

## 5 Health Conditions and Causes of Death

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

### 5.1 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).

#### Leading causes of death

- Cancer was the leading cause of death in Oxfordshire (for the combined years 2013, 2014 and 2015), accounting for 26% of deaths of males and 22% of deaths of females.
- The second highest cause was:
  - Males: Heart diseases (affecting the supply of blood to the heart), 14% of deaths.
  - Females: Dementia and Alzheimer disease, 15% of deaths.
- Between 2007 and 2015, the number of deaths of older people (aged 75 and over) from circulatory diseases in Oxfordshire declined by 15%, while deaths from dementia more than doubled.

#### 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): 87,500 patients
  - Depression: 50,900 patients
  - Asthma: 41,100 patients
  - Diabetes: 28,600 patients

#### Mental Health

- National survey data shows that, over the past 15 years, mental health disorders have been increasing in women and young women have emerged as a high risk group.
  - One adult in six had a common mental disorder (depression or anxiety), about one woman in five and one man in eight. Since 2000, the rate for women has steadily increased.
  - As of 2014, common mental disorder symptoms were about three times more common in young women (aged 16 to 24) than young men.
- The number and rate of people in Oxfordshire with depression or anxiety appears to have increased significantly.
  - Between 2014-15 and 2015-16, the number of GP-registered patients with diagnosed depression in the Oxfordshire CCG group area increased by around 8,300 or **+19%**.
- Trend data for Oxfordshire districts shows an increase in the percentage of patients with a recorded diagnosis of a severe and enduring mental health problem in the GP-registered population in Oxford city and Cherwell. The rate in Oxford city remains well above the average for NHS Oxfordshire CCG.

### Cancer

- The proportion of GP-registered patients with a cancer diagnosis in Oxfordshire has remained above the national average.
- Between 2013 and 2015, deaths from cancer remained at a similar level, with the exception of females in Oxford where the rate in 2015 was just above the national average.
- There were 5 wards in Oxfordshire with a significantly higher mortality ratio for cancers than England (2010-14). The ward with the highest rate was Banbury Ruscote 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.
- There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for coronary heart disease than England (2010-11 to 2014-15): Banbury Ruscote in Cherwell and Northfield Brook in Oxford.
- Mortality due to heart disease has declined in every district in Oxfordshire, with the exception of Cherwell where male mortality due to heart disease increased in both 2014 and 2015.

### Stroke

- The proportion of GP-registered patients in the Oxfordshire CCG with stroke has remained below the regional and national averages.
- There were 7 wards in Oxfordshire with a significantly higher mortality ratio from stroke than England (2010-14), mainly in rural areas. The ward with the highest rate was Caversfield in Cherwell district.

### 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 and 2015 to well above the national and regional averages.

### 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 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.
- 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.

### Back pain

- Work related musculoskeletal disorders (WRMSDs) in Great Britain remains an ill health related condition that places significant burdens on employers and employees accounting for 41% of all work related ill-health.

## 5.2 Causes of death

There were **5,299** deaths registered in Oxfordshire in 2015<sup>1</sup>(calendar year), a decline of 2% (-100) compared with 2014.

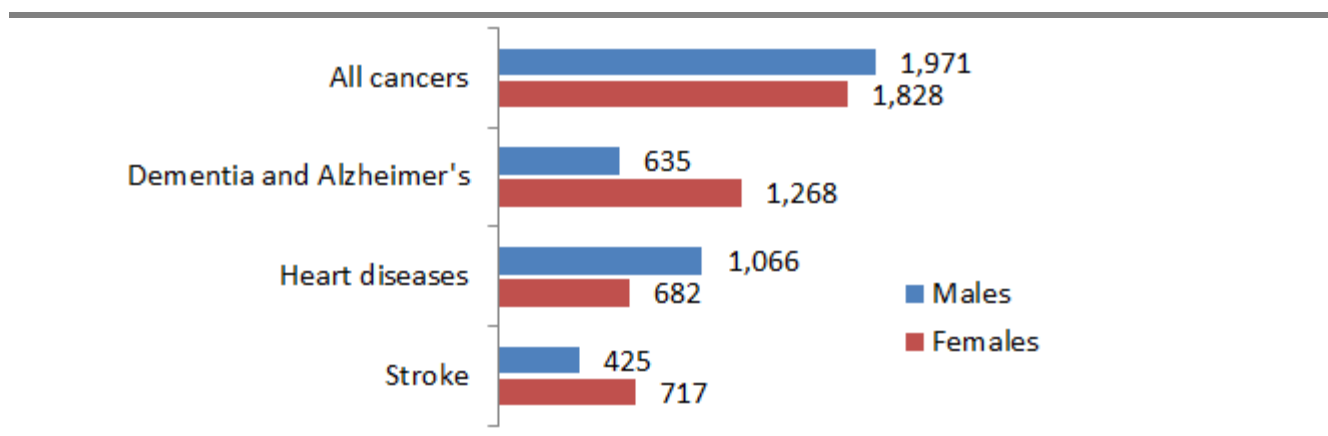
### Leading causes of death

Cancer was the leading cause of death in Oxfordshire (for the combined years 2013, 2014 and 2015), accounting for 26% of deaths of males and 22% of deaths of females.

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- Males: Heart diseases (affecting the supply of blood to the heart), 14% of deaths.
- Females: Dementia and Alzheimer disease, 15% of deaths.

**Figure 1 Leading causes of death in Oxfordshire by gender (2013 to 2015)**



Source: ONS from nomis

In 2014, some wards in Oxfordshire had significantly higher standardised mortality ratios than the England average for certain conditions – see table below.

**Table 1 Wards in Oxfordshire with significantly higher standardised mortality ratios than England average (2010 to 2014)**

<sup>1</sup> ONS (released July 2016)

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

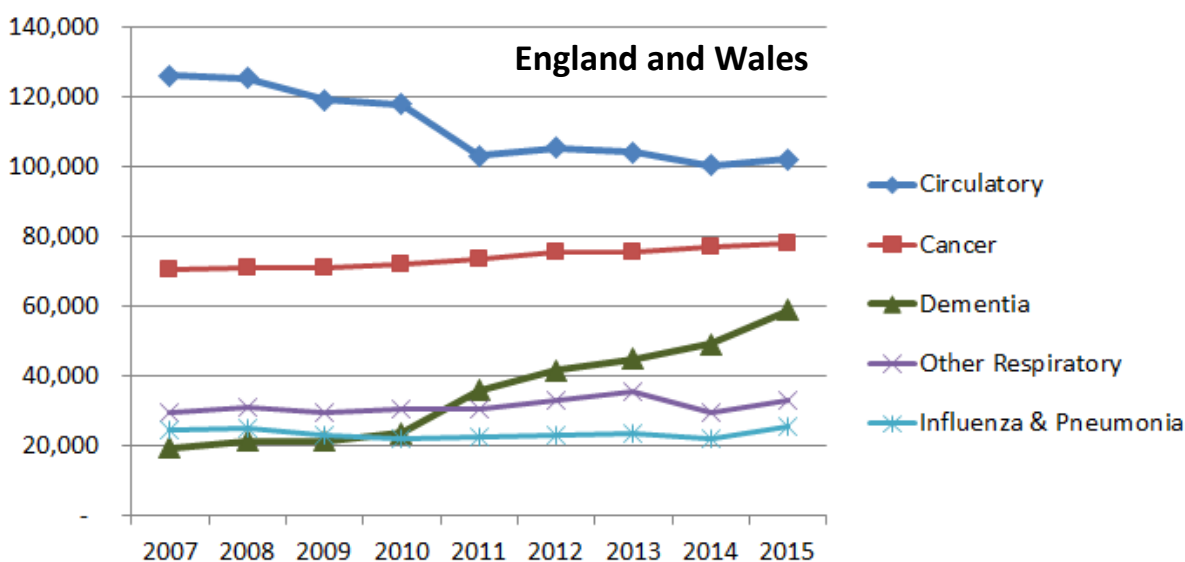
## JSNA 2017 Chapter 5 Health Conditions and Causes of Death

	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
Circulatory disease SMR (under 75 years)		Blackbird Leys			
Stroke SMR (all ages)	Caversfield Banbury Ruscote	Cowley	Didcot West		Chipping Norton Ascott & Shipton Freeland & Hanborough
Respiratory diseases SMR (all ages)	Caversfield Banbury Ruscote	Northfield Brook Blackbird Leys	Sandford & Wittenhams	Faringdon	Chipping Norton

Source: Public Health England, Local Health tool

Nationally and locally the leading causes of death of older people (aged 75+) have changed significantly with a reduction in deaths due to circulatory diseases (including heart disease and stroke) and a significant increase in deaths from dementia.

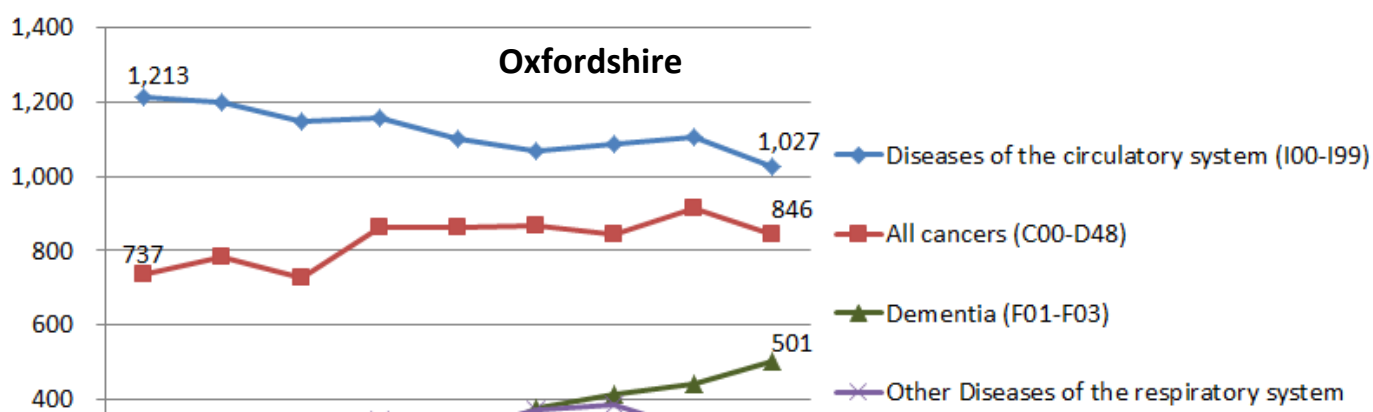
**Figure 2 Leading causes of death in people aged 75 and over – England and Wales**



Source: ONS (user requested data)

Between 2007 and 2015, the number of deaths of older people (aged 75 and over) from circulatory diseases in Oxfordshire declined by 15%, while deaths from dementia more than doubled.

**Figure 3 Leading causes of death in people aged 75 and over - Oxfordshire**



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Source: ONS data for 2007 to 2013 sourced from that received by Public Health when in Oxfordshire PCT. Data for 2014 and 2015 are sourced from NOMIS. (Note: data for 2014 and 2015 for Other respiratory diseases appear to be quite low. Please use with caution.)

## Preventable mortality

According to a 2015 Local Government briefing by the National Institute of Clinical Excellence<sup>2</sup>

*A wide range of factors can lead to illness and premature death. This includes someone's living and working conditions for example, poor housing, social isolation, and where they live. (Children who live in more deprived areas are at much greater risk of an unintentional injury – a leading cause of death among children and young people.)*

*These 'wider determinants' of health can adversely affect both physical and mental wellbeing and the health-related lifestyle choices people make (for example, whether to smoke or misuse alcohol).*

From 2013 to 2015, 59% of deaths of people aged under 75 in Oxfordshire were considered preventable (2,586 of 4,399).

There was a gender difference, with 60% of male deaths under 75 considered preventable and 58% of female deaths under 75.

The highest cause of preventable death aged under 75 was cancer with 40% of the total considered preventable in Oxfordshire, just over 1,000 deaths from 2013 to 2015.

**Table 2 Deaths under the age of 75 considered preventable, Oxfordshire (2013 to 2015)**

Preventable deaths aged under 75 by cause	Males	Females	TOTAL	
			(n)	%
Cancer	510	536	1,047	40%
Heart disease & stroke	421	138	559	22%
Liver disease	117	72	189	7%
Lung disease	97	89	186	7%
Other considered to be preventable	386	220	605	23%
<b>Total considered to be preventable</b>	1,531 59%	1,055 41%	2,586 100%	100%

Source: Public Health England Outcomes Framework (Healthcare and Premature 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

<sup>2</sup> NICE guidance: Tackling the causes of premature mortality (early death) Local government briefing [LGB26] Published date: February 2015 <https://www.nice.org.uk/advice/lgb26/chapter/introduction>

## 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.

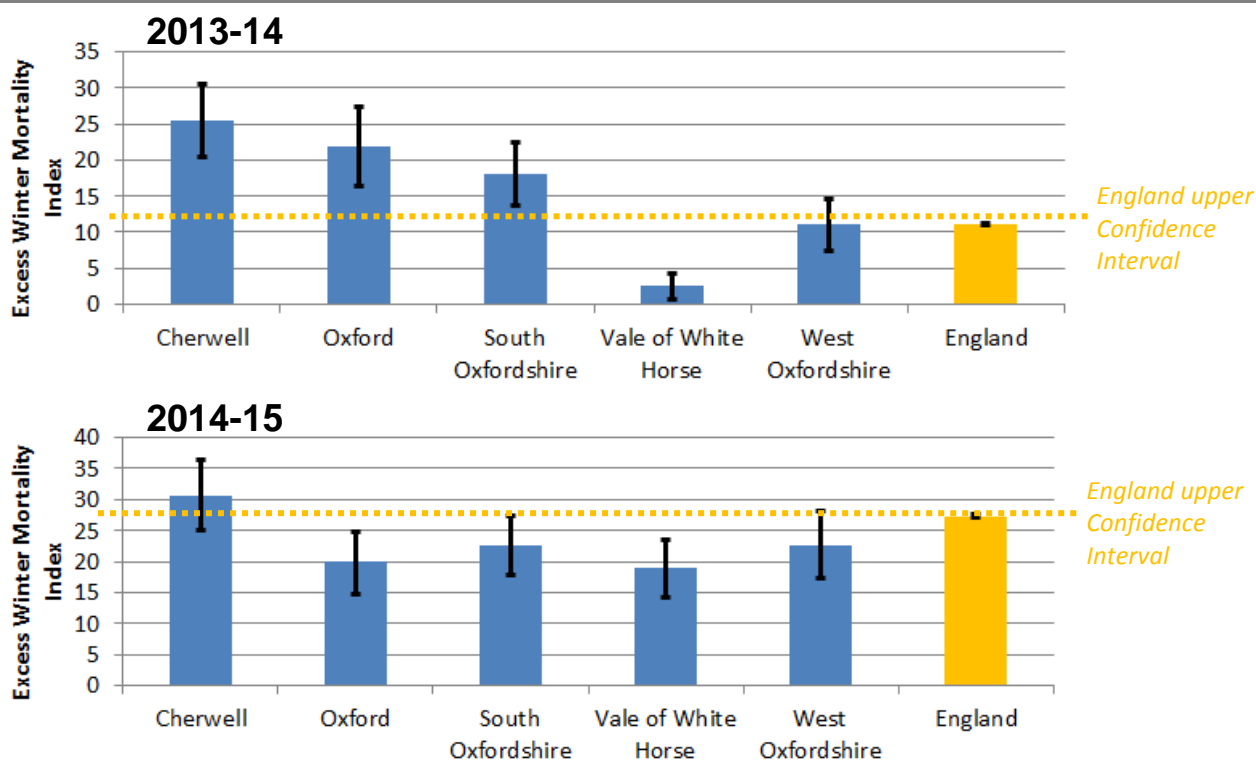
ONS Excess winter mortality methodology

The most recent data shows an increase in the number of Excess Winter Deaths in Oxfordshire from **270** in 2013-14 to **380** in 2014-15.

The district in Oxfordshire with the highest number of excess winter deaths and the highest Excess Winter mortality rate was Cherwell.

In 2014-15, the mortality rate was below the national average in Oxford, South Oxfordshire and Vale of White Horse and statistically similar to the national average in Cherwell and West Oxfordshire.

Figure 4 Excess Winter Mortality Index 2013-14 and 2014-15



Source: ONS, released Nov16

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

## Road casualties

There was a total of 2,146 police-reported road casualties in Oxfordshire in 2015 of which 361 were more serious “killed or seriously injured” (KSI). This was a decline of 2.7% on the number in 2014 (2,205 in total including 379 KSI).

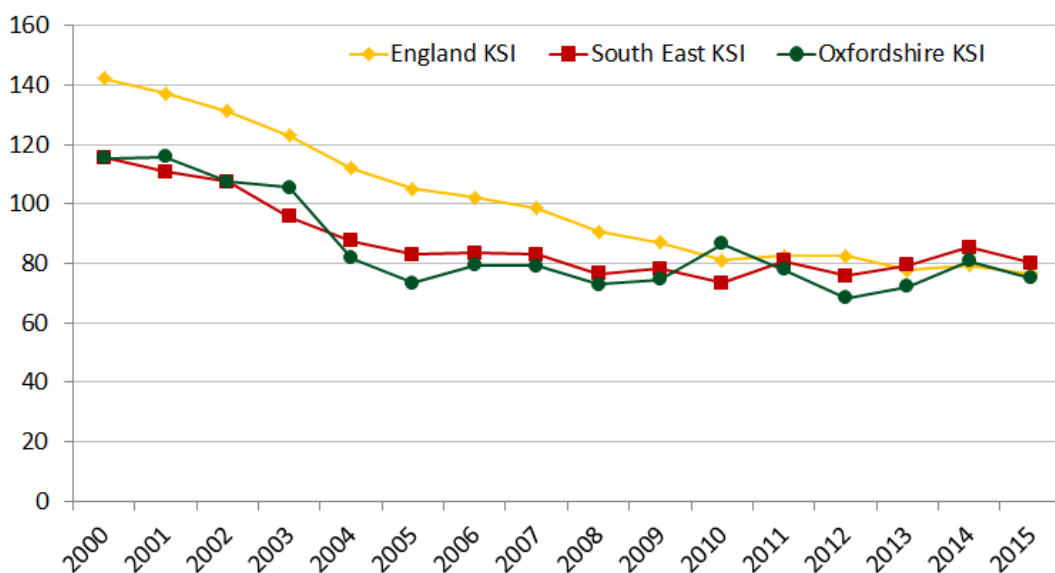
### Per head of population

Oxfordshire continues to have a significantly higher rate of people killed or seriously injured (road casualties) per head of population (52.9 in 2013-15) than in the South East (49.1) and England overall (38.5). All districts, with the exception of Oxford, had rates exceeding the national average. The highest – and significantly above the Oxfordshire average - was Cherwell with 66.9.

### 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 2015 the rate in Oxfordshire was 75 compared with 80 in the South East and 76 in England.

**Figure 5 Rate of Killed and Seriously Injured per billion vehicle miles**



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



## 5.3 Health conditions

The Quality and Outcomes framework provides a count of GP-registered patients by health condition. The following table shows the change between 2014-15 and 2015-16 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 3 Change in prevalence of health conditions recorded by GPs (Quality and Outcomes Framework) for Oxfordshire CCG, 2014-15 to 2015-16**

	2014-15		2015-16		Eng average rate
	Count	Rate	Count	Rate	
<b>Cardiovascular group</b>					
Atrial fibrillation	10,967	1.54	11,805	1.65 (↑)	1.71
Cardiovascular disease	4,362	1.13	4,496	1.15 (↑)	1.07
Coronary heart disease	17,854	2.51	17,759	2.48 (↓)	3.20
Heart failure	4,068	0.57	4,524	0.63 (↑)	0.76
Hypertension	86,222	12.13	87,506	12.21 (↑)	13.81
Peripheral arterial disease	3,616	0.51	3,643	0.51 (-)	0.61
Stroke and transient ischaemic attack	11,643	1.64	11,963	1.67 (↑)	1.74
<b>Respiratory group</b>					
Asthma	41,800	5.88	41,126	5.74 (↓)	5.91
Chronic obstructive pulmonary disease	9,161	1.29	9,557	1.33 (↑)	1.85
<b>Lifestyle group</b>					
Obesity	42,996	7.35	43,231	7.55 (↑)	9.45
<b>High dependency and other long term conditions group</b>					
Cancer	17,428	2.45	19,453	2.71 (↑)	2.42
Chronic kidney disease	19,583	3.45	19,836	3.46 (↑)	4.10
Diabetes mellitus	28,058	4.87	28,627	4.92 (↑)	6.55
Palliative care	1,933	0.27	1,858	0.26 (↓)	0.34
<b>Mental health and neurology group</b>					
Dementia	4,985	0.70	5,268	0.74 (↑)	0.76
Depression	42,594	7.50	50,865	8.88 (↑)	8.26
Epilepsy	3,977	0.70	4,048	0.71 (↑)	0.80
Learning disabilities	2,561	0.36	2,599	0.36 (-)	0.46
Mental health	5,581	0.78	5,822	0.81 (↑)	0.90
<b>Musculoskeletal group</b>					
Osteoporosis	561	0.23	1,559	0.63* (↑)	0.31
Rheumatoid arthritis	3,529	0.60	3,670	0.62 (↑)	0.73

Source: Health and Social Care Information Centre Quality Outcomes Framework; \*Data on patients with Osteoporosis appears to be cumulative rather than single year – needs further investigation.

### **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/>

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): 87,500 patients
- Depression: 50,900 patients
- Asthma: 41,100 patients
- Diabetes: 28,600 patients

## 5.4 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.’

According to the evidence-base report by the Mental Health Foundation and the Faculty of Public Health<sup>3</sup>

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 improvement**<sup>4</sup>..

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](http://www.nomisweb.co.uk) rather than being released as a separate dataset.

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

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<sup>3</sup> <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

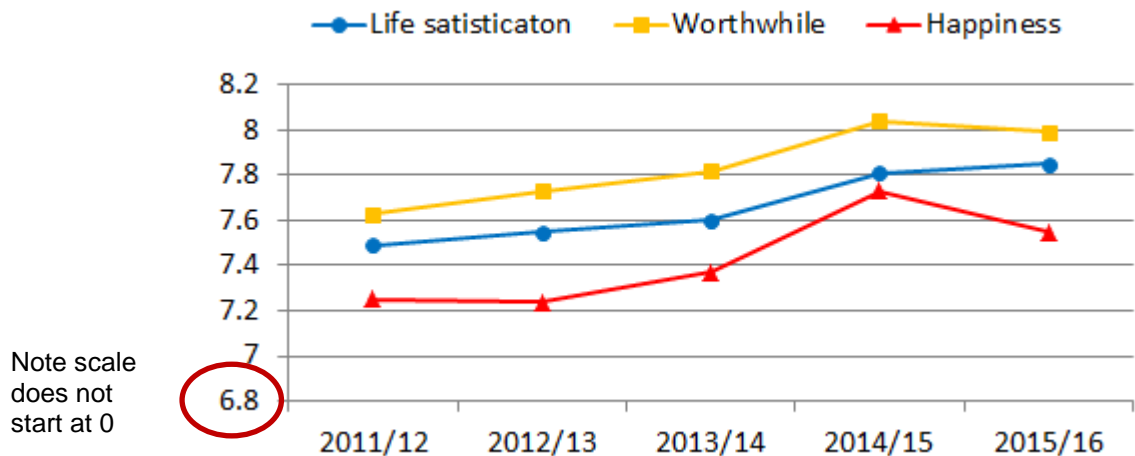
<sup>4</sup> Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

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Across the UK, reported personal well-being had improved every year since the financial year ending 2012, when data were first collected; however, the financial year ending 2016 sees the first instance where there has not been an annual improvement across all of the measures.

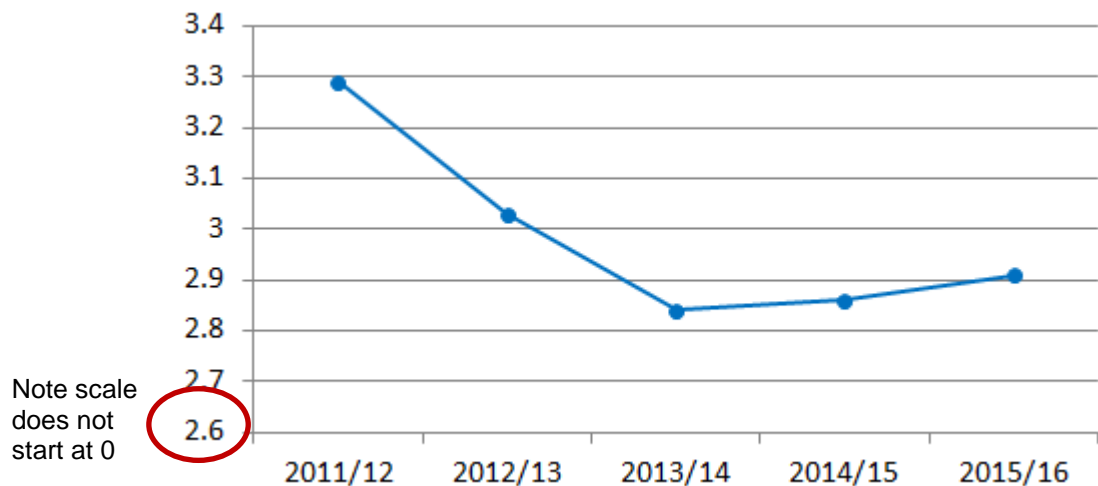
The worthwhile and happiness means for Oxfordshire are slightly lower in 2015-16 compared to 2014-15 and anxiety mean is higher.

**Figure 6 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

**Figure 7 Trend in mean score for anxiety - Oxfordshire**



Source: Office for National Statistics Personal Wellbeing

At a UK level, women's happiness rating remained higher than men's, however the gap between men and women's happiness ratings is closing<sup>5</sup>.

- Although the differences were small, in financial year ending 2012 there was a statistically significant difference in happiness ratings across the UK between the sexes, with women reporting higher "happy yesterday" levels. By financial year ending 2016, there was no longer a significant difference between the happiness ratings of men and women.

## 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.*<sup>6</sup>

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 pupils<sup>7</sup>:

- 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 latest (2015), Health Survey for England<sup>8</sup> 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.

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<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015to2016>

<sup>6</sup> <https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement>

<sup>7</sup> Lavis, P. (2015). Promoting children and young people's emotional health and wellbeing: A whole school and college approach. London: Public Health England

<sup>8</sup> <http://www.content.digital.nhs.uk/catalogue/PUB22610>

## 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.<sup>9</sup>

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.
- 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>

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<sup>9</sup> Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (Sept 2016) NHS Digital <http://content.digital.nhs.uk/catalogue/PUB21748>

## Depression

GP (QOF) data on the number of patients **diagnosed with depression** shows that in 2015-16 there were around **50,900** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with depression (9% of patients). This was an increase of around 8,300 or **19%** since 2014-15.

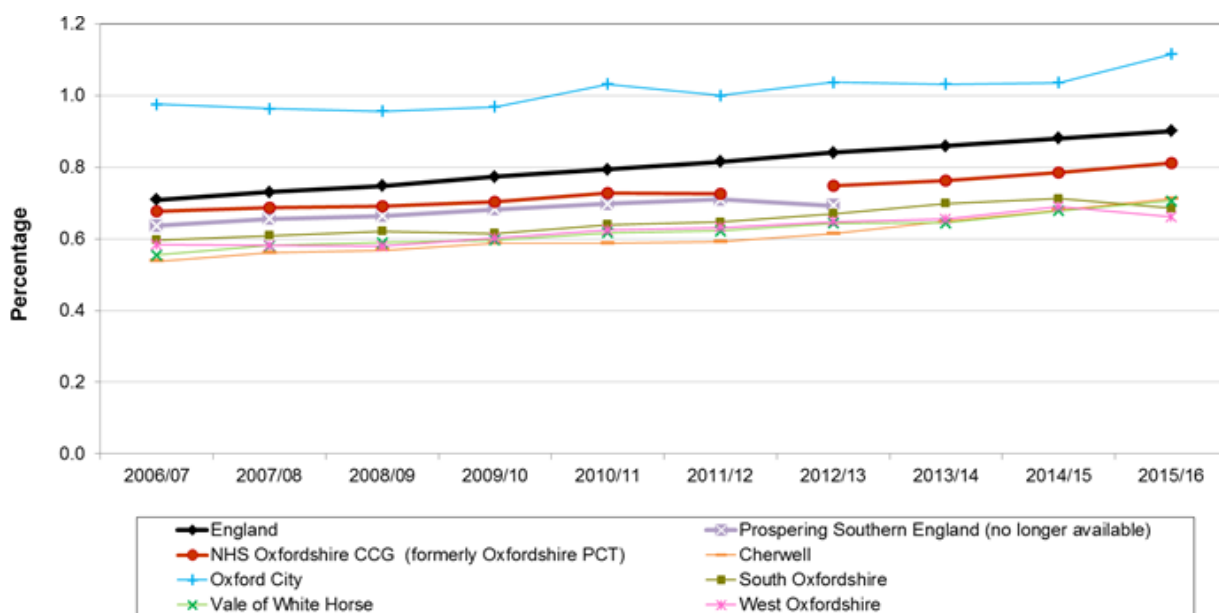
## Severe and enduring mental disorders

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 2015-16 there were around **5,800** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with these conditions. This number has increased by around 200 or 4% since 2014-15.

Trend data for Oxfordshire districts shows an increase in the percentage of patients with a recorded diagnosis of a severe and enduring mental health problem in the GP-registered population in Oxford city and Cherwell. The rate in Oxford city remains well above the average for NHS Oxfordshire CCG.

**Figure 8 Percentage of patients with a recorded diagnosis of a severe and enduring mental health problem in the GP registered population 2006-07 to 2015-16**



Source: NHS Digital; quality and outcomes framework



## 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.

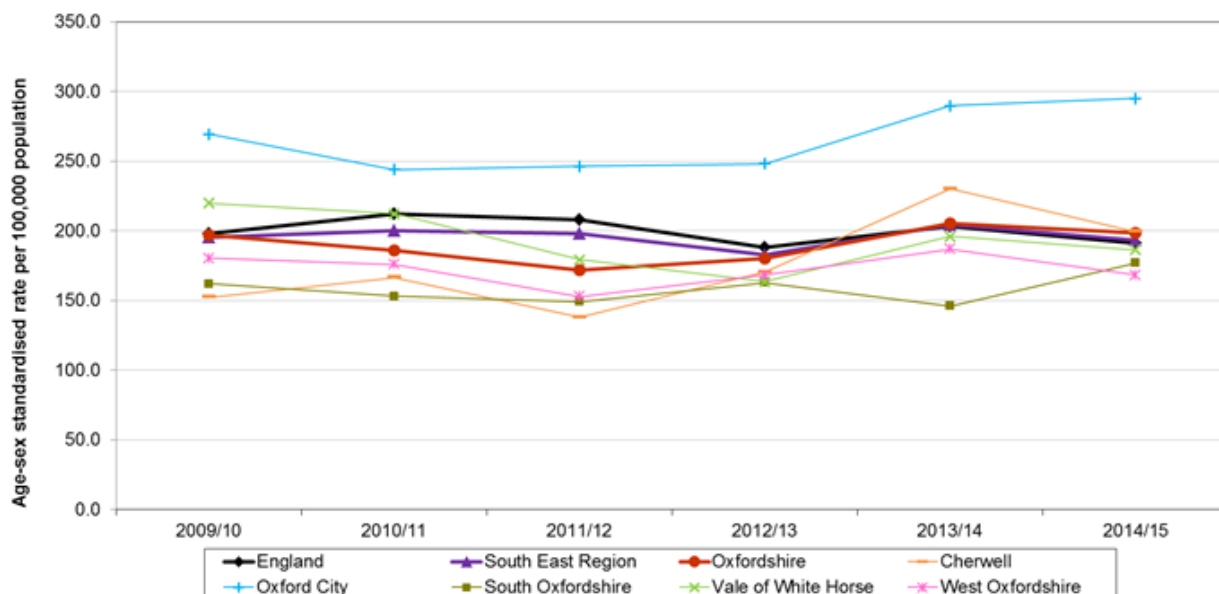
The available indicator of self-harm is the rate of emergency hospital admissions. This is likely to be an under-estimate of the true scale however as:

- 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.

During 2014-15 the number of emergency hospital admissions for intentional self-harm in Oxfordshire was 1,387<sup>10</sup>, this was similar to the number recorded in 2013-14 (1,421).

Oxfordshire's rates of hospital admissions for self-harm have been significantly lower than England, but are no longer significantly different. There is insufficient data to know whether this is a trend or if self-harm is on the increase.

**Figure 9 Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population (2009-10 to 2014-15)**



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

<sup>10</sup> Public Health England health profiles <https://fingertips.phe.org.uk>

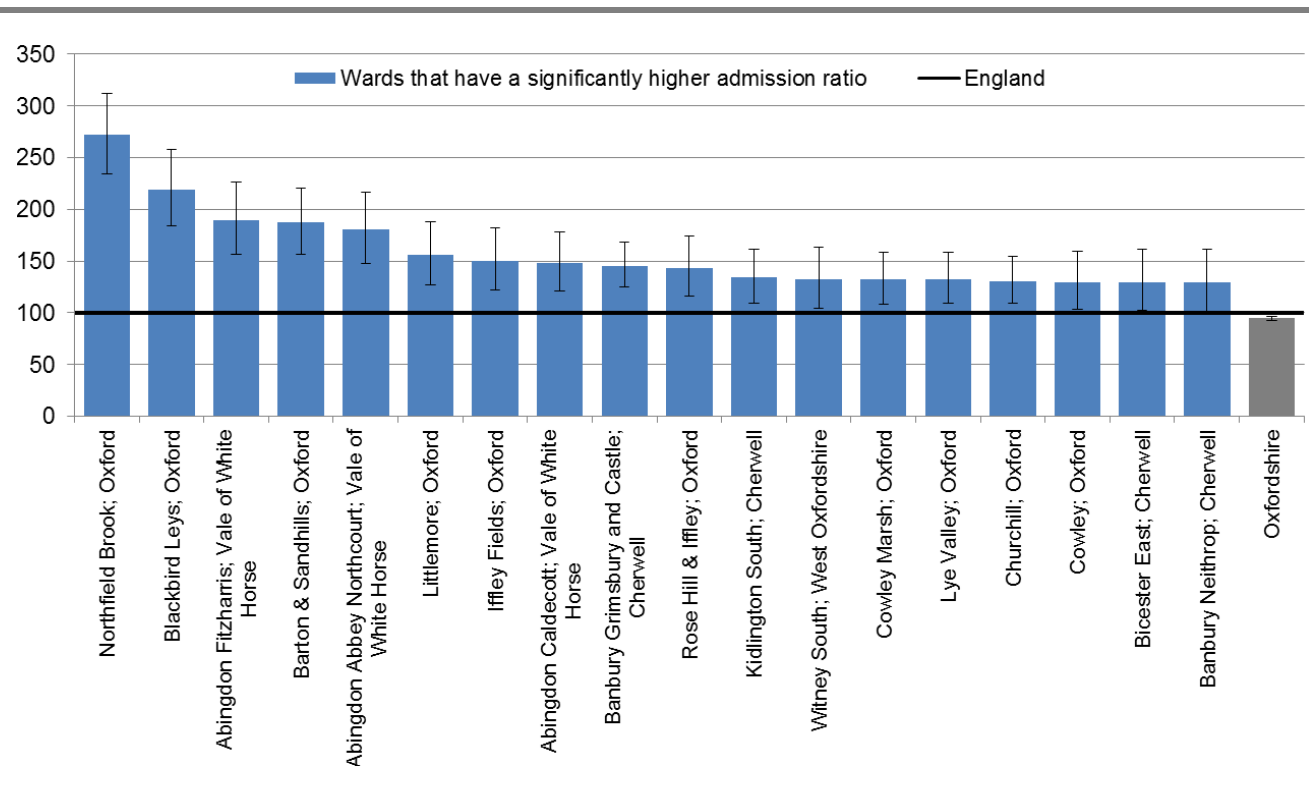


Rates of hospital admission in Oxford City are significantly higher than Oxfordshire as a whole. This may be due to the presence of areas of deprivation, the higher proportion of drug and alcohol and mental health service users who live in the city as well as more facilities for the homeless.

A report produced by K Hawton et al in 2010 concluded that, contrary to popular belief, rates of self-harm in Oxford University students are much lower than in other young people but that the risk of self-harm may increase around the time of examinations.

There were 18 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2010-11 to 2014-15), these included 10 in Oxford, 4 in Cherwell, 3 in Vale of White Horse and 1 in West Oxfordshire. The two wards with the highest rates were Northfield Brook and Blackbird Leys in Oxford.

**Figure 10 Wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2010-11 to 2014-15)**



Source: Hospital Episodes Statistics from the Public Health England Local Data Tool

## Suicide

Between 2013 and 2015, there was a total of **164** deaths registered as suicides in Oxfordshire<sup>11</sup>. The rate of suicides was not significantly different to England.

In the five year period, between 2011 and 2015, there was a total of **71** deaths registered as suicides for young people (aged under 35) in Oxfordshire.

<sup>11</sup> ONS Suicides in England and Wales by Local Authority (released Dec17)

The Oxfordshire district with the greatest number of registered suicides in under 35s in Oxfordshire was Cherwell.

**Table 4 Number of suicides by local authority, persons aged under 35, deaths registered 2011-2015**

	2011	2012	2013	2014	2015	2011 to 2015
Cherwell	4	7	3	6	1	<b>21</b>
Oxford	3	5	1	5	3	<b>17</b>
South Oxfordshire	1	2	1	3	1	<b>8</b>
Vale of White Horse	1	3	6	1	1	<b>12</b>
West Oxfordshire	1	4	1	3	4	<b>13</b>
<b>OXFORDSHIRE</b>	<b>10</b>	<b>21</b>	<b>12</b>	<b>18</b>	<b>10</b>	<b>71</b>

Source: ONS (released 12 Dec16)

## 5.5 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.<sup>12</sup>

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 conditions<sup>13</sup>.

In January 2016, there were **1,220 pupils** in Oxfordshire schools with special educational needs (SEN) whose primary type of need was ASD.<sup>14</sup> This is just above the number in January 2015 (1,140). Of these, 455 were in state funded primary schools, 494 were in state-funded secondary schools and 271 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.<sup>15</sup>

Estimates of the prevalence of autism in Oxfordshire (from 2013) suggest that there could be<sup>16</sup>:

- 40-60 pre-school autistic children

<sup>12</sup> The National Autistic Society <http://www.autism.org.uk/about/what-is.aspx>

<sup>13</sup> The National Autistic Society <http://www.autism.org.uk/about/diagnosis/criteria-changes.aspx>

<sup>14</sup> Department for Education SEN Statistics (January 2015):  
<https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>

<sup>15</sup> Oxfordshire Autism Joint Commissioning Strategy 2013-2017:  
<https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/business/providers/OxfordshireAutismStrategy.pdf>

<sup>16</sup> 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>

- 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)

The recently published Adult Psychiatric Morbidity Survey (2014)<sup>17</sup> 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 autism<sup>18</sup> 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.<sup>19</sup>

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.

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<sup>17</sup> Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 published Sept2016 <http://content.digital.nhs.uk/catalogue/PUB21748>

<sup>18</sup> Estimating the Prevalence of Autism Spectrum Conditions in Adults, 2012, Brugha T et al The Health and Social Care Information Centre

<sup>19</sup> <http://www.autism.org.uk/about/what-is/gender.aspx>

## 5.6 Cancer

### Prevalence

In 2015-16 there were around **19,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group who had a cancer diagnosis, up from 17,400 in 2014-15. The prevalence increased from 2.45% of patients to 2.71% in 2015-16, this was above the national average of 2.42%.

**Table 5 GP-registered patients with a cancer diagnosis (count and % of list)**

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	17,400	19,500	
NHS Oxfordshire %	2.45%	2.71%	+0.26pp
South of England (health region) %	2.54%	2.74%	+0.21pp
England %	2.26%	2.42%	+0.16pp

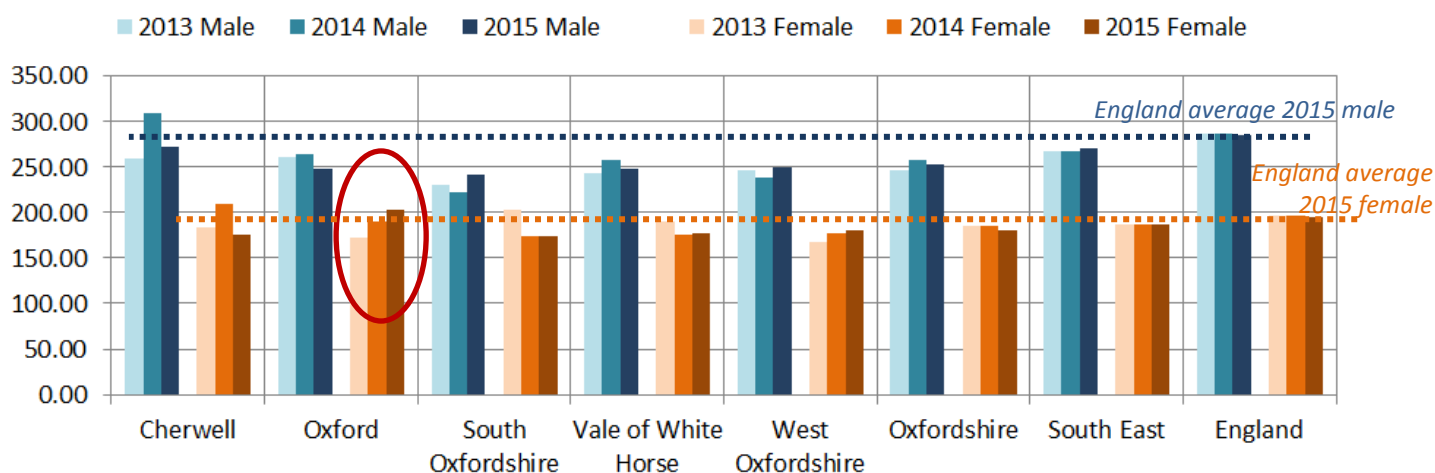
Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

Lung, bowel, breast and prostate cancers together accounted for almost half (46%) of all cancer deaths in the UK in 2014. More than a fifth of all cancer deaths are from lung cancer. More than half (53%) of cancer deaths in the UK are in people aged 75 years and over (2012-2014).

### Deaths

Between 2013 and 2015, age standardised mortality rates for cancer in Oxfordshire remained at a broadly similar level. The cancer mortality rate for females in Oxford increased to just above the national average.

**Figure 11 Age standardised mortality rate, 2013 to 2015, Cancer**



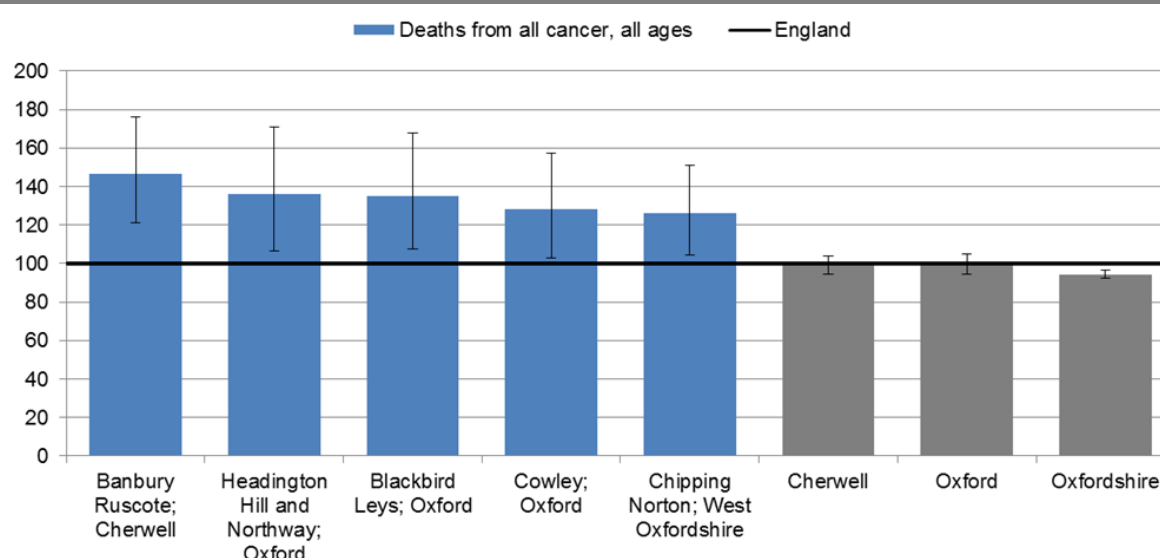
Source: ONS mortality statistics (from nomis "life events")

**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

There were 5 wards in Oxfordshire with a significantly higher mortality ratio for cancers than England (2010-14). The ward with the highest rate was Banbury Ruscote in Cherwell district.

**Figure 12 Wards in Oxfordshire with a significantly higher standardised mortality ratio of deaths from cancers than England (2010-14)**



Source: Public Health England Local Data Tool

## 5.7 Heart disease

### Prevalence

In 2015-16 there were around **17,800** GP-registered patients in the Oxfordshire Clinical Commissioning Group with coronary heart disease, down from 17,900 in 2014-15. The prevalence decreased from 2.51% of patients to 2.48%, remaining below regional and national averages.

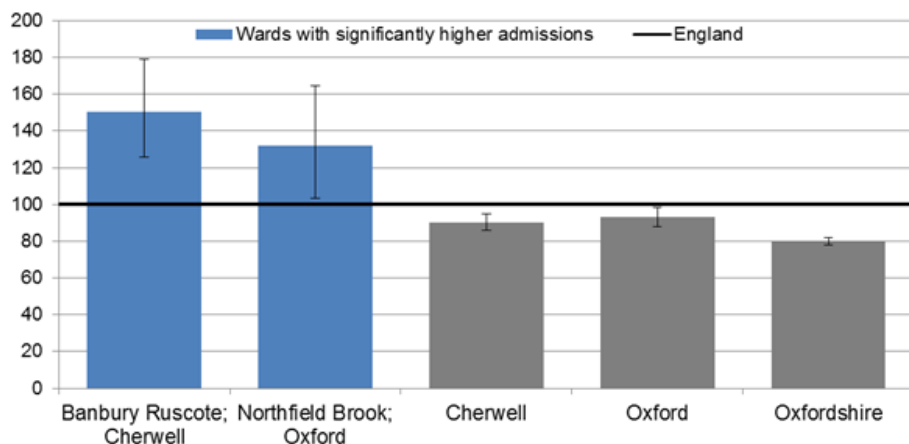
**Table 6 GP-registered patients with Coronary Heart Disease (count and % of list)**

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	17,854	17,759	
NHS Oxfordshire %	2.51	2.48	-0.03pp
South of England (health region) %	3.18	3.16	-0.02pp
England %	3.25	3.2	-0.05pp

Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for coronary heart disease than England (2010-11 to 2014-15): Banbury Ruscote in Cherwell and Northfield Brook in Oxford.

**Figure 13 Emergency hospital admissions for Coronary Heart Disease, standardised admission ratio 2010-11 to 2014-15**

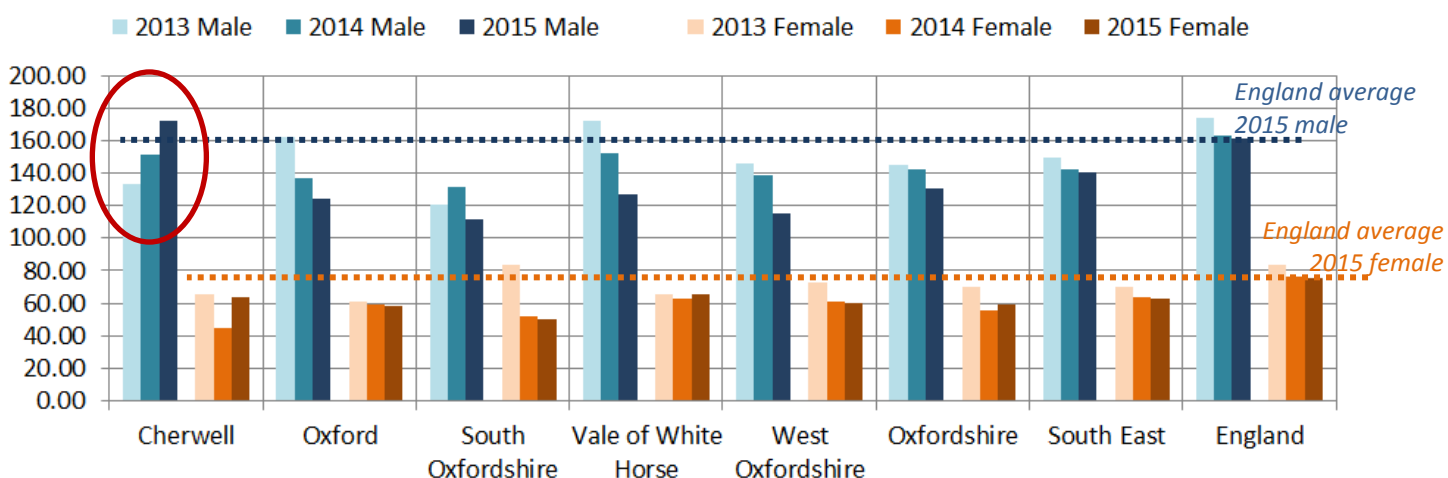


Source: Public Health England Local Data tool.

### Deaths

Mortality due to heart disease has declined nationally and in every district in Oxfordshire with the exception of Cherwell where male mortality due to heart disease increased in both 2014 and 2015.

**Figure 14 Age standardised mortality rate, 2013 to 2015, Ischaemic heart diseases**



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

## 5.8 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 2015-16 there were around **12,000** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of stroke and transient ischaemic attack, up from 11,600 in 2014-15. The prevalence increased from 1.64% of patients to 1.7%, remaining below the regional and national averages.

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

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	11,643	11,963	
NHS Oxfordshire %	1.64	1.67	0.03pp
South of England (health region) %	1.86	1.87	0.01pp
England %	1.73	1.74	0.01pp

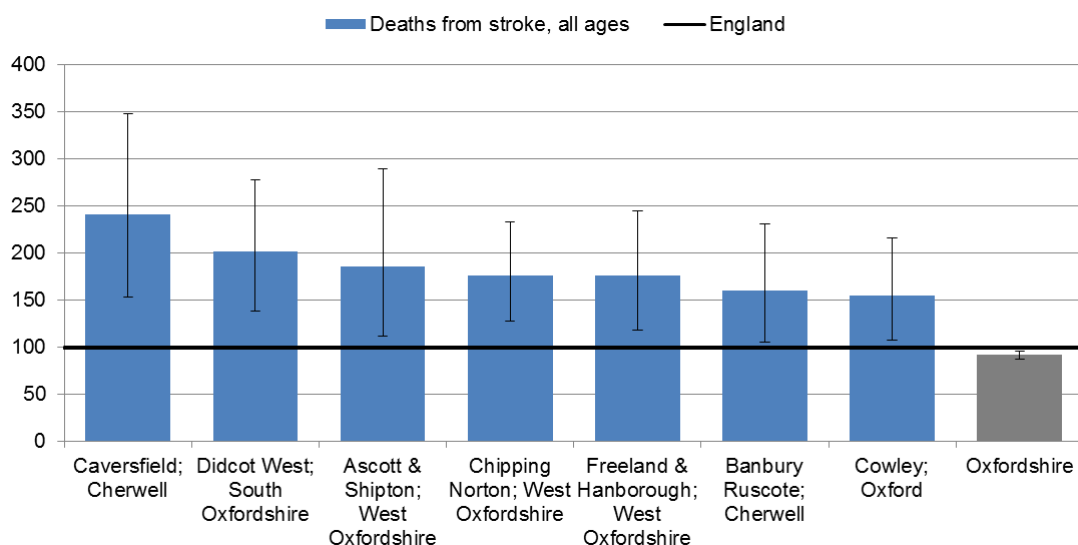
Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

### Deaths

The age-standardised mortality rate for stroke in Oxfordshire was below the England and South East average in 2015. The rate in South Oxfordshire and West Oxfordshire were each above average<sup>20</sup>.

There were 7 wards in Oxfordshire with a significantly higher mortality ratio from stroke than England (2010-14), mainly in rural areas. The ward with the highest rate was Caversfield in Cherwell district.

**Figure 15 Deaths from stroke, all ages, standardised mortality ratio, 2010-2014.**



Source: Public Health England Local Data tool. Deaths from stroke defined using ICD-10 codes I60-I69, for all persons.

<sup>20</sup> Source: ONS mortality statistics (from nomis “life events”)

## 5.9 Dementia and Alzheimer’s disease

### Prevalence

In 2015-16 there were around **5,300** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of Dementia and Alzheimer’s disease, up from 5,000 in 2014-15. The prevalence increased from 0.7% of patients to 0.74%, just below the national average.

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

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	4,985	5,268	
NHS Oxfordshire %	0.70	0.74	+0.03pp
South of England (health region) %	0.82	0.84	+0.02pp
England %	0.74	0.76	+0.02pp

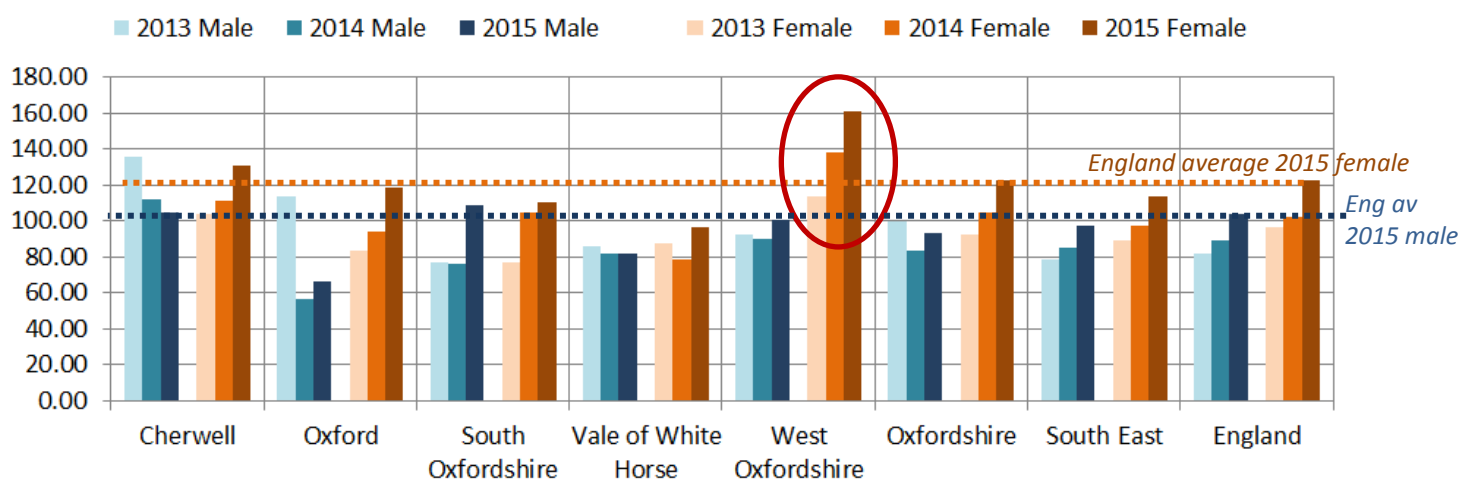
Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

### Deaths

The age-standardised mortality rate for females due to Dementia and Alzheimer’s disease increased in every district in Oxfordshire in 2015.

- In West Oxfordshire the rate increased in 2014 and 2015 to well above the national and regional averages.
- In South Oxfordshire in 2015 the rate for males was above the England average.

**Figure 16 Age standardised mortality rate, 2013 to 2015, Dementia and Alzheimer's disease**



Source: ONS (from nomis “life events”)



## 5.10 Diabetes

Diabetes mellitus is a condition that causes a person's blood sugar level to become too high. There are two types of diabetes<sup>21</sup>:

- 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 2015-16 there were around **28,600** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of diabetes, up from 28,100 in 2014-15.

The prevalence increased from 4.87% of patients to 4.92% in Oxfordshire, remaining below the national and regional averages.

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

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	28,058	28,627	
NHS Oxfordshire %	4.87	4.92	+0.06pp
South of England (health region) %	5.83	6.00	+0.17pp
England %	6.37	6.55	+0.18pp

Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

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

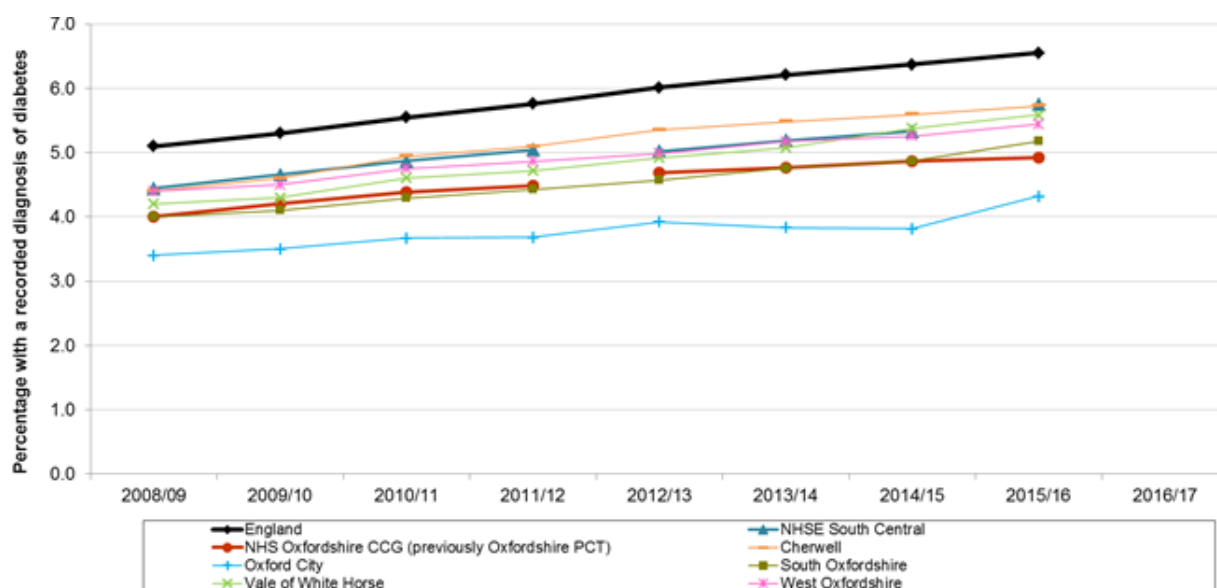
- All five district council areas in Oxfordshire have significantly lower percentages of patients recorded with diabetes than the England and regional averages.
- When compared with the Oxfordshire average...
  - Oxford City has a significantly lower percentage of patients recorded with diabetes.
  -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

It is estimated that there are 1.1 million people in the UK who have diabetes but have not been diagnosed<sup>22</sup>.

<sup>21</sup> <https://www.diabetes.org.uk/Diabetes-the-basics/>

<sup>22</sup> This figure was worked out using the diagnosed figure from the 2014/15 Quality and Outcomes Framework, the 2016 Diabetes Prevalence Model and the 2012 AHPO diabetes prevalence model. A figure for Northern Ireland was not predicted by the AHPO model, so undiagnosed prevalence for Northern Ireland was extrapolated on the % undiagnosed figure for Scotland.

Figure 17 Percentage of patients aged 17+ with a recorded diagnosis of diabetes in the GP registered population 2004-05 to 2015-16



Source: NHS Digital; quality and outcomes framework

As recent national survey data from the Health Survey for England 2015 shows, the prevalence of diabetes is higher for men than women and significantly higher in those who are overweight or obese.

Table 10 Diabetes status, as % of people aged 16+, by body mass index (BMI) status and sex (England from HSE 2015)

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

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

## 5.11 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 hypertension<sup>23</sup> 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 2015-16 there were around **86,500** GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of Hypertension, up from 86,200 in 2014-15. The prevalence increased from 12.13% of patients to 12.21%, remaining below the national and regional averages.

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

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	86,222	86,506	
NHS Oxfordshire %	12.13	12.21	+0.09pp
South of England (health region) %	14.0	14.05	+0.06pp
England %	13.79	13.81	+0.03pp

Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

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 but, as of 2015-16, this was no longer the case.
- 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.

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

**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
	<b>All men with hypertension</b>	<b>21</b>	<b>26</b>	<b>43</b>	<b>27</b>
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
	<b>All women with hypertension</b>	<b>18</b>	<b>24</b>	<b>37</b>	<b>23</b>
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
	<b>All adults with hypertension</b>	<b>19</b>	<b>25</b>	<b>40</b>	<b>25</b>

Source: Health Survey for England 2015. Aged 16 and over with three valid blood pressure measurements, and both valid height and weight measurements.

## 5.12 Asthma

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

In 2015-16 there were around **8,000** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with asthma. This was a similar number to 2014-15. The prevalence declined slightly from 5.31% of patients to 5.18% 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)	7,998	7,960	
NHS Oxfordshire %	5.31	5.18	-0.13pp
South of England (health region) %	6.11	6.05	-0.06pp
England %	5.99	5.91	-0.08pp

Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

## 5.13 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 2015-16 there were around **9,600** GP-registered patients in the Oxfordshire Clinical Commissioning Group area with a diagnosis of Chronic Obstructive Pulmonary Disease. This was an increase of 400 on the number in 2014-15 (9,200). The prevalence increased from 1.29% of patients to 1.33%.

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

	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	9,161	9,557	
NHS Oxfordshire %	1.29	1.33	+0.05pp
South of England (health region) %	1.67	1.72	+0.05pp
England %	1.82	1.85	+0.04pp

Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

## 5.14 Epilepsy

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

In 2015-16 there were around **4,000** GP-registered patients in the Oxfordshire Clinical Commissioning Group area who were receiving drug treatment for Epilepsy. This was a similar number to 2014-15. The prevalence increased from 0.7% of patients to 0.71%.

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

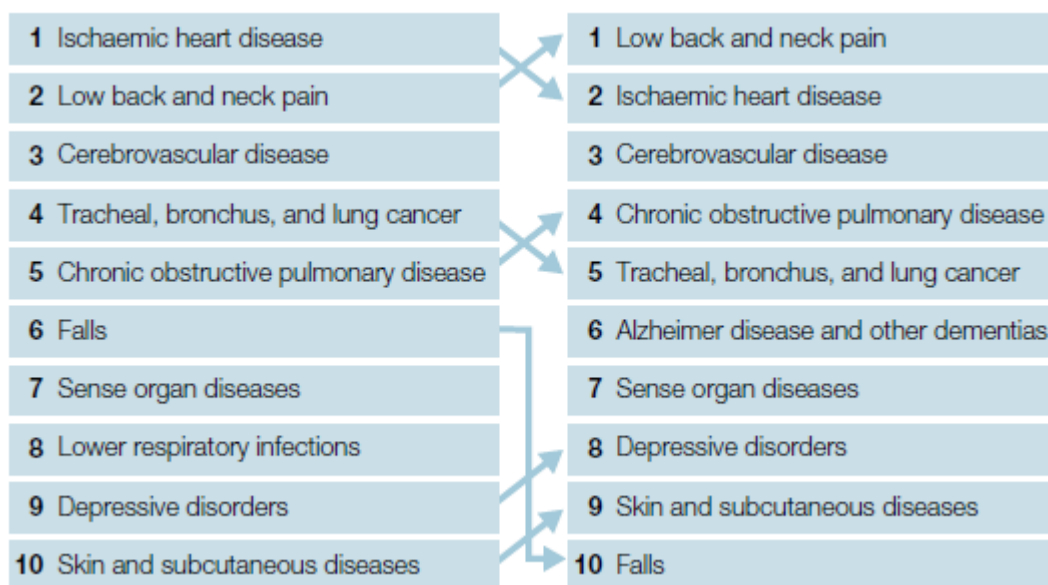
	2014-15	2015-16	2014-15 to 2015-16
NHS Oxfordshire (count)	3,977	4,048	
NHS Oxfordshire %	0.70	0.71	+0.01pp
South of England (health region) %	0.78	0.78	0
England %	0.79	0.8	+0.01pp

Source: Quality and Outcomes Framework (QOF) 2015-16, published Oct 2016

## 5.15 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 18 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/](http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/)

The 2016, Health and Safety Executive report<sup>24</sup> on Work Related Musculoskeletal Disorders (WRMSDs) found that:

- Work related musculoskeletal disorders (WRMSDs) in Great Britain remains an ill health related condition that places significant burdens on employers and employees accounting for 41% of all work related ill-health.
- The number of new cases of WRMSDs (incidence) in 2015/16 was not significantly different from the previous year and the rate has been broadly flat for the last five years.

<sup>24</sup> <http://www.hse.gov.uk/Statistics/causdis/musculoskeletal/index.htm>

- An average of 16 days were lost for each case of WRMSD. This is not significantly different from the previous year. Work related musculoskeletal disorders account for 34% of all working days lost due to work related ill health.
- Agriculture, forestry and fishing, Construction, Transportation and storage and Human health and social work activities are industries with significantly higher rates of WRMSDs when compared with the rates for all industries.
- The occupations that have statistically significantly higher rates of work related musculoskeletal disorders are those in skilled trade occupations and process and machine operatives.

## 5.16 Sight loss

As at the end of March 2014, there was a total of 3,095 people in Oxfordshire registered as blind or partially sighted<sup>25</sup>. More than three quarters of these were aged 65 or over. Two thirds were recorded as having an additional disability.

According to the RNIB Sight Loss Data tool<sup>26</sup> there was an estimated total of 21,100 people with mild to severe sight loss in Oxfordshire. The highest rates were in South Oxfordshire and West Oxfordshire.

**Table 16 Estimated number of people living with sight loss by district (2015)**

	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. References: Pezzullo L., Streatfield J., Simkiss P., and Shickle D. (2016). The economic impact of sight loss and blindness in the UK adult population. RNIB and Deloitte Access Economics. Manuscript submitted for publication. Office for National Statistics (ONS) (2016). Subnational Population Projections, 2014-based projections release. ONS.

In 2014-15 there was a total of 209 residents of Oxfordshire with preventable sight loss (age related, glaucoma and diabetic eye disease)<sup>27</sup>. The rate of preventable sight loss was significantly lower than the England average.

<sup>25</sup> Registered Blind and Partially Sighted People - Year Ending 31 March 2014, England <http://content.digital.nhs.uk/catalogue/PUB14798> ; next update due 2017

<sup>26</sup> <http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool>

<sup>27</sup> Public Health profiles, <https://fingertips.phe.org.uk>

## 5.17 Hearing loss

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.<sup>28</sup> Nationally, around one in six people are thought to have some form of hearing loss.<sup>29</sup>

Data on people registered as deaf or hard of hearing were collected every three years up to 2010.<sup>30</sup> 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.

## 5.18 Tuberculosis (TB)

Over the past 3 years, the rate of Tuberculosis per 100,000 population in England has fallen.

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

Oxford City has a significantly higher rate of Tuberculosis than Oxfordshire as a whole.

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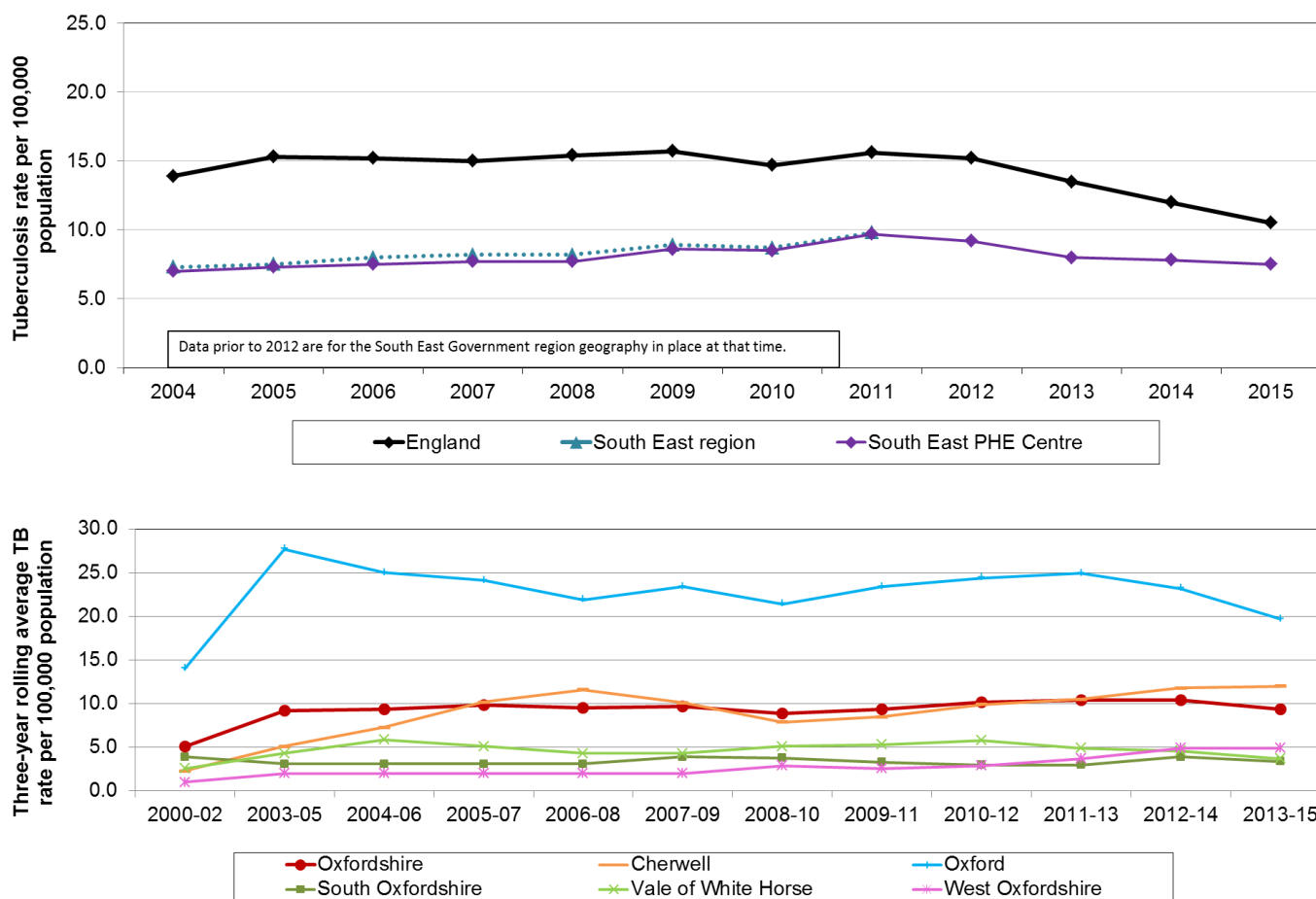
<sup>28</sup> For further information, see the Action Plan on Hearing Loss (Department of Health/ NHS England, March 2015): <http://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf>

<sup>29</sup> 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>

<sup>30</sup> 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>



Figure 19 Tuberculosis (TB) - Rate per 100,000 population (2004 to 2015)



Source: Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance; Since The Health and Social Care Act 2012, data are now provided at different geographic levels. Data relating to Tuberculosis Incidence are supplied district level, and for Public Health England (PHE) centres. Data for the county of 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.