Oxfordshire's

Joint Strategic Needs Assessment 2008:

Using information to keep people well

Oxfordshire NHS
Primary Care Trust

OXFORDSHIRE COUNTY COUNCIL
www.oxfordshire.gov.uk

Contents

Executive summary 01

1. Introduction 03

What is the JSNA? 03

Why is a JSNA being done? 03

How does the JSNA relate to what's been done before? 05

What will the JSNA enable us to achieve? 06

How has this JSNA informed our priorities? 07

2. Oxfordshire as a place 08

What is Oxfordshire like as an area? 08

What are the implications for people's needs? 10

What is revealed about health inequalities? 11

3. What we know - key findings 13

Reducing premature mortality is a priority 14

Supporting people with long-term conditions is a priority 16

Promoting independence for older people is a priority 20

Improving children and young people's life chances is a priority 23

Supporting people to make healthy life choices is a priority 27

4. Messages from consultation 30

5. How to find out more 33

6. What we are doing next 34

Annex A - JSNA topic based needs assessments 37

Annex B - Methodology 38

Annex C - Caveats on data quality 39

Annex D - How to read the scorecards 42

Annex E - Definition of all the indicators comprising the core data set 43

Annex F - Missing indicators and improvements for next refresh 51

Annex G - Map of the six GP Consortia for Practice Based Commissioning 54

Executive summary

A Joint Strategic Needs Assessment (JSNA) is the means by which the Primary Care Trust (PCT) and local authorities work together to understand the future health, care and well-being needs of their community. This understanding is critical to ensure that services meet the needs of the local population. The knowledge this yields underpins the evidence-based strategic plans that PCTs and local authorities are required to produce. It also informs the Local Area Agreement (LAA) targets and priorities and the Delivery Plan for the Sustainable Community Strategy (Oxfordshire 2030) for the next 3 to 5 years.

The dual aim of this document is to describe what a JSNA is and tell you about the potential of the process that underpins it. This JSNA is the first time such a huge wealth of data has been brought together into a single product shared between both Oxfordshire PCT and Oxfordshire County Council. This combination of health, social care and other data produces much added value and gives us some key messages about the totality of the circumstances in which local people are living. Although there is much that is new about the JSNA, we have had a long-standing legacy in Oxfordshire of making good use of needs assessments and a strong tradition of working jointly across social care and health for adults and children.

The most immediate findings of this JSNA confirm what we already knew about our communities. Generally Oxfordshire is a healthy place, where life expectancy is above average and increasing. Our ageing society is something to celebrate as it has led to an increase in the number of relatively fit and active older people. Many older people want to continue to be active contributors to society in employment, in their families and in their communities. However forecasts show that there will be significant changes to the structure of our population in the coming years. Health inequalities are often, but not always, associated with aspects of deprivation. And these pose additional challenges if we are to continue to improve health and well-being for everyone in the county.

Using the JSNA to dig beneath the surface of this overall picture, the critical importance is to prioritise our combined efforts to address the following key strategic issues:

- *tackling inequalities and breaking the cycle of deprivation;*
- *reducing mortality and improving life expectancy;*
- *responding to an ageing society and the needs of older people;*
- *meeting the needs of those with long-term conditions and improving the availability of mental health services;*
- *improving children and young people's life chances;*
- *increasing healthy lifestyles to prevent and reduce harm (e.g. obesity).*

The knowledge produced by this assessment and the processes around it enable us to ask some important questions such as, have we got our current understanding right? Are there some critical gaps which we need to give more attention? Do we have the right plans and services in place and, if not, what more should we be doing to make life better for local people? This year, we have included information obtained from a number of consultations with local people. In future years, we are planning to integrate this with knowledge gathered from the new ways in which we shall seek to obtain feedback about the JSNA itself.

Local authorities and the PCT will continue to work closely together to combine their efforts to make Oxfordshire a good and healthy place to live. We know from feedback and consultation that this is likely to be welcomed by most people. We see needs assessments as an essential step towards putting local people and their needs at the centre of our planning processes. We also see it as part of a general move towards greater investment in prevention that preserves health and well-being.

The value of the JSNA has already been demonstrated in a number of very concrete ways by informing us to deliver better services that are targeted in the right places, for example:

- *JSNA information was presented to the Strategy & Performance review of Adult Social Care in preparation for budget setting for 2008-09;*
- *JSNA findings were presented in a PCT Planning workshop to help inform investment, disinvestment and/or service improvement priorities for 2009-10;*
- *Data from the JSNA was used by the PCT Trust Board (April) to help determine the location of a new walk-in, GP-led health facility;*
- *Community Development for Older People are putting additional resources into six wards where need has been revealed as highest;*
- *The PCT has used the JSNA to inform its review of the PCT Operational Plan;*
- *JSNA data was used to support an Extra Care Housing grant bid to the Department of Health. South Oxfordshire, Vale of White Horse and West Oxfordshire district councils have also used joint analysis of housing needs to develop their Extra Care Housing provision. Cherwell District Council used JSNA data to assist in its housing needs analysis;*
- *JSNA data was requested in May 2008 to inform the planning and development of services provided via the Mental Health pooled budget;*
- *In June 2008, a Service Manager used JSNA information to help her identify the training needs for Home Support staff.*

This assessment raises the awareness of the core data set. It outlines some of the key health and care messages about our local population that are captured by this information. This should give you a flavour for the type of analysis that is possible and how this can help inform service planning, change, improvement and decision making. We hope you will be encouraged to find out more and to think about how else you can use the core data set in your work.

John Jackson - *Director for Adult Social Services, Oxfordshire County Council*

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Alan Webb - *Director for Commissioning, Oxfordshire Primary Care Trust*

More information about the JSNA and its core data set can be found on the Health and Well-Being Partnership website: www.oxfordshirepartnership.org.uk/wps/wcm/connect/OxfordshirePartnership/Partnerships/Health+and+Well-Being+ Partnership/

If you want to request information or give us feedback please email or telephone using the contact details below: *Email:* ***JSNA@oxfordshire.gov.uk*** *Telephone:* ***01865 337016.***

1. Introduction

What is the JSNA?

The aim of this document is to describe some of the key messages about the circumstances in which local people are living. It will explain how those messages have been produced and the processes involved, along with what it is that constitutes the JSNA core data set. It will also tell you what else the core data set can do and the range of possibilities that it opens up to help inform decision making. Section 5 gives details about how to use even more of the data that has been captured.

Behind the JSNA is a process that **identifies current and future needs in relation to health, social care and well-being**. It compares these needs with the pattern of existing services **to inform future service planning** so that more people can stay healthy and well. In turn, this will begin to identify any gaps in current care provision, or where existing services are not delivering the desired outcomes for our patients. It is designed to inform and drive future investment priorities and thereby enable commissioners of services to:

- *take into account evidence of effectiveness;*
- *achieve a shift towards services that are personal and sensitive to individual need and that maintain independence and dignity;*
- *produce a strategic reorientation towards promoting health, social care and well-being, by investing in preventative measures now to reduce future ill health costs.*

To create this JSNA a systematic method for reviewing needs has been developed. This enables shared priorities to be agreed by those who provide and commission services for improving health, social care and well-being outcomes. It is very much focused on finding out where needs are greatest so that resources can be better targeted and in this way reduce the inequalities that exist. The process is designed to build stronger partnerships between communities, local government, and the NHS – a vision reinforced in the cross sector concordat *'Putting People First: a shared vision and commitment to the transformation of adult social care (2007)'*.

Why is a JSNA being done?

The PCT and the county council believe that a great number of benefits flow from jointly carrying out assessments of need at a strategic level. For example, it begins to identify where further work is required to improve our health. Even more importantly, it puts local people and their needs at the centre of planning and means we focus on things that really concern the local community. It helps to establish shared priorities and increases the extent to which intelligence concerning health and social care is joined up. It provides a joint data set upon which the PCT, the county council and other local authorities can plan services together. This means that when gaps in provision are identified agencies can work together to close those gaps.

The JSNA process has resulted in easy access to a shared core data set which can be built on in future years, alongside other analysis and benchmarking. It develops baselines and benchmarks for ongoing trend comparisons and defines meaningful correlations between indicators, which improves understanding about how best to target resources and make improvements in future. Gaps identified in the core data set have been helpful in recognising the future developments that are needed as part of the assessment and where more relevant information can be added in a systematic manner. Having such a large amount of comparative data

enables localities and GP practices to see where they might differ from the majority and to decide whether any action is needed to deal with this. For example, a practice may have a population more susceptible to a specific illness, or a locality may have a lot of births and want to invest in more maternity services.

The effectiveness of JSNA arrangements will be one of the means by which the government evaluates local activities. The JSNA was first proposed in the *Commissioning Framework for Health and Well-being*. Later guidance was published in Dec 2007 alongside the *NHS Operating Framework* that clarified the close fit of the NHS with wider public sector performance frameworks for the next three years. It also cross references '*Our Health, Our Care, Our Say: a new Direction for Community Services*' and Guidance on the Children and Young People's plan.

The Local Government and Public Involvement in Health Act (2007) changes the statutory landscape upon which the new local performance framework, and in particular new LAAs, are founded. The Act includes provisions for:

- a duty on local authorities and PCTs **to undertake a joint strategic needs assessment of the health and well-being needs of the local community;**
- a duty on the local authority and named statutory partners (including PCTs, NHS trusts and NHS foundation trusts) to **co-operate with each other in determining LAA targets, of which up to 35 will be national priority targets agreed with central government;**
- a duty on those partners to **have regard to those targets they have agreed;** and
- the establishment of the new local involvement networks (LINks) which will help ensure local communities have a stronger voice in the process of commissioning health and social care. LINks will also be a key mechanism for PCTs to discharge their duty to involve and consult.

Further information

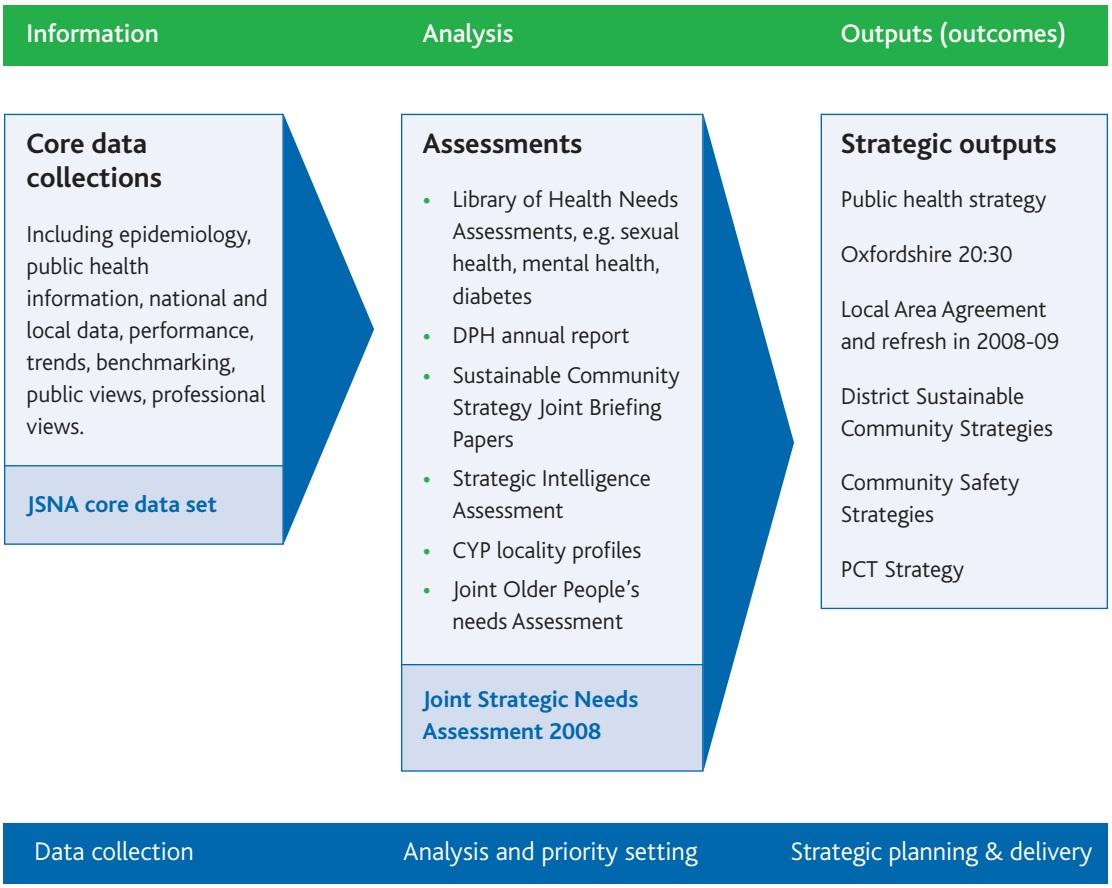
To download the publication go to the relevant website address.

The specific duty to undertake JSNA is set out in Section 116 of the Local Government and Public Involvement in Health Act (2007), and described in draft statutory guidance 'Creating Strong, Safe and Prosperous Communities'.

How does the JSNA relate to what's been done before?

The principle of using core data collections to inform priority setting is well established in the county, as illustrated in Figure 1. The JSNA (2008) is the latest in a series of assessments, data sets and consultations that have informed joint strategic planning.[1] This is the first document that has been produced since the publication of Department of Health guidance on JSNA and is therefore the first to take this title. Although the principle of using needs assessments to inform planning and commissioning is not new, the power of the JSNA lies in its level of detail, comprehensiveness and that it is a collaborative undertaking. Working closely together in this way means that for the first time there is a common and consistent evidence-base across health and social care.

Figure 1 - Assessments informing strategic planning.



[1] *Annex A lists a few of the key documents produced by this approach in Oxfordshire to date.*

What will the JSNA enable us to achieve?

Ultimately, every locality should seek to have a single support system for local people based in their community and focussed on their health and well-being. A system that binds together local government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice, education and training. Our ambition is that the JSNA is a means to achieving such a system.

The process helps to identify the "bigger picture" by drawing on a wide range of information and data sources - including:

- the structure of the population and how it is changing;
- socio-economic factors that influence health (e.g. unemployment, housing condition, deprivation);
- education attainment levels;
- lifestyle choices; as well as the
- accessibility and effectiveness of health services and access to social care.

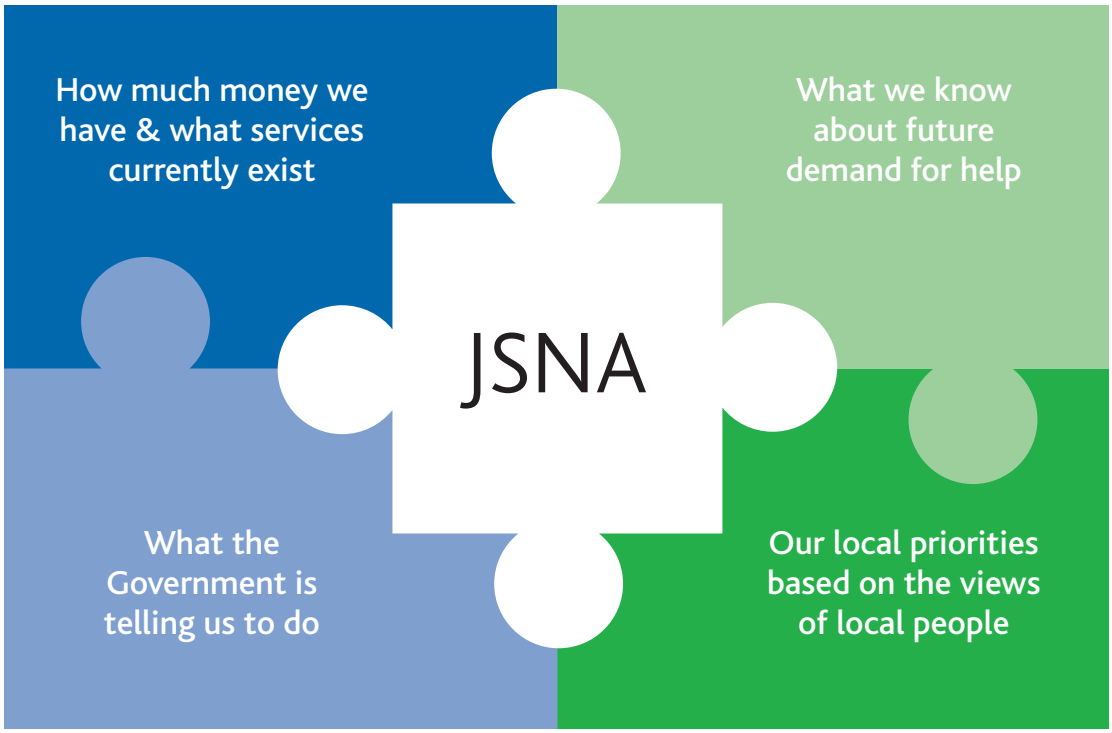
It is estimated that as little as 10% of the causes of health inequalities fall within the direct influence of the NHS. In other words, the determinants of health and well-being are hugely varied and cut across the responsibilities of almost all the bodies comprising the public and other sectors. It is essential that any response is delivered in partnership. Sharing data will help to identify issues that can be tackled jointly.

The NHS, both nationally and locally, is moving away from its concentration on being a reactive 'sickness treatment' service; it is becoming a proactive 'health and well-being' service. The JSNA will bring about the following benefits for local people:

- *provide analysis of data to show the health and well-being status of local communities and identify where inequalities exist and what the major health risks are;*
- *identify where gaps in unmet need within localities or wards exist;*
- *use local community views and evidence of effectiveness of interventions to shape the future of local services;*
- *define achievable improvements in health and well-being outcomes for the local community;*
- *provide information to existing and future providers of services about potential service changes;*
- *identify opportunities to promote healthy lifestyles;*
- *support the delivery of better health and well-being outcomes for the local community;*
- *inform the next stages of planning and aid better decision-making; and*
- *feedback its findings to the local community using various publications and other means.*

These will form the basis of criteria by which we can evaluate the JSNA and make judgements about its success. Ultimately it is a means to establish if we are spending our resources in the right way. In fact Oxfordshire PCT has already undertaken further analysis on the JSNA data set findings to inform its health strategy. A presentation (available on the Health and Well-Being Partnership website) has been complied which looks at trends in health improvement, the strategic challenges facing health organisations and benchmarked performance against national targets and indicators at a national and local level.

Figure 2 - Are we spending your money on the right things?



How has this JSNA informed our priorities?

The main findings from this Joint Strategic Needs Assessment are discussed in Section 3. In many ways these confirm preceding assessments derived from recent work to analyse locally held data and point to a number of issues which must remain as important local strategic priorities to improve health, prevent illness and reduce health inequalities:

- *reducing premature mortality and improving life expectancy;*
- *meeting the needs of those with long-term conditions;*
- *responding to an ageing society and the needs of older people;*
- *improving children and young people's life chances;*
- *increasing healthy lifestyles and breaking the cycle of deprivation.*

The next section puts these priorities in context by providing an overview of what Oxfordshire is like as a place in terms of health and well-being. A short commentary is included to emphasise the implications these local circumstances have for health and social care.

2. Oxfordshire as a place

What is Oxfordshire like as an area?

Oxfordshire is a predominantly rural county in which approximately 630,000 people live. Indeed, the county is the most rural in the South East region and West Oxfordshire is one of the region's least densely populated districts. Over 50% of the population live in settlements of less than 10,000 people. There are also urban areas, such as Oxford and Banbury.

The county is best described as a mix of areas with distinctive characteristics as follows:

- Urban Oxfordshire – Oxford city;
- Major towns – Banbury, Bicester, Witney, Abingdon, Didcot;
- Market towns – 19 smaller towns serving rural communities;
- Rural settlements – villages, hamlets and isolated dwellings.

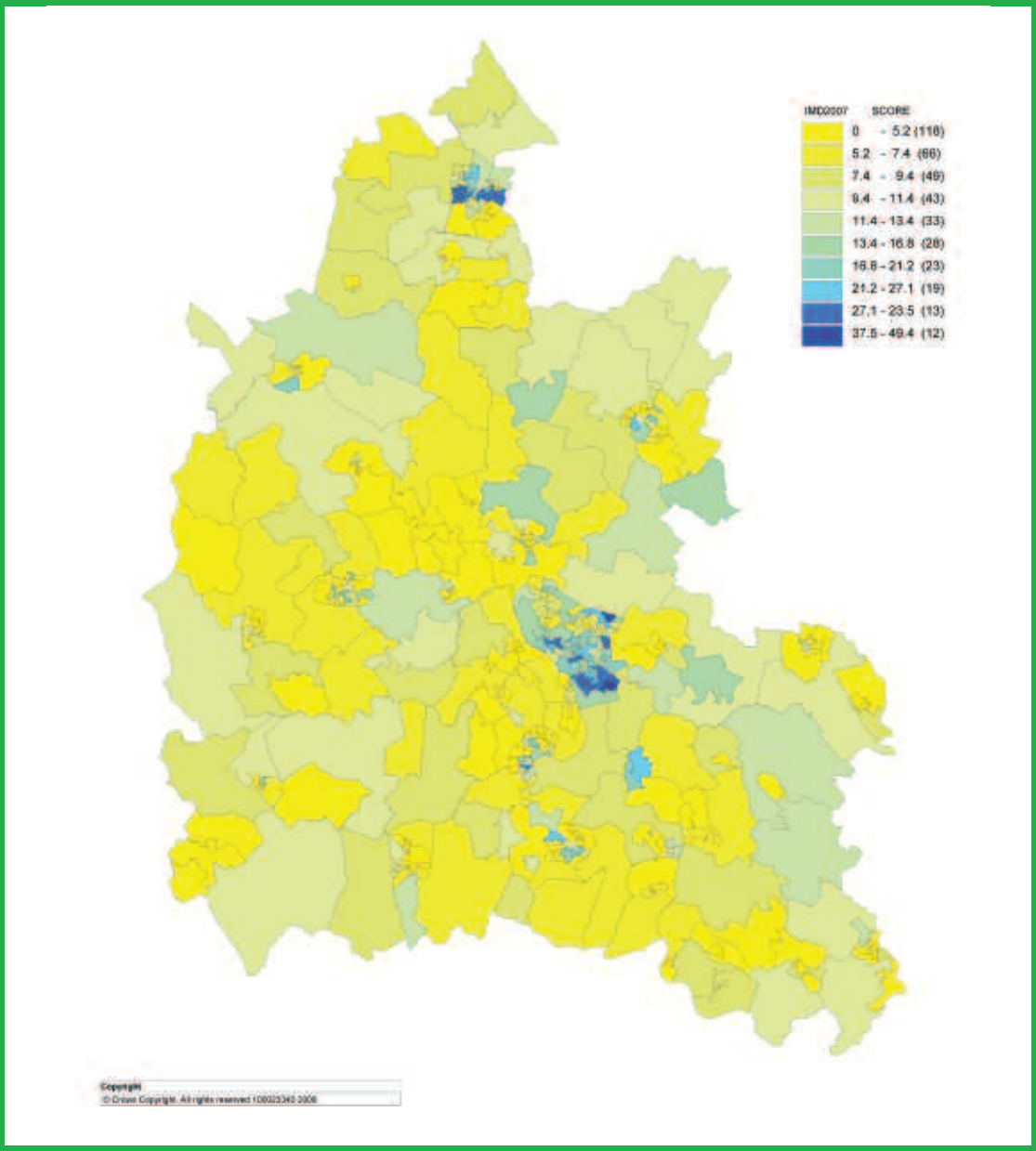
Future population growth in the county is expected to be concentrated around Banbury, Bicester, Didcot, Witney and Wantage, where several thousand new homes will be built over the next 15 to 20 years.

Health and well-being in Oxfordshire has been improving for many years. In general the population is healthy and compares well with the South East region and the rest of the country. The recent publication of Health Profiles for district areas highlighted the generally good health of the population. This message is reinforced by steadily increasing life expectancy which, on average, has gone from around 79.1 years (1998-2000) to 80.7 years (2004-06). The rate of improvement in longevity is in line with that across the country; average life expectancy in Oxfordshire is now 1 year 3 months longer than the rest of England.

Data from the Index of Multiple Deprivation (IMD) shows that Oxfordshire is overall relatively well-off and on average it scores better than most places. However, the distribution of income amongst the local population is very uneven. Closer inspection reveals inequalities of outcomes affecting particular parts of the county. This is well illustrated by the contrast in overall deprivation; the majority of Oxfordshire areas are in the least deprived quartile for England however, there is 3% of the county that features in the most deprived. Most of these pockets of deprivation are in Oxford and Banbury.

When deprivation is broken down into specific dimensions, Oxfordshire has many more areas that feature in the least rather than the most deprived quartile nationally. The exception to this being the 'barriers to housing and services' measure of deprivation, where a higher percentage of Oxfordshire areas are in the most deprived national quartile than in the least deprived. These figures also show that there are three times as many areas that feature in the most deprived quartile for 'education and skills' than there are for deprivation as a whole, meaning that this is the second most significant aspect of deprivation locally.

Figure 3 - Index of Multiple Deprivation in Oxfordshire (2007).



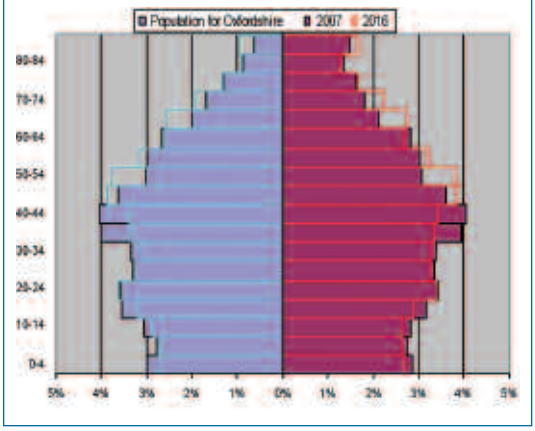
Improvements in income and health care and healthier lifestyles have led to improved longevity which, combined with declining fertility, means there is a profound shift in the structure of our population. Population projections show that the adult population (18-65 years) is set to remain broadly at the same level as today. However, the number of older people will continue to grow, most notably in rural districts (the exception is in Oxford city). It is estimated that by 2010, there will be nearly 15,000 people aged over 85 years in Oxfordshire, and there will be over 24,000 by 2028. The increase in the numbers of older people may result in more people needing support to remain independent in later life. In contrast, the number of children under 10 years in the county is expected to decline. This partly reflects the reduction in the number of women of child-bearing age as the post-war 'baby-boom' generation grow older.

Changes can be seen in the population pyramids at Figure 4, which show the effect of a low birth rate, combined with increasing longevity. Over time, fewer children and greater numbers of older people (males on the left, females on the right) produces a much more rectangular shape, as opposed to the more traditional triangle or pyramid.

The ageing of our population is something to celebrate. It represents a great success for our society that people can live healthier and longer lives.

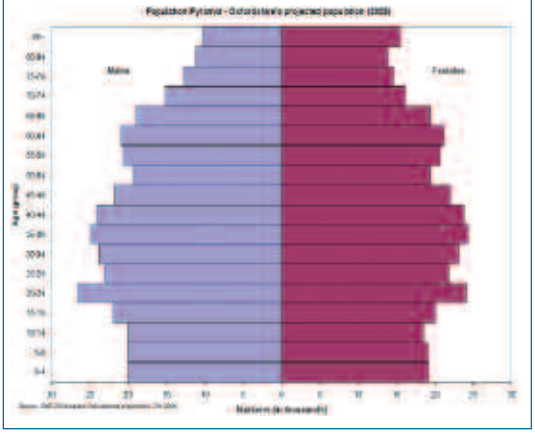
Figure 4 - Oxfordshire population pyramids.

2007-16



Source: 2007 OCC GLA forecasts

2029



Source: ONS 2004-based Sub-national projections, Oct 2006

What are the implications for people's needs?

Rural areas of Oxfordshire tend to have higher proportions of older people for whom rural transport can be a focal issue. By contrast, Oxford city is a densely populated, diverse, urban area. Oxford has higher levels of migration, including residents born outside the UK, and Black, Minority, Ethnic (BME) communities than rural districts in Oxfordshire. This mix of urban and rural and the inequalities of outcome, with specific areas of the county having significant levels of deprivation, demonstrates that one size will not fit all and there is a need to plan appropriate initiatives in different parts of the county.

Older people are more likely to suffer from the effects of poverty and experience social exclusion due to a range of factors such as reduced social contact, poor health, low income, lack of mobility and abuse. Whilst children and young people who experience deprivation find it is harder to get the same start in life as those living in more prosperous circumstances. Poverty for all age groups is often strongly correlated with poor health and lower life chances. Life expectancy in more deprived wards is significantly lower compared with the county as a whole.

Long term conditions (such as, learning disability, cystic fibrosis, diabetes, coronary heart disease, stroke, acquired brain injury, mental health disorders, etc.) continue throughout life and though they can be controlled by medication and other therapies, they cannot always be cured. They may occur at any age but their incidence increases with age. The numbers of people with a learning disability and younger physically disabled people is increasing year on year as young people with complex conditions survive into adulthood and, in line with the rest of the population, benefit from increased longevity. People with long term conditions are the major users of health and social care. They account for 55% of GP consultations, 68% of outpatient and A&E appointments and 77% of inpatient bed days. People with mental health problems and/or learning disabilities are more likely to experience major illness. They are more likely to develop serious health conditions at an earlier age and to die from these conditions sooner than other people. High rates of obesity were found nationally in people with mental health problems. Black and Minority Ethnic (BME) groups have worse health than the general population nationally.

There are some implications for health and social care arising from the characteristics of Oxfordshire's population:

- *the diversity of Oxfordshire means different solutions for different needs/ areas;*
- *the ageing population, especially in smaller rural communities, means there are more people potentially needing support;*
- *nearly 9% of the population in the county are unpaid carers, many are aged over 65 years and provide over 50 hours care to a relative per week;*
- *long term conditions are increasing; for example, there are over 20,000 people with diabetes in Oxfordshire and the numbers are rising;*
- *the number of people with a significant learning disability is expected to increase by 80 people per year in Oxfordshire;*
- *obesity rates are rising across localities and age groups.*

Attention needs to be given to both primary prevention (stopping people becoming ill) and secondary prevention (preventing complications of existing long term conditions).

What is revealed about health inequalities?

By a range of measures relating to health and well-being, Oxfordshire (like most areas in the country) is a county of some variation. The same group of wards tends to come to the fore as having the poorest health and well-being, as a number of indices reflects. In general, many of these areas tend to be the ones with the highest proportions of people from minority ethnic groups and to be the wards with the greatest levels of deprivation. Some components of health and well-being have a very strong relation to deprivation. These include shorter life expectancy, increased likelihood of mental illness, greater prevalence of circulatory disease and infectious respiratory disease and lower take-up of preventative services like cancer screening.

If the worst health outcomes are compared with the average outcomes for Oxfordshire as a whole, the following inequalities are revealed:

- *life expectancy 2 years 10 months lower;*
- *overall mortality rate is one third higher;*
- *the death rate from stroke is over one fifth higher;*
- *the death rate from all circulatory and all infectious respiratory diseases in people under 75 is approximately 50% higher;*
- *the death rate from cancer in people under 75 is almost one fifth higher;*
- *the number of hospital admissions for broken bones as a result of falls is 40% higher;*
- *the number of hospital admissions for injuries to young people is one third higher;*
- *the number of people with a long term illness is almost a quarter higher;*
- *recorded prevalence of smoking is just under one fifth higher;*
- *the prevalence of mental illness in people over 18 years is more than double;*
- *the proportion of children and young people living in poverty is nearly 75% higher;*
- *the proportion of people living in rented council housing is three times as high;*
- *the proportion of older people living without central heating is 40% higher.*

The persistent levels of deprivation suggest that the demand on health and social care services will remain high. Long-term engagement with all of the communities in Oxfordshire is necessary to develop a culture that seeks health through a social and physical environment that supports being more physically active, being more in control of health improvement and taking fewer risks to health. Greater insight is required into the use of services, including screening and health improvement services, among minority ethnic groups to inform the delivery of appropriate and culturally sensitive services.

By looking at wards in the lowest quartile, both by rate of referrals into Adult Social Care amongst the over 65s and the measure of overall deprivation, 11 Oxford city wards and a mixture of rural and urban areas have lower than normal rates, and are yet relatively deprived. This suggests that the need for services is not closely matched with actual referrals to social care. However the correlation between these two factors is classed as weak. The companion wall chart to this JSNA (available separately) provides a visual, albeit general, representation of the extent to which the provision of services matches levels of need. Inequities in service provision can then be tracked over time to observe progress.

This section has given a flavour of what Oxfordshire is like. The next section of this assessment will focus on what the data suggests are key priorities that need to be addressed to see a noticeable improvement in health and well-being across the county and to narrow the gaps of inequality.

3. What we know - key findings

The preceding section shows how the core data set that sits behind the JSNA has been used, alongside information from other sources, to give a general account of the health and care needs of communities in Oxfordshire. The following section begins to unpick some of the messages produced from the core data set to see what can be learnt about a selection of pressing needs. The needs examined in this first analysis of the data have been grouped into a number of priority areas and these address the following questions.

3a. What are people dying from?

3b. What health conditions are people living with?

3c. How many people are over 75? What difficulties do they have?

3d. How many children are living in poverty? Where do they live?

3e. What lifestyle issues pose risks to well-being now and in the future?

3a. What are people dying from?

This section looks at issues to do with life expectancy and common causes of death in Oxfordshire. Life expectancy is commonly measured by PCTs across the country through a proxy indicator known as 'all age all cause mortality'. This indicator means that populations with different age-structures can be compared between areas and through time. Although they are not exactly the same, if all age all cause mortality rates improve, then life expectancy will improve.

Figure 5 - Causes of death in Oxfordshire PCT, 2006.

Cause of death (broad heading)	Number of deaths	As a % of total deaths
Diseases of the circulatory system	1,593	32.2%
Cancers	1,411	28.5%
Diseases of the respiratory system	624	12.6%
Diseases of the digestive system	275	5.6%
External causes (including accidents)	202	4.1%
Diseases of the nervous system	179	3.6%
Mental disorders (e.g. dementia)	145	2.9%
Diseases of genitourinary system	101	2.0%
Other	414	8.4%

Source: Annual District Deaths Extract (ADDE) for Oxon PCT, 2006.

Reducing premature mortality is a priority

All age all cause mortality rates in Oxfordshire are better than the average for England. They are approximately 8.5% lower. Improvement in male mortality in Oxfordshire is down from 820 deaths per 100,000 population in 1996, to 652 per 100,000 in 2006. This represents a 20% reduction over this period. Improvement in female mortality in Oxfordshire is down from 541 deaths per 100,000 in 1996, to 451 per 100,000 in 2006. This represents a 17% reduction over this period.

Heart disease, hypertension and stroke, which are all classified as diseases of the circulatory system, are the most common cause of death for both men and women in Oxfordshire. Almost a third of the population will die from these conditions. Cancer and diseases of the respiratory system are the other significant causes of mortality, killing at least 4 out of every 10 people. It is also notable that diseases of digestion, including liver cirrhosis, have been increasing over time as an important cause of ill health and mortality. This is probably related to levels of alcohol consumption having increased over a long period.

From 1996 to 2006, mortality rates from all circulatory diseases in people under 75 years have been better (i.e. lower) in Oxfordshire than in England, and have reduced by 45%. This means that for Oxfordshire PCT performance in this area was broadly equivalent with reductions for England as a whole. Over the same ten years, mortality rates from all cancers in people under 75 years were also better (i.e. lower) in Oxfordshire than in England. However, the rate of improvement for mortality from cancer was 11%, compared with a reduction of 19% for

England as a whole. In other words, the rest of the country is rapidly becoming as good as Oxfordshire has been.

Premature mortality is measured in terms of the number of years lost for each person who dies under the age of 75 years old. Many of the causes of premature death are correlated with levels of deprivation. Breast cancer is one of the few conditions where there is an inverse correlation to deprivation levels. High incidence & mortality in breast cancer needs further investigation. In terms of absolute numbers, deaths from undetermined injury and especially suicide are low. Mortality rates from undetermined injury and suicide have fluctuated; often being lower in Oxfordshire than the national average, occasionally in some years they have been higher.

The JSNA data is broken down to the level of individual wards and GP practices. This enables very local comparisons to be made. There are early signs that the inequalities gap in Oxfordshire has begun to close. The latest figures show that the gap in death rates between the best 20% of wards and the worst 20% of wards has narrowed slightly in recent years. This suggests progress is on track to meet the 2010 target for narrowing this gap by a reduction of 10% from rates recorded in 2002.

There will still be a significant variation of approximately 40% between the best and worst quintile for mortality rates. The preceding commentary has considered life expectancy at birth. When additional life expectancy at age 65 is examined, results range from less than 15 to over 32 further years.

This section has given a very broad overview of some of the key messages to have come out of the JSNA about the sorts of conditions that people are most likely to die from in Oxfordshire. The next section looks at what we know about the most common conditions people are frequently living with that may give rise to long-term health and social care needs.

3b. What health conditions are people living with?

This section reviews a number of the most significant long-term health conditions also referred to as life 'limiting long-term illnesses' (LLTI). People with these conditions are major users of health and social care, accounting for 55% of GP consultations, 68% of outpatient/ A&E appointments and 77% of inpatient bed days. The first piece of analysis (Figure 6) looks at variations across the 5 districts in Oxfordshire; instances where the district average for a particular measure varies by more than 10% above (pink) or below (green) the average for the whole county are highlighted. It is critical to understand more about these differences.

Figure 6 - Differences by district in long-term care needs.

Long-term conditions	Whole county	Cherwell	Oxford	South Oxon	Vale of White Horse	West Oxon
Proportion of people over 65 with a limiting long-term illness in 2001	41.7%	42.0%	45.1%	40.6%	41.2%	39.6%
Proportion of all people referred to social care in 2006/07	1.4%	1.3%	1.3%	1.5%	1.4%	1.4%
Proportion of social care clients with learning disability in 2006/07	0.20%	0.21%	0.20%	0.19%	0.20%	0.21%
Proportion of social care clients with a mental health diagnosis in 2006/07	0.31%	0.26%	0.46%	0.29%	0.26%	0.26%
Proportion of other vulnerable clients in 2006/07	0.03%	0.02%	0.06%	0.03%	0.02%	0.03%
Proportion of households with a single pensioner resident in 2001	12.9%	11.5%	14.3%	12.9%	12.5%	13.4%

Supporting people with long-term conditions is a priority

The JSNA is rich in demographic data and an attempt is made to use this information to understand how the prevalence of a condition may change in the future. This section also reviews information about carers living in Oxfordshire. The provision of care by family members, or neighbours, is essential to improve the quality of life for many people with long-term conditions.

Based on these differences, some observations are that the highest general referral rates into social care for adults are from South Oxfordshire, with a rate of 1.5% compared with the county average of 1.4%. Referral numbers are moderately correlated with the rates of older people living alone. Some of the highest rates of older people living alone are in the relatively prosperous areas of the south of the county. Information about housing tenure shows that older people in socially rented accommodation are proportionally more likely to have some form of LLTI than those in owner occupation. Limiting long-term illness amongst the over 65s is typically highest in Oxford city with almost 46% of the population in this category; the lowest being in Cherwell, with just under 40%.

By 2016, it is forecast that there will be over 8,000 more people aged over 65 years old living with long-term conditions, if current rates continue. The

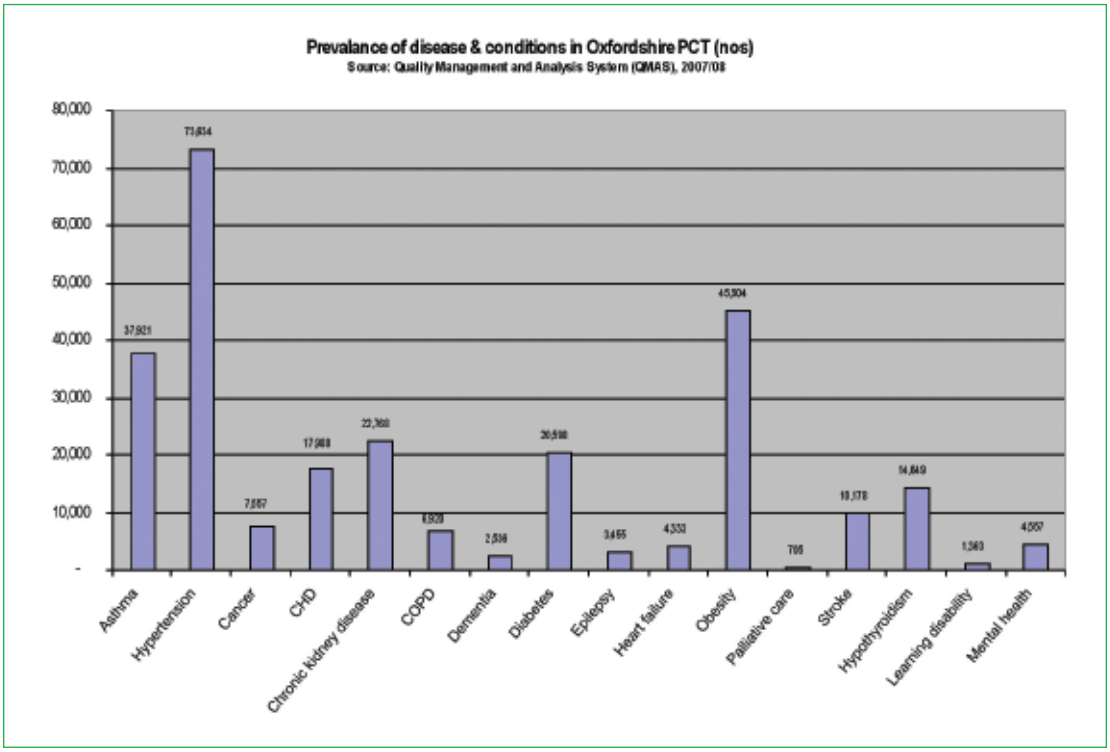
implication of this rise in the number of people living with LLTI and chronic conditions will be a greater demand for care that requires a response from services that are community based, primary care led and integrated with social care. When looking at specific areas with high proportions of people living with a long-term condition (over 40%) and cross-referencing them with those wards that have a higher than average projected growth in the proportion of their population aged over 65 (above 25%), 25 wards (Figure 7) are identified as potential places where these needs are most likely to grow.

The chart below (Figure 8) shows the number of people registered with the most common long-term diseases or conditions.

Figure 7 - Wards with high potential growth in needs due to LLTI.

West	Witney West; Witney North; Carterton North West; Bampton and Clanfield; Ducklington;
Vale	Wantage Segsbury; Shrivenham; Marcham and Shippon; Longworth; Greendown
South	Woodcote; Thame North; Garsington; Didcot Northbourne; Chinnor; Chalgrove; Benson
Cherwell	Launton; Kidlington North; Hook Norton; Bicester West; Bicester East; Banbury Ruscote; Banbury Hardwick; Banbury Calthorpe

Figure 8 - Prevalence of diseases and conditions in Oxfordshire.



The information shown in Figure 8 is broken down further in the table at Figure 9 to show the proportion of patients in each of the 6 Practice Based Commissioning localities that are on the patient register for that disease or condition. Those blocks coloured green show prevalence rates below the middle quintile for the county, those in red have rates above the middle quintile. For example, 6.5% of patients in West Oxfordshire practices are identified as having asthma, which is more than 10% above the county average.

Caution must be taken when interpreting these figures. Some practices that have older people registered may have more patients with specific diseases, for example dementia, whilst those practices with younger families registered may have higher rates of learning disability. A more detailed analysis which combines these figures

Figure 9 - Prevalence of diseases and conditions in Oxfordshire.

	North East Oxfordshire	North Oxfordshire	Oxford City	South East Oxfordshire	Vale	West Oxfordshire	% for whole county	Total numbers
Hypertension	11.3%	12.0%	8.3%	12.8%	11.7%	12.9%	11.0%	73,634
Obesity	8.6%	7.0%	9.4%	5.6%	3.7%	4.3%	6.8%	45,504
Asthma	5.9%	6.0%	4.7%	6.3%	5.8%	6.5%	5.7%	37,921
Kidney disease	4.7%	3.9%	2.1%	3.0%	4.6%	3.0%	3.4%	22,768
Diabetes	4.5%	2.8%	4.5%	2.5%	1.6%	1.3%	3.1%	20,598
CHD	2.8%	2.9%	2.1%	3.1%	2.9%	3.0%	2.7%	17,980
Hypothyroidism	3.0%	2.1%	3.1%	2.0%	1.1%	0.9%	2.2%	14,649
Stroke	2.3%	1.4%	2.3%	1.2%	0.7%	0.5%	1.5%	10,178
Cancer	1.3%	1.1%	0.9%	1.4%	1.1%	1.3%	1.1%	7,557
COPD	1.6%	0.9%	1.6%	0.8%	0.5%	0.4%	1.0%	6,920
Mental health	1.0%	0.7%	0.9%	0.6%	0.4%	0.3%	0.7%	4,557
Heart failure	0.9%	0.7%	0.9%	0.5%	0.3%	0.3%	0.6%	4,333
Epilepsy	0.8%	0.5%	0.7%	0.4%	0.3%	0.2%	0.5%	3,455
Dementia	0.7%	0.3%	0.5%	0.3%	0.2%	0.2%	0.4%	2,536
Learning disability	0.3%	0.2%	0.3%	0.2%	0.1%	0.1%	0.2%	1,363
Palliative Care	0.1%	0.1%	0.2%	0.1%	0.1%	0.0%	0.1%	705

Source: Quality Management and Analysis System (QMAS), 2007/08.

with demographic data will give more meaningful results. Whilst bearing in mind these cautionary caveats, and that some practices are better than others at recording such information, there are a number of immediate observations that can be made.

Hypertension (high blood pressure), obesity, asthma, kidney disease and diabetes are the most common conditions. Demand for services which address the needs of people living with these problems will be highest. This is true for all 6 consortia. It is also interesting that Oxford City GP Commissioning Consortium is almost a mirror image of South East Oxfordshire and West Oxfordshire consortia. In other words, those conditions that are lower than the middle fifth for Oxford, are higher than middle fifth for the two more rural practice consortia. And conversely, hypertension, asthma, coronary heart disease, and cancer, which are all above average in South East and West Oxfordshire consortia, are lower than average in Oxford.

The similarity between North East Oxfordshire and Oxford is also striking, which may perhaps reflect the fact that Bicester and Kiddlington share many of the same urban characteristics as Oxford. However there are still differences, most notably levels of asthma, hyper-tension and coronary heart disease (CHD) are much closer to the average for the county, whereas in Oxford all 3 conditions are less prevalent.

North East Oxfordshire consortium has to deal with higher rates of dementia. This may be due to better diagnosis rather than greater actual prevalence but it does suggest that links with social care need to be well developed in this area. The North East consortium also has the highest rates of kidney disease and epilepsy. North Oxfordshire is most often in the middle quartile for the county, although it has higher than average levels of heart failure and kidney disease and lower than average rates of dementia.

The predominantly rural practices consortia of South East, Vale and West Oxfordshire have very similar populations to each other where long-term conditions are concerned. They have an above average number of patients living with hyper-tension, asthma, heart disease and cancer, and below average numbers for almost all other conditions.

For some conditions, notably breast and cervical cancers, prevention and early intervention are highly effective. If an overall screening coverage of 80% can be achieved, the evidence suggests that a reduction in death rates from cervical cancer (around 95%) is possible in the long-term. The uptake of cervical screening in the PCT in 2006/07 was 78.6%, this reveals over one fifth of women who would benefit from cervical cancer screening are not doing so. This falls below the national target of 80% of eligible women (aged between 25-64 years) to be tested within the last 5 years. Forty (out of 82) GP practices in Oxfordshire failed to achieve above 80%. It is a priority to increase the number of women participating in cancer screening programmes in Oxfordshire. There are shared characteristics between women who are not being tested, that are identifiable from the data but the reasons why they do not attend are poorly understood. The barriers to screening need to be identified and removed.

Immunisation is another vital preventative measure. In September 2008, a national programme to implement the Human Papilloma Virus Vaccination for girls aged 12-13 years will be implemented by Oxfordshire PCT through its school nursing service. This aims to immunise 86% of girls in the first year rising to 90% in 2010. Screening will still be required as this public health initiative will protect against some, but not all, of the viruses that cause cervical cancer.

The prevalence of most mental illnesses is set to increase over the next decade by 3-4%. In particular the number of cases of psychosis over the age of 35; the number of people with obsessive compulsive and panic disorders as well as the prevalence of people with personality disorders. Up to 20% of the PCT's population are affected by common neurotic symptoms such as sleep problems, fatigue and anxiety, these do not meet the threshold for a diagnosis of mental illness. These symptoms are also expected to increase by up to 3% in the next decade, especially amongst those over the age of 50 years. The prevalence of mild to moderate mental illness in adults of working age is significantly higher in Oxford (4.6 per 1,000 population) compared to the prevalence in the other remaining districts (2.6 per 1000 population). This means the mental health needs within the city are dramatically different compared with the rest of the county.

In addition, mental health service users in Oxford report the most difficulty in obtaining suitable housing and employment to enable their reintegration into the community. Also of note, is the fact that Oxford has the highest concentration of people of ethnic minority origin who have been shown to have higher mental health needs and have more difficulty accessing formal mental health services. These factors impact on an individual's chances of recovery. Access needs to be improved to talking therapies, especially cognitive behavioural interventions which can be shown to achieve efficient and effective benefits, even online. Another finding is that, outside of the city, carers in Cherwell report the greatest burden of unpaid caring responsibility (over 50 hours per week) this is a known risk factor for mental illness.

Although not the largest group of people with a mental disorder, those with dementia will see the largest increase in numbers, as a result of an increasingly ageing population, in particular people aged 75 and over. The service costs associated with dementia are far higher than all other conditions put together. They currently make up 66% of all mental health service costs; by 2026 it is estimated that they will make up 73% of all mental health service costs (at 2007 prices). Numbers of people with dementia are projected to increase from 580,000 to 940,000, an increase of 62% to 2026.

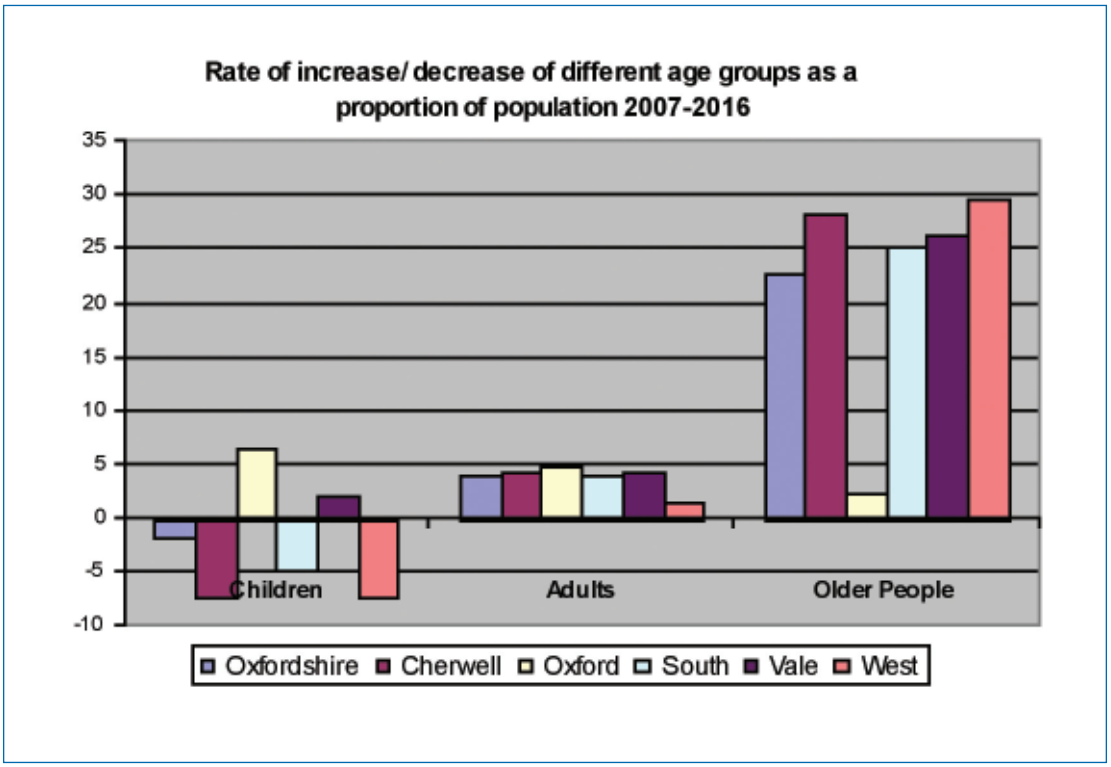
It has long been recognised in Oxfordshire that carers (unpaid relatives, friends and neighbours) are increasingly providing a significant proportion of care, helping people to remain living at home; coupled with this it is recognised that caring for others can have a detrimental impact on health and well-being. Research by Carer's UK suggests that as many as one in five carers give up work. Such messages reinforce the importance of continuing to invest in those services developed through the Oxfordshire Carers Strategy, that support people to care and provide them with breaks.

This section has considered some of the evidence with regard to long-term conditions and has demonstrated a strong correlation between their prevalence and older age. The next section examines some of the key messages around ageing and older people.

3c. How many people are over 75? What difficulties do they have?

This section examines what is known about the age profile of local communities and considers how this may affect the needs people have. Oxfordshire's ageing population means the number of older people is increasing, particularly amongst the over 75s.

Figure 10 - Rates of change in population proportions.



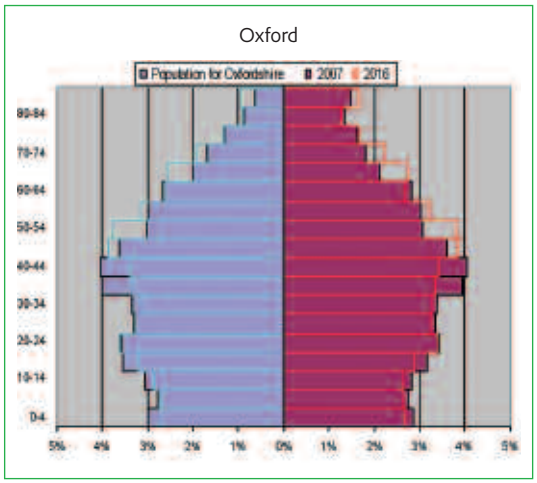
Promoting independence for older people is a priority

This increase in the older population will be uneven across the county, with the southern half of the county expected to show the largest increase in numbers. This area already has higher proportions of older people than average. The over 65s amount to more than 17% of the current population in West Oxfordshire and growth in the over 65s over the next 5 years is set to be highest in this district.

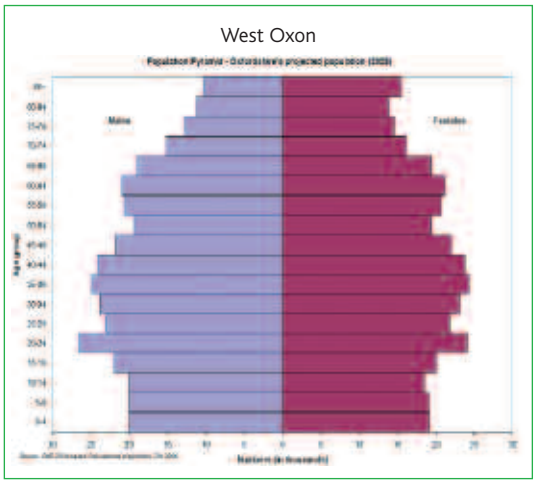
Looking further forward, population projections show the over 85s population in Oxfordshire during the next 25 years will more than double; this means an increase of more than 14,000 people in this particular age group. These are the people most likely to be frail and in need of the greatest care; the specific impact of this oldest of all age groups is highest in Cherwell.

In Oxford, by contrast, the over 65s make up just 11% of the population, with a net fall predicted over the next 5 years. Projections show the lowest impact of over 85 year olds again in Oxford City. These forecasts combine to strengthen the structural difference in age profiles across the county. These differences are starkly revealed by population pyramids at a district level, these highlight the difference between Oxford and the rest of the county. Increasing numbers of older people in particularly rural areas gives rise to access issues that planners and commissioners of services will need to address; it means that transport remains a high priory need.

Figure 11 - Population pyramids 2007-16.



Source: 2007 OCC GLA forecasts



Source: 2007 OCC GLA forecasts

Such variations mean that the need for services varies across the county, as illustrated in Figure 12 (pink is used to show where the district average for the measure is more than 10% higher and green where the district is 10% lower than the average for the whole county). This reveals that West Oxfordshire has the highest proportion of people aged over 75 years old. However, fewer of these people may need services to help them.

Cherwell has the highest percentage of its over 75 year old who are frail, physically disabled or sensory impaired amongst older clients. One-fifth of its over 75s fall into this category, compared with about one-sixth in West Oxfordshire. When the proportion of frail and disabled people are examined for the over 65s, Cherwell's rates are similarly about 25% higher than West Oxfordshire.

Figure 12 - Variations in older people indicators by district.

Older people data	Whole county	Cherwell	Oxford	South Oxon	Vale of White Horse	West Oxon
Proportion of people aged over 75 in 2007	7.2%	6.8%	6.0%	7.7%	7.7%	8.3%
Proportion of people aged over 75 referred to social care in 2006/07	13.0%	13.1%	13.2%	14.0%	12.9%	11.6%
Proportion of over 75s with physical disabilities, frailty and sensory impairment in 2007	18.1%	20.3%	18.0%	18.1%	18.1%	16.0%
Proportion of households with a single pensioner resident in 2001	12.9%	11.5%	14.3%	12.9%	12.5%	13.4%

Although growth across Oxfordshire in the over 75 age group from 2007 to 2016 will be 13% this disguises large variations, with many localities showing increases of over 40%, which represents a significant ageing of their local population. In some wards the over 75 age group is increasing at a much higher than average rate (more than 30%) and is also increasing as a proportion of the population (more than 27%). During this same period, growth in the over 85s reaches well above 75% in 13 wards, including 5 wards in the Vale, 2 wards in South Oxfordshire, all three Bicester wards, Blackbird Leys, and parts of Witney and Carterton. By contrast between 2007 and 2016, 20 wards are predicted to have falling populations for the over 75 age group in both absolute and relative terms. Of these 20 wards, 15 are in Oxford City and the other five are Banbury Grimsbury & Castle and Bicester Town (in Cherwell), Didcot Northbourne and Henley South (in South Oxfordshire) and North Hinksey & Wytham (in the Vale).

In Adult Social Care, service delivery is linked to income deprivation levels in older people. Many of the localities showing the highest rates of service take-up amongst the over 75s (greater than 12%) being within the county's urban populations. There are 24 wards in the highest quadrant with respect to their Access to Services together with Income Deprivation amongst older people. This combination of circumstances prevails significantly in 18 wards in Oxford City, the remaining 6 being in rural districts; these are Caversfield and Otmoor (in Cherwell), Freeland & Hanborough and Hailey, Minster Lovell & Leafield (in West Oxfordshire), and Greendown and Craven (in the Vale).

Average life expectancy at age 65 varies from around 15 to 32 additional years. When this data is cross referenced with the numbers of older people supported by social care to live independently at home, 11 wards are found to have low scores on both dimensions. These are shown in Figure 13 below.

Figure 13 - Wards with potentially greater needs for older people's services.

Cherwell	Bicester East
West	Freeland and Hanborough; Chadlington and Churchill; Brize Norton and Shilton
Oxford	St Mary's; Jericho and Osney; Carfax
Vale	Kingston Bagpuize with Southmoor; Stanford
South	Chinnor; Shiplake

Referral numbers are moderately correlated with the rates of elderly people living alone. Some of the highest rates of the elderly living alone are in Oxford city and in the relatively prosperous areas of the south of the county (the score of Income Deprivation Affecting Older People reveals higher relative wealth amongst the older people living in the South and Vale). Most people say they prefer to stay where they are rather than go into a home, despite the onset of age-related problems that can increase their need for care. Local services aim wherever possible to help people stay in their own home, although sometimes people's circumstances are such that going into residential care is the better, or only, option. In 2006-07 around 1,000 people were given intensive support to live in their own homes, avoiding the need to be admitted to hospital or care homes. This type of support service will have to increase in quantity as the population ages. For instance, it is anticipated that more than a quarter of people aged 85 and over will suffer from some form of dementia.

This section has looked at the needs of people as they approach the end of their life, the next section considers what is known about the needs of people at the start of their lives. In particular, the data has been used to paint a picture of what is known about the effects of deprivation on the life chances of children and young people.

3d. How many children are living in poverty? Where do they live?

Every Child Matters states that "the services that reach every child and young person have a crucial role to play in shifting the focus from dealing with the consequences of difficulties in children's lives to preventing things from going wrong in the first place." Commissioners recognise the importance of ensuring everyone gets a good start in life and services have been developed in Oxfordshire to reflect this approach to the health and well-being of children and young people.

Figure 14 - Deprivation affecting children and young people.

2007	Number of children living in poverty	Children living in poverty as a **proportion** of all children	Infant mortality (death under 1 yr) 2005
Cherwell	4,355	14.9%	0.77%
Oxford	5,911	23.7%	0.34%
South Oxfordshire	3,035	10.9%	0.26%
Vale of White Horse	2,805	10.2%	0.44%
West Oxfordshire	2,370	10.7%	0.18%
All Oxfordshire	18,476	14.0%	0.43%

Source: Annual District Deaths Extract (ADDE) for Oxon PCT, 2006.

Improving children and young people's life chances is a priority

Infant mortality in Oxfordshire is lower than the national average (approximately 0.43% compared to 0.51%), although a higher rate in Cherwell is being investigated. Overall this is good news and is to be expected in a county that is relatively prosperous. Over 130,000 children and young people live in Oxfordshire and in 2007 almost 18,500 of them were living in poverty (defined as living in a family in receipt of state benefits such as Income Support), representing some 14% of the under 18 population. By far the highest proportion live in Oxford, with substantially lower rates, below 11%, in the South, West and Vale districts.

All the wards in Oxford City (apart from North Oxford, Summertown and St Margaret's) have more children and young people living in poverty than the county average. In the other four districts, 26 out of 112 wards (almost a quarter) have higher than average numbers of children and young people living in poverty and high rates of forecast growth. These are the town-centre wards in Abingdon, Banbury, Bicester, Witney and Didcot. Individual wards are broken down into 3 or 4 smaller sub-units known as lower super output areas (each of which includes approximately 1,500 people). When figures are considered at this most local level, 9 such areas in Oxfordshire are within the poorest 10% of areas in England for income deprivation affecting children and young people. One lower super output area within the Barton and Sandhills ward is within 3.1% of the absolute poorest in the country. When the number of children and young people living in poverty is cross-referenced against the 2007 score of Income Deprivation affecting children, 27 of the county's 136 wards are in the worst quartile by both measures, these are shown in bold in Figure 15a.

Figure 15a - Wards with high levels of child poverty.

Ward	Number	Proportion
Oxford city		
Barton & Sandhills	480	33.5%
Northfield Brook	475	21.9%
Blackbird Leys	435	29.6%
Littlemore	430	36.1%
Rose Hill & Iffley	375	26.7%
Hinksey Park	340	33.4%
St. Mary's	290	40.6%
Cowley	290	23.5%
Lye Valley	285	22.8%
Churchill	275	28.8%
Iffley Fields	275	24.4%
Cowley Marsh	260	27.0%
Jericho & Osney	255	28.9%
St. Clement's	250	30.9%
Quarry & Risinghurst	180	15.9%
Headington Hill & Northway	170	18.4%
Marston	165	16.2%
Wolvercote	160	18.7%
Headington	125	14.9%
Carfax (incl Holywell ward)	76	24.0%
West Oxfordshire		
Witney South	220	15.1%
Witney Central	145	16.5%
Witney North	130	15.2%
Carterton South	120	14.3%

Ward	Number	Proportion
Cherwell		
Banbury Grimsbury & Castle	605	28.8%
Banbury Ruscote	565	25.2%
Banbury Neithrop	330	25.5%
Kidlington South	275	16.7%
Banbury Hardwick	240	14.7%
Banbury Easington	215	15.1%
Bicester Town	195	21.1%
Banbury Calthorpe	170	16.1%
Yarnton Gosford & W. Eaton	140	18.3%
Kidlington North	125	14.4%
Adderbury	80	17.6%
South Oxfordshire		
Didcot Northbourne	240	19.6%
Berinsfield	205	16.3%
Wallingford North	195	15.0%
Didcot Park	185	15.4%
Henley North	135	16.9%
Sandford	90	24.3%
Garsington	75	15.8%
Vale of White Horse		
Abingdon Caldecott	225	19.1%
Abingdon Abbey & Barton	200	17.7%
Abingdon Ock Meadow	160	16.8%
Greendown	65	14.7%

Figure 15b - Wards with high levels of child poverty.

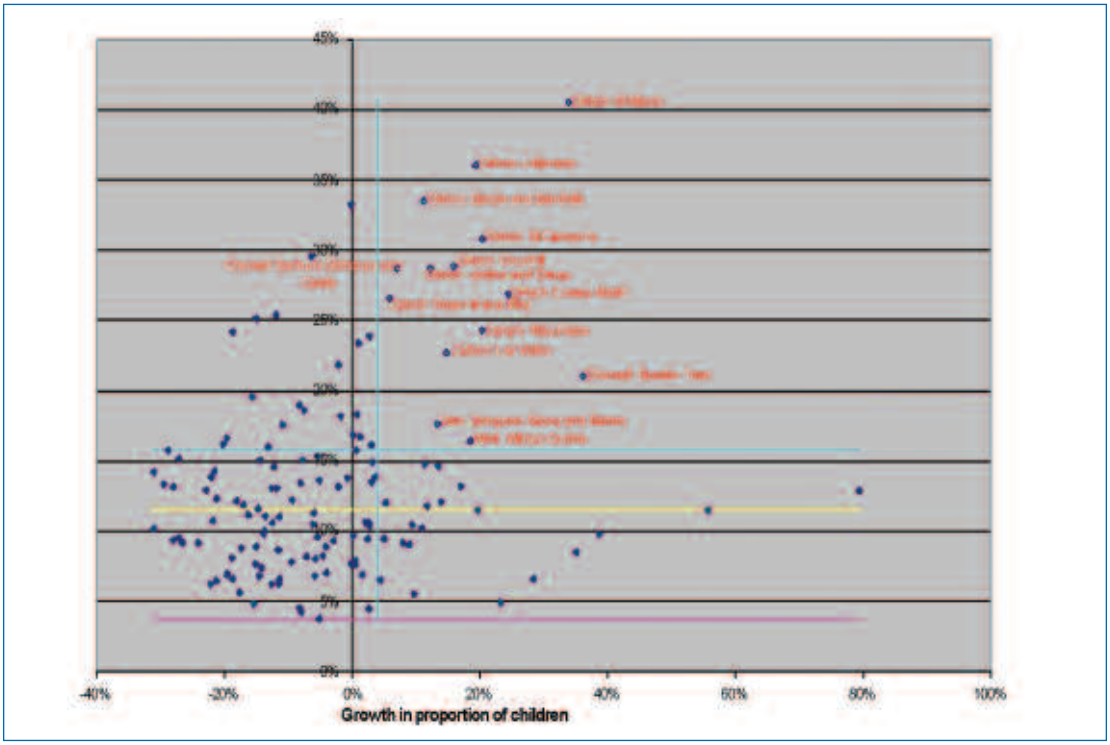
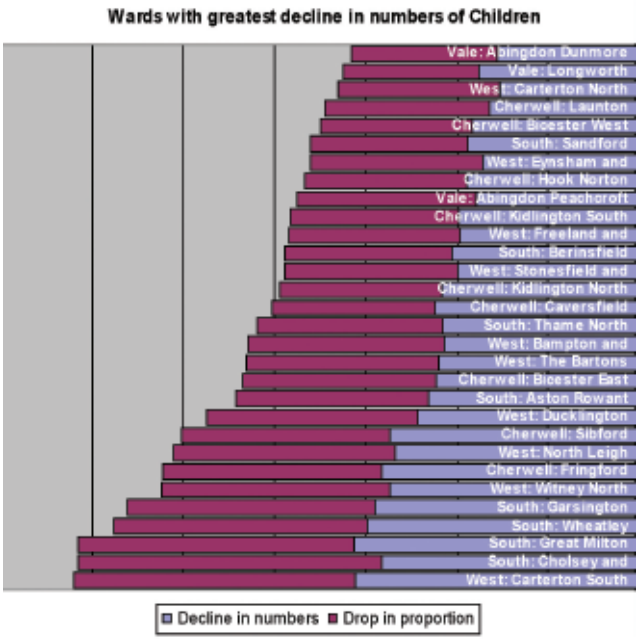


Figure 15b shows the 14 wards with the highest rates of both children and young people in poverty and forecast growth in the 0-19 age group; 10 of these are in Oxford city. Over 40% of children and young people in St Mary's ward are living in poverty, the highest amount anywhere in the county.

Figure 16 - Wards with the greatest decline in child numbers.

Many rural areas are forecast to see declining child populations by 2016. These falls are both in the proportion of children and young people that make up the total population and in their absolute numbers; the proportion of young people is reducing at a faster rate than the overall county decline. As shown in Figure 16, 30 wards in the county have both a 15% or greater decline in numbers and in proportion of children. Two thirds of these areas are rural.

Future investment plans will be informed by such information to ensure targeted resources match patterns of need.



Teenage conceptions have been consistently lower (by about a third) in Oxfordshire than the national average. Figures for 2006 showed an overall drop of about 25% compared to the previous year. However, prior to 2006 they had been showing an increase from the 1998 baseline. Overall this has resulted in a drop of almost 13% in the rate of teenage conceptions from 1998 to 2006. This is marginally lower than the fall in the rate for the whole of England. Within the county there is considerable variation; South Oxfordshire, West Oxfordshire and the Vale of White Horse have the lowest (and falling) rates, whilst Cherwell and Oxford have the highest (and rising) rates. The rate in Oxford is approximately twice that of South Oxfordshire and exceeds that of England as a whole.

Figure 17 shows those wards with a conception rate amongst young women aged 15–17 years over 5.4% in 2003-05, which means they are in the highest 20% in England. The absolute numbers of conceptions are relatively small at this level, consequently one or two cases may greatly change the position.

Figure 17 - Wards with high rates of under 18 conceptions (2003-05)

Ward	Number	Proportion
Oxford city		
Barton & Sandhills	20	5.5%
Blackbird Leys	32	8.1%
Cowley	23	7.6%
Cowley Marsh	23	10.7%
Iffley Fields	30	9.1%
Littlemore	33	10.2%
Lye Valley	27	9.4%
Northfield Brook	29	8.1%
St Mary's	19	8.1%
Rose Hill and Iffley	25	7.4%
Cherwell		
Banbury Calthorpe	16	5.4%
Banbury Grimsbury & Castle	44	10.1%
Banbury Hardwick	27	8.1%
Banbury Neithrop	23	7.7%
Banbury Ruscote	49	8.6%
Vale of White Horse		
Abingdon Abbey and Barton	20	7.0%
Abingdon Caldecott	17	5.7%
West Oxfordshire		
Witney Central	15	7.2%
Carterton South	17	6.7%

Key factors that determine children's future health begin at a very early age and can influence the likelihood of later events. Breastfeeding is viewed as a protective factor and for this reason is generally encouraged by health practitioners. Breastfeeding initiation rates (mothers starting to breast feed shortly after delivery) in the county have increased steadily over the last 4 years in the 30 most deprived wards, bringing them closer to the best performing ward. About three quarters of new mothers are now initiating breastfeeding. In Oxfordshire the proportion of new mothers still breastfeeding at 6-8 weeks in 2006-07 was above the England average, 57% compared with an estimated 50% (although this latter figure is based on a survey from the previous year using a slightly different definition).

The habits and behaviours developed by children often remain throughout adulthood. Encouraging children and young people to develop healthy lifestyles can therefore be hugely preventative. For example, nutrition and physical activity are second only to smoking in their influence on developing heart disease in later life. Lifestyle issues like these and their serious health consequences for example in terms of obesity, are picked up in the next section.

3e. What lifestyle issues pose risks to well-being now and in the future?

The main lifestyle choices addressed in this section are: diet, physical activity, smoking, alcohol and sexual health. It is clear from the JSNA data that such lifestyle choices have an important impact on the health of individuals and society, and are often associated with health inequalities and deprivation.

Supporting people to make healthy lifestyle choices is a priority

Accurate local data about obesity is limited but current and projected levels of obesity at a national level are causing great concern. Nationally, it is known that obesity is rising and that being obese reduces life expectancy by an average of 9 years. There are also strong correlations between obesity and rising levels of diabetes. In the last 25 years, levels of obesity have nearly trebled in the UK and the recent Foresight Report (Oct 2007) has predicted that from current trends 55% of adults and 25% of children and young people will be obese by 2050. This rising national trend is mirrored in the South East region, although absolute levels are lower than for the UK as a whole. Increasing levels of obesity will inevitably result in ever-increasing calls upon NHS and local authority budgets. It is feared that unless action is taken now obesity will lead to significant levels of ill health and disability within the near future. There is a danger that support and treatment for those with weight problems may exceed beyond current financial restraints.

Owing to these known health risks it is a local priority to take baseline data now and to focus on better measurement in the future, so there will be a better understanding of changes next year and to build a picture of trends over future years. GP practices have recorded the Body Mass Index (BMI) of a third of their patients in the last year. Of those measured, 6.8% (45,000 patients) were found to be obese (defined as having a BMI over 30). Although it is not known if this proportion would be replicated in the other two thirds of the population, trend data from the Health Survey England (2004) for Oxfordshire, suggests that the general county picture is no different. Forecasts for Oxfordshire similarly predict an increase in the number of type two obesity related diabetes, rising from approximately 14,500 patients in 2006 to almost 27,000 in 2026. These figures are by their very nature only estimates but it is certain that diabetes related expenditure will grow if obesity grows. It has been costed that diabetes in the UK currently accounts for 5% of all NHS expenditure and 9% of hospital expenditure.[1] If obesity trends are not reversed then diabetes healthcare costs alone are forecast to increase by 15% between 1997 and 2011.[2]

Baseline data has also been collected for childhood obesity through a programme begun in June 2007 to calculate children's BMI by recording their height and weight at primary school. This shows that 8% of children in their reception year are obese, rising to 15% in year 6, this suggests that rates of obesity are approximately twice as high for children as they are for adults. Although results are slightly better than the national picture, obesity is alarmingly high in children and young people. This will put a further strain on future resources. Obesity itself is the 'tip of the iceberg' and simply being overweight can have health implications. For overweight, but not obese, children the corresponding figures are 12% in reception and 13% in year 6.

Data relating to physical activity is not available at ward or practice level. Information taken from the Active People Survey 2006 (the largest of its kind ever to be conducted in this country) yields data at district council level as set out in Figure 18. This reveals a lower proportion of the population taking regular physical activity in Oxford compared to the UK average of 21% and a higher proportion in the rest of the county.

Figure 18 - Adult participation in sport by district.

Indicators for all adults	Oxford	Cherwell	South	Vale	West
KPI 1 - At least 3 days a week x 30 minutes moderate participation	20.5%	24.0%	22.3%	25.0%	25.7%
KPI 2 - At least 1 hour a week volunteering to support sport	4.7%	6.3%	7.1%	6.1%	4.9%
KPI 3 - Club member	25.5%	24.8%	30.6%	28.1%	27.4%
KPI 4 - Received tuition from an instructor/ coach in last 12 months	19.2%	19.5%	25.4%	21.4%	19.9%
KPI 5 – Taken part in organised competitive sport in last 12 months	16.0%	17.2%	21.3%	19.4%	17.6%
KPI 6 - Satisfaction with local sports provision	70.7%	64.6%	72.4%	77.8%	75.2%

Smoking is the single most important public health problem in Britain. This is also true locally, although it is estimated that Oxfordshire has fewer smokers than the average in England. A little more than one-fifth of Oxfordshire adults were smoking in 2005 as compared with just under a quarter for the country as a whole. Interventions to help smokers quit have been shown to be among the most cost-effective interventions the NHS provides. Over 3,300 people gave up smoking for at least a month in Oxfordshire in 2005-06. This dropped slightly to just over 3,000 quitters in the following year but then rose dramatically to over 4,000 quitters in 2007-08. The PCT are committed to reducing smoking rates in the more deprived communities and the current year will see both national and local targeting of routine and manual worker groups. Opportunities to expand the provision of these interventions to help people quit will be actively sought and implemented where feasible. For example, the PCT are working closely with Children's Centres and other community groups to provide appropriate smoking cessation training to staff.

Alcohol data is not readily available but synthetic estimates for 2000-02 show that alcohol consumption is increasing and is a particular issue within Oxford. Nationally it is known that conditions resulting from unhealthy lifestyles are placing a significant yet preventable burden on the NHS and local authority services. The county council and the PCT recognise the potential benefits in terms of securing real and cost effective health improvement. Actions have been taken to strengthen their performance with regard to preventative services that help to tackle problems like obesity and alcohol misuse. In the meantime, work is ongoing to improve alcohol, obesity and physical activity data.

[1] *Commissioning Systematic Diabetic Retinopathy Screening, NHS English National Screening Programme for Diabetic Retinopathy, January 2007, p.3.*

[2] *Working Group on Outcome Indicators for Diabetes, Report to the Department of Health, 1997.*

4. Messages from consultation

What do local people tell us?

Views and comments are needed from local people, service users and provider organisations to inform how the services provided locally are refocused and re-shaped. A variety of consultations have been carried out in recent years with people of different ages, with service users, with carers and with the general public as a whole, to gain an understanding of the population's expectations and wishes. These are listed in Annex A.

Ipsos MORI were commissioned by the council to conduct a detailed consultation on what people liked and disliked about the area and how they viewed council services. They found overall satisfaction with the area as a place to live, is higher than average in Oxfordshire, with over 4 in 5 residents satisfied (82%). Only 6% of residents are dissatisfied with their area. Most residents do not feel that they can influence local decisions (68% disagree that they can influence decisions affecting their local area). Less than a quarter are dissatisfied with opportunities for participation in local decision-making, or would like to get more involved in decisions affecting their local area. Similarly, when local people were asked how satisfied they are with the opportunities for participating in NHS decision making, Oxfordshire scored far below the average for the 9 PCTs in this Strategic Health Authority area; it was third from bottom.

With the exception of libraries, satisfaction with recreational services is above the national average. Importantly, Oxfordshire is top performer for museums and galleries (54% satisfied) and satisfaction with theatres and concert halls is also much higher than the national average for all counties. Seven in ten residents are satisfied with libraries. Levels of satisfaction with planning services, personal social services, and local authority education services have gradually decreased since the first residents' general survey in 2001.

What messages does NHS consultation provide?

According to a recent Strategic Health Authority (SHA) survey, considerably more people in Oxfordshire than in South Central generally (83% as opposed to 72%) say their local NHS is providing them with a good service. This is the highest satisfaction level of all the 9 PCTs in the South Central SHA area. With regard to how satisfied they are with the NHS nationally, Oxfordshire residents are in line with the average for the whole south central area. However, there are areas where there is room for improvement. For example, satisfaction with NHS hospitals and GPs scored lower than national averages. There are high levels of dissatisfaction with:

- cleanliness of hospitals;
- registration/access to NHS dental care;
- waiting times for appointments and A&E;
- numbers of hospital beds and nurses;
- low perceived recollection of 'choice' being offered.

The vast majority of Oxfordshire patients are very satisfied with access to their general practice however, it is important to note that the generally high levels of satisfaction disguise some low satisfaction rates in some practices, especially around patients ability to book appointments more than 2 days ahead. A substantial proportion think it is difficult getting access to GP when needed - this is highest among full time workers & social grade AB.

What do people aged over 50 tell us?

A consistent message from several consultations is that as people get older they want to continue working for as long as possible. Work is especially important in providing both shape and social

contact in their lives. They want to stay independent and not to be a burden. They want to live at home; they do not want residential care but most would accept it rather than being a burden on their family. Specific consultations by Age Concern and the Oxfordshire Rural Community Council looking at the aspirations and future expectations of younger older people concurred with these findings. Many also had concerns about ageist attitudes in society.

Information is very important to people to help them understand how things work and what help is available. They want information when they retire and then again should they need support for some reason. They do not like the idea of having to pay for social care and do not distinguish between the NHS and Social Services.

Older people say remaining active is very important in maintaining their well-being. They want community facilities close to where they live. Those people who have received home equipment were very happy with it but a minority (13%) were not shown how to use it. Those people using day services said a change of scenery was important, as was meeting friends and eating a freshly cooked lunchtime meal. They want more help with collecting pensions, more outings and transport to appointments. They generally like where they live and those in Blackbird Leys especially, like living there because of the sense of community. People like living in Extra Care Housing where they feel safe and secure. They want to influence future service provision.

What do people caring for an elderly or disabled relative tell us?

They want timely and good quality information, especially about support. They want GPs to identify and refer carers for support. They would prefer a single source for help and information between social, health and other services. They want help in an emergency and to get a break when they need it.

What do people with mental health needs tell us?

They want to be very involved with how services are organized and delivered. They want to talk to senior managers, they want adequate professional support for involvement and they want more people from black and ethnic minority groups to be actively involved. They want the PCT, the county council and the Oxfordshire and Buckinghamshire Mental Health Trust to improve how they work together.

What do younger disabled people tell us?

They tell us they want access to decent transport because without it they cannot participate in anything. They often feel threatened or bullied when they are out. They want better access to health services and to housing. They want to be considered as local citizens and would like to participate more in local democratic processes.

What do children and young people tell us?

The Oxfordshire Children and Young people's Survey 2007 provided a lot of information about children's behaviour and their attitudes towards health. For example, two thirds of children and young people said they receive enough information about smoking, drugs, sex and relationships. Over 80% said they feel very or quite healthy. Almost 40% of year 3-11 said they ate five portions of fruit and vegetables most days (6% never do) and over 70% sit down for a family meal more than twice a week. Of those surveyed, four out of five said they participate in sporting activities outside of school.

Absence from school, eating nothing or only crisps/ chocolate/ fizzy drinks for breakfast, bullying, special needs and living in temporary accommodation were all correlated with regular smoking and drinking in years 7-11. Children and young people who reported these factors were less likely to say they feel very healthy. Those who smoke and drink regularly are also much more likely to report taking illegal substances. Older children and young people in general were less likely to agree that there is enough to do, and young drinkers and smokers in particular were much less likely to agree. Two further priorities were identified, which were to tackle bullying and to make sure children and young people feel 'safe' at home and in the street.

What are the major health and social care issues?

The combined key messages from people that use services can be summarised as:

- *older people want the stereotypes and negative images of being an older person broken down;*
- *older people want to lead a full life and be valued as participants in the community;*
- *most people who need support, and their family carers, want real choice;*
- *people of all ages want quick and easy access to information and advice;*
- *people of all ages want their needs to be identified early to prevent a crisis;*
- *younger disabled people want the opportunity to work, to see their friends and to have a home of their own;*
- *children and young people have generally positive attitudes towards their health. Older ones have concerns that there isn't always enough to do.*

5. How to find out more

This JSNA has been undertaken to support action to improve local people's health and well-being. It is designed to help plan services more effectively. It will only succeed if the information and knowledge that the data yields is actually taken into account. To this end a Communications Plan has been produced to make sure that these messages are widely circulated and well understood. A number of outputs, in addition to this JSNA report have therefore been made available. These are described in this section along with contact details, to obtain further information email: **JSNA@oxfordshire.gov.uk.**

One of the first things that is being done to make sure messages reach their primary audience is to give briefings to management teams, within the PCT and county council, starting with the Senior Management Team of Social & Community Services and the Clinical Executive of the PCT. This will be followed up with a presentation to the County Council Management Team, and other operational management teams as appropriate. Other requests for a JSNA presentation to be included within a particular team meeting should be made via the mail box below.

Three separate workshops are planned for September to ensure widespread awareness of the wider process around this JSNA. These are:

1. *Health and Well-Being Partnership Board members (extended to other district council staff and third sector reps);*
2. *Internal OCC and PCT staff and GPs;*
3. *Councillors and other interested parties (e.g. co-opted Scrutiny members).*

The actual data collected for this JSNA is held in a huge spreadsheet that extends in excess of 20,000 rows of scores. This is rather difficult for people to navigate and read without some form of user-friendly software being added to enable users to select particular comparisons. It is hoped that accessibility can be addressed in future versions. In the meantime a bespoke analysis service is being offered to people who wish to make use of this data to help them plan or deliver a service and they can make specific requests for information. However, the scores for each location, on each of the indicators for which results have been collected, has been published in a static form, as a compilation of scorecards. These files display each of the indicators on a separate page and have been made available in two separate views: one that shows the results by ward (grouped into 5 district areas) and one that shows the same information but organised by individual GP practice (grouped into 6 practice consortia).

Another way in which the information has been presented is in the form of a high level, and very visual, wall chart illustrating data from across the whole county on a single page. This chart colour codes the results for each ward for a majority of the indicators, which enables patterns and clusters to be identified. These patterns may suggest inequalities and issues that require further exploration. It is hoped that this will help to engage audiences with the powerful analytical capabilities that the JSNA offers.

A dedicated public website (set up to provide easier access to the work of the Health and Well-Being Partnership) hosts all the JSNA information and resources. Additionally, it contains links to the work of other partnerships and the Data Observatory which can be a useful source of extra information. Links are also provided to the *Area Health Profiles,* which are available at an entire county level and for each of the 5 district council areas. These do not consider social care needs but are a very useful additional source of information about the health of an area. All materials can be downloaded from the website – just follow JSNA links at www.oxfordshirepartnership.org.uk

6. What we are doing next

Information is useful to the extent that it creates a deeper understanding of the patterns of need within the county. Throughout the main body of this report, references have been made as to what issues need to be addressed. This section aims to give a brief outline of how the local authority and the PCT are acting on these findings.

One of the first points to note is that the JSNA enables service providers and commissioners to use segmentation to gain deeper insights into the diversity of the local population. The intention is, wherever possible, to intervene early so that the need for intensive support, precipitated by a crisis, can be avoided whenever possible. This requires that services be accessible and appropriate to the needs and demands of people regardless of their geographical location, spending power, occupational or family background. In order to make the best use of resources, partners will link up their data to plan and target services in the areas where they are needed most. For example, targeting those people aged over 75 who are living alone, in poor housing and on a low income. The decision to locate the new GP-led health centre in Banbury has been one very practical response to improve access to services in an area of higher need. The JSNA data has already been put to a number of specific practical uses, details of which are supplied in Figure 19:

Figure 19 - Examples of how JSNA has been used.

- *Information included in the core data set informed priority setting for the Sustainable Community Strategy and the Local Area Agreement.*
- *JSNA information was presented to the Strategy & Performance review of Adult Social Care (June) in preparation for 2009-10 budget setting.*
- *JSNA findings were presented in a PCT Planning workshop to help inform investment, disinvestment and/ or service improvement priorities for 2009-10*
- *Data from the JSNA was used by the PCT Trust Board (April) to help determine the location of new walk-in, GP-led health facility.*
- *The Head of Strategy in Cherwell District Council (May) was provided with JSNA data. This will inform future joint work (not yet initiated) to tackle deprivation and health inequalities in the district.*
- *A request has been received from the S&CS contracts team for an analysis of the supply of care homes in south Oxfordshire.*
- *JSNA data was used by a Health Improvement Practitioner to help determine the location of preventative service for older people.*
- *JSNA data was used to support an Extra Care Housing Grant bid to the Department of Health. South Oxfordshire, Vale of White Horse and West Oxfordshire district councils have also used joint analysis of housing needs to develop their Extra Care Housing provision.*
- *Mental Health pooled budget planning and development was informed by JSNA data (May).*
- *A S&CS Service Manager used JSNA information to help her better identify training needs for Home Support staff (June).*
- *Community Development for Older People are putting additional resources into six wards where need has been revealed as highest – notably Ruscote, Grimsbury and Neithrop in Banbury; Barton; Farringdon; and Berinsfield.*

The JSNA can be used by Partnerships such as the Oxfordshire Partnership, the Children's Trust, the Health and Well-Being Partnership and the Safer Communities Partnership to inform their decision-making in relation to delivering their strategic priorities. The core data set will also be used to inform a variety of additional strategies and plans. These include an assortment of PCT and county council commissioning strategies and the Oxfordshire PCT Operational Plan. Individual Public Health specialists within the PCT are working in partnership with each of the district councils who are developing their own local Public Health Strategies. This will further help to address local differences and ensure that the commissioning priorities of the NHS and the county council compliment the district councils' priorities. The PCT is also required to incorporate the findings of the JSNA into its new Prospectus which will be produced in 2009.

Oxfordshire residents can make a difference themselves by getting more involved in health, and in the things that all of us can do to stay well and avoid preventable ill health. Behavioural changes can significantly reduce the risks of ill health and help people to enjoy independence and well-being for as long as possible. Making healthier choices can also help to ensure the next generation are given the very best possible start in life. Changing people's behaviour and encouraging the adoption of healthier lifestyles is one of the mainstays of public health work. In future, the Director of Public Health will incorporate relevant findings of the JSNA into his *annual report*.

Improving the process - what we have learnt

This framework is the latest initiative in a growing momentum to join up health and social care. This is the first JSNA for Oxfordshire and much has been learned in its preparation. One of the areas where further improvement is necessary is through engagement with communities about what their aspirations for health are and what support they need to achieve these. This will be a key theme of future work to ensure gaps in current knowledge are minimised.

Particular shortfalls in available data have also been highlighted and these will be addressed in an ongoing basis by the performance information teams that underpin decision making within each organisation. Additional fields will be added to the data collected for existing statutory returns to government to enhance their usefulness to the JSNA process. Two good examples that have already been identified include ensuring post code data is collected on clients and that more detailed sports activity information is added in future years (listed at Annex F)

The data contained in the core data set will be updated annually. A refreshed document will be produced to outline any new points of learning. This will enable a richer picture to be built up over time as trends in relation to current baselines emerge. Further information about these arrangements will be made available on the website.


GARDEN
of BEAUTY

ANNEX A - JSNA topic based needs assessments

The essence of Oxfordshire's initial approach to the JSNA is to be in a position not only to explore the crude variations between our principal regions but to focus on local areas. To this end, all data can be analysed to the level of ward or GP surgery catchment to reveal information that can be used to enable more focused commissioning and to target change projects and other resources aimed at addressing specific health and well-being issues. For example, the types of training courses accessed in a particular area can match the pattern of needs in that area better, so that professionals are more likely to discuss those issues with patients and thus help to ensure effective early intervention.

The JSNA takes account of a range of data sets, the JSNA core data set and additional data sets with topic based needs assessments. Some of these are listed here.

Needs assessments 2008

- *Joint Older peoples Needs Assessment*
- *Diabetes Needs Assessment*
- *Mental Health Needs Assessment*
- *Older People's Mental Health Assessment*
- *Maternity Needs Assessment*
- *Oral Health Needs Assessment*
- *Horton Hospital Needs Assessment*
- *Polish Migrant Needs Assessment*
- *Bicester Needs Assessment*
- *Henley Needs Assessment*
- *Bullingdon Prison Needs Assessment*
- *Huntercombe Needs Assessment*
- *End of Life Needs Assessment*
- *12 Briefing Papers for the Sustainable Community Strategy*
- *Cherwell District Council Public Health Strategy*
- *South Oxfordshire District Council Public Health Strategy*
- *West Oxfordshire District Council Public Health Strategy*
- *Director of Public Health's Annual Report*
- *Director of Public Health's Annual Report II*

Consultations

- *Best Value Performance Indicators Survey (BVPI), Ipsos MORI/ Oxfordshire County Council, Jan 2007*
- *Get The Picture: Older people's day-to-day lives in rural West Oxfordshire, Age Concern/ Oxford Brookes University, Aug 2007*
- *The Aspirations and Expectations of Tomorrow's Older People, Age Concern Oxfordshire, May 2008*
- *Fundamental service review of Day Services for Older People, Social & Community Services, Sep 2008*
- *ISIS Court Extra Care Housing survey, Order of St John/ S&CS, Jan 2008*
- *Telecare Alarm Systems and Supported Housing, Social & Community Services, Oct 2007*
- *Equipment Survey, Social & Community Services, Mar 2008*
- *Adult Placement Service Customer Satisfaction Survey, Social & Community Services, Nov 2007*
- *Learning Disability Day Services Carers Survey, Oxfordshire Learning Disability Day Services, Mar 2007*
- *Valuing People Now, Oxfordshire Learning Disability Day Services, Mar 2008*
- *Public Perception Market Research Baseline Survey, South Central Strategic Health Authority, Mar 2008*
- *Community Health Services Patient Satisfaction Survey, Oxfordshire PCT, 2008*
- *Service User and Carer involvement in the commissioning and monitoring of Mental Health Services, , Oxfordshire PCT, Mar 2008*
- *Carers Survey, Oxfordshire & Buckinghamshire Mental Health Trust/ S&CS, May 2008*
- *Oxfordshire Children & Young People's Survey, CYP&F, Jul 2007*
- *Researching Volunteers' experience, Oxfordshire Council for Voluntary Action, Oct 2007*

ANNEX B - Methodology

How was the JSNA put together?

Oxfordshire's JSNA was produced as a joint project between Oxfordshire Primary Care Trust and Oxfordshire County Council. The project was supported by a firm of external consultants (CHKS) who have previous experience of producing JSNA core data sets.

A recommended list of indicators provided by the Department of Health was reviewed to identify those which made sense in the context of services in Oxfordshire and for which data was currently available. National information was gathered (e.g. census data and population forecasts) to supplement the data held locally. Additional key local measures were also identified and added, despite not being a statutory requirement, to improve the product's utility to local commissioners.

The agreed core data set was grouped by post code or GP practice by the council and PCT respectively. Data collected at GP practices was then 'mapped' into council wards and vice versa. This was sent to CHKS who collated all the data into a single JSNA core data set. The scorecards and data behind them were then checked for processing errors by the council and PCT before being published.

Two further stages of work were applied to the data. The first was done to protect confidentiality and involved identifying where there were such small numbers of people for any indicator in a particular ward that individuals might effectively be identified. This data has not been published. The second was applied to improve clarity using a statistical technique known as 'winsoring'. Where values are extreme compared with other wards the values for that ward have been reset to the average. The effect of this is to prevent the bunching up of all the other values such that they are hard to distinguish from each other. Where this has been done it has been documented on the relevant scorecard.

How is the JSNA core data set presented?

The same data has been analysed, and presented in two different sets of scorecards:

*(i) a **Ward Based View** which orders results by wards and districts to reflect the geographical boundaries that are of most interest to local authority audiences;*

*(ii) a **GP Practice Based View** which orders results by GP practices and consortia (groups of practices) to reflect the geographies most familiar to the PCT. In the practice-based scorecards Luther Street Clinic has been removed as it specialises in services to homeless people and this has biased the data.*

These sets of scorecards are available separately (Section 5 for details).

Social deprivation is a highly significant factor contributing towards many aspects of health and social care provision. Areas have been ordered consistently throughout this report using the latest Index of Multiple Deprivation (IMD) scores from 2007 (see indicator social 002.1). This allows a swift assessment of whether overall socio-economic deprivation is a key contributor to any of the many other indicators contained within these documents.

Only the key findings have been presented in this assessment. To complement the picture derived from this JSNA commentary, further specific in-depth needs assessments are undertaken jointly where possible, for example around older people and adult mental health (listed at Annex A). For tailor-made analysis, contact the JSNA team at: JSNA@oxfordshire.gov.uk

ANNEX C - Caveats on data quality

Data can sometimes lead to constructing misleading pictures, and some data is more vulnerable to misinterpretation than others. Some cautionary notes are included in this section to highlight where data is not always fully complete, up to date, or is perhaps compiled by means of people self-reporting their behaviour. Users of the JSNA should bear in mind that the presentation of messages through phrases, graphs and maps are based on an interpretation of data; something which is often forgotten once they have been put onto paper. At times, these messages suggest areas for further investigation. They prompt more questioning rather than simply supplying incontestable answers or truths. Occasionally statutory indicators have not published due to data quality concerns. Such gaps are also explained in this section.

1) People receiving services not included in the data

The scorecards on services include services provided by both the PCT and the council. The data in these scorecards on social care services only includes people where the council is making a financial contribution to their care. This does not include all people, it excludes people who:

- *choose not to approach the council;*
- *have social care needs, but either have sufficient savings and or income and therefore do not qualify for publicly funded care;*
- *have assessed needs below the locally established eligibility threshold.*

We do not have detailed information on people where the council is not making a financial contribution. However we estimate that of 4,262 care beds in Oxfordshire, 2,600 (61%) beds are either purchased by self funders or other authorities. Levels and amounts of community based services purchased and arranged by self funders in Oxfordshire, is not known. However, based on national figures provided by the Commission for Social Care Inspection and our local market intelligence around care homes, we estimate that 50% of the home support capacity would be purchased by self funders. We assume that the rest arrange their own care in the community or are supported by their families and carers.

2) Service records not included in the analysis

Records are mapped to wards by post code. Not all records had current Oxfordshire post codes. There are three main reasons for this.

- Some people funded by Oxfordshire County Council live outside Oxfordshire. These are mainly people who have been placed in care homes or in supported living houses outside Oxfordshire;
- not all service records contain post-codes;
- some records contain old post-codes and in some areas post-codes have been changed and the record has not been updated.

Figure 20 identifies the proportion of cases we were able to map for each of the social care service related indicators. This is the first year the JSNA has been published. When it is refreshed next year the following improvement will have been made to the core indicator data set:

- Review records to ensure current post codes are available;
- for people placed in residential or nursing care that we fund we will report on both where they now live, but also where they lived before they moved to the residential or nursing home;
- recording all of people's needs not just the primary needs.

3) Population forecasts do not always match ONS projections

The JSNA data set uses the most recent population and household forecasts for wards in Oxfordshire, which were published in August 2007 and forecast population changes at ward level up to 2016. A key feature of these OCC forecasts is the inclusion of known and expected housing developments. A full report on the methodology used to produce the forecasts can be downloaded from, http://portal.oxfordshire.gov.uk. It should be noted that the small area forecasts are produced using a different model to that used for the ONS projections and have not been aligned with the district and county totals produced by the Office

Figure 20 - Social care indicators - proportion of cases that were mapped.

Indicator Code	Indicator Name	Actual Clients	Number mapped	% Mapped
Services 002	Numbers - Referrals	9307	8680	93%
Services 003	Numbers - Nursing care	1174	1011	86%
Services 004	Numbers - Residential Care funded by Oxfordshire (excluding those housed outside of the county)	1966	1550	79%
Services 005	Numbers - Adult placement	122	111	91%
Services 006	Numbers - Home Support	2216	1969	89%
Services 007	Numbers - Receiving community equipment	1723	1679	97%
Services 008	Numbers - Telecare	492	492	100%
Services 010	Numbers - physical disability, frailty and sensory impairment (older clients)	10771	9777	91%
Services 011	Number - physical disability, frailty and sensory impairment (older clients) receiving community-based services	9628	8686	90%
Services 012	Numbers - physical disability, frailty and sensory impairment (clients aged 18+)	12965	11733	90%
Services 013	Number - physical disability, frailty and sensory impairment receiving community-based services aged 18+	11787	10597	90%
Services 014	Numbers - learning disability (older clients)	157	135	86%
Services 015	Number learning disability clients (older clients) receiving community-based services	138	116	84%
Services 016	Numbers - learning disability (clients age 18+)	1537	1261	82%
Services 017	Number learning disability clients aged 18+ receiving community-based services	1387	1190	86%
Services 018	Numbers - mental health (older clients)	823	719	87%
Services 019	Number - mental health (older clients) receiving community-based services	605	493	81%
Services 020	Numbers - mental health (clients age 18+)	2190	1942	89%
Services 021	Number - mental health receiving community-based services age 18+	1956	1692	87%
Services 026	Numbers - other vulnerable people (older clients)	203	148	73%
Services 027	Number - other vulnerable people (older clients) receiving community-based services	195	141	72%
Services 028	Numbers - other vulnerable people (clients)	309	209	68%
Services 029	Number - other vulnerable people receiving community-based services	295	199	67%
Services 030	New Clients where assessment was undertaken	6731	6316	94%
Services 031	People supported to live independently through social services (NATIONAL INDICATOR)	11461	9821	86%
Services 032	Numbers - Homecare (Inc intensive home support) - Extra Care Housing	43	43	100%
Services 033	Numbers - Homecare (Inc intensive home support) - Supported living	523	502	96%
Services 035	Number of carers - Respite Care	677	538	79%
Services 036	Number of carers - Direct Payments	197	78	40%
Services 053	Numbers - Library users	131909	102855	78%
Services 054	Numbers - Information and Advocacy	205	148	72%

for National Statistics. It is also worth noting that should planned developments not take place, or provide fewer or greater properties, current forecasts will no longer be fully accurate.

4) Waiting times for social care assessments not included

The Department of Health does recommend that we published how quickly people were assessed for adult social care. This has not been included in the JSNA as all assessments for social care in Oxfordshire are undertaken by one central team, so performance would not be affected by geography. The guidance did not ask us to identify where people who were assessed lived. However, this has been added as a useful local measure.

5) Boundary issues mean some people not included

Thame is not part of Oxfordshire PCT as the GPs in this area are aligned with Buckinghamshire PCT. This means that within the health data broken down at ward level, data is missing from the wards which are within this area (i.e. Thame South, Thame North and Chinnor).

6) Data that is out of date or otherwise less reliable

Some of this data comes from the 2001 Census which is now 7 years out of date, and so figures must be treated with caution. Data on the proportion of people eating five portions of fruit and vegetables per day was calculated from Tesco Clubcard data from 2004. This does not show what percentage of the purchased fruit and vegetables was consumed as opposed to thrown away, nor which members of the family ate it. The year of collection also pre-dates a significant marketing campaign to raise awareness of the five-a-day message.

7) Data not published in the scorecards

To protect confidentiality, where there were such small numbers of people for any indicator in a particular ward such that individuals might effectively be identified, data has not been published. In the GP practice-based view for the scorecards, Luther Street Clinic has been removed as it specialises in services to homeless people and this has biased the data (for example its life expectancy results were the lowest, and its hospital admission rates were 3 - 5 times higher than the next highest practice).

This assessment gives many of the key messages that emerge from the data and illustrates the variety of ways in which the richness of the data can be mined. However, since there are an almost infinite number of cross-referencing options that can be done, where one indicator can be compared with any of the others, there are yet many more learning points to be identified. Data is at its most useful when it is being tested to address particular questions. Rather than doing further investigation for its own sake, commissioners, planners and operational service managers are encouraged to make contact with their specific requests for tailor-made analysis. Any such requests for information and analysis can be sent to: JSNA@oxfordshire.gov.uk

ANNEX D - How to read the scorecards

In the Ward Based View, the scorecards depict for each ward their relative score on the measure or indicator described in the title, compared with the council average. The wards are listed within district council areas and are listed based on their relative score on the index of multiple deprivation, with the first ward having the highest level of deprivation.

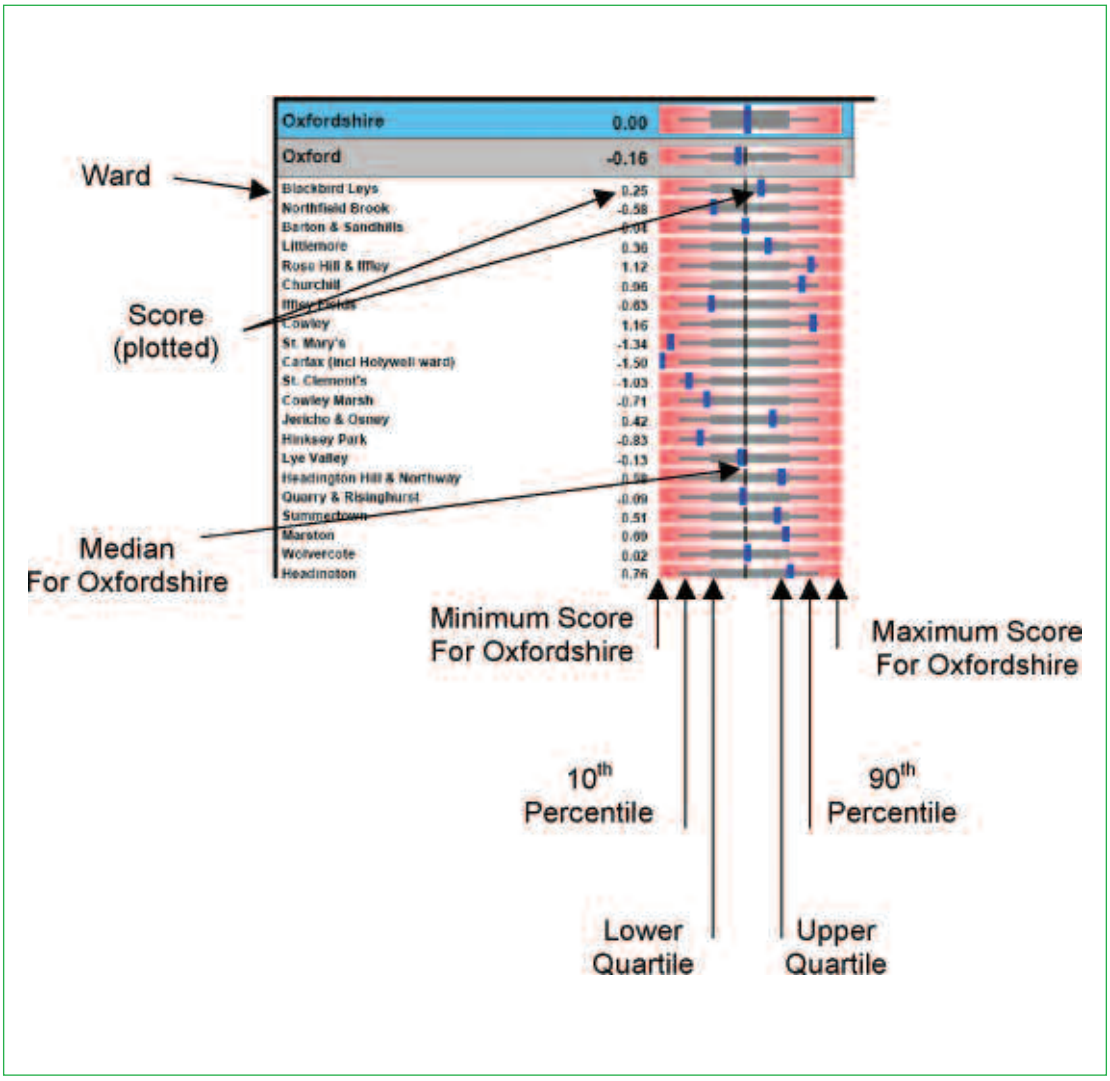
The chart below describes how to read the table.

Data in the table has been 'winsorised'. This is a statistical technique which is used to reduce the impact of extreme outlying values of the population. This is done by changing the value of these outliers to value at the same as the nearest non-outlying value.

The number that is plotted is the Z-score (also called the standard score). This is the distance a value is away from the population mean in units of the standard deviation (a measure of distribution) of the population.

In the GP Practice Based View, the scorecards are read in exactly the same way, only the listed results depict for each GP practice their relative score on the measure or indicator, compared with the average for all practices across the 6 consortia.

Readers are referred to JSNA Annex C which lists some caveats and notes of caution concerning the published data.



ANNEX E - Definition of all the indicators comprising the core data set

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Burden001	All causes -ALL-age All-cause mortality NATIONAL INDICATOR 120	Per 1000 population	Annual District Deaths Extract for Oxfordshire (ONS)	Total Population	2004-2006	2004-2006
Burden002	All causes - Life expectancy at birth	Years x.x	Total life years	Total Population	1999-2003	2001
Burden004.01	All causes - Top 12 causes for admission: 18X Maternity and Reproductive Health	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.02	All causes - Top 12 causes for admission: 02X Cancers and Tumours	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.03	All causes - Top 12 causes for admission: 17B Renal problems	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.04	All causes - Top 12 causes for admission: 15X Problems of the Musculo skeletal system	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.05	All causes - Top 12 causes for admission: 16X Problems due to Trauma and Injuries	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.06	All causes - Top 12 causes for admission: 07A Chronic Pain	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.07	All causes - Top 12 causes for admission: 13B Lower GI	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.08	All causes - Top 12 causes for admission: 11X Problems of the respiratory system	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.09	All causes - Top 12 causes for admission: 08X Problems of Vision	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.10	All causes - Top 12 causes for admission: 07X Neurological	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.11	All causes - Top 12 causes for admission: 17X Problems of Genito-Urinary system	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden004.12	All causes - Top 12 causes for admission: 17A Genital tract problems	Spells per 1000 pop	Spells	Current population	2006/07	2007
Burden005	All causes - Self reported measure of overall health and well-being - NATIONAL INDICATOR 119	Percent	People in good health	Total Population	2001	2001
Burden006	All causes - Healthy life expectancy at age 65 - NATIONAL INDICATOR 137	Years over 65 (x.x)	Life years for over 65s	Population over 65	2002-2006	2006/07
Burden008.1	Diabetes general - Quality and Outcomes Framework QMAS data (diabetes prevalence)	Percent	Disease register Diabetes	Practice list size	2006/07	2006/07

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Burden008.2	Diabetes general - Predicted versus known prevalence (diabetes prevalence)	Index (x.x)	Actual Prevalence	Expected prevalence	2006/07	2006/07
Burden009	Circulatory general - Mortality rate all circulatory disease -for under 75s NATIONAL INDICATOR 121	Per 1000 population	Deaths aged <75	Population under 75	2004-2006	2006/07
Burden010	CHD - mortality	Per 1000 population	Deaths	Total Population	2004-2006	2006/07
Burden011.1	CHD - QOF QMAS data (CHD Prevalence)	Percent	Disease register CHD	Practice list size	2006/07	2006/07
Burden011.2	CHD - Predicted versus known prevalence (CHD prevalence)	Index (x.x)	Actual Prevalence	Expected prevalence	2006/07	2006/07
Burden012	CHD -Hospital admission rate for heart attack (proxy for incidence) OPTIONAL	Spells per 000 (x.x)	Spells	Current population	2006/07	2007
Burden013	Admissions for cardiac revascularisation OPTIONAL	Per 000	Spells	Current population	2006/07	2007
Burden014	Stroke - mortality	Deaths per 000 (x.x)	Deaths	Current population	2004-2006	2007
Burden015	Stroke - Hospital admission rate for stroke (proxy for incidence) OPTIONAL	Per 000	Spells	Current population	2006/07	2007
Burden016	Cancer general - Mortality rate all cancers - for under 75s NATIONAL INDICATOR 122	Deaths per 000 (x.x)	Deaths aged <75	Population under 75	2004-2006	2007
Burden017	Cancer registrations - Quality and Outcomes Framework QMAS data (cancer prevalence)	Percent	Disease register Cancer	Practice list size	2006/07	2006/07
Burden018	Infectious respiratory - COPD mortality	Deaths per 000 (x.x)	Deaths	Current population	2004-2006	2007
Burden019.1	Infectious respiratory - Quality and Outcomes Framework QMAS data (COPD prevalence)	Percent	Disease register ID	Current population	2006/07	2007
Burden019.2	Infectious respiratory - Predicted versus known prevalence (COPD prevalence)	Index (x.x)	Actual Prevalence	Expected prevalence	2006/07	2006/07
Burden027	Trauma falls - hospital admissions for fractured neck of femur (proxy for incidence) OPTIONAL	Per 1000	Numbers of hospital admissions for fractured neck of femur	Total Population	2006/07	2007
Burden030	Hospital admissions -unintentional and deliberate injuries to young people per 10,000 population NATIONAL INDICATOR 70	Per 10,000	Total Numbers of children and young people admitted to hospital as a result of injury.	The total population of children and young people in the PCT area	2006/07	2007
Burden031	Musculoskeletal - arthritis - admissions for hip and knee replacement OPTIONAL	Per 1000	Numbers of hospital admissions for hip or knee replacement	Total Population	2006/07	2007

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Burden032	Limiting long term illness	Percent	2001 Census persons with limiting long-standing illness	Total Population	2001	2001
Demog001.01	Current population estimates 1-4	Percent	Current population estimates 1-4	Total population	2007	2007
Demog001.02	Current population estimates 5-9	Percent	Current population estimates 5-9	Total population	2007	2007
Demog001.03	Current population estimates 10-14	Percent	Current population estimates 10-14	Total population	2007	2007
Demog001.04	Current population estimates 15-19	Percent	Current population estimates 15-19	Total population	2007	2007
Demog001.05	Current population estimates 20-24	Percent	Current population estimates 20-24	Total population	2007	2007
Demog001.06	Current population estimates 25-29	Percent	Current population estimates 25-29	Total population	2007	2007
Demog001.07	Current population estimates 30-34	Percent	Current population estimates 30-34	Total population	2007	2007
Demog001.08	Current population estimates 35-39	Percent	Current population estimates 35-39	Total population	2007	2007
Demog001.09	Current population estimates 40-44	Percent	Current population estimates 40-44	Total population	2007	2007
Demog001.10	Current population estimates 45-49	Percent	Current population estimates 45-49	Total population	2007	2007
Demog001.11	Current population estimates 50-54	Percent	Current population estimates 50-54	Total population	2007	2007
Demog001.12	Current population estimates 55-59	Percent	Current population estimates 55-59	Total population	2007	2007
Demog001.13	Current population estimates 60-64	Percent	Current population estimates 60-64	Total population	2007	2007
Demog001.14	Current population estimates 65-69	Percent	Current population estimates 65-69	Total population	2007	2007
Demog001.15	Current population estimates 70-74	Percent	Current population estimates 70-74	Total population	2007	2007
Demog001.16	Current population estimates 75-79	Percent	Current population estimates 75-79	Total population	2007	2007
Demog001.17	Current population estimates 80-84	Percent	Current population estimates 80-84	Total population	2007	2007
Demog002	% change population projections 3 years time	Index	3 year projection	Current population	2010	2007
Demog003	% change population projections 5 years time	Index	5 year projection	Current population	2012	2007
Demog004	Current births	Percent	2007 Births	Current population	2007	2007
Demog005	Projected birth rates	Index	2011 projected births	2006 Births	2011	2006
Demog006.1	Current total population aged 65+	Percent	Population over 65	Current population	2007	2007
Demog006.2	Proportion of over 65s as males	Percent	Males over 65s	Current population	2007	2007
Demog006.3	Proportion of over 65s as females	Percent	Females over 65	Current population	2007	2007
Demog007.1	Aged 65+, male five-year projection	Index	Males over 65s	Males over 65s	2012	2007
Demog007.2	Aged 75+, male five-year projection	Index	Males over 75s	Males over 75s	2012	2007
Demog007.3	Aged 85+, male five-year projection	Index	Males over 85s	Males over 85s	2012	2007
Demog008.1	Aged 65+, female five-year projection	Index	Females over 65s	Females over 65s	2012	2007

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Demog008.2	Aged 75+, female five-year projection	Index	Females over 75s	Females over 75s	2012	2007
Demog008.3	Aged 85+, female five-year projection	Index	Females over 85s	Females over 85s	2012	2007
Demog010	Non white ethnic groupings Current percentages	Percent	Non white ethnic groupings	Total Population	2005	2005
Demog013	Limiting long term illness	Percent	Limiting long term illness	Total Population	2001	2001
Lifestyle001.1	Smoking - recorded prevalence	Percent	Numbers of smokers	Practice list size	2006/07	2006/07
Lifestyle001.2	Smoking Risk factor data (smoking prevalence) - OPTIONAL	Percent	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE
Lifestyle001.3	Smoking - quit rates	Per 1000 pop	Numbers of people who have quitted	Total Population	2006/07	2006/07
Lifestyle002.1	Eating - 2002-2004 adult fruit & veg consumption OPTIONAL	Percent	HSE score * population	Total Population	2002-2004	2002-2004
Lifestyle002.2	Eating - 2002-2004 child fruit & veg consumption OPTIONAL	Percent	HSE score * population	Total Population	2002-2004	2002-2004
Lifestyle003	Eating - Prevalence of breast feeding at 6-8 weeks from birth NATIONAL INDICATOR 53	Percent	Numbers breast feeding	New mothers	2006/07	2006/07
Lifestyle004	Alcohol - Alcohol-harm related admission rates NATIONAL INDICATOR 39	Per 1000 pop	Admissions	Population	2006/07	2006/07
Lifestyle005	Alcohol - recorded prevalence	Percent	Synthetic Estimates of Healthy Lifestyle Behaviours at Ward Level, 2000 - 02 %	100%	2000-2002	2002-2004
Lifestyle009.1	Hypertension - Quality and Outcomes Framework QMAS data (hypertension prevalence) OPTIONAL	Percent	Numbers with Hypertension	Practice list size	2006/07	2006/07
Lifestyle009.2	Hypertension - Predicted versus known prevalence (hypertension prevalence) OPTIONAL	Index (x.x)	Actual Prevalence	Expected prevalence	2006/07	2006/07
Lifestyle010.1	Obesity - Quality and Outcomes Framework QMAS data (obesity prevalence) OPTIONAL	Percent	Numbers with obesity	Practice list size	2006/07	2006/07
Lifestyle010.2	Obesity - Predicted versus known prevalence (obesity prevalence) OPTIONAL	Index (x.x)	Actual Prevalence	Expected prevalence	2006/07	2006/07
Services002	Numbers - Referrals	Percent	Numbers of referrals (from RAP R3)	Total Population	2006/07	2007
Services003	Numbers - Nursing care	Percent	Numbers of people currently receiving permanent nursing care	Total Population	2006/07	2007
Services004	Numbers - Residential Care (excluding those housed outside of the county)	Percent	Numbers of people currently receiving permanent residential nursing care	Total Population	2006/07	2007
Services005	Numbers - Adult placement	Per 1000	Numbers - Adult placement	Total Population	2006/07	2007
Services006	Numbers - Home support	Percent	Numbers - Home support	Total Population	2006/07	2007
Services007	Numbers - Receiving community equipment	Percent	Numbers of people who have received community equipment in one year	Total Population	2006/07	2007

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Services008	Numbers - Telecare	Per 10,000	Numbers of people currently receiving telecare	Total Population	2006/07	2007
Services010	Numbers - physical disability, frailty and sensory impairment (older clients)	Percent	Numbers of older people (>65) with physical disabilities, frailty and sensory impairment	Number of older people (>65)	2007	2007
Services011	Numbers - physical disability, frailty and sensory impairment (older clients) receiving community-based services	Percent	Numbers of older people (>65) with physical disabilities, frailty and sensory impairment provided with community based services	Number of older people (>65)	2007	2007
Services012	Numbers - physical disability, frailty and sensory impairment (clients age 18+)	Percent	Numbers of clients with physical disability, frailty and sensory impairment	Total Population	2006/07	2007
Services013	Numbers - physical disability, frailty and sensory impairment receiving community-based services aged 18+	Percent	Numbers of clients with physical disability, frailty and sensory impairment receiving community-based services	Number of clients with physical disability, frailty and sensory impairment (clients)	2006/07	2007
Services014	Numbers - learning disability (older clients)	Per 1000	Numbers of older people (>65) with learning difficulties	Number of older people (>65)	2007	2007
Services015	Numbers - learning disability (older clients) receiving community-based services	Per 1000	Numbers of older people (>65) with learning difficulties provided with community based services	Number of older people (>65)	2007	2007
Services016	Numbers - learning disability (clients age 18+)	Per 1000	Numbers of clients with learning disability	Total Population	2006/07	2007
Services017	Numbers learning disability clients age 18+ receiving community-based services	Percent	Numbers of clients with learning disability receiving community-based services	Number of clients with learning disability	2006/07	2007
Services018	Numbers - mental health (older clients)	Per 1000	Numbers of older people (>65) with mental health issues	Number of older people (>65)	2007	2007
Services019	Numbers - mental health (older clients) receiving community-based services	Per 1000	Numbers of older people (>65) with mental health issues provided with community based services	Number of older people (>65)	2007	2007
Services020	Numbers - mental health (clients age 18+)	Per 1000	Numbers of clients with a mental health diagnosis	Total Population	2006/07	2007
Services021	Numbers - mental health receiving community-based services age 18+	Percent	Numbers of clients with a mental health diagnosis receiving community-based services	Number of clients with a mental health diagnosis	2006/07	2007
Services026	Numbers - other vulnerable people (older clients)	Per 1000	Numbers of older people (>65) who are also classified as vulnerable provided with community based services	Number of older people (>65)	2007	2007

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Services027	Numbers - other vulnerable people (older clients) receiving community-based services	Per 1000	Numbers of older people (>65) who are also classified as vulnerable	Number of older people (>65)	2007	2007
Services028	Numbers - other vulnerable people (clients)	Per 1000	Numbers of other vulnerable clients	Total Population	2006/07	2007
Services029	Numbers - other vulnerable people receiving community-based services	Percent	Numbers of other vulnerable clients receiving community-based services	Number of other vulnerable clients	2006/07	2007
Services030	New clients where assessment was undertaken	Percent	New clients where assessment was undertaken	Current population	2007	2007
Services031	People supported to live independently through social services (NATIONAL INDICATOR)	People per 1000 pop	Numbers of adults (>18) assisted directly through social service assessed/care planned, funded support to live independently	Number of adults (>18)	2007	2007
Services032	Numbers - Homecare (Inc intensive home support) - Extra Care Housing	Percent	Numbers of people provided with extra care housing	Current population	2007	2007
Services033	Numbers - Homecare (Inc intensive home support) - Supported living	Percent	Numbers of people provided with supported living	Current population	2007	2007
Services035	Numbers of carers - Respite Care	Per 1000	Numbers of carers provided with a period of respite care for their dependent	Number of carers	2007	2007
Services036	Numbers of carers - Direct Payments	Per 1000	Numbers of carers provided with direct payments	Number of carers	2007	2007
Services037	Cervical screening uptake	Percent	Numbers of patients screened in the last 5 years	Number of patients eligible for screening 30 June 07	2006/07	2007
Services038	Cervical screening never tested	Per 1000	Numbers of patients eligible who have not been screened	Number of patients eligible for screening 30 June 07	2006/07	2007
Services039	Flu Immunisation uptake over 65	Percent	Numbers of people over 65 vaccinated in previous 12 months	Number of older people (>65)	2007	2007
Services040	Flu Immunisation uptake at risk population	Percent	Numbers of patients defined as at risk vaccinated 2006/07	Number of patients defined as at risk 30 June 07	2006/07	2007
Services041	Pneumococcal vaccine coverage over 65	Percent	Numbers of patients aged over 65 who received the pneumococcal vaccine in last 12 months	Number of patients aged over 65 at 30 June 07	2006/07	2007
Services042	Pneumococcal vaccine uptake over 65	Percent	Numbers of patients aged over 65 who received the pneumococcal vaccine any time up to 31st March 2007	Number of patients aged over 65 at 30 June 07	2006/07	2007

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Services043	Breast screening uptake in last 3 years	Percent	Numbers of patients who have been screened in the last 3 years	Patients registered on the day of extraction	2006/07	2007
Services044	Breast screening never screened	Percent	Numbers of eligible patients who have not been screened	Patients registered on the day of extraction	2006/07	2007
Services045	Uptake for MMR vaccine	Percent	Numbers of patients who received MMR vaccine	Number of children aged < 1 year	2006/07	2007
Services053	Numbers - Library users	Memberships per 1000 pop	Numbers of library memberships as of 2007	Current population	2007	2007
Services054	Numbers - Information and Advocacy	Requests per 1000 pop	Numbers of information and advocacy requests received	Current population	2007	2007
Social001	Proportion of children in poverty (NATIONAL INDICATOR 116)	Percent	Numbers of working age claimants for JSA, IB/SDA, IS and Pension Credit	Number of children 17 and under	2007	2007
Social002.1	Index of Multiple Deprivation (all people) from ID2007	Score (2 dec)	Sum of weighted IMD Scores	Total Population	2007	2005
Social002.2	IDACI (Children's Index Score) 2007	Score (2 dec)	Sum of weighted IMD Scores	Total Population	2007	2005
Social002.3	IDAOPI (Older people's Index Score) 2007	Score (2 dec)	Sum of weighted IDAOPI Scores	Total Population	2007	2005
Social003.1	Housing tenure - % owns outright	Percent	Numbers of households that are owned outright	Total Households	2001	2001
Social003.2	Housing tenure - % owns with a mortgage or loan	Percent	Numbers of households that are owned with a mortgage or loan	Total Households	2001	2001
Social003.3	Housing tenure - % owner occupied - shared ownership	Percent	Numbers of households that are owned in a shared arrangement	Total Households	2001	2001
Social003.4	Housing tenure - % rented from council/local authority	Percent	Numbers of households rented from the council or local authority	Total Households	2001	2001
Social003.5	Housing tenure - % rented from housing association/ registered social landlord	Percent	Numbers of households rented from a housing association or registered social landlord	Total Households	2001	2001
Social003.6	Housing tenure - % rented from private landlord	Percent	Numbers of households rented from a private landlord	Total Households	2001	2001
Social003.7	Housing tenure - % rented from other	Percent	Numbers of households rented from another source not listed above	Total Households	2001	2001
Social004	Living arrangements/over-crowding [From C2001]	Percent	Numbers of households categorised as being overcrowded (based on an occupancy rating of -1 or less)	Total Households	2001	2001

Indicator Code	Indicator Name	Unit	Numerator Name	Denominator Name	Data time period - numerator	Data time period - denominator
Social005	Elderly living alone	Percent	Numbers of households with a single pensioner resident	Number of households	2001	2001
Social006	Older people living without central heating	Percent	Numbers of older people living without central heating	Number of people over 65	2001	2001
Social009	No access to car or van [From C2001]	Percent	Numbers of households with no access to a car or a van	Total Households	2001	2001
Social010	Overall employment rate NATIONAL INDICATOR 151 [From C2001]	Percent	Numbers of ILO employees of working age	Working age population (16-64 Males, 16-59 Females)	2001	2001
Social011	Working age people on out-of work benefits (NATIONAL INDICATOR 152)	Percent	Numbers of working age people (i.e. m 18-64, f 18-59) claiming job seekers allowance in May 2007	Number of working age people (i.e. m 18-64, f 18-59)	2007	2007
Social012	Income deprivation score from ID 2007	Score (2 dec)	Sum of weighted IMD Scores	Total population	2007	2005
Social013.1	Income Support Claimants - As of May 2007	Percent	Numbers of working age people (i.e. m 18-64, f 18-59) claiming income support in May 2007	Number of working age people (i.e. m 18-64, f 18-59)	2007	2007
Social013.2	Income support and incapacity benefit or severe disablement allowance claimants - As of May 2007	Percent	Numbers of working age people (i.e. m 18-64, f 18-59) claiming income support and incapacity benefit or severe disablement allowance in May 2007	Number of working age people (i.e. m 18-64, f 18-59)	2007	2007
Social015	Benefits data relating to people/households on low incomes (Lone parent income support claimants) - As of May 2007	Percent	Numbers of working age people (i.e. m 18-64, f 18-59) who are lone parents (child under 16 and no partner) claiming income support in May 2007	Number of working age people (i.e. m 18-64, f 18-59)	2007	2007
Social016	Dependency on health-related benefits (Incapacity benefit or severe disablement allowance claimants) - As of May 07	Percent	Numbers of working age people (i.e. m 18-64, f 18-59) who are claiming incapacity benefit or severe disablement allowance in May 2007	Number of working age people (i.e. m 18-64, f 18-59)	2007	2007
Social017	Dependency on health-related benefits (Disability living allowance claimants) - As of May 07	Percent	Numbers of working age people (i.e. m 18-64, f 18-59) who are claiming disability living allowance in May 2007	Number of working age people (i.e. m 18-64, f 18-59)	2007	2007
Social019	The health and disability domain within ID	Score (2 dec)	Sum of weighted Sub Domain IMD Scores	Total Population	2007	2005
Social023	Access to services (e.g. from indices of deprivation)	Score (2 dec)	Sum of weighted IMD scores for Access to Services domain	Total Population	2007	2005

ANNEX F - Missing indicators and improvements for next refresh

Figure 21 - Indicators NOT included this time with reason for their exclusion.

Indicator Code	Indicator Name	Reason for non-inclusion and any other points of note
Burden020	Infectious respiratory - TB notifications OPTIONAL	The PCT have reported that no data are available.
Burden021	STIs - KC 60 GUM STI data, particularly gonorrhoea	
Burden022	STIs - Chlamydia in under 25s	The PCT have reported that no data are available.
Burden023	STIs - New diagnosis of HIV/Aids	The PCT have reported that no data are available.
Burden024	STIs - Late diagnosis of HIV	The PCT have reported that no data are available.
Burden025	Dental: % DMFT 5-year-olds - trend OPTIONAL	In 2005/2006 Oxfordshire PCT undertook a survey into dental health of 5 year olds. This survey revealed that 1.07% of 5 year olds had decayed missing or filled teeth.
Burden026.1	Mental Dementia - predictions from POPPI 2010	In 2010 there are estimated to be 7,681 cases of mental dementia from an over 65 population of 102,000. This represents 7.5% of the target population.
Burden026.2	Mental Dementia - predictions from POPPI 2012	In 2012 there are estimated to be 8,053 cases of mental dementia from an over 65 population of 106,000. This represents 7.6% of the target population and a 4.8% increase from 2010.
Burden028	Trauma road accidents - people killed or seriously injured on roads	This indicator has raised issues about whether to record where accidents took place or where the people involved lived, which are yet to be resolved. Data from Oxford County Council's Casualty Report 2006 and Road Safety Strategy and Plan 2007/08 reports 68 fatal road casualties in Oxfordshire in 2006. In addition, there were 304 serious road casualties. Taken together, this represents a serious road accident rate of 58.86 per 100,000 population.
Burden029	Trauma road accidents - children killed or seriously injured on roads NATIONAL INDICATOR 48	Numbers for this indicator are extremely small, such that most wards would report a nil return. Data from Oxford County Council's Casualty Report 2006 and Road Safety Strategy and Plan 2007/08 reports 2 fatal road casualties of children in Oxfordshire in 2006. In addition, there were 17 serious road casualties of children.
Demog001.18	Current population estimates 85 and over	
Demog011	Ethnic group Projections 3 years	Only 5 year projections were accessed (Demog012). This indicator was only available at County level and for Oxford City.
Demog012	Ethnic group Projections 5 years	This indicator was available (based on ONS experimental data) for both Oxfordshire County and Oxford City (but projections for other Local Authority Districts were not calculated because of unreliability associated with small numbers). In overall terms non white ethnic groupings (defined as all people NOT classified as wither "White British" or "Other White") are projected to increase by 10% for the county and 9% for Oxford City. The proportion of populations within these classifications in relation to total population is also projected to rise - especially in Oxford City (14.3% to 15.4%). Largest proportionate growth is anticipated in the over 60s.
Demog013.1	Limiting long term illness (>65)	This is a duplicate indicator of Burden032.
Demog014	% of population as migrant workers	This indicator was available only at district but not ward level. Oxford City has the most significant proportion of migrant workers - 3.5%, Cherwell is the next highest district - 1.2%, South Oxon - 0.9%, with Vale and West both having 0.7%.
Lifestyle001.4	Smoking - Deaths due to	Smoking deaths were not available at ward or practice level. Deaths for the period were 895 giving a rate of 0.14% or 14 deaths per 10,000 people per year.
Lifestyle006	Physical activity , e.g. from Active people survey	Data taken from the Active People Survey 2006 (commissioned by Sport England, and conducted by Ipsos MORI), which is the largest of its kind ever to be conducted in this country, was available at district level. Data was not available at ward or GP practice level.

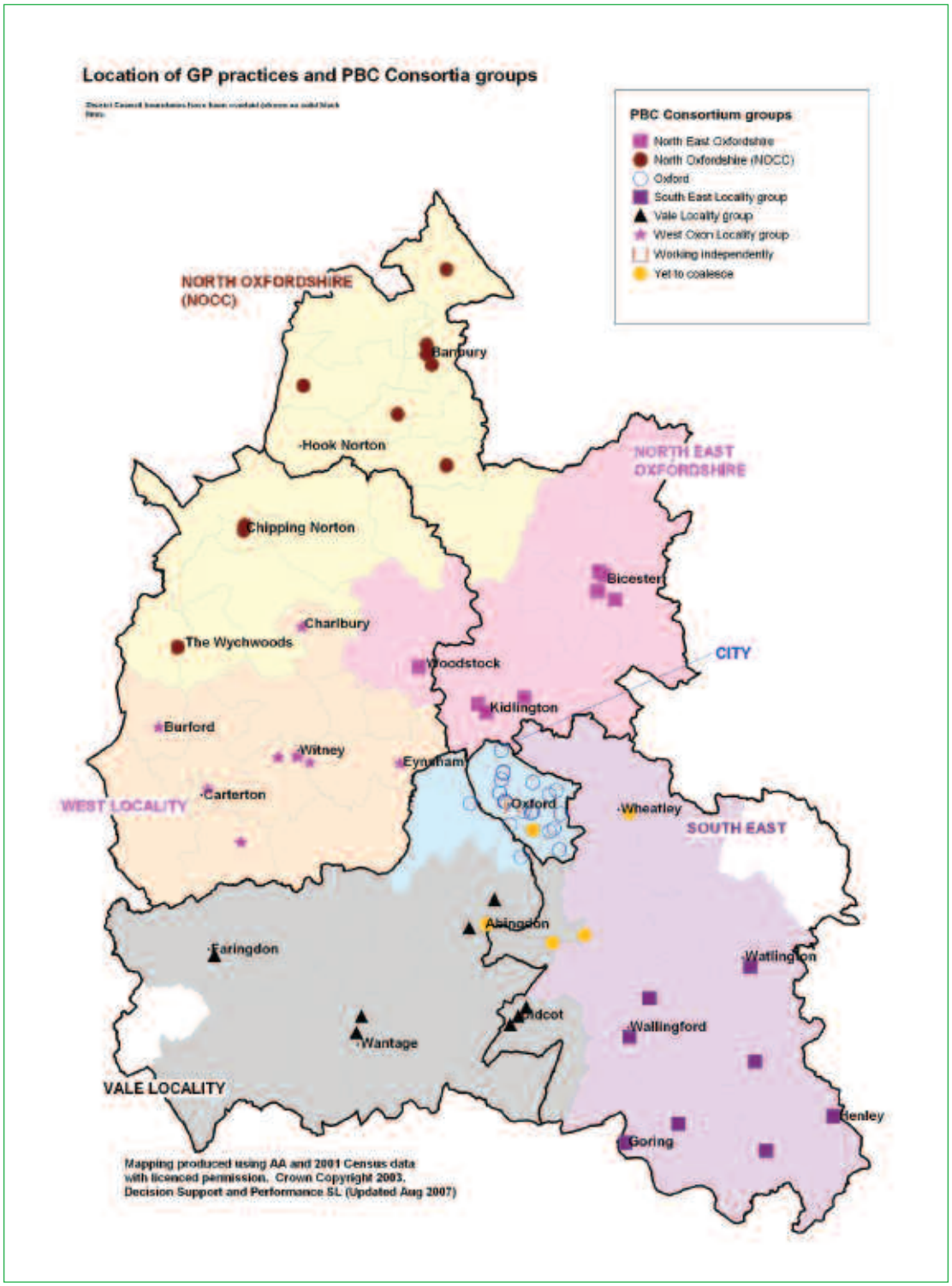
Indicator Code	Indicator Name	Reason for non-inclusion and any other points of note
Lifestyle007	Sexual behaviour -Teenage conceptions Age <18 rate plus 95% CI NATIONAL INDICATOR 112	The information was not available at practice level and the PCT has indicated that it is not permitted to share this information with other government agencies.
Lifestyle008	Sexual behaviour - Teenage conceptions Age <16 rate plus 95% CI	
Lifestyle011.1	Obesity - among young primary school children in Reception Year- NATIONAL INDICATOR 55	Information from the National Childhood Measurement Programme 2006/ 07 was available for children in reception and year 6 for the first time.
Lifestyle011.2	Obesity - among young primary school children in Year 6 - NATIONAL INDICATOR 56	
Services001	Numbers - Enquiries	This information is not routinely collected in Oxfordshire. This will be collected manually for a sample week in 2008-09.
Services009	Numbers - Day Services	Most day services in Oxfordshire are directly accessed by service recipients and details were not kept centrally of their home address. Home addresses are known for a smaller subset of the total number accessing these services - i.e. those who have this specifically included as a component within their care plan. In 2008-09 this information will be collected for all people attending centres that we provide funding for.
Services022	Numbers - substance misuse (older clients)	In Oxfordshire these clients were included within Mental Health category and not separately recorded.
Services023	Numbers - substance misuse (older clients) receiving community-based services	In Oxfordshire these clients were included within Mental Health category and not separately recorded.
Services024	Numbers - substance misuse (clients age 18+)	In Oxfordshire these clients were included within Mental Health category and not separately recorded.
Services025	Numbers - substance misuse receiving community-based services age 18+	In Oxfordshire these clients were included within Mental Health category and not separately recorded.
Services030	Timeliness of social care assessment (NATIONAL INDICATOR 132)	NI 132 has been replaced with a measure on the number of assessments that have been undertaken. In Oxfordshire all assessments are undertaken by a central team which covers the county. The time taken to complete an assessment should therefore not be dependent on geography. However there was no indicator in the national set which actually asked about where people we assessed lived. We therefore used the denominator of NI 132 as the numerator of a new indicator on the number of assessments and have used the local population as the denominator. The predecessor to NI 132 was PAF Indicator D55 'Timeliness of social care assessment'. This was banding by the Commission for Social Care Inspection on a 5 point scale. Oxfordshire completed 80% of its assessments in 2006/7 on time, which was described as 'acceptable, but room for improvement'. The current prediction for 2007-08 is 85% or 'good'.
Services034	Carers receiving needs assessment or review and a specific carer's service or advice and information (NATIONAL INDICATOR 135)	This indicator has not been reported on as the denominator (number of carers) is not available at ward level. The predecessor to NI 135 was PAF Indicator D62 'Carers services' - this is the same as NI 135, but excludes the provision of advice and information. This was banded by the Commission for Social Care Inspection on a 5 point scale. Oxfordshire provided carer services to 13% of its community based service recipients, which was described as 'very good'. The current prediction for 2007-08 is to remain at 13% or 'very good'.
Services046	Offer of an appointment at a GUM service within 48 hours	This data was available at Oxon PCT level only. Based on data for the period October 2006 to September 2007, 74.8% of first attendances received an offer to be seen within two normal working days (Source: GUMAMM on UNIFY2). The government target is 100% to be achieved by March 2008.
Services047	Long acting reversible contraception methods as a percentage of all contraception	The PCT have reported that no data are available.

Indicator Code	Indicator Name	Reason for non-inclusion and any other points of note
Services048	Access to NHS funded abortions before 10 weeks gestation	This information was only available for the Oxfordshire PCT. It was reported that 77% of all NHS funded abortions were carried out under 10 week's gestation (DoH Statistical Bulletin, Abortion Statistics England and Wales 2006. This compares favourably with the reported English national average of 65% in 2006 and exceeds the government target of 70%.
Services 050	The extent to which older people receive the support they need to live independently at home NATIONAL INDICATOR	This indicator will not be available until after March 2008. Will be included in future JSNA work.
Services 051	User perspective social care - Self reported experience of social care users NATIONAL INDICATOR	This indicator will not be available until after March 2008. Will be included in future JSNA work.
Services055	Numbers - Sport and leisure	
??	Satisfaction of people over 65 with both home and neighbourhood (NATIONAL INDICATOR 138)	At the moment it is unclear which questions will be used from the Place Survey to generate this indicator. It may be based on either on proposed question 2 (satisfaction with home) or question 3 (satisfaction with neighbourhood) or a combination of both. Question 2 is based on the Survey of English Housing 2005/6 and the data is not available to the council. Question 3 is bases on the MORI poll, so the data is available to the council. However it was neither gathered nor reported based on age. It is therefore not recommended to attempt to publish data on this.
Social007	Adults with learning disabilities in settled accommodation NATIONAL INDICATOR 146	This is a new measure to be collected from April 2008, which will be included in future JSNA work.
Social008	Adults in contact with secondary mental health services in settled accommodation NATIONAL INDICATOR 150	This is a new measure to be collected from April 2008, which will be included in future JSNA work.
Social014	Working age people claiming out-of work benefits in worst performing neighbourhoods (NATIONAL INDICATOR 153)	This data is available in indicator Social 011.
Social018	Numbers in employment who are registered disabled	This data was not made available by the Department of Work and Pensions.
Social020	Household income	CHKS were unable to access data in relation to this indicator.
Social021	% households on low income	CHKS were unable to access data in relation to this indicator.
Social022	Rural or urban location	
Social024	Satisfaction of people over 65 with home and neighbourhood NATIONAL INDICATOR 138	No data below all England level have been accessed.

We have discovered that a number of enhancements to the data that is collected need to be made to improve the usefulness of the JSNA, including:

- *e.g. more children and young people's data*
- *e.g. sports and activity data broken down below district level*
- *e.g. specific engagement of local people on the JSNA itself*
- *e.g. better quality, granularity and timeliness of ethnicity data*
- *e.g. better granularity of data relating to migrant workers*
- *e.g. routine recording of ethnicity as part of GP practice registers*
- *e.g. more and better consultation of people living in Oxfordshire*

ANNEX G - Map of the six GP Consortia for Practice Based Commissioning




BICESTER
BALLY

اشكال بديلة لهذا المنشور موجودة حسب الطلب. هذه تشمل لغات مختلفة و الطبعة البارزة وطريقة بريل و اشرطة كاست و اقراص الحاسوب او البريد الالكتروني.

Arabic

আপনি যদি অনুরোধ করেন তাহলে এই পুস্তিকাটি বিকল্প ছাঁদে, যেমন, অন্য কোনও ভাষায়, বড় হরফে, ব্রেইলে, অডিও-ক্যাসেটে, কমপিউটারের ডিস্কে বা ইমেলের মারফত পেতে পারেন।

Bengali

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Chinese

प्रार्थना करने पर यह प्रकाशन दूसरे रूपों में प्राप्त किया जा सकता है। जिस में सम्मिलित है, दूसरी भाषाओं में, बड़े छापे में, ब्रेअल, सुनने की टेप पर, कम्यूटर की डिस्क पर या ई-मेल द्वारा।

Hindi

"ਇਹ ਪੁਸਤਕ ਬੇਨਤੀ ਕਰਨ ਤੇ ਹੋਰ ਰੂਪਾਂ ਵਿਚ ਵੀ ਉਪਲਬਧ ਹੈ । ਜਿਵੇਂ ਕਿ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਛਾਪੇ ਤੇ, ਬ੍ਰੇਲ ਵਿਚ, ਸੁਣਨ ਵਾਲੀ ਟੇਪ ਤੇ, ਕੰਪਿਊਟਰ ਡਿਸਕ ਜਾਂ ਈ ਮੇਲ ਤੇ।"

Punjabi

"اس اشاعت کو متبادل اشکال میں درخواست کرنے پر حاصل کیا جا سکتا ہے۔ اس میں دوسری زبانیں، بڑا پرنٹ، بریل (جسے اندھے چھو کر پڑھ سکیں)، آڈیو کیسٹ، کمپیوٹر ڈسک یا ای میل شامل ہیں۔"

Urdu

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Polish

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Oxfordshire NHS
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70%

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