Health

This topic addresses:

SA Objective: To improve the health and well-being of the population and reduce inequalities in health

SEA Theme: Human Health

Introduction

There are many indicators of health; a range of physical and mental wellbeing indicators are identified below to try and build a general picture of the health of Oxford. Whilst in Oxford the percentage of physically active adults is high and the percentage of obese adults is low, mental health problems and substance misuse are prevalent within the population.

The health of people in Oxford is varied compared with the England average. There are real disparities across the city with some areas benefiting from much greater quality of health than others only a few miles away. Life expectancy for Oxford residents is 80 years for men and 84 years for women. This is similar to the national average. There are geographical inequalities in life expectancy - men from the least deprived areas can expect to live 9.7 years longer than those in the most deprived areas. For women there is a much smaller gap of 3.3 years.

This discussion of health links very directly to that of air quality, the health aspects of air pollution are discussed in that section.

Plans policies and programmes

National Planning Policy Framework (NPPF) and Planning Practice Guidance (PPG)

The NPPF states that planning's social role includes creating a high quality environment, with accessible local services that reflect the community's needs and support its health, social and cultural well-being (paragraph 7).

The NPPF includes a section on 'Healthy Communities'. This states, in paragraph 69, that *the planning system can plan an important role in facilitating social interaction and creating healthy, inclusive communities.* The focus of this section is on encouraging strong communities. General health is mentioned in this section in relation to green spaces. Paragraph 73 states that *access to high quality open spaces and opportunities for sport and recreation can make an important contribution to the health and well-being of communities.*

Mentions of health are scattered throughout the NPPF. Transport policies should be considered in terms of their role in contributing to health objectives (paragraph 29). The effects of pollution on health should be taken into account (paragraph 120).

In gathering the evidence base, *local authorities should work with public health leads and health organisations to understand and take account of the health status and needs of the local population*

(such as for sports, recreation and places of worship), including expected future changes, and any information about relevant barriers to improving health and well-being. (paragraph 171)

Oxfordshire's Joint Health and Wellbeing Strategy 2015-19

The Health and Wellbeing Board is the principal structure in Oxfordshire responsible for improving the health and wellbeing of the people of the County. The Board is a partnership between Local Government, the NHS and the people of Oxfordshire. Members include local GPs, Councillors, Healthwatch Oxfordshire and senior officers from Local Government. The Board has produced a strategy setting out priority areas for joint action.

The Strategy has a number of overarching themes, most of which have implications for the Local Plan to some extent:

- The need to shift services towards the prevention of ill health;
- The need to reduce inequalities, break the cycle of deprivation and protect the vulnerable;
- The need to give children a better start in life;
- The need to reduce unnecessary demand for services;
- To help people and communities help themselves;
- The need to make the person's journey through all services smoother and more efficient;
- The need to improve the quality and safety of services;
- The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

These are then translated into priorities for action:
Priority 1: All children have a healthy start in life and stay healthy into adulthood
Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups
Priority 3: Keeping all children and young people safe
Priority 4: Raising achievement for all children and young people
Priority 5: Working together to improve quality and value for money in the Health and Social Care System
Priority 6: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential
Priority 7: Support older people to live independently with dignity whilst reducing the need for care and support
Priority 8: Preventing early death and improving quality of life in later years
Priority 9: Preventing chronic disease through tackling obesity
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
Priority 11: Preventing infectious disease through immunisation

The Joint Strategic Needs Assessment Annual Summary Report 2015

The Joint Strategic Needs Assessment (JSNA) monitors trends in the health and wellbeing of Oxfordshire's population and assesses changing patterns of need and demand for services across the county. Much of this data is taken from that report.

Oxfordshire Clinical Commissioning Group Strategy for 2014/15-2018/19 and Implementation Plan for 2014/15-2015/16

The CCG has set out five year vision for the Oxfordshire health and social care system. Several elements of this vision are relevant to the Local Plan:

- Delivering fully integrated care, close to home, for the frail elderly and people with multiple physical and/or mental health needs.

- A primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
- Routinely enabling people to live well at home and to avoid admission to hospital when this is in their best interests.
- Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities.

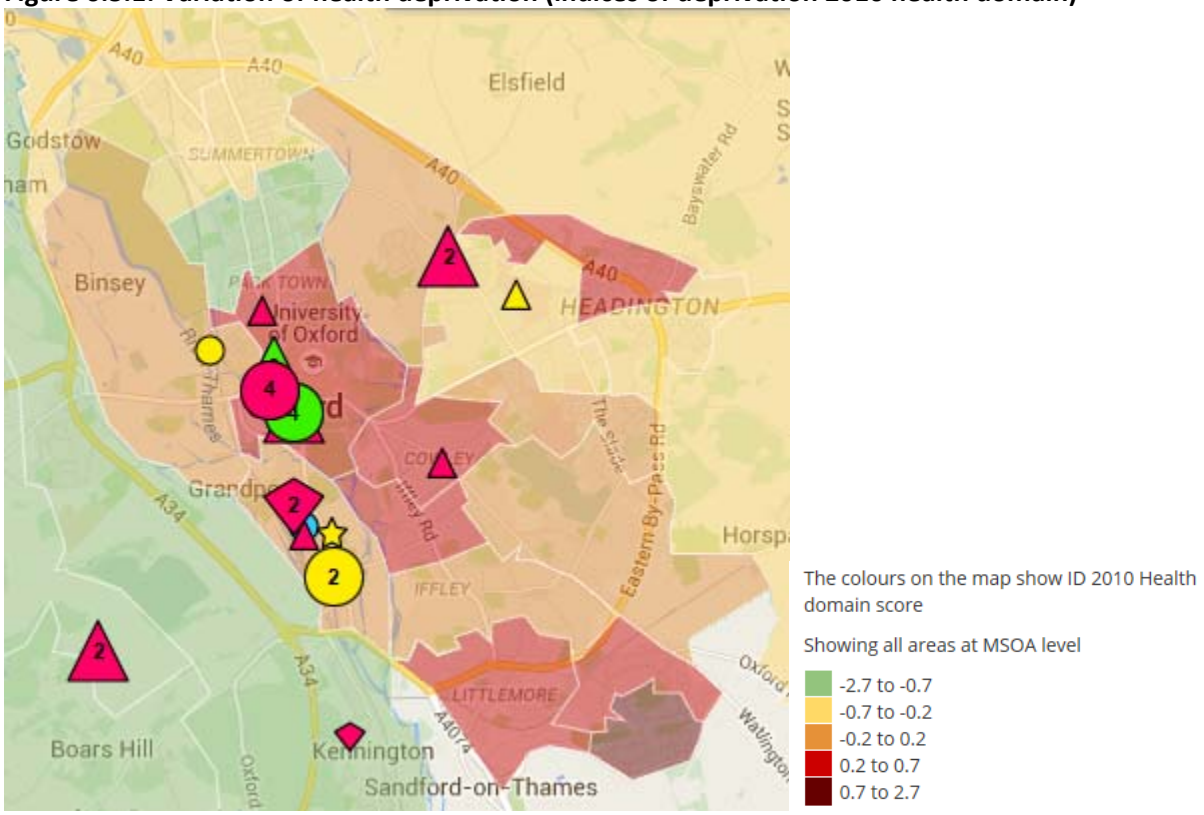
The CCG is aiming to reduce the amount of time spent avoidably in hospital through the provision of better integrated care in the community. To achieve this they will increase investment in primary care and in community services and aim to *"deliver a substantial shift in activity and resources from acute services into community and primary care."*

Current situation

Health deprivation

The Health domain is one of the indices of deprivation. It measures morbidity, disability and premature mortality. There is variation in the level of health deprivation found across the city, as shown in the map in figure 6.5.1 below. The area with the greatest level of health deprivation is Greater Leys. The lowest level of health deprivation is found in Summertown.

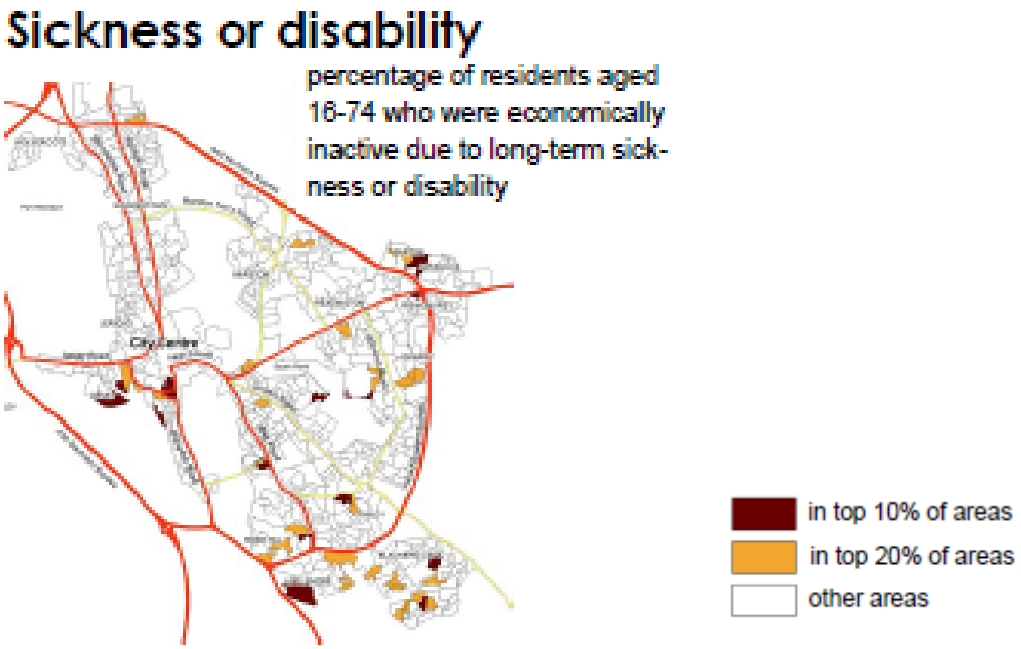
Figure 6.5.1: Variation of health deprivation (indices of deprivation 2010 health domain)



Sickness and disability

The map in figure 6.5.2 below shows that the percentage of residents who are economically inactive due to long-term sickness or disability is in most parts of Oxford outside of the top 20% of areas. However, there are a few areas in Oxford within the top 10% of areas in England.

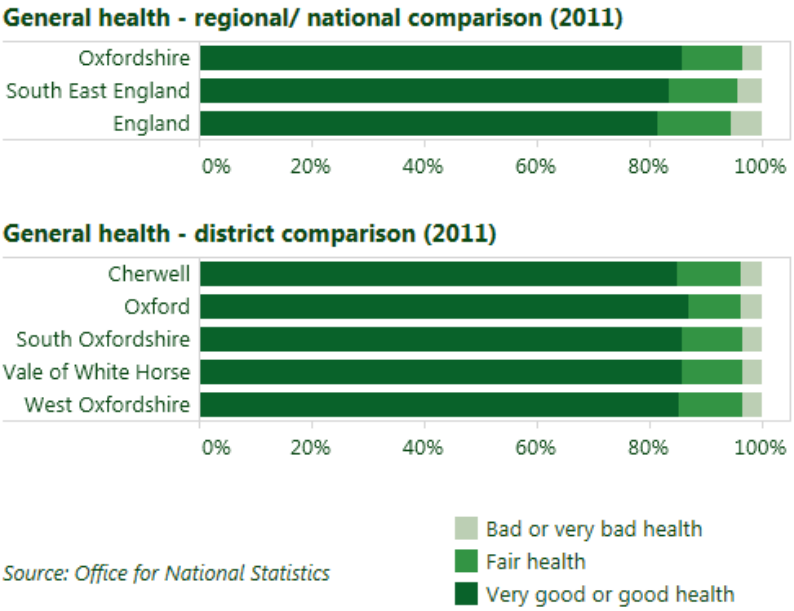
Figure 6.5.2: Map to show areas with higher concentrations of residents who are economically inactive due to sickness or disability



General health

The graphs in figure 6.5.3 below, show that a higher percentage of people in Oxfordshire report good or very good health, than in the South East or in England. Within Oxfordshire, people in Oxford report the highest percentage of very good or good health.

Figure 6.5.3: Population reporting good health

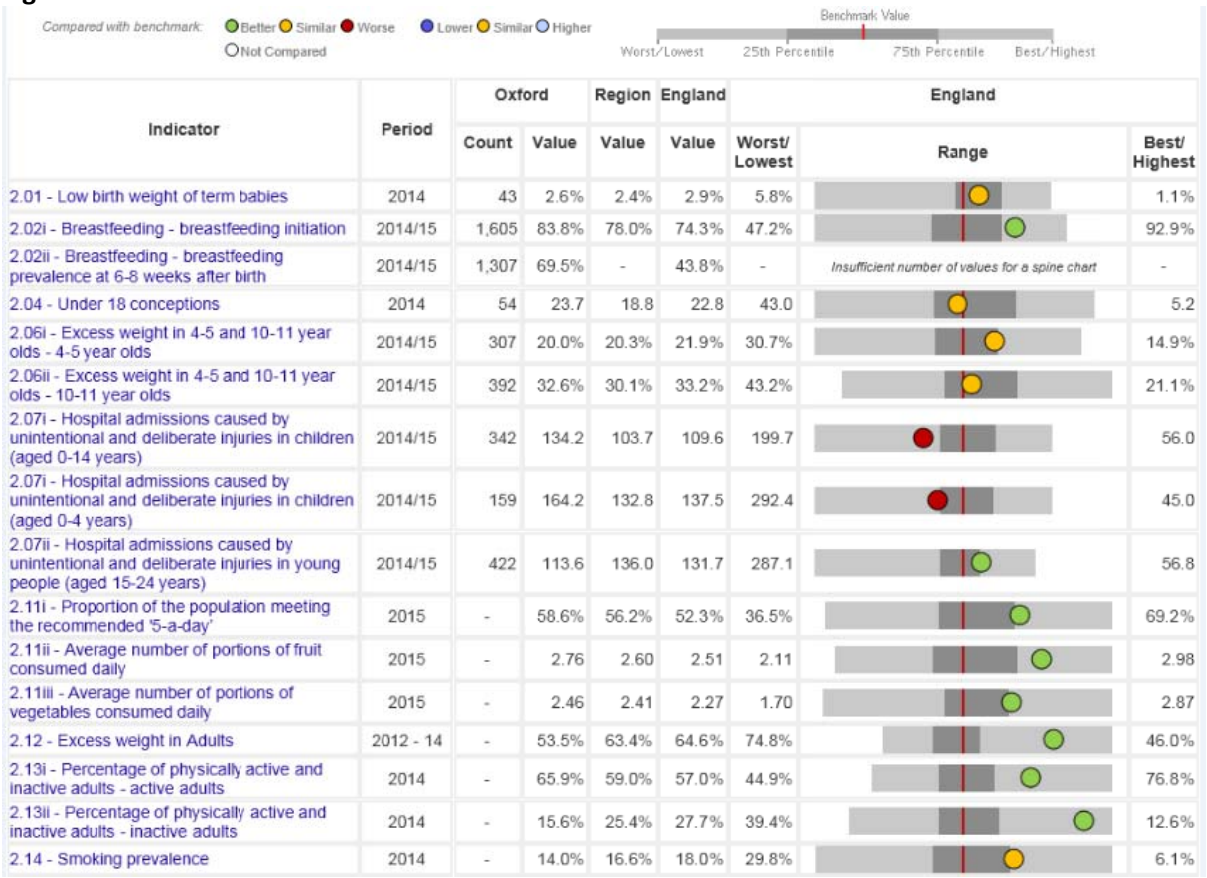


Source: Office for National Statistics

Health indicators

There are many indicators of good health and wellbeing. The chart in figure 6.5.4 below lists many of these indicators and shows where Oxford compared to the benchmark of the South East performs better, similar or worse. For many indicators Oxford performs better than the benchmark. It performs worse in one particular indicator shown in the chart, which is hospital admissions from injuries to children.

Figure 6.5.4: General health indicators



Indicator	Period	Oxford		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
2.01 - Low birth weight of term babies	2014	43	2.6%	2.4%	2.9%	5.8%		1.1%
2.02i - Breastfeeding - breastfeeding initiation	2014/15	1,605	83.8%	78.0%	74.3%	47.2%		92.9%
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth	2014/15	1,307	69.5%	-	43.8%	-	*Insufficient number of values for a spine chart*	-
2.04 - Under 18 conceptions	2014	54	23.7	18.8	22.8	43.0		5.2
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2014/15	307	20.0%	20.3%	21.9%	30.7%		14.9%
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2014/15	392	32.6%	30.1%	33.2%	43.2%		21.1%
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2014/15	342	134.2	103.7	109.6	199.7		56.0
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2014/15	159	164.2	132.8	137.5	292.4		45.0
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2014/15	422	113.6	136.0	131.7	287.1		56.8
2.11i - Proportion of the population meeting the recommended '5-a-day'	2015	-	58.6%	56.2%	52.3%	36.5%		69.2%
2.11ii - Average number of portions of fruit consumed daily	2015	-	2.76	2.60	2.51	2.11		2.98
2.11iii - Average number of portions of vegetables consumed daily	2015	-	2.46	2.41	2.27	1.70		2.87
2.12 - Excess weight in Adults	2012 - 14	-	53.5%	63.4%	64.6%	74.8%		46.0%
2.13i - Percentage of physically active and inactive adults - active adults	2014	-	65.9%	59.0%	57.0%	44.9%		76.8%
2.13ii - Percentage of physically active and inactive adults - inactive adults	2014	-	15.6%	25.4%	27.7%	39.4%		12.6%
2.14 - Smoking prevalence	2014	-	14.0%	16.6%	18.0%	29.8%		6.1%

Mental health

The Office for National Statistics (ONS) began measuring personal wellbeing in April 2011, through the Annual Population Survey (APS).

Figure 6.5.5: Personal wellbeing

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

Source: ONS Personal Wellbeing in the UK 2013/14

Analysis of national surveys suggests that peak onset of mental ill health is 8-15 years and half of lifetime mental ill health starts by age 14. National-level research indicates higher incidence of

mental health problems among children and young people with learning disabilities, looked after children, and children who are homeless or sleeping rough.

In 2013/14 around 11,000 Oxfordshire residents were referred to Oxford Health mental health services and seen at least once. This represents an increase of around a thousand from the previous two years. More female than male residents were referred, making up 56% of the service users, compared with 44% male. Nine in ten Oxfordshire service users for whom ethnicity data have been recorded were from White British backgrounds (90%).

Of the total number of referrals for Oxford Health mental health services, the largest proportion were among people aged 15-19 (12.5%), followed by those aged 10-14 (8.9%), those aged 20-24 (8%) and those aged 25-29 (7.6%)Almost half of the referrals were for Oxfordshire Adult Mental Health Services (47%). Around a quarter were for Children and Adolescent Mental Health Services (24%) and nearly two in ten were to the Oxfordshire Older Adult Mental Health Services (18%). Significant minorities of referrals were for Oxfordshire Psychological Services (8%) and Eating Disorders Oxfordshire (2%). The remaining referrals were to one of 14 other mental health services.

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

In 2013/14 the recorded prevalence of dementia stood at 0.6% of people registered with GPs in the Oxfordshire Clinical Commissioning Group area.

In 2012/13 the rate of emergency hospital admissions for intentional self-harm Oxfordshire was 180 per 100,000 people. This represents a slight increase on the previous year (171.7 people per 100,000). The figure was similar to rates in the South East (183) and England overall (187). Across the county, the rate of emergency hospital admissions for intentional selfharm was higher in Oxford than in other districts (248 per 100,000 people, significantly worse than the rate for England). The data does not include patients who attended but were not admitted to hospital; and is therefore likely to be an underestimate of the true rate of self-harm in the population.

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

Section 136 of the Mental Health Act enables the police to act if they believe that someone is suffering from a mental illness and is in need of immediate treatment or care. The police may take that person from a public place to a place of safety, either for their own protection or for the protection of others. This is known as a Section 136 detention. In 2013/14 Thames Valley Police made 347 Section 136 detentions across Oxfordshire. This represented an increase of 19% from the previous year. During the first eight months of the 2014/15 financial year there were 187 detentions. Across the county 44% of the detentions made between April 2012 and November 2014 were in Oxford.

In 2010-12 the rate of suicide in Oxfordshire was 8.5 people per 100,000. This was similar to rates seen across the South East (8.4) and England overall (8.5). The number of suicides reduced to 47 in 2012 from 55 in 2011. The suicide rate in men is three times that in women, similar to the national picture. In Oxfordshire the suicide rate in men is comparable to surrounding areas and the national rate. Generally, rates in younger people have decreased and rates in older people have increased.

The highest risk group is men aged 45-59. Because of the small numbers involved, it is difficult to establish clear patterns in suicide rates over time or across different parts of the county.

Isolation and loneliness

Various national and international research studies have linked social isolation and loneliness with adverse health outcomes, including higher mortality rates. Social engagement has also been found to be a driver of quality of life. A national survey of GPs in 2013 found that over a quarter saw one to five people per day who they thought had come in mainly because they were lonely. One in ten reported seeing between six and ten lonely patients a day, and a small minority (4 per cent) said they saw more than 10 lonely people a day.

A 2013 study of people aged 55 and over in Great Britain[1] found that 15% reported often feeling lonely. Moreover, 57% experienced at least half of the symptoms identified by academics as being associated with loneliness (the gap between these figures could be ascribed to the stigma of loneliness). The same study found that around a third of people aged 55 and over 'never' or 'not very often' met up for an outing with friends or family (34%) and a quarter 'never' or 'not very often' had a chat on the phone (25%). In 2013/14 half of social care users in Oxfordshire[2] said they had as much social contact as they would like (49.7%). This continues an improving trend since 2011/12 (when 41.5% said they had as much social contact as they would like). The proportion of Oxfordshire social care users satisfied with the amount of social contact they had was higher than for England overall (44.2%).

Although living alone does not necessarily imply loneliness, people who make the transition to living alone in later life (primarily due to the death of a cohabiting partner) have been found to be more vulnerable to psychological distress in the initial period thereafter. In 2011 28.8% of people aged 65 and over in Oxfordshire lived alone. In Oxford proportionately more older people lived alone (36.4%) relative to the other districts.

Physical activity and weight

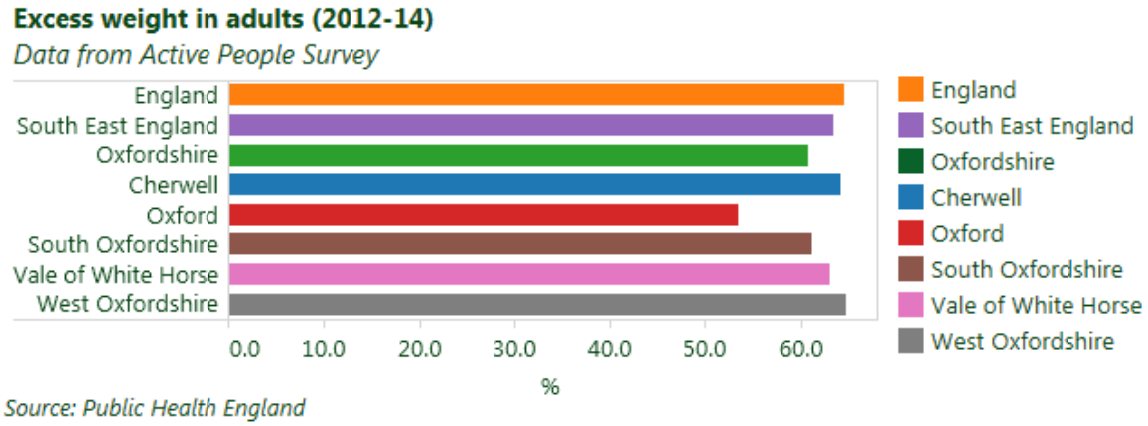
Levels of physical activity and of obesity are important contributors to health. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared with those who have a sedentary lifestyle. Physical inactivity has been linked to a range of other health conditions, including diabetes and some cancers; it is estimated to be responsible for a significant proportion of premature all-cause mortality. Oxford's population reports higher than average levels of activity. The proportion of active adults in Oxford in 2014 was 65.9%, compared to 57% in England.

Excess weight in adults is recognised as a major determinant of premature mortality and avoidable ill health. The Active People Survey began including questions on height and weight for the first time from January 2012 to enable the monitoring of excess weight in adults at a local level. Self-reported data for 2012 indicated that almost 61% of Oxfordshire's adult population were overweight or obese. This was significantly lower than the national average (64%). Data for the districts indicated similar levels except in Oxford where the proportion is slightly lower at 55%.

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

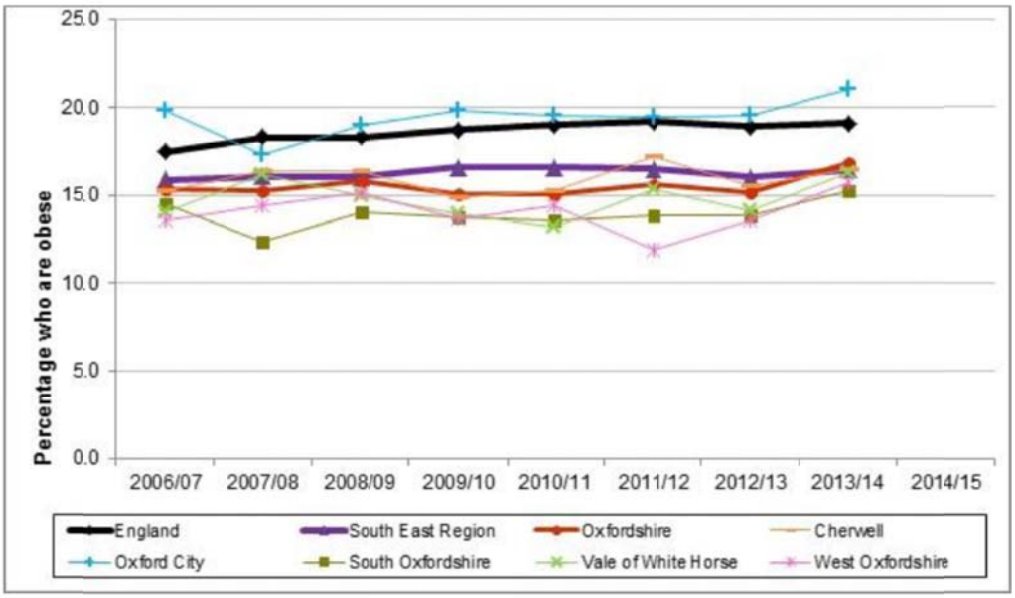
[2] Adult Social Care User Survey: http://www.hscic.gov.uk/socialcare/usersurveys

Figure 6.5.6: excess weight in adults



Being obese or overweight as a child can increase the risk of developing a range of serious diseases in later life. Children in Reception year and Year 6 have been measured in schools since 2006/7 under the National Child Measurement Programme (NCMP). The latest data available are for the school year 2013/14. Oxford has a significantly higher obesity rate in Year 6 children than the county as a whole.

Figure 6.5.7: Obesity in Year 6 children



Other lifestyle factors

Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. In 2013 smoking prevalence in Oxfordshire was estimated to be 14.7%. This has been declining since 2010 (when it was 18.5%). Prevalence in Oxfordshire was significantly lower than in the South East (17.2%) and England overall (18.4%). However, prevalence among those in routine and manual employment was much higher at 28% (similar to the average for England).

The health harms associated with alcohol consumption are widespread, with around 9 million adults in England drinking at levels that pose some risk to their health. Public Health England produces local alcohol profiles for lower tier local authorities in England. In 2012/13 the directly age-

standardised rates for alcohol-specific hospital admissions in both male and female residents were relatively high in Oxford: 654.5 male admissions per 100,000 in the population; and 286.2 female admissions. These were significantly above the rates for the Thames Valley area and England.

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

Poor oral health can have important physical and psychological effects for both children and adults, including pain, sleeplessness and poor dietary intake. In 2011/12 the proportion of five year old children with some tooth decay experience in Oxfordshire was 32.9%. This represented an increase from 25.7% in 2007/8. It was higher than the proportion for England overall (27.9%) but similar to that for the Thames Valley. In Oxford, 39% of two to ten year olds had some tooth decay experience.

In 2013 Oxfordshire had a rate of 720.8 Sexually Transmitted Infections per 100,000 people. This was below the rate for England (834.2) but significantly higher rate than in the Thames Valley area (640.5). Below county level it can be seen that the high rate is driven by Oxford. The reasons for this are complex and are currently being investigated. It may be influenced by the proportionally larger younger population in Oxford, given that younger people tend to have riskier sexual behaviour. In addition, individuals who do not provide their residential postcode are allocated the postcode of the clinic they attend, which would either be in Oxford or Banbury.

HIV is associated with serious morbidity, high costs of treatment and care, significant mortality and a high number of potential years of life lost. The prevalence of HIV in Oxfordshire, (1.3 people per 1,000 15-59 year olds in 2012) remains significantly lower than the average across England (2.1). However the prevalence rate in Oxford (2.4 in 2012) is significantly higher than the national average. This is likely to be due to the diverse population including more young people and proportionately more people from ethnic minority groups: HIV is more prevalent in Black African communities and Oxford has a relatively high proportion of Black ethnic minorities.

Housing and health

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

At the time of the 2011 Census, 38.5% of people in Oxford lived in households with more than one person per bedroom; this compares with 33.3% in Oxfordshire as a whole and 34.9% in the South East and 36.8% in England overall.

Cold homes are linked to increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. The elderly have been found to be particularly likely to suffer ill health in a cold home. In 2012 Oxford had 12.4% of people living in fuel poverty[3]; in Oxfordshire this was 8%, in the South East 7.8% and 10.4% in England overall.

[3] Under the 'Low Income High Cost' measure of fuel poverty, households are considered to be fuel poor when: (i) they have required fuel costs that are above average (the national median level) and (ii) were they to spend that amount, they would be left with a residual income below the official fuel poverty line.

Homelessness is associated with adverse health. Across the county, Oxford had higher rates of statutory homelessness than Oxfordshire overall. This is could in part be related to the presence of homeless facilities in the city. In 2013/14 45 people were estimated to be homeless in Oxford and a count of rough sleepers found 19 people.

Likely trends without a new Local Plan

Much of the data presented above includes information on trends over time. It can be seen that many health indicators have shown an improvement (even if only slight) in recent years. Much of this is likely to be as a result of health interventions, improvements to services and treatments and also improvements in awareness and education of lifestyle factors in particular. The data also shows however that there are several areas where Oxford performs below the local or national average, where more focus is needed to secure similar improvements.

Causes of death

The graphs in figures 6.5.8 and 6.5.9 below show that there was and increasing number of deaths from dementia and Alzheimer's disease in Oxfordshire from 2011 to 2013. This became the most common cause of death of women in Oxfordshire by 2013 (having been the third most common form of death in 2011). For men in Oxfordshire it was the fifth most common form of death in 2011 to the second most common form of death in 2013.

Figure 6.5.8 leading causes of male death in Oxfordshire (time series)

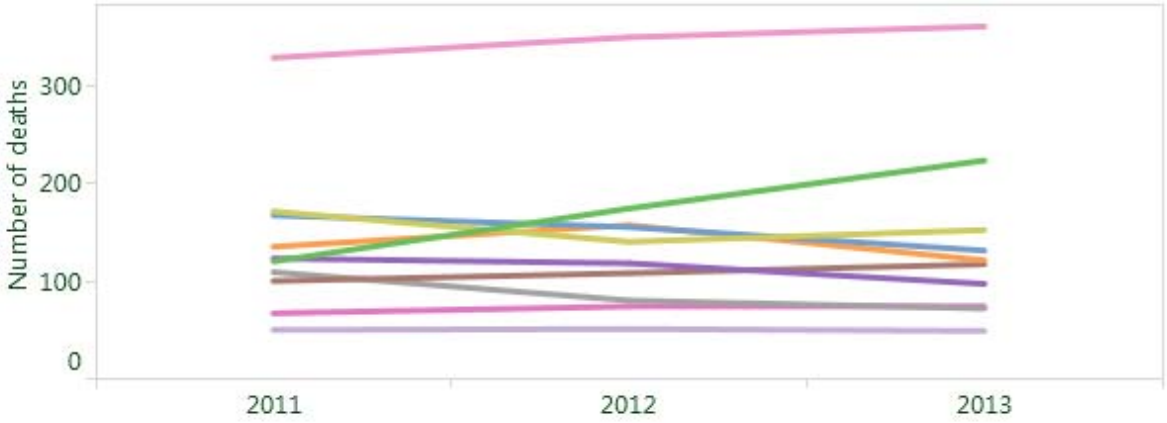
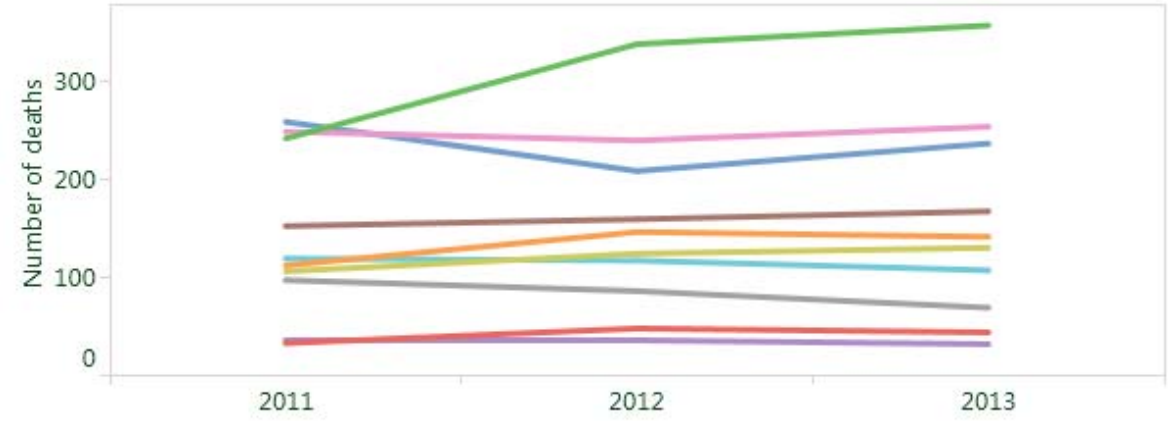


Figure 6.5.9 leading causes of female death in Oxfordshire (time series)



Dementia and Alzheimer's disease
Ischaemic heart diseases
Cerebrovascular diseases
Influenza and Pneumonia
Chronic lower respiratory diseases
Malignant neoplasm of trachea, bronchus and lung
Malignant neoplasms of female breast
Malignant neoplasm of colon, sigmoid, rectum and anus
Diseases of the urinary system
Heart failure/ complications and ill-defined heart disease

Sustainability/Plan Issues

- The disparity in health deprivation and sickness and disability across the city needs to be reduced
- Higher than average levels of activity and lower than average levels of obesity need to be maintained and increased
- There may be opportunities to address the issue of mental health and wellbeing through the Local Plan for example through improving quality of housing, access to open spaces and a focus on building communities