

5 Health Conditions and Causes of Death

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

5.1 Key findings – Health Conditions and Causes of Death

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

Health profile - overall

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

Leading causes of death

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

Health conditions

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

Mental Health

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



Data has been updated in this version



Data has been reviewed and is unchanged

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

Cancer

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

Heart Disease

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



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

Stroke

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

Dementia and Alzheimer's disease

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

Diabetes

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

Hypertension (high blood pressure)

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

Musculoskeletal disorders (Knee and Back pain)

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



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Data has been reviewed and is unchanged

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



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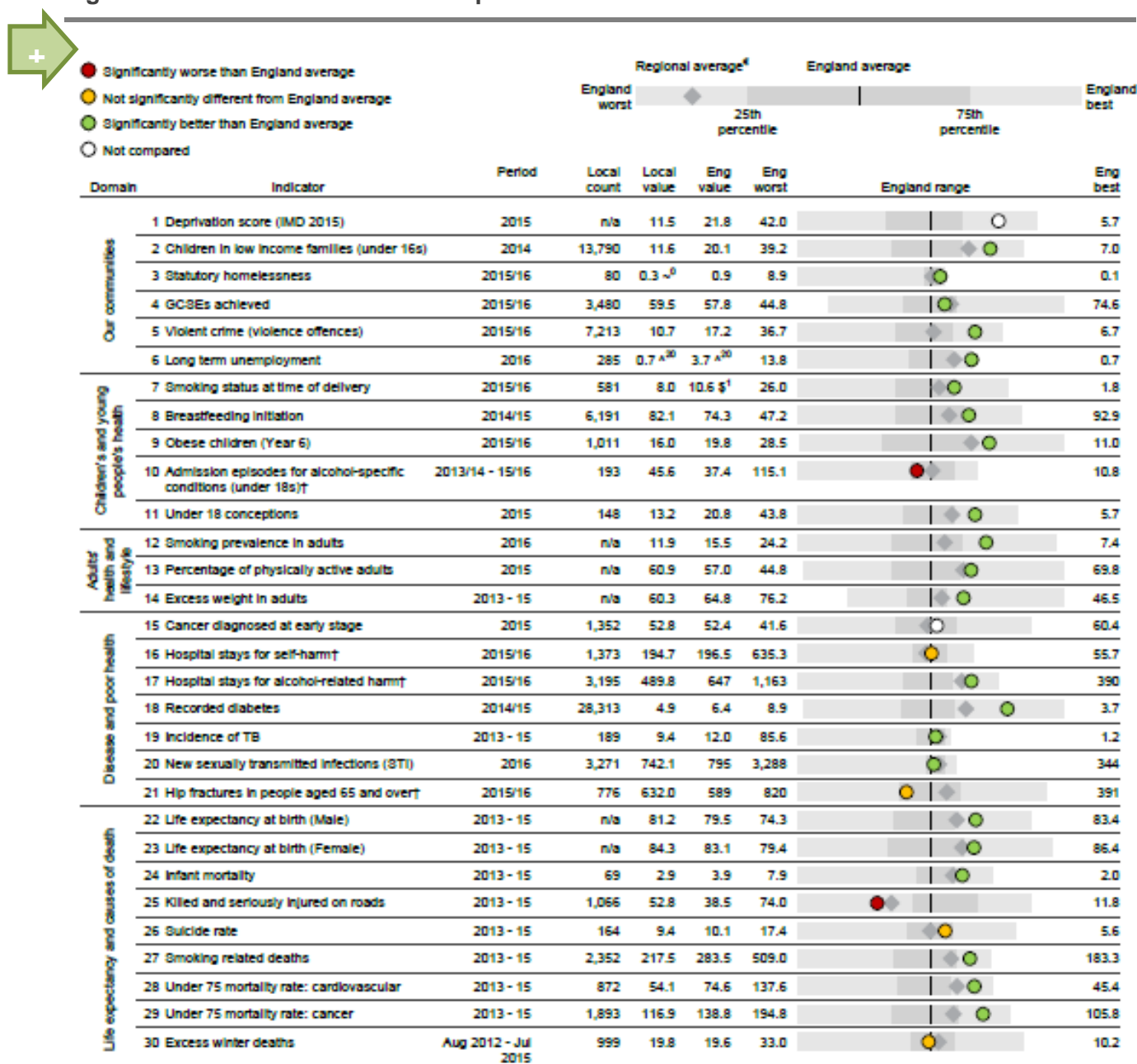
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5.2 Oxfordshire Health Profile

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

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

Figure 1 Oxfordshire Public Health profile 2017



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



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Data has been reviewed and is unchanged

5.3 Causes of death

➔ There were **5,435** deaths registered in Oxfordshire in 2016¹(calendar year), a slight increase on 2015 (5,299). There were slightly more deaths in females (2,797) than males (2,638).

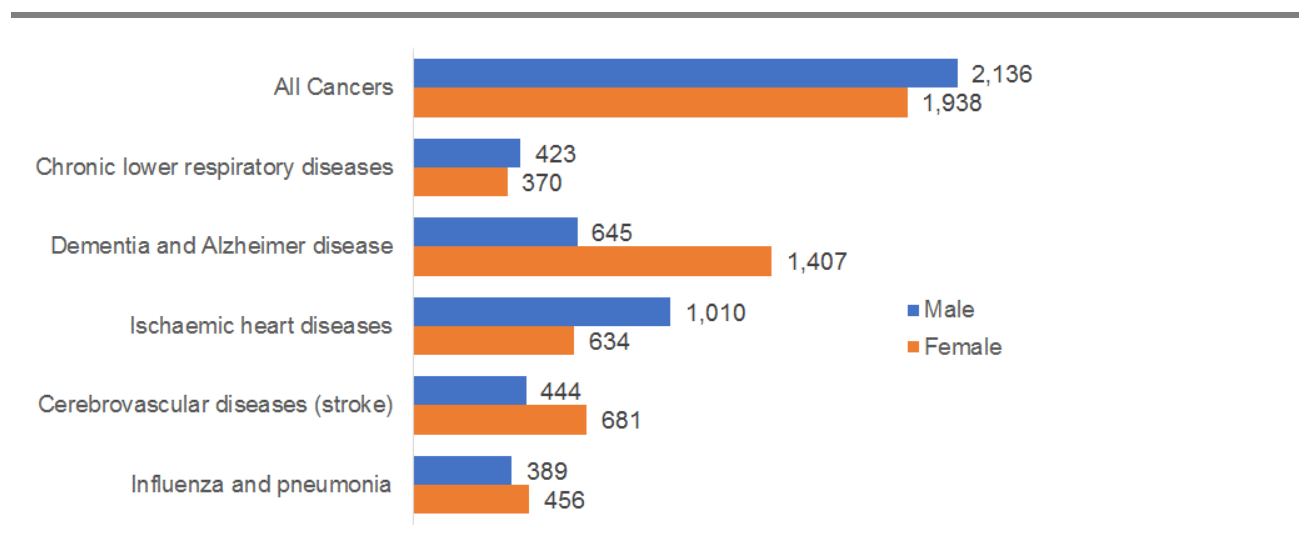
Leading causes of death

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

The second highest cause was:

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

➔ **Figure 2 Leading causes of death in Oxfordshire by gender (2014-2016)**



Source: ONS from nomis

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

¹ ONS (released July 2017)

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



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Data has been reviewed and is unchanged

Preventable mortality

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

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

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

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

Public Health

England

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

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

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

➔ **Table 1 Deaths under the age of 75 from four causes considered preventable, Oxfordshire (3 years, 2014 to 2016)**

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

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

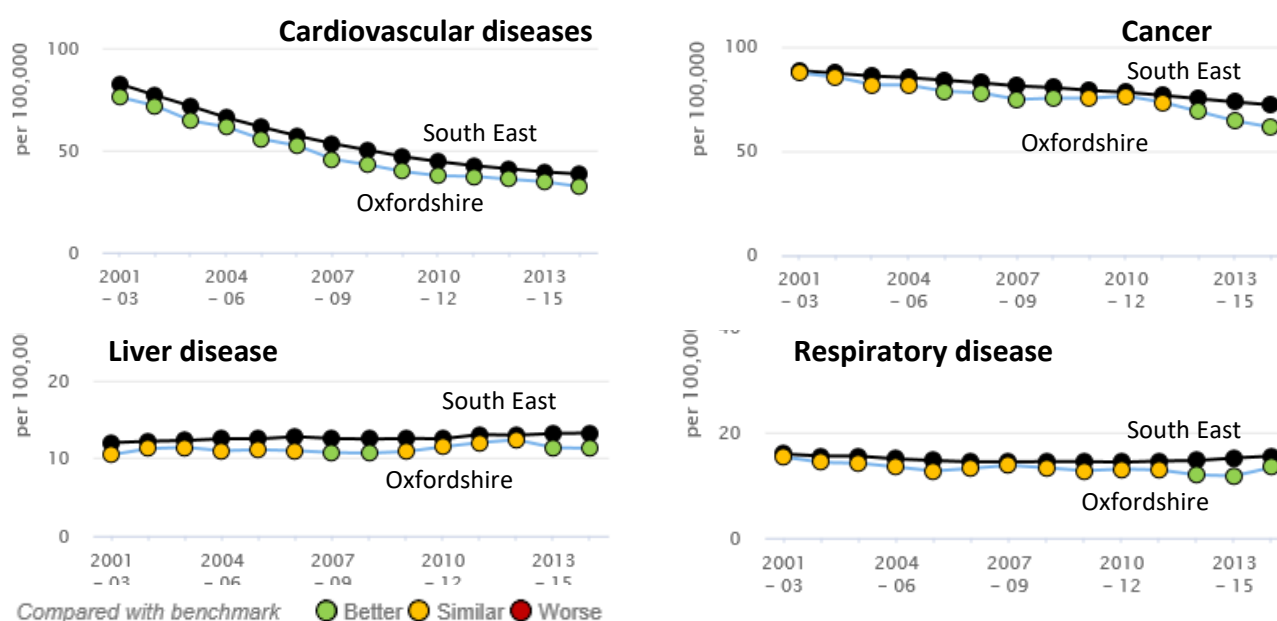


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Figure 3 Trend in preventable mortality (aged under 75) by leading causes, Oxfordshire vs South East region; 2001-03 to 2014-16



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

Excess winter deaths

About Excess winter deaths

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

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

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

ONS Excess winter mortality methodology

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

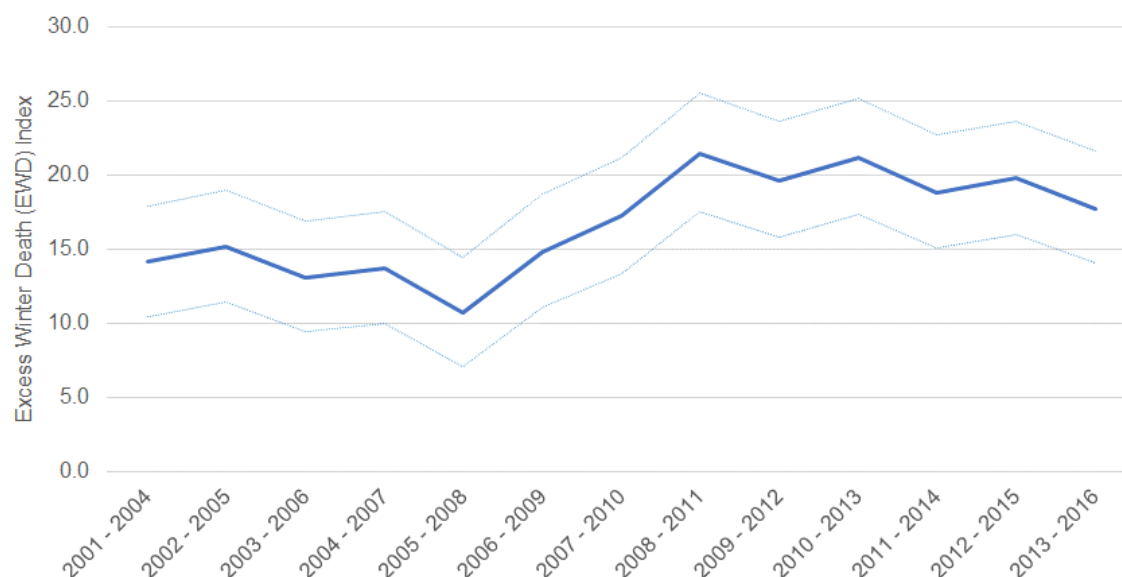


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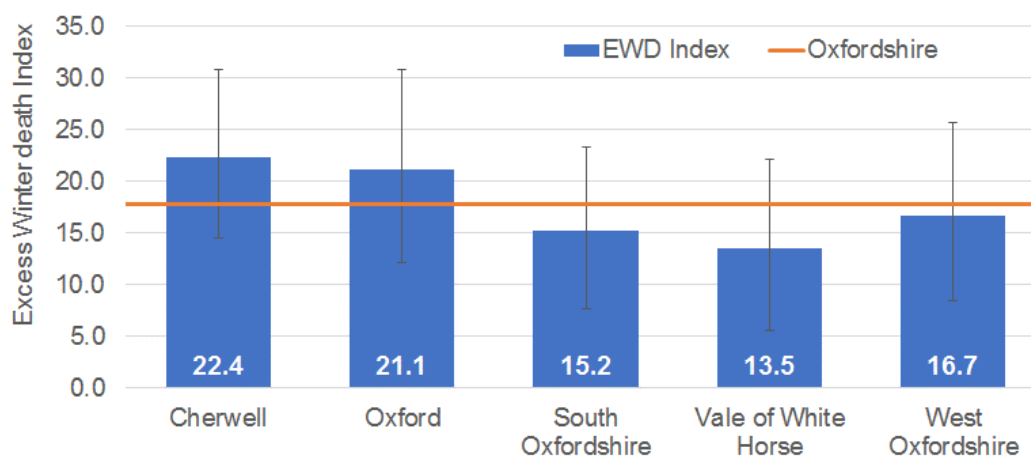
Figure 4 Excess Winter Mortality Index (3-years combined) – trended data for Oxfordshire 2001-2004 to 2013-2016



Source: Public Health Outcomes Framework

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

Figure 5 Excess Winter Mortality Index – districts in Oxfordshire – 2013-2016 (3 years combined)



Source: Public Health Outcomes Framework



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Road casualties

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

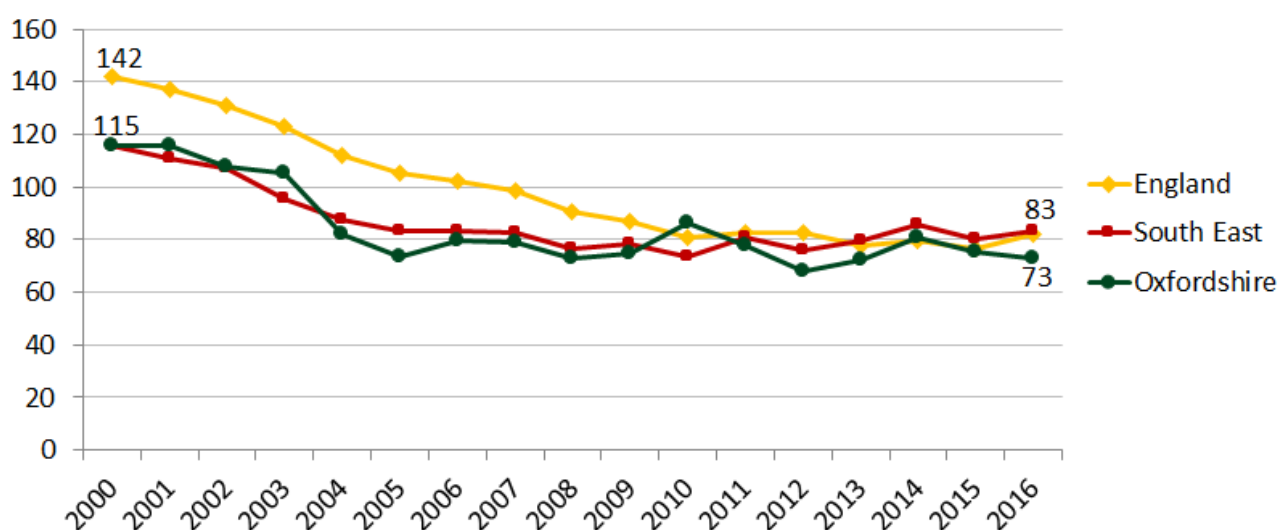
Per head of population

➔ According to the Public Health England road casualties indicator³, Oxfordshire continues to have a significantly higher rate of people killed or seriously injured per head of population (53.9 in 2014-16) than in the South East (50.6) and England overall (39.7). All districts, except for Oxford, had rates exceeding the national average. The highest was Cherwell with 62.3.

Per billion vehicle miles

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

➔ **Figure 6 Rate of Killed and Seriously Injured per billion vehicle miles**



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

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

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

² Source: Oxfordshire County Council

³ Source: Public Health England Outcomes Framework, Killed and Seriously Injured Casualties on Roads, crude rate per 100,000



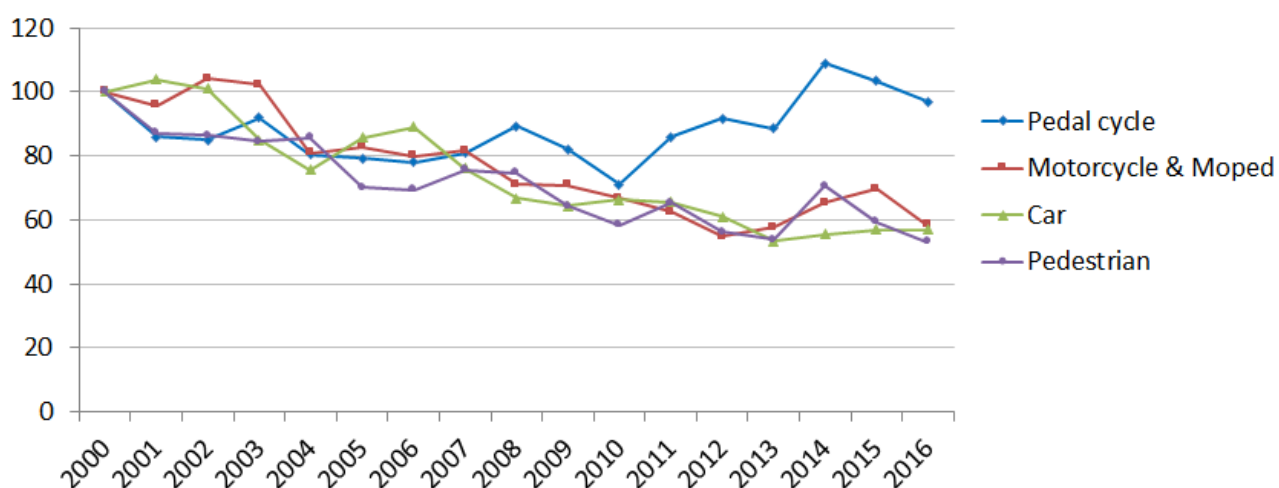
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Figure 7 Road casualties in Oxfordshire by vehicle type (indexed to yr 2000)



Source: Oxfordshire County Council

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



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5.4 Health conditions

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


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

Table 2 Change in prevalence of health conditions recorded by GPs (Quality and Outcomes Framework) for Oxfordshire CCG, 2015-16 to 2016-17

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




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

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

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

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

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

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



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About the Quality and Outcomes Framework (QOF)

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

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

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

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

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

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

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

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

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

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

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




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Data has been reviewed and is unchanged

5.5 Mental health

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

As reported in the evidence-base report by the Mental Health Foundation and the Faculty of Public Health⁴

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

As reported in **Better Mental Health For All** - A public health approach to mental health improvement⁵..

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

Adult wellbeing

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


About the ONS wellbeing indicators

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

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


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

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

 Releasing the wellbeing data for April 2016 to March 2017⁶, ONS commented..

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

⁴ <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

 ⁵ Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

⁶ ONS Personal well-being in the UK: April 2016 to March 2017



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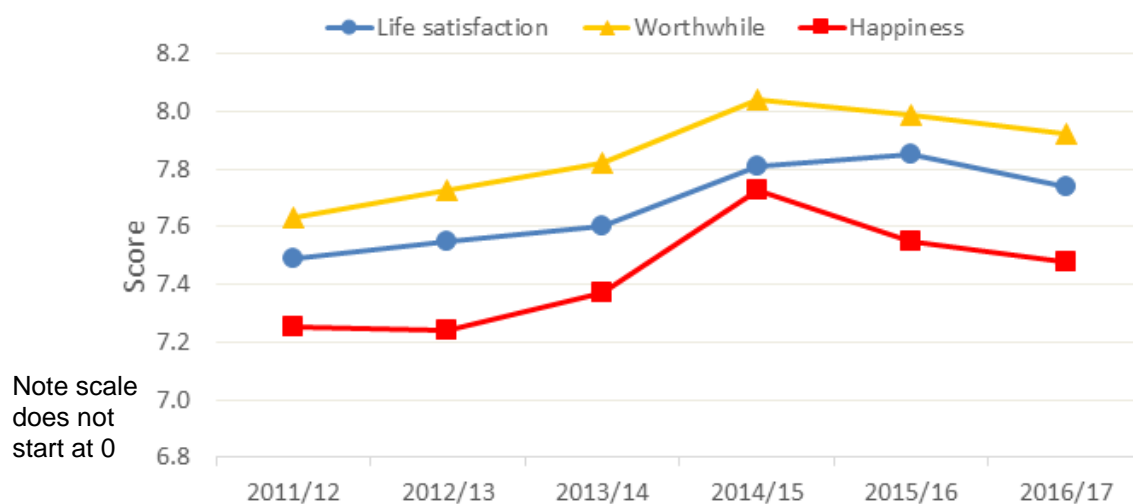


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financial situations and in the overall economy. These are factors we believe may account for some people's increased sense of personal well-being.

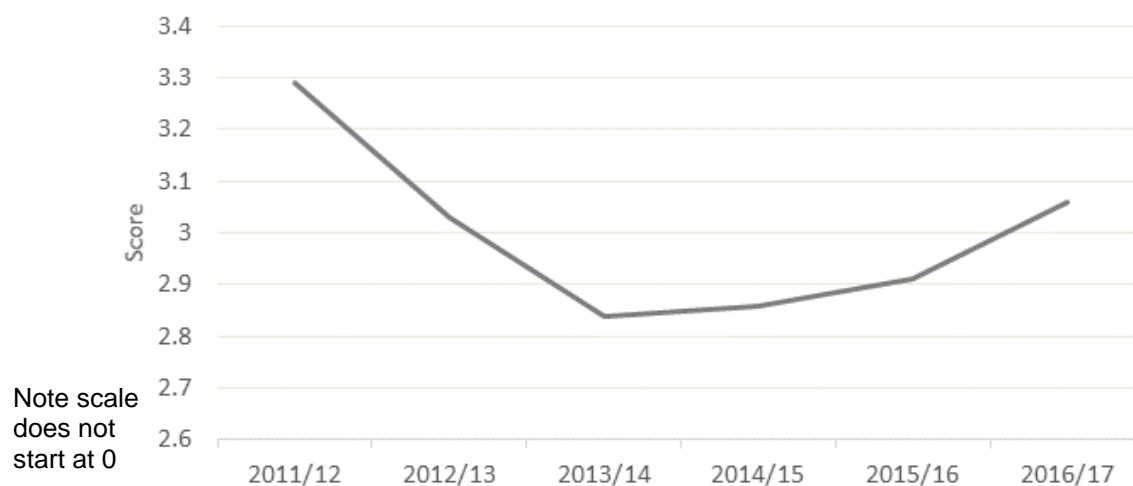
In Oxfordshire, the average wellbeing scores for: life satisfaction, "things you do are worthwhile" and happiness, are slightly lower in 2016-17 compared with 2015-16 and the anxiety mean is higher.

Figure 8 Trend in average wellbeing scores in Oxfordshire for (a) life satisfaction, (b) things you do that are worthwhile and (c) happiness



Source: Office for National Statistics Personal Wellbeing released Nov17

Figure 9 Trend in mean score for anxiety - Oxfordshire



Source: Office for National Statistics Personal Wellbeing released Nov17



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Data has been reviewed and is unchanged

Child wellbeing

Over three quarters of all mental health problems have emerged by the age of twenty, making childhood determinants primary in future mental wellbeing.⁷

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

According to the Public Health England report on Promoting children and young people's emotional health and wellbeing, in an average class of 30 15-year-old pupils⁸:

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

The 2015 Health Survey for England⁹ was the latest health survey to report on child wellbeing and found that:

- The majority of 13 to 15 year olds had high or very high scores on the ONS measures of life satisfaction (81%), feeling that the things they did were worthwhile (78%) and feeling happy yesterday (74%). More than half, 61%, also reported low or very low ratings for feeling anxious yesterday.
- The ONS measures showed some variation by age and sex, but these were not consistent. In general, older children and girls recorded lower levels of well-being than younger children and boys.
- Well-being was associated with whether or not 13 to 15 year olds had ever smoked or ever drunk alcohol. Children who had never smoked reported higher levels of well-being than those who had ever done so. Similarly, children who had not drunk alcohol reported higher levels of well-being than those who had drunk alcohol.

Common mental disorders

Common mental disorders (CMDs) include different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMDs to society is great.¹⁰

The 2014 Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing (a national survey, published Sept 2016) found that:

- **One adult in six had a common mental disorder (CMD):** about one woman in five and one man in eight. Since 2000, overall rates of CMD in England steadily increased in women and remained largely stable in men.

⁷ <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

⁸ Lavis, P. (2015). Promoting children and young people's emotional health and wellbeing: A whole school and college approach. London: Public Health England

⁹ <http://www.content.digital.nhs.uk/catalogue/PUB22610>

¹⁰ Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (Sept 2016) NHS Digital <http://content.digital.nhs.uk/catalogue/PUB21748>



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Data has been reviewed and is unchanged

- Reported rates of self-harming increased in men and women and across age groups since 2007. However, much of this increase in reporting may have been due to greater awareness about the behaviour.
- Young women have emerged as a high-risk group, with high rates of CMD, self-harm, and positive screens for posttraumatic stress disorder (PTSD) and bipolar disorder.
- The gap between young women and young men increased.
 - In 1993, 16 to 24 year old women (19.2%) were twice as likely as 16 to 24 year old men (8.4%) to have symptoms of CMD. In 2014, CMD symptoms were about three times more common in women of that age (26.0%) than men (9.1%).
- Most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed.

About the Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing

- The Adult Psychiatric Morbidity Survey series provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over).
- The 2014 survey (published September 2016) is the fourth in a series and was conducted by NatCen Social Research, in collaboration with the University of Leicester, for NHS Digital.
- The previous surveys were conducted in 1993 (16-64 year olds) and 2000 (16-74 year olds) by the Office for National Statistics, which covered England, Scotland and Wales. The 2007 Survey included people aged over 16 and covered England only.
- The survey used a robust stratified, multi-stage probability sample of households and assesses psychiatric disorder to actual diagnostic criteria for several disorders.

<http://content.digital.nhs.uk/catalogue/PUB21748>

Depression



GP (QOF) data on the number of patients **diagnosed with depression** shows that in 2016-17 there were around **56,800** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with depression, 9.7% of patients.

Between 2015-16 and 2016-17 the number of patients with depression in Oxfordshire CCG increased by 14%.

The rate of patients with depression in Oxfordshire (9.7%) has been above average for the South of England commissioning region and the average for England in each of the past 5 years.



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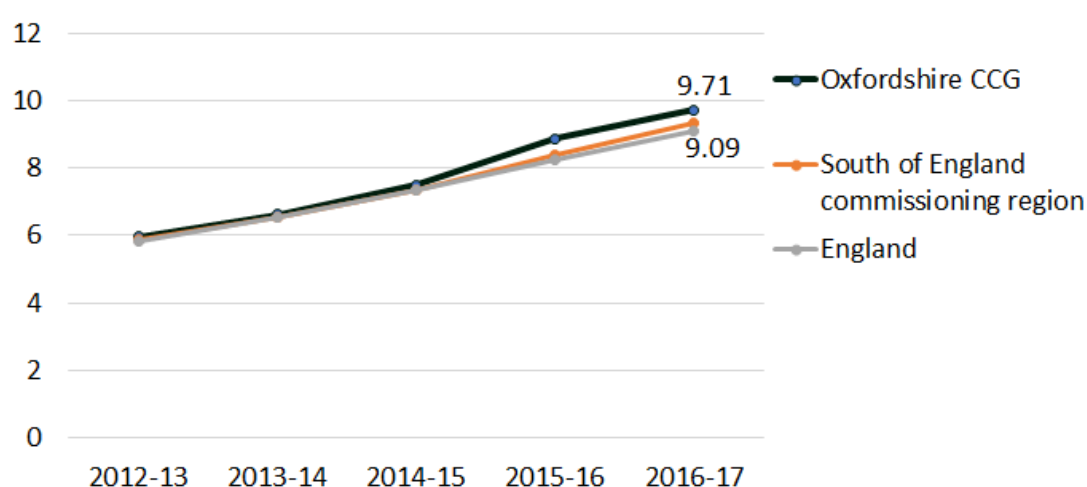
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Table 3 Patients registered with depression – count and percent

Count	2012-13	2013-14	2014-15	2015-16	2016-17
Oxfordshire CCG	32,634	37,002	42,594	49,662	56,795
<i>Change from previous year</i>		+4,368	+5,592	+7,068	+7,133
		+13%	+15%	+17%	+14%
Percent of patients aged 18+	2012-13	2013-14	2014-15	2015-16	2016-17
Oxfordshire CCG	5.97	6.62	7.5	8.88	9.71
South of England commissioning region	5.88	6.53	7.35	8.39	9.33
England	5.84	6.52	7.33	8.24	9.09

Source: NHS Digital Quality Outcomes Framework

Figure 10 Trend in prevalence of depression (percent of patients aged 18+), Oxfordshire CCG vs South of England and England



Source: NHS Digital Quality Outcomes Framework; indicators of depression at GP practice level are included in Annex

Severe and enduring mental disorders

People diagnosed with severe and enduring mental disorders are at increased risk of deprivation due to the challenges of maintaining employment, housing and social connections.

The Quality and Outcomes framework provides GP data on the number of patients diagnosed with schizophrenia, bipolar affective disorder or other psychoses; or who were on lithium therapy. In 2016/17 there were around 6,100 GP-registered patients in the Oxfordshire Clinical Commissioning Group area with these conditions. This number has increased by around 400 or 0.2% since 2015/16.



Data has been updated in this version

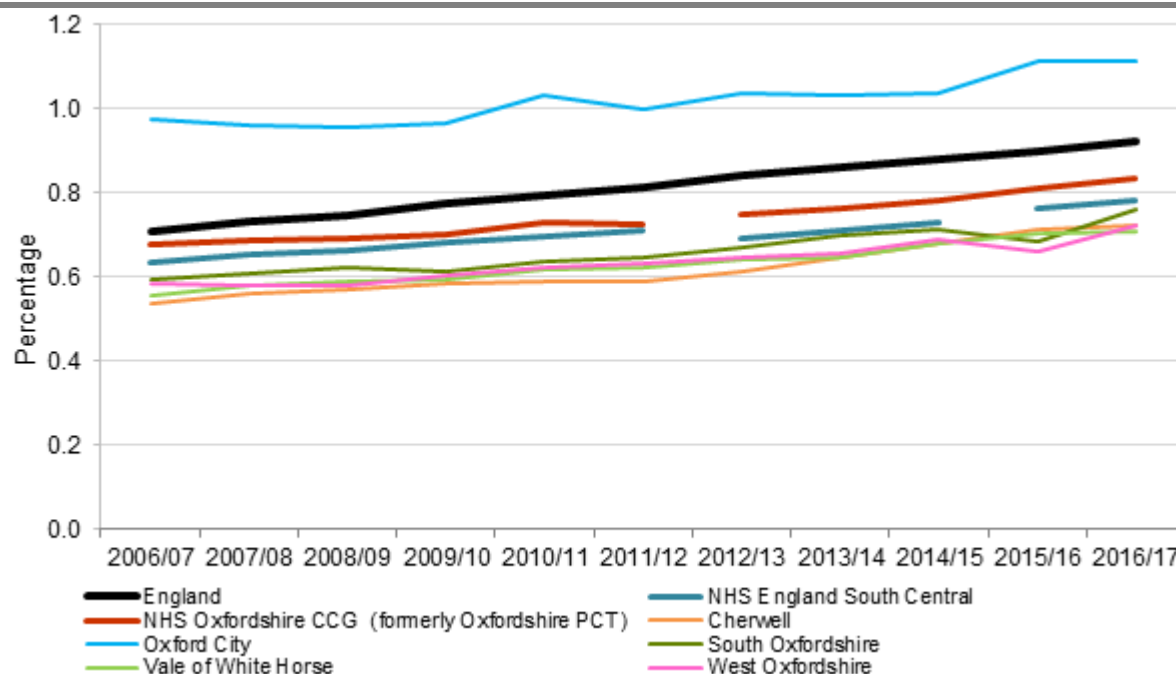


Data has been reviewed and is unchanged

The percentage of GP-registered patients with a recorded diagnosis of a severe and enduring mental health problem has increased in all districts since 2006-07. The rate in Oxford City remains well above the average for NHS Oxfordshire CCG.



Figure 11 Percentage of patients with a recorded diagnosis of a severe and enduring mental health problem in the GP registered population 2006-07 to 2016-17



Source: NHS Digital; quality and outcomes framework; indicator at GP practice level is included in Annex



Data has been updated in this version



Data has been reviewed and is unchanged

Intentional self-harm


Self-harm is a manifestation of emotional distress and a behavioural indication that something is wrong rather than a primary disorder. For each person, the contributing circumstances are unique.

An act of self-harm is not necessarily a suicide attempt or even an indicator of suicide but people who self-harm are statistically at a high and persistent risk of suicide.

Common reasons for self-harm are: difficult personal circumstances; past trauma and social/economic deprivation together with some level of mental disorder. Self-harm can be associated with the misuse of drugs or alcohol.

The available indicator of self-harm is the rate of emergency hospital admissions. This is likely to be an under-estimate of the true scale however as:

- The identification and coding of intent may be subject to recording bias.
- A variation in completeness of hospital records and quality of coding between hospital trusts (e.g. whether an injury is intentional).
- Data includes only those patients who were admitted to hospital therefore any patients attending A&E or Minor Injury Units (MIU) and NOT admitted are not included.
- Many will not attend hospital at all.

 During 2016-17 the number of emergency admissions for intentional self-harm in Oxfordshire was 1,465, this was greater than the number recorded in 2015-16 (1,373).

Oxfordshire's rates of hospital admissions for self-harm have been significantly lower than England, but the rate in 2016-17 has increased (unlike the decline across the South East region) and was significantly higher than England. There is insufficient data to know whether this is a trend or if self-harm is on the increase.

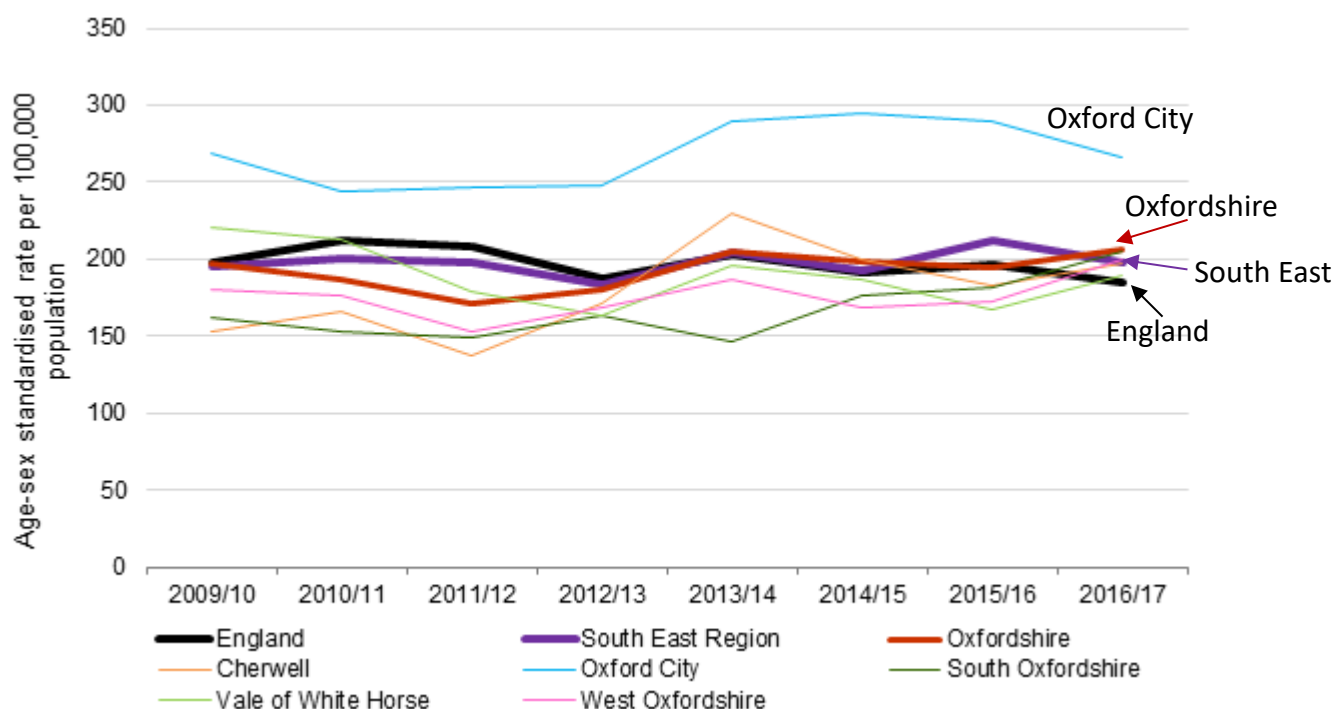


Data has been updated in this version



Data has been reviewed and is unchanged

Figure 12 Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population (2009-10 to 2016-17)



Source: Hospital Episode Statistics (HES) published via Local Authority Health Profiles (Public Health Observatories). Office for National Statistics (ONS) mid-year population estimates

Rates of hospital admission in Oxford City are significantly higher than Oxfordshire as a whole. This may be due to the presence of areas of deprivation, the higher proportion of drug and alcohol and mental health service users who live in the city as well as more facilities for the homeless.

➔ There were 15 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2011-12 to 2015-16), these included 7 in Oxford, 3 in Cherwell, 3 in Vale of White Horse, 1 in South Oxfordshire, and 1 in West Oxfordshire.

The two wards with the highest rates were the relatively deprived areas of Northfield Brook and Blackbird Leys in Oxford.

See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in intentional self-harm across Oxfordshire

Suicide

➔ Between 2014 and 2016, there was a total of **156** deaths registered as suicides in Oxfordshire ¹¹. The rate of suicides was not significantly different to England.

¹¹ ONS Suicides in England and Wales by Local Authority (released Sept17)



Data has been updated in this version



Data has been reviewed and is unchanged


There were 23 suicides of people aged under 25 in the Oxfordshire Clinical Commissioning Group area in 2014-16¹². The OCCG rate of 5.7 (age standardised) was statistically above the England average (4.7).


5.6 Autism

Autism is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them.¹³

The common diagnostic term for autism is 'autism spectrum disorder' (ASD). Autism as a spectrum condition means that autistic people share certain difficulties, but being autistic will affect them in different ways.

Some autistic people also have learning disabilities, mental health issues or other conditions¹⁴.

 In January 2017, there were **1,319 pupils** in Oxfordshire schools with special educational needs (SEN) whose primary type of need was ASD.¹⁵ This is above the number in January 2016 (1,220). Of these, 503 were in state funded primary schools, 537 were in state-funded secondary schools and 279 were in special schools.

 As reported in the 2016 Oxfordshire JSNA, Oxfordshire County Council's 2013 estimate was that there could be in the region of **6,850** people in Oxfordshire who are on the autistic spectrum.¹⁶

Estimates of the prevalence of autism in Oxfordshire (from 2013) suggest that there could be¹⁷:

- 2,000-3,000 adults with both autistic spectrum disorder and learning disabilities (defined as having an IQ below 70);
- Well over 2,000 adults with autistic spectrum disorder but no learning disabilities (many of whom will have Asperger's syndrome);
- Oxfordshire supports about 1100 school age children with autism and estimates that there are 40 – 60 pre-school children with autism who could benefit from early years support prior to starting school.

¹² Number of suicides by sex, age and clinical commissioning groups in England, 2014 to 2016 death registrations (user request released 18 Dec17)

¹³ The National Autistic Society <http://www.autism.org.uk/about/what-is.aspx>

¹⁴ The National Autistic Society <http://www.autism.org.uk/about/diagnosis/criteria-changes.aspx>

¹⁵ Department for Education SEN Statistics (January 2017, published July 2017): <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2017>

¹⁶ Oxfordshire Autism Joint Commissioning Strategy 2013-2017: <https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/business/providers/OxfordshireAutismStrategy.pdf>


¹⁷ Data from the Oxfordshire Autism Joint Commissioning Strategy 2013-2017: <https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/business/providers/OxfordshireAutismStrategy.pdf>



Data has been updated in this version




Data has been reviewed and is unchanged

 The Adult Psychiatric Morbidity Survey (2014)¹⁸ includes a chapter on Autism, although the survey was only able to include a very small sample (12 probable cases). This found that the estimated prevalence of autism in 2014 was 0.7% of the adult population in England. The estimated prevalence of autism in the 2007 data (1.0%) was similar to the 2014 estimate; with largely overlapping confidence intervals.

This finding is similar to a 2012 study of autism¹⁹ which indicated that 1.1% of the population in the UK may have autism.

Gender difference

 In 2015, the ratio of men to women who used National Autistic Society (NAS) adult services was approximately 3:1, and in those that use NAS schools it was approximately 5:1.²⁰

The NAS references a wide range of studies on the gender difference in diagnosis of autism and possible reasons why women and girls with autism may have been missed by professionals.

¹⁸ Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 published Sept2016 <http://content.digital.nhs.uk/catalogue/PUB21748>

¹⁹ Estimating the Prevalence of Autism Spectrum Conditions in Adults, 2012, Brugha T et al The Health and Social Care Information Centre

²⁰ <http://www.autism.org.uk/about/what-is/gender.aspx>



Data has been updated in this version



Data has been reviewed and is unchanged

5.7 Cancer

Prevalence

➔ In 2016-17 there were around **21,200** GP-registered patients in the Oxfordshire Clinical Commissioning Group who had a cancer diagnosis, up from 19,000 in 2015-16.

The prevalence increased from 2.73% of patients to 2.91% in 2016-17, this was above the national average of 2.58%.

Table 4 GP-registered patients with a cancer diagnosis (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	19,076	21,222	2,146
NHS Oxfordshire %	2.73%	2.91%	+0.17pp
South of England (health region) %	2.75%	2.94%	+0.2pp
England %	2.42%	2.58%	+0.16pp

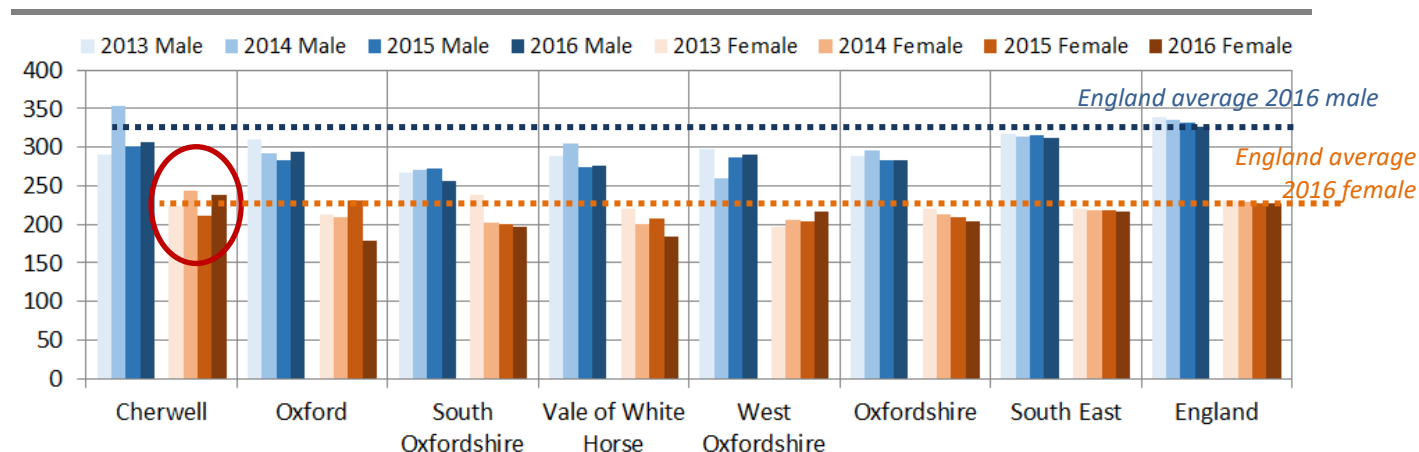
Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

Deaths

➔ In 2016, ONS statistics show 1,497 deaths from cancer in Oxfordshire.

Between 2013 and 2016, age-standardised mortality rates for cancer in Oxfordshire remained at a broadly similar level. The cancer mortality rate for females in Cherwell increased to just above the national average.

➔ **Figure 13 Age-standardised mortality rate, 2013 to 2016, Cancer**



Source: ONS mortality statistics (from nomis "life events")



Data has been updated in this version



Data has been reviewed and is unchanged

Age-standardised mortality rates (ASMRs) allow for differences in the age structure of populations and therefore allow valid comparisons to be made between geographic areas, over time and between sexes. Using the direct method, the age-standardised rate for a particular condition is that which would have occurred if the observed age-specific rates for the condition had applied in a given standard population.

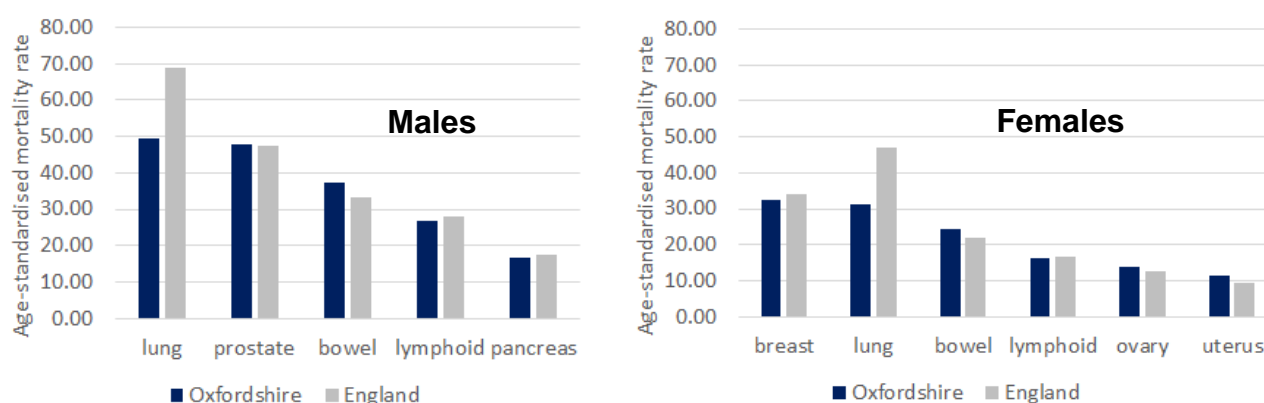
ONS User Guide to Mortality Statistics July 2016

In 2016, the causes of the greatest number of deaths from cancer in Oxfordshire were cancers of the lung, prostate, breast, bowel and lymphoid. Together these 5 causes accounted for just over half of all deaths from cancer (807 deaths, 54%).

For both males and females, rates of lung cancer deaths in Oxfordshire in 2016 were well below the England average.

Rates of bowel cancer deaths were above average in Oxfordshire in 2016 for both males and females.

Figure 14 Age-standardised mortality rate by cancer type, males and females, Oxfordshire vs England (2016)



Source: ONS mortality statistics (from nomis "life events")

Table 5 Count and age-standardised mortality rate by cancer type, males and females, Oxfordshire vs England (2016)

Males				Females			
	Oxfordshire count	Oxfordshire rate (SMR)	England rate (SMR)		Oxfordshire count	Oxfordshire rate (SMR)	England rate (SMR)
lung	137	49.36	68.95	breast	113	32.48	34.09
prostate	128	48.03	47.48	lung	107	31.42	47.07
bowel	103	37.32	33.24	bowel	87	24.2	22.1
lymphoid	75	26.81	28.04	lymphoid	57	16.39	16.88
pancreas	49	16.67	17.57	ovary	48	14	12.75
				uterus	39	11.46	9.48

Source: ONS mortality statistics (from nomis "life events")



Data has been updated in this version



Data has been reviewed and is unchanged



There were 4 wards in Oxfordshire with a significantly higher mortality ratio for cancers than England (2011-15). As in the previous dataset (2010-14), the ward with the highest rate was Banbury Ruscote in Cherwell district.

See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in cancer mortality across Oxfordshire

5.8 Heart disease

Prevalence



In 2016-17 there were just below **17,800** GP-registered patients in the Oxfordshire Clinical Commissioning Group with coronary heart disease, up from 17,400 in 2015-16. The prevalence decreased from 2.50% of patients to 2.43%, remaining below regional and national averages.

Table 6 GP-registered patients with Coronary Heart Disease (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	17,422	17,768	+346
NHS Oxfordshire %	2.50	2.43	-0.06
South of England (health region) %	3.15	3.14	-0.01
England %	3.19	3.15	-0.04

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for coronary heart disease than England (2011-12 to 2015-16): Banbury Ruscote in Cherwell and Northfield Brook in Oxford.

See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in admissions for heart disease across Oxfordshire



Data has been updated in this version

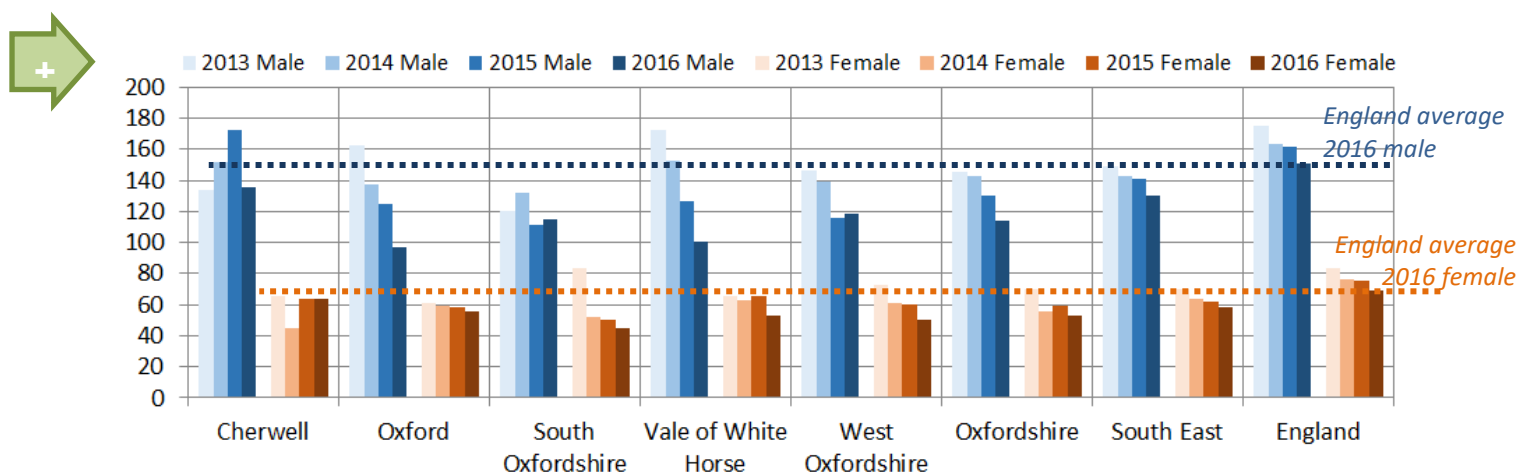


Data has been reviewed and is unchanged

Deaths

➔ Mortality due to heart disease has declined nationally and in every district in Oxfordshire except for South and West Oxfordshire where male mortality due to heart disease increased slightly between 2015 and 2016.

Figure 15 Age standardised mortality rate, 2013 to 2016, Ischaemic heart diseases



Source: ONS mortality statistics (from nomis "life events")

5.9 Stroke

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

Prevalence

➔ In 2016-17 there were around **12,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of stroke and transient ischaemic attack, up from 11,800 in 2015-16. The prevalence increased from 1.68% of patients to 1.71%, remaining below the regional and national averages.

Table 7 GP-registered patients with stroke and transient ischaemic attack

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	11,759	12,477	+718
NHS Oxfordshire %	1.68	1.71	+0.02pp
South of England (health region) %	1.87	1.89	+0.03pp
England %	1.74	1.75	+0.01pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



Data has been updated in this version



Data has been reviewed and is unchanged



There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for stroke than England (2011-12 to 2015-16): both in Banbury (Cherwell).

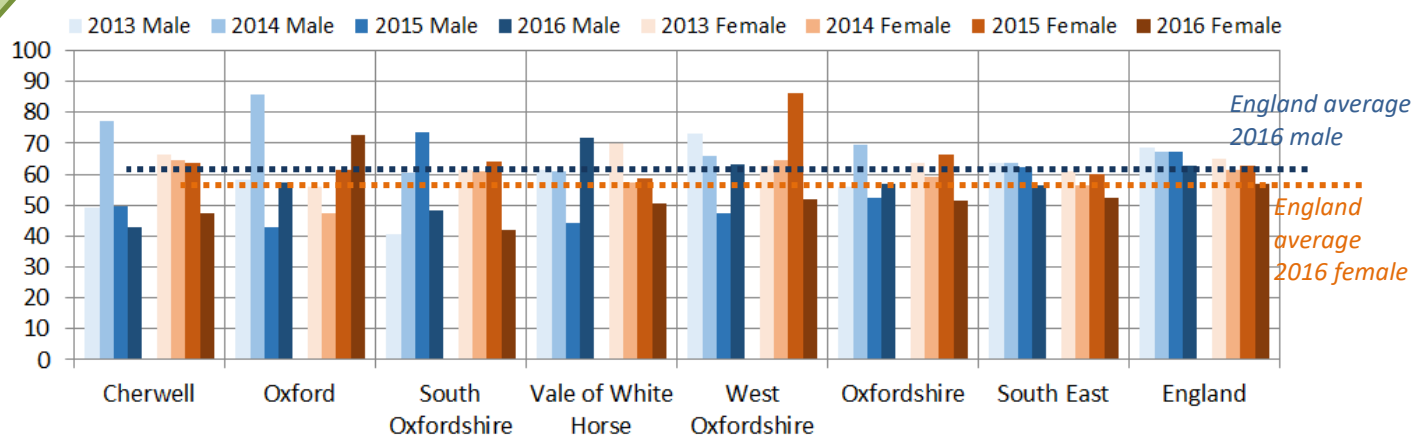
See JSNA 2018 ANNEX Health Inequalities Basket of Indicators for differences in admissions for stroke across Oxfordshire

Deaths

Between 2015 and 2016, the age-standardised mortality rate for cerebrovascular diseases (stroke) increased in males in Oxfordshire, against the declining national and regional trend.

The rates by district show females in Oxford and males in Vale of White Horse each above average in 2016.

Figure 16 Age standardised mortality rate, 2013 to 2016, Cerebrovascular diseases



Source: ONS mortality statistics (from nomis "life events")



Data has been updated in this version



Data has been reviewed and is unchanged

5.10 Dementia and Alzheimer's disease

Prevalence


 In 2016-17 there were almost **5,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of Dementia and Alzheimer's disease, up from 5,200 in 2015-16. The prevalence increased from 0.74% of patients to 0.75%, just below the national average and below the regional average.


Table 8 GP-registered patients with Dementia and Alzheimer's disease (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	5,176	5,461	+285
NHS Oxfordshire %	0.74	0.75	+0.01pp
South of England (health region) %	0.84	0.84	0pp
England %	0.76	0.76	+0.01pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

The estimated total number of people living with dementia in Oxfordshire (diagnosed and undiagnosed) is around 8,000²¹.

Deaths

 In West Oxfordshire, the age-standardised mortality rate for females due to Dementia and Alzheimer's disease increased in 2014, 2015 and again in 2016 to well above the national and regional averages.

The mortality rate for females due to Dementia and Alzheimer's disease was above the national average in Cherwell in 2015 and 2016.

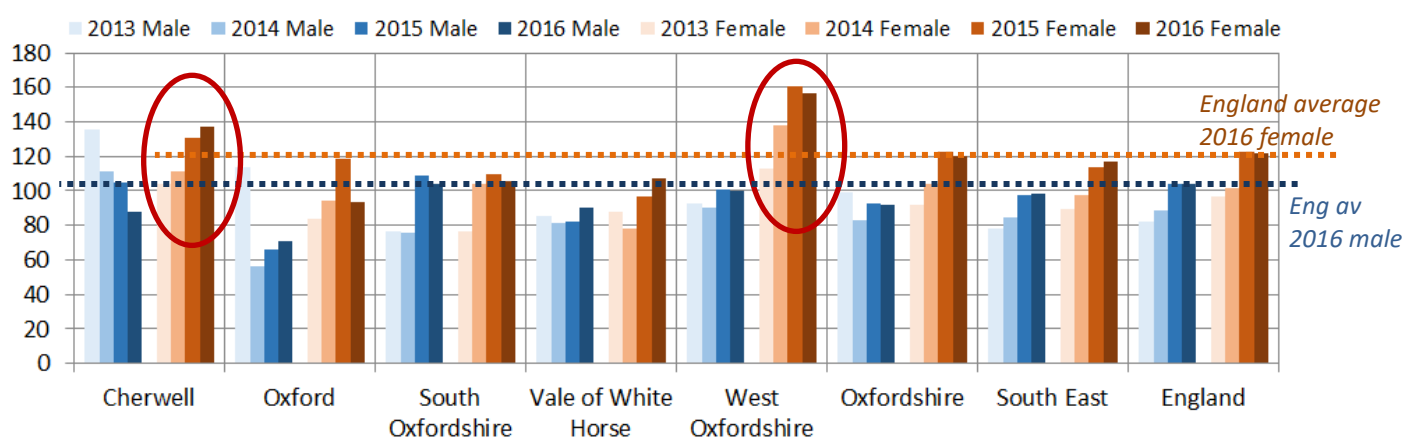
²¹ Oxfordshire Clinical Commissioning Group



Data has been updated in this version



Data has been reviewed and is unchanged

Figure 17 Age standardised mortality rate, 2013 to 2016, Dementia and Alzheimer's disease

Source: ONS (from nomis "life events")

5.11 Diabetes

Diabetes mellitus is a condition that causes a person's blood sugar level to become too high. There are two types of diabetes²²:

- Type 1 diabetes is an autoimmune condition where the body attacks and destroys insulin-producing cells, meaning no insulin is produced. This causes glucose to quickly rise in the blood.
- In Type 2 diabetes, the body doesn't make enough insulin, or the insulin it makes doesn't work properly, meaning glucose builds up in the blood. Type 2 diabetes is caused by a complex interplay of genetic and environmental factors. Up to 58 per cent of Type 2 diabetes cases can be delayed or prevented through a healthy lifestyle.
- About 90 per cent of people with diabetes have Type 2.

In 2016-17 there were around **29,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of diabetes, up from 27,900 in 2015-16.

The prevalence increased from 4.92% of patients to 4.97% in Oxfordshire, remaining below the national and regional averages.

²² <https://www.diabetes.org.uk/Diabetes-the-basics/>



Data has been updated in this version



Data has been reviewed and is unchanged

Table 9 GP-registered patients with a recorded diagnosis of diabetes (count and % of list)

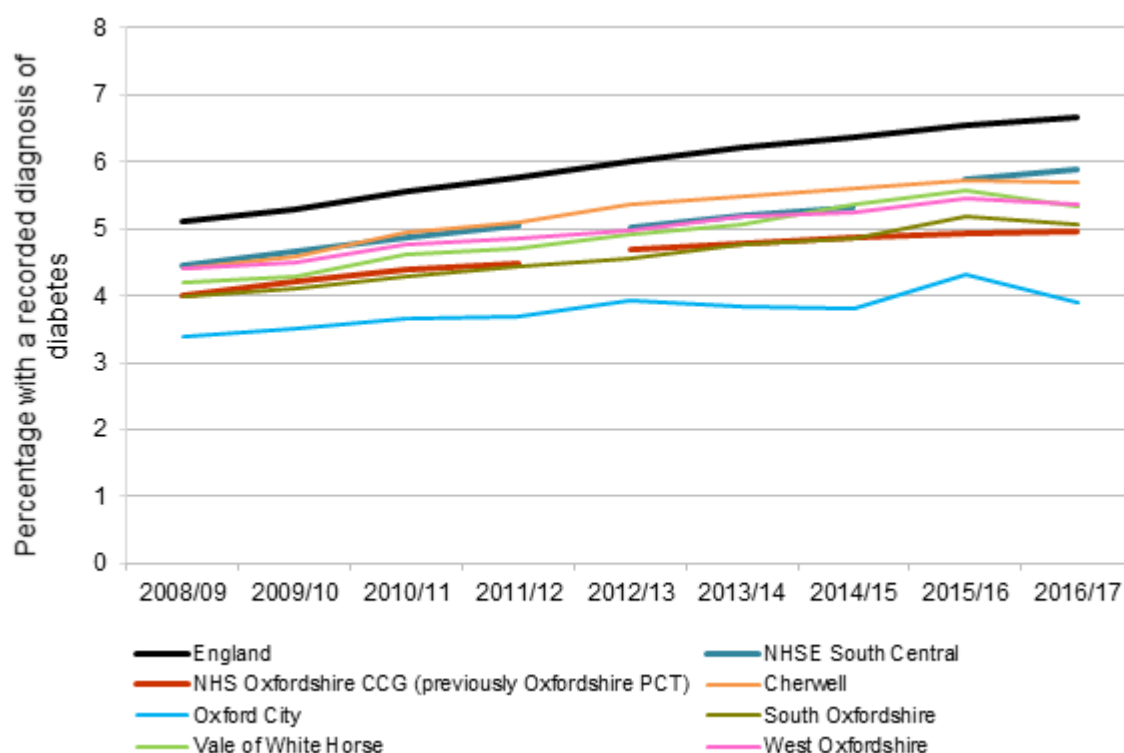
	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	27,925	29,469	+1,544
NHS Oxfordshire %	4.92	4.97	+0.04pp
South of England (health region) %	5.99	6.14	+0.15pp
England %	6.54	6.67	+0.13pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

QOF data for GP practices located within Oxfordshire's districts shows that:

- All five district council areas in Oxfordshire have significantly lower percentages of patients recorded with diabetes than the England and regional averages.
- When compared with the Oxfordshire average:
 - Oxford City has a significantly lower percentage of patients recorded with diabetes.
 - Cherwell, Vale of White Horse and West have a significantly higher percentage of patients recorded with diabetes.

Figure 18 Percentage of patients aged 17+ with a recorded diagnosis of diabetes in the GP registered population 2004-05 to 2016-17



Source: NHS Digital; quality and outcomes framework



Data has been updated in this version



Data has been reviewed and is unchanged

The Health Survey for England 2015 shows the prevalence of diabetes as higher for men than women and significantly higher in those who are overweight or obese (this data is not included in the HSE 2016 update).

Table 10 Diabetes status, as % of people aged 16+, by body mass index (BMI) status and sex (England from HSE 2016)

	Diabetes status (%)	BMI status			
		Normal	Overweight	Obese	Total
Men	Diagnosed diabetes	3	5	8	6
	Undiagnosed diabetes	1	2	8	3
	Total diabetes – men	4	8	17	9
Women	Diagnosed diabetes	2	4	9	5
	Undiagnosed diabetes	1	2	6	2
	Total diabetes – women	3	5	14	7
All adults	Diagnosed diabetes	2	5	9	5
	Undiagnosed diabetes	1	2	7	3
	Total diabetes – all adults	3	7	15	8

Source: Health Survey for England 2015. Aged 16 and over with both valid height and weight measurements, and glycated haemoglobin measurement



Data has been updated in this version



Data has been reviewed and is unchanged

5.12 Hypertension (high blood pressure)

Hypertension is also known as high blood pressure. It is often called ‘the silent killer’ as, if left untreated, increases the risk of a heart attack or stroke.

Risk factors for hypertension²³ include being over 65 years of age, family history, having African or Caribbean descent, being overweight, poor diet, lack of exercise, excessive alcohol and coffee consumption.


 In 2016-17 there were around **89,900** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of Hypertension, up from 85,800 in 2015-16. The prevalence increased from 12.29% of patients to 12.31%, remaining below the national and regional averages.

Table 11 GP-registered patients with a diagnosis of Hypertension (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	85,799	89,882	+4,083
NHS Oxfordshire %	12.29	12.31	+0.02pp
South of England (health region) %	14.05	14.14	+0.09pp
England %	13.79	13.83	+0.04pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

QOF data for GP practices located within Oxfordshire's districts shows that:

- West Oxfordshire GPs have had a significantly higher percentage of patients with a recorded diagnosis of hypertension than England
- Oxford City has a significantly lower percentage of patients with a recorded diagnosis of hypertension than all other local authorities in Oxfordshire.

The Health Survey for England 2015 shows the prevalence of Hypertension is higher for men than women and significantly higher in those who are overweight or obese (this data is not included in the HSE 2016 update).

²³ [http://www.nhs.uk/Conditions/Blood-pressure-\(high\)/Pages/Causes.aspx](http://www.nhs.uk/Conditions/Blood-pressure-(high)/Pages/Causes.aspx)



Data has been updated in this version



Data has been reviewed and is unchanged

 **Table 12 Hypertension status, as % of people aged 16+, by body mass index (BMI) status and sex (England from HSE 2015)**

	Hypertension categories (%)	BMI status			
		Normal	Overweight	Obese	Total
Men	Normotensive untreated	79	74	57	73
	Hypertensive controlled	7	8	15	9
	Hypertensive uncontrolled	3	5	7	5
	Hypertensive untreated	11	13	21	13
	All men with hypertension	21	26	43	27
Women	Normotensive untreated	82	76	63	77
	Hypertensive controlled	6	8	13	8
	Hypertensive uncontrolled	4	6	10	6
	Hypertensive untreated	8	11	14	9
	All women with hypertension	18	24	37	23
All adults	Normotensive untreated	81	75	60	75
	Hypertensive controlled	6	8	14	9
	Hypertensive uncontrolled	3	6	9	5
	Hypertensive untreated	10	12	17	11
	All adults with hypertension	19	25	40	25

Source: Health Survey for England 2016. Aged 16 and over with three valid blood pressure measurements, and both valid height and weight measurements.

5.13 Asthma

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


 In 2016-17 there were around **42,200** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with asthma up from 40,100 in 2015-16. The prevalence increased from 5.75% of patients to 5.78% and remained below the regional and national averages.

Table 13 GP-registered patients with Asthma (count and % of list)

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	40,087	42,213	+2,126
NHS Oxfordshire %	5.75	5.78	+0.04pp
South of England (health region) %	6.04	6.10	+0.06pp
England %	5.91	5.94	+0.04pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



Data has been updated in this version



Data has been reviewed and is unchanged

5.14 Chronic Obstructive Pulmonary Disease (lung diseases)

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


 In 2016-17 there were around **9,900** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with a diagnosis of Chronic Obstructive Pulmonary Disease. This was an increase of 500 on the number in 2015-16 (9,400). The prevalence increased from 1.34% of patients to 1.36%, remaining below the regional and national averages.

Table 14 GP-registered patients with Epilepsy (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	9,381	9,897	516
NHS Oxfordshire %	1.34	1.36	+0.02pp
South of England (health region) %	1.71	1.76	+0.04pp
England %	1.85	1.87	+0.03pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017

5.15 Epilepsy

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


 In 2016-17 there were around **4,100** GP-registered patients in the Oxfordshire Clinical Commissioning Group area who were receiving drug treatment for Epilepsy, up from just under 4,000 in 2015-16. The prevalence remained the same and below the regional and national averages.

Table 15 GP-registered patients with Epilepsy (count and % of list)

	2015-16	2016-17	2015-16 to 2016-17
NHS Oxfordshire (count)	3,953	4,131	178
NHS Oxfordshire %	0.71	0.71	0pp
South of England (health region) %	0.78	0.79	+0.01pp
England %	0.8	0.8	0pp

Source: Quality and Outcomes Framework (QOF) 2016-17, published Oct 2017



Data has been updated in this version

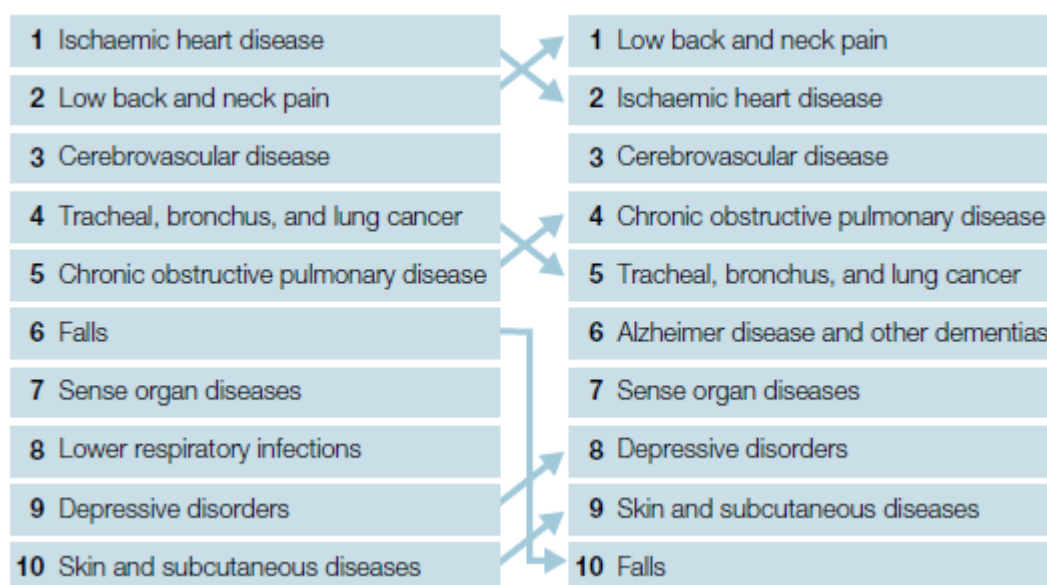


Data has been reviewed and is unchanged

5.16 Musculoskeletal disorders (Knee and Back pain)

According to Public Health England, in 2013, low back and neck pain was the top cause of disability adjusted life years lost, moving up from the second highest cause in 1990.

Figure 19 Change in the main causes of disability adjusted life years lost in England between 1990 and 2013



Source: Public Health England Strategic plan 2016

About Disability-Adjusted Life Year (DALY)

One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences.


http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/



Data has been updated in this version



Data has been reviewed and is unchanged

 Prevalence data for Musculoskeletal conditions (MSK) in the recently released Public Health England MSK tool ²⁴ has been derived from the Arthritis Research UK MSK Calculator.

Using the MSK tool prevalence estimates and the most recent population data (ONS 2016) gives an estimate for Oxfordshire of:

- **49,600** people aged 45 and over with lower back pain
- **50,200** people aged 45 and over with chronic knee pain

Table 16 Estimated number of people aged 45 and over with lower back pain or chronic knee pain (using 2016 population estimates)


	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire	Oxfordshire total
Population aged 45 and over (ONS 2016)	64,757	47,646	67,023	60,473	52,483	292,382
Prevalence of lower back pain in people aged 45 or over	17.3%	14.0%	17.8%	17.5%	17.6%	17.0%
Count of people with lower back pain aged 45 or over	11,200	6,700	11,900	10,600	9,200	49,600
Prevalence of chronic knee pain in people aged 45 or over	18.4%	16.0%	16.9%	17.5%	16.7%	17.2%
Count of people with chronic knee pain aged 45 or over	11,900	7,600	11,300	10,600	8,800	50,200

Sources: PHE Musculoskeletal conditions tool (Dec 2017) and ONS mid-year population estimate for 2016.

Notes on source from PHE tool...

For lower back pain, the prevalence source was the Health Survey for England 2011. Severity of back pain is determined using the chronic pain grade based on GCPS version 2.0. No severe back pain was defined as Grade 0 and Grade 1 (low intensity). Severe back pain was defined as Grade 2 (high intensity) or 3 (moderately limiting) or 4 (severely limiting). In the model, general back pain is reported as the prevalence for lower back pain which is grade 0 to grade 4.

For knee pain, the source for prevalence was knee pain due to OA taken from the English Longitudinal Study of Ageing (ELSA)-Waves 1 (2000/01) to Wave 5 (2010/11).

 The national 2017, Health and Safety Executive report²⁵ on Work Related Musculoskeletal Disorders (WRMSDs) found that:

- The total number of WRMSDs cases (prevalence) in 2016/17 was 507,000 out of a total of 1,299,000 for all work-related illnesses, 39% of the total and a rate of 1,550 cases per 100,000 workers. The rate is not statistically significantly different from the previous year.
- The rate of total self-reported work-related musculoskeletal disorders showed a generally downward trend.

²⁴ Public Health England Musculoskeletal conditions: return on investment tool, released December 2017
<https://www.gov.uk/government/publications/musculoskeletal-conditions-return-on-investment-tool>

²⁵ <http://www.hse.gov.uk/Statistics/causdis/musculoskeletal/index.htm>



Data has been updated in this version





Data has been reviewed and is unchanged

- The number of new cases of WRMSDs (incidence) in 2016/17 was 159,000, an incidence rate of 480 cases per 100,000 workers. This rate is not statistically significantly different from the previous year.
- An estimated 8.9 million working days were lost due to WRMSDs in 2016/17, an average of 17.6 days lost for each case. This is not statistically significantly different from the previous year.
- Work-related musculoskeletal disorders account for 35% of all working days lost due to work-related ill health. Working days lost per worker due to self-reported work-related musculoskeletal disorders showed a generally downward trend up to around 2010/11; since then the rate has remained broadly flat.
- Construction, Agriculture, forestry and fishing, Transportation and storage and Human health and social work activities remain the industries with significantly higher rates of WRMSDs when compared with the rates for all industries.

5.17 Sight loss

A Certification of Vision Impairment (CVI) certifies a person as either sight impaired (partially sighted) or severely sight impaired (blind). The CVI enables local government to offer registration as blind or partially sighted and other relevant advice and support. Registers are maintained by local authorities.

 As of 2016-17 there were 2,360 people in Oxfordshire that are registered as blind or partially sighted, equivalent to a crude rate of 345 per 100,000 people. This was well below the rate in England (526) and the South East region (486)²⁶.

 The RNIB estimates that, as of 2016, there was an estimated total of 21,110 people living with some degree of sight loss in Oxfordshire. The estimated prevalence is 3.1% (the same as England).

The districts with the highest estimated prevalence of people with mild to severe sight loss in Oxfordshire were South Oxfordshire and West Oxfordshire.

Table 17 Number of people estimated to be living with sight loss in Oxfordshire (2016 and future estimates to 2030)

	2016	2020	2025	2030
Mild	13,630	15,050	17,090	19,560
Moderate sight loss	4,690	5,160	5,800	6,570
Severe sight loss	2,800	3,130	3,620	4,200
Total	21,110	23,340	26,510	30,330

²⁶ Source: NHS Digital <http://digital.nhs.uk/catalogue/PUB30161> The SSDA902 data is collected every three years from Councils with Adult Social Services Responsibilities (CASSRs). In 2016-17, it was collected as part of the Short and Long Term (SALT) activity collection.



Data has been updated in this version




Data has been reviewed and is unchanged

Table 18 Estimated number of people living with sight loss by district (2016)

	Mild sight loss	Moderate sight loss	Severe sight loss	Total	Prevalence
Cherwell	2,920	1,010	600	4,520	3.1%
Oxford	2,290	780	450	3,520	2.2%
South Oxfordshire	3,140	1,080	660	4,880	3.5%
Vale of White Horse	2,810	970	580	4,360	3.4%
West Oxfordshire	2,470	850	510	3,830	3.5%
Oxfordshire	13,630	4,690	2,800	21,110	3.1%

Source: RNIB Sight Loss Data Tool

Blind and partially sighted children

 RNIB estimate²⁷ that there are over 25,000 blind and partially sighted children (0-16 years) in the UK and around 15,000 aged 17-25 years. Around half of those aged 0-16 years will have additional disabilities and/or special educational needs.

In Oxfordshire estimated numbers are:

- 259 blind and partially sighted children 0-16 years
- 32 blind and partially sighted young people 17-18 years and
- 130 blind and partially sighted young people 19-25 years
- 91 pupils with a statement of special educational needs (SEN) with vision impairment as their primary SEN

Preventable sight loss


 Crude rates (2015-16) of preventable sight loss from age-related macular degeneration (AMD), glaucoma and diabetic eye disease are shown in the table below. The numbers (count) in Oxfordshire are relatively low.

Table 19 Crude rates of preventable sight loss from age-related macular degeneration, glaucoma and diabetic eye disease 2015-16

	Oxfordshire count	Oxfordshire rate	South East region	England
Age-related macular degeneration (AMD) – 65+ years	97	81.9	101.5	114.0
Glaucoma – 40+ years	28	8.4	10.3	12.8
Diabetic eye disease – 12+ years	16	2.8	2.7	2.9

Source: Public Health Outcomes Framework (Indicators 4.12i, ii, iii)

²⁷ RNIB sight loss data tool <http://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics/sight-loss-data-tool>




Data has been updated in this version




Data has been reviewed and is unchanged

5.18 Hearing loss


11 million people are currently living with hearing loss in the UK. Hearing loss means not just the big things in life like staying in employment; it affects everyday things like being able to hear the door-bell or crossing the road²⁸.

 As reported in the 2016 Oxfordshire JSNA, hearing loss can be socially isolating and has been associated with increased risk of physical and mental health problems.²⁹ Nationally, around one in six people are thought to have some form of hearing loss.³⁰

 Data on people registered as deaf or hard of hearing was collected every three years up to 2010.³¹ At this time an estimated 915 people in Oxfordshire were either deaf or hard of hearing. The bulk of these (550) were 75 years and over and were hard of hearing. Overall there were around 145 people in the county registered as deaf and a further 775 who were hard of hearing.

5.19 Tuberculosis (TB)

The rate of Tuberculosis (TB) per 100,000 population in England has fallen over recent years.

 Data at a local level are not strictly comparable due to averaging of data over a three-year period. Overall, however, Oxfordshire has a slightly lower incidence rate than England and South East Public Health England Centre.

Oxford City continues to have a significantly higher rate of Tuberculosis than Oxfordshire as a whole.

²⁸ Source: Action on Hearing Loss <https://www.actiononhearingloss.org.uk/>

²⁹ For further information, see the Action Plan on Hearing Loss (Department of Health/ NHS England, March 2015): <http://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf>

³⁰ Action on hearing loss statistics (accessed January 2016): <http://www.actiononhearingloss.org.uk/your-hearing/about-deafness-and-hearing-loss/statistics.aspx> This figure is in line with data from the latest Health Survey for England (data for 2014, published December 2015): <http://www.hscic.gov.uk/searchcatalogue?productid=19585&q=health+survey+for+england&sort=Relevance&size=10&page=1#top>

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



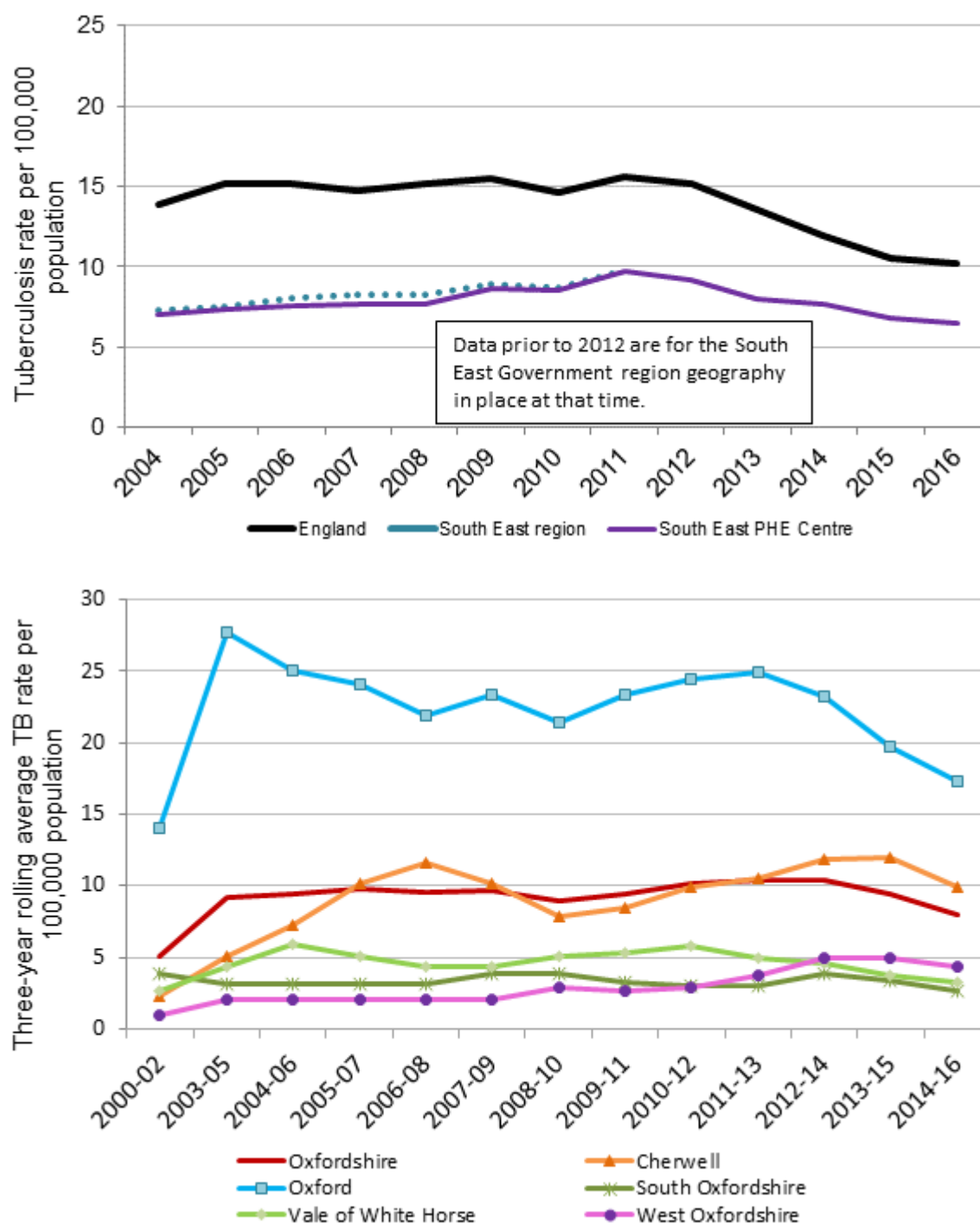
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Figure 20 Tuberculosis (TB) - Rate per 100,000 population (2004 to 2016)



Source: Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

After the Health and Social Care Act 2012, data were provided at different geographic levels. Data relating to Tuberculosis Incidence are supplied at district level and for Public Health England (PHE) centres. Data for Oxfordshire are calculated using district level numbers. A three-year average is given which, at district level, often remains below 10. Numbers below 10 are suppressed to ensure patient confidentiality.



Data has been updated in this version



Data has been reviewed and is unchanged