a lower proportion of residents with chronic diseases than other areas in the county. This is likely due to the high numbers of students residing there.

According to NHS Health Check data from 2014-2015, people older than 65 are most at risk of cardiovascular disease (Lygo, NHS Health Check Data Analysis, 2016). Under 75 mortality rate from cardiovascular disease increases with deprivation; 59.7 deaths per 100,000 in the least deprived group compared to 103.6 deaths per 100,000 in the most deprived group (England, Public Health Outcomes Framework, 2014). Men over 55 years are of higher risk of cardiovascular disease than women of the same age (Lygo, NHS Health Check Data Analysis, 2016). Proportionately it appears that females from more deprived areas are at higher risk of CVD than males (Lygo, NHS Health Check Data Analysis, 2016). However, when looking at NHS Health Check attendance data, more females attend health checks than men, and more people from the least deprived areas of Oxfordshire attend (Lygo, NHS Health Check Data Analysis, 2016). This may impact the reliability of this data.

Working age adults living with a physical disability are fairly evenly spread across the county (see table 2 below).

| | 18-64 year olds with moderate physical disability | 18-64 year olds with serious physical disability |
|---|---|---|
| **Cherwell** | 6,900 (7.9%) | 2,000 (2.3%) |
| **Oxford** | 6,900 (6.4%) | 1,800 (1.7%) |
| **South Oxfordshire** | 6,500 (8.1%) | 2,000 (2.5%) |
| **Vale of White Horse** | 5,900 (8%) | 1,800 (2.5%) |
| **West Oxfordshire** | 5,200 (8.1%) | 1,600 (2.5%) |
| ***Oxfordshire*** | *31,400 (7.6%)* | *9,200 (2.2%)* |

**Table 2 Estimates of physical disability prevalence among 18-64 year olds in Oxfordshire and its districts (Council, Health and Wellbeing Report: Working Age Adults, 2015)**

**Alcohol**

Over Oxfordshire, the number of A&E attendances with alcohol related problems (such as accidental injury and overdose) are the highest in patients from Oxford City and Banbury (C, 2015). Hospital admissions for alcohol-related conditions (such as colorectal and oral cancers) in Oxford and Cherwell are increasing; in 2012, rates of admission in Oxford city reached just under 750 per 100,000, a figure worse than the England average (England, Public Health Outcomes Framework, 2014). Rates in Cherwell have been climbing at a similar rate, and are now almost equal to the England average rate, having previously been significantly below average (England, Public Health Outcomes Framework, 2014). The reasons behind these figures are complex and could be due to factors such as changes to data collection strategies or increased diagnosis, and are under investigation.

**Adult social care**

The majority of adult social care clients are older people (3866). However, of the remaining adults aged 18-65, 668 clients have a physical disability, 1752 a learning disability, and 208 mental health or other care needs (Council, Health, 2015).

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. 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 (Council, Joint Strategic Needs Assessment, 2015). Women are more likely to provide unpaid care than men- nearly a quarter of women aged 60-64, compared to around one in six men (Statistics O. f., England Census, 2011). Black, Asian and minority ethnic (BAME) carers are more likely to provide care for older or disabled loved ones but are less likely to access support from other services (Council, Health and Wellbeing Report: Working Age Adults, 2015).

**Living with mental health problems**

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

[19] 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

2014/15 financial year there were 187 detentions. 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 (Council, Joint Strategic Needs Assessment, 2015).

Women in contact with secondary mental health services in Oxfordshire are slightly less likely than men to live in stable accommodation (Council, Public Health Surveillance Dashboard, 2015). Women in Oxfordshire in contact with secondary mental health services are also less likely to live in stable accommodation as compared to the national figures, although the significance of this has not been tested (Council, Public Health Surveillance Dashboard, 2015).

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) (Council, Public Health Surveillance Dashboard, 2015).

7.5% of adults over the age of 18 in Oxfordshire were diagnosed with depression in 2014/2015 (England, Public Health Profiles). There is no significant relationship between diagnosed depression and deprivation in the county; however, this data does not account for people living with depression who are not in touch with their GP (England, Public Health Profiles).

Previously there have been concerns over the length of waiting times for talking therapies for mental health disorders in the county; because of this, waiting time targets are due to be introduced in April 2016 (Council, Director of Public Health Report 2015, 2015).

**Living with learning disabilities**

Female adults with learning disabilities in Oxfordshire are slightly less likely to be in stable accommodation compared to men with learning disabilities, although the difference may not be significant (Council, Public Health Surveillance Dashboard, 2015).

Adults living with learning disabilities are fairly evenly spread across the county (see table 3 below).

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that person from a public place to a place of safety, either for their own protection or for the protection of others.

| | 18-64 year olds with learning disability | 18-64 year olds with moderate or severe learning disability |
|---|---|---|
| **Cherwell** | 2100 (2.4%) | 500 (0.6%) |
| **Oxford** | 2700 (2.5%) | 600 (0.6%) |
| **South Oxfordshire** | 1900 (2.4%) | 400 (0.5%) |
| **Vale of White Horse** | 1800 (2.5%) | 400 (0.5%) |
| **West Oxfordshire** | 1600 (2.5%) | 400 (0.6%) |
| ***Oxfordshire*** | 10,000 (2.4%) | 2,300 (0.6%) |

**Table 3 Estimates of learning disability prevalence among 18.64 year old in Oxfordshire and its districts (Council, Health and Wellbeing Report: Working Age Adults, 2015)**

### Overcrowding and Fuel Poverty

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 (Council, Joint Strategic Needs Assessment, 2015).

Oxford had proportionately more people living in fuel poverty (12.4% or around one in eight people) (Council, Joint Strategic Needs Assessment, 2015). For the other districts, fuel poverty affected around 7% of people (approximately one in fourteen) (Council, Joint Strategic Needs Assessment, 2015).

### Sexual health

Diagnosed HIV prevalence in the county (1.31 cases per 1000 people) is similar to the England value (2.22 cases per 1000 people) (England, Sexual Health Profile, 2014). HIV testing rates in Oxford are better than in other areas of the county, possibly due to the higher proportion of young people living in the area, and are increasing (England, Sexual Health Profile, 2014).

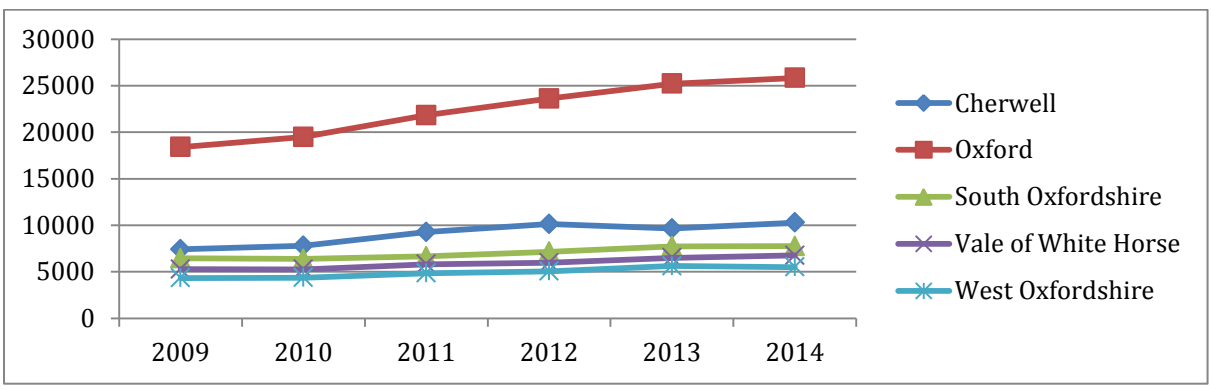



**Figure 2 Number of HIV tests undertaken on eligible adults**

Oxfordshire had 689 new STI diagnoses per 100,000 people in 2014 (England, Public Health Outcomes Framework, 2014). The greatest number of these cases are found in Oxford; the reasons behind this are complex, and could be to do with the higher proportion of young people living in the city, or the fact that people attending GUM clinic anonymously are allocated the clinic's postcode, which may distort data further.

## 2. Protected Characteristics Data Sources

Age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity are protected characteristics under the Equality Act 2010. Oxfordshire County Council produces regular briefing reports based on best available data. The latest report available was produced in November 2015, and contains a wealth of information on the variation of these factors across the county; the latest brief can be found here (Council, Equalities Briefing Summary, 2015). The quality and reliability of data used to generate this report varies by topic; for example, data on age and pregnancy status is more complete and accurate than data on race or religion.

## 3. Local Best Practice

The Oxfordshire Mental Health Partnership was established in December 2015 to coordinate activity between the Oxford Health NHS Trust and five local charities (Oxfordshire Mind, Response, Restore, Connection Floating Support and Elmore Community Services) in the support of patients with mental health problems (Trust O. M.). It is hoped that the partnership will increase joint working between agencies, improve user experience and lead to better outcomes.

Oxfordshire Exercise on Referral is a scheme provided by Oxfordshire Sport and Physical Activity offering tailored exercise programmes to Oxfordshire residents who are not currently active, but would like to use physical activity to manage a health condition (Activity). These conditions may include cardiovascular disease, obesity, mental health problems, musculoskeletal complaints and respiratory disease. Residents must be ages 16 or over and registered with a GP to be eligible for referral.

The Oxfordshire Street Triage Scheme is part of a Thames Valley wide initiative run between Thames Valley Police and NHS mental health services to provide support and ensure appropriate care for people who may come into contact with the police during an acute mental health crisis (Police). This innovative model has led to improved experiences and outcomes for people in

Oxfordshire experiencing mental health crisis, and has reduced the rising numbers of section 136 detentions seen in previous years (Police).

Oxfordshire Safer Communities Partnership is a county-wide strategy for preventing crime and anti-social behaviour. A Community Safety Practitioner (CSP) is currently posted in Oxford University Hospitals NHS Trust, providing advice and support for people experiencing homelessness, mental health crisis, domestic abuse and substance misuse issues. The CSP also act as a link between hospital professionals and community support mechanisms, and has been invaluable in protecting the safety of vulnerable adults across the county (C, 2015).

## Ageing Well

### 1. Local Data

#### Location

Older people (over the age of 65) make up around 17% of the population in Oxfordshire (Office for National Statistics, 2014). Table 1 demonstrates the number of people aged 65 and over living in each of the districts in Oxfordshire (Office for National Statistics, 2014). Older people make up over a quarter of the population in 13 wards in Oxfordshire; the highest proportions can be found in Burford (32.5%) and Goring (28.7%) (Office for National Statistics, 2014). Oxford has seen a decline in the number of people aged 65-84 living there between the 2001 and 2011 census, whereas all other districts have seen an increase (Council, Needs Analysis for Older People (pending publication), 2016).

**Table 4 Number of people aged 65 and over in Oxfordshire and its districts**

| Area | Number of people aged 65+ | % of area's population |
|---|---|---|
| Cherwell | 24,500 | 17% |
| Oxford | 17,800 | 11.3% |
| South Oxfordshire | 27,300 | 19.9% |
| Vale of White Horse | 24,400 | 19.5% |
| West Oxfordshire | 21,600 | 19.9% |
| *Oxfordshire Total* | *115,600* | *17.2%* |

The urban-rural profiles of Oxfordshire's districts for older people vary considerably (Statistics O. f., 2011 Census, 2011). National research has shown that older people in rural areas tend to be healthier overall than their counterparts in urban areas, but they face some specific challenges, particularly in their readiness and ability to access services (Council, Needs Analysis for Older People (pending publication), 2016). Figure 1 summarises the urban-rural profile for each district (Council, Needs Analysis for Older People (pending publication), 2016).

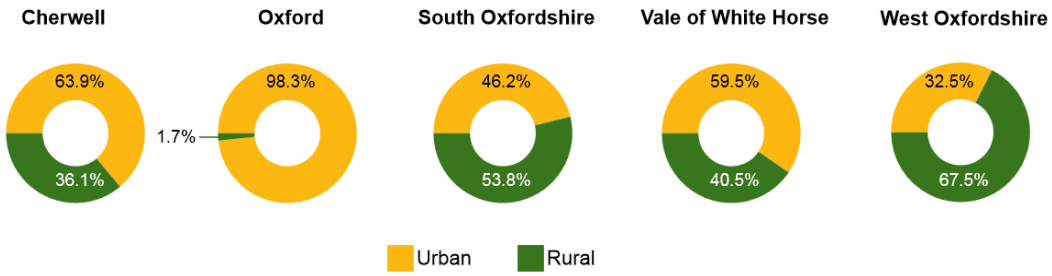



**Figure 3 Older people living in urban and rural areas by district**

## Deprivation

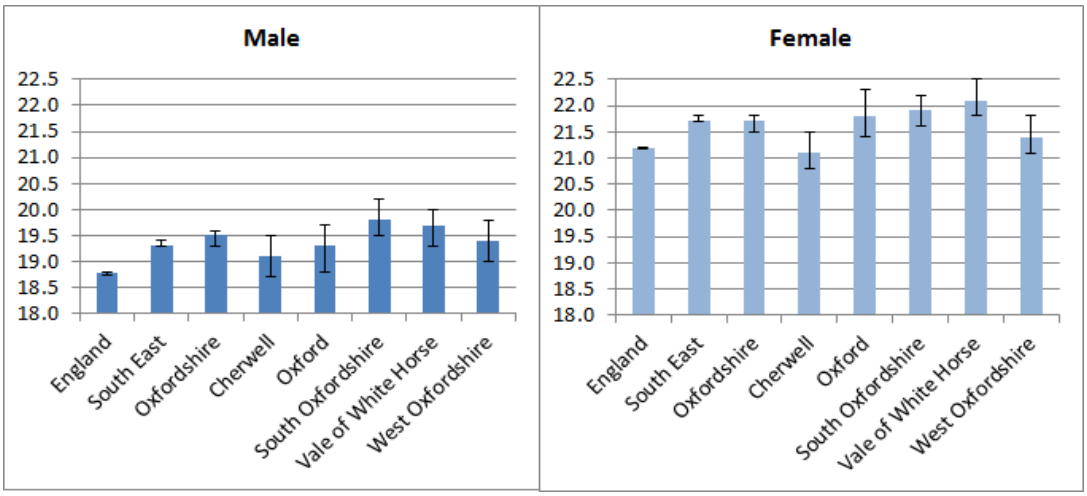
Oxfordshire has relatively low levels of income deprivation affecting older people. However, parts of Banbury Grimsbury and Castle ward are in the top 10% most deprived nationally for older people (Council, Needs Analysis for Older People (pending publication), 2016). Looking at the whole county, it is estimated that around 13,900 people aged 60 and over are affected by income deprivation (Council, Needs Analysis for Older People (pending publication), 2016). A further 12 small areas are in the 20% most deprived nationally. These are concentrated in Banbury Ruscote and Neithrop, and Oxford City (in parts of Northfield Brook, Rose Hill and Iffley, Barton and Sandhills, Churchill, Carfax, St Mary's, and St Clement's wards) (Council, Needs Analysis for Older People (pending publication), 2016).

## Life Expectancy

The average life expectancy of men and women at age 65 in Oxfordshire is better than the England and South East averages, as shown in figure 2 (Office for National Statistics, 2014). Trends in life expectancy for those aged 65 and over have changed for some districts between 2011/13 and 2012/14 for males and females, and are summarised in table 2 (Lygo, Trends in life expectancy at older ages local data analysis (internal), 2016). Cherwell has the lowest life expectancy for those age 65 and over for both males and females (Council, Needs Analysis for

Older People (pending publication), 2016). Although we cannot predict whether these trends will continue, they will be important to monitor in the coming years.

### Figure 4 Life expectancy at 65 by district with England and SE benchmarks




### Table 5 Trends in life expectancy for those aged 65 and over in Oxfordshire districts

| Local Authority | Change from 2011/13 to 2012/14 - Males | Change from 2011/13 to 2012/14 - Females |
|---|---|---|
| Cherwell | Fall | Fall |
| Oxford | Rise | Fall |
| South Oxon | No change | No change |
| Vale of White Horse | Rise | Rise |
| West Oxon | Rise | Fall |

**Loneliness**

Older people living on low income are at higher risk of experiencing loneliness than those who are better off (Oxfordshire, 2012). Loneliness has been shown to have significant negative impacts on physical health, mental health, quality of life and mortality (Oxfordshire, 2012). The Office of National Statistics have published predictions regarding the prevalence of loneliness amongst people aged 65 and over in the districts of Oxfordshire (Statistics O. o., Log odds of loneliness for those aged 65 and over, 2011). Oxford has the highest predicted prevalence of loneliness and South Oxfordshire the lowest, however we cannot say whether this difference is significant or not.

**Dementia**

In 2014 the Alzheimer's Society estimated that there were over 7,700 older people with dementia in Oxfordshire (Alzheimers Society national prevalence data, 2014). A breakdown by local authority is shown in figure 2.

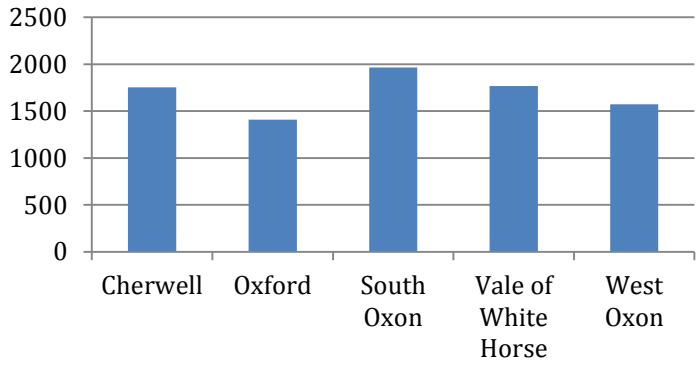



**Figure 5 Number of people living with dementia by local authority**

The five GP practices in Oxfordshire with the highest prevalence rates for dementia are demonstrated in table 3 (council, 2016). Although ward and district is noted, it is important to consider that the patients may live elsewhere.

**Table 6 Oxfordshire GP practices with the highest rates of Dementia**

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

Dementia and Alzheimer's disease were the leading cause of female mortality in Oxfordshire between 2011 and 2013, followed by ischemic heart disease and cerebrovascular disease (stroke) (council, 2016). Dementia and Alzheimer's disease were the second leading cause of mortality amongst men in Oxfordshire in the same period behind ischemic heart disease (council, 2016).

**Falls**

Nationally, falls are the most common cause of death from injury among older people. Non-fatal falls can result in fractures, and affect older people's ability to get around independently.

Older women in Oxfordshire have a higher rate of hospital admissions due to falls than men. This value is also higher than national and regional averages (Council, Needs Analysis for Older People (pending publication), 2016). Those in the oldest age groups (aged 80 and over) have a higher rate of admissions than the national and regional averages, and is higher than the rate seen in those age 65-79 (Council, Needs Analysis for Older People (pending publication), 2016). Residents of Oxford and Vale of White Horse had higher rates than other districts in the county, and are also higher than national and regional averages (Council, Needs Analysis for Older People (pending publication), 2016).

**Hip Fractures**

In 2014/15 there were over 700 emergency admissions for hip fractures among older people in Oxfordshire. Rates of hip fractures amongst older women in Oxfordshire are higher than older men, in line with national trends (Council, Needs Analysis for Older People (pending publication), 2016). The latest Local Health profile data shows no clear relationship between emergency hospital admissions for hip fracture in people aged 65 and over and the percentage of older people living in deprivation or living alone in a particular district in Oxfordshire (England, Local Health, 2016).

**Winter Deaths**

According to the latest Excess Winter Deaths Index data, South Oxfordshire was one of 4 areas (out of 67) in the South East that had a significantly higher ratio of extra deaths to expected deaths than anticipated (Council, District Data Service Chart of the Month, 2015). Oxford's value was also high but statistically similar to the regional average. The ratio of extra deaths to expected deaths amongst females for the county was higher than expected during this period, and may be driving the increases seen in South Oxfordshire and Oxford. Excess winter deaths could be a reflection of fuel poverty or of increasing rates of illness during the winter months, and although is more likely to affect older people, does include data for all ages. Because of this, the Excess Winter Deaths Index can only be used to track trends and should not be used to attribute causation.

## 2. Protected Characteristics Data Sources

Age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity are protected characteristics under the Equality Act 2010.

Data from 2014 estimated that women make up over half the 65 years and older population in Oxfordshire, likely due to their longer life expectancy than men (Council, Needs Analysis for Older People (pending publication), 2016). Disability-free life expectancy at age 65 for men in Oxfordshire between 2009 and 2011 was estimated to be 13.2 years (Council, Needs Analysis for Older People (pending publication), 2016). Oxfordshire was ranked 7th of 150 upper tier local authorities on this measure. For women aged 65, disability-free life expectancy was estimated to be 12.2 years (Council, Needs Analysis for Older People (pending publication), 2016). Oxfordshire was ranked 36th of 150 upper tier local authorities on this measure.

Table 5 demonstrates the differences between healthy life expectancy and total life expectancy for men and women, as well as the difference in life expectancy for the best and worst off in the county (Equity I. o., 2015). We can see that although men and women in Oxfordshire can experience more years lived in good health than the England average, there is still almost a decade difference between the most and least deprived in the county.

Data from the 2011 census indicated that older people in Oxford are slightly more likely than those in other districts to have a main language other than English. Their main language was most often a European language (spoken by 2.2% of Oxford's older people), a South Asian language (spoken by 1.8%), or an East Asian language (spoken by 0.7%) (Council, Needs Analysis for Older People (pending publication), 2016). Of those older people in Oxfordshire who did not speak English well or at all, over half lived in Oxford (Council, Needs Analysis for Older People (pending publication), 2016). Table 5 summarises the Oxfordshire wards with the largest proportions of BAME origin older people (Council, Needs Analysis for Older People (pending publication), 2016).

### Table 7 Oxfordshire wards with largest proportions of BAME older people

| **Ward name** | **% older people of BAME origin** |
|---|---|
| Cowley Marsh | 22.1% |
| Iffley Fields | 16.9% |
| St Clement's | 13.8% |
| Blackbird Leys | 12.2% |
| Northfield Brook | 10.9% |
| Holywell,St Mary's | 10.1% |
| Lye Valley | 9.7% |
| Cowley | 8.9% |
| Hinksey Park | 7.8% |
| Barton and Sandhills | 7.2% |

### Table 8 Comparison of life expectancy at birth and healthy life expectancy at birth

| | **Oxfordshire** | **England** |
|---|---|---|
| Men – **healthy** life expectancy at birth (total life expectancy at birth) | 67.7 (80.6) | 63.5 (79.1) |
| Men – inequality in **healthy** life expectancy at birth (inequality in total life expectancy) | 9.3 (5.6) | 12.8 (6.6) |
| Women – **healthy** life expectancy at birth (total life expectancy at birth) | 69 (84) | 64.8 (83) |
| Women – inequality in **healthy** life expectancy at birth (inequality in total life expectancy) | 8.8 (3.8) | 12.5 (5) |

## 3. Local Best Practice

In April 2016 Oxfordshire County Council are publishing a comprehensive needs assessment for older people living in the county (Council, Needs Analysis for Older People (pending publication), 2016). This will be invaluable for service planning and commissioning.

Oxford University Hospitals Foundation Trust has undertaken a wide variety of projects to improve accessibility of services to older people. This includes (Trust O. U., OUHFT Equality Delivery System 2 (EDS2) Evidence Review, 2015):

- Improving engagement with older people through the 'Seldom Heard' project
- A 'Carer's Surgery' to identify carers and provide structured advice and support
- The Trauma Directorate 'Dementia Care Bundle' including a patient care passport, orientation resources and reminiscence work
- A trust-wide Dementia Initiative Strategy to support identification, staff support, education and ongoing research in to dementia
- A Dementia Information Café providing interventions and advice from external voluntary organisations

There are many voluntary organisations working in Oxfordshire to improve the health and wellbeing of older people. Some of these include:

- Age UK Oxfordshire- provides information and advice for older people and coordinates various local projects
- Oxfordshire Volunteer Befriending Service- providing respite for carers living in the county
- Oxfordshire Advocacy- supporting older people to have their views heard and taken in to account regarding decisions affecting their lives
- Contented Dementia Trust- providing practical help and resources to people living with dementia and their carers
- Oxfordshire Befriending Network- a telephone befriending service to tackle loneliness amongst older people living in the county

## Cross Cutting Themes

## 1. Local Data

### Deprivation

There is a wealth of evidence demonstrating the negative effects deprivation has on health and wellbeing. A common measure of deprivation is the Index of Multiple Deprivation, based on over 30 separate indicators across 7 domains (income; employment; health and disability; education, skills and training; crime; barriers to housing and services; and living environment). Each

geographical area is ranked using this index on its level of deprivation relative to that of other areas (Government D. o., 2015).

Most of Oxfordshire's 407 lower layer super output areas[20] (LSOAs) are less deprived than the national average, with 110 being in the least deprived 10% nationally (Council, Joint Strategic Needs Assessment, 2016). Overall, nearly half (46%) of the county's population lives in areas that are among the least deprived 20% in England (Council, Joint Strategic Needs Assessment, 2016).

However, two LSOAs are among the 10% most deprived in England. These are in parts of Rose Hill and Iffley ward, and Northfield Brook ward (Council, Joint Strategic Needs Assessment, 2016). The former has moved in to this category since 2010. A further 13 LSOAs are among the 10-20% most deprived (down from 17 in 2010). These are concentrated in parts of Oxford City, Banbury, and Abingdon (Council, Joint Strategic Needs Assessment, 2016).

**Education**

Inequalities in education and skills have significant impacts on physical and mental health, as well as income, employment and quality of life (Equity U. I., 2015). There are recognised trends between poor education outcomes and health inequalities such as smoking, obesity and cancer (Council, Joint Strategic Needs Assessment, 2016).

Data for "Children with free school meal status" is collected nationally, and is a good indicator representing children coming from relatively deprived households. In Oxfordshire, the number of children with free school meal status who achieve a good level of development at the end of their reception year is significantly worse than the number over the whole of England at 45.2% compared to 51.2% (England, Children and Young People's Health Benchmarking Tool, 2015). We can interpret this as there being a difference in early years development between children coming from richer versus poorer families in Oxfordshire, and that this difference is worse in the county than for the whole country.

The percentage of children in Oxfordshire achieving over five A* to C grades in English and Maths GCSEs is above the England average (59.4% compared to 56.8%) (Lygo, Educational Attainment

[20] Standardised geographical area constrained by local authority boundaries with an average population of 1500, used to report small area statistics.

Analysis Tables, 2015). However, rates are considerably lower than the England average in the most deprived areas of Oxfordshire. The areas where children live who have the lowest achievement are Blackbird Leys (33%) and Rose Hill and Iffley (33.8%) (Lygo, Educational Attainment Analysis Tables, 2015).

**Housing**

The availability of affordable and safe housing is an essential determinant of health and wellbeing. A lack of such housing can lead to people facing considerable financial strains to afford rent or mortgage payments, delays in starting a family due to lack of money and space, and pressures on social relationships as families are forced to live further away from each other (Shelter, 2010). Living in sub-standard housing can negatively affect mental health and wellbeing, and the physical health impacts of living in damp or dirty conditions are numerous (Shelter, 2010).

The availability of social housing in Oxfordshire varies between districts. In South Oxfordshire and Vale of White Horse in particular, there is demand for over half as much again of social housing than currently exists (Council, Joint Strategic Needs Assessment, 2016). Social housing rent in Oxfordshire is rising, and remains higher than in most of the other local authorities in England (Council, Joint Strategic Needs Assessment, 2016).

Housing in Oxfordshire is generally expensive. In all districts of the county, median house sale prices are rising and remain higher than most other local authorities (Council, Joint Strategic Needs Assessment, 2016). The ratio of house prices to salaries is high and rising, and Oxfordshire is now one of the most unaffordable places in England to live (Council, Joint Strategic Needs Assessment, 2016).

People living in overcrowded conditions tend to experience poor health. In the 2011 census, a third of people (33.3%) in Oxfordshire reported living in a household with more than one person per bedroom. The proportion in Oxford and Cherwell were slightly higher than the rest of the county (38.5% and 35.1% respectively) (Council, Joint Strategic Needs Assessment, 2016).

Homelessness is also linked to significant poor outcomes in terms of health and wellbeing. A report from Crisis stated that on average, homeless people die at 47 years old, 30 years before the national average of 77 (Crisis, 2015). Although the county itself has a consistently low rate of homelessness, Oxford City has higher rates of people who are homeless or in temporary accommodation than the rest of the county (Council, Joint Strategic Needs Assessment, 2016).

This could be partly due to the number of homeless shelters and other facilities present in the city. Data recently presented to the Oxfordshire County Council Health Improvement Board indicated that there were 90 rough sleepers in 2015-2016. The majority of these (56) were in Oxford with 21 in Cherwell, 5 in Vale of White Horse and South Oxfordshire and 3 in West Oxfordshire (Lygo, Internal communication, 2016).

**Work and earnings**

Unemployment is linked to poor health outcomes in terms of both physical and mental health (Equity I. o., 2015). Oxford City has the highest proportion of working age adults that have never worked or are long-term unemployed, and the highest proportion of full-time students (Council, Public Health Surveillance Dashboard, 2015). Although Job Seekers Allowance (JSA) in Oxfordshire as a whole is low, the highest proportion of claimants live Oxford City (NOMIS).

| Area | Economically active % | Unemployed % | JSA claimants % |
|---|---|---|---|
| **Oxford** | 79.1 | 3.6 | 0.6 |
| **Cherwell** | 78.4 | 3.1 | 0.4 |
| **South Oxfordshire** | 86.5 | 2.6 | 0.4 |
| **West Oxfordshire** | 82.1 | 2.7 | 0.4 |
| **Vale of White Horse** | 79.9 | 2.8 | 0.4 |
| **Oxfordshire** | 81.1 | 3.6 | 0.5 |
| **South East** | 80.3 | 4.3 | 1 |
| **England** | 77.7 | 5.4 | 1.5 |

**Table 9 Employment and JSA Receipts (NOMIS)**

Between 2014 and 2015, 11.4% of working age adults in Oxfordshire were economically inactive due to long term sick leave (NOMIS). This is better than the total value for the whole of the South East of 18.1%. District level data for this is not available due to the small numbers involved.

Overall, Oxfordshire residents earn a higher income than the national average, but similar to the rest of the South East (Council, Joint Strategic Needs Assessment, 2016). No significant differences in average income are found at district level in the county (Council, Joint Strategic Needs Assessment, 2016).

Nationally the Citizen's Advice Bureau (CAB) has reported successfully solving 2 out of every 3 client's debt problems through its debt advice service (Team, 2015). They estimate that CAB clients accessing their financial services are on average £10 better off per week as a result of the information and support received (Team, 2015).

In Oxfordshire the Benefits in Practice scheme funds the provision of welfare rights advisors to work out of primary care settings across the county. The service aims to address debt issues and maximise patient's income in order to address health inequalities and improve health and wellbeing. In quarter one and quarter two of the financial year running from 2015-2016, 552 appointments were attended across Oxford, Banbury and West Oxfordshire (Austin, 2016). Total annualised gains for clients in each quarter ranged from £13,994.29 to £53,134.28, depending on site, number of appointments and individual client situation (Austin, 2016).

**Fuel poverty**

Living in a home that is too cold has significant impacts on health. These include (Earth, 2011):

- More cardiovascular and respiratory disease
- Higher rates of excess winter deaths
- Paediatric respiratory problems
- Mental health problems
- Exacerbation of arthritis and rheumatism
- Reduced dexterity leading to more accidents within the home

Fuel poverty has also been demonstrated to be associated with poor child educational attainment and family dietary opportunities and choices (Earth, 2011).

The latest data from 2013 estimates that 21800 people in Oxfordshire live in fuel poverty, accounting for 8.2% of the total population (Council, Joint Strategic Needs Assessment, 2016). This is broadly similar to the previous two years, and is also similar to the regional average (Council, Joint Strategic Needs Assessment, 2016). Oxford has the greatest proportion of people living in fuel poverty at around 1 in 10 people (Council, Joint Strategic Needs Assessment, 2016).

**Car ownership**

Car ownership, particularly in rural areas, is an important factor influencing access to services. More people living in rural areas own cars compared to those living in urban areas in Oxfordshire

(see tables 2 and 3) (Statistics O. f., 2011 Census, 2011). Over half of urban households consisting of a lone older person in Oxfordshire and over a third of urban lone parent households do not have a car (see figure 1) (Statistics O. f., 2011 Census, 2011).

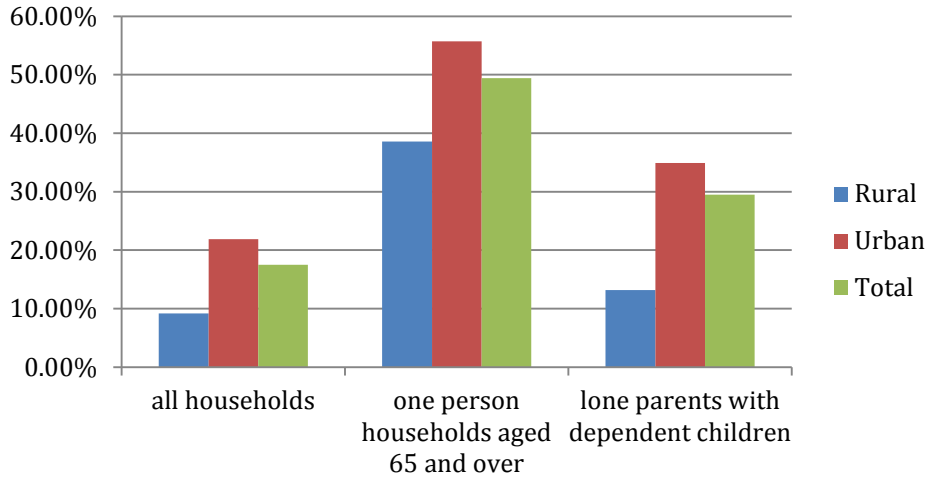
### Table 10 Car ownership in urban wards

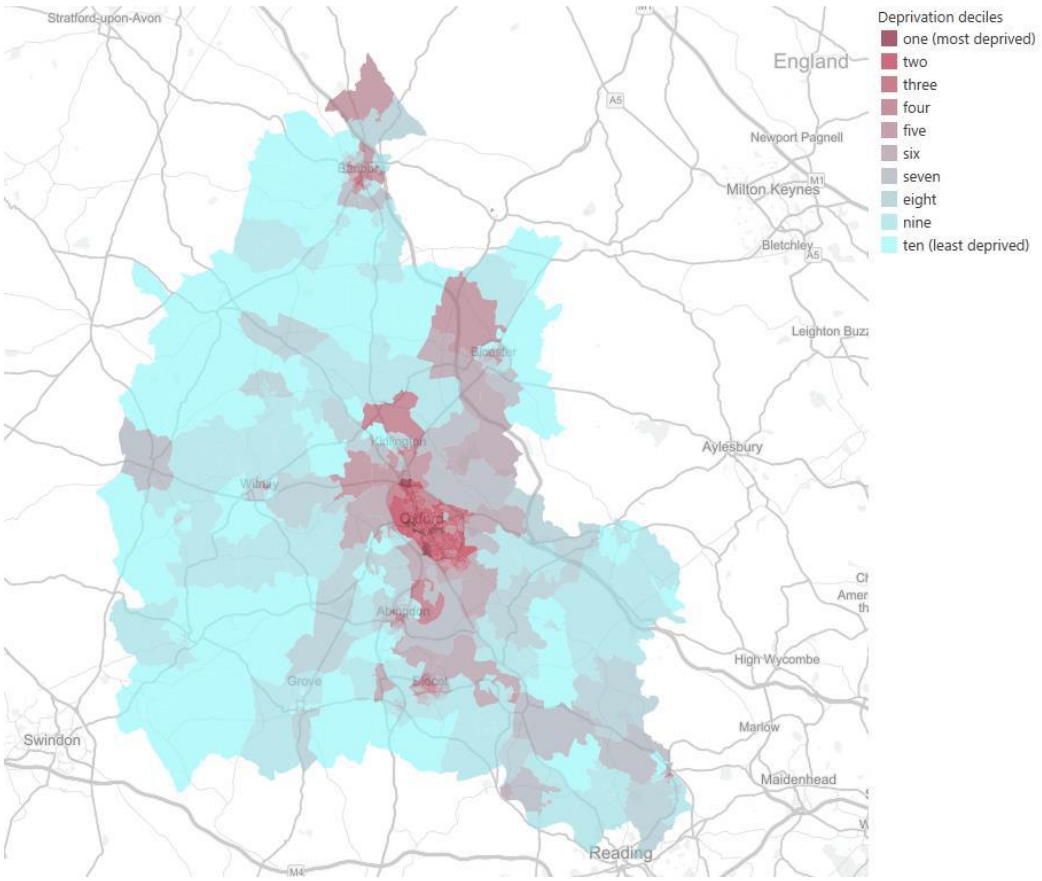
| Urban Wards | | | |
|---|---|---|---|
| | With car | No car | % no car |
| **Cherwell** | 1,515 | 2,373 | 61% |
| **Oxford** | 2,333 | 3,716 | 61% |
| **South Oxfordshire** | 1,732 | 1,624 | 48% |
| **Vale of White Horse** | 1,878 | 1,898 | 50% |
| **West Oxfordshire** | 882 | 891 | 50% |
| **Oxfordshire total** | 8,340 | 10,502 | 56% |

### Table 11 Car ownership in rural wards (no wards in Oxford classified as rural)

| Rural Wards | | | |
|---|---|---|---|
| | With car | No car | % no car |
| **Cherwell** | 1,362 | 717 | 34% |
| **Oxford** | - | - | - |
| **South Oxfordshire** | 2,011 | 1,203 | 37% |
| **Vale of White Horse** | 1,297 | 874 | 40% |
| **West Oxfordshire** | 2,092 | 1,454 | 41% |
| **Oxfordshire total** | 6,762 | 4,248 | 39% |

## Figure 6 Percent of households without a car




## Figure 7 Map of outdoor environment deprivation in Oxfordshire (Council, Joint Strategic Needs Assessment, 2016)

### Environment

Living environment deprivation is measured by the Index of Multiple Deprivation and includes indicators such as lack of central heating, poor quality housing, air quality and road traffic accidents (Statistics O. o., Index of Multiple Deprivation Technical Report 2015, 2015). The majority of lower super output areas that are in the top 10-20% most deprived in terms of environment are in Oxford City (see figure 2).

Access to and use of outdoor green spaces has been demonstrated to have positive impacts on physical health, mental wellbeing and cognitive functioning (Council, Joint Strategic Needs Assessment, 2016). The latest data from March 2013 to February 2014 estimated that the proportion of people in Oxfordshire using outdoor space had fallen from 19.4% (in 2012/13) to 15.7% (Council, Joint Strategic Needs Assessment, 2016). It is difficult to say whether this is a statistically significant difference or just due to small year on year changes, but nevertheless can be seen as a sign that use of outdoor space can be improved.

## 2. Protected Characteristic Data Sources

### Gypsies and Travellers

Gypsies and Travellers are protected from discrimination by the Race Relations Amendment Act 2000 and the Human Rights Act 1998 (About the travelling community, 2016). The 2011 Census indicated that 600 people in Oxfordshire identified their ethnic background as White Gypsy or Irish Traveller (Council, Joint Strategic Needs Assessment, 2016). There are 6 permanent sites in Oxfordshire for gypsies and travellers, providing 89 pitches for caravans (About the travelling community, 2016). Oxon and Bucks Gypsy and Traveller Service currently provides support for residents of and local communities surrounding permanent and unauthorised sites (About the travelling community, 2016).

The last health needs assessment for this group was conducted in 2011 and found several barriers to accessing services including scepticism and negative views towards healthcare, concerns over a lack of same-sex practitioner GP appointments and fears of discrimination (Bagaria, 2011).

### LGBTQ

The term Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) designates a community with a culture based on sexual or gender identity. Data on sexual orientation is not captured on national census but is included on the Integrated Household Survey. The 2014 survey indicates that 92.6%

of people in the South East identify themselves as heterosexual, 1% gay or lesbian, 0.5% bisexual and 0.4% other; the remainder chose not to identify their sexual orientation (Council, Joint Strategic Needs Assessment, 2016). Local level data is not available.

Other areas in England have conducted needs assessments for the health of the LGBTQ community (Devon, 2014) (Network, 2013) (Wirral, 2012). Common issues raised included:

- Sexual health
    - Higher rates of sexually transmitted diseases and cervical cancer
    - Women identifying themselves as lesbian less likely to access cervical screening
- Mental health
    - Greater proportions of the community reporting suffering from depression and anxiety than the general population
    - Higher rates of self harm and suicide attempts
    - Experiences of negative or mixed reactions from mental health professionals
- Risk behaviours

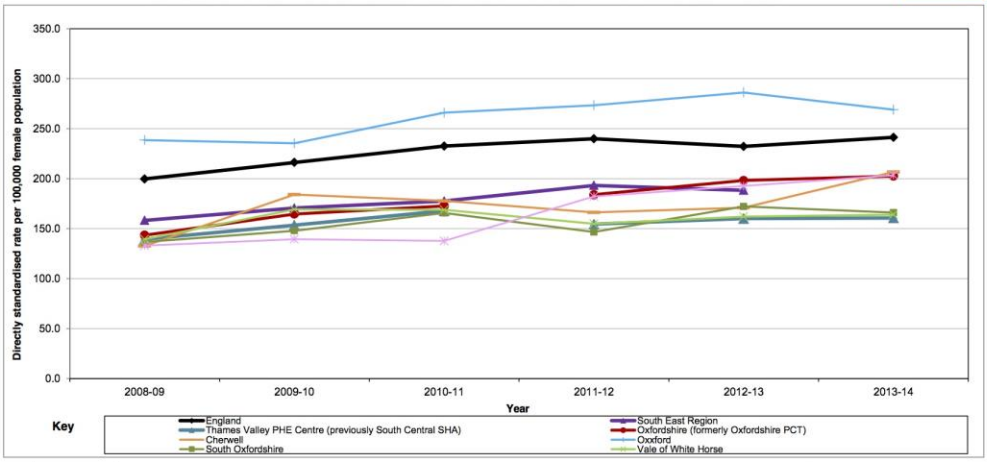
## Alcohol data on hospital admissions (Source Emily Phipps)

Females:

Unique ref: B-005b

RAG rating: Needs monitoring

**Directly age-standardised rate of alcohol-specific hospital admissions in females- 2005/06 to 2013/14**
**England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire**




| | | |
|---|---|---|
| Definitions and data quality | Definition | Directly standardised rate per 100,000 - females admitted to hospital due to alcohol-specific conditions (all ages),. Does not include attendance at A&E.<br>Conditions included are only those wholly attributable (100%) to alcohol (2014 version):<br>E24.4 Alcohol-induced pseudo-Cushing's syndrome; F10 Mental and behavioural disorders due to use of alcohol; G31.2 Degeneration of nervous system due to alcohol; G62.1 Alcoholic polyneuropathy; G72.1 Alcoholic myopathy; I42.6 Alcoholic cardiomyopathy; K29.2 Alcoholic gastritis; K70 Alcoholic liver disease; K85.2 Alcohol-induced acute pancreatitis; K86.0 Chronic pancreatitis (alcohol induced); Q86.0 Fetal alcohol syndrome (dysmorphic); R78.0 Excess alcohol blood levels; T51.0 Ethanol poisoning; T51.1 Methanol poisoning; T51.9 Toxic effect of alcohol, unspecified; X45 Accidental poisoning by and exposure to alcohol; X65 Intentional self-poisoning by and exposure to alcohol; Y15 Poisoning by and exposure to alcohol, undetermined intent; Y90 Evidence of alcohol involvement determined by blood alcohol level; Y91 Evidence of alcohol involvement determined by level of intoxication.<br>These should not be confused with alcohol-related conditions which include alcohol-specific conditions (listed above) plus the percentage contribution alcohol makes to other conditions e.g. stomach cancer, diabetes or ischaemic heart disease. |
| | Source | Public Health England<br>Local Alcohol Profiles |
| | Numerator | Females, resident in the area, admitted to hospital where the primary diagnosis or any of the secondary diagnoses contain one of the listed conditions specific to alcohol misuse - females all ages, for relevant year. |
| | Denominator | Office for National Statistics (ONS) mid-year population estimates by five year age band (females). |
| | Strengths & Limitations | 1. Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. All cases (100%) are caused by alcohol.<br>2. Hospital admission data can be coded differently in different parts of the country. In some cases details of patient's residence are insufficient to allocate patient to a particular area and in other cases patient has no fixed abode. These cases are included in England total but not in LA or regional figures.<br>3. In 2014, alcohol-attributable fractions applied to mortality and hospital admission data were updated to take into account new epidemiological evidence for the association between alcohol consumption and health-related outcomes. This exercise resulted in some important changes to the number of health conditions and external causes that are identified as being alcohol-related and also a recalculation of the attributable fractions for some of the existing health measures. Data for previous years back to 2008/09 are recalculated based on these new figures.<br>4. Children under 16 years were included if they had an alcohol-specific diagnosis (meaning alcohol consumption was a contributory factor in all cases).<br>5. Oxfordshire PCT no longer exists following Health & Social Care Act 2012. Data is not provided at a county level. |
| | Latest available data | 2013-14 |
| | Next available data | Jun-15 \| Jul-15 \| Aug-15 \| Sep-15 \| Oct-15 \| Nov-15 \| Dec-15 \| Jan-16 \| Feb-16 \| Mar-16 \| Apr-16 \| May-16 \| Jun-16 \| Jul-16 \| Aug-16 \| Sep-16 \| Oct-16 \| Nov-16 \| Dec-16 \| Jan-17 \| Feb-17 \| Mar-17<br>2014-15 |
| Epidemiological Facts | Time Trend | 1. The general trend for alcohol-specific admissions rates in females is increasing across all areas.<br>2. There is more fluctuation at district level due to the relatively low numbers. |
| | Benchmarking Outside Oxfordshire | 1. South Oxfordshire, Vale of White Horse and, until recently, Cherwell have significantly lower rates than England. West Oxfordshire is lower but not significantly so.<br>2. Rates in Oxford City are higher than England (and in 2012-13 they were significantly higher). |
| | Benchmarking within Oxfordshire | 1. Oxford City has a significantly higher rate than Oxfordshire overall. It is also signficantly higher than South Oxfordshire and Vale of White Horse districts. |
| Expert interpretation and conclusions with additional information | | 1. National and local figures show an increase over the first part of this time period in the number of women admitted to hospital with "alcohol-specific" conditions. These conditions are a direct result of alcohol consumption and are often related to high consumption levels. This is defined as harmful drinking which includes alcohol dependency ("alcoholism"). Continued upward trends in the consumption of alcohol at a population level and the relative affordability of alcohol may mean that upward trends are likely to continue.<br>2. There is some variation across the local district areas - the rate of admission for women from Oxford City are higher than national and other district rates; the most recent data indicates this is now significant. Oxford hosts medical facilities for homeless people (many of whom are dependent drinkers) and this may partially explain the higher rates in Oxford.<br>3. There was a total number of 670 alcohol-specific admissions in women in 2013/14 in Oxfordshire. Individuals may have been admitted more than once so the number of people will be equal to or less than this.<br>4. The chart B-005a shows that admission rates for men with alcohol-specific conditions are higher than for women. Whilst the rates for men appear to be levelling off, in women the trend appears ot be upwards.<br>5. There should be a concentration on services that minimise the harm caused by alcohol.<br>6. The ready supply of cheap alcohol, relaxed licensing laws and public attitudes mean that persuading people to decrease consumption is unlikely to be effective.<br>7. Nonetheless we should persevere with prevention messages to the general population and continue to monitor this indicator, hence the RAG rating is amber. |

**Directly age-standardised rate of alcohol-specific hospital admissions in females- 2005/06 to 2013/14**
**England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire**

Table

| Year | England | | | | | South East Region | | | | | South Central SHA / Thames Valley PHE Centre | | | | | Oxfordshire PCT / Oxfordshire | | | | | Cherwell | | | | | Oxford City | | | | | South Oxfordshire | | | | | Vale of White Horse | | | | | West Oxfordshire | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pop* | Num | Rate | LCI | UCI | Pop* | Num | Rate | LCI | UCI | Pop* | Num | Rate | LCI | UCI | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En |
| 2005-06 | | 523152 | 198.7 | 198.0 | 201.4 | | 67651 | 158.2 | 154.5 | 162.1 | | | 139.5 | | | | | 143.4 | | | L | | 93 | 132.0 | 106.8 | 162.4 | L | | 169 | 236.0 | 201.7 | 280.7 | | | 90 | 136.0 | 109.4 | 168.2 | L | | 83 | 139.4 | 111.7 | 173.1 | L | | 68 | 133.0 | 102.4 | 169.7 | L |
| 2006-07 | | 569443 | 216.2 | 214.4 | 218.0 | | 73211 | 170.8 | 166.7 | 174.9 | | 3230 | 153.5 | 148.1 | 158.9 | | 526 | 184.6 | 169.2 | 200.9 | L | | 129 | 184.0 | 153.4 | 218.9 | L | | 172 | 298.3 | 255.5 | 346.6 | L | | 99 | 147.9 | 119.9 | 180.6 | L | | 101 | 169.2 | 137.9 | 205.9 | L | | 68 | 139.9 | 109.2 | 175.4 | L |
| 2007-08 | | 615363 | 232.5 | 230.7 | 234.4 | | 76911 | 177.5 | 173.7 | 181.6 | | 3593 | 167.8 | 162.3 | 173.5 | | 564 | 172.6 | 158.4 | 187.2 | L | | 126 | 177.8 | 147.9 | 211.3 | L | | 194 | 266.5 | 226.8 | 309.6 | | | 110 | 165.7 | 135.7 | 200.2 | L | | 100 | 168.9 | 137.2 | 205.7 | L | | 71 | 137.7 | 107.3 | 174.0 | L |
| 2011-12 | 26974 | 636301 | 240.0 | 238.1 | 241.8 | | 84171 | 193.3 | 189.1 | 197.6 | 1022 | 1537 | 194.5 | 146.8 | 162.5 | 330.7 | 605 | 183.9 | 169.5 | 199.3 | | 71.88 | 118 | 166.3 | 137.4 | 199.4 | L | 75.49 | 194 | 273.4 | 233.3 | 318.0 | | 68.54 | 98 | 146.6 | 118.8 | 178.9 | L | 61.23 | 94 | 154.8 | 124.9 | 189.7 | L | 69.07 | 99 | 162.1 | 147.7 | 222.1 | L |
| 2012-13 | 27160 | 62028 | 232.3 | 230.4 | 234.1 | | 82451 | 188.4 | 184.3 | 192.5 | 1031 | 1622 | 180.1 | 152.3 | 168.2 | 333.3 | 666 | 198.1 | 183.1 | 214.1 | | 72.21 | 116 | 171.0 | 141.3 | 205.1 | L | 76.56 | 214 | 286.2 | 246.0 | 330.7 | H | 68.84 | 114 | 172.2 | 141.7 | 207.1 | L | 61.55 | 99 | 162.1 | 131.5 | 197.5 | L | 62.09 | 104 | 192.7 | 157.1 | 233.8 | |
| 2013-14 | 27332 | 64855 | 241.1 | 239.4 | 243.2 | | | | | | 1040 | 1620 | 160.7 | 152.9 | 168.8 | 335.5 | 670 | 202.6 | 187.5 | 218.7 | | 72.61 | 150 | 206.7 | 174.6 | 242.8 | | 77.09 | 209 | 269.0 | 230.2 | 312.0 | | 69.07 | 110 | 166.1 | 135.9 | 200.9 | L | 62.09 | 100 | 164.0 | 133.1 | 199.9 | L | 54.68 | 110 | 203.4 | 166.7 | 245.8 | |

Data are no longer supplied at this level

EN is England
* figures in thousands
LCI is lower limit of 95% confidence interval.
UCI is upper limit of 95% confidence interval.

Following the Health and Social Care Act 2013, some NHS organisations changed - South Central Strategic Health Authority and Oxfordshire Primary Care Trust no longer exist. Data are now provided at a county level and Thames Valley Public Health England Centre is included for a more regional picture..

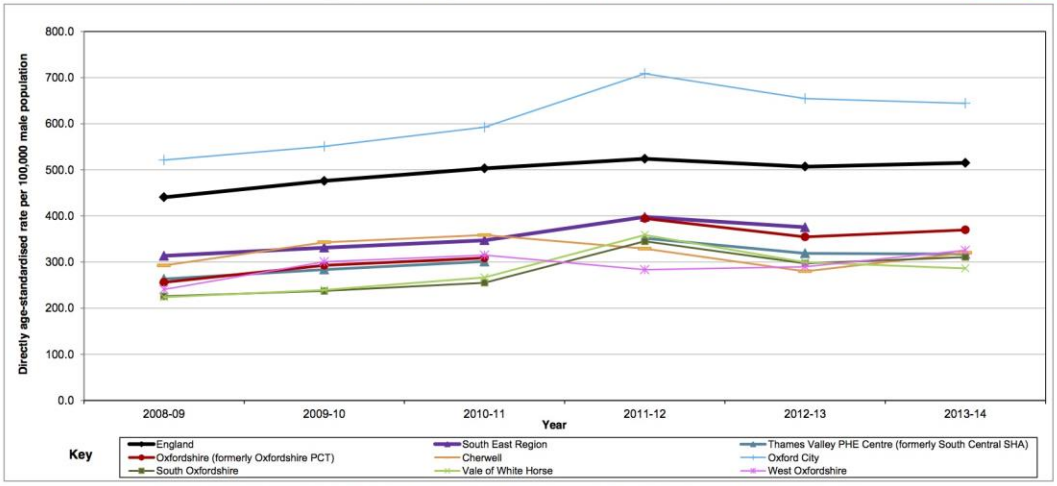
Key:
Rate suggests significantly higher rate compared to Oxfordshire rate.
Rate suggests significantly lower rate compared to Oxfordshire rate.
H suggests significantly higher rate compared to England rate.
L suggests significantly lower rate compared to England rate.

# Males

**Unique ref: B-005a**

**RAG rating:** Needs monitoring

## Directly age-standardised rate of alcohol-specific hospital admissions to males- 2005/06 to 2013/14
### England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire




| | | |
|---|---|---|
| Definitions and data quality | **Definition** | Directly standardised rate per 100,000 - males admitted to hospital due to alcohol-specific conditions (all ages),. Does not include attendance at A&E.<br>Conditions included are only those wholly attributable (100%) to alcohol (2014 version):<br>E24.4 Alcohol-induced pseudo-Cushing's syndrome; F10 Mental and behavioural disorders due to use of alcohol; G31.2 Degeneration of nervous system due to alcohol; G62.1 Alcoholic polyneuropathy; G72.1 Alcoholic myopathy; I42.6 Alcoholic cardiomyopathy; K29.2 Alcoholic gastritis; K70 Alcoholic liver disease; K85.2 Alcohol-induced acute pancreatitis; K86.0 Chronic pancreatitis (alcohol induced); Q86.0 Fetal alcohol syndrome (dysmorphic); R78.0 Excess alcohol blood levels; T51.0 Ethanol poisoning; T51.1 Methanol poisoning; T51.9 Toxic effect of alcohol, unspecified; X45 Accidental poisoning by and exposure to alcohol; X65 Intentional self-poisoning by and exposure to alcohol; Y15 Poisoning by and exposure to alcohol, undetermined intent; Y90 Evidence of alcohol involvement determined by blood alcohol level; Y91 Evidence of alcohol involvement determined by level of intoxication.<br>These should not be confused with alcohol-related conditions which include alcohol-specific conditions (listed above) plus the percentage contribution alcohol makes to other conditions e.g. stomach cancer, diabetes or ischaemic heart disease. |
| | **Source** | Public Health England<br>Local Alcohol Profiles for England |
| | **Numerator** | Males, resident in the area, admitted to hospital where the primary diagnosis or any of the secondary diagnoses contain one of the listed conditions specific to alcohol misuse - males all ages, for relevant year. |
| | **Denominator** | Office for National Statistics (ONS) mid-year population estimates by five year age band (males). |
| | **Strengths & Limitations** | 1. Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. All cases (100%) are caused by alcohol.<br>2. Hospital admission data can be coded differently in different parts of the country. In some cases details of patient's residence are insufficient to allocate patient to a particular area and in other cases patient has no fixed abode. These cases are included in England total but not in LA or regional figures.<br>3. In 2014, alcohol-attributable fractions applied to mortality and hospital admission data were updated to take into account new epidemiological evidence for the association between alcohol consumption and health-related outcomes. This exercise resulted in some important changes to the number of health conditions and external causes that are identified as being alcohol-related and also a recalculation of the attributable fractions for some of the existing health measures. Data for previous years back to 2008/09 are recalculated based on these new figures.<br>4. Children under 16 years were included if they had an alcohol-specific diagnosis (meaning alcohol consumption was a contributory factor in all cases).<br>5. Oxfordshire PCT no longer exists following Health & Social Care Act 2012. Data is not provided at a county level. |
| | **Latest available data** | 2013-14 |
| | **Next available data** | Jun-15 \| Jul-15 \| Aug-15 \| Sep-15 \| Oct-15 \| Nov-15 \| Dec-15 \| Jan-16 \| Feb-16 \| Mar-16 \| Apr-16 \| May-16 \| **Jun-16** \| Jul-16 \| Aug-16 \| Sep-16 \| Oct-16 \| Nov-16 \| Dec-16 \| Jan-17 \| Feb-17 \| Mar-17<br>2014-15 |
| Epidemiological Facts | **Time Trend** | 1. The general trend for alcohol-specific admissions rates among males was increasing across all areas. For the most recent data points all areas appear to have levelled off but it is too soon to tell if this will be a continuing trend. |
| | **Benchmarking Outside Oxfordshire** | 1. Oxfordshire and all districts in Oxfordshire, except Oxford City, have a significantly lower rate than England.<br>2. Oxford City has a significantly higher rate than England. |
| | **Benchmarking within Oxfordshire** | 1. Oxford City has a significantly higher rate of alcohol-specific hospital admissions for males than all other districts in Oxfordshire.<br>2. For the most recent data point (2013/14) Vale of White Horse has a significantly lower rate than Oxfordshire overall. |
| **Expert interpretation and conclusions with additional information** | | 1. National and local figures show an increase at the beginning of this time period; the most recent data points indicate that the number of men admitted to hospital with "alcohol-specific" conditions may be levelling off. These conditions are a direct result of alcohol consumption and are often related to high consumption levels. This is defined as harmful drinking which includes alcohol dependency ("alcoholism"). Continued upward trends in the consumption of alcohol at a population level and the relative affordability of alcohol indicated that the upward trend would continue. However the most recent data indicates a slight levelling but it is too early to know if this is a new trend.<br>2. There is variation across the district areas - the rate of admission for men from Oxford City are significantly higher than other districts in Oxfordshire and are significantly higher than national rates. Oxford hosts medical facilities for homeless people (many of whom are dependent drinkers) and this may partially explain the higher rates in Oxford but overall it must be concluded that there are higher rates in the general population of men.<br>3. There was a total number of 1165 alcohol-specific admissions for men in 2013/14 in Oxfordshire. Individuals may have been admitted more than once so the number of people will be equal to or less than this.<br>4. The chart B-005b shows that admission rates for women with alcohol-specific conditions are lower than for men ; however rates for women in Oxford City are now significantly higher than national figures.<br>5. There should be a concentration on services that minimise the harm caused by alcohol.<br>6. The ready supply of cheap alcohol, relaxed licensing laws and public attitudes mean that persuading people to decrease consumption is unlikely to be effective.<br>7. Nonetheless we should persevere with prevention messages to the general population and continue to monitor progress, hence the RAG rating is amber. |

## Directly age-standardised rate of alcohol-specific hospital admissions to males- 2005/06 to 2013/14
### England, South East Region, Thames Valley PHE Centre, Oxfordshire and districts within Oxfordshire

**Table**

| Year | England | | | | | South East Region | | | | | South Central SHA / Thames Valley PHE Centre | | | | | Oxfordshire PCT / Oxfordshire (county) | | | | | | Cherwell | | | | | | Oxford City | | | | | | South Oxfordshire | | | | | | Vale of White Horse | | | | | | West Oxfordshire | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pop* | Num | Rate | LCI | UCI | Pop* | Num | Rate | LCI | UCI | Pop* | Num | Rate | LCI | UCI | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En | Pop* | Num | Rate | LCI | UCI | En |
| 2008-09 | | 108459 | 440.4 | 437.8 | 443.1 | | 12579 | 313.5 | 308.0 | 319.1 | | | 263.2 | | | | | 256.0 | | | | | 196 | 292.7 | 252.5 | 337 | | | 319 | 321.2 | 460.8 | 586.9 | | | 140 | 225.7 | 189.5 | 266.7 | | | 126 | 224.0 | 187 | 267 | | | 121 | 240.7 | 199.4 | 288.1 | |
| 2009-10 | | 118102 | 475.9 | 473.1 | 478.8 | | 13374 | 331.2 | 325.5 | 336.9 | | 5993 | 283.6 | 276.4 | 290.9 | | 932 | 292.9 | 274.2 | 312.4 | L | | 23 | 342.8 | 299.8 | 390.5 | L | | 341 | 660.8 | 488.6 | 818.3 | H | | 152 | 237.3 | 200.8 | 278.6 | L | | 136 | 239.4 | 200.9 | 283.1 | L | | 149 | 300.6 | 253.6 | 353.5 | L |
| 2010-11 | | 125684 | 503.2 | 500.4 | 506.0 | | 14147 | 347.3 | 341.5 | 353.1 | | 6464 | 301.2 | 293.8 | 308.6 | | 1002 | 308.9 | 289.9 | 328.8 | L | | 242 | 358.6 | 314.2 | 407.4 | L | | 357 | 682.4 | 527.0 | 863.2 | H | | 163 | 255.2 | 217.3 | 297.8 | L | | 158 | 266.7 | 225.7 | 312.8 | L | | 156 | 314.9 | 267.0 | 368.9 | L |
| 2011-12 | 26133.2 | 131517 | 524.0 | 521.1 | 526.8 | 1003 | 16282 | 398.0 | 391.8 | 404.2 | 1003 | 3267 | 351.2 | 339.7 | 364.4 | 324.1 | 1190 | 394.5 | 371.9 | 418.0 | L | 70.4 | 218 | 329.0 | 285.7 | 377 | L | 74.8 | 409 | 708.5 | 636.1 | 786.6 | H | 66.42 | 220 | 345.1 | 300.6 | 394.2 | L | 60.66 | 203 | 356.8 | 310 | 413 | L | 51.91 | 142 | 283.7 | 238.4 | 334.3 | L |
| 2012-13 | 26333.4 | 127860 | 508.9 | 504.1 | 509.8 | | 15484 | 375.5 | 369.6 | 381.5 | 1012 | 3033 | 318.0 | 307.4 | 330.7 | 327.4 | 1120 | 354.5 | 333.7 | 376.2 | L | 70.6 | 191 | 280.3 | 241.3 | 323 | L | 76.0 | 410 | 694.5 | 587.5 | 726.5 | H | 66.71 | 190 | 297.1 | 256.1 | 342.8 | L | 61.21 | 178 | 299.7 | 257 | 347 | L | 52.95 | 150 | 290.1 | 245.3 | 340.7 | L |
| 2013-14 | 26534* | 130590* | 515.1 | 512.2 | 517.9 | | Data no longer supplied at this level | | | | 1021* | 3025* | 317.7 | 306.1 | 329.2 | 330.5* | 1165* | 369.8* | 348.6* | 391.9* | L | 71.0* | 215* | 320.1* | 279.5* | 366* | L | 77.7* | 415* | 644.1 | 578.5* | 714.7* | H | 66.95* | 200* | 310.8* | 269.1* | 357.0* | L | 61.55* | 165* | 266.5 | 226* | 334* | L | 53.31* | 170* | 325.5* | 278.0* | 378.8* | L |

EN is England
* figures in thousands
LCI is lower limit of 95% confidence interval.
UCI is upper limit of 95% confidence interval.

Following the Health and Social Care Act 2013, some NHS organisations changed - South Central Strategic Health Authority and Oxfordshire Primary Care Trust no longer exist. Data are now provided at a county level and Thames Valley Public Health England Centre is included for a more regional picture..

**Key:**

Rate suggests significantly higher rate compared to Oxfordshire rate.
Rate suggests significantly lower rate compared to Oxfordshire rate.

H suggests significantly higher rate compared to England rate.
L suggests significantly lower rate compared to England rate.

## Appendix 4: Commission Members

| Member | Biography |
|---|---|
| Professor Sian Griffiths OBE (Chair) | Trained as a doctor Professor Griffiths practiced as a service based public health physician at local, regional and national level in the UK.<br>Sian co chaired the HKSAR governments inquiry into the 2003 SARS epidemic whilst President of the UK Faculty of Public Health.<br>In 2005 she moved to her academic career as Director of the School of Public Health and Primary Care and Founding Director of Centre for Global Health at the Chinese University of Hong Kong.. She remains Senior Adviser on International Academic Development to the Vice Chancellor and Emeritus Professor at CUHK.In the UK she has been Associate Board member for Public Health England since 2014,chairing PHE's Global Health Committee .She is Visiting Professor at the Institute of Global Health Innovation at Imperial College, London, Trustee of the Royal Society of Public Health and chairs the Board of the Centre for Health and Development [CHAD]at Staffordshire University . |
| Allison Thorpe (project manager and secretariat) | Allison is a freelance researcher/Prince 2 project manager, with extensive experience of working on public health projects at a range of levels within the health system. Since 2010, when she was awarded a Global Research Report Fellowship for TDR/WHO, she has undertaken multiple time limited research projects on a broad range of areas. She is an experienced researcher, who has utilised quantitative and qualitative skills to undertake both academic studies, and more pragmatic outcome focused studies. |
| Dr Joe McManners | Joe has been a GP for 11 years. For the past 9 years, he has been a partner at a GP practice in Oxford where he has joint responsibility for the running of the practice. He is also a GP trainer.<br><br>He was elected Oxfordshire CCG Clinical Chair in February 2014. Oxfordshire CCG is one of the biggest CCGs in the country with a population of 650,000 patients and a budget circa £700 million. Previously he had been the Clinical Director for Oxford City Locality, and a member of the CCG Governing Body. He previously was also Clinical Lead for older people.<br>He is Vice Chair of Oxfordshire Health and Wellbeing Board. |

| Member | Biography |
|---|---|
| | His priorities as Chair of Oxfordshire CCG are; integrating health and social care for local population management, tackling health inequalities and building a sustainable primary care led system.<br><br>He has a Masters degree in Public Policy in 2005, and is a King's Fund Associate in Clinical Leadership.<br><br>For 7 years he was a Local Councillor in Oxford City, and for 3 of those years had executive responsibility for housing. In whatever spare time not taken up by work or family, he likes to relax by getting out cycling around Oxfordshire. |
| Professor Trish Greenhalgh | Trish Greenhalgh is Professor of Primary Care Health Sciences and Fellow of Green Templeton College at the University of Oxford. She studied Medical, Social and Political Sciences at Cambridge and Clinical Medicine at Oxford before training as an academic GP. She has previously worked at University College London (1986-2010) and Barts and the London School of Medicine and Dentistry (2010-2014).<br><br>Trish leads a programme of research at the interface between the social sciences and medicine. Her work seeks to celebrate and retain the traditional and the humanistic aspects of medicine and healthcare while also embracing the unparalleled opportunities of contemporary science and technology to improve health outcomes and relieve suffering. Three particular interests are the health needs and illness narratives of minority and disadvantaged groups; the introduction of technology-based innovations in healthcare; and the complex links (philosophical and empirical) between research, policy and practice. She is the author of 250 peer-reviewed publications and 8 textbooks. She was awarded the OBE for Services to Medicine by Her Majesty the Queen in 2001 and made a Fellow of the Academy of Medical Sciences in 2014. |
| Cllr Ed Turner | Ed Turner is Deputy Leader of Oxford City Council, leading on Finance, Corporate Assets and Public Health. He has represented Rose Hill and |

| Member | Biography |
|---|---|
| | Iffley on the authority since 2002, overseeing a major regeneration project in his ward. Alongside his council role, he is Senior Lecturer and Head of Politics and International Relations at Aston University, Birmingham. He has published widely on German politics and, more recently, has developed a specialisation in the areas of housing and planning. He has served on three major national reviews of housing policy: the Harman Review, the Technical Housing Standards Review and, most recently, the Lyons Review. As such, he is particularly interested in the relationship between bad housing and poor health, and the role of housing improvement in narrowing health inequalities |
| Paul Cann | Paul Cann joined Age Concern (now Age UK) Oxfordshire as its Chief Executive in April 2009. Age UK Oxfordshire works at grassroots level to help older people and their families live in comfort, with support and enjoying opportunities to live life to the full.<br><br>Paul read English Literature at King's College Cambridge, also holding a Choral Scholarship. After teaching for five years, he joined the Civil Service where he held a range of postings at the Cabinet Office, including working as a Private Secretary to successive Cabinet Ministers, including the Minister for the Arts. A subsequent spell in the private sector included working for 'The Independent' newspaper. He joined the charity world in 1992 as Director of the British Dyslexia Association and subsequently of the National Autistic Society. He was a Trustee of the disability charity Contact a Family for five years, a charity which supports carers and people with special needs or disabilities.<br><br>From 2000 to his arrival at Age Concern Oxfordshire he was Director of Policy and External Relations at Help the Aged, where he had responsibility for research, policy, international strategy, media and external relations. He brought together research and policy, and was particularly involved in Help the Aged's work on pensioner poverty, social exclusion and care issues. As Director with responsibility for international affairs, he helped to reshape the charity's international programme and increased Help the Aged's own profile and activity. |

| Member | Biography |
|---|---|
| | From 2004-07 Paul held a Visiting Fellowship at the Oxford Institute of Ageing.<br><br>In 2008 Paul was awarded the medal of the British Geriatrics Society for an outstanding contribution to the well-being of older people. In 2009 he was appointed an Associate Fellow of the International Longevity Centre and also in that year a Charter Member of the charity Independent Age. He co-edited 'Unequal Ageing (Policy Press, 2009), which examines in turn the injustice and inequalities experienced by older people in income, housing, health, and many other aspects of daily life. Paul chairs the Public Policy Panel of the national charity Age UK. He and Age UK Oxfordshire are founding members of the national Campaign to End Loneliness. He is a Board member of NDTi, an agency promoting social inclusion across all ages and stages.<br><br>A keen singer and lover of the arts, and a Director of Creative Dementia Arts Network, (CDAN), Paul believes that "the arts" should be at the centre of our lives and public policy; taking part in the arts simulates, connects, fulfils us and makes us happy. The charity's project www.ageofcreativity.co.uk aims to promote and celebrate arts activities of all kinds and their value to older people across the UK and beyond. |
| Richard Lohman | Richard Lohman has been a director on the board of Healthwatch Oxfordshire and its predecessor 'Oxfordshire LINK' since 2008. Richard is a registered and qualified social worker with a Masters in Advanced Social Work with Adults. He was a founding member of Unison's National LGBT Committee and has 15 years NHS experience serving people undergoing homelessness. Richard is the Healthwatch representative on the Faculty of General Dental Practitioners Lay and Patient panel. |
| Andrew Stevens | Andrew joined the NHS in 1982 as a national general management trainee. After posts in North Wales and Manchester, he spent two years in a public and patient engagement role as Secretary of the Community Health Council in Swindon. |

| Member | Biography |
|---|---|
| | Andrew moved to Hampstead Health Authority in 1988 and undertook a variety of senior planning-related roles in the hospital and community sectors. He project-managed the Royal Free's first wave NHS Trust application before becoming the Trust's Director of Business Planning.<br><br>Andrew joined what was then the Oxford Radcliffe Hospitals NHS Trust (ORH) in 1999. He was the ORH lead for its merger with the Nuffield Orthopaedic Centre, which resulted in the creation of the Oxford University Hospitals NHS Trust (OUH). Andrew heads up the Trust's planning, commissioning, IM&T and media and communications functions. He also leads the Trust's developing public health activities. He was the lead executive for the OUH's NHS Foundation Trust application process and for the implementation of the Trust's Electronic Patient Record. |
| Tamsin Jewell | Tamsin has worked with and for a wide range of organisations from charities like Crisis and Oxfordshire Mind to large international bureaucracies like UNAIDS. Social work trained, her career spans social and development work in the UK and internationally, with a focus on health – both mental and physical – forced migration and human rights. Tamsin has been at Elmore Community Services since April 2015. |
| Dan Leveson | Dan is currently Associate Director of Strategy and OD at Oxford Health NHS FT. He has a long history of working in international development and health, working for Oxfam GB and Goal, managing emergency and post conflict humanitarian programmes in Afghanistan, Ethiopia, Bosnia-Herzogovena, various countries in West Africa and the Democratic Republic of the Congo |
| Cllr Hilary Hibbert-Biles | Hilary has been a County Councillor since 2005. She has been a member of the planning committee at both District & County. Hilary has been the vice chairman of the County Council 2009-10 and the Chairman of the County Council 2010-11. She has also held the post of Cabinet Member for the Environment. She is also on the Health Improvement Board as well as the Health & Wellbeing Board and the Childrens Board (now called the Childrens Trust). She was a West Oxfordshire District Councillor from 2002-2014 holding cabinet positions |

| Member | Biography |
| --- | --- |
| | covering Health, Housing, Leisure & Tourism, Children & Young people. She enjoys spending time with her family and gardening. Hilary is married with two daughters and two grandchildren |

## Appendix 5: List of people who submitted evidence to each session and overall

| Submissions to the Commission |
|---|
| Beginning Well<br>• Teenage Cancer Trust<br>• Children's Centres<br>• James Plunkett<br>• National Deaf Children's Society<br>• OxSPA<br>• Brighter Futures<br>• Individual responses from Barton and Farringdon residents<br>• Perinatal care Group<br>• MIND |
| Living Well<br>• Bicester Healthy New Town<br>• Luther Street<br>• Terrence Higgins Trust<br>• West Oxon District Council<br>• OxSPA |
| Ageing Well |
| • Susanna Pressel (Cllr)<br>• Eynsham Medical Practice - Teresa Young<br>• South Oxfordshire District Council and the Vale of White Horse District Councils,<br>• Amalgamated responses from Oxford City Locality meeting – responses from GPs<br>• Getting the picture and the Chinese Happy Centre<br>• Age Concern Oxford<br>• Cherwell District Council<br>• Oxspa |
| Cross Cutting themes<br>• Getting the picture and the Happy Place Centre<br>• Oxford City Council<br>• Gene Webb<br>• Oxford County Council Transport Team<br>• Oxford Child Poverty Action Group<br>• Oxford County Council Department of Adult Social Services<br>• Asylum Welcome<br>• Citizens Advice Bureau<br>• GP responses<br>• Oxford Association for the Blind<br>• Oxford Health<br>• Luther Street<br>• Good Food Oxford<br>• Connections Floating Support Team<br>• Clockhouse<br>• Refugee Resources<br>• Elmore Community Services |

## Appendix 6 List of organisations/people who presented to the commission

| **Organisations who presented to the Commission** |
|---|
| **Beginning Well** |
| Perinatal group<br>Brighter Futures Partnership<br>The Oxford Academy<br>Banbury Children's Centres<br>OxSPA<br>Community paediatrics team<br>Yippee Meeting – Oxford Radcliffe Hospitals Patient Participation Group<br>Meeting with Oxford County Council Youth Group |
| **Living Well** |
| Bicester Healthy New Town<br>Luther Street<br>Terrence Higgins Trust<br>West Oxon District Council<br>OxSPA<br>Unipart |
| **Ageing Well** |
| Eynsham Medical Practice<br>Getting the Picture and the Friendleys<br>Age UK<br>Generation Games<br>Healthwatch UK |
| **Cross Cutting themes** |

Housing and homelessness:

- Luther Street Medical Practice
- Connections Floating Support Team
- Oxford City Council

Transport

- Oxfordshire County Council
- Gene Webb – Member of the public

Ethnic inequalities

- Getting the Picture and Chinese Happy Centre
- Asylum Welcome
- Refugee Resource

Benefits:

- CAB

Social Care

- Adult Social Services

Physical and Mental health

- Oxford Health
- Clockhouse (dementia)
- Association for the blind

Other:

The Stroke Association

Elmore Community Services

## Appendix 7: Bibliography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