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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Health Improvement Partnership Board

Notice of a Meeting of the Health Improvement Partnership Board

Tuesday, 26 September 2017 at 2.00 pm

Town Hall, Oxford

Peter G. Clark
Chief Executive

September 2017

Contact Officer: ***Katie Read, Policy Officer***
Tel: 07584 909530; Email: katie.read@oxfordshire.gov.uk

Membership

Chairman – District Councillor Anna Badcock
Vice Chairman - District Cllr Marie Tidball

Board Members:

Cllr Jeanette Baker	West Oxfordshire District Council
Cllr John Donaldson	Cherwell District Council
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Education
Richard Lohman	Healthwatch Ambassador
Cllr Monica Lovatt	Vale of White Horse District Council
Dr Jonathan McWilliam	Strategic Director for People and Director of Public Health
Dr Paul Park	Vice Clinical Chair of Oxfordshire Clinical Commissioning Group
Diana Shelton	West Oxfordshire District Council
Jackie Wilderspin	Public Health Specialist

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned….."*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chairman, District Councillor Anna Badcock

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Minutes of the last meeting (Pages 1 - 6)

2.05pm
5 minutes

To approve the minutes of the meeting held on 27th June 2017 and to receive information arising from them.

6. Performance report (Pages 7 - 10)

2.10pm
15 minutes

Performance report presented by Dr Jonathan McWilliam, Director of Public Health, Oxfordshire County Council.

The Board is asked to note the report on progress against the targets of the Health Improvement Board in Quarter 1, 2017-18.

7. Director of Public Health Annual Report (Pages 11 - 86)

2.25pm
20 minutes

Report presented by: Johnathan McWilliam, Director of Public Health, Oxfordshire County Council

The Director of Public Health will present a draft of his Annual Report for 2016/17 which will be presented to the County Council for approval.

It is an independent report for all organisations and individuals that summarises key issues associated with the Public Health of the county. It includes details of progress over the past year, as well as recommendations for future work.

8. Health Protection and Air Quality Management (Pages 87 - 98)

2.45pm
25 minutes

Health Protection Forum Annual Report presented by: Eunan O'Niell, Oxfordshire County Council

A report on the activity of the Public Health, Health Protection Forum during 2016-17, followed by:

Air Quality Management Annual Report presented by: Claire Spendley, South Oxfordshire District Council and Mai Jarvis, Oxford City Council

An overview of what is being done to tackle poor air quality across the County, including the role of Local Authorities and the Health Improvement Board.

9. Oxfordshire Suicide Prevention (Pages 99 - 106)

3.10pm
20 minutes

Report presented by: Donna Husband, Oxfordshire County Council and David Colchester, Thames Valley Police

A report to inform the Board about multi-agency suicide prevention work coordinated across Oxfordshire. The Board is recommended to consider its role in improving mental wellbeing to encourage, co-ordinate and oversee wellbeing initiatives across a range of organisations.

10. Loneliness and Isolation (Pages 107 - 166)

3.30pm
25 minutes

Report presented by: Penny Thewlis, Age UK

A discussion paper to encourage the Board to consider ways of working together across Oxfordshire to combat chronic or persistent loneliness.

11. Exercise on referral (Pages 167 - 172)

3.55pm
20 minutes

Report presented by: Ed Nicholas, Oxfordshire Sport and Physical Activity

An overview of the exercise on referral programmes running across Oxfordshire. The Board is asked to endorse Oxfordshire Sport and Physical Activity's proposal to bring together organisations involved in Exercise and Referral to share best practice and look to ways forward on county-wide issues.

12. Approach to Fuel Poverty in Oxfordshire (Pages 173 - 176)

4.15pm
20 minutes

Report presented by: Debbie Haynes, Oxford City Council

The report provides an overview of fuel poverty work in Oxfordshire, its links with health and some principles for moving towards an integrated, multi-referral service that the Board is asked to approve.

13. Oxford green health conference (Pages 177 - 178)

4.35pm
10 minutes

Presented by: Ian Brooke, Oxford City Council

A proposal to arrange a green health conference for providers of outdoor spaces to collaborate with healthcare and public health organisations in order to meet health priorities and tackle inequalities.

14. Forward Plan (Pages 179 - 180)

4.45pm
5 minutes

Presented by: Councillor Anna Badcock, Chairman of the Health Improvement Board

A discussion about the forward plan for the Health Improvement Board

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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Tuesday 27th June commencing at 3.00 pm and finishing at 5.00 pm.

Present:

Board Members:	Councillor Anna Badcock (Chairman), South Oxfordshire District Council Councillor Marie Tidball (Vice-Chairman), Oxford City Council Councillor Jeanette Baker, West Oxfordshire District Council Councillor Monica Lovatt, Vale of White Horse District Council Councillor John Donaldson, Cherwell District Council Jackie Wilderspin, Public Health Specialist Dr Jonathan McWilliam, Director of Public Health Dr Jonathan Crawshaw, Oxfordshire Clinical Commissioning Group (substituting for Dr Paul Park) Diane Shelton, West Oxfordshire District Council
Officers:	
Whole of meeting:	Val Johnson, Oxford City Council Katie Read, Oxfordshire County Council
Part of meeting:	
Agenda item 6	Jon Dearing, West Oxfordshire District Council
Agenda item 8	Kate Austin, Oxfordshire County Council Azul Strong, Oxford City Council
Agenda item 9	Chris Freeman, Oxfordshire Sport and Physical Activity

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Katie Read (Tel 07584 909530; Email: katie.read@oxfordshire.gov.uk)

ITEM	ACTION
1. Welcome The Chairman, Councillor Anna Badcock, welcomed all to the meeting. As the meeting was Val Johnson's last, she was thanked for her commitment to the Board and her support as the district/city council partnership officer.	
2. Apologies for Absence and Temporary Appointments Apologies were received from Cllr Hilary Hibbert-Biles and Dr Paul Park. Dr Jonathan Crawshaw substituted for Dr Paul Park.	
3. Declaration of Interest There were no declarations of interest.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Minutes of Last Meeting The minutes of the April meeting were approved. As a matter arising under the Strategic Review of Domestic Abuse, Sarah Carter, Strategic Lead for Domestic Abuse and Sarah Breton, Lead Commissioner – Children shared the outcomes of the Domestic Abuse Summit. It was agreed that: - The Domestic Abuse Strategic Board will report formally to the Health Improvement Board twice a year and once a year to the Oxfordshire Health and Wellbeing Board. - Representatives from Thames Valley Police and the County Council's Children's Services will be invited to attend the Health Improvement Board when Domestic Abuse Services are discussed.	
6. Performance Report Jonathan McWilliam presented the end of year performance report. At 10.6 – it was queried whether the aspirational target for young people leaving supported housing with positive outcomes was too high, particularly as performance is only just exceeding the base target. Members were reminded that there had been lengthy discussion with the Board about an appropriate target for the young people's supported housing pathway and this had resulted in both a base target and aspirational target being agreed. At 11.3 – a request was made to explore the differentiation between localities regarding seasonal flu vaccination rates. There was support from the Board for future performance reports to include a breakdown of inequalities across district localities and particular population groups.	

A proposal for inequalities indicators will be brought to a future meeting. At 8.4 – a request was made to unpack the data on smoking cessation, particularly in light of Public Health messages on the use of e-cigarettes. It was reported that Public Health is in the process of revising the smoking cessation contract. **A report card on Public Health messages about smoking cessation will be brought to a future meeting.** Jon Dearing, Chairman of the Housing Support Advisory Group presented the annual basket of housing indicators report. The Board was keen to know the outcomes of work on a hospital discharge protocol for homeless patients. It was reported that the Trailblazer project will include specific resources to focus on this. Members were keen that this also includes a focus on s.117 mental health cases. **A report on progress with the Trailblazer project will be brought to the February meeting of the Board.** Members also explored the practical impacts of the benefit cap. It was reported that the cap is now starting to affect households with 2 children, not just larger families and the role of housing teams is becoming much broader, including debt advice.	**Jackie Wilderspin** **Eunan O'Neill** **Jon Dearing**
7. Draft priorities for the Oxfordshire Joint Health and Wellbeing Strategy Jonathan McWilliam presented the proposed revised indicators for the Health Improvement Board to be included in the 2017-18 Health and Wellbeing Strategy. It was considered sensible to continue with the inclusion of an aspirational target for the measure of young people leaving supported housing with positive outcomes (10.5). There was discussion about whether the smoking target (8.5) should reflect current Public Health messages about the use of e-cigarettes as a valid stepping stone towards quitting. As there is still debate about whether these messages are helpful, it was considered wise to leave the target focused on quitters for this year. The rationale behind focusing on inactivity (at 9.2) as opposed to the harmful outcomes of obesity was queried. It was explained that the Health Improvement Board's remit is primary prevention, rather than the treatment of symptoms. Other Boards reporting to the Health and Wellbeing Board would be more likely to have 'disease-based' measures. The measures proposed for inclusion in the 2017-18 Strategy were agreed by the Board.	

8. Barton Healthy New Town Kate Austin and Azul Strong presented the achievements of the Barton Healthy New Town programme to-date and learning from the project. The Board discussed the approach to integrating the existing community (approx. 4,000 people) with those you will occupy the new homes (approx. 3,000 people). Parallels were drawn with the expansion of Berinsfield and members were keen for learning to be shared between these two areas. Members queried how much of the New Town work is influencing national and local policy. It was reported that the Public Health team is influencing developers through work with the Town and Country Planning Association, and locally through work with district/city planners to encourage the use of health impact assessments. Learning is also being shared through the Buckinghamshire, Oxfordshire, Berkshire and Milton Keynes planning network. The Board was keen to understand how the programme is being made sustainable. Work is ongoing to establish baseline data to ensure that the impact of the New Town approach can be measured and replicated. There was thought to be natural crossover between the initiatives relating to the physical environment and community initiatives. There are also national tools available to help measure the impact on health. **Ways for the Board to take this work forward will be explored, including how learning from Healthy New Towns can influence Local Plans and new housing developments can be influenced to include an emphasis on health improvement.**	**Kate Austin**
9. Exercise on Referral Chris Freeman presented an overview of the scale and impact of inactivity across the county and referral schemes in place to tackle this. Board members felt that there was an opportunity for joint work on referrals for exercise that would encourage greater consistency across the districts/city. Members were made aware that OxSPA has recently completed a physical activity needs analysis for Oxfordshire which demonstrates the impact of varying provision across the county. The CCG communications strategy for exercise on referral was queried, in particular the links made with other services, e.g. physiotherapy. OxSPA has looked at developing a physical activity pathway, but it is difficult to communicate this message to Oxfordshire the large number of different surgeries across the county. OxSPA was recommended to make contact with the CCG Locality leads to facilitate this. Members also discussed barriers to accessing sports provision for disabled individuals. GP referrals for exercise were identified as an important method	

for addressing barriers to access. The Board requested information on where the gaps in access are. **A more detailed report will be brought to the next Board meeting providing an analysis of the current gaps in provision and breakdown in inactivity across the districts/city, as well as an overview of referral schemes.**	**Chris Freeman**
10. Fuel Poverty workshop outcomes The Chairman fed back to all Board members the outcomes of the fuel poverty workshop arranged on behalf of the Board. **Minutes of the workshop will be circulated to Board members.** **A report will be brought to the next Board meeting proposing areas for further joint work on fuel poverty and outlining the direction of travel in this area.**	**Katie Read** **Debbie Haynes / Kate Eveleigh**
11. Forward Plan From discussion at the meeting the following items will be added: • Trailblazer project, including work on a hospital discharge protocol for homeless people. • Report card on smoking cessation messages – i.e. stop vs. swap • Strategic direction for joint work to tackle fuel poverty • Breakdown of physical inactivity across the county and exercise referral schemes. • Proposed indicators to highlight inequalities	**Katie Read**
The meeting closed at 5.00pm	

..... in the Chair

Date of signing

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Health Improvement Board

26 September 2017

Q1 Performance Report

Background

1. The Health Improvement Board is expected to have oversight and of performance on four priorities within Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, and ensure appropriate action is taken by partner organisations to deliver the priorities and measures, on behalf of the Health and Wellbeing Board.

2. The four priorities the Board has responsibility for are:

   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

Current Performance

3. A table showing the agreed measures under each priority, expected performance and current performance is attached as appendix A.

4. There are some indicators that are only reported on an annual basis and these will be reported in future reports following the release of the data.

5. For the indicators that can be regularly reported on, current performance can be summarised as follows:

   4 indicators are Green.
   2 indicators are Amber (defined as within 5% of target).
   0 indicators are Red
   3 indicators do not yet have information available for Q1 – these are indicators 8.1, 10.2 and 10.5.

Sue Lygo
Health Improvement Practitioner
13 September 2017

Oxfordshire Health and Wellbeing Board
Performance Report

Priority 8: Preventing early death and improving quality of life in later years											
	Indicator	**Target**	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Comments**
			Fig.	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	**Fig.**	**RAG**	
8.1	At least 60% of those sent bowel screening packs will complete and return them (aged 60-74 years) - and adequately screened	60%	0.0%		0%		0%		0%		Data at least six months in arrears.
8.2	At least 95% of the eligible population 40-74 will have been invited for a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 80%	95% over 5-year period Q1 84%, Q2 88%, Q3 92%, Q4 95%	85.2%	G	0.0%		0.0%		0%		
8.3	At least 45% of the eligible population 40-74 will have received a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 40%.	45% over 5-year period Q1 42%, Q2 43%, Q3 44%, Q4 45%	42.3%	A	0.0%		0.0%		0.0%		
8.4	Rate of successful quitters per 100,000 smokers aged 18+ should exceed the baseline set in 2017-18	>2315	2432	G	0		0		0		
8.5	The number of women smoking in pregnancy should remain below 8% recorded at time of delivery	<8%	8.0%	G	0.0%		0.0%		0.0%		-
8.6	Oxfordshire performance for the proportion of opiate users who successfully complete treatment. KEEP UNDER SURVEILLANCE IN 2017/18	NO TARGET	7.3%		0.0%		0.0%		0.0%		

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
8.7	Oxfordshire performance for the proportion of non-opiate users who successfully complete treatment KEEP UNDER SURVEILLANCE IN 2017/18	NO TARGET	44.6%		0.0%		0.0%		0.0%		-
Priority 9: Preventing chronic disease through tackling obesity											
9.1	Ensure that obesity level in Year 6 children is held at below 16% (in 2016 this was 16.0%) No district population should record more than 19% (NCMP)	<=16%					0.0%				
9.2	Reduce by 0.5% the percentage of adults classified as "inactive" (Oxfordshire baseline Nov 2016 of 17%).	Reduce by 0.5% from baseline (17%)					0.0%				
9.3	63% of babies are breastfed at 6-8 weeks of age (county). KEEP UNDER SURVEILLANCE IN 2017/18	63%	60.1%		0.0%		0.0%		0.0%		
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness											
10.1	The number of households in temporary accommodation on 31 March 2018 should be no greater than level reported in March 2017 (baseline161 households in Oxfordshire 2016-17).	≥161			0				0		
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.3% in 2016-17)	≥75%	0.0%		0.0%		0.0%		0.0%		
10.3	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 80% in 2016-17).	80%			0.0%				0%		

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
10.4	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2016-17 (baseline 79)	≥79					0				
10.5	At least 70% of young people leaving supported housing services will have positive outcomes in 2017-18	<=70% Aspire 95%	0.0%		0.0%		0.0%		0.0%		
10.6	At least 1430 residents are helped per year over the next 4 years where building based measures account for 25% of those interventions by the final year. KEEP UNDER SURVEILLANCE in 2017/18	NO TARGET							0		
Priority 11: Preventing infectious disease through immunisation											
11.1	1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 94.6%) No CCG locality should perform below 94%	95%	95.0%	G	0.0%		0.0%		0.0%		
11.2	2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 5 (currently 93.1%) No CCG locality should perform below 94%	95%	93.6%	A	0.0%		0.0%		0.0%		
11.3	At least 55% of people aged under 65 in “risk groups” receive flu vaccination	≥ 55%							0.0%		
11.4	At least 90% of young women to receive both doses of HPV vaccination. KEEP UNDER SURVEILLANCE in 2017/18	≥ 90%							0%		Data available annually for school year Sept-Aug so published after September.

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT X

Reporting on 2016/17
Produced: August 2017

Contents

Foreword

Every Director of Public Health must produce an Annual Report on the population's health.

This is my 10th Annual Report for Oxfordshire.

It uses science and fact to describe the health of Oxfordshire and to make recommendations for the future.

It is for all people and all organisations.

I hope you find it interesting, but more than that I hope it is found to be useful in shaping the County's services for the future.

I am responsible for its content, but it draws on the work of many too numerous to name. I thank you all for your help, support and encouragement.

With best wishes,

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
August 2017

Chapter 1: The Demographic Challenge

Let's keep this simple.

There are two major challenges facing Oxfordshire:

- How do we cope with the increasing stresses and strains a growing population brings?
- How do we keep children and adults of all ages healthy so that disease is minimised as the population grows?

Of course there are many other problems and issues, but these two are the overwhelming ones, and this report looks at these two issues from many different angles.

This chapter focusses on the first of these two – the demographic challenge.

The demographic challenge is a challenge because of 5 interlocking factors:

1. The population is growing
2. The population is ageing
3. The proportion of older people is increasing
4. Public expectations are high
5. Money is tight

A further problem is rapidly approaching which will further complicate matters – being overweight is the new norm in adults and increasingly prevalent in younger people, and this will inevitably lead to higher levels of disease – but that's for chapter 4.

Disadvantage also acts as a brake to stop people achieving their full potential and this is another confounding factor – you will find that topic in chapter 3.

Population growth means we have to plan our communities better and poor air quality - generated by more people and more activity – is an important issue - covered in chapter 2.

All of these changes put stresses and strains on the mental wellbeing of young people – see chapter 5.

…… and of course, let's never forget the shadow cast by infectious disease – sleeping, but not defeated - chapter 6.

So let's look first at population growth and population ageing.

Population Growth

Between 2000 and 2015, the total population of Oxfordshire increased by 70,700 people (+12%) compared with 11% across England.
Plans for a significant expansion in new housing, following the Oxfordshire Strategic Housing Market Assessment, imply a growth in the population of Oxfordshire over the next 15 years of more than double that of the previous 15-year period.

Oxfordshire County Council population forecasts, based on expected housing growth, predict an increase in the number of Oxfordshire residents of 183,900 people (+27%) between 2015 and 2030.

This is a massive increase by any standards and will put a huge strain on our already stretched infrastructure such as roads and schools- a factor I will pick up in chapter 2.

Will Government funding of statutory services keep pace? No one knows the answer, but we do know that health and social services are already stretched to breaking point.

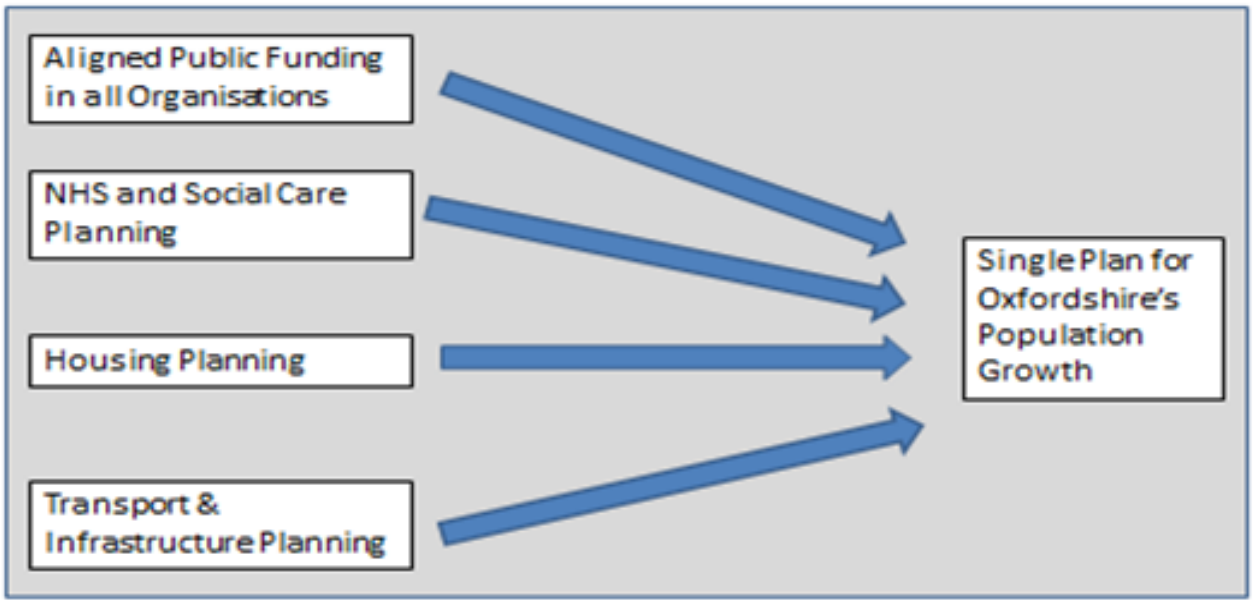
What we also know is that the old ways of doing things aren't likely to cope with such an increase as they stand. Our planning systems need to work far more slickly and intelligently if we are to have the transport systems people will demand. The daily commute will become increasingly tortuous and movement more difficult. Perhaps home working and IT solutions point the way forward.

Of course, people tend not to like change – it's hard-wired into us. During the last year local NHS organisations put forward proposals about radically changing the way hospitals and community services might be changed to cope with this pressure. The response was - to put it mildly - mixed. It's like one of those problems in which you push the problem down in one place but that makes it pop up in another – for example, the NHS proposed increasing the care carried out by people coming to hospitals for the day (ambulatory care), but it is outside the NHS's remit to plan for the increase in journeys and traffic and parking that implies, and so another problem is created.

All of this means that the problem of population growth is too big for any one organisation to cope with alone – we need to harness plans for housing, transport, the NHS and social care to the same yoke so that we can plough a single furrow.

We haven't solved this yet but the problem is staring senior executives and senior Councillors in the face. Necessity will, as always, drive the solution, and the solution we need is to craft a unified planning system.

In simple terms it will need to look something like this:



There are signs that we are closer to this than ever before, and these have occurred during the last 18 months. These are:

- Council Leaders and the NHS, Local Enterprise Partnership and the Universities debating new forms of local Government and Devolution
- The NHS trying to join up the currently fractured system through a single plan
- The Hospital Trusts and Universities reaching out to Local Authority planners to seek a `joined up' approach.

This is good. These are green shoots. They cause much controversy, but they are clear signs that all the big organisations are saying 'we can't go on as we are' and that is always the first step. No one knows where it will lead, but we seem to have begun the journey, and this is to be welcomed, for the problem of population growth is very real and the solution is likely to be radical.

Expected growth in housing

The plans for housing growth recommended for Oxfordshire shed a factual side-light on the scale of future population growth. In April 2014 the Oxfordshire Local Authorities, published the Strategic Housing Market Assessment (SHMA) for Oxfordshire.

The Assessment suggested that the demographic trends and growth of the County economy and the level of affordable housing required would necessitate **100,060** additional new homes in Oxfordshire between 2011 and 2031. More houses mean more people. There are currently over 600,000 people living in Oxfordshire. 100,060 more houses will swell this number considerably.

Up to the end of March 2016, just under 11,700 homes had been built in Oxfordshire and, since 2011, the year with the highest rate of housing completions was 2015/16 with 3,350 homes built. This leaves a remaining requirement of 88,400 new homes to be built by 2031, or just under

6,000 homes per year for each of the next 15 years. This is a contentious topic and is much debated. Where will the houses go? When exactly will they be built? Will they be grouped to make best use of the 'developer contributions' which can fund the sensible road and transport links we need? The risk is that a piecemeal planning system which doesn't take a view of the whole is less likely to help. This is another reason why organisations need to pull together if we are to cope.

The Strategic Housing Market Assessment represents a view of how Oxfordshire 'should' grow in the national context. Of course it's not just about houses. Houses mean people and people mean more roads, more schools and more workplaces….and more diseases. More people also implies a much higher volume of attendances at GP surgeries and hospitals and more need for social care. All of this requires careful planning and, as highlighted in previous annual reports, there is a widely shared view that our current planning processes are fragmented and won't cope well as they stand. Hence the need to move towards a single planning process.

During the year, a useful start has been made on this and the infrastructure requirements of all organisations across the County have been drawn together in one place in a document called Oxfordshire Infrastructure Strategy. This is a start and is to be applauded. The question is, can this be used to make the disparate cogs of the planning process turn as one smooth machine to serve local people? Only time will tell.

Where will the nurses, home care workers and ancillary staff come from?

The very real and tangible effects of population growth, the relative prosperity of Oxfordshire, low unemployment and sluggish housing growth of affordable housing all combine to create a very big problem for services.

It is becoming increasingly difficult to recruit the staff we need to fill nursing, caring and ancillary posts. In the last few weeks, I attended meetings where the hospital and social care services were spelling this out very clearly. Some hospital wards are for example reported to be running with 25% vacancies. This is unlikely to be sustainable. Looking at local house prices sheds light on this and underlines the problems of high house prices in Oxfordshire. The statistics are as follows:

Housing affordability

- In 2016, house prices in Britain were 10 times the annual salary of residents.
- **Oxford was the least affordable city, with house prices being 16.7 times higher than annual earnings** - on a par with London.
- Burnley was the most affordable city, with house prices being 4.1 times the average annual earnings – 4 times more affordable than Oxfordshire.
- All the top 10 least affordable cities were located in the South of England. The majority of the most affordable locations were in the North West and Yorkshire regions.

Here is the relevant table.

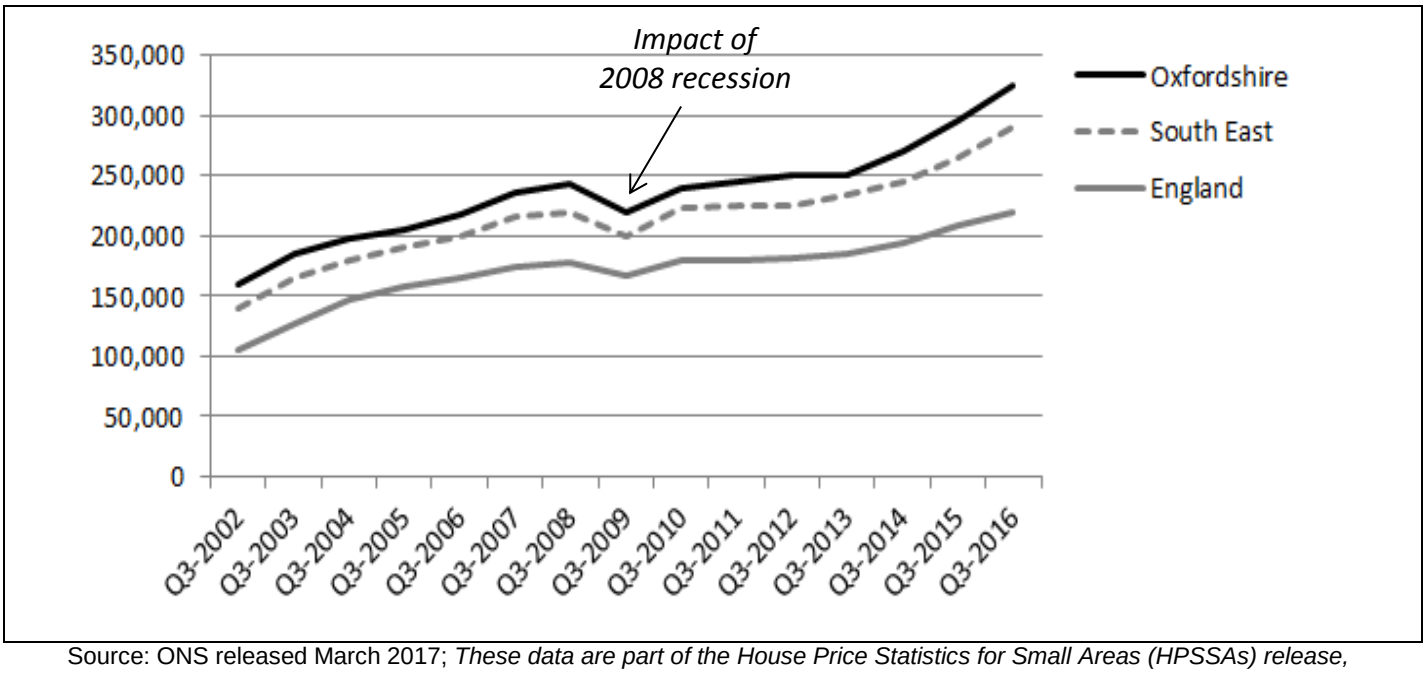
Housing affordability ratio

Rank	City	Affordability ratio	Average house price, 2016 (£)	Yearly wages, 2016 (£)
10 cities with the highest affordability ratio				
1	Oxford	16.7	491,900	29,400
2	London	16.7	561,400	33,700
3	Cambridge	15.8	475,800	30,100
4	Brighton	13.7	367,900	26,800
5	Bournemouth	12.5	309,300	24,700
6	Aldershot	11.6	360,400	31,200
7	Reading	11.3	375,200	33,300
8	Worthing	10.7	279,100	26,100
9	Exeter	10.5	253,500	24,100
10	Bristol	10.4	275,900	26,600

Trends in house prices

Over the past 10 years the increase in the median (mid-point) house price in Oxfordshire has been above the South East region and England. Between 2006 and 2016, the median price of housing in Oxfordshire increased from £218,000 to £325,000, an increase of 49% compared with 46% in the South East and 33% in England. The districts seeing the highest increase were Cherwell (60%) and Oxford (60%). In other words, the local affordability gap is getting worse compared with England.

Median house price 2002 to 2016



Source: ONS released March 2017; *These data are part of the House Price Statistics for Small Areas (HPSSAs) release, produced by ONS. These statistics report the count and median price of all dwellings sold and registered in a given year. They are calculated using open data from the Land Registry, a source of comprehensive record level administrative data on property transactions.*

Median house price 2006 to 2016

	Q3-2006	Q3-2016	Q3-2006 to Q3 2016	
Cherwell	£183,000	£292,250	*£109,250*	*+60%*
Oxford	£235,000	£375,000	*£140,000*	*+60%*
South Oxfordshire	£241,100	£355,000	*£113,900*	*+47%*
Vale of White Horse	£225,000	£325,000	*£100,000*	*+44%*
West Oxfordshire	£212,000	£300,000	*£88,000*	*+42%*
Oxfordshire	**£218,000**	**£325,000**	***£107,000***	***+49%***
South East	£198,950	£290,000	*£91,050*	*+46%*
England	£165,000	£220,000	*£55,000*	*+33%*

Source: ONS, released March 2017

All services are trying to find new ways to address this problem, and we are likely to need to look beyond the county boundary to developments around, say, High Wycombe to find the solution. Other options such as building hostels for workers are also being considered.

I have dwelt on housing prices because they illustrate with crystal clarity why the demographic challenge is real, it is here now, and it our most pressing challenge.

The ageing population

It is a blessing and a great achievement that people are living longer, often into a productive and active old age…… But it brings with it a new raft of issues for society to deal with…….

Growth of the population aged 65+

Between 2015 and 2030, Oxfordshire County Council predicts that the growth of people in the age group 65+ to be, 62,700 or **an increase of 53%.** This takes into account the plans available for new housing.

Growth of the population aged 85+

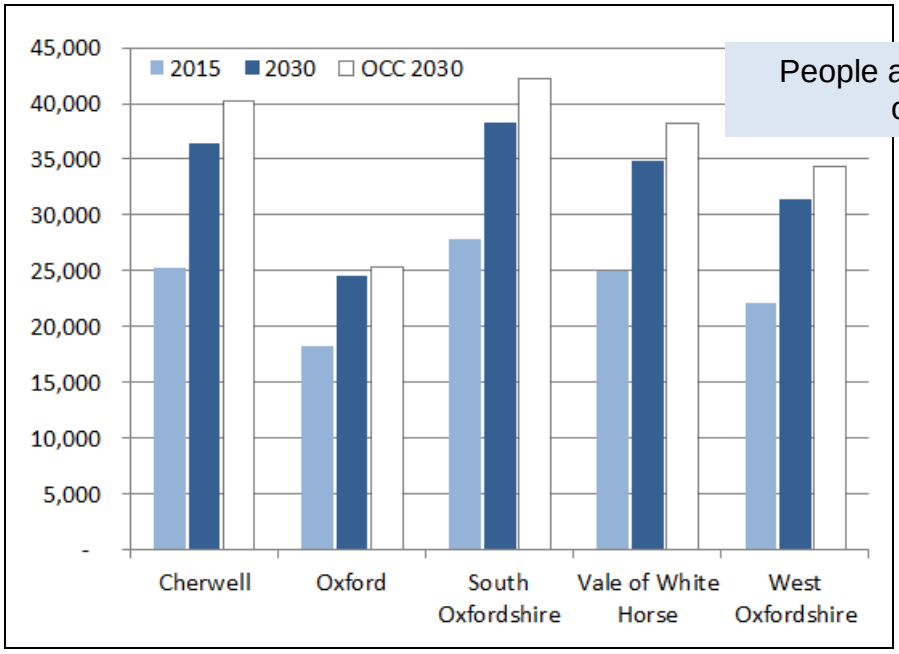
Between 2015 and 2030, Oxfordshire County Council predicts that the increase in people aged 85 and over in Oxfordshire to increase by +15,600 or **an increase of 96%** - a huge percentage increase.

Why does this matter? It is to be welcomed that life expectancy is increasing and in terms of opportunities it has been said that “70 is the new 50”. But in planning terms it presents a serious dilemma. It matters because as well as being simply more people, it means more people in the age group who experience most long term disease and disability, and, with advances in treatment and care that means more expense per head than in previous decades….. and not only that…….

……It matters also because at the same time the proportion of older to younger adults is increasing and this puts a pressure on the tax-base. Every penny going into the exchequer has to be made to go further while the demand on every pound increases.

Looking at this in more detail, different parts of the county are affected differently. The chart below tells the story. It shows the 65 plus population in 2015 and then shows two growth scenarios for 2030. The middle bar in each group shows the growth without house building and the bar on the right of each group takes account of what we know of planned housing growth.

Forecast growth in the number of people aged 65 and over between 2015 and 2030– ONS vs Oxfordshire County Council projections



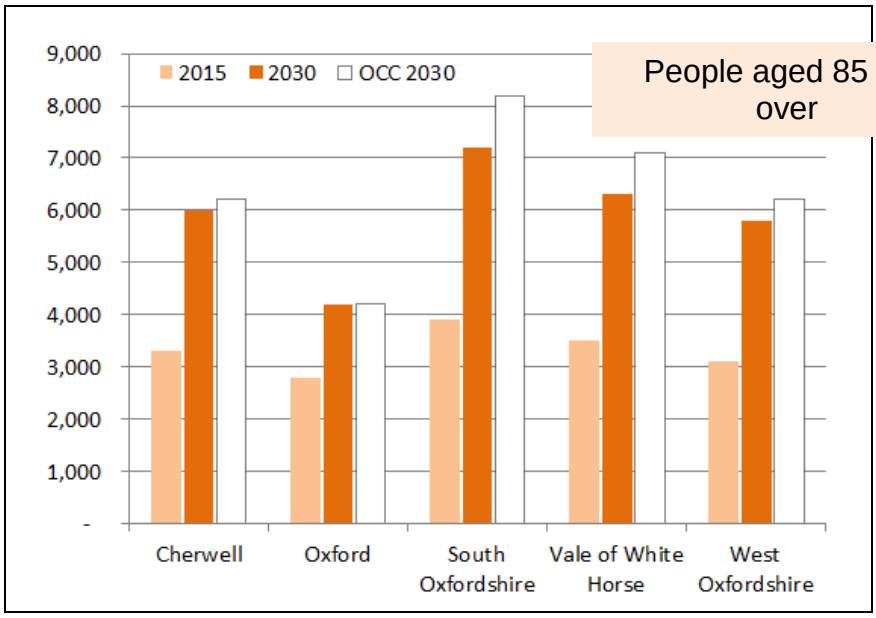
Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

- The rate of growth is pretty evenly spread across all Districts
- Housing increase swells the numbers considerably, apart from in Oxford where housing growth is constrained

Looking at the same data for over 85's using the same format gives the picture below:

Forecast growth in the number of people aged 85 and over between 2015 and 2030
ONS and Oxfordshire County Council projections



Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

- There is uneven growth. The city is the outlier as it has a 'younger' population.
- Housing growth adds to the predicted rise more in South Oxfordshire and Vale of the White Horse than elsewhere.

OK, one might ask, so ***the population is ageing, but is it getting healthier?***

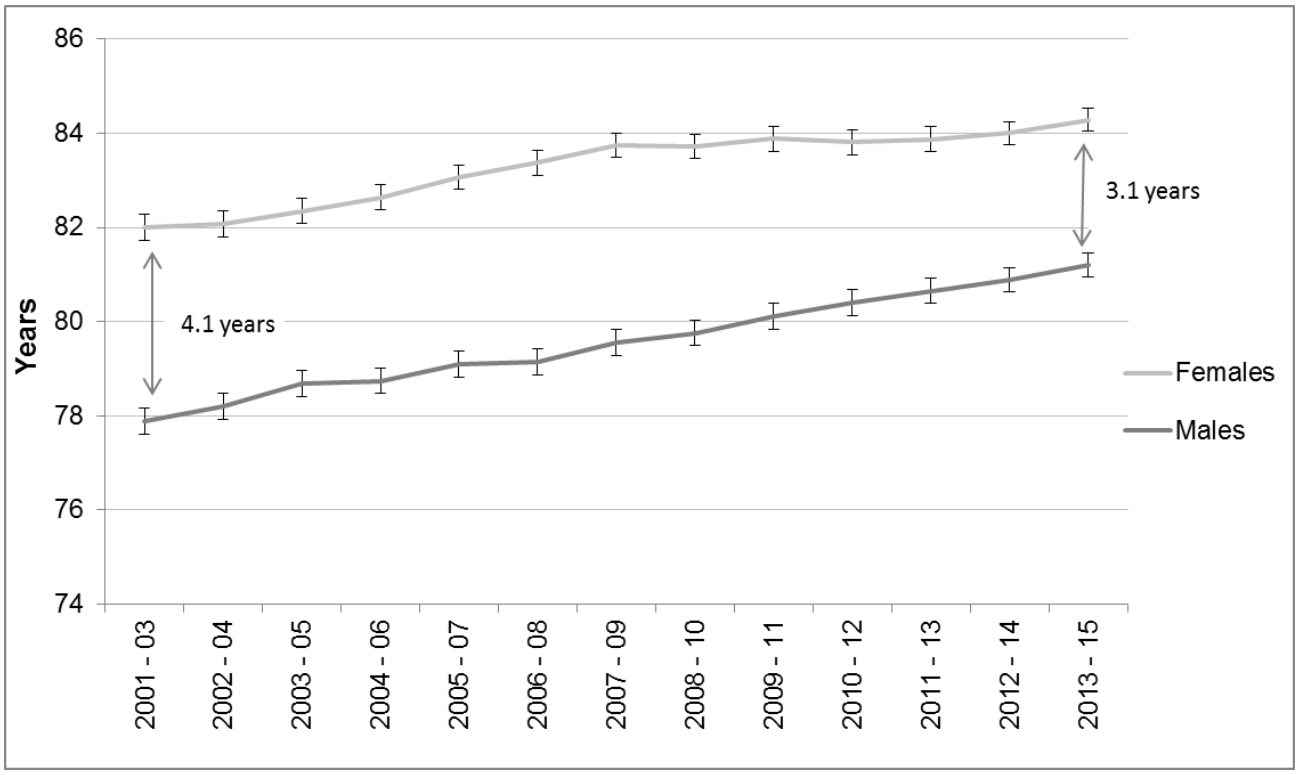
……An interesting question with no easy overall answer.

We can shed light on it by comparing two statistics.

The first is called 'life expectancy at birth' which estimates the average number of years a person born in an area could expect to live if they were to experience that area's mortality rates in the future. It's a best estimate, as no one really knows the exact answer.

It predicts that both males and females will continue to live longer. The gap between male and female life expectancy in Oxfordshire is narrowing. The gap in 2013-15 is the same as it was in 2012-14. A similar narrowing can be seen for England and in the South East region, so this is a national trend.

Male and female life expectancy at birth in Oxfordshire, 3-year rolling data for 2001-03 to 2013-15



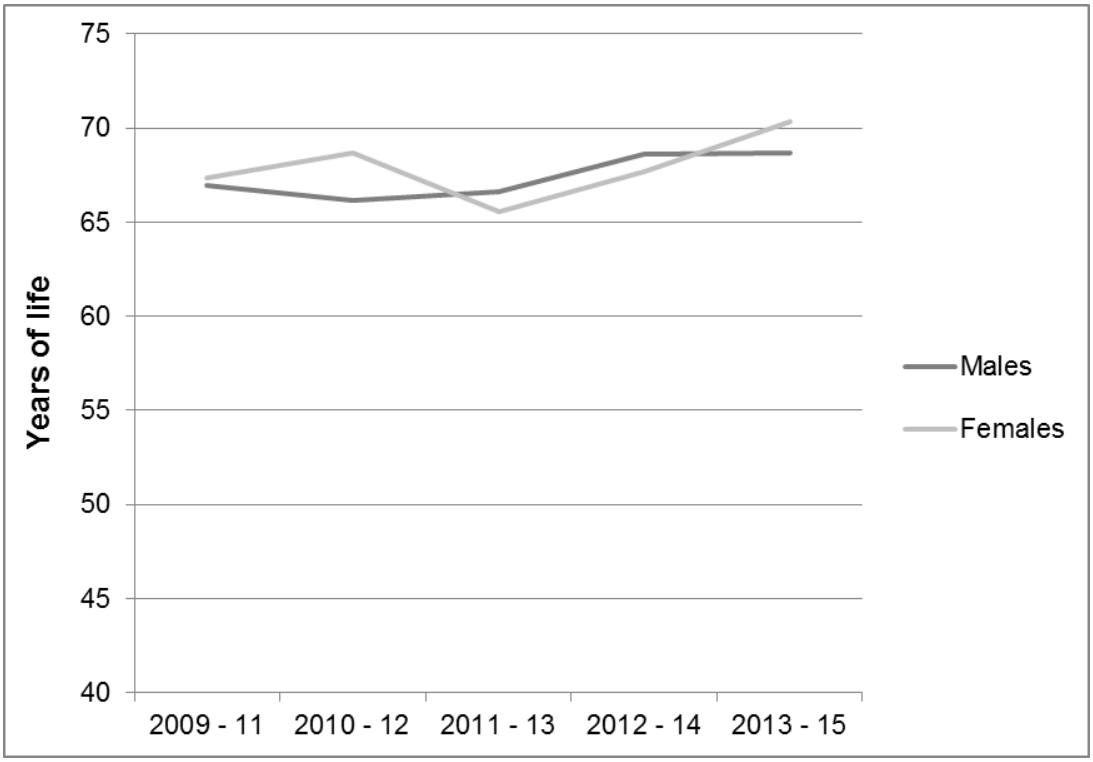
Source: Office for National Statistics (ONS). Vertical axis starts at 74 years, not zero

So far so good – longer life is the engine which drives the demographic challenge with regard to ageing, but the big question is ***are we ageing well or will more older people add to the demand for health and social care?***

A second statistic called 'Healthy Life Expectancy' points towards an answer. This statistic estimates how long we can expect to live in a reasonable state of health.

The picture is shown over the page:

Healthy Life expectancy at birth in Oxfordshire (2009-11 to 2013-15)



It shows that, on average, healthy life expectancy lasts into one's late sixties and the trend is moving slowly upwards – which is a good thing, BUT it isn't increasing as fast as average overall life expectancy……

So we can conclude that ***an ageing population will indeed create a further increase in demand for services because 'good health' isn't increasing as fast as 'long life'.*** This in turn means that services really do need to adapt quickly to demographic change, or, other things being equal, they will simply not cope.

What should we do about it?

Keeping it very simple again, and assuming the exchequer doesn't find a crock of gold any time soon, the answer would seem to contain the following elements:

1. Stay in good health for longer through preventing ill health

2. Coordinate all health and social care services so that they pull together, using new technologies to find new solutions

3. Create a single planning system for Oxfordshire encompassing health, social care, housing, and infrastructure planning

4. Be open to new ways of doing things because……

The demographic challenge means the change is inevitable.

What did we say last year and what progress has been made?

Last year's recommendations have essentially been met. They talked about the need to have a full debate about the NHS's consultation and to scrutinise it thoroughly. The recommendations also proposed that health and social care should be better integrated and more should be done to prevent disease before it starts. So what has been achieved? Looking at the big picture:

- The NHS has put forward significant proposals for change to meet these challenges in a lengthy consultation. Its reception was mixed to say the least. Overall, I think the need for change was broadly accepted, but the specific changes put forward proved controversial. A decision has now been made and is currently being challenged – we await the results.

- Local Government leaders have debated publicly the need to pull together via the many different proposals for reshaping Local Government and through devolution proposals. This has also proved to be very contentious.

- Integration of health and social care has moved forward through the Government's new 'Improved Better Care Fund' and we have a new Director of Adult Social Services in post who is reviewing current arrangements thoroughly so that we can move forward.

- The basics of prevention are in good order (immunisation, screening, maternal health etc.), but organisations have not been able to release funding to make a further step change as tight budgets are swallowed by the immediate service needs of today.

What should we do next?

Again, keeping it very simple, essentially we need to resolve these issues and move on – which is what we are all trying to do. It sounds easy but in practice it is difficult because the precise solutions are not obvious and so debate continues. However, being locked in debate and achieving little is unlikely to suffice for long. Perhaps we need to find a 'good enough' solution that everyone can agree to live with so that we can move on. I understand that this is a re-statement of the obvious, but I am hoping it might help to do just that. The key is that these are interlocking issues that need to solved as a single whole.

Recommendations

1. The NHS, County Council, District Councils, Universities and the Local Enterprise Partnership should pull together to resolve the current debates about 4 topics:

   - What is the best shape for NHS services for Oxfordshire?

   - What is the best way of achieving a sensible integration of health and social care - including local democracy in health care planning?

   - How can all organisations pull together a 'masterplan' to tackle issues such as the future use of NHS sites in Headington and Banbury, including travel and transport issues, so that services are improved and the 'knowledge economy' boosted?
   - How should housing growth be best coordinated so that developments and their supporting infrastructure are planned as one?

2. Local Government organisations should work together to create a single planning framework including 'health and social care planning', housing planning and infrastructure planning as a single whole.

3. All organisations should agree how to fund a step change in preventative services.

Chapter 2: Building Healthy Communities

For the last two years I have concentrated on public health aspects of the built environment. This year I want to combine that topic with a focus on air quality because two are closely connected in terms of solutions. I will look at air quality first.

Air quality

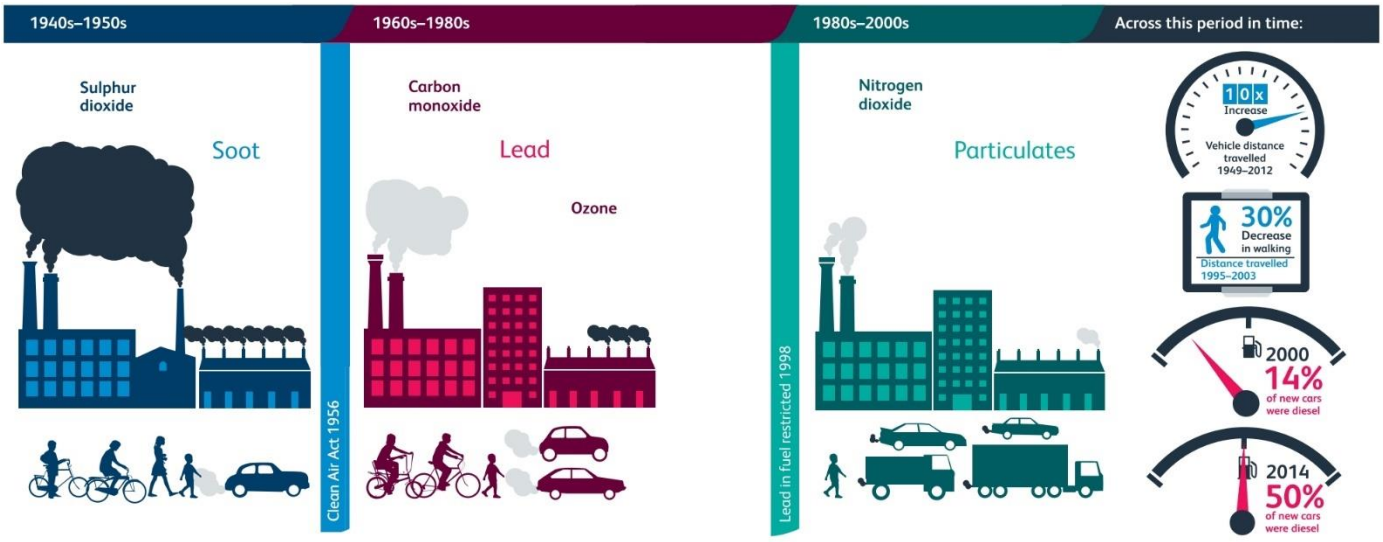
Air quality is a complex topic and I want to approach it from a Public Health point of view. The history of the long term improvement of the air we breathe is a jewel in Public Health's crown.

It's also an interesting topic because it underlines a historical truth of all public health activity – you solve one problem and another rises up to take its place.

Just as beating off many infectious diseases leads to the challenges of long life, and just as improving prosperity and diet leads to the challenges of obesity, so it is with air quality.

In this case it's an issue of scientific advances revealing underlying problems we didn't know were there before – in this case the problems of 'particulates' in the air and their health consequences.

The history of Public health and air quality is summarised in the following schematic:



This shows that in the 19th and 20th centuries the big problem was soot from coal fires and industry – which we solved. In the mid to late 20th century the big problem was lead, mainly from petrol – which we solved.

The new problem is oxides of nitrogen - nitrogen dioxide and its family of gasses – shorthanded as NOx. This has grabbed the headlines recently and is now being grappled with by Government because it is the only atmospheric pollutant where the UK fails to meet EU standards and the Government have been obliged to tackle this by the High Court.

Road transport makes up 38% of all NOx pollution, and it is highly concentrated in towns & cities where people live. Road traffic continues to grow: between 2000 – 2015 the number of licensed

cars increased from 24.4m to 30.3m. Diesel cars, the worst offenders when it comes to nitrogen oxide, have increased their share of the car market from 12.9% to 37.8%. The widely reported controversy over the accuracy of testing vehicles for particulate emissions has helped to push this issue to the top of the agenda.

Historically the problems of air pollution have generally been solved through national and European standards and legislation. There is a huge debate raging as I write about the Government's proposals to tackle NOx. This includes extending initiatives such as clean air zones and whether responsibility should sit at national or local level. Whatever the outcome of that debate, money remains tight and we need to seek out low cost options we can start to do today.

In this report I want to concentrate on what we can do NOW in Oxfordshire and under our own steam as individuals and within current organisational budgets irrespective of Government's deliberations

Let's look in more detail at particulates in the air

In the 1990s it was felt that air pollution was no longer a major health issue in the United Kingdom. Legislation had made the great smogs of the 1950s a thing of the past. But evidence started to emerge that small particles emitted to the air from various sources, such as road transport, industry, agriculture and domestic fires, were still having an effect on health. This type of air pollution is so small that it can't be seen by the naked eye, but can get into our respiratory systems. For example, nitrogen dioxide and sulphur dioxide are produced by burning fuel, whilst ozone is formed by chemical reactions in the air.

The scientific understanding of the health effects of everyday air pollution has changed dramatically in recent years. Population effects of air pollution that were largely unknown in the 1990s and uncertain until recently are now quantifiable.

Studies have shown that long-term exposure **(over several years)** reduces average life-expectancy, mainly due to triggering death from cardiovascular and respiratory causes and from lung cancer. Air pollution is now associated with much greater public health risk than was understood even a decade ago.

In the UK, the Committee on the Medical Effects of Air Pollutants (COMEAP) estimated the burden of particulate air pollution in the UK in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 life years lost.

It is important to understand that long-term exposure to air pollution is not thought to be the sole cause of deaths. Rather, it is considered to be a contributory factor – this is an important point.

Impact on deaths

An Air Quality Toolkit for Directors of Public Health was published by Defra in March 2017 and looks at the health impact of air pollution and particulates in particular. According to the toolkit:

> *'Short-term exposure to particulates over a period of a few hours to weeks can cause respiratory effects such as wheezing, coughing and exacerbations of asthma and chronic*

bronchitis. It can trigger CVD-related mortality and non-fatal events including myocardial ischemia and myocardial infarctions (MI), acute decompensated MI, arrhythmias and strokes.'

In plain English, this means that if you are exposed to particulates for a period of time, it may cause breathing problems and in some cases it can trigger underlying heart problems and strokes. These may in turn contribute to one's death. This is, it seems, the mechanism through which particulates impact on health.

Because of the indirect nature of the effect, it is difficult to measure, estimate or be certain about.

The toolkit sets out a method for calculating the rate of mortality 'attributable' to Particulate Matter. We always need to be careful with 'attributable' statistics. It means that a group of experts have looked at the science and have made a best estimate. In Oxfordshire this rate is 12.6 deaths per 100,000 population per year. What does this actually mean? Well, there is a sort of 'league table' of 'attributable' causes of death (all are best estimates) which looks like this for under 75s:

Measure	**Mortality rate, per 100,000**	
	Oxfordshire	**England**
Overall preventable mortality	142.6	184.5
Preventable cancer	64.5	81.1
Preventable heart disease and stroke	34.7	48.1
Mortality attributable to Particulate Matter	12.6	39.0
Preventable Liver disease	11.3	15.9
Communicable diseases	9.4	10.5

It is very clear that the number of deaths relating to air quality, preventable cancer, heart disease stroke, preventable liver disease and communicable diseases in Oxfordshire are well below the national averages and this is a good result. However, this does not mean that we should be complacent. We need to act to consolidate this position and strengthen it further.

The figures mean that preventable deaths associated with particulates are estimated to be associated around 1/5th of the number of preventable deaths due to cancer and around 1/3 of the number of preventable deaths associated with preventable heart disease and stroke.

It is important to grasp when particulates contribute to a death they generally act as a trigger. This isn't like smoking or alcohol related deaths where the main cause is the tobacco or the alcohol directly.

Clearly this isn't an exact science. It is easy to build castles on sand using these statistics, but it does give us a guide – enough to say that the experts think that particulates are a real health issue and should be tackled.

The Government's recent consultation on the topic summed it up as follows,

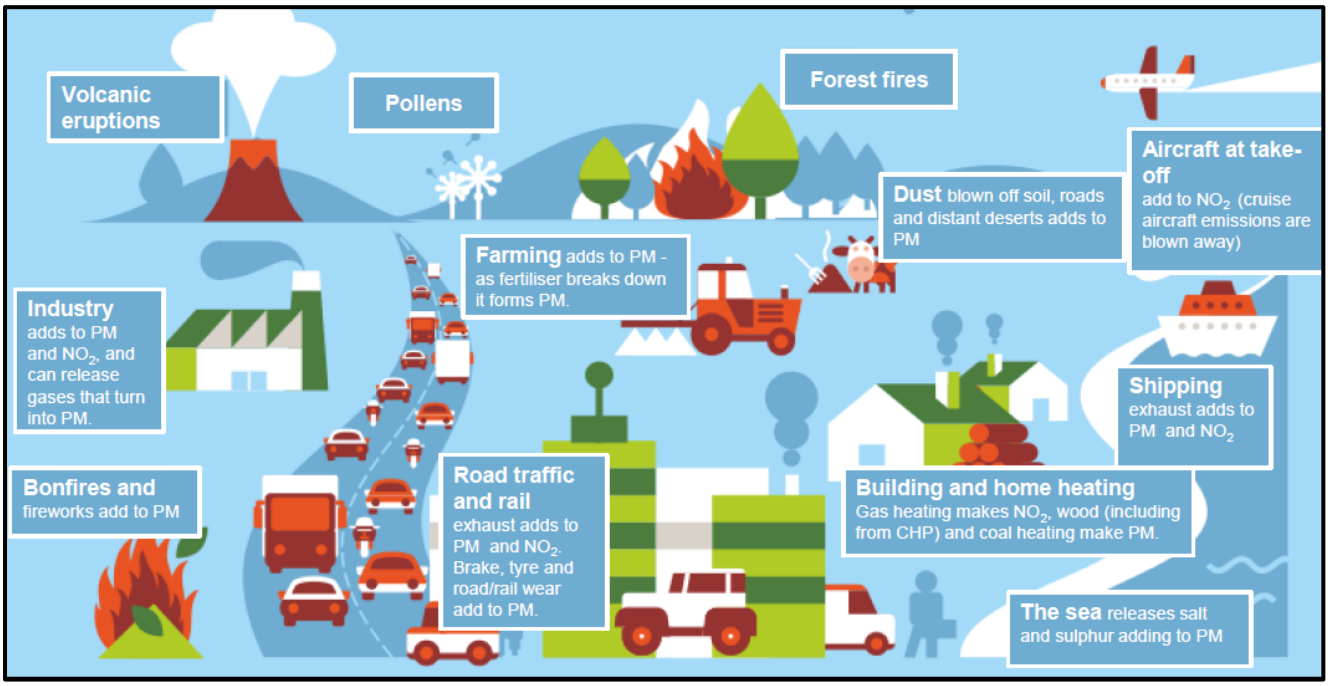
*Poor air quality is the largest **environmental** risk to public health in the UK. It is known to have more severe effects on vulnerable groups, for example the elderly, children and people already suffering from **pre-existing** health conditions such as respiratory and cardiovascular conditions. Studies have suggested that the most deprived areas of Britain bear a disproportionate share of poor air quality.*

I would stress that this isn't the biggest threat to the public's health, but it is judged the most pressing environmental risk.

Much of the action has to come nationally from Government, but there is evidence that people are voting with their feet and sales of diesel cars are reported to have fallen recently.

Where does air pollution come from?

The following schematic paints the picture and shows that the sources of pollution are many and varied from the fire in your hearth, to traffic, to pollen, to aircraft, to industry, to agriculture. There's no escape, but this diversity of sources *does* mean that we can all do something about it. for example, 39% of these tiny particles of dust that lodge in the lungs are caused by coal and wood burning.



Exposure to air pollution in everyday life can come from ordinary activities like being near traffic, sitting in traffic jams, traditional home fires and bonfires.

The effects are localised, so, although they are more concentrated in towns, they also occur at hot spots in rural areas like busy crossroads.

Also, air pollution levels tend to be higher in less well-off areas, this is yet another cause of disadvantage which being less well-off brings. These are analysed in chapter 3.

What can we do about it?

While we wait for Government to decide what to do, there are actions we can take – and the good news is that many of these are already in hand. For example, we can:

- Make it easier for people to cycle and walk more through better planning
- Plan cycle routes through quiet areas
- Build pedestrian areas and green spaces into the design of communities and regeneration schemes
- Shift transport fleets to electric or electric hybrid vehicles
- Choose new cars with more care.
- Encourage fewer car journeys through 'park and ride' and similar schemes
- If you suffer from diseases that high levels of pollution might trigger, you can keep an eye on DEFRA's pollution warnings and adapt your lifestyle to avoid areas with high levels of emissions.
- Consider 'no-idling zones' outside schools and similar areas
- Consider where possible installing gas central heating, or modern wood stoves rather than open fires, smokeless coal rather than house coal or burning dry high quality wood rather than green wood.

Whatever the outcomes of the debate on air pollution, the local actions will all boil down to better local planning, which builds health into community design, and residents making choices which are heathy ones.

All of which leads us nicely into an update on the main featured item from last year's report, namely getting health into local planning and the 2 healthy new towns we have as pilot sites in Oxfordshire in Bicester and in Barton.

What did we say last year and what has been done?

Last year we talked about the benefits of building green spaces, community areas, cycle paths and the like into the design of communities. I want to report on progress in two ways – a report of a workshop we held and an update on the Healthy New Towns.

'Planning For Health' Workshop

In November 2016, the County Council hosted a County-wide Health and Planning learning event for Officers working in areas such as planning, transport planning, health commissioning and health improvement. Officers from County, District and City Councils and the local NHS attended. The idea of the event was to enable us to learn together about best practice for creating healthy environments. We were grateful for the support from our regional colleagues at Public Health England (South East) who helped with guiding the learning themes and sourcing the key note speakers.

We aimed for participants to be able to:

- understand the link between health and the built environment
- understand how the planning system works and how it can contribute to health improvement
- keep abreast of national, regional and local work to improve health through the built environment

- learn about current good practice through case studies
- meet other health and planning colleagues from across Oxfordshire to network and learn more about each other's roles.

A wide range of speakers gave the national, regional and local perspective. Some of our speakers included Public Health England, the Town and Country Planning Association, other Local Authorities and both Healthy New Towns in Oxfordshire.

The event was really 'buzzing' and enthusiastic. The main lessons learned included:

- **Early involvement in the Planning Process** - including the need for early health involvement in planning and for a Health Impact Assessment (HIA) to be completed early on for new developments.

- Working in constructive partnerships is essential.

- Understanding the **roles of stakeholders/organisations** and how they could contribute to health through planning.

- Understanding the specialist 'tools' that help to make sound plans.

- Learning from **examples of good practice** elsewhere.

- **Evidence and statistics** being useful to be able to demonstrate the impact of planning innovation on health

- **Understanding the health Issues** within communities, and that loneliness and isolation are big issues that need to be addressed. There was recognition of the impact of disadvantage on health and the potential of small initiatives to make a big difference.

- **Understanding the economic benefits** of greener and healthier forms of transport and how these can be encouraged - including the long term benefits of investment in walking. Considering and encouraging active travel (i.e. going by bike or walking) at the earliest possible stage in planning new communities.

The event was a real boost to this area of work, and we need to keep this momentum going. We all have a part to play in this. We need to remember though, it's not just about infrastructure. It's about creating a place where people can actually meet and get together, and where it is easy to stroll, cycle and play in safety.

Healthy New Towns – what has happened in the year since my last report?

Last year I highlighted the NHS Healthy New Town Programme and the opportunities that this could bring to Oxfordshire. With two Healthy New Towns, Barton and Bicester, both within our County there is a real chance to make a difference to the health of not only those living in (or who will be living in) those areas to benefit, but momentum to share this benefit and learning wider – and this is perhaps the real added value.

We can see that the builders are on site now, but what else is happening in the actual community, and what does it mean for the people who live in those areas now or who might live there in the future?

I can report that it's been a productive year. Both areas have been:

- Fine-tuning priorities and keeping the dialogue between organisations flowing.

- Engaging the community to pave the way for new residents coming to the area. Various engagement workshops/meetings have taken place. Everyone tells me that getting residents involved early on is the key.

Bicester is taking a whole town approach and similarly Barton a whole area approach as 'One Barton'

We can look at some of the key achievements and successes of each of the Healthy New Towns in more detail.

Barton

- Funding was secured through WREN (a not-for-profit business that awards grants for to communities) for physical improvements to Fettiplace Road linking the 'linear park' to Barton Park via what is now called 'Barton's Park'. This will mean that people can access green space, play areas and socialise and it will join the new community to the existing community.

- Carrying out a **'**Health Impact Assessment' (a device for systematically recording the impact on residents' health when new initiatives are planned) was commissioned which suggested improvements.

- Supporting Bury Knowle's social prescribing pilot (a jargon term for 'prescribing' healthy activities to people instead of pills and powders). This might include joining a group or a club to reduce loneliness and isolation or attending a local exercise class or health walk to become more active.

- Commissioning research to gain a deeper understanding of existing and potential residents' health needs. This can be used by health and other service providers including the voluntary and community sector providers, GPs, leisure and physical activity services, green spaces etc, to help inform the planning of services for the area.

- Providing training for people working in Barton to:

    - understand the link between food, poverty, poor diet and health, and how all that links to the price and availability of fresh fruit and veg and how to avoid the really fatty and salty foods.

    - give people brief advice about stopping smoking, cut down on drinking and tips for staying mentally healthy.

- Supporting the Oxford Brookes University's Healthy Urban Mobility study to look into how access to cycling in Barton can be improved for older people.

- Eight community-led health and wellbeing pilot projects receiving grant-funding to generate learning from practice. The grant scheme was open for applications up to £5,000. Projects included a full independent review of Food Banks to shape the future management of the food bank within the Barton Neighbourhood Centre, ensuring that people needing to access the food bank are best supported. This work then led to the creation of a Barton Community Cupboard - a market-style provision which includes a fridge, recipe cards and a cook book inspired by recipes from local residents' attending a cooking session for all ages. The project has aimed to reduce the stigma attached with using a food bank.

- Another real success story has been the work in Barton to increase the uptake of Healthy Start Vouchers. Healthy Start is a national service through which free vouchers are given to selected families every week to spend on milk, fresh and frozen fruit and vegetables, and infant formula milk. You can also get free vitamins. You qualify for Healthy Start if you're at least 10 weeks pregnant or have a child under four years old and you or your family receive:

    - Income Support, or
    - Income-based Jobseeker's Allowance, or
    - Income-related Employment and Support Allowance, or
    - Child Tax Credit *(with a family income of £16,190 or less per year)*
    - Universal Credit *(with a family take home pay of £408 or less per month)*
    - You also qualify if you are under 18 and pregnant, even if you don't get any of the above benefits.

    This was done by an outfit called Good Food Oxford. They did it by producing:

    - A paper and electronic map of retailers which accept Healthy Start Vouchers
    - Promotion by local retailers their participation in the scheme
    - Use of posters and community newspaper
    - A guidance leaflet for frontline service providers to help individuals to complete the form

Bicester Healthy New Town

Initiatives during the year included:

- Launch of the community activation programme with small grants available up to £1000. Some of the activities funded have included:

    - A Scout Group purchasing equipment to provide adventurous outdoor activities for children aged 6+.

    - A pilot street-play activity delivered by Oxfordshire Play Association.

- Setting up a Bicester meeting for local learning disabled adults through the voluntary organisation My Life My Choice. The programme has encouraged the group to be active and take responsibility for their health as well as offering the usual support of the organisation which promotes volunteering and social activity.

- Bicester and Kidlington Ramblers were funded for the printing of a book of local walks of 5 miles and under. The book aims to encourage people to get out and enjoy their local area more and to become more active.

- Looking at how to improve the care of people with diabetes between primary, secondary and community care. Some of this will involve collaborative working with other Healthy New Town sites to work out the impact of population growth on demand for GP services.

- A Healthy Weight Strategy produced to address childhood obesity in Bicester. The plan outlines life stages, services, key messages and initiatives. The plan aims to provide a co-ordinated approach, with consistent messages which will link to national and local initiatives.

- Engaging all Bicester schools to participate in Walk to School week for May 2017. A springboard to promote a year round walking to school programme.

What else have we done in the past year?

There are many signs that the penny has dropped and that 'getting health into planning' is now a necessity. The Public Health team's work with planners at County and District level has increased remarkably and there is a demand for more – which is a really positive development.
BUT

It doesn't just happen by accident and it needs a sustained and coordinated approach which we are now moving towards – on a shoe-string….

The key is to

- know your topic so you have something positive and easy to offer

- Know the people and get involved in the networks

- concentrate on the economic benefits and the need to cut diseases such as diabetes, heart disease and some cancers off at the source – as well as slowing the progress of dementia….. and avoid preaching and nannying!

- keep selling the message:

'planning is health and health is planning'

Recommendations

1. All Local Authorities should improve air quality at local level under our own steam through keeping up the work to integrate 'public health and planning'.

2. All Local Authorities should continue to monitor and actively engage with the Healthy New Towns programme and use the lessons learnt to improve all local planning across the County

Chapter 3: Breaking the Cycle of Disadvantage

This year I want to achieve 4 things:

1. To keep the issue of disadvantage high on organisations' agendas
2. To describe overall disadvantage in Oxfordshire in a straightforward way
3. To report in detail on the basket of indicators agreed last year to monitor progress
4. To report on the work of the excellent Health Inequalities Commission

Why is this topic important?

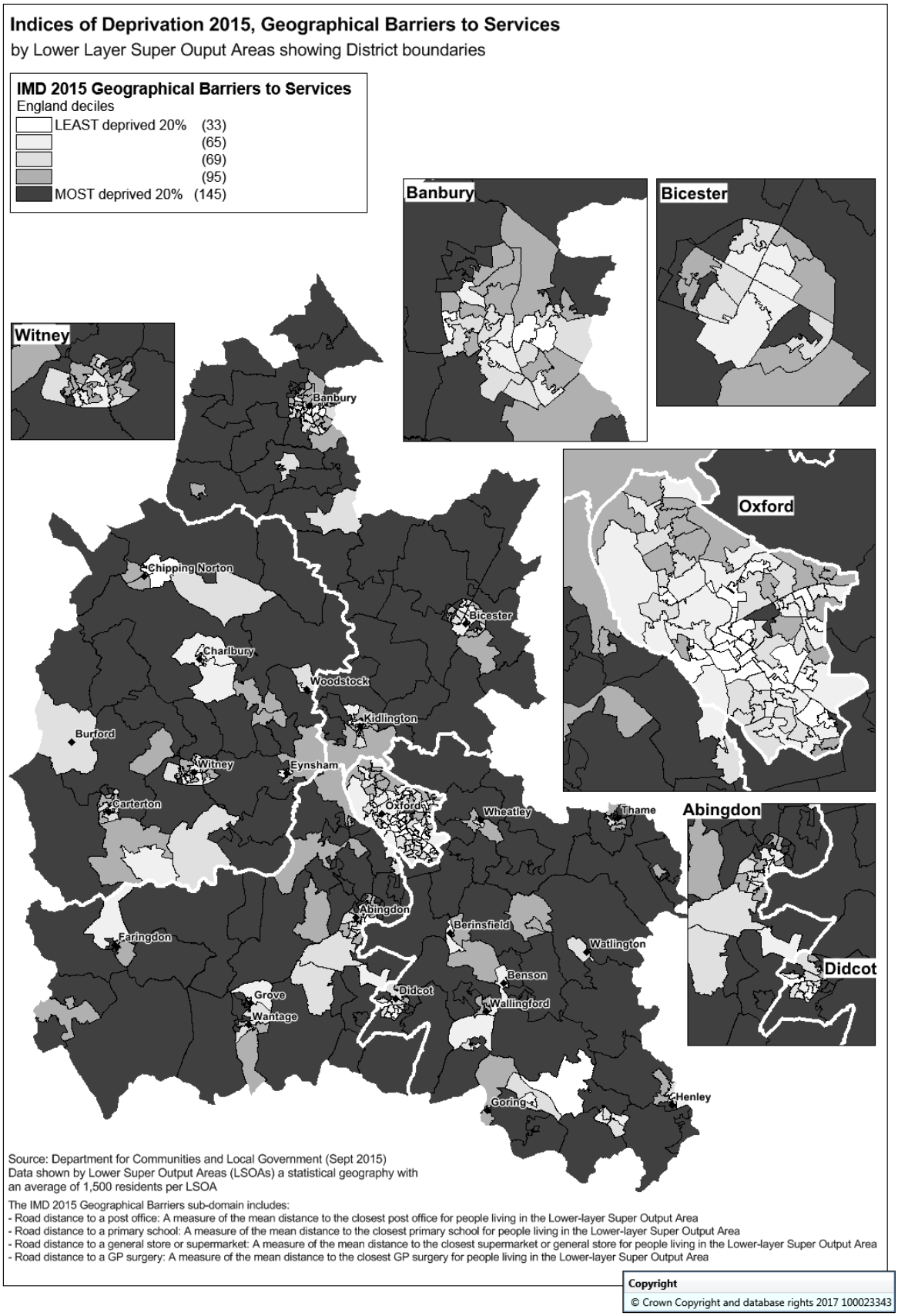
Because disadvantage is one of the factors strongly associated with poor health and poor life chances. Reducing disadvantage will directly improve health and will help people to live lives which are productive and less burdened by disease.

Overall disadvantage in Oxfordshire in two pictures

If I were asked to give a 'helicopter view' of disadvantage in Oxfordshire, I would do it through two pictures, one highlighting rural disadvantage and one urban disadvantage.

Rural Disadvantage

A major cause of disadvantage in the County stems from its rural nature. This means that some areas have more difficulty in accessing services as well as having a high proportion of older people. This is shown in the map below in a measure called 'geographical barriers'. It takes into account the many challenges posed by rurality in terms of accessing services. It was updated in 2015. This index is based on road distances to post offices, primary schools, GP surgeries, and general stores or supermarkets.


Indices of Deprivation 2015, Geographical Barriers to Services
by Lower Layer Super Ouput Areas showing District boundaries
IMD 2015 Geographical Barriers to Services
England deciles
LEAST deprived 20% (33)
(65)
(69)
(95)
MOST deprived 20% (145)
Banbury
Bicester
Witney
Oxford
Abingdon
Didcot
Chipping Norton
Charlbury
Woodstock
Kidlington
Burford
Eynsham
Carterton
Wheatley
Thame
Faringdon
Berinsfield
Watlington
Benson
Grove
Wantage
Wallingford
Goring
Henley
Source: Department for Communities and Local Government (Sept 2015)
Data shown by Lower Super Output Areas (LSOAs) a statistical geography with an average of 1,500 residents per LSOA
The IMD 2015 Geographical Barriers sub-domain includes:
- Road distance to a post office: A measure of the mean distance to the closest post office for people living in the Lower-layer Super Output Area
- Road distance to a primary school: A measure of the mean distance to the closest primary school for people living in the Lower-layer Super Output Area
- Road distance to a general store or supermarket: A measure of the mean distance to the closest supermarket or general store for people living in the Lower-layer Super Output Area
- Road distance to a GP surgery: A measure of the mean distance to the closest GP surgery for people living in the Lower-layer Super Output Area
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The map shows that the majority of Oxfordshire's 407 small areas are more deprived according to this measure than the national average. 85 are among the 10% most deprived nationally and are concentrated outside the main urban centres. A further 60 small areas are in the 10-20% most deprived nationally.

The implications of this mostly fall on older people and we see the results particularly in terms of isolation and loneliness and in terms of difficulty in getting about. This is where the demographic challenge will be felt the most and services will need to be designed to meet the needs of these communities.

This is difficult because:

- modern hi-tech services tend to need centralised kit and centralised specialists
- it gets harder for anyone to do home visits because of the increasing busyness of the roads

The way to square the circle seems to be to use hi-tech aids (like the alarm systems some people wear on their wrists or round their necks) and on-line communication, and to plan the routes of home carers really carefully. The other solution was discussed in the previous chapter – i.e. planning new communities around communal spaces and local facilities. Nonetheless, there are inevitable challenges to come as GP surgeries coalesce, becoming more specialist and less local.

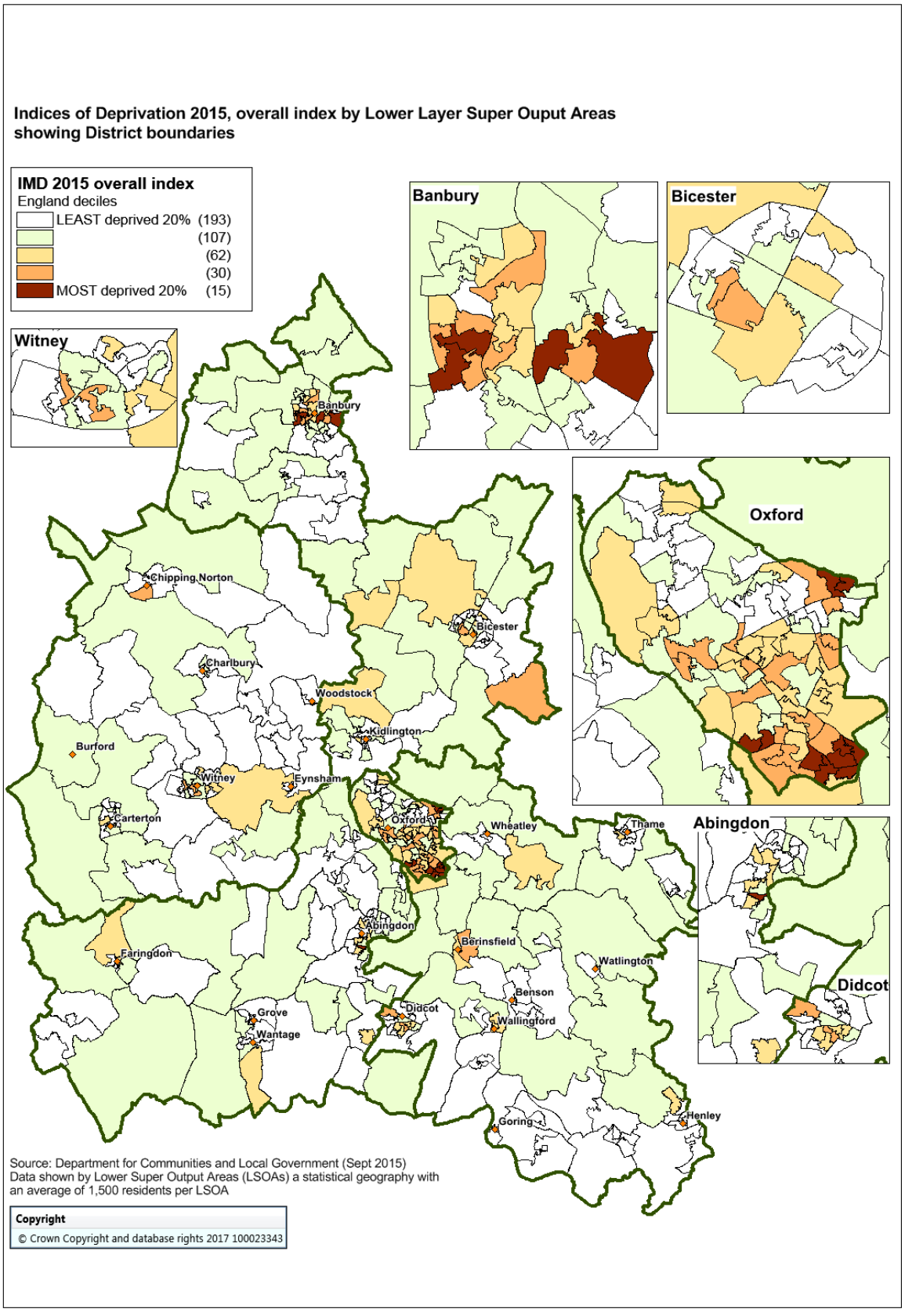
In conclusion, this picture of rural disadvantage presents one side of the coin of disadvantage in Oxfordshire.

Urban Disadvantage – the 'Index of Multiple Deprivation' (IMD)

This is the flip side of the coin and tends to pick out disadvantage in areas of greater population density - which I am loosely calling 'urban'.

This measure uses 37 indicators spanning seven broad types of disadvantage. These indicators are used to calculate an overall Index of Multiple Deprivation (IMD). The indicator looks at 407 small areas within Oxfordshire and compares them with national figures.

Overall, Oxfordshire has relatively low levels of disadvantage. It is the 11th least deprived of 152 upper tier local authorities in England (up from 12th least deprived in 2010). However, as we know, there is significant variation across different parts of the county. The map below tells the story – the areas in Oxfordshire which fall within the 20% most disadvantaged in England are shaded the darkest and the areas which fall within the least disadvantaged 20% of areas are not shaded at all.



The map shows that:

- Most of Oxfordshire's 407 small areas are less disadvantaged than the national average.
- 110 are among the least deprived 10% nationally.
- Overall, nearly half (46%) of the county's population lives in areas that are among the least disadvantaged 20% in England.
- More than four in five residents (82%) live in areas that are less disadvantaged than the national average.
- Of course this does not mean that there is no disadvantage in those areas –Berinsfield is a good example of an area where disadvantage is 'masked' by being included in larger more affluent areas, and many rural communities can tell the same story.
- 13 areas are among the 10-20% most disadvantaged (down from 17 in 2010).
- Two areas are among the 10% most disadvantaged in England. These are in Oxford City, in parts of Rose Hill and Iffley ward and Northfield Brook ward. In 2010 only Northfield Brook was among the 10% most disadvantaged areas in the country

The most disadvantaged areas are concentrated in parts of Oxford City and Banbury with one in Abingdon.

In general, the areas of Oxfordshire that were identified as the most deprived in 2010 remain the most deprived. However, in Oxford City, one area in Holywell ward, and another in Littlemore, have moved out of the 10-20% most deprived. However, one in Rose Hill has moved into the 10-20% category.

In Banbury, one area in Ruscote ward has moved out of the 10-20% most deprived.

In summary, these two 'faces of Oxfordshire' usefully sum up the overall picture when it comes to disadvantage.

Conclusion: Breaking the cycle of disadvantage in Oxfordshire is all about targeting services to level the experience of all up to the best. Disadvantage in small areas of the County remains the biggest challenge, and services need to be designed to focus on them.

Report on the Basket of Indicators

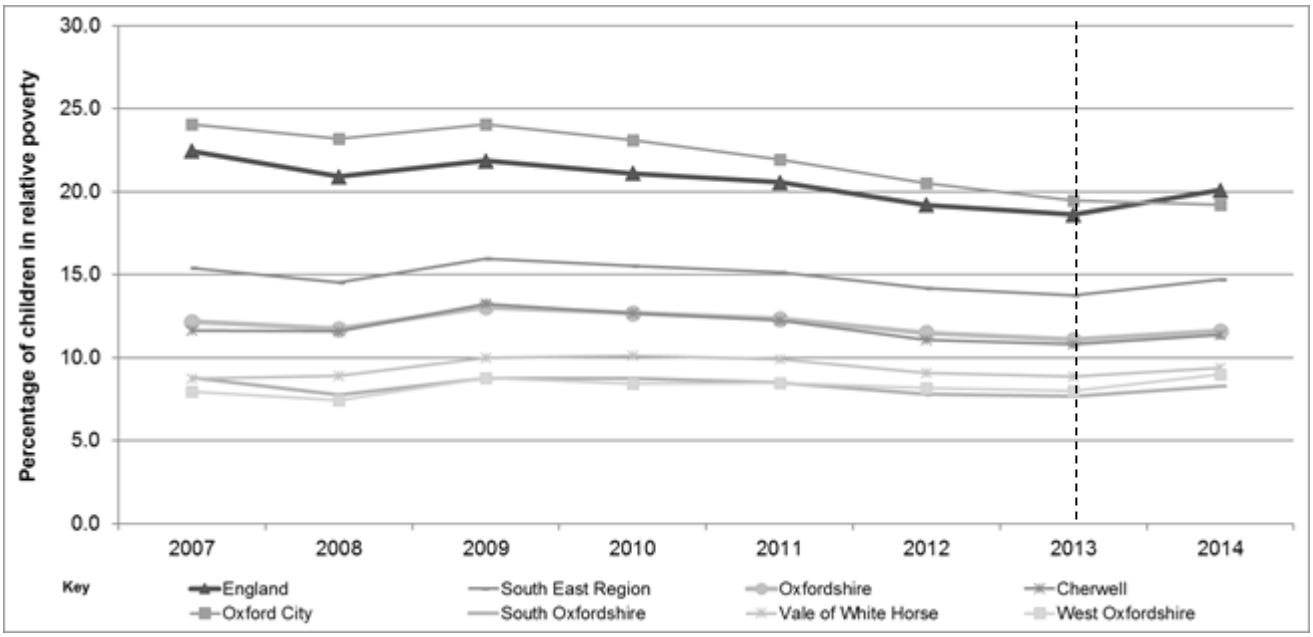
In last year's report I identified a basket of high quality indicators which would help us to measure progress in the fight against disadvantage. I set a baseline figure for comparison and will report on progress against these one by one.

Indicator 1. Child poverty

Percentage of children (under 16 years) in Low-Income Families (2007 to 2014 calendar years)

The proportion of families classed as having 'children in poverty' had fallen for the last few years but has increased slightly across the board according to the latest data from 2014. This is a national trend. The reasons for this are unclear, and a single year's figures need to be treated with caution but it is important that we closely monitor this figure going forward. The correct name for this is indicator is 'relative poverty'. An individual is considered to be living in relative poverty if their household income is less than 60% of median national income. Nationally two-thirds of children in poverty are living in households where at least one adult is in work.

Percentage of children (under 16 years) in Low-Income Families Local Measure (2007 to 2014 calendar years)



Source: Child Poverty Statistics (extracted from Public Health England: Public Health Outcomes Framework)

The chart shows that:

- The proportion of children in poverty has increased slightly since we set the baseline (2013 data) across all geographic areas.
- Oxfordshire has a significantly lower percentage of children in low-income families than England. This is good news.
- Oxford City has higher levels than the rest of the County and is closer to the national average.

Note: this is a national statistic and takes time to collate and so we are still seeing historic data from 2014.

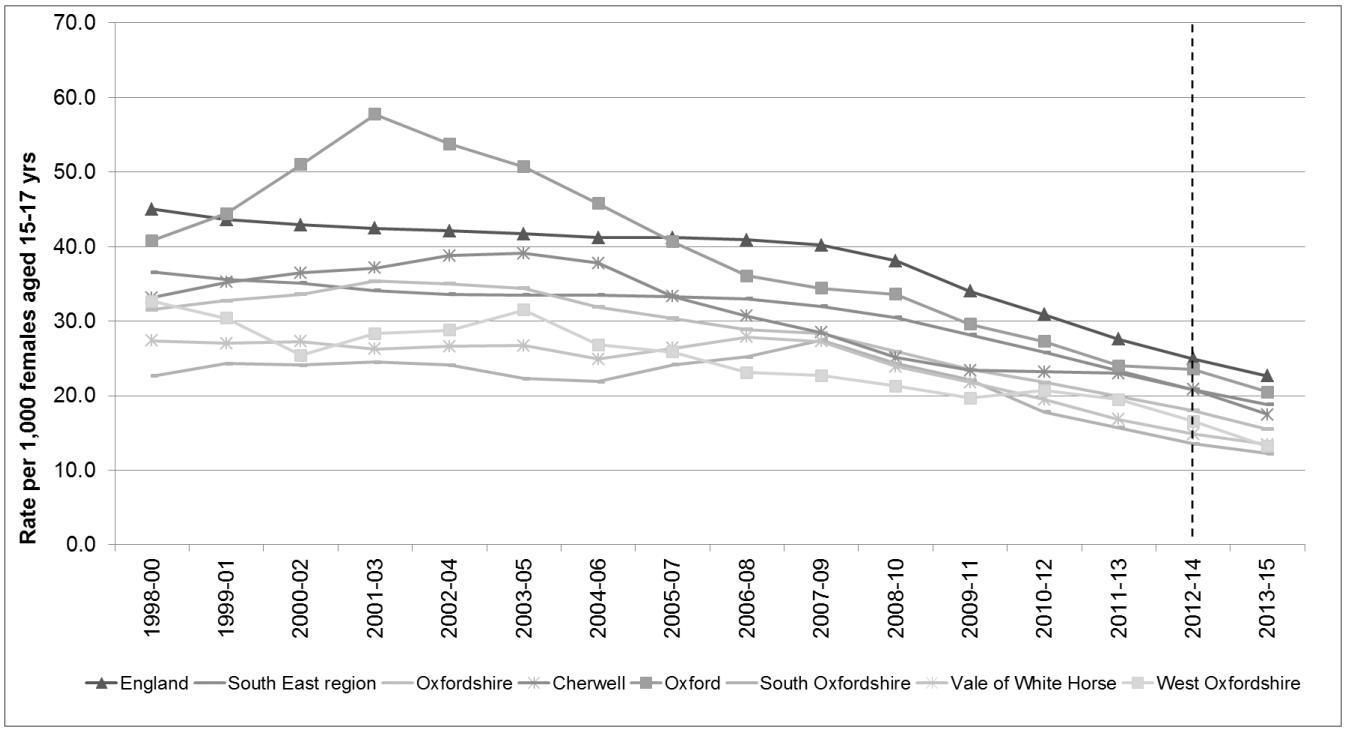
The profound influence and impact of poverty on health needs to be widely recognized and systematically addressed.

Also, as ever, if we drill down into the figures the gaps widen. Whilst Oxfordshire is overall a very 'healthy and wealthy' county, there are significant differences in poverty. For example: children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in less wealthy families.

Indicator 2. Teenage pregnancy

This indicator measures all conceptions in females under 18 years of age, no matter whether the pregnancy ends in birth or in a termination.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998-2000 to 2013-15 (3-years combined)



Source: Office for National Statistics (ONS) - combining information from birth registrations and abortion notifications

The chart shows that:

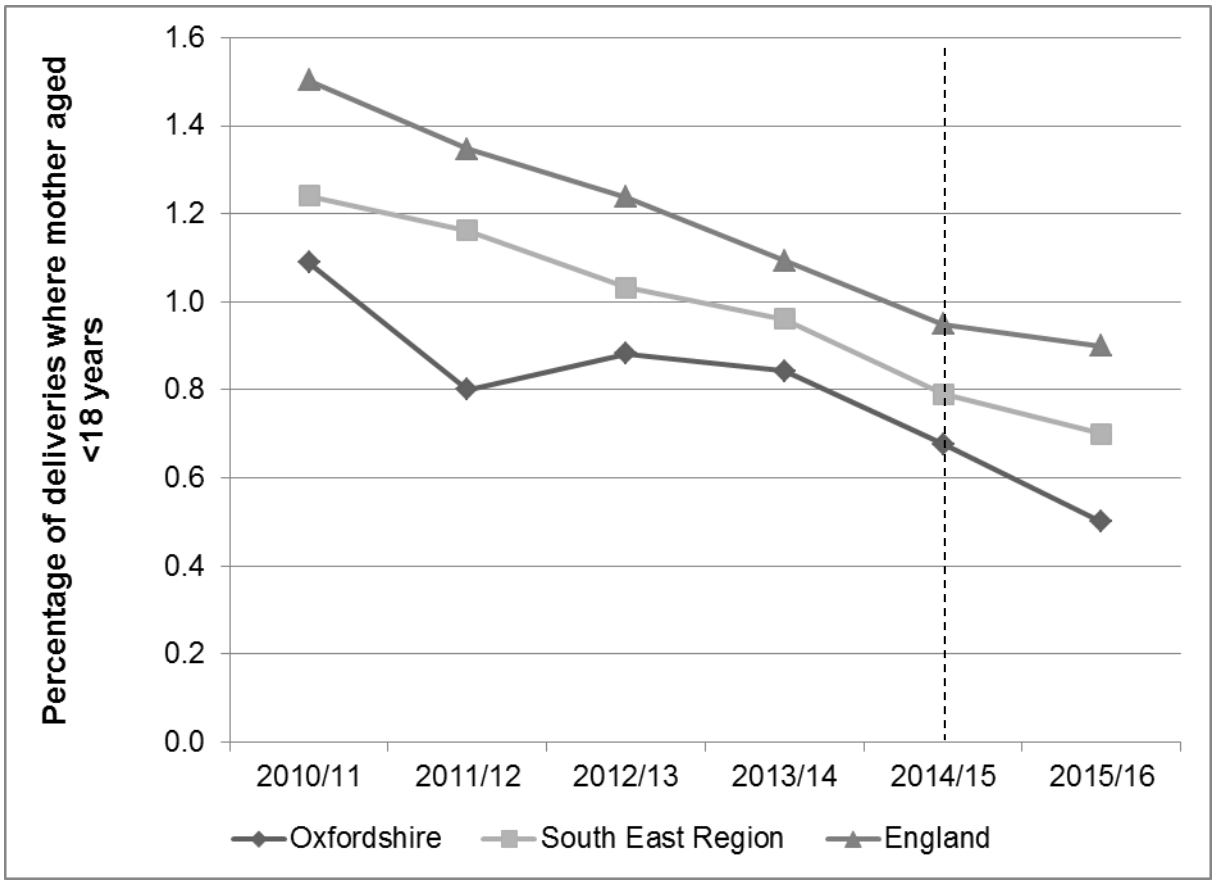
- The teenage conception rate in Oxfordshire is lower than the national average and is decreasing broadly in line with national and regional trends.
- There has been a welcome sharp decline in Oxford City since 2001-03
- Most recent data (2013-15) continues on a downward trend across all geographies.
- This is a good result.

Indicator 3. Percentage of Teenage Mothers

This indicator measures the percentage of babies delivered where the mother was under 18 years of age.

Almost half of teenage conceptions result in termination. This indicator measures the percentage of births to mothers aged under 18.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998-2000 to 2013-15 (3-years combined)



Source: Public Health England: Child Health Profiles: Pregnancy & Birth

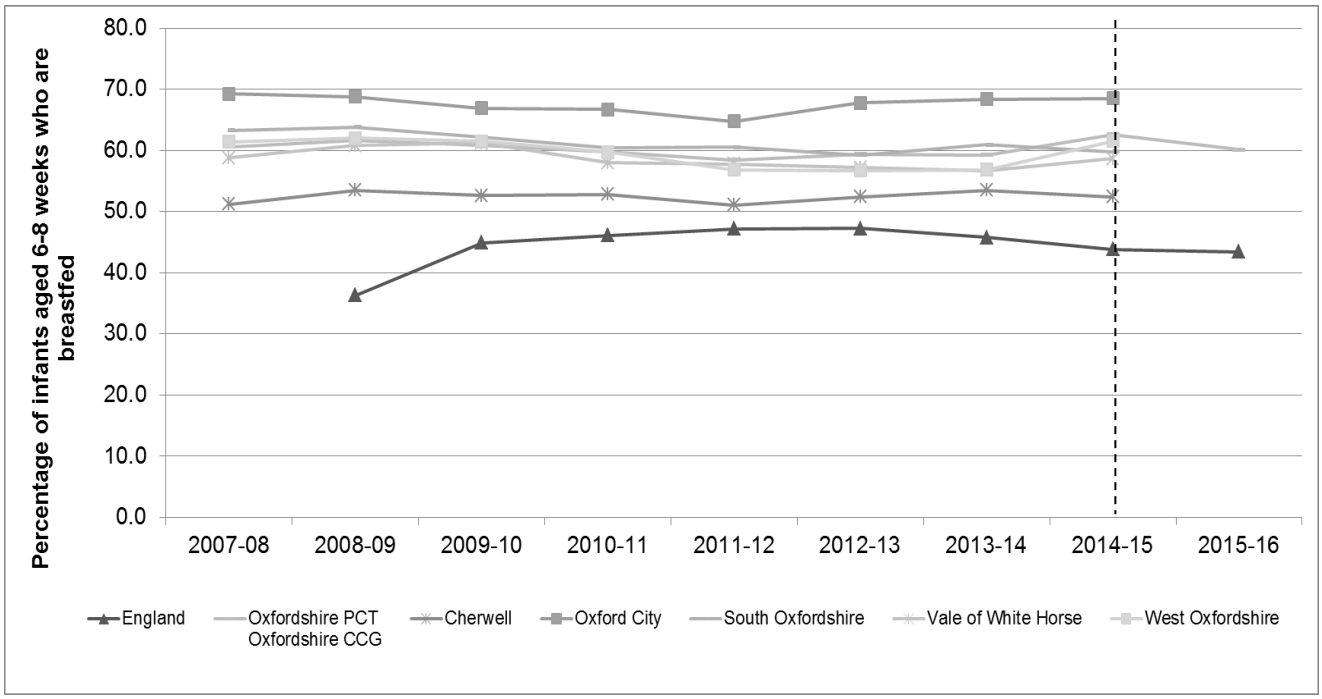
The chart shows that:

- The proportion of births to mothers under 18 years has reduced.
- This is a national trend.
- The proportion in Oxfordshire continues to be lower than the national or regional figures.
- This is another good result, and particularly good in Oxfordshire.

Indicator 4. Breastfeeding at 6-8 weeks

Breastfeeding is important and underpins a healthy life. Its positive effects on health are long-lasting. The breastfeeding rate remains high in Oxfordshire compared to England. The challenge is to get the rates higher in the lowest areas which are historically: Banbury, Bicester, Kidlington, Didcot, Wantage and South East Oxford.

Percentage of infants aged 6-8 weeks who are being breastfed (partially or wholly) – 2007/08 to 2015/16



Source: NHS England

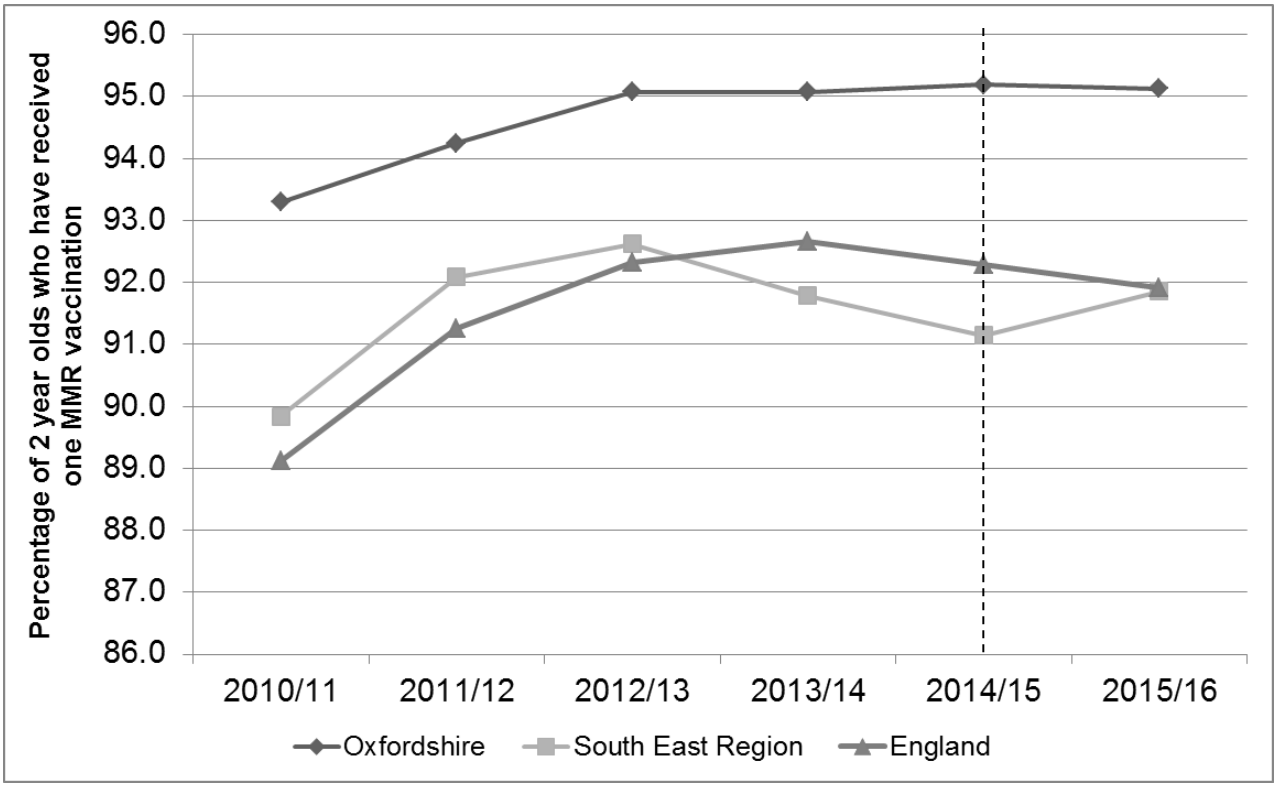
The chart shows that:

- Nationally the prevalence of breastfeeding at 6-8 weeks increased over this time period and now appears to be levelling off at around 43%
- Oxfordshire has a significantly higher rate of breastfeeding at 6-8 weeks than England average at just over 60% This is a good result.
- Locally breast feeding rates remain fairly stable for the county as a whole.
- Data at district level are currently not available for 2015/16

Indicator 5. Childhood Immunisation

Children should receive two Measles, Mumps and Rubella (MMR) vaccinations, one by the time they are 2 years old and the second by 5 years old. We use this as an indicator for the uptake of all immunisations as this is one of many immunisations for children. We monitor all the rates thoroughly through the Public Health Protection Board and through the Health Improvement Board. Oxfordshire's results are very good and NHS England and Public Health England are to be congratulated. An initiative has begun to push the rates higher by tracking down the families who slip through the net individually and offering their children the vaccine.

Percentage of 2 year olds who have received one MMR vaccination



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England

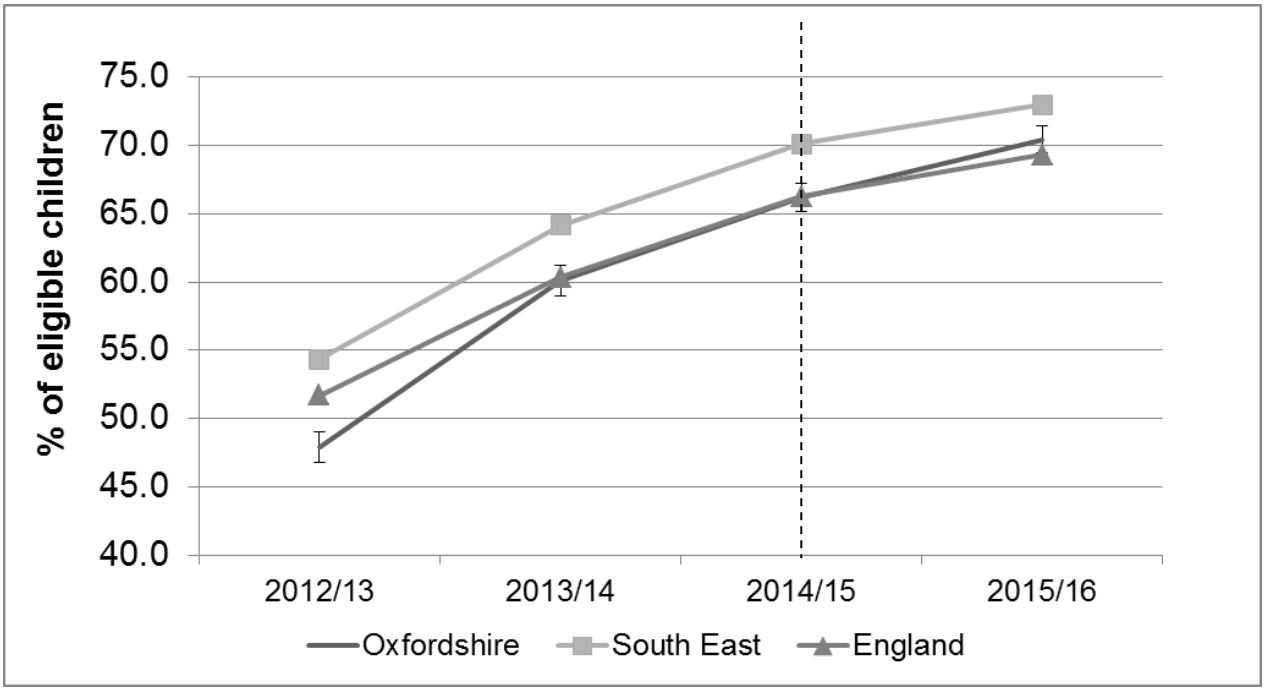
The chart shows that:

- Oxfordshire remains significantly higher than national and regional average. This is an excellent result – our vigilance is paying off.
- Nationally this vaccination coverage is falling and we are bucking this trend.

Indicator 6. School readiness

This indicator measures children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children. Children are defined as having reached a good level of development if they achieve at least the expected level in their 'early learning goals' in the following areas: personal, social and emotional development; physical development and, communication and languages, as well as early tests of mathematics and literacy. This is a useful measure of health in its broadest sense of 'life potential' and a useful marker for disadvantage between different groups of children.

Percentage of children achieving a good level of development at the end of reception year



The data shows that:

- Oxfordshire has a slightly higher percentage of children with a 'good development' compared with the England average but remains below the regional average.
- The proportion of children achieving a good level of development at the end of reception year has increased across all three geographies.
- There is a clear gap between males (63%) and females (78%) in Oxfordshire, similar to national and regional figures.
- The percentages in children with free school meal status is much lower at 51% (43% in males and 59% in females).
- This is reasonable progress but shows the need to focus on disadvantaged groups if performance is to improve.

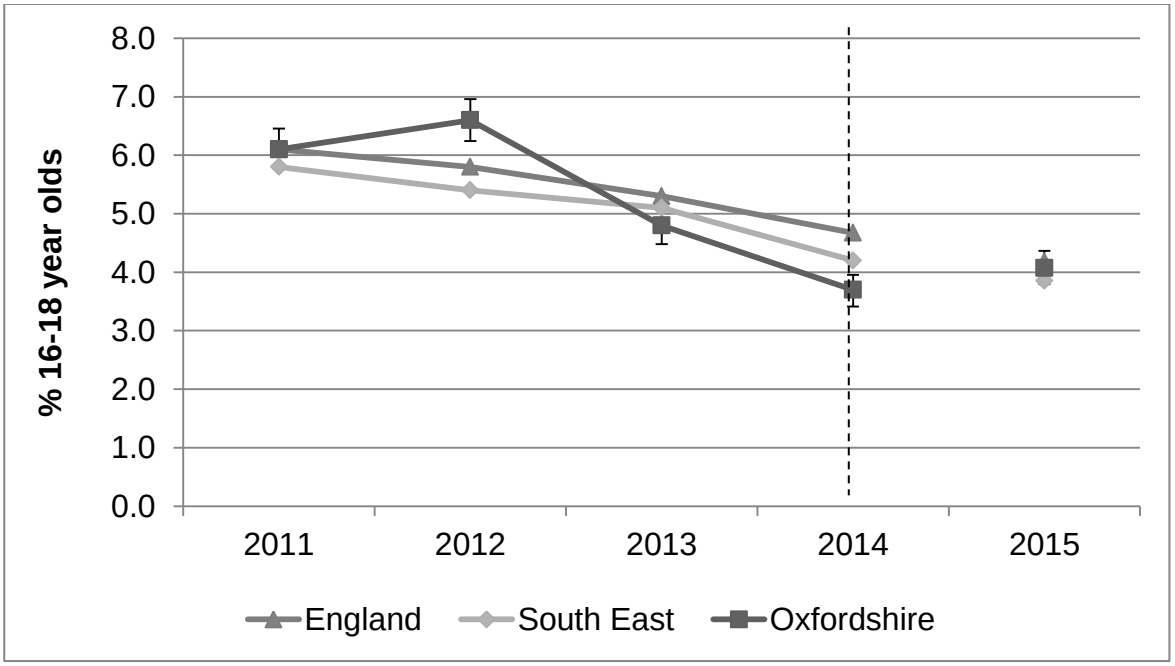
Indicator 7. GCSE results

Unfortunately, the previous indicator which allowed us to measure GCSE performance between different areas and different groups of children in the County has been discontinued by Government. It is unclear whether the new 'performance 8' statistic will be as useful – and there is as yet little data for comparison. Rather than report on this figure prematurely this year, I will need to see how well it is received before I use it to draw conclusions.

Indicator 8. 16-18 year olds not in education, employment or training

This is a useful general indicator of future life chances and prosperity for young people.
The way the data has been counted has also changed since last year to try to make it more accurate, so we can't compare it accurately with previous years. The problem comes because for some young people it is not known what their status is. To try to account for this, the new method takes figures for where it is not known if young people are not in education, employment or training and assumes a proportion of them are not and adds this to the old figure. For that reason, there is a break in the line in the chart below and then new figures are shown as a new 'blob' for 2015.

Percentage of 16-18 year olds not in education, employment or training



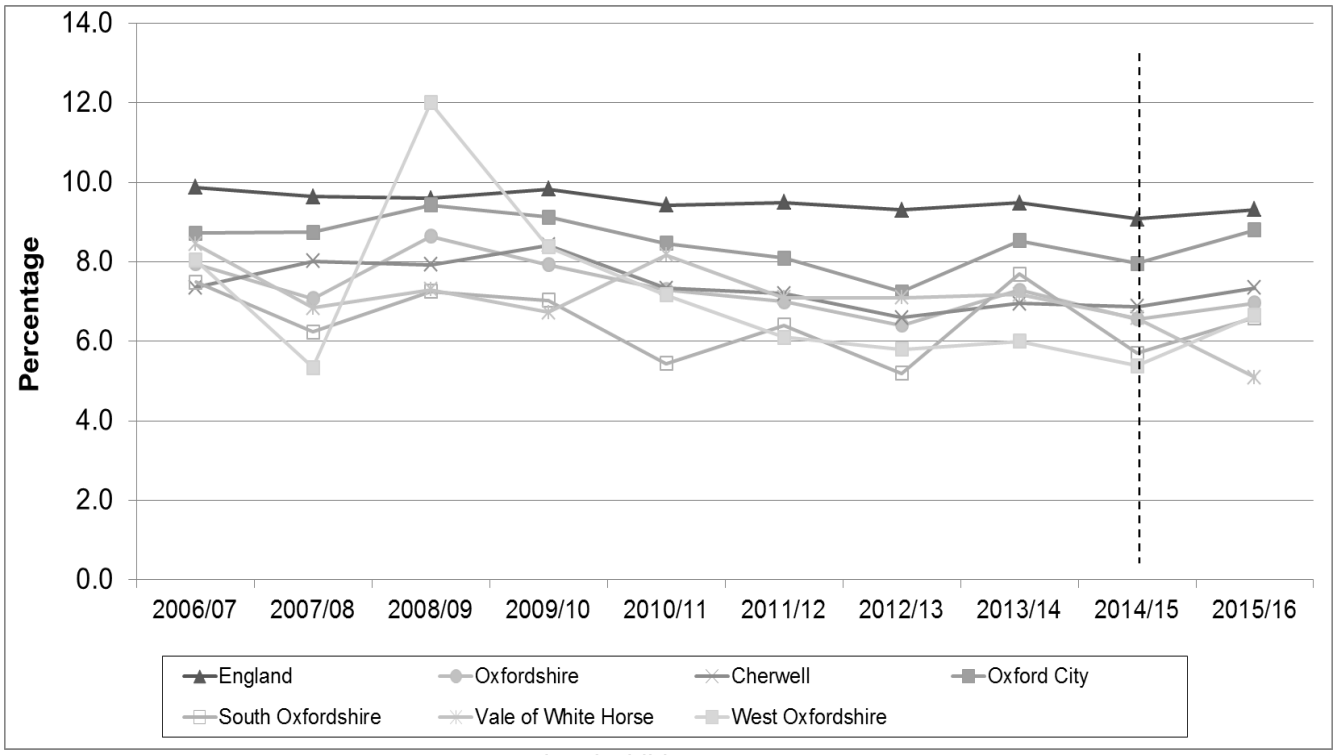
Source: Public Health Outcomes Framework

The data shows that:

- The Oxfordshire figure is comparable to regional and national levels.
- We will monitor this new data in future reports.

Indicator 9. Obesity in children in reception year

Percentage of children in Reception Year (4/5 year olds) who are obese 2006/07 to 2015/16 (Academic years)

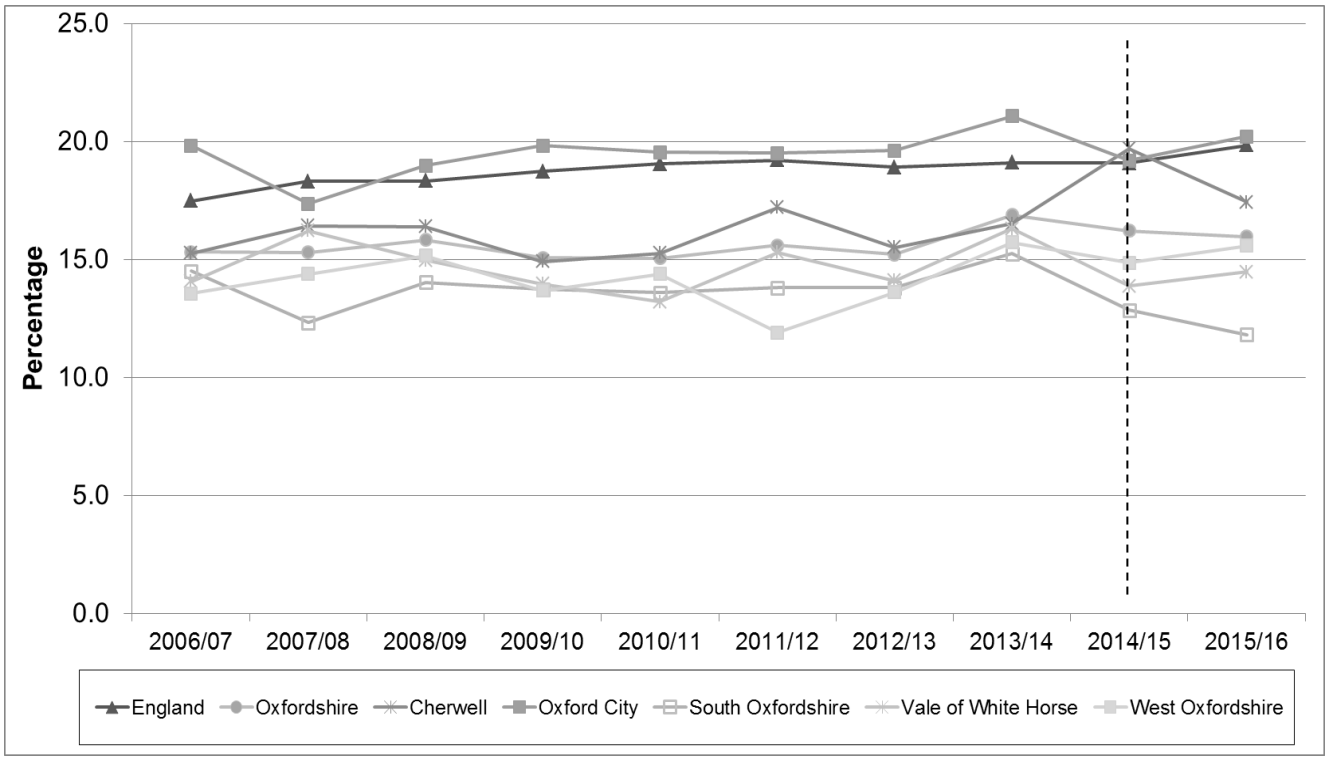


Source: National Child Measurement Programme

- Prevalence of childhood obesity among this age group has remained fairly level at around 7% with some fluctuation at a district level.
- We continue to buck the national trend which is just over 9% and this is a good result.
- Levels of obesity in this age group remain higher in Oxford City, probably reflecting the association between social disadvantage and higher levels of obesity.

Indicator 10. Obesity in Year 6 (10/11 years)

Percentage of year 6 children (10-11 years old) who are obese 2006/07 to 2015/16 (Academic years)

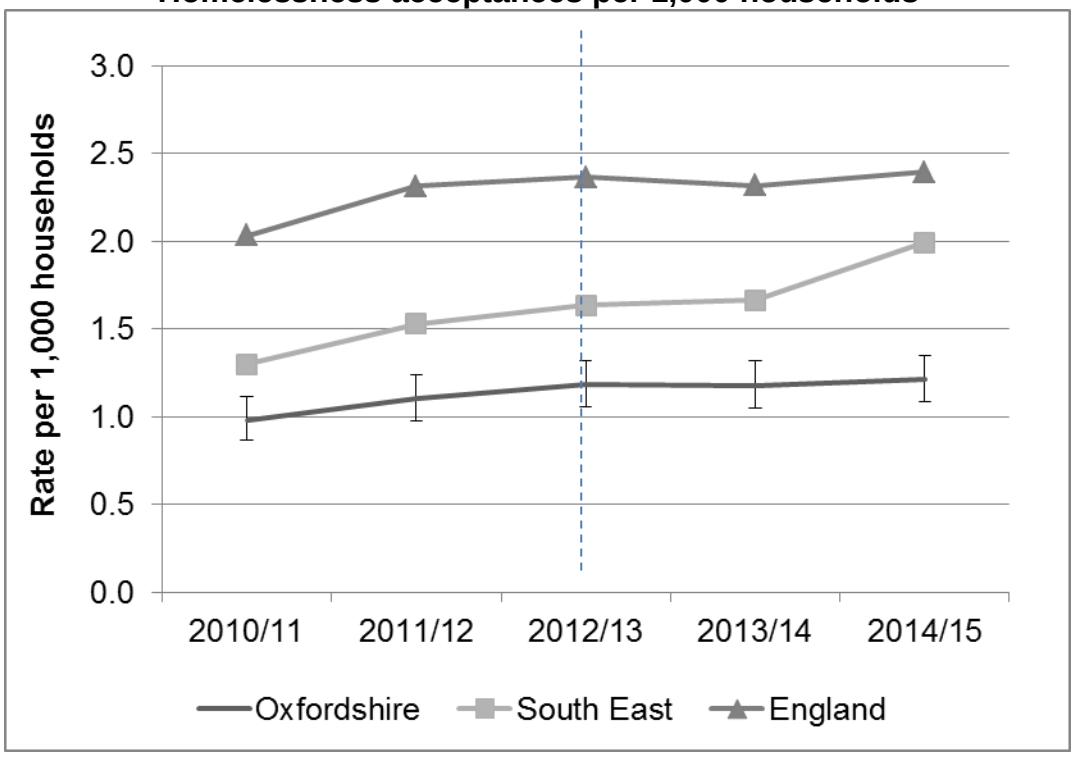


- The county figure has continued to fall and is around 16% - better than the England average by almost 4 percentage points (19.8%). This is a significant achievement.
- Oxford City has a higher rate at 20%, again, probably reflecting higher average rates of social disadvantage.
- After an increase in 2014/15 the rate in Cherwell has decreased to 17% for 2015/16 which is good news.

Indicator 11. Homeless Households

Homelessness is a direct reflection of disadvantage to families and is therefore a useful overall indicator.

Homelessness acceptances per 1,000 households

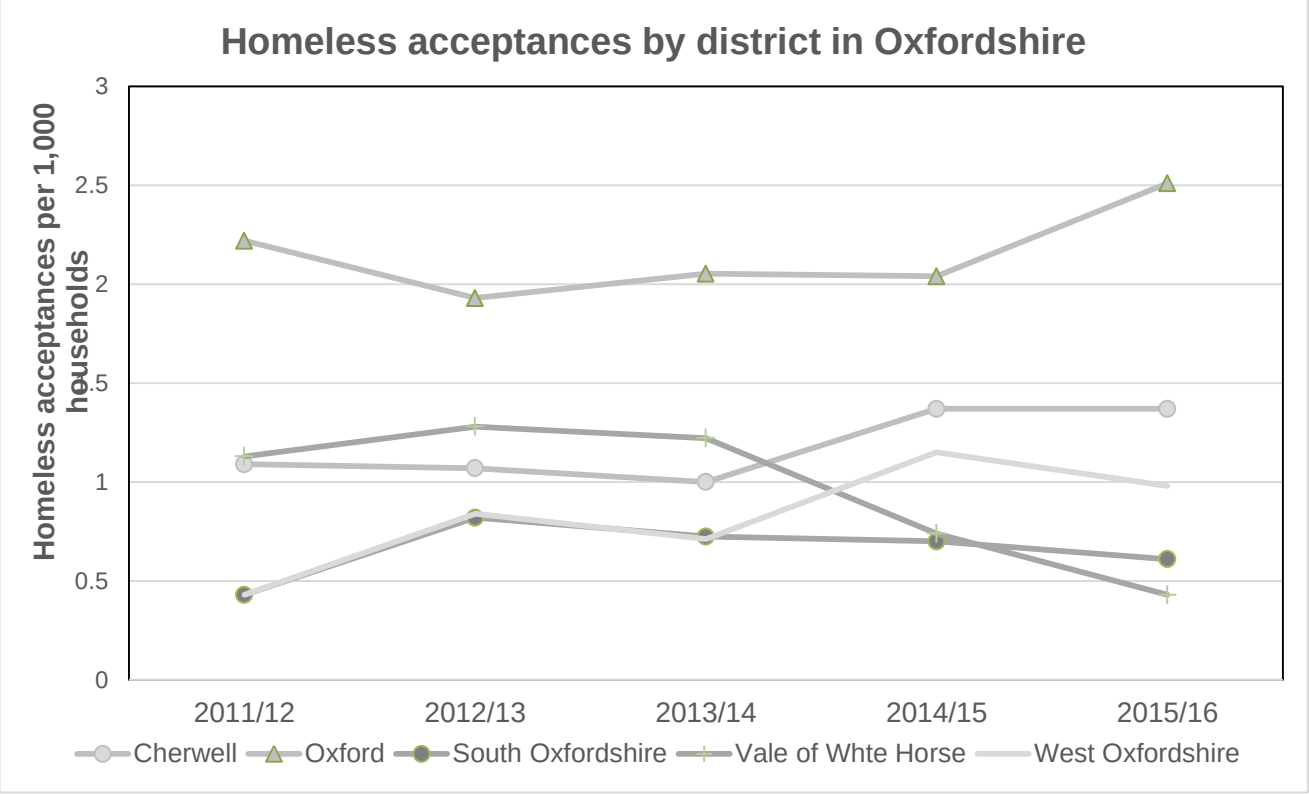


The chart shows that:

- Oxfordshire's results are well below the national average and have remained fairly stable.
- National figures are slightly up and regional figures show a sharp upward trend.
- It is a good result that Oxfordshire's figure is both lower and more stable than our regional neighbours.

Homelessness acceptances per 1000 households by districts in Oxfordshire

We know that homelessness varies widely across the different Districts. As this is an important indicator, it is worth drilling down more into the data to look at the trends at District level.



The chart shows that:

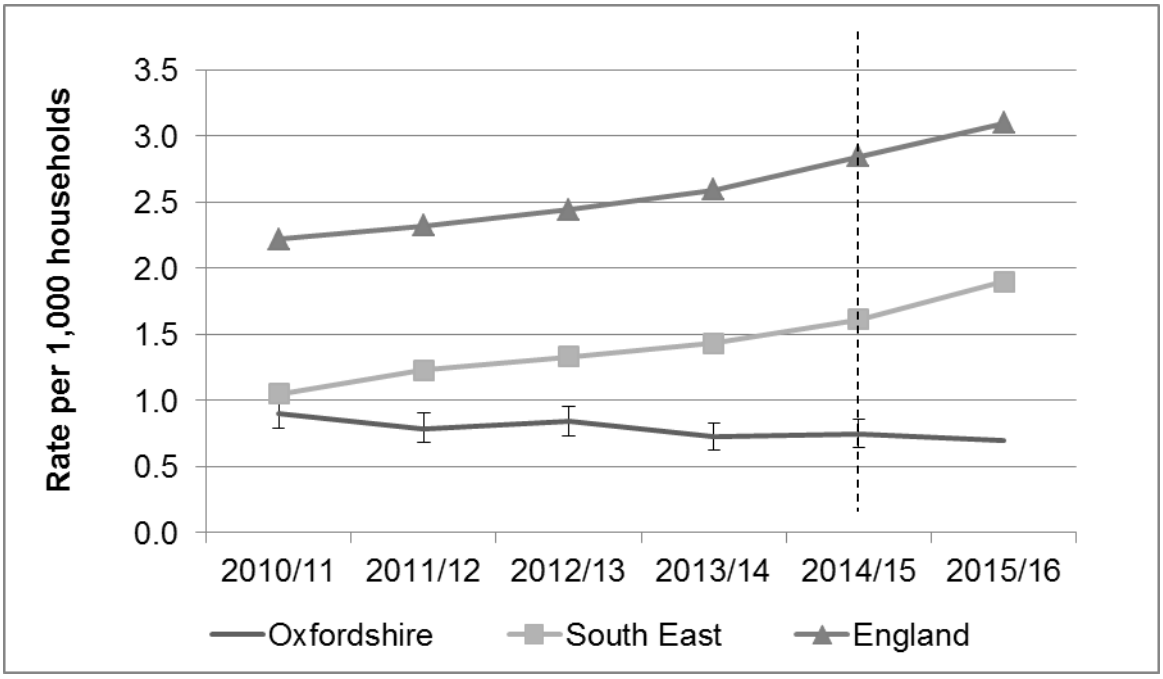
- Oxford City has increased to 2.5 homeless acceptances per 1,000 households (higher than the rate for England), putting the level higher than it has been in recent years. This is concerning and the trend needs to be monitored closely. It is possible for quite wide random fluctuations to occur in this data as the numbers involved are quite small and so a watching brief is appropriate, but the figure is a cause for concern.

- The rates in the other districts have also fluctuated – up slightly in Cherwell and down in South Oxfordshire and West Oxfordshire. Vale of the White Horse continues to show a marked downward trend.

Indicator 12. Households in temporary accommodation

Homelessness is prevented in part by placing families in temporary accommodation. This is not a good option in terms of life-chances, but it is better than facing homelessness.

Households in temporary accommodation per 1,000 households



The chart shows that:

- The rate in Oxfordshire shows a gradual continued reduction while rates nationally and regionally have increased.
- This is a good result and indicates overall success in tackling disadvantage.

Summary from the basket of indicators.

Statistics around teenage pregnancy, teenage mothers, obesity, young people in employment and training, households in temporary accommodation, homelessness overall and breastfeeding show good or reasonable results indicating that progress is being made.

Statistics around child poverty, school readiness and homeless acceptances in the city require a close watching brief.

What we said last year and what we have done about it

Last year's recommendations are set out below with a commentary on progress made:

1. The report of the Commission for Health Inequalities should be studied carefully when it is published and all organisations should use it to challenge current practice and make appropriate changes to services.
   Progress report: Good progress has been made and this is set out immediately below.

2. Trends in disadvantage should continue to be monitored closely in Director of Public Health Annual Reports
   Progress: This has been done through the Joint Strategic Needs Assessment and through this report.

3. The Children's Trust is requested to consider the basket of children's indicators proposed in this report and to drill down into indicators to uncover further inequalities at more local level using data from services.
   Progress: This is scheduled to happen shortly.

4. The NHS's Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The NHS 'offer' should not be 'one size fits all'.
   Progress: In the event, the consultation was divided into two parts. Disadvantage featured in the local phase 1 consultation document published by the CCG earlier in the year. However, it is the mooted phase 2 consultation on community services which will probably reflect whether variations between localities have been adequately taken into account to ameliorate health inequalities, so it is too early to form a judgement.

The Work of Oxfordshire's Health Inequalities Commission

I want to report here on the most significant event in tackling health inequalities and disadvantage which happened during the year – a report on the work of Oxfordshire's Health Inequalities Commission.

What is the Health Inequalities Commission?

The independent Health Inequalities Commission for Oxfordshire was commissioned by the Health and Wellbeing Board and carried out its work throughout 2016. It was the brainchild of the Chair of Oxfordshire's Clinical Commissioning Group and took two years of persistent effort to bring about. The Clinical Commissioning Group, the County Council's Public Health team, along with many other partners, including Oxfordshire Healthwatch played a midwife role. The report of the Commission was presented by the independent Chair, Professor Sian Griffiths, to the Health and Wellbeing Board in November 2016 and at a launch event on 1st December, chaired by the Leader of the County Council, attended by the media and a wide range of partners.

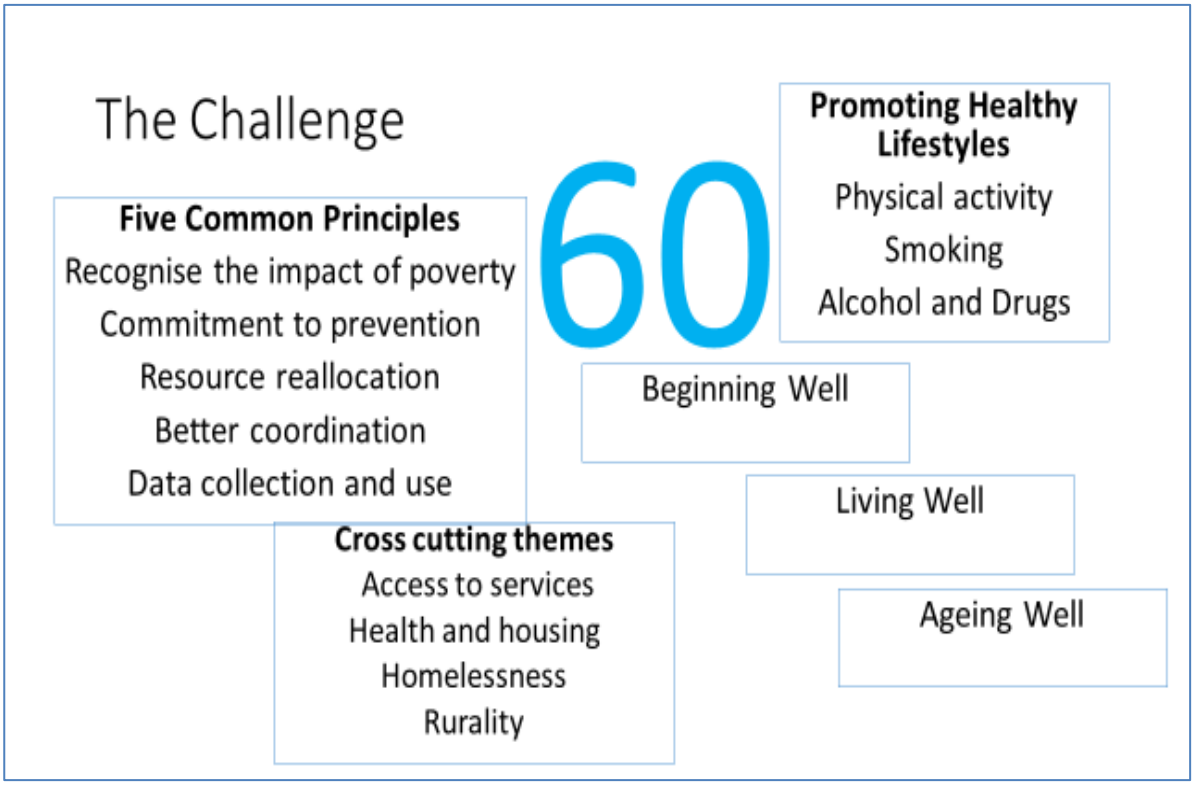
The Health Inequalities Commissioners were independent members selected from statutory and voluntary sector organisations and academia. They received written submissions and verbal presentations from a wide range of people and organisations at four public meetings held around Oxfordshire in the winter and spring of 2016. Local data and information on health inequalities were also presented to the Commissioners supported by access to a wide range of local and national documents, including the Director of Public Health Annual Reports, the Joint Strategic Needs Assessment and data from Public Health England.

What did it say and who signed up to its recommendations?

The Introduction to the report of the commission summarised their remit as follows:

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. But as Sir Michael Marmot has highlighted, health inequalities are not just poor health for poorer people but affect us all – "it is not about them, the poor, and us the non-poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone".

There are 60 recommendations in the report which are arranged in a set of themes as follows:



How are we taking it forward and who is involved?

The Health and Wellbeing Board agreed to oversee the implementation of the recommendations and receive regular updates.

The report was discussed by a wide range of organisations who signed up to deliver the recommendations, including:

- Oxfordshire Health and Wellbeing Board and its subgroups - The Children's Trust, The Health Improvement Board and the Joint Management Group for Older People.
- Oxfordshire Clinical Commissioning Group Executive, Board and Localities.
- Oxford University Hospitals Foundation Trust Management Executive and Public Health Steering Group

- Oxford Health Foundation Trust Board
- The Stronger Communities partnership in Oxford and the linked Local health partnerships in Wood Farm and Rose Hill
- Cherwell Local Strategic Partnership and 'Brighter Futures' in Banbury
- Oxford City Council Scrutiny Committee, in their oversight capacity.

In addition, an Implementation Workshop was held in May 2017 attended by a wide range of public and voluntary sector organisations. They began the process of identifying current work and discussing how this can be developed.

It may be impossible to keep a complete overview of the activity that develops as a result of the report, as many groups and organisations have renewed their efforts and energy in addressing health inequalities – that was one of the goals of the Commission, to mainstream the debate about health inequalities. This is good news. In addition, a multi-agency Implementation Steering Group has now been set up and will work together in taking forward the recommendations in a more formal way. Their first tasks include:

- Making sure there is a comprehensive overview of all the recommendations and what is being done in response
- Setting up a workshop to explore social prescribing (prescribing healthy activities) as a means of improving health inequalities and beefing up existing prevention initiatives
- Setting up a (modest) Innovation Fund and determining the criteria by which money pledged by all local authorities and the Clinical Commissioning Group can be used effectively.

How do we keep this initiative going?

It is important to maintain the interest and focus on tackling inequalities and disadvantage that have been stoked by the Health Inequalities Commission. This can be done in several ways:

- Demonstrating the impact of current work and new developments on tackling inequalities will keep the momentum going. Keeping watch over a range of indicators that show the variation in health outcomes will be important and a basket of indicators is being drawn up to help with that.
- Changing systems so that they address inequalities. For example, commissioning new services should consider the needs of people in the population who have worse outcomes or poor access to services. The Joint Strategic Needs Assessment and other sources of information will help with this needs assessment.
- Adopting the "Health in All Policies" approach to developing public policies which looks at the health implications of decisions, tries to join things up and prevents harmful health impacts.

- Making sure major plans, such as the Sustainability and Transformation Plan and Joint Health and Well Being Strategy, include action to address inequalities and deliver results.

- Using the Innovation Fund well and attracting more funding to sustain and develop good practice and make a difference.

This annual report is part of that process, and also aims to help carry the torch lit by this work.

What concrete things have happened as a result?

Individual organisations will of course be taking their own actions, not all of which we will know about, and this is to be welcomed. The report aims to galvanise us all – not just the big organisations. The process of bringing about change in the statutory services will be a long haul and we are still putting the foundations in place - but there are already some encouraging signs that things are happening:

The response to the call to improve prevention initiatives includes:

- Oxfordshire Sport and Physical Activity have begun to prepare plans for improving levels of physical activity in disadvantaged groups. Although an initial bid to Sport England to take the work forward was unsuccessful, other opportunities are being worked through.

- A database of food banks and other free or affordable food suppliers has been drawn up by Good Food Oxford. They are also providing 'food poverty awareness' training for front line services and have developed guidelines on "healthy cooking" for those who are training people in cooking skills.

Challenges to improve inequalities faced by vulnerable groups are being responded to, for example:

- Planning to make Barton a dementia friendly community as part of the Barton Healthy New Town initiative.

- A Trailblazer grant to reduce homelessness on discharge from hospital or prison. This involves a wide range of partners, led by the City Council.

- Programmes that promote personal resilience and positive lifestyle choices are being run for specific vulnerable groups. This includes a programme for people recovering from drugs or alcohol misuse which is called "Get Connected", run by Aspire and Turning Point. A similar programme, "Active Body, Healthy Mind", is run for mental health service users along with access to regular physical health checks.

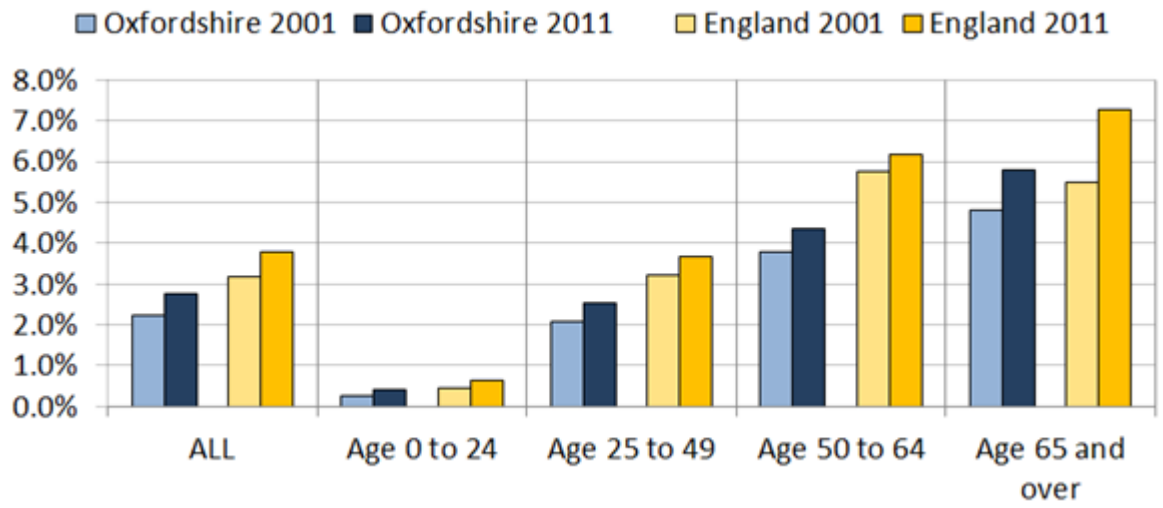
- A pilot project has been set up to provide counselling to children who are asylum seekers or refugees. This is already in place in Oxford Spires Academy and needs more funding to be expanded. This is led by Refugee Resource.

Caring for others as a cause of disadvantage

Previous reports have highlighted caring for others as a factor which can cause disadvantage. Before I close this chapter I am keen to report on the current situation.

Looking at the last two censuses shows the following picture for Oxfordshire compared with national data:

% of people providing 20 or more hours of unpaid care per week by age 2001 to 2011, Oxfordshire and England



The chart shows:

- An increase in the proportion of people providing unpaid care (of 20 or more hours per week) across all age group in Oxfordshire.
- The proportion of carers in each of the broad age groups in Oxfordshire remains below the England average.
- Between 2001 and 2011, the increase in the proportion of carers in the age group 50 to 64 in Oxfordshire was above the increase in that age group nationally.

As highlighted in previous reports, carers do a marvellous job, and organisations should continue to make sure they are well supported and taken into account when planning new services.

Recommendations

1. The Health and Wellbeing Board should ensure that the work of the Health Inequalities Commission continues to be taken forward.
2. The Basket of indicators of inequalities in childhood should be reported in the DPH annual report next year. The Health Improvement board should monitor homeless acceptances closely during the year.
3. The next phase of the Oxfordshire Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The service 'offer' should not be 'one size fits all' and the needs of different parts of the county should be recognised.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

We are what we eat, breathe, drink and do: whichever way we look at it, how we live our lives has a huge impact on our health. True, our genetics at birth deal us a basic hand of cards to play, but how well we feel, and how long we live has a lot to do with how we play our hand. What's your game-plan?

This chapter looks at some of the things people in Oxfordshire do that affect their health and looks at some of the actions we are taking to inform them of their choices and give them a helping hand.

This isn't about nannying, it's about giving the people the inside info to help them make the best choices they can.

The Health Survey for England gives us a good place to start – and the picture here will apply pretty well to Oxfordshire. In 2015 a total of 8,034 adults (aged 16 and over) and 5,714 children (aged 0 to 15) were interviewed. 5,378 adults and 1,297 children had a nurse visit as part of the survey.

The headlines (which we will unpack in this chapter) were:

- Smoking in adults fell from 28% in 1998 to 18% in 2015 – this is excellent. However, we know that around 25-30% of manual workers still smoke – this is a serious health inequality

- Alcohol consumption in adults is falling slowly (bringing with it a decline in alcohol related disease) – good news

- Obesity and overweight increased – it is now the new 'norm', with around half of adults overweight or obese – this is bad news for our future health.

- Children reporting smoking and drinking both fell steeply – more good news –though of course new threats like 'new psychoactive substances' (formerly called "legal highs") may be filling some of this gap.

- I would also add that teenage pregnancy continues to fall both locally and nationally – which is also good news.

So, what does this quick overview tell us?

It tells us that the lifestyle challenge that is still on the rise is all about obesity. Let's look at that first.

Obesity, Diet and Exercise

I'm not for a moment minimising other challenges and issues, but the unavoidable fact is that as a society the problem we are storing up for ourselves is all about our weight. Why? Because it leads to heart disease, cancer, mobility and disability problems and costs the economy an estimated £27bn, the NHS £6bn and social care £350m each year.

We also know that it is an inequalities issue and affects women more than men, unskilled workers more than skilled and Black and Asian ethnic groups more than white.

The UK Millennium Cohort Study, published an update in 2017 which illustrates this point beautifully. The following chart from the report shows very clearly that prevalence of children overweight increased by age and by lower maternal academic attainment. Mothers without qualifications (and so with less income and fewer choices) had on average children who were around 75% more likely to be overweight than mothers with degrees. The chart also underlines the steady increase in overweight children with age.

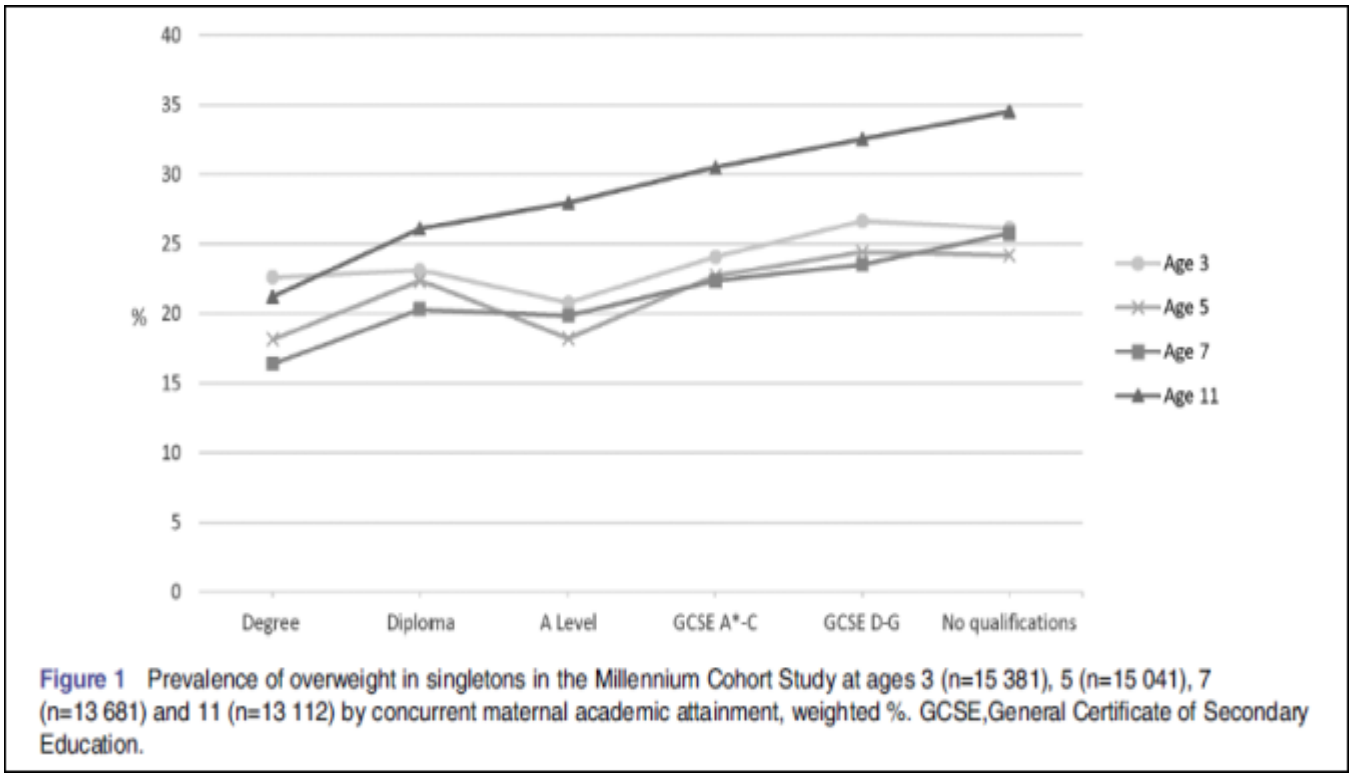


Figure 1 Prevalence of overweight in singletons in the Millennium Cohort Study at ages 3 (n=15 381), 5 (n=15 041), 7 (n=13 681) and 11 (n=13 112) by concurrent maternal academic attainment, weighted %. GCSE,General Certificate of Secondary Education.

We saw again in the previous chapter that obesity begins early – doubling between reception year and year 10, and continues to increase into adulthood.

A recent report from Public Health England sets out the situation with regard to physical inactivity well;

"Put simply, we are not burning off enough of the calories that we consume. People in the UK are around 20% less active now than in the 1960s. If current trends continue, we will be 35% less active by 2030. We are the first generation to need to make a conscious decision to build physical activity into our daily lives. Fewer of us have manual jobs. Technology dominates at home and at work, the 2 places where we spend most of our time. Societal changes have designed physical activity out of our lives."

This won't be news to anyone who has read these reports before as it has featured as an issue in ten out of ten reports. Why? Because it is still a problem and, as a collective, we still haven't cracked it…… although there may be some 'green shoots' of hope emerging.

If it matters so much, and we all know about it, why is it so hard?

I suspect this is for a number of reasons which I have teased out below. This isn't about victim blaming – absolutely not – this is really hard stuff – if it wasn't, it wouldn't be such a problem. In brief, the issues seem to be:

1. What we want regarding our lifestyles short-term works against us long- term when it comes to weight gain. We want comfortable lives, we want to travel by car or public transport, we want to watch TV, we want fast and easy food - and all these things lead to weight gain over time.

2. Our genetic programming may work against us. The evolutionists tell us we are programmed to gobble goodies when we see them to hedge against times of famine from our hunter-gatherer days (e.g. a glut of ripe fruit on a tree) by building up a fat store. That makes sense, but we are fortunate that the famine doesn't come any more, and so the fat builds up.

3. Because weight gain is insidious and we are hard-wired for short term responses. We seem to be programmed to respond to immediate dangers and tend to be blind to longer term issues.

4. Because the problem becomes invisible when the majority have it – I suspect that if you could bring a coach full of time-travellers from the 1950's they would be truly surprised to see us now.

5. Because the answer is multi-facetted. The answer isn't simple and implies change by individuals, families, organisations employers and government. We need a 'team UK' effort – and this is always difficult.

6. Because it isn't fair –Our metabolic rates and our genetic make-up are like hands of cards dealt to us at birth. It means that we put on the pounds in different patterns to one another. Where one loses another gains – it isn't fair. It also means that the answer isn't a one shot deal. The answer will vary from individual to individual and this makes setting a consistent policy harder.

7. Because it changes with age. I think many of us know that if we were to eat now what we ate as twenty-somethings we would put on weight very quickly. We are probably on average also less active than in our younger days. This implies that our eating and exercise patterns need to change with age. It is another challenge of an ageing society – how do we adapt to each decade, because the answers at 25 do not apply to 55.

8. Because it's so easy to put on weight and so hard to get it off. It's a bit like a lobster pot: easy to get into and hard to get out again. Many of us have tried slimming, and I think we all know how difficult it is to keep the pounds off once they have been lost. It does take a lifestyle change- and that can be hard graft.

9. Because we don't like preaching – especially if it makes us feel a bit uncomfortable. The messages are I think clear to us all. But they can get a bit 'preachy' and that tends to make us close our ears.

So what do we do?

The answer has to come through teamwork between the individual, family, government, employers, planners and organisations. It's about 1000 adjustments to 1000 tillers to turn the flotilla we all sail in…….. and there *are* green shoots - for example, in the last year or two:

- The health messages continue to seep home into the public's mind – the '5 a day' message is well embedded and shoppers are demanding healthier prepared foods – and the supermarkets are responding.
- At national level, Government has taken steps to improve food labelling and to reduce the sugar content of drinks.
- The climate in schools is changing – take for example the adoption of the 'daily mile' in schools across the country.
- Health and exercise options are being main-streamed by planners into new developments.
- The inequalities issues are clearer - and our Health Inequalities Commission report helps.
- Front-line health professionals are more willing to consider giving lifestyle advice during routine consultations.

And more locally……

- We have made very good progress in building exercise options into planning through the Healthy New Towns.
- The Health Improvement Board has made useful efforts to begin bringing recreation and leisure services together with the Sports Partnership to update its healthy weight strategy.
- The NHS has taken the topic of 'making every contact count' more seriously so as to get health advice into more face to face consultations.
- More schools are looking at options such as the 'daily mile'.

What Did We Say Last Year and What Have We Done About It?

We said that this topic should become a priority for the NHS's Sustainability and Transformation Plan – this has happened on paper, but there is no spare cash to fund the scale of change needed.

We said that the Health Improvement Board should play its part in partnership activity and this has been more than achieved.

What should we do next?

To keep it brief, this is a long haul, so essentially it is more of the same – more awareness, more coordination and more money are required.

Recommendations regarding obesity, diet and physical activity.

1. The NHS should continue to seek a serious investment fund to take this work forwards.

2. The Health Improvement Board should continue to coordinate the activities of all Local Authorities and the NHS

3. Planners should continue to plan communities that support active lifestyles until this is the norm.

Alcohol

There seems to have been a helpful shift in drinking patterns that will reap benefits in the decades to come.

Previous reports have set out the real health risks of alcohol as a causative factor for a wide range of diseases and its corrosive effects on society when consumed to excess.

I am not saying the problems have gone away altogether because:

- There were over 1 million alcohol related hospital admissions in England in 2015 and over 23,000 deaths related to alcohol.

- Alcohol is a causal factor in many medical conditions including mouth, throat, colon, liver and breast cancers; strokes and heart failure; liver disease and pancreatitis as well as road traffic accidents and injuries due to falls.

- Alcohol affects us all – for example, the highest earners (those earning £40,000 and above annually) are more likely to be frequent drinkers and "binge" on their heaviest drinking day when compared with the lowest earners.

But on the other hand:

- Overall alcohol consumption in the UK has decreased between 2000 and 2014, reducing from over 10 litres of pure alcohol per person aged 15+ to around 9.5 litres per head

- The proportion of the adult population of Great Britain (aged 16 and over) who drink alcohol has fallen from 64% in 2005 to only 60% in 2016).

- Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group.

- Alcohol consumption in young people in general is falling

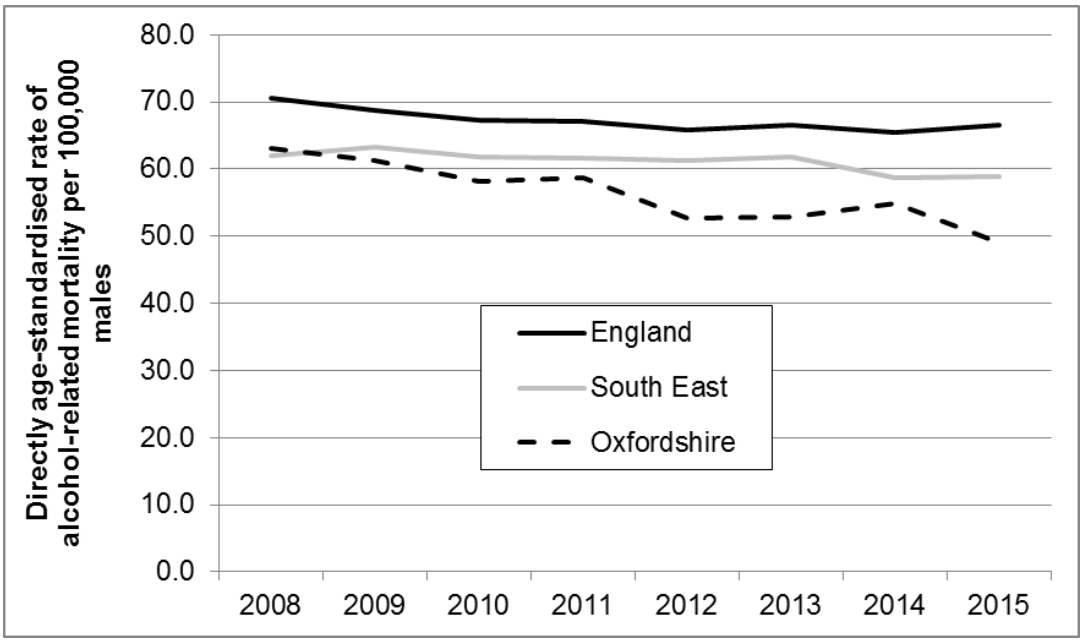
Why should this be?

I'm not sure anyone really knows. It may be that the health messages have hit home, or it may just be one of those complex societal 'fashions'. My money would be on the latter. Looked at over centuries, the average trend in alcohol consumption per capita has always fluctuated. We may have entered a down-turn and, whatever the reason, that is very good long term news.

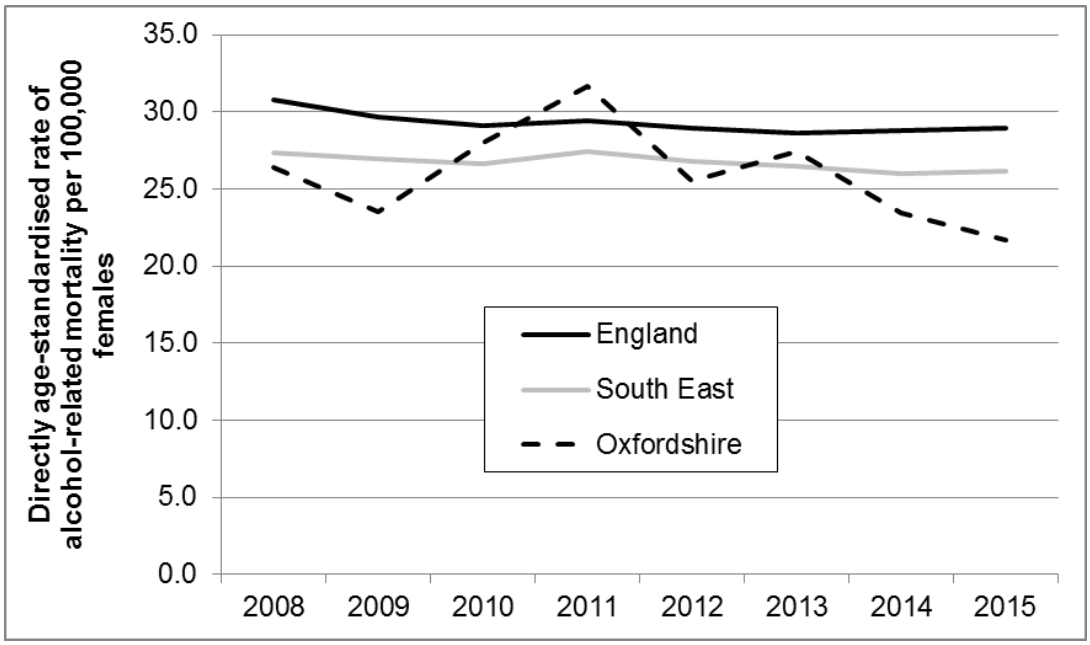
The statistics paint the picture well:

- Alcohol related deaths in males and females have been declining over the last 6 of 7 years and the figures are better for Oxfordshire than nationally. Also, deaths in females are around half of those in men

Alcohol-related mortality – males



Alcohol-related mortality – females

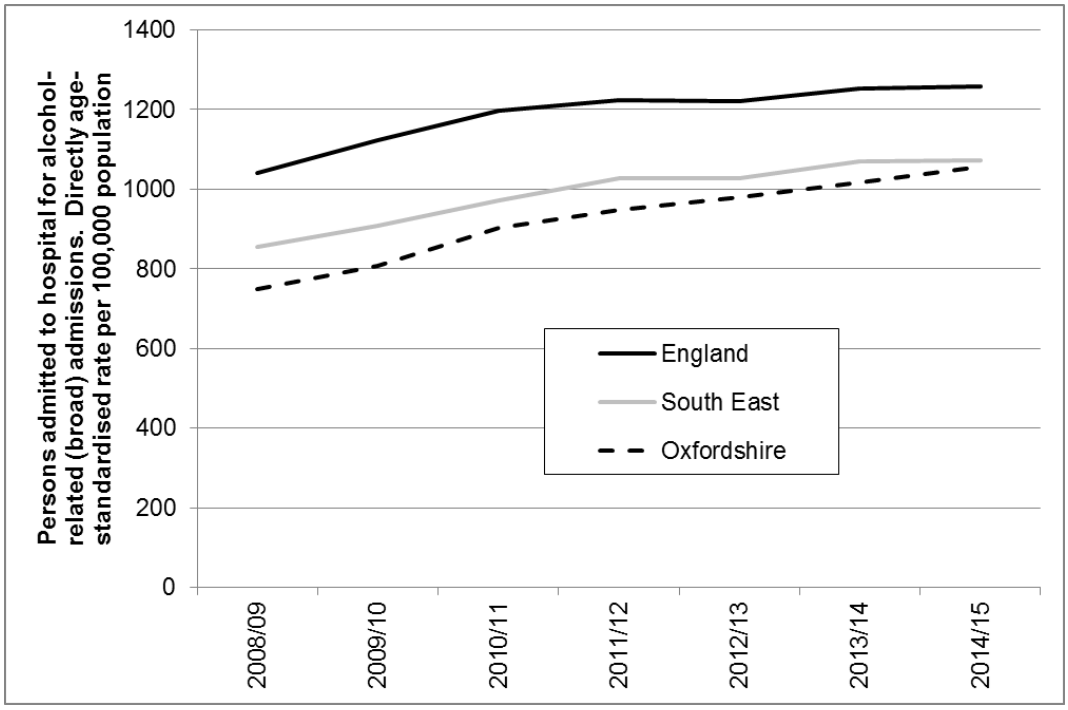


However, we aren't out of the woods yet as the figures for alcohol-related hospital admissions continue to show an upward trend. You can see this in the charts below which show people

admitted to hospital each year per 100,000 population. Because alcohol-related disease is long term, this might be the long term legacy of the drinking habits of previous decades – time will tell.

Whatever the reason, it is good news that the levels in Oxfordshire are well below national levels.

Persons admitted to hospital for alcohol-related conditions) - all ages



What Did We Say Last Year and What Have We Done About It?
Achievements in 2016-17

The Alcohol and Drugs Partnership reports the following progress in partnership work:

1. Identification and Brief Advice (IBA)

   The goal is to equip professionals with the confidence to give brief advice to people who are drinking too much. The partnership's role is to train the professional. This year the training was expanded to include smoking cessation and all sessions have been well attended by a range of professionals including those working in adult social care, early Intervention services, mental health organisations, charities, housing providers, primary care, pharmacies and Oxford University Hospitals Trust.

2. Targeted alcohol campaigns

   This year the Dry January campaign was again supported by the Fire and Rescue Service, and included 'mocktail' sessions run by Alcohol Concern. Advertising for the campaign included social media, the County Council's Yammer pages as well as an article in the Oxford Mail.

3. Improvement in Pathways to treatment.

Oxfordshire treatment services have been working hard to improve pathways between local hospitals and their services. Referral routes from both A&E and ward admissions back into the community have been reviewed as well as barriers to communication and continuation of prescribing. Staff from Turning Point (a drug and alcohol treatment organisation) continue to develop joint-working with the NHS, and a community alcohol detoxification nurse attends the John Radcliffe Hospital weekly to discuss patients and provide on-going community support for patients leaving hospital.

4. Street Pastors

Street Pastor schemes continue to flourish in the City and several market towns across Oxfordshire. Street Pastor schemes work in partnership with organisations such as the Police, Local Authorities, local door staff and licenced premises. They patrol the streets with a remit to 'care, listen and help'. Between April and September 2016 over 577 people were assisted by the street pastors.

What we said last year and progress made

Recommendations for 2016-17 were set out as follows:

1. The NHS should use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This is a real opportunity to nip alcohol related diseases in the bud.

2. This should be backed up by staff training and support.

Progress report: This work is ongoing and, due to delays in publishing the Transformation Plan for Oxfordshire, it is not yet clear that last year's recommendations have been fully implemented.

Recommendations for 2017-18

1. The NHS should continue use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This should be backed up by staff training and support.

2. Campaigns should focus on the impact of alcohol on health so that there is increased awareness of the harmful effects of alcohol on cancer and cardiovascular disease in particular.

NHS Health Checks

The NHS Health Check is a national cardiovascular risk assessment and prevention programme which is commissioned by the County Council. It is delivered by local GPs and has been commissioned by the County Council's Public Health team since 2013

NHS Health Checks specifically target the top seven causes of preventable death: high blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Eligible individuals aged 40-74 years are invited for a Check every five years (191,000 people), which means that 20% of this age group are invited per year and every eligible person is invited at least once every five years. The 40-74 age range is set nationally because it has been determined that this is the group in which detection and prevention of cardiovascular disease is most cost effective.

In Oxfordshire, the Health Improvement Board has set a target of 55% of those invited for a NHS Health Check take up the offer and receive the Check.

In 2016/17 in Oxfordshire 34,667 people were offered NHS Health Checks (18.2% of eligible population) and 17,847 checks were completed (9.3% of the total eligible population and 51.5% of those offered a check). This is an improvement on 2015/16 in terms of uptake (51.2% in 2015/16), but a decrease in percentage offered (20% in 2015/16) and percentage completed.

During 2016/17 of the 17,847 people who had a Health Check:

- **896 people were found at high risk of CVD, with 417 people now taking a statin**
- **275 people diagnosed as having high blood pressure, with 252 now on an antihypertensive drug**
- **63 people were diagnosed with diabetes**
- **1537 people were given brief advice regarding smoking, with 148 people referred/signposted to the local stop smoking service**
- **6310 people were given brief advice regarding physical activity, with 1706 people referred/signposted to the local physical activity services**
- **5821 people were given brief advice regarding weight management, with 283 people referred/signposted to the local weight management services**
- **1574 people completed a screening tool for their alcohol consumption. In addition1658 people were given brief advice regarding alcohol, with 8 people referred to the local alcohol services.**

This is a good result.

What Did We Say Last Year and What Have We Done About It?

Last year we said we would continue to bring the NHS Health Check programme to the public's attention in new and innovative ways to further raise awareness in the local community. This peaked with a month long campaign in January using local radio and advertising on transport links- which is thought to have contributed to the increased uptake in quarter 4.

We also said we would continue to work with GPs to improve the uptake of the offer, including the invitation process. Commissioners are working with GPs to investigate a combined approach of electronic communications from GPs and simultaneous targeted marketing online to improve uptake of the offer.

The commissioning team continue to closely support practices and have visited every practice as part of quality auditing the programme. They provide feedback to GP practices on how to improve on the quality of the programme. The approach to quality auditing taken by the public health team is still considered a national exemplar.

Recommendations for NHS Health Checks

The NHS Health Check programme continues to perform well, is now well embedded in the health system and is well received by the public. However, the concerted efforts to raise the profile of this programme with the public and improve on it must be maintained. In order to achieve this we need to:

1. Continue to market the NHS Health Check programme in new and innovative ways which take advantage of emerging technologies to raise awareness and understanding of the benefits of the programme with the public.

2. Continue to work with GPs to improve on the uptake of the offer of a free NHS Health checks and investigate new ways to best collaborate on improving the invite process.

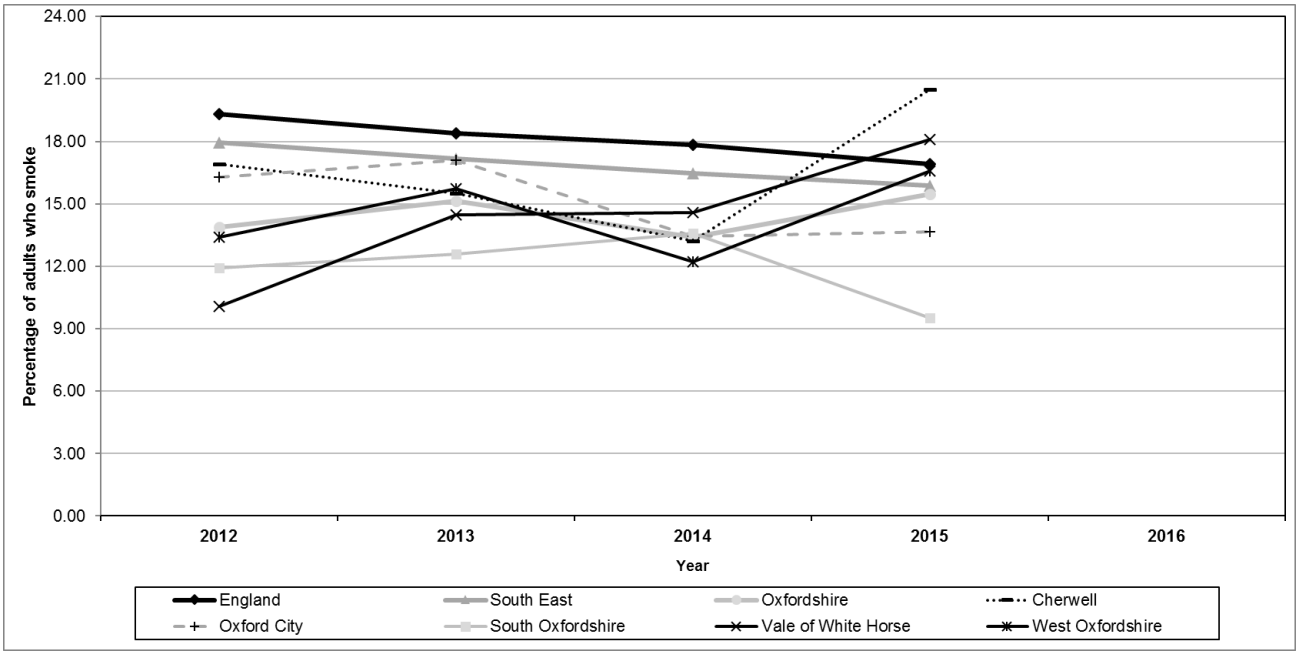
3. Better identify and engage with high risk groups to take up the offer of a free NHS Health Check.

Smoking Tobacco

Smoking Tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, vascular diseases and events such as heart attacks and strokes, and dementia. In Oxfordshire the prevalence of adult smokers has seen a very welcome continued decline in the past few years. This decline is shown in the figure below. The prevalence of adults who smoke in Oxfordshire is currently estimated to be 15.5% (an estimate of 91,892 people) which is better than the national prevalence (16.9%). This is a good result.

The chart below shows the results. Because this is based on a survey of a limited number of people, the national line will be accurate, the County line fairly accurate and the District lines far less accurate and subject to wide fluctuations.

Smoking prevalence in individuals aged 18+ by District in Oxfordshire



(Source PHE)

However, we still cannot be complacent about smoking rates in the County. There is still an inequality in who smokes, with much higher levels of smoking found in more disadvantaged communities. Indeed, in routine and manual workers the level of smoking is as high as 29% - double the County average. To meet this challenge, we need to target services at the groups who need help the most.

Smoking is highly addictive and the best thing for health is not to start. Although the trend for smoking in young people is falling the prevalence of young people aged 15 years who report in the survey that they are current smokers is 10.4%. This is significantly worse than the national average of 8.2%. While this is of concern some caution has to be exercised as the data is estimated based on responses provided to surveys of young people and can be subject to statistical errors (i.e. in plain speak it may be a 'blip'.). We should monitor this trend to see if this is a consistent finding.

Stop Smoking Services

The decline in people accessing traditional stop smoking services seen in recent years was halted in Oxfordshire with 1923 quits recorded for 2015/16 – three less than in the previous year total of 1926. This was against the national decrease of 10% in the recorded number of quits recorded nationally. This is to be applauded but preventing a further decline in recorded quits is becoming increasingly difficult. Why? Because there are fewer smokers 'out there' and there has been a sea-change in the way people choose to quit tobacco – increasingly opting for self-help solutions rather than statutory services.

The impact of the dramatic increase in the use of e-cigarettes in the UK is the most significant contributor to the reduction in people accessing stop smoking services. Latest data estimates:

- An estimated 2.9 million adults in Great Britain currently use e-cigarettes up from 700,000 in 2012

- For the first time there are more ex-smokers (1.5 million) who use e-cigarettes than current smokers (1.3 million).

- Over half (52%) of e-cigarette users are now ex-smokers and 45% continue to smoke as well.

- The main reason given by ex-smokers who are currently vaping is to help them stop while for current smokers the main reason is to reduce the amount they smoke.

- The use of e-cigarettes as a quit aid and their increasing usage has opened a debate in the public health community on a national and international scale. Currently in 2017, public perceptions of harm from e-cigarettes still remains inaccurate with only 13% accurately understanding that e-cigarettes are a lot less harmful than smoking. Among those who smoke, perceptions of e-cigarettes are also getting more negative, with only 20% accurately believing in that e-cigarettes are a lot less harmful than smoking compared with 31% in 2015.

With the increasing amount of conflicting information for and against e-cigarettes becoming available in the public arena there has naturally been confusion for the public and health professionals alike.

Public Health England have helped to clarify the position and published an evidence update which concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking.

The report also concluded there is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers. This is further supported by a report from the Royal College of Physicians published in April 2016 which states that e-cigarettes are an effective method for people wanting to quit tobacco and the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.

How should we move forward?
Our current services are now outdated. We need to move to a service which helps the general public but which also actively seeks out smokers in the most at-risk groups.

The public health team, in line with The National Institute for Health and Care Excellence (NICE) recommendations, are considering the following main areas for future services:

- Mass media and other education campaigns
- General education campaigns aimed at everyone;
- Media campaigns aimed at under 18s.
- Planning evidence based stop smoking services;
- Preventing children and young people from taking up smoking;
- Illegal sales
- Coordinated approach in schools
- Developing services which encourage better uptake in disadvantaged and minority communities who have higher rates of smoking.

Recommendations regarding smoking

1. The Health Improvement Board should continue to monitor activities of local smoking services and wider agencies to help people quit smoking and also not start in the first place.

2. Commissioners should re-commission services to deliver a blend of services to meet the changing attitudes and use of stop smoking services.

Oral Health

The marked improvement in oral health and the number of adults keeping their teeth as a result of better brushing with fluoride toothpaste and more awareness of oral health is welcome. However nationally in England the biggest cause of child hospital admission for general anaesthetic procedure is to provide dental extractions due to severe tooth decay. Tooth decay is one of the most easily preventable diseases and the high level of extractions under general anaesthetic is avoidable.

The picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions at lower than County level. However, looking at the national data, we can see that tooth decay is linked with other measures of general social disadvantage and so is a further source of inequality in the County. Latest available data from the 2015 oral health survey of five-year-old children shows that 77% of 5-year-old children are now free from any dental decay which is higher than the national average of 75% and improved locally from 67% since the 2012 survey. Whilst this is a good result there is room for improvement, the number of children who are decay free is significantly lower in Oxford than the other districts at 67%, probably reflecting social disadvantage.

During the 2016/17 dental teams have been conducting the latest national five-year-old children's survey and we expect to refresh the local data in the next twelve months.

The major sources of sugar which causes decay in children are found in soft drinks and cereals. Locally we will continue the work to educate children and parents about the impact of dietary choices on teeth and also wider health.

The picture in adults

Tooth decay has fallen in adults in England from 46% having active decay in their teeth in 1998 to 28% in 2009. The main sources of sugar in adults' diets come from cereals, soft drinks, jams and sweets.

Older adults are now keeping their own teeth into old age as the norm. The proportion of 65 to 75 year olds with their own teeth increased from just 26% in 1979 to 84% in 2009- a significant change. As the population ages it will be important that the NHS keeps pace with this changing need - particularly as the number of people needing more complex dental work rises steadily with age.

What are we doing and what should we do next?

Since the NHS reorganisation, the responsibility for oral health has been split three ways. The NHS has a responsibility for dentists and more specialised oral surgery, Public Health England

provides dental public health advice while Local Government has an emphasis on prevention and commissioning oral surveys in line with the national programme.

The oral health promotion and dental epidemiology service commissioned by the County Council has been in operation since 1st April 2015. This service aims to work in collaboration with wider dental services to prevent oral health problems in children and adults. The range of activities provided by the service include:

- Accreditation scheme for pre-school settings
- Piloting tooth brushing programme in primary schools. Four primary schools took part in the pilot programme in which children brushed their teeth under supervision of staff. The programme developed better understanding of oral health and improved brushing skills in children, making tooth brushing a routine part of the day which improved attitudes to brushing in the young children involved.
- Training of school health nurses in oral health promotion to promote a 'whole school' approach to oral health in education such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting evidence-based, age-appropriate, oral health information for parents, carers and children, including details on how to access local dental services.
- Piloting an accreditation scheme for care homes for elderly residents. The pilot successfully accredited three care homes as oral health promoting environments. The service trained staff to better understand the oral health needs of residents, the causes of oral disease, good oral hygiene for their residents and how to access dental services. The participating care homes also developed policies to better promote oral health for residents.
- Delivering oral health promotion sessions and events throughout the county
- Training health visitors in oral health to better understand the causes of tooth decay, oral development in young children, looking after teeth in young children and accessing dental services.
- Training staff who work in the community with children and adults to promote oral health with their client and user groups including causes of tooth decay, oral hygiene and access to dental services.
- Delivery of oral health promotion in local workplaces including Siemens and Thames Valley Police.
- Promotional events during National Smile Month and Mouth Cancer Awareness Month
- Provision of a lending service of health promotion resources for local stakeholders.

In the next year the oral health promotion service will

- Continue the supervised tooth brushing scheme in primary schools. Two of the schools in the pilot are planning to continue the programme and the service is looking to recruit new schools for the 2017/18 academic year.

- Find ways to reach a wider number of care homes.

- Continue to train staff in healthcare and community settings to become oral health promoters within their workplace with their service users and make every contact count.

- Continue support of oral health promotion development within both school health nurse and health visitor services.

- Continue to participate in oral health promotion events and sessions in the community to directly work with the public on raising the awareness of the importance of good oral health and accessing dental services.

Recommendations for Oral Health

1. The NHS should ensure that improvements in access to NHS dentistry are maintained including complex care and domiciliary care for older people and work continue to work to reduce child admissions for dental extractions under general anaesthetic.

2. Providers of care home facilities should be aware of maintaining good oral health in their clients which can significantly affect their quality of life. Commissioners of the oral health promotion should work with colleagues to develop this programme to increase the number of care homes who sign up to this programme.

3. Continue to work with school health nurse and health visitor services to embed oral health prevention and promotion into children's health from 0-19, allowing for a healthier oral health start to life.

4. Continue to develop the supervised brushing scheme in primary schools, developing on the encouraging work of the pilot programme.

Chapter 5: Mental Health

Mental Health - Children and Young People

I reported last year on mental health in children and young people and I want to keep that focus this year.

Last year I reported on two topics – trends in mental wellbeing in this age group in general and self-harm.

Looking at each of these in turn, we noted that:

- mental wellbeing and mental distress are difficult to define and measure in this age group and that what is classed as a mental health problem changes over time

- however, the indications are that living in the modern world and a digital age puts new stresses and strains on young people

- young people are coming forward to seek help – and we can see this in the work of our school health nurses and through rising referrals to NHS services

- this increase is no bad thing as it also shows young people's awareness of the issues they face and also young people's general self-help attitude.

To recap, the picture of emotional resilience and mental wellbeing can be summed up as being built up in the following ways:

- Positive relationships with caring adults
- Effective caregiving and parenting
- Intelligence and problem-solving skills
- Self-regulation skills
- Perceived efficacy and control
- Achievement / motivation
- Positive friends or romantic partners
- Faith, hope, spirituality
- Beliefs that life has meaning
- Effective teachers and schools

In contrast, when these factors are deficient, the individual's resilience is likely to be lowered and there is a greater vulnerability to stresses and strains.

Regarding more severe mental health problems in Children and Young People, the main facts are:

- 1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder; that is around three in every class at school or 8,000 children across Oxfordshire. According to national prevalence rates about half of these (5.8%) have a 'conduct disorder', whilst others have an emotional disorder (anxiety, depression) and Attention

Deficit Hyperactivity Disorder (ADHD). The prevalence increases with age and rises to 20% for the 16-24 age groups.

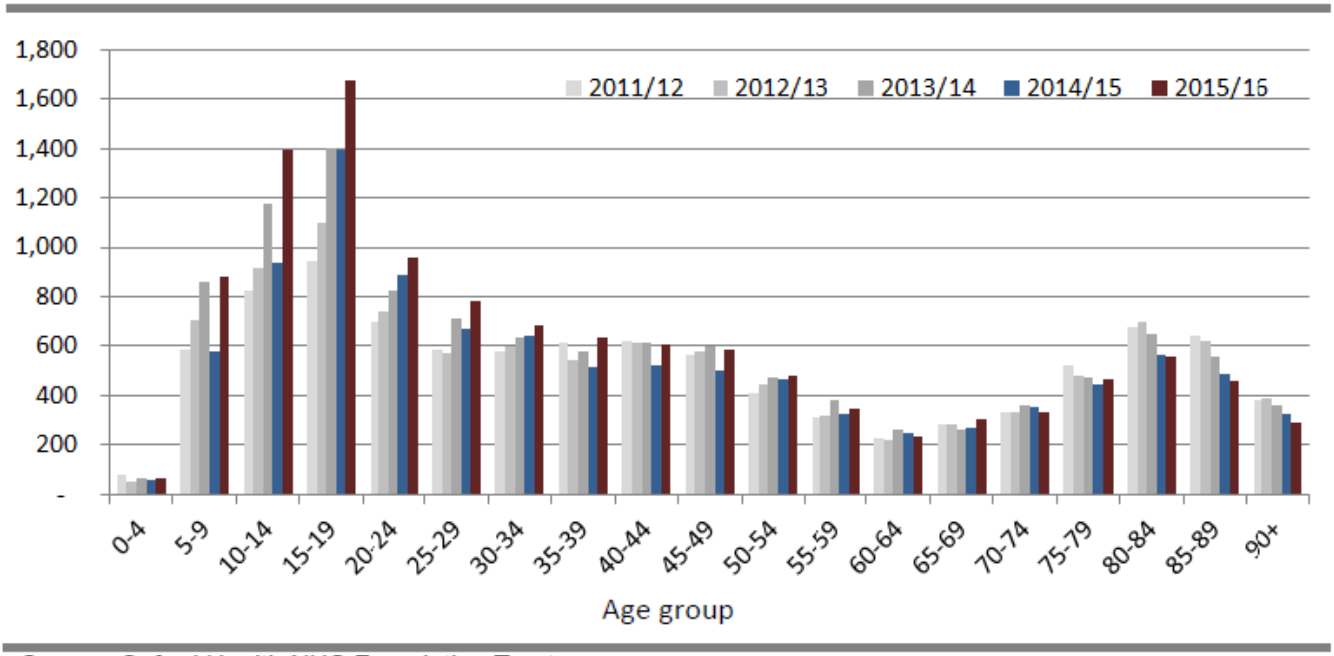
- The most disadvantaged communities and the most disadvantaged groups have the poorest mental and physical health and wellbeing. **Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%.** Parental unemployment is also associated with a two-to three-fold greater risk of emotional or conduct disorder in childhood. This doesn't mean that one causes the other, it simply points out that the two factors are found together in the same families.

- Children and young people with poor mental health are more likely to have poor educational attainment and employment prospects, social relationship difficulties, physical ill health, substance misuse problems and to become involved in offending.

- These issues are therefore significant and important.

In very general terms I suspect that what we are seeing overall is a generation who are subject to more moderate stresses (cyber-bullying for example), and that they have an increasing awareness of this, and, most importantly that they are seeking help. The chart below shows this through the rise in referrals of young people to mental health services.

Number of Oxfordshire residents referred to Oxford Health mental health services (2011-12 to 2015-16)



Source: Oxford Health NHS Foundation Trust

- The 15-19 age group continues to make up the largest proportion and number of patients referred to Oxford Health mental health services in 2015-16 and has seen the biggest increase since 2011-12.

- Between 2011-12 and 2015-16, the number of patient referrals aged 15-19 increased by 77%

I reported last year that children and young peoples' mental health service had just been overhauled. This is timely. The results of this were that a new contract for a new service model was awarded. The new service focusses on early prevention and intervention in partnership with voluntary agencies, public health services, education and children's social care to ensure children, young people and their families can get information, advice and support (including self-care) when there are emerging mental health problems. This is aimed at preventing more chronic and complex mental health problems, which can affect long term outcomes into adulthood.

We should also note the very valuable contribution our School Health Nurses make to the treatment of mental distress day in day out in our secondary schools.

The new service features:

- A single point of access for all referrals including self-referrals and clear publicised pathways for the most common conditions
- Active support for families and individuals to help them access other community services where this is more appropriate
- Partnership with voluntary organisations to support families better and improve movement between services for the young people with the most complex problems
- Reducing waiting times to improve access to support and treatment using evidence- based interventions to improve long term outcomes into adulthood
- Consultation, information and advice to families, young people and the wider children's workforce and the promotion of self-care and use of technology.
- Prevention and early intervention by working in schools and colleges to provide consultation, training and treatment in partnership with school health nurses and children's social care services

The service will include newly established specialist services such as:

- A dedicated Eating Disorder Service
- A new therapeutic team specifically working with young victims of child abuse and child sexual exploitation
- A new team to work with children who are 'Looked After' and those young people who are on 'the edge of care'
- An Autism Diagnostic Service with support for families after a diagnosis has been made
- A forensic psychiatry post working in the young people's housing pathway providing mental health expertise to some of our most complex young people and building capacity in the housing provider market

The focus for the first year is to deliver the 'single point of access' which will improve access to consultation, information and advice and treatment and, in addition, to start transforming the service into providing prevention and early intervention through working with primary and secondary schools across Oxfordshire. This includes School Health Nurses and improving integration and joint working with Children's Social Care. Voluntary organisations will play a key role as partners in delivering Child & Adolescent Mental Health Services (CAMHS).

This is clearly a substantial change and seems to respond well to the needs of young people. Implementation will take time – working with every Oxfordshire school is a huge task and a long process.

I think these are useful steps in the right direction.

Careful monitoring of this service and of new trends in the overall wellbeing of this age group will be essential.

Self Harm

I also reported last year on self-harm and reviewed the recent upward trend.

The last year has seen a mixed picture.
Measuring self-harm using hospital admissions shows that:

- rates in 10-14 year olds are down slightly
- rates in 15-19 year olds are up slightly
- rates in 20-24 year olds are down slightly

All of these figures are similar to the national picture. The trends we are seeing in Oxfordshire around self-harm are part of a national picture rather than a local one.

The new service mentioned above is intended to help to relieve the stresses that result in self-harm. It will be important to monitor the situation to see if there is a lasting impact.

In addition, last year I reported on an initiative that the Public Health team had undertaken locally. To recap, we commissioned a local Oxfordshire theatre company, Pegasus, to perform a play on self-harm in secondary schools across the county. The play was called 'Under My Skin'. Its aims were to:

- Give young people vital information about coping with feelings around self-harm, stress and the relevant services that can support them.
- Reduce the stigma of discussing self-harm and accessing support.
- Highlight the School Health Nursing service as a first port of call in schools for young people and professionals who have concerns over self-harm.
- Give professionals information and subsequent confidence about how to support a young person, and who to refer to.

The evaluation of the play showed that:

- It went to 28 secondary schools and was very well received.
- Approximately 5000 young people in years 8/9 (ages 12-14) watched the play.
- 50% reported the play increased their knowledge of self-harm a lot.
- 71% of young people knew how to access support after seeing the play.

As a result, we have re-commissioned the play again for the academic year 2016/2017.

It is important that professional help to young people is made part of the mainstream of many services rather than as a stand-alone service.

Examples of this in action are shown by the following 'snapshots' of work in hand in mainstream services across Oxfordshire:

- School Health Nurses have been trained in child & young person mental health through a programme called PPEPcare. The training includes:

  - Supporting young people with low mood
  - Supporting young people with anxiety
  - Supporting young people who self-harm

- In addition, our nurses have run awareness campaigns to ensure that young people are aware of techniques they can use to improve their well-being and where they can access support should they need it.

- School Nurses also support young people with exam stress – and example comes from the Matthew Arnold School where the School Nurse ran sessions with sixth formers approaching exams. This will lead to 'Chill Out Tuesday' and 'Wind Down Wednesday' next year for all young people approaching exams.

- By the end of March 2017, the Oxfordshire Young Carers Service had identified and supported a total of 2,684 children and young adults (aged 0 -25 years) who provide unpaid care to a family member. Caring is also well known as an additional cause of stress for young people. This included 456 new young carers identified in the year 2016-17.

- The Health Visiting service also has a role to play - the County Council have commissioned Oxford Health NHS Foundation Trust to create a specialist post which will set up new postnatal mental health groups and train those who run them. This recognises that addressing mental health needs of mothers is paramount in promoting mental wellbeing and preventing mental health problems in their children.

In summary, self-harm is an important issue. There is evidence that services are responding well, but this situation needs to be actively monitored.

Recommendation

Children and Young Peoples' mental health and wellbeing and its related services should be monitored in future Director of Public Health annual reports.

Chapter 6 – Fighting Killer diseases

Main messages for this chapter:

Part 1. Epidemics and Antimicrobial Stewardship

The improvement in the quality of our living conditions and the advances in modern medicine have meant that the threat of major illness and large numbers of deaths due to communicable disease are seen as a problem of times past.

The continuing vigilance of Public Health services and sound planning of local and national organisations to respond to the spread of communicable diseases means that most of us can go about our daily lives without being aware of the efforts to protect the wider community from disease. The Ebola and Zika outbreaks of recent times are stark reminders of the continuing threat that can arise at any time and present a very real risk to us all, irrespective of borders. The Ebola cases in the Democratic Republic of Congo and elsewhere act as a stark reminder of the need for continual vigilance across the world.

We need to continue to prioritise the work that is done in the background every day of the year to prepare for the worst and the unimaginable. Directors of Public Health work closely with Public Health England and the NHS across Thames Valley to ensure that the response to any threat will be matched by a coordinated response to any outbreak, wherever it may arise. It is important that this partnership and cooperation is continued.

The right response still remains systemic and calm planning and organising ourselves NOW so we can respond when the need arises without fear or panic. The need to remain vigilant still holds true.

A continuing cause for concern is the threat of **antibiotic resistance** and the rise of “superbugs”. Antibiotics are important drugs for animals and humans in fighting bacterial infections which were once life-threatening. Bacteria are highly adaptable and the widespread misuse of antibiotics and inappropriate prescribing of antibiotics continues to lead to bacteria which have developed resistance to the antibiotics which were once effective.

The risk of bacteria which cannot be treated by any existing antibiotics is a real threat here in the UK and throughout the world. We continue to see outbreaks of resistant strains of bacteria, if we do not act we will see the number of resistant strains increase.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections, returning us to the situation before the discovery of penicillin.

How do we keep this work going?

Success depends on several key elements:

- Maintaining a well-qualified and well trained cadre of Public Health specialists in Local Government.
- Continuing to build and maintain long standing relationships with colleagues in Public Health England and the NHS.
- Mainstreaming our plans by working with the Police, Military and many of the other organisations under the auspices of the Thames Valley Local Resilience Forum (LRF).
- Educating and advising professionals and the public of their role as individuals in limiting antibiotic resistance.

It is vital to keep the specialist workforce we have now to continue with this important work.

Part 2. Infectious and Communicable Diseases

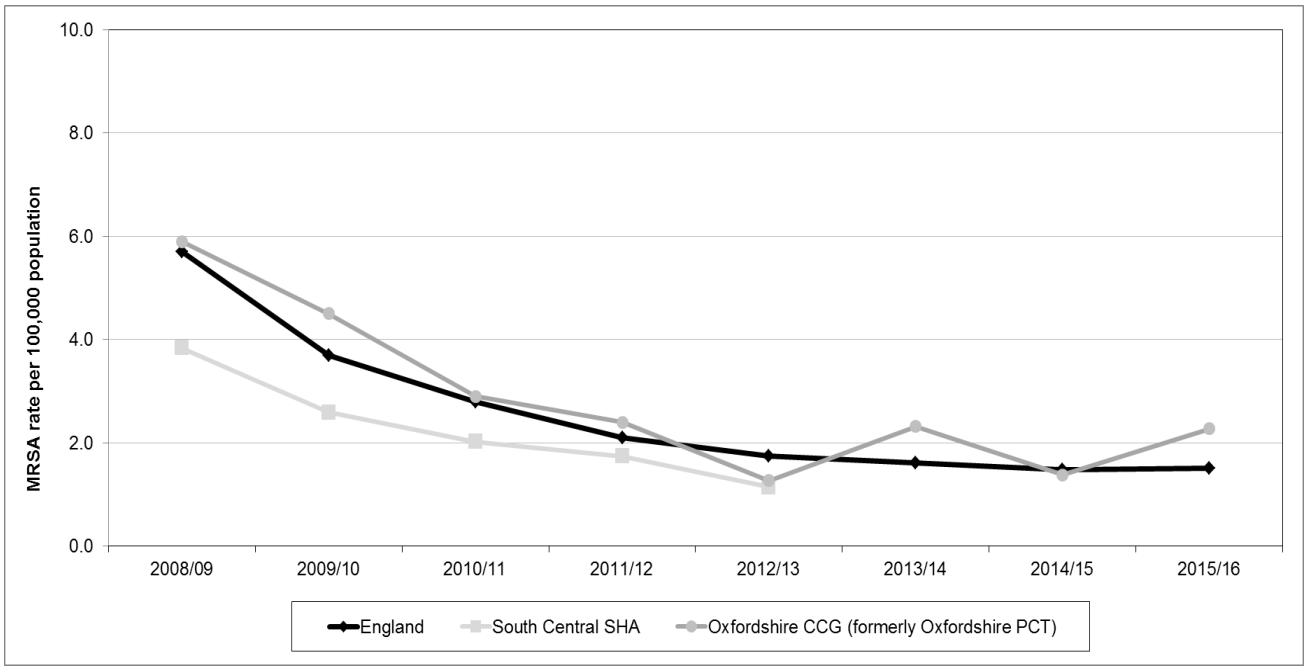
Health Care Associated Infections (HCAIs)

Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff.) continue to be an important cause of avoidable sickness and death, both in hospitals and in the community. These infections do not grab headlines as they have in the past but they still need everyone to remain vigilant to limit an increase in the incidence of infection.

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through an invasive procedure or a chronic wound) it can cause blood poisoning (bacteraemia). It can be difficult to treat people who are already very unwell so it is important to continue to look for causes of the infection and identify measures to further reduce our numbers of new cases of infection. MRSA has fallen gradually in Oxfordshire in response to the direct measures taken by hospital and community services to combat it. The local situation is shown below.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 - 2015/16)



Public Health England (PHE), Health Protection Agency (HPA)

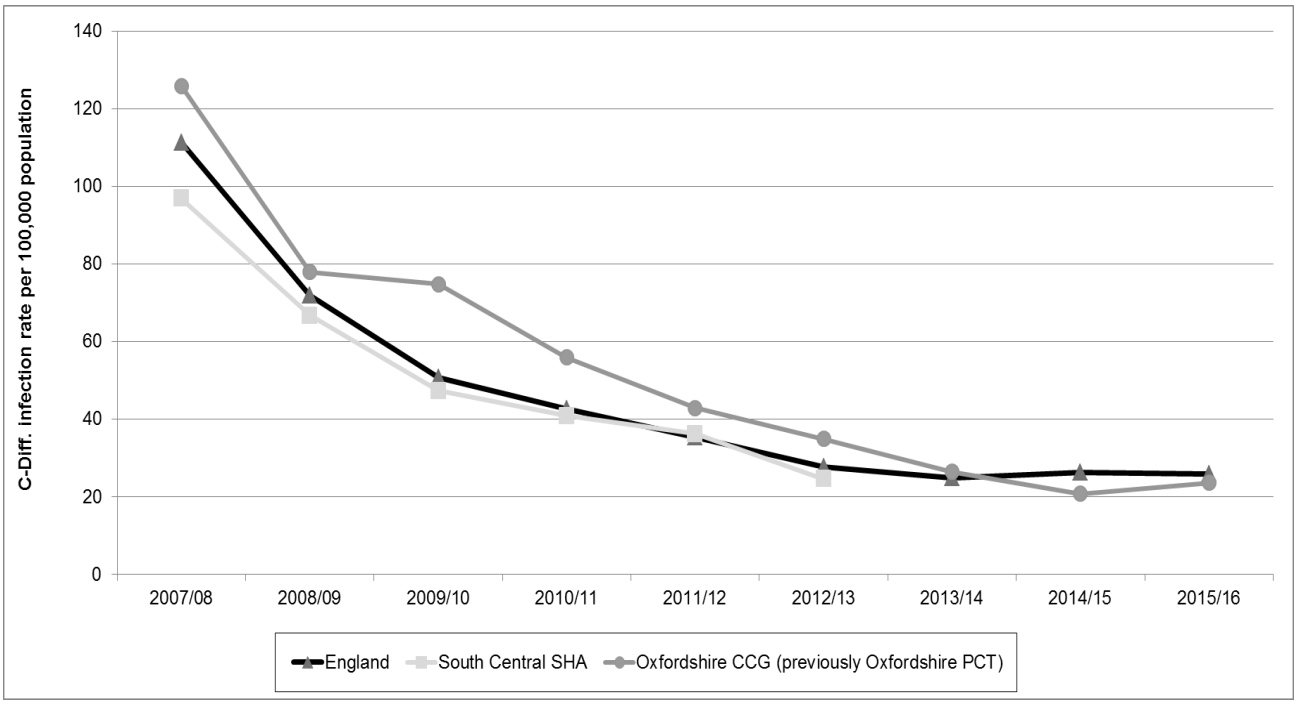
This shows that infections can be tackled, often by traditional hygiene methods. Nationally there is a zero tolerance policy and the rate of MRSA is still higher than we would like. There have been improvements in Oxfordshire over the past few years. However, the levels in Oxfordshire have increased slightly again in 2015/16 to be higher than the national average. This slight increase, which may be a statistical 'blip' due to the small number of cases each year reaffirms why continued vigilance is required by all hospital and community services to combat MRSA infections.

Clostridium difficile (C.diff)

Clostridium difficile is a bacterium that causes mild to severe diarrhoea which is potentially life-threatening especially in the old and infirm. This bacterium commonly lives harmlessly in some people's intestines but commonly used broad spectrum antibiotics can disturb the balance of bacteria in the gut which results in the C.diff bacteria producing illness.

A focussed approach on the prevention of this infection has resulted in a steady reduction in cases in Oxfordshire since 2007/08 as shown in the chart below which is in line with the National trend. The reduction in C.diff involves the coordinated efforts of healthcare organisations to identify and treat individuals infected and also careful use of the prescribing of certain antibiotics in the wider community. There are still on-going concerted efforts locally to continue to improve on the rate of C.diff infections.

Clostridium Difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2015/16)



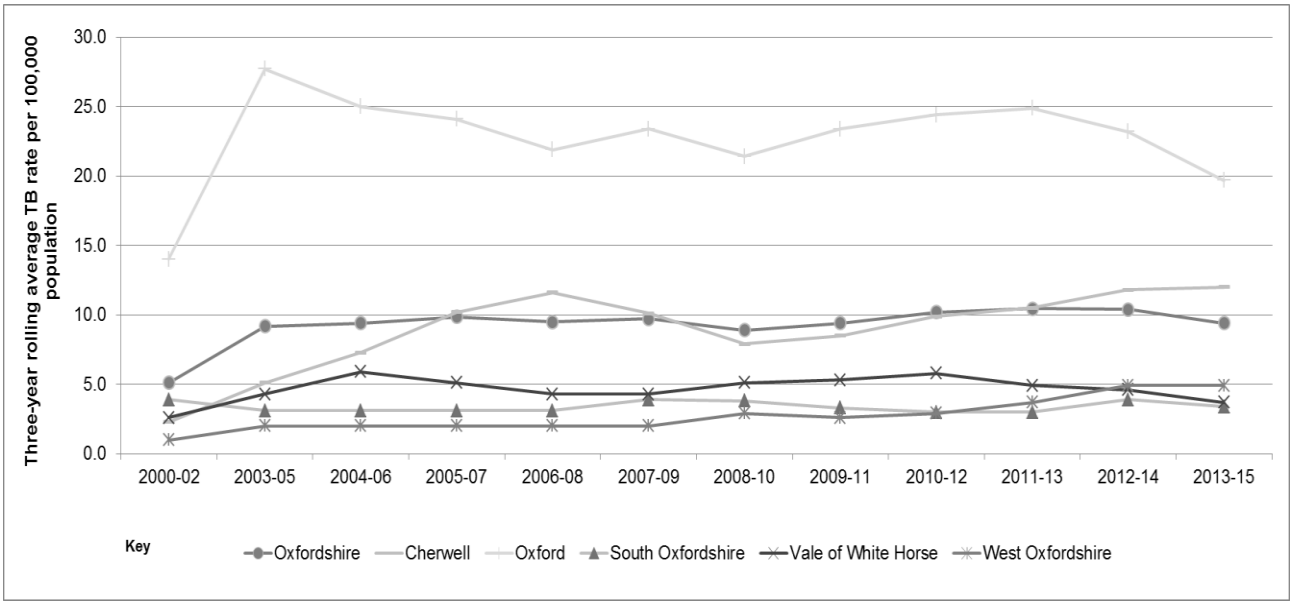
Public Health England (Health Protection Agency)

Tuberculosis (TB) in Oxfordshire

TB is a bacterial infection caused by Mycobacterium Tuberculosis which mainly affects the lungs but which can spread to many other parts of the body including the bones and nervous system. If TB is not treated, active TB can be fatal.

In Oxfordshire, the numbers of cases of TB at local authority level per year are very low. The local figures are shown below.

Tuberculosis (TB) – Incidence rate per 100,000 population (2000-2 to 2013-15)



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

The levels of TB in the UK are beginning to show a reduction due to coordinated efforts by TB control boards across England to improve TB prevention, treatment and control.

The rate of TB in Oxfordshire is lower than the National average and similar to average levels in Thames Valley. In the UK the majority of cases occur in urban areas amongst young adults, those moving into the area from countries with high TB levels and those with a social risk of TB (e.g. homeless people). This is reflected in the higher rate of TB in Oxford compared to other Districts in the County.

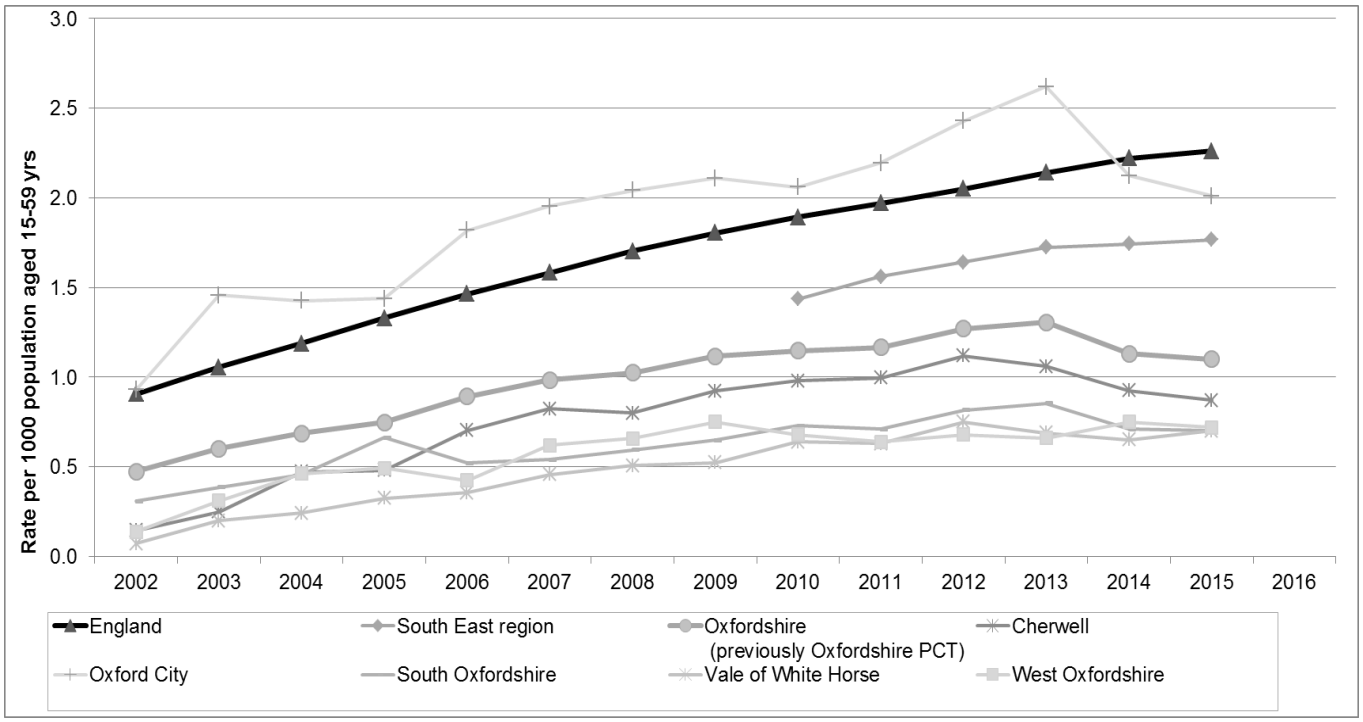
Public Health England has developed a TB strategy to address TB nationally. The TB control boards look at regional levels of TB and services to provide treatment. The Oxfordshire Clinical Commissioning Group is developing a model for a latent TB screening programme as part of a national initiative to identify and treat new entrants from high TB prevalence countries.

Sexually transmitted infections

HIV & AIDS

HIV does not raise public alarm like it did in the 1980s, but is still remains a significant disease both nationally and locally. Due to the advances in treatment, HIV is now considered a long term condition and those who have HIV infection can now expect to have a longer lifespan than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2015 data shows that there were 448 people diagnosed with HIV living in Oxfordshire, 221 out of these 448 live in Oxford City. This trend is shown in the chart below and shows another decrease this year across the County.

Rate of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 years. England, South East region, Oxfordshire and districts



Public Health England Sexual and Reproductive Health Profiles

Finding people with HIV infection is important because HIV often has few symptoms and a person can be infected for years, passing on the virus before they are aware of the illness. Also the sooner an infected individual begins their treatment the more effective treatment is with a better prognosis for the individual concerned. Trying to identify people with undiagnosed HIV is vital. We do this in three ways:

- Providing accessible testing for the local population. Since it started providing services in 2014, the sexual health service has provided 48,885 HIV tests across the service.

- Through community testing - we have 'HIV rapid testing' in a pharmacy in East Oxford. This test gives people an indication as to whether they require a full test: the rapid test takes 20 minutes and gives a fast result, although fast tracking to the sexual health service for a full test is required to confirm diagnosis.

- Prevention and awareness. Educating the local population about safe sexual practices and the benefit of regular testing in high risk groups. In addition, the eligibility for accessing the condom scheme has been extended to men who have sex with men (MSM) and commercial sex workers, both groups being at higher risk of contracting HIV.

Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments available. HIV still cannot be fully cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly can be decreased. Beyond Oxfordshire there are interesting developments nationally in preventing the spread of HIV in high risk groups using drugs to halt transmission (PrEP). NHS England will be trialling PrEP over the next three years.

Sexual Health

Sexually Transmitted Infections (STIs) are still high in England with the greatest number of cases in young heterosexual adults, and men who have sex with men (MSM). STIs are preventable through practicing 'safe sex'. Total rates of STIs in Oxfordshire are still below the national average except in the City which has remained at a similar rate since 2013. The local picture is shown in the chart below.

Looking at each disease in turn gives the following picture which is generally good:

- Gonorrhoea- is below national average for Oxfordshire as a whole and all districts except in Oxford City. This is likely to be due to its younger age profile. There is a new system of testing to reduce the number of false positive diagnoses and it is expected that a reduction in diagnoses should be seen when the latest data are released.

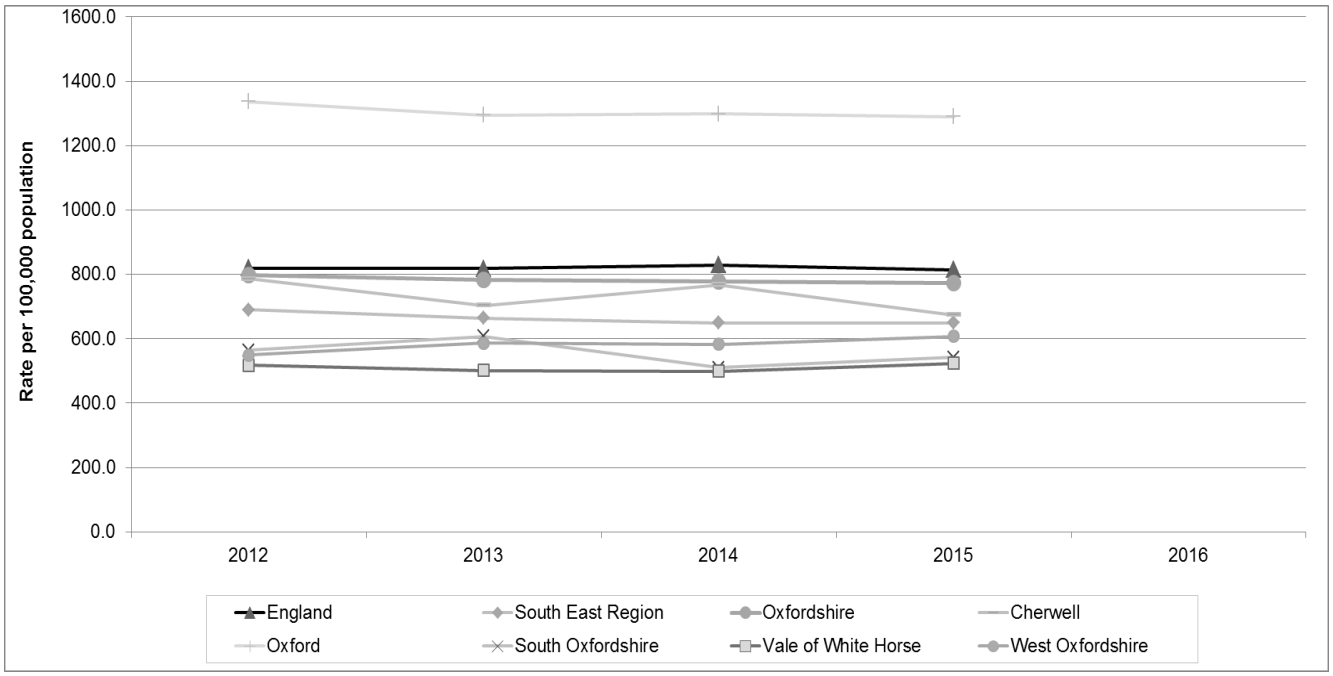
- Syphilis- still continues to fall and is below average in all areas of the County.

- Chlamydia- levels are lower than the national average in all Districts. Following evaluation and consultation the local service has been reshaped to be more focussed on accessing testing through online services. It is hoped that this will be more acceptable and accessible for young people to have a Chlamydia test.

- Genital Warts – rates are still below national average and have seen a decline in line with the National trend. Oxford City still has significantly higher number of cases (reflecting the significantly younger age group) but the trend is stable. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.

- Genital Herpes – rates are lower than national average except in the City which has higher levels. However the total number of cases in the year is small. Again this reflects the predominantly younger population of the City.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2015



Public Health England / Health Protection Agency - Sexual and Reproductive Health Profiles

The local sexual health service, which began in 2014, has seen good levels of activity and this is to be welcomed. The service has improved access to contraceptive and sexual health services conveniently in the same location which has improved the service for local users.

Since the service began in the first three years of operation, the service has delivered

- **91,763 STI treatment and testing consultations**
- **Provided 171,213 tests for STIs and 48,885 HIV tests**
- **Positively identified 32,629 STIs, HIV infections and other sexual health diagnoses**
- **Provided 51,156 consultations for family planning**
- **Fitted 5995 contraceptive devices (Long Acting Reversible Contraception)**
- **Prescribed 27,402 other forms of contraception**
- **Prescribed 3004 Emergency Hormone Contraception Treatments**

The service has continued to deliver on its established reputation in the community as a provider across a range of locations across the county where the local population can access all their sexual health services in one location.

In addition to this in the same period GP providers have delivered 15,760 coils and contraceptive implants and pharmacies have provided 4,103 doses of emergency hormonal contraception.

In line with best practice a partnership of local stakeholders continues to work together to identify and address priorities locally to further meet the sexual health needs of Oxfordshire and further improve on the decline of STI's in Oxfordshire.

Recommendation

The Director of Public Health should report on progress on killer diseases in the next annual report and should comment on any developments.

A Report to the Health Improvement Partnership Board 26th September 2017

Public Health Protection Forum business 2016/17

Purpose
This document will report on the activity of the Health Protection Forum for 2016/17

1. **Introduction**
   1.1 Oxfordshire County Council (and the director of public health (DPH) who acts on behalf of the local authority) has a critical role in protecting the health of its population. This role is to act as a watchdog, ensuring that all organisations working within Oxfordshire coordinate their activities and provide high quality services to protect the population.
   1.2 If organisations fall short of the required standards the DPH has a duty to help them ameliorate the situation. It is therefore a leadership role rather than a managerial role.
   1.3 In order to carry out this role the DPH works in partnership with the relevant organisations via the Public Health Protection Forum which reports to the Health improvement board and hence to the health and wellbeing board.
   1.4 Most problems are dealt with directly by the Public Health Protection Forum, but should persistent difficulties arise these will be escalated to the Health Improvement Board and Health and Wellbeing Board as required.
   1.5 The Public Health Protection forum therefore facilitates the DPH in fulfilling the statutory function of protecting the health of the population of Oxfordshire.

2. **Role of the Health Protection Forum**

The group report on the following issues

- Prevention
- Planning and preparedness
- Relationships and accountabilities
- Monitoring of local data
- Reporting of local issues which may affect the health of the local population

3. Membership of the forum

Membership of the forum includes;

- Director of Public Health, Oxfordshire County Council (Chair)
- Oxfordshire County Council Portfolio Holder for Public Health
- Consultant in Public Health/Public Health Medicine with responsibility for Public Health Protection/emergency planning – Oxfordshire (Deputy Chair)
- Director of Public Health England Centre – Thames Valley (or nominated deputy)
- District representation of Environmental Health colleagues
- Associate Director Medicines Management, Quality and Innovation, Oxfordshire Clinical Commissioning Group
- Head of Public Health Commissioning, NHS England Thames Valley

- Consultant in Public Health Screening and Immunisation, NHS England Thames Valley
- Consultant in Health Protection/CCDC with responsibility for Health Protection in Oxfordshire – Public Health England
- Specialist advisors will be invited as necessary

4. **Meetings**

The forum met three times in the financial year 2016/17. There were no extraordinary meetings held in this time.

5. Activity Reporting

The following activity was reported to the forum during the year

6. Topical Infections (Lead Role Public Health England)

6.1 There is an ongoing outbreak of Hepatitis A in the UK and Europe of involving three strain types. This outbreak is predominantly affecting men who have sex with men (MSM), but it is increasingly being detected in the wider population. Hepatitis A is a vaccine-preventable viral infection of the liver that is mainly spread faeco-orally through contaminated food or inadequate hand washing but can also be sexually acquired. PHE worked with sexual health services including our local provider to ensure that vaccination was offered to at risk MSM in local GUM services. OUHFT continue to offer vaccination and raise awareness about risk in line with national guidance. PHE are ensuring that suitable supplies of vaccine are available for local GUM services and for GPs for post exposure prophylaxis for close contacts of hepatitis A.

6.2 During the winter season 2016/17 there were 15 flu outbreaks reported in Oxfordshire. There were 10 reported respiratory tract outbreaks which were considered less likely to be influenza like illnesses. For influenza like illness outbreaks, public health advice is still to provide Tamiflu to care home residents prophylactically, as a preventive measure for those without symptoms, and for those with symptoms as treatment, if it can be delivered in a timely manner and is not contraindicated for the individual.

7. **Healthcare Acquired Infections (Lead Role Oxfordshire CCG)**

Clostridium Difficile (C.Diff.)

7.1 In 2016/17 there were 135 cases of C.Diff. reported. This was below the target threshold of 145 for the county and an improvement of the previous year (157), reflecting the efforts to improve the management of C.Diff. with local providers in primary care.

Methicillin Resistant Staphylococcus Aureus (MRSA)

7.2 In 2016/17 there were 8 reported cases of MRSA which is an improvement on 2015/16 (15 cases).

7.3 Oxfordshire CCG continue to work with providers to continue the improvement on limiting and managing healthcare acquired infections.

8. Environmental Health Issues (Lead Role District Councils)

8.1 Air pollution has become more of an issue at both local and national level and gained more prominence. This has been discussed the health protection forum and a separate, more detailed report is being presented to the board for discussion.

9. Immunisation Programmes (Lead Role NHS England)

Influenza Vaccination

9.1 There were moderate levels of flu locally in the 2016/17 winter season and this was seen also nationally. Overall the programme for influenza vaccinations performed better that 2015/16 for all age groups. The Oxfordshire activity for vaccination was also the best in Thames Valley. The flu vaccination activity for 2016/17 season in Oxfordshire is detailed below.

9.1.1 Children's vaccinations 2016/17 Season

2-year-old children in Oxfordshire vaccinated 47.5% (last year 43.7%)
3-year-old children in Oxfordshire vaccinated 51.5% (last year 44.2%)
4-year-old children in Oxfordshire vaccinated 41.2% (last year 38.3%)
5-year-old children in Oxfordshire vaccinated 68.3% (last year 32.6%)
6-year-old children in Oxfordshire vaccinated 64.2% (last year 28.2%)

This year saw a change in the programme delivery, which vaccination of 5 & 6-year-old children being delivered through school based services which has resulted in a significant improvement in uptake of vaccination. The programme was also extended to 7-year-old children and achieved 63.5% uptake in 2016/17 for these children.

The ambition for 2017/18 is to extend the programme to offer vaccinations to 8-year-old children.

9.1.2 Adult vaccinations 2016/17 Season

Adults aged over 65 in Oxfordshire vaccinated 73.8% (last year 72.4%)
Adults aged under 65 at risk in Oxfordshire vaccinated 52.4% (last year 45.9%)
Pregnant women in Oxfordshire vaccinated 52.8% (last year 51.3%)

10. Other Childhood vaccination programmes (Lead Role NHS England)

10.1 The performance of other childhood vaccinations is still generally performing similar to previous years of activity and is better that most areas in Thames Valley. The DPH and forum continue to monitor activity and ensure that the performance is maintained at an acceptable level. Vaccinations of note:

Measles

10.2 The number of children receiving the MMR vaccine aged 2 years was 95.0% which meets target uptake. However, the rate for MMR vaccination at 5 years was 92.4% (previous year 92.8%). The catch up cohort of 5-year-old children continues to present challenges to improve on the uptake.

The commissioning team have invested in staff to target this group and follow up on those who have not had a second MMR vaccination. The public health team have developed materials to raise awareness of the importance of the MMR vaccination with parents of children in the county. These combined efforts are hoped to produce an increase in the uptake of MMR vaccination in both aged cohorts.

Rotavirus

10.3 The uptake of this vaccination in 2016/17 was 93.6% which was a continued improvement on the previous year's uptake of 92.5%.

11. Adult Vaccinations (Lead Role NHS England)

Shingles

11.1 The cohort for vaccination in 2016/17 was 70 & 78-year-old adults. In Oxfordshire CCG 94.2% of practices had submitted data (91.3% in previous year). The table below provides information on activity from 01/09/13 to 31/08/16

	% of practices responding			% of patients immunised aged 70			% of patients immunised aged 78		
Year	**13/14**	**14/15**	**15/16**	**13/14**	**14/15**	**15/16**	**13/14**	**14/15**	**15/16**
OXFORDSHIRE	**95.1**	**91.3**	**94.2**	**52.7**	**63.2**	**58.0**	**55.6**	**63.3**	**61.1**
Thames Valley Total	**97.9**	**95.3**	**92.1**	**53.1**	**63.1**	**58.0**	**55.8**	**63.6**	**58.9**

The performance in Oxfordshire has seen a slight decrease on the previous year which has also been seen across Thames Valley. However, this change in activity may be associated with the data quality. Commissioners are working with providers to improve on the quality of the data submitted for this and also improving uptake within their registered patients.

12. Screening Programmes (Lead Role NHS England)

Antenatal Screening Programmes

12.1 Programme activity continues to perform satisfactorily. Last year the commissioners worked with the provider to improve on the avoidable repeat of blood spot tests. This has produced a reduction on the repeat tests from 4.8% to 2.8%.

Bowel Screening

12.2 Screening is offered to people aged 60-74 years of age. The most recent annual data was in 2016 when 58.3% of the eligible population took up the offer of screening. While this is below regional levels of 60.1% it is better than national averages of 57.9%. Latest data for Q2 2016/17 was 59.3%

Breast Screening

12.3 This programme is available to women aged 50-70 every three years. Latest data showed that in 2016 79.3% of eligible women had a breast screen. This is better than regional (77.1%) and National (75.5%) levels.

Cervical Screening

12.4 This programme is available to women aged 25-64. The percentage of those that took up the offer of screening in 2016 was 72.5% (73.4% in 2015). This is lower than regional (73.9%) and National (72.7%) levels. The uptake of screening in this programme still continues to struggle throughout the country. Nationally the uptake is lowest in women aged 25-49 years of age.

Aortic Abdominal Aneurism Screening

12.5 This programme is available to men aged 65 to 74 over 10 years. Locally the programme screened 77.2% in 2015/16 (72.5% in previous year) of eligible individuals which exceeds the national target of 75%. However, this is below regional (80.6%) and National (79.9%) levels.

13. HIV and Sexually Transmitted Infections NHSE (Lead Role NHS England & Oxfordshire County Council)

HIV

13.1 Due to the advances in treatment, HIV is now considered a long term condition and those who have HIV infection can now expect to have a longer lifespan than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2015 data shows that there were 448 people diagnosed with HIV living in Oxfordshire, 221 out of these 448 live in Oxford City.

13.2 Early diagnosis of HIV is important as it improves the prognosis of treatment, reduces the cost of treatment and lowers the risk of transmission. Latest data for 2013-15 revealed that 33 cases of late diagnosis occurred in Oxfordshire.

Sexually Transmitted Infections (STIs)

13.3 Total rates of STIs in Oxfordshire are still below the national average except in the City which has remained at a similar rate since 2013.

Gonorrhoea

13.4 Gonorrhoea levels are below national average for Oxfordshire as a whole and all districts except in Oxford City. This is likely to be due to its younger age profile. There is a new system of testing to reduce the number of false positive diagnoses and it is expected that a reduction in diagnoses should be seen when the latest data are released.

Chlamydia

13.5 Chlamydia levels are lower than the national average in all Districts. Following evaluation and consultation the local service has been reshaped to be more focussed on accessing testing through online services. It is

hoped that this will be more acceptable and accessible for young people to have a Chlamydia test.

14. Blood Bourne Viruses

There were no major incidents locally to report.

15. Recommendations

The board are requested to consider the contents of this report on the health protection activity in the year 2016/17

Contact officer: Eunan O'Neill, Consultant in Public Health, Eunan.ONeill@Oxfordshire.gov.uk

Oxfordshire Air Quality Group Annual Report 2016/17
Health Improvement Board

National Context

1. Poor air quality is the largest environmental risk to public health in the UK. It is known to have more severe effects on vulnerable groups, for example the elderly, children and people already suffering from pre-existing health conditions such as respiratory and cardiovascular conditions. Two studies have suggested that the most deprived areas of Britain bear a disproportionate share of poor air quality.
2. In February 2016 the Royal College of Paediatrics and Child Health published a study, estimating the amount of premature deaths in the UK attributable to exposure to outdoor air pollution to be 40,000/year. In the same study, air pollution was linked to diseases such as cancer, asthma, stroke, heart disease, diabetes, obesity and dementia.

3. In April 2016, the Committee on the Medical Effects of Air Pollutants, responsible for carrying out research into the link between air quality and human health stated that considered epidemiological evidence was suggestive of an association between long term exposure to particulate pollution and chronic bronchitis. The committee's sensitivity analyses estimated that over 722,000 cases of chronic phlegm in 2010 could be attributable to exposure to particulate pollution (anthropogenic PM10) in the UK, and that a reduction of 1 µgm-3 of this pollutant in 2010 could have led to over 65,000 fewer cases in 2010.

4. A new national Air Quality Action Plan was published by the English Government in July of this year, as a response to court orders imposed by the Supreme Court as a result of actions led by Client Earth. The plan presents some important new measures such as clean air zones (CAZ's). This plan is however still seen by the majority of the scientific community as not strong enough to tackle air pollution in the fastest time possible

5. EU courts have threatened infraction action over non-compliance with EU regulations. Under Part 2 of the Localism Act the Government could require local authorities to pay all or part of an infraction fine.

The role of District Councils

6. The Environment Act 1995 requires district councils to carry out periodic review and assessment of air quality within their area. The air quality objectives applicable to Local Air Quality Management (LAQM) in England are set out in the Air Quality (England) Regulations (2000). Short and long term objectives are set for a number of pollutants including nitrogen dioxide and particulate matter.

7. District councils are required to designate an Air Quality Management Area (AQMA), if any of the air quality objectives are not being achieved.

8. Once an AQMA has been designated the district council should prepare an Action Plan that sets out how it will achieve the air quality standards or objectives for the area that it covers.
9. District councils report annually to the Department for Environment, Food and Rural Affairs (Defra) on the results of monitoring in their area and progress with the implementation of their Action Plans.

The role of County Councils

10. Where a district council is preparing an Action Plan, the county council is obliged to submit measures related to their functions (i.e. local transport, highways and public health) to help meet air quality objectives in their local area.

11. Oxfordshire County Council developed Local Transport Plan 4 (LTP4) which contains a commitment to improve public health and wellbeing by increasing levels of walking and cycling, reducing transport emissions, reducing casualties, and enabling inclusive access to jobs, education, training and services.

Air Quality in Oxfordshire

12. Air quality across Oxfordshire is considered to be generally good as the county is largely rural in nature. In the more densely populated areas of the county, and those which experience high traffic flows such as Oxford, Banbury and Bicester, levels of air pollution are of concern. In these areas, road traffic is the most significant source of pollutant emissions.

13. Air quality is regularly monitored at many locations across Oxfordshire. At some locations air quality is at levels where legal intervention is required by Local Authorities. There are currently 13 AQMAs in Oxfordshire, where the annual mean objective for nitrogen dioxide is being exceeded (four in Cherwell, one covering the whole of Oxford city, three in South Oxfordshire, three in Vale of White Horse and two in West Oxfordshire). The table below summarises monitoring results from 2014, 2015 and 2016.

14. The figures in the table below are the average annual concentrations of Nitrogen Dioxide measured by diffusion tube in each of the AQMAs in 2014, 2015 and 2016. The Government objective level is an annual mean concentration of nitrogen dioxide of 40 µg/m^3. **PLEASE NOTE In those AQMAs with more than one diffusion tube the worst i.e. highest result has been used.**

Air Quality Management Areas in Oxfordshire

District	AQMA	NO_2 $\mu g/m^3$ 2014	NO_2 $\mu g/m^3$ 2015	NO_2 $\mu g/m^3$ 2016
Oxford	Whole of city	65	67	61
West	Witney town centre	47	53	71*
	Chipping Norton town centre	58	55	63*
South	Watlington village centre	49	41	50
	Wallingford town centre	41	34	41
	Henley-on-Thames town centre	59	47	47
Vale	Abingdon-on-Thames town centre	45	45	40
	Marcham village centre	50	48	53
	Botley A34	53	48	57
Cherwell	Banbury Hennef Way	79	78	
	Banbury town centre	42	41	
	Bicester town centre	47	46	
	Kidlington Bicester Road	44	41	

*Not a full years data set only 6 month average – so figures cannot be compared

15. The data highlights exceedances of the objective levels in all of the AQMA's.

16. The figures highlight a mixed year for air pollution across the District in comparison to the 2015 data with increases being seen in Marcham, Botley, Watlington and Wallingford and drops in Oxford City and Abingdon with Henley remaining unchanged.

What is being done?

17. The District Councils have either developed, or are in the process of developing Air Quality Action Plans for the AQMAs in their areas.

18. As the cause of all the AQMAs is road traffic, the actions focus on reducing emissions from vehicles and can be grouped into the following themes:
    a. Influencing the development of the Local Transport Plan and area specific strategies to ensure that impacts on air quality are considered at an early stage;
    b. Reducing emissions from transport, for example through the introduction of Low Emission Zones;
    c. Promoting more sustainable forms of transport, particularly electric vehicles;
    d. Encouraging modal shift to more active forms of transport such as walking and cycling;
    e. Education and awareness raising around air quality to promote behavioural change; and
    f. Ensuring that air quality is given due consideration as part of the planning process.

19. Opportunities to draw down funding from a variety of sources to implement measure to improve air quality in Oxfordshire have been taken where possible.

20. Further details of specific action by district can be found in appendix 1.

What could the Health Improvement Board do?

21. Defra's Local Air Quality Management Policy Guidance (PG16) recommends that local Directors of Public Health and 'Health and Wellbeing' boards should work closely with local authorities. Working in partnership will increase support for measures to improve air quality, with co-benefits for all. Defra recommends that the following local action is taken:
    a. Ensuring the Joint Strategic Needs Assessment has up to date information on air quality impacts on the population; and
    b. Working closely with local authority health and air quality officers – e.g. have regular update meetings on key, emerging issues.
    c. That Directors of Public Health/ H&W Boards sign off on air quality Annual Status Reports and Action Plans prior to submission to Defra.

22. Introduce policies that encourage a shift from motorised transport to walking and cycling as this is expected to reduce total vehicle emissions, including particulate pollution. If this could be achieved in towns and cities, then we could expect local improvements in air quality leading to health improvements, as well as additional health benefits through increased physical activity through walking and cycling.

23. To date, aside from Public Health England attendance at our recent air quality meetings there has been no joint working between Oxfordshire Air Quality Partnership and health boards or organisations. We welcome your ideas in finding co-beneficial ways of working and for assisting us in identifying relevant contacts.

Contact officer: Claire Spendley, Environmental Health Officer
Claire.Spendley@southandvale.gov.uk

Appendix 1.
Recent Actions

The launch of the Oxfordshire air quality website (https://oxfordshire.air-quality.info/) in 2015 was a great success and allows users to see real-time air quality data in a visual map based format whilst providing a raft of air quality data and information for Oxfordshire all in one place. The webpage comes complete with a children's section and quiz.

In addition to this the Districts have been working closely with the County Council and as a result the County have approved an air quality appendix to their Local Transport Plan 4, the key themes are;

- Encouraging walking and cycling
- Restricting diesel vehicles in town centres through the introduction of clean air zones
- Working more proactively with the district councils on action planning
- Introducing low or zero emission mass transit vehicles

South specific actions:

- Our low emission strategy underwent 2 rounds of public consultation and is now awaiting licensing committee for a decision on adoption later this year
- Work on actions within our action plan continues, this year we focussed on the provision of electric charging points and on a community cycling project

Vale specific actions:

- Draft developer guidance to be integrated in to the local planning process.

Cherwell specific actions:

- Development of a comprehensive and workable air quality action plan to improve air quality in partnership with other organisations that will assist in the implementation of the measures.

Oxford City Council specific actions

- Requiring AQAs for all planning applications for major developments

- Submitted a successful bid for the provision of electric vehicle charging infrastructure for the use of hackney carriages and private hire taxis in the city.

- Commissioning of a feasibility study investigating the introduction of a zero emission zone in Oxford city centre from 2020 which would be expanded so that the entire city is covered by around 2030/2035. This study was supported by both Oxfordshire county council and Oxford City Council.

- Recruited over 20 participants for the Go Ultra Low Oxford electric charging infrastructure trials –The first phase of the project will see 30 charging stations installed. Ten of these will be available for the general public, 10 for Co-wheels Car Club vehicles, and the remaining for individual households. Installation of the charging stations started in August 2017 and they will be ready for residents and the general public to use in October 2017. The trial will last for 12 months. The best solutions from the trial will then be rolled out in approximately 100 sites across Oxford's residential streets. This is expected to happen in 2018.

- Ran successful "Test Drive the Future" annual event which saw over 600 people attened.

- Working with some of Oxford city's primary and secondary schools. The project aims to install real time, indicative air quality sensors in 6 schools across the city and provides educational material to integrate into the national curriculum

- Increased resourcing of the City Councils Air Quality Officer role, increasing the post from 0.8 to 1 FTE reflecting the importance the City Council places on this matter

Oxfordshire Suicide Prevention

Purpose of the paper

1. The purpose of this paper is to inform the Health Improvement Board on suicide prevention in Oxfordshire. It will provide data on rates of suicide within the county and describe the work of the multi-agency suicide prevention group. It will also advocate that promotion of mental wellbeing is everyone's business and it a significant contributor to suicide prevention. The Health Improvement Board is in a unique position to take on a leadership role for mental wellbeing to encourage, co-ordinate and oversee wellbeing initiatives by a variety of organisations in different settings.

Introduction

2. This paper is to inform the Health Improvement Board on progress in Oxfordshire in relation to Suicide Prevention. It will focus on the data and intelligence relating to suicide nationally and locally, describe the work of the multi-agency suicide prevention group. It also describes the risk factors for suicide and explains how positive mental wellbeing initiatives could contribute to a reduction in self-harm and suicide.

3. Every day in England around 13 people take their own lives. The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Each one of these deaths is a tragedy. Every life lost represents someone's partner, child, friend or colleague and their death will affect people in their family, workplace, school, and residential neighbourhood. This will impact their ability to work effectively, to continue with caring responsibilities and to have satisfying relationships. This in turn significantly raises their own risk of future mental ill health and suicide.

Data on Suicide

4. Suicide data is presented as 3-year rolling data as the rates are subject to variation due to the very small numbers involved at a local level which makes it difficult to draw conclusions.

5. National data
    - Suicide is the leading cause of death in England for adults aged under 50 years.[1]
    - There were 6,122 cases of suicide in the United Kingdom in 2014 (all ages), with a suicide rate of 10.8 per 100,000.
    - This number has increased year on year since 2008, peaking in 2013 at 6,233 deaths.
    - In 2014 there were 149 children aged 10-19 years in England who died by suicide
    - The suicide rate in England for children and young people 10-19 years has remained relatively stable since 2005, however the rate in 15-19 year olds has risen in the last 3 years.

6. Oxfordshire data
    - The suicide rate in Oxfordshire in 2013-15 was 9.4 per 100,000 of population (all ages) compared to the England rate of 10.1 per 100,000.

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015

- The rate in Oxfordshire has not fluctuated dramatically in the last 10 years and the increase in suicide rates noted nationally since the economic crisis of 2008 has not been experienced locally.
- Compared to other Local Authority areas in the South East, Oxfordshire's suicide rate is slightly lower than the South East rate of 10.2 per 100,000
- In 2014 there was one suicide of a young person aged under 18 years.

National Suicide Guidance

7. The need to develop local suicide prevention strategies and action plans that engage a wide network of stakeholders in reducing suicide is set out in two national documents; the governments national Strategy for England, *Preventing suicide in England: a cross government outcomes strategy to save lives*[2] and the Mental Health Taskforce's report to NHS England, *The five year forward view for mental health*[3] as a key recommendation.

8. The national strategy outlines two principle objectives to reduce the suicide rate in the general population and to provide better support for those bereaved or affected by suicide. There are six areas for action:
    1. Reduce the risk of suicide in key high-risk groups
    2. Tailor approaches to improve mental health in specific groups
    3. Reduce access to the means of suicide
    4. Provide better information and support to those bereaved or affected by suicide.
    5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
    6. Support research, data collection and monitoring.

9. From the All Party Parliamentary Group on Suicide and Self-Harm Prevention[4] came 3 strong recommendations:
    - carrying out a **suicide audit** which involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups.
    - the development of a **suicide prevention action plan** setting out the specific actions that will be taken, based on the national strategy and the local data, to reduce suicide risk in the local community.
    - the establishment of **a multi-agency suicide prevention group** involving all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.

    Local Authority Public Health Teams are tasked with coordinating work for suicide prevention through multi-agency working, however this is not a mandated function.

Oxfordshire Suicide Audit

10. Suicide audits are typically undertaken every 3 years. In 2016 the Public Health Directorate collected and analysed suicide data from the calendar year 2014 to inform the development of the local suicide prevention plan.

[2] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[3] https://www.england.nhs.uk/mentalhealth/taskforce/
[4] https://www.papyrus-uk.org/news/archive/item/all-party-parliamentary-group-report-on-local-suicide-plans-in-england

11. The information was sourced by reviewing coroners' records to gain a detailed retrospective insight into the circumstances of individual suicides. Coroners investigate all deaths that are considered to have been sudden, violent or not due to natural causes.

12. Findings from the audit
    - Overall 60 suicides occurred in 2014 and were spread fairly evenly around the County
    - There was one suicide of a young person aged under 18 years
    - 77% of deaths were in men and the age-band with the highest number of deaths was 45-59 year olds (40%)
    - Almost half of the cases lived alone which is significantly higher than the county average of 27%
    - Most suicide's occurred in the individual's own home (60%), with hanging the most common means used (52%) for both men and women
    - No correlation was found between suicide and socio-economic deprivation, measured using area level data from the Index of Multiple Deprivation 2015[5]
    - The following risk factors were present most commonly; formal or informal diagnosis of depression, relationship problems, job or work stress and previous suicide attempt

Oxfordshire Suicide Prevention Action Plan

13. The aim of the suicide prevention plan is to combine actions by all agencies in Oxfordshire to reduce the number of suicides in Oxfordshire (see appendix 1). The plan includes reducing the risk within key high risk groups, reducing access to means of suicide, suicide awareness training for partner agencies, monitoring suicide data to provide timely support to bereaved people and to respond to emerging patterns, increasing trends or new methods of death. Oxfordshire's action plan is agreed by the multi-agency suicide prevention group and is reviewed at each meeting.

Oxfordshire Multi-Agency Suicide Prevention Group

14. The purpose of the multi-agency suicide prevention group is to
    - Understand patterns of suicide and collate data
    - Steer the development of the local suicide prevention work
    - Develop and co-ordinate responses to suicide and activities to reduce suicides
    - Monitor progress towards reducing suicide and evaluating the impact of interventions

15. Membership of a multi-agency group does depend on local context in order to reflect a community wide approach. Current partner agencies who attend Oxfordshire's group are from the following organisations:
    - Thames Valley Police
    - Oxford Health NHS Foundation Trust
    - Oxford University Hospitals NHS Foundation Trust
    - Oxford University Student Welfare and Support
    - University of Oxford Centre for Suicide Research

[5] Department for Communities and Local Government (2016) English indices of deprivation 2015. Available from: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

- Coroners
- Public Health England
- SeeSaw
- Cruse
- Oxford Samaritans
- Oxfordshire Clinical Commissioning Group
- Oxfordshire Safeguarding Adult Board
- Oxfordshire Safeguarding Children Board
- HMP Bullingdon
- Probation Service

16. The meetings are chaired by Oxfordshire County Council, Public Health Directorate. There are meetings twice a year with members of the group working on the action plan between meetings. There are also additional agencies whom form part of the wider partnership network and are involved as required by members of the group.

Risk Factors for Suicide

17. In March 2017 the Health Select Committee published its report on the action which is necessary to improve suicide prevention in England. It reported that for many people who experience suicidal thoughts, certain challenges may push them towards a crisis. These challenges might include bereavement, poverty, unemployment, relationship breakdown, gambling, housing issues, alcohol and drug misuse, financial problems or any one of a number of other issues. In many of these situations, the development of suicidal thoughts could have been avoided if appropriate support had been provided for an individual's particular situation[6].

18. Self-harm is the single biggest indicator of suicide risk. Approximately 50% of people who have died by suicide have a history of self-harm. When the Government published its third progress report of the cross government suicide prevention strategy in January 2017[7], a key focus of this update was to expand the strategy to include self-harm prevention in its own right.

19. A study by National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[8] found that there were 10 common themes in suicide by children and young people are
    - family factors such as mental illness
    - abuse and neglect
    - bereavement and experience of suicide
    - bullying
    - suicide-related internet use
    - academic pressures, especially related to exams
    - social isolation or withdrawal
    - physical health conditions that may have social impact
    - alcohol and illicit drugs
    - mental ill health, self-harm and suicidal ideas
20. The research also explains that self-harm is strongly associated with an increased risk of future suicide and nationally the self-harm rates in young people appear to be rising.

[6] https://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/108703.htm
[7] https://www.gov.uk/government/publications/suicide-prevention-third-annual-report
[8] http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

21. National guidance[9] identifies that some population groups are particularly vulnerable to suicide clusters, including young people, people with mental health problems and prisoners. Also clusters of suicidal behaviour are more common in certain settings including schools, workplaces, psychiatric facilities and prisons.

Mental Wellbeing

22. Mental health is now recognised as being profoundly important to growth, development, learning and resilience. Mental wellbeing protects the body from the impact of life's stresses and traumatic events, and enables the adoption of healthy lifestyles and the management of long term illness. This in turn provides a significant contribution to suicide prevention.

23. Mental wellbeing is a valuable resource for individuals, families and communities. It is associated with better physical health, positive interpersonal relationships and socially healthier societies. It helps people to achieve their potential, realise ambitions, cope with adversity, work productively and contribute to their community and society.

24. Responsibility for improving mental wellbeing is everyone's business. At the same time, this way of working can lack direction and be fragmented. The Health Improvement Board is in a unique position to take on a leadership role for mental wellbeing to encourage, co-ordinate and oversee wellbeing initiatives by a variety of organisations in different settings.

Recommendation

25. The overall recommendation is to continue to reduce the risk of suicide in young people and adults by all partner agencies across Oxfordshire working to address the wider determinants of health and wellbeing. This can be achieved through the following:

    1. Focusing on improving the mental wellbeing of the population will go a significant way to combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. With the support of the Board, Public Health would like to facilitate a workshop bringing partners together to evidence what is already happening to promote mental wellbeing in the county which will inform an Oxfordshire wide Mental Wellbeing Framework.

    2. Public Health will continue to coordinate the work of all partners in the multi-agency suicide prevention work and to monitor suicide data. This will include the progression of the real time data surveillance project with Thames Valley Police and the Coroner's office and monitoring progress for the suicide prevention action plan.

    3. The Child Death Overview Panel process will continue to identify actions for partner agencies following the death of a young person from suicide.

Donna Husband
Head of Commissioning - Health Improvement
July 2017

[9] https://www.gov.uk/government/publications/suicide-prevention-identifying-and-responding-to-suicide-clusters

APPENDIX 1 – Oxfordshire Suicide Prevention Plan

Multi-Agency Group Members: Oxfordshire County Council Public Health (PH), Thames Valley Police (TVP), Coroners, SeeSaw, Cruse, Oxford Samaritans (OS), Oxford Health (OH), Oxford University Hospitals (OUH), University of Oxford (UO), National Probation Service, Network Rail, Centre for Suicide Research University of Oxford (CSR), Oxfordshire Clinical Commissioning Group (OCCG), HMP Bullingdon, Public Health England, (PHE), Oxfordshire Safeguarding Children's Board (OSCB), Oxfordshire Safeguarding Adult Board (OSAB)

Theme	Action Area	Partners
Leadership and Multi-Agency Group (MAG)	1. Build upon the work of the Multi-Agency group and hold 2 meetings a year 2. MAG oversee the delivery of the Suicide Prevention Plan and update the action plan with progress each year 3. Strategic engagement with key Oxfordshire Partnership Boards: e.g. OSCB, OSAB, Health Improvement Board	ALL ALL PH
Evidence, data and intelligence	4. Collect data through Thames Valley Real Time Data Project and Inquests to share with MAG and inform approach in Oxfordshire 5. Incorporate Suicide and Self-harm data into the Joint Strategic Needs Assessment for Oxfordshire 6. Work to identify clusters, local hotspots and opportunities to reduce access to means for suicide 7. Complete Centre for Suicide Research University of Oxford annual report on self-harm 8. Share Oxfordshire self-harm data nationally with All Parliamentary Group on Prevention of Suicide and Self-Harm	TVP, PH, Coroners, PH ALL CSR CSR
Evaluation and Dissemination	9. Share findings from data collection and intelligence in a timely manner to MAG and wider organisations as required, to include Self-Harm Network, OSCB and OSAB serious case reviews and learning	ALL
Postvention	10. Strengthen, develop and promote support avaliable for people bereaved or affected by suicide: this will include families and friends, workplaces, schools and colleges, GP Practices	SeeSaw, Cruse, OH, TVP, OCCG
Suicide Prevention Awareness	11. Develop and deliver key messages and communications about suicide prevention to key groups (men and students) and workplaces 12. Primary prevention and education in schools and universities 13. Conference for World Suicide Prevention Day (September)	ALL OH, UO, OS OH
Mental health and Wellness promotion	14. Increase awareness of self-harm and suicide amongst key groups; schools, universities, workplaces 15. Promotion of mental wellbeing to enable people to adopt and maintain healthy lifestyles	ALL ALL

Training	16. Work to ensure key staff groups that come into contact with people at risk of suicide are equipped to provide appropriate adequate support e.g. Probation staff, Primary Care Staff, Schools	ALL
Suicide Intervention and on-going clinical/support services	17. Effective suicide intervention services will provide a range of options depending on the severity of the situation using evidence based programmes and processes 18. Establish pathways into appropriate community support for people who are at risk of self-harm or suicide following admission to EDPS Self-Harm service at John Radcliffe Hospital	OH, OCCG OH, OCCG
Capacity building/sustainability	19. Embed suicide prevention into relevant strategies and plans 20. Integrate suicide prevention into existing approaches to community-asset building and self-care	ALL ALL

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Loneliness is everybody's business: working together to combat chronic loneliness in Oxfordshire

A discussion paper for Oxfordshire Health Improvement Board, Sept 2017

This brief discussion paper is written as a supplement to the 2016 Age UK report 'No one should have no one: working to end loneliness in older people' and focuses on ways in which we can work together across Oxfordshire to combat chronic or persistent loneliness.

The paper builds on discussions at and arising from the Oxfordshire Jo Cox Loneliness Summit, hosted in Oxford on 14th July, 2017, which brought together a hundred people to raise awareness of loneliness and what we know about avenues out of loneliness, particularly in later life, to spotlight good practice and to pledge action.

In 2015, Age UK and The Campaign to End Loneliness published 'Promising approaches to reducing loneliness and isolation in later life' www.ageuk.org.uk/reducing-loneliness which identified the importance of combined, system-wide approaches and set out a new **framework** for tackling loneliness. The framework suggests that all of the following need to be in place to tackle loneliness systematically and successfully:

- **foundation services** to reach and understand the specific needs of those experiencing loneliness
- **direct interventions** (a menu of services) to improve the number and quality of relationships people have
- **gateway services** (transport and technology) to help people retain connections and independence)
- **structural enablers** (neighbourhood approaches, community development, volunteering, positive ageing) to create the right conditions in local communities to reduce the numbers of people experiencing or at risk of loneliness.

The Board is asked to note the importance of system-wide approaches and to consider the following actions at strategic, organisational, community and individual level:

Working together at a strategic level

The following strategic actions are all worthy of consideration:

- increasing the understanding of loneliness and its impact system-wide through having more information about loneliness in the JSNA
- making tackling loneliness a priority of the Joint HWB Strategy, with tangible action(s) eg support for 'social prescribing'

- review existing ways of measuring progress and agree on a system-wide approach. A chart on the current Four Measures of Wellbeing, which includes some of the technical detail, can be found here: http://insight.oxfordshire.gov.uk/cms/personal-wellbeing-201112-201516. Campaign to End Loneliness have produced guidance on 'Measuring your impact on loneliness in later life', which contains some useful tools (copy attached).

Age UK Oxfordshire is in discussion with a range of organisations that have a focus on loneliness to set up a time-limited "action alliance" to review current activity against the framework and to facilitate joint working.

Working at an organisational level

We can all consider one or more of the following initiatives within our own organisations:

- raising awareness of loneliness, its impact and what can be done to tackle it amongst staff and the wider public, including making leaflets and other resources available
- urging staff to volunteer and considering actively supporting volunteering in work hours (eg as little as 30mins per week would enable staff to make a regular, weekly phone call to an isolated and / or housebound person. Across all our organisations, that would allow us to make a sea change
- prioritising loneliness and isolation for the support given to VCS organisations through grants
- facilitating road closures to enable community events to happen.

Working at community level

There are myriad ideas to stimulate new opportunities to help people connect at a community level, but here are a few that we could all support:

- encourage a **Good Neighbour Scheme** in every community in Oxfordshire: we currently have 80+ and rising. Their role in providing local transport, befriending and shopping and other small tasks is a vital tool to combat loneliness. Contact oxfordshiregns@hotmail.co.uk
- the **WI** have resolved to take action in local communities to address loneliness and will be launching their campaign on 13th November, World Kindness Day. They will be keen to work with others coordinating local work. Contact local WIs.
- intergenerational initiatives tackle loneliness across generations. www.fullcircleoxon.org.uk
- **The Big Lunch** initiative is a Lottery funded national initiative to bring communities together. They produce packs to help communities to organise events. www.edenprojectcommunities.com

Individually.....

.....we can all have an impact. A little kindness goes a long way!

Penny Thewlis, Sept 2017

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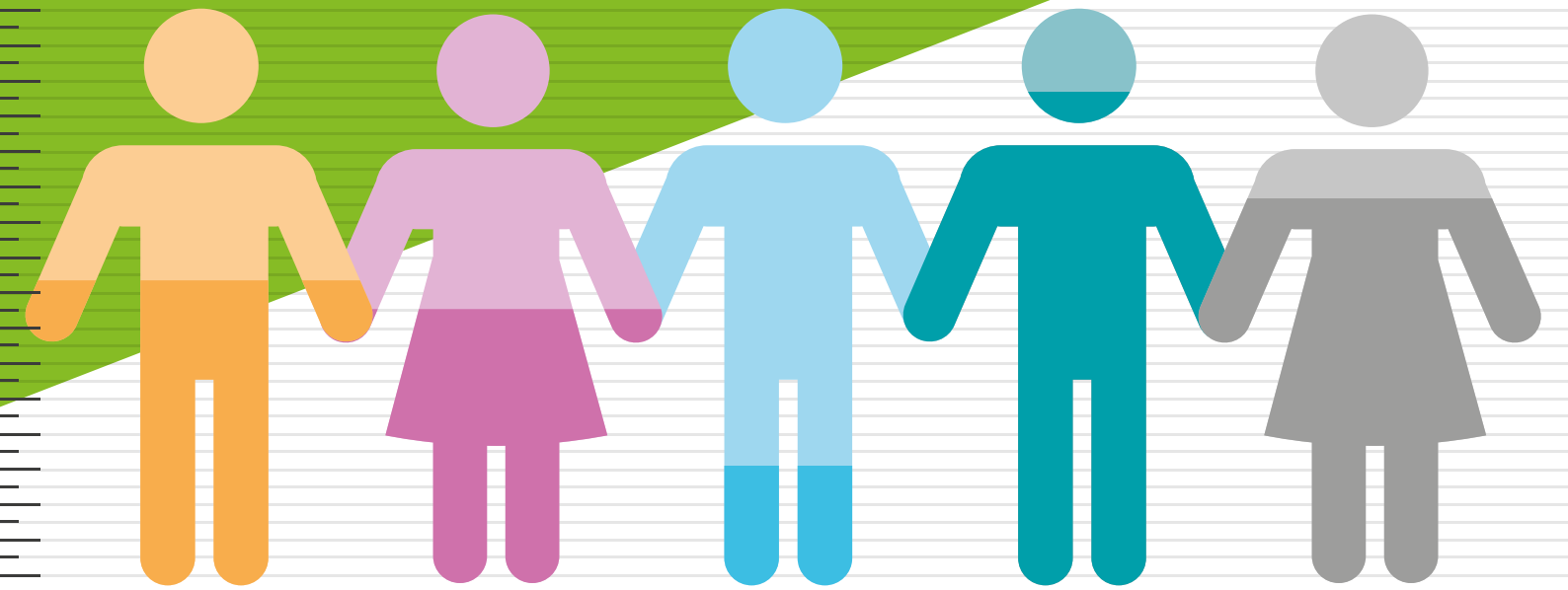
MEASURING YOUR IMPACT ON LONELINESS IN LATER LIFE

Campaign to EndLoneliness
CONNECTIONS IN OLDER AGE

Contents



What does this guidance cover?

Are you working to prevent or reduce loneliness in your community?

Can you articulate the difference you are making to the lives of older people?

We're all working in an increasingly competitive funding environment, and we all need to be able to demonstrate robustly that we make a difference. Funders across the public, voluntary and private sectors also face their own financial pressures and need evidence that the programmes they fund are delivering real change for the people they support.

This guidance offers information and advice on choosing and using a scale to measure the impact of your services on loneliness in older age.

Why measure loneliness?

In a recent report, published with Age UK, we demonstrate that there is a lack of good quality evidence on the impact of different types of services on loneliness.[1] This concerns us, as feeling lonely is linked to risk of an earlier death[2], depression[3], dementia[4] and poor self-rated health[5]. We need to know more about 'what works' to prevent or alleviate it.

You might be thinking about measuring how your service is reducing social isolation or improving wellbeing. Whilst isolation and wellbeing are linked to feelings of loneliness, they are distinct experiences and concepts (we talk more about this later on, in the Introduction to this guidance). We would like to encourage you to measure loneliness for two reasons. Firstly, loneliness has a negative impact on our quality of life, and mental and physical health. Secondly, measuring loneliness will help you to demonstrate the positive impact of your work on the way people ***feel*** about their relationships and connections – and give you a more detailed understanding than a wellbeing measure can.

1 Jopling, K. 2015. *Promising approaches to reducing loneliness and isolation in later life.* Age UK and Campaign to End Loneliness: London.

2 Penninx, B., van Tilburg, T., Kriegsman, D. Deeg, D., Boeke, J. and van Eijk, J. 1997. Effects of Social Support and Personal Coping Resources on Mortality in Older Age: The Longitudinal Aging Study Amsterdam. *American Journal of Epidemiology.* 146(6) pp. 510-519

3 Green B. H, Copeland J. R, Dewey M. E, Shamra V, Saunders P. A, Davidson I. A, Sullivan C, McWilliam C. 1992. Risk factors for depression in elderly people: A prospective study. *Acta Psychiatrica Scandinavica* 86(3) pp.213–7

4 Holwerda, T. J. Deeg, D., Beekman, A. van Tilburg, T.G., Stek, M.L., Jonker, C., and Schoevers, R. 2012. Research paper: Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL) *Journal of Neurology, Neurosurgery and Psychiatry*

5 Stickley, A., Koyanagi, A., Roberts, B., Richardson, E., Abbott, P., Tumanov, S. and McKee, M. 2013. Loneliness: Its Correlates and Association with Health Behaviours and Outcomes in Nine Countries of the Former Soviet Union. *PLOS One*

Why use a scale?

A scale is simply a way of numerically measuring an opinion or emotion, and it one way to gather evidence about the effectiveness of a service. There are other approaches to collecting information, for example qualitative methods collect evidence without focusing on numbers. They can be used to gain an in-depth understanding about ***how*** or ***why*** someone came to feel lonely, and allow you to produce detailed case studies about how you've helped prevent or alleviate it. Examples of qualitative research techniques include one-to-one interviews and focus groups.

However, facing continued financial pressures, services across the health, social care and voluntary sectors need more 'hard' evidence on the effectiveness of loneliness interventions. Using a scale will enable you to ask about loneliness in a more structured way – and produce numbers that can help you illustrate ***how much*** of a difference you've made. Using a scale could also allow you to compare the impact of different activities or services on loneliness.

Choosing the right scale for you

As you read through this guidance and look at the different scales we suggest, you may also want to bear the following questions in mind to help you make a decision about the right tool for you:

- Are you comfortable asking **direct questions** about loneliness or painful experiences?
- How much **time** do you have to ask people about loneliness?
- **Who** will be asking the questions, and analysing the results?
- What does your service or activity **do**? For example, are you only addressing the 'social' dimension of loneliness?
- How much **time and money** can you allocate to monitoring and evaluation?

Summary of Scales

In this guidance we describe four different scales, which have been developed by different people, and have their own strengths and limitations. We encourage you to read on to learn more about their particular strengths and limitations, but this page presents their 'vital statistics' – four initial categories to help you compare them:

- **Length** – how many questions does the scale contain?
- **Language** – are the questions negatively or positively worded, or both?
- **Initially developed for...** – was this originally intended for use by researchers or services?
- **Mentioning the 'L' word** – does it ask directly about loneliness, or ask around the topic?

The Campaign to End Loneliness Measurement Tool

Scale 1

Length: 3 Questions

Language: Positive wording

Initially developed for: Service providers

Does it mention loneliness? No

This scale is for you if: you want a short and sensitively-worded tool that is easy to use.

De Jong Gierveld Loneliness Scale

Scale 2

Length: 6 Questions

Language: Mixes positive and negative wording

Initially developed for: Researchers

Does it mention loneliness? No

This scale is for you if: you want an academically rigorous tool that distinguishes between different causes of loneliness.

The UCLA Loneliness Scale

Scale 3

Length: 3 Questions

Language: Negative wording

Initially developed for: Service providers

Does it mention loneliness? No

This scale is for you if: you want a short and academically rigorous tool, with a simple scoring system.

Single-Item 'Scales'

Scale 4

Length: 1 Question

Language: Negative wording

Initially developed for: Researchers

Does it mention loneliness? Yes

This scale is for you if: you want to get to the heart of the issue with just one question.

Introduction

In 2013, a survey of Campaign to End Loneliness supporter organisations found over half said that they would value more support in evaluating their impact on loneliness. The brief was clear: services said they wanted a straightforward, flexible loneliness measurement tool that was suitable to use with older people who may be vulnerable.

What is loneliness?

It may surprise you to learn that there is no agreed definition of "loneliness" in research. One explanation of loneliness is that it is a painful feeling that occurs when this is a gap, or a mismatch, between the number and quality of social relationships and connections that we have, and those we would like.[6]

Others suggest that there are two dimensions to loneliness: social and emotional. Social loneliness occurs when someone is missing a wider social network and emotional loneliness is caused when you miss an "intimate relationship".[7]

On the whole, loneliness is described as an unwelcome, painful and unpleasant feeling.[8] There is a general agreement that loneliness is distinct from social isolation and wellbeing. Social isolation is an objective state that only measures the number and/or frequency of social contact.[9] Wellbeing is a broader concept, which examines our psychological and physical resources, as well as social connections.[10]

Loneliness is a fluid experience: it can come and go over a short time, or persist in the longer term. Recent research found that over 8 years, 7% of older people in England said they were always lonely, 10% of people moved out of loneliness, 9% moved into loneliness and 9% fluctuated in and out of loneliness.[11]

It is worth thinking about what the different tools and questions in this document are measuring, and how this relates to your service or activity.

6 Perlman, D. and Peplau, L. A. Chapter 2: Toward a Social Psychology of Loneliness, in Duck and Gilmour (eds.) 1981. *Personal Relationships in Disorder.* London: Academic Press.

7 de Jong Gierveld, J. and van Tilburg, T. 2006. 6-Item Scale for Overall, Emotional, and Social Loneliness: Confirmatory Tests on Survey Data *Research on Ageing* 28(5) pp. 582-598

8 Hauge, S. and Kirkevold, M. 2010. Older Norwegians' understanding of loneliness. *International Journal of Qualitative Studies on Health and Well-being* 5: 4654

9 Victor, C., Scambler, S., Bond, J. and Bowling, A. 2001. Being alone in later life: loneliness, social isolation and living alone. *Clinical Gerontology* 10(04) pp. 407 - 417

10 Dodge, R., Daly, A., Huyton, J., & Sanders, L. 2012. The challenge of defining wellbeing. *International Journal of Wellbeing* 2(3), 222-235.

11 Victor, C. 2013. Professor Christina Victor, Brunel University - Who is lonely and when? [video online] Available at: https://www.youtube.com/watch?v=U7u1kvDFAng [Accessed 15 March 2015]

Who experiences loneliness?

Loneliness is also a common emotion and it is likely that, at some point in our lives and whatever our age, we will experience it. Various studies estimating the levels of loneliness in Great Britain show that 5 – 16% of people aged 65 or over report feeling lonely all or most of the time and up to a further 30% say they feel lonely "sometimes".[12] As our population ages, there may be an increase in the real numbers of older people experiencing loneliness. You can learn more about the triggers for loneliness in the Campaign's recent report: ***Hidden Citizens: how can we identify the most lonely adults?***[13]

Why evaluate?

Evaluation can help you to demonstrate that you are really helping the people your service has contact with. It can also help you better understand how a particular service or activity works. Anyone can collect and use data, and you needn't be discouraged from evaluating your intervention just because you don't have past experience of doing this.

In essence, planning an evaluation involves asking yourself the following things:

- What are your desired outcomes
- What services or mechanism is delivering these outcomes
- How they will be measured
- Who will measure them – and when
- How long the evaluation will run for
- How will the information be used

A good evaluation has been shown to have two overarching principles. Firstly, ***independence***, i.e. those carrying out an evaluation can produce independent and objective reports. Secondly, ***transparency*** – the research methods used and findings are accessible and available to all. There are a number of comprehensive resources – from the Charities Evaluation Services[14] and Joseph Rowntree Foundation[15] – about evaluating the work of charities and community projects, which may be helpful to read alongside this guidance.

12 Cann, P. and Jopling, K. 2011. *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness.* Oxfordshire: Age UK Oxfordshire. http://tinyurl.com/njsgx6z

13 Goodman, A., Adams, A., & Swift H.J. 2015. *Hidden citizens: How can we identify he most lonely older adults?* The London: Campaign to End Loneliness. http://www.campaigntoendloneliness.org/hidden-citizens/

14 Charities Evaluation Services. *Tools and Resources:* http://www.ces-vol.org.uk/tools-and-resources/tools-and-resources [Accessed 27 April 2015]

15 Joseph Rowntree Foundation. *Evaluating community projects A practical guide:* http://www.jrf.org.uk/system/files/1859354157.pdf [Accessed 27 April 2015]

About these scales

In the following section, we have described and provided advice on how to use the following four loneliness scales:

- **The Campaign to End Loneliness Measurement Tool**
- **The De Jong Gierveld Loneliness Scale**
- **The UCLA Loneliness Scale**
- **Single-item 'scale'**

We have chosen these four scales because we think they have a range of different strengths and limitations. For example, the Campaign tool has been developed specifically for people providing services or running activities, whilst the Gierveld scale is a well evaluated measure of different types of loneliness.

However, you'll see that loneliness scales can vary in a number of ways. This is because they have been developed for different contexts and circumstances. For example, the De Jong Gierveld Scale was developed in the Netherlands for use in large surveys but has since been adapted for smaller questionnaires and evaluating interventions.

All the scales in this publication can measure the ***intensity*** of loneliness and, if you use them regularly, how it ***changes over time***. However, you can only ask about how often loneliness occurs in someone's daily life by asking this directly, for example: in the past month, how often would you say you felt lonely?

There are a number of limitations to these scales that you should bear in mind.

- Firstly, they only give you a 'snapshot' of how someone is feeling on a particular day because feelings of loneliness can fluctuate
- Whilst the scales are designed to pick up small changes in loneliness we cannot know, exactly, the intensity that the different scores represents. For example someone with a score of "4" may not be half as lonely as someone with a score of "8" (although we can confidentially say one is less lonely than the other)
- It may also be difficult to tell if another person, experience or circumstance – independent of your service – is having a positive or negative impact on changes in someone's loneliness. However, we do make some suggestions for how to overcome this in "Asking open follow-up questions" on page 27)

The following sections outline the structure and design of four different scales, explains how to score and interpret your results, and sets out their strengths and limitations.

The Campaign to End Loneliness Measurement Tool

Scale 1

This tool contains the following statements:

1. **I am content with my friendships and relationships**
2. **I have enough people I feel comfortable asking for help at any time**
3. **My relationships are as satisfying as I would want them to be**

To each of these statements, ask your respondents to give one of the following answers:

Strongly Disagree / Disagree / Neutral / Agree / Strongly Agree / Don't Know

In order to avoid a 'response set' – where people give the same answer to a question almost by rote, it is important to alternate the direction of answers. E.g. for questions 1 and 3 you start with the 'Strongly Disagree' end of the scale and for question 2 you start with 'Strongly Agree'.

Asking all three of these questions together produces the most reliable information on people's experience of loneliness. You can see a copy of the questions in full scale form in Appendix A.

Using this scale: how to score and interpret your results

In order to score somebody's answers, their responses should be coded as follows:

Response	Score
Strongly disagree	4
Disagree	3
Neutral	2
Agree	1
Strongly agree	0

The scores for each individual question need to be added together. This gives a possible range of scores from 0 to 12, which can be read as follows:

So someone with a score of 0 or 3 can be said to be unlikely to be experiencing any sense of loneliness, whereas anyone with a score of 10 or 12 is likely to be experiencing the most intense degree of loneliness. Scores in-between these two extremes are on a spectrum of feelings of loneliness; however it is not possible to say that each point on the scale represents an equal increase or decrease in the degree of loneliness someone might be feeling.

The main purpose of this tool is to measure the change that happens as a result of an intervention to address loneliness. The key thing to focus on is how people's scores change over time. If someone scores "9" at one point, and then "7" three months later (after having been matched with a befriender, for example) it is reasonable to assume that their experience of loneliness has decreased. You should not say "this person's loneliness has decreased by 22%" because it is not possible to say by how much it has decreased – just that it has improved.

SUMMARY

The Campaign to End Loneliness Measurement Tool

Scale 1

Length: **3 Questions**

Language: **Positive wording**

Initially developed for: **Service providers**

Does it mention loneliness? **No**

This scale is for you if: **you want a short and sensitively-worded tool that is easy to use.**

STRENGTHS

- **Positive language about a tricky issue:** The particular strength of this tool is that it is written in language which is non-intrusive and unlikely to cause any embarrassment or distress.
- **Practical:** It is therefore a very practical resource for organisations in the field to use in their face-to-face work with older people.
- **Co-designed:** It has been designed with a number of different people and organisations, to try and ensure it is appropriate for a ranges of contexts.
- **Length:** It has been kept as short as possible and is easy to score.
- **Validity:** The tool has undergone academic tests to ensure it is valid and reliable.

LIMITATIONS

- **Newness:** This tool has not yet been used extensively by services, so we do not yet know how it picks up changes over time – although the Campaign to End Loneliness will be working with services in 2015 and 2016 to monitor how it performs, and it worked well in an initial pilot.
- **Only using positive language:** The use of only positive worded questions could also lead to respondents under-reporting their loneliness, although we cannot test for this.
- **Not a screening tool:** Finally, we strongly advise organisations not to use these questions as a "screening tool" to establish eligibility to their services. It has not been designed for this purpose and may therefore give misleading results.

How was this tool developed?

All tools should be based upon a way of seeing the issue (a conceptualisation) and the Campaign to End Loneliness Measurement Tool is based upon the following definition: loneliness occurs when there is a gap between the number and quality of relationships and contacts that we have, and those that we want. This is sometimes known as a cognitive discrepancy theory of loneliness.[16]

This tool was developed over the course of 2014 by the Campaign, in partnership with over 50 older people, service providers, commissioners and housing associations. Three focus groups were held with older people in Bristol and London. These were followed by three design workshops, during which the organisations and older people present created an outcome 'map' of the steps that can be taken to address loneliness, and wrote questions reflecting these outcomes.

These draft questions were then reviewed and short-listed. Four prototype tools were drafted, and voted upon, and two prototypes were tested across 18 organisations and 785 older people (over 350 people per tool), alongside the De Jong Gierveld Scale which is considered by many researchers specialising in older age as the gold standard for measuring loneliness.

A statistical validation process was conducted on the results, and the tool that was shown to be the most accurate measure of loneliness was selected. You can request a report from the Campaign that explains this validation process in more detail, if you are interested in learning more.[17]

16 Perlman, D. and Peplau, L. A. Chapter 2: Toward a Social Psychology of Loneliness, in Duck and Gilmour (eds.) 1981. *Personal Relationships in Disorder.* London: Academic Press.

17 Please email info@campaigntoendloneliness.org.uk

The De Jong Gierveld 6-Item Loneliness Scale

Scale 2

In this 6-item scale, 3 statements are made about 'emotional loneliness' and 3 about 'social loneliness'. (Social loneliness (SL) occurs when someone is missing a wider social network and emotional loneliness (EL) is caused when you miss an "intimate relationship".[18])

1. **I experience a general sense of emptiness [EL]**
2. **I miss having people around me [EL]**
3. **I often feel rejected [EL]**
4. **There are plenty of people I can rely on when I have problems [SL]**
5. **There are many people I can trust completely [SL]**
6. **There are enough people I feel close to [SL]**

The scale generally uses three response categories: **Yes / More or less / No**

See Appendix B for the scale and responses in full.

Using this scale: how to score and interpret your results

To score the answers to the scale, the neutral and positive answers are scored as "1" on the negatively worded questions (in this instance, questions 1-3). On the positively worded items (questions 4-6), the neutral and negative answers are scored as "1". Therefore, someone's responses to the negative, emotional loneliness questions should be coded as follows:

Response	Score
Yes	1
More or less	1
No	0

To score somebody's answers to the positive, social loneliness questions, use the following coding:

Response	Score
Yes	0
More or less	1
No	1

18 de Jong Gierveld, J. and van Tilburg, T. 2006. 6-Item Scale for Overall, Emotional, and Social Loneliness: Confirmatory Tests on Survey Data Research on Ageing 28(5) pp. 582-598

Note: this does mean that an answer of 'more or less' is given the same score as 'yes' or 'no', depending on the question. This produces an emotional loneliness score, ranging from 0 (not emotionally lonely) to 3 (intensely emotionally lonely) and a social loneliness score, also ranging from 0 (not socially lonely) to 3 (intensely socially lonely). The scores for each individual question can be added together although you should also look at the individual scores for emotional and social loneliness. This gives a possible range of scores from 0 to 6, which can be read as follows:

You can use the complete scale, or the 3 question emotional or social loneliness subscales separately.

SUMMARY

De Jong Gierveld Loneliness Scale

Scale 2

Length: 6 Questions

Language: Mixes positive and negative wording

Initially developed for: Researchers

Does it mention loneliness? No

This scale is for you if: you want an academically rigorous tool that distinguishes between different causes of loneliness.

STRENGTHS

- **Different types of loneliness:** The focus on both emotional and social loneliness produces results that can give insight into why someone might be experiencing loneliness. For example, are they lonely because they'd like larger social networks, or is it because of the loss of a key relationship?
- **Designed for older people:** The Gierveld scale was designed for use with older people, and also tested with large samples of people aged 18+.
- **Extensively used and tested:** This scale is widely used across Europe, and very well-tested and evaluated for use in a number of languages and countries.
- **Avoids automatic answers:** The mix of positive and negative can help avoid a 'response set' – where someone falls into giving automatic answers rather than considering what they are asked.

LIMITATIONS

- **Length:** a significant limitation – for service providers at least – is its length, which can make it difficult to insert into existing monitoring and evaluation. This could be because it was initially designed for use by researchers and larger population surveys.
- **Tricky questions on a tricky subject:** Some staff or volunteers may also find it difficult to ask negatively-worded questions, and may require some support and training to ask these sensitively.

How was this tool developed?

The scale was developed in the Netherlands in the early 1980s and was initially based on Weiss's 1973 theory which defines loneliness as a subjective experience that occurs when the number of friendships or relationships someone has is smaller than desired (social loneliness) or when someone is missing intimacy from their relationships, friendships or acquaintances (emotional loneliness). 34 questions were initially developed in the 1980s by analysing over 100 accounts written by people experiencing loneliness. The questions were then tested with a further 59 men and women, and refined to pick up less intense feelings of loneliness.

From this long-list of questions, an 11 question-long scale was developed with six questions asking about emotional loneliness, and five asking about dimensions of social loneliness. This was piloted and used extensively before a shorter 6 question version was created in 2006 for use in larger surveys. The shorter version of the scale has been tested for reliability and validity in seven countries, including the Netherlands, France, Russia and Japan.

The UCLA 3-Item Loneliness Scale

Scale 3

This scale comprises 3 questions that measure three dimensions of loneliness: relational connectedness, social connectedness and self-perceived isolation. The questions are:

1. **How often do you feel that you lack companionship?**
2. **How often do you feel left out?**
3. **How often do you feel isolated from others?**

The scale generally uses three response categories: **Hardly ever / Some of the time / Often**

See Appendix C for the scale and responses in full.

Using this scale: how to score and interpret your results

In order to score somebody's answers, their responses should be coded as follows:

Response	Score
Hardly ever	1
Some of the time	2
Often	3

The scores for each individual question can be added together to give you a possible range of scores from 3 to 9. Researchers in the past have grouped people who score 3 – 5 as "not lonely" and people with the score 6 – 9 as "lonely".[19]

19 Steptoe, A., Shankar, A., Demakakos, P. and Wardle, J. 2013. Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences*. 110(15) pp.5797–5801

SUMMARY

The UCLA Loneliness Scale

Scale 3

Length: 3 Questions

Language: Negative wording

Initially developed for: Service providers

Does it mention loneliness? No

This scale is for you if: you want a short and academically rigorous tool, with a simple scoring system.

STRENGTHS

- **Widely used:** Both the longer and shorter versions of the UCLA loneliness scale are widely used across the world. The original paper has been cited over 1,500 times.
- **Can be used in different ways:** The tool has been found to be accurate when it is part of a self-completed questionnaire, and when an interviewer asks questions over the phone.[20]
- **Comparability to national studies:** The scale is regularly asked of over 12,000 people aged 50+ as part of the English Longitudinal Study of Ageing (ELSA). This means that UCLA results from a small population can be compared to a national sample, which may be of benefit to some services.

LIMITATIONS

- **Original development:** One of the main criticisms of the full UCLA scale is that it was developed in the USA with students – and therefore is not necessarily suitable for a UK context or use with older adults. However, the shorter, 3-item questionnaire has since been tested with older people.
- **Only uses negative wording:** Another limitation is that it does not use a mix of positive and negative wording, which could lead to a 'response set' – where participants give the same answer without really thinking about what they are being asked.
- **Easy to distort results:** The results of the UCLA scale across a population are sometimes turned into an average, e.g. a mean score of 4.2 in a group of 30 older adults. Creating a mean could prove unreliable as the scale does not quantify loneliness but simply gives it a numerical category.
- **Tricky questions on a tricky subject:** Some staff or volunteers may also find it difficult to ask negatively-worded questions, and may require support and training to ask these sensitively.

20 Hughes, M. E., Waite, L. J., Hawkley, L. C. and Cacioppo, J. T. 2004. A Short Scale for Measuring Loneliness in Large Surveys: Results from two population-based studies. *Research on Ageing*. 26(6) pp.655-672.

How was this tool developed?

Developed in the 1970s and revised in the 1990s, the scale uses the cognitive discrepancy theory of loneliness (i.e. loneliness occurs when there is a gap between the quantity and quality of connections we have and want). It is drawn from two older scales, including a 75-item scale based on statements describing loneliness from 20 psychologists. 25 questions were selected from these scales and tested with 239 students. Finally 20 items were selected, which aimed to measure both loneliness and social isolation.[21]

The longer scale was shortened to three questions in 2004 so that it could be used in larger surveys and over the telephone. The 3-item version was first tested with over 2,100 older adults and found to be a reliable and valid measure of loneliness by comparing the results against a self-identifying statement. The researchers concluded that the 3 question UCLA scale gauged general feelings of loneliness "quite well" and it was a robust measure of loneliness in self-administered questionnaires and telephone interviews.[22]

21 Russell, D., Peplau, L. A. and Ferguson, M. L. 1978. Developing a measure of loneliness. *Journal of Personality Assessment* 42(3) pp.290-294

22 Hughes, M. E., Waite, L. J., Hawkley, L. C. and Cacioppo, J. T. 2004. A Short Scale for Measuring Loneliness in Large Surveys: Results from two population-based studies. *Research on Ageing*. 26(6) pp.655-672.

Single-item questions

Scale 4

Single-item questions are sometimes known as self-rating measures of loneliness as they have to ask directly for the individual's assessment of how lonely they feel. There are many variants on this theme, and we suggest three here that come from different studies and use slightly different wording. The first example was first used by Joseph Sheldon in 1948.[23] He asked people:

Are you:

- Very lonely
- Lonely at times
- Never lonely

Our second example is currently used in the English Longitudinal Study of Ageing (ELSA):

How often do you feel lonely?

- Hardly ever or never
- Some of the time
- Often

The third example is adapted from the Center for Epidemiologic Studies Depression Scale (CES-D), which is commonly used screening questionnaire for depression. This is 20 questions long but includes one question about loneliness:

During the past week, have you felt lonely:

- Rarely or none of the time (e.g. less than 1 day)
- Some or a little of the time (e.g. 1-2 days)
- Occasionally or a moderate amount of time (e.g. 3-4 days)
- All of the time (e.g. 5-7 days)

23 Sheldon, J. 1948. *The Social Medicine of Old Age: Report of an Inquiry in Wolverhampton*. Arno Press.

24 See example on Counselling Resource website: http://counsellingresource.com/lib/quizzes/depression-testing/cesd/

SUMMARY

Single-Item 'Scales'

Scale 4

Length: 1 Question

Language: Negative wording

Initially developed for: Researchers

Does it mention loneliness? Yes

This scale is for you if: you want to get to the heart of the issue with just one question.

STRENGTHS

- **Short:** A single-item measure of loneliness has a number of benefits. It is short, asks directly about the issue of interest and is easy to administer and score. It may also be a starting point for a more in-depth conversation about experiences of loneliness.
- **Age-friendly:** Some research suggests that single questions are more appropriate with an older age group, particularly if someone is experiencing cognitive decline or has difficulty communicating.[25]
- **Academics use it:** Single, self-reporting questions are also the most commonly used measure in academic research studies.[26]
- **Challenges stigma?** There is an argument for asking directly about someone's loneliness as it challenges the stigma attached to the issues. This should be done in a private environment, where the interviewee has the opportunity to explain further about how they are feeling.

LIMITATIONS

- **May not be reliable:** These questions have never been thoroughly examined for their reliability, and ability to pick up change over time.
- **Ignores stigma?** There is also a concern that asking directly about loneliness can lead to underreporting, as the stigma that is attached to the experience means that people may be unwilling to admit to feeling lonely.[27]
- **May be too 'blunt':** Using a single-item scale will make it harder pick up on smaller gradations of change in loneliness, that you might expect after someone has had contact with a service.
- **Limitations of adding a time period:** a question that asks about loneliness over a certain time period (e.g. the CES-D question) may produce a misleading result, if that person has had an unusually stressful or difficult week or month.[28] It would also fail to reflect any long term feelings of loneliness.

25 Holmen, K., Ericsson, K., Andersson, L., and Winblad, B. 1992. Loneliness among elderly people living in Stockholm: A population study. *Journal of Advanced Nursing 17* pp.43-51

26 Pinquart, M. & Sorenson, S. 2001. Influences on loneliness in older adults: A meta-analysis. *Basic and Applied Social Psychology* 23 pp.245-266.

27 Victor, C., Scambler, S., Bond, J. and Bowing, A. 2001. Being alone in later life: loneliness, social isolation and living alone. *Reviews in Clinical Gerontology* 10(04) pp. 407 - 417

28 Pikhartova, J., Bowling, A. and Victor, C. 2014. Does owning a pet protect older people against loneliness? *BMC Geriatrics* 14(106) Available at: http://www.biomedcentral.com/1471-2318/14/106#B11 [Accessed 21 April 2015]

How to use your chosen scale

This section shares some advice on how to design and deliver a robust evaluation of your service. It recommends sampling techniques, how to introduce and complete a survey and suggests additional open questions, amongst other things, to help you to get the best results.

a. Introducing a survey

In most situations, it will be important to give some introduction and guidance about the questions and how to answer them, to those taking part in your evaluation. The following wording could be used:

> We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:
>
> - There are no right or wrong answers
> - We would like you to be completely honest
> - In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)
> - You don't have to answer any question you don't want to

You may like to remind people being interviewed that the research questions are separate from the rest of the support offered by your organisation, and that there will be other opportunities for them to tell you about their situation in more detail, and for you to provide support. You may wish to set time aside after an interview to make it easier to discuss any issues or questions that arise because of the questions.

This additional time, post-survey, can help you to feel comfortable asking direct questions about loneliness in a dispassionate style, as a 'researcher'. You could use wording such as:

> The questions are quite brief and only require brief answers. Some of the questions are quite personal, so if you want to have a chat about anything in more detail, let me know and we will make sure we talk about it afterwards or at a later date.

b. Encouraging staff or volunteers to use a loneliness scale

It can be difficult to ask people about how they feel, particularly when questions might evoke memories of a painful experience like loneliness. There are a number of things you could do to ensure that staff and volunteers get on board with your evaluation and help you survey your members, including:

- Clearly explaining to them the purpose and value of asking the questions, and giving them time to ask questions of you about the survey
- Ensuring that there is support available that staff can offer or signpost to, if the person being interviewed feels upset after the interview
- Reassuring staff that most people are happy to answer questions about loneliness (even negatively-worded ones) and may welcome the opportunity to talk about it with someone

It may also help to add an open-ended question at the end of the survey and invite the interviewee to make any further observations they want to. Sometimes, closed questions do not perfectly capture an experience or feeling and this might be frustrating for both the interviewer and the interviewee.

c. How regularly should you use a tool or scale?

The principal aim of this guidance is to provide information on different scales that organisations can use to measure the impact of their interventions on loneliness in older age. In order to do this, you will need to incorporate your chosen scale into any procedures for recording information about a new service user – sometimes called a baseline survey.

To see if there have been any positive or negative changes, you will then need to ask people to answer the same questions again periodically (for example, at three or six monthly intervals) and again when they stop taking part.

Comparing the results over these kinds of time periods should allow a decision to be made about whether someone's experience of loneliness has changed in the intervening period. If so, judgements can be made about whether the service that you have provided has been of benefit to individuals.

It may be difficult to ask personal questions of someone when you have only just met them. However, if your evaluation is to have any chance of showing positive change, you do need to make sure that a scale is used before someone starts using your service or taking part in your activity or group. You may want to use the words in the above section – "Introducing a survey" – to help explain why you are asking the questions at an early stage.

d. How to sample

Depending on how many people take part in your service or activity, it may be possible to ask a survey of everyone you are supporting. However, if that is not practical – or would take too much time or money – then you can survey a sample of your population instead.

Sampling is the process of selecting people to take part in your evaluation from a whole population of interest (i.e. everyone who is receiving support from you, or attending your activities). The aim is to be able to assume the results from the people in the sample are typical of the population from which they were chosen. There are three steps to creating a sample:

1. CREATE YOUR SAMPLING FRAME

This is simply a comprehensive list of everyone who is taking part in your service or activity. You may have this list already, or you may need to ask service managers to create one for you. Whether or not you have a sampling frame will influence the next stage – choosing the way that you are going to create a sample.

2. CHOOSE A SAMPLING STRATEGY

A 'random' approach to sampling is called **probability sampling**. A simple example of probability sampling would be to put everyone's names into a hat, and then pick a certain number and only approach those people to take part. The simplest type of probability sampling is **simple random sampling**, which is easy to do and it is reasonable to generalise the results from the sample back to the population. First, create your sampling frame and then randomly select the number of people you'd like to interview, e.g. 100.[29]

If you want to be sure to represent certain sub-groups within your research (for example various ages, genders, ethnicities) you may want to use **stratified sampling**. This will generally have more statistical precision than simple random sampling. To do this, you will need a bit more information about your population in your sampling frame. For example if you'd like to sample a representative number of men and women, you'll need this recorded by their name. Simply separate your sampling frame into the sub-groups of interest and then carry out simple random sampling on each group, selecting the same proportion (not number – e.g. 20%) from each group.

If you do not have a sampling frame, you may wish to use a non-probability (non-random) sampling strategy. The benefits of this are that they are much easier to assemble and can be lower cost. The main problem is that you ***cannot*** make any claims about your whole population based on this sample – because it will not be representative.

29 Excel has a random number feature that can be used to generate a random sample. To use this, paste everyone's names into an Excel column. In the column alongside, enter the function =RAND() alongside each entry, then sort both columns by the random numbers (select "Sort and Filter" and then "Sort A to Z"). They will appear in number order and you can use the first 100 names that appear as your random sample

Two of the most common non-probability sampling strategies are convenience sampling and quota sampling. Convenience sampling is also known as accidental or haphazard sampling as you simply interview a selection of people who are easy to reach and likely to agree to answer questions. For example, when a television reporter interviews the 'person on the street' to gauge public opinion. There is no way of knowing if these samples are representative of the wider population.

Instead, we could sample with purpose to target specific groups of people. An example is **quota sampling** – selecting people non-randomly according to some fixed quota. The stricter form of quota sampling is **proportional quota sampling** which aims to represent the major characteristics of the population by sampling a comparative amount of each. For instance, if you know the population you are interested in has 40% women and 60% men, and that you want a total sample size of 100, you will continue sampling until you reach those percentages and then you will stop. The problem here is that you have to decide the specific characteristics on which you will base the quota.

The less strict form of quota sampling is non-proportional quota sampling. In this method, you specify the minimum number of people you want in each category. You may decide to sample at least 40 women, at least 40 men and let the remaining 20 respondents 'fall out naturally'. Here, you simply want to have enough respondents to be able to talk about even small groups in the population.

3. DECIDING ON YOUR SAMPLE SIZE

Your sample size is the number of people you are going to survey, within your 'population'. Choosing your sample size may be decided by the capacity of your team to conduct surveys and analyse their results. However, if you would like to generalise from your sample to your larger population you can use a Sample Size Calculator, such as the one from Survey Monkey.[30]

To calculate your sample size, simply enter the total population size, keep the confidence level at 95% and set the margin of error at 5%. (You can learn more about what these things represent via the Survey Monkey Sample Calculator – referenced above). You'll notice that a big population does not necessarily need a big sample but if your population is small, the sample may make up a large proportion of it. If you would like to learn a bit more about the principles behind sampling, we'd recommend the Research Methods Knowledge Base website.[31]

30 Survey Monkey. 2015. *Sample Size Calculator.* [online] Available at: https://www.surveymonkey.com/mp/sample-size-calculator/ [Accessed 27 April 2015]

31 Research Methods Knowledge Base. 2006. Sampling [online] Available at: http://www.socialresearchmethods.net/kb/sampling.php [Accessed 27 April 2015]

e. Gaining informed consent

The principle of informed consent is used widely in academic research. In essence, it means making sure that the people you are interviewing fully understand what you are doing, and have given permission to you to ask questions, and store and use their information.

It is therefore important that the older people you work with fully understand:

- What the evaluation is aiming to do
- How you will be using, storing and publishing any information about them
- How you will make sure their information remains confidential, and how anything they tell you will be kept anonymous if published
- How to opt-out, at any point, during the process, should they no longer want to take part

You may wish to prove this information both in writing and verbally, to make sure that people understand – and have something to refer back to later in case they have any questions about the evaluation.

f. Understanding and minimising interviewer bias

The researcher (the person asking the questions) has a key role in obtaining high quality data, which depends on their clarity, consistency and neutrality – in terms of their words spoken, tone of voice and body language. It is important to ask all questions in a completely open way, without assuming what the likely response will be. If the person has not understood the question:

- Try to slow down the delivery of the question
- Ask which parts of the question they do not understand
- Try to keep to the original wording, maybe with additional explanations if needed

The researcher's reaction to each response should acknowledge what has been said without empathising or encouraging as this can lead the user to alter their future responses to gain a certain reaction. For anyone more used to working in a supportive role, this can take some practice.

Sometimes research participants will like to digress and engage the researcher in conversation. Try to gently bring them back to the task in hand, with perhaps the promise that you can resume that conversation later, after the research questions.

Prepare and practice a brief, consistent response to typical queries you may encounter, such as:

- Queries about use of the data
- Refusal to answer certain questions or parts of questions
- Options within questions, such as the list of ethnicities or 'marital status'

g. Advice on different modes of data collection

It will be important to consider how the new user is to provide the information. There are three main ways that you could collect data about the people taking part in your service:

- Asking questions of your users, face-to-face, and recording their answers yourself
- Asking questions over the phone, and recording their answers yourself
- Asking people to complete the survey on paper by themselves (they could do this on the spot, and hand it back – or you could send them the survey by post and ask them to send it back to you)

There are pros and cons to all of these methods. It can sometimes be hard, for example, to get a good response rate on postal surveys, and people may not answer all questions - unlike in a face-to-face interview. Tests on the De Jong Gierveld Scale and the CTEL tool have both shown there can be a difference in how people answer, depending on whether they completed it themselves or had some assistance from a member of staff or volunteer. When people were helped to complete it they tended to report much lower levels of loneliness compared to those who completed it on their own. This is not that surprising. Given the stigma surrounding loneliness people can be reluctant to reveal how they truly feel in front of someone.

So, where possible, our advice is that people are encouraged to answer the questions without help. Where this is not possible the tool could still be used as a useful measure of impact as long as the same method of asking the questions is used at each subsequent application of the tool.

h. Asking open, follow-up questions

Open-ended questions can allow you to understand more about ***what*** is happening, ***how*** it is happening, ***why*** someone is, or is not, experiencing loneliness and ***who*** may be particularly affected by loneliness in your local area. Asking open questions can also help people to feel listened to and valued.

Before you write your open questions, do take a moment to consider and clarify your purpose in asking them. It may be worth bearing in mind that open-ended questions can generate a lot of data that you will need to record and analyse later on. You will need to record full responses so that you can reduce the risk of misinterpreting answers.

If you would like to attribute quotes verbatim, you can:

- Keep it anonymous – quote only, with no attribution
- Attribute the quote with a description, such as Male, aged 75
- Attribute the quote with a pseudonym – can be a useful technique for writing up a case study

If you do want to use verbatim quotes from people interviewed, make sure you ask their permission and explain or show them how you will be using the quotes. They may be interested to receive a copy of your report or case study when it is ready.

The timing for asking any open questions is important. It should take place after completing the scale so as not to influence responses to any scale questions.

Even though open questions are more conversational than survey questions, it is still good practice to ask the same questions of all your interviewees. Try to give your interviewees as much chance to talk about the positive as the negative. It can help to start with a very general question before moving on to more targeted questions.

You may want to ask questions about the context someone is in, such as existing family or friendship relationships, or their aspirations for change. Some examples of open-ended questions that you may wish to ask include:

- *Can you tell me a little bit about any contact you have with friends or family right now?*
- *What aspects of your relationships with friends or family are working well for you?*
- *Are there any changes you would like to make to those relationships with friends or family?*
- *Do you consider loneliness to be an issue for you/someone like you?*
- *What do you think could be the main factors that contribute to loneliness?*
- *Is there anything else that you'd like to add?*
- *Can you tell me about how taking part in/becoming a member of <<ORGANISATION NAME>> has made any difference to your life, if at all?*

The final question, or something like it, can be used to demonstrate just how your service has helped. You may also want to ask about any other changes that have happened since you last interviewed them. For example, changes in circumstances or use of other services – and how these too have helped or hindered.

The best strategy for obtaining full and honest answers is to leave enough time for your interviewee to respond. There may be some moments of silence as they consider their response but this does not need to feel uncomfortable for either of you.

i. Collecting demographic data

You will need to consider what level of demographic data you wish to collect as part of your evaluation. It is good practice to ask for information about some key characteristics of the people taking part in your project, e.g. age, gender, ethnicity and location.

This information can be particularly important if you would like to compare your sample to a larger population. For example, you could take a look at the demographic characteristics of your local population – the Office for National Statistics, your local council and the census[32] will be good place to start for this – and see how the people taking part in your evaluation compare to this.

If you are able to survey or interview a large enough group, it could even enable you to differentiate between different sub-groups (for example, people from different cultural backgrounds). This segmentation might offer you insights that you would have missed by only looking at the whole group. Examples of commonly used questions to collect demographic data on age, gender, marital status and ethnicity, are set out at Appendix D. To ask about location, simply ask for someone's postcode.

j. Keeping personal information confidential

Respecting and maintaining confidentiality can help build trust between you and the people you support, and encourage them to take part in your research. Personal information can be defined as anything that can be used to identify someone – be that their name, or other things like age or where they live. In smaller communities, it may be easier to identify someone from less information. There are a number of steps you can take to keep information about someone confidential.

1. Assign everyone who is taking part in your evaluation an ID number, and keep a record of this ID number and their name in a secure file that can only be accessed by staff that need to use the information (e.g. a password protected Excel file)

2. Use this number – not their name – on the questionnaire, and in any file that records responses

3. If you want to go back to the people you interviewed at baseline, refer to the identification file, get their ID number and ask the survey again using the ID number

It is important that you do not make public any information that could be used to identify someone, without their permission. For example, you may have interviewed a retired doctor, who is the only person in your group with that past occupation. Even if you do not reveal their name, writing about a retired doctor in an evaluation report could lead to them being identified, and personal information becoming accidentally public.

Using a tool with people with sensory loss

Written by Nicola Venus-Balgobin, Project Manager, Sense

There are an increasing number of older people in the UK who have sensory loss. 70% of those over 70 have hearing loss[33], one in five people aged over 75 have sight loss[34] and an estimated 250,000 have a dual sensory loss[35]. However older people's sensory loss often goes unrecognised and undiagnosed due to an assumption by staff, and older people themselves, that it is a common part of ageing.

It is therefore likely that – even if you aren't aware of it – many of the older people you support will have some kind of sensory loss and may need additional help or adaptions to be able to participate fully in an evaluation. This will also ensure the information you gather is accurate.

Before you start, try and find out whether any of your participants have any sensory needs before you decide how to implement the tool. You should also people with sensory needs what adaptions they will need to be able to participate fully in the tool. You may want to ask:

- Is it better to conduct a survey in person or via post?
- If in person, does the person have any particular communication needs? Ask them how you should best to communicate (See Top Tips 1 below)
- If via post, what will make the information accessible to them? (See Top Tips 2)

TOP TIPS 1: COMMUNICATING WITH PEOPLE WITH SENSORY LOSS:

- Ask the person what works best for them
- Make sure you have the person's attention before trying to communicate with them
- Gently touching the top of a person's arm is one way to attract attention without startling them
- Identify yourself clearly
- Check that you are in the best position to communicate

33 Action on Hearing Loss. 2014. Factsheet: Caring for Older People with Hearing Loss. Action on Hearing Loss: London. Available at: http://tinyurl.com/me9mlou [Accessed 27 April 2015]

34 RNIB. 2015. Key Information and Statistics. [Online] RNIB: London. Available at: http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics [Accessed 27 April 2015]

35 Emerson, E & Robertson, J. 2010, *Estimating the Number of People with Co-Occurring Vision and Hearing Impairments in the UK*. Centre for Disability Research

- Avoid noisy places and background noise
- Adapt the conditions to suit the individual
- Speak clearly and a little slower, but don't shout
- Make your lip patterns clear without over-exaggerating
- Keep your face visible – don't cover your mouth
- Use gestures and facial expressions to support what you are saying
- If necessary, repeat phrases or re-phrase the sentence
- Be aware that communicating can be hard work. Take regular communication breaks
- Try writing things down, experiment with different sizes of letters and coloured paper and pens
- For phone conversations consider using a text relay service
- Some people with sensory loss will use a particular communication method, e.g. British Sign Language, deafblind manual or Block and you may need a communication support professional.

TOP TIPS 2: MAKING INFORMATION ACCESSIBLE

- Ask people how they would like the tool provided; if they are using technology to read the document they may need it in a different format e.g. plain text, without boxes, outside of tables
- Many people will be able to read large print – usually size 14 bold or above. It is a good idea to provide information in size 14 as standard
- Some people will need the information in an accessible format such as braille, moon or audio, a good transcription service will be able to provide this

For more information on communicating with people who have a sensory impairment visit:
www.sense.org.uk/content/communicating-people-who-are-deafblind

Acknowledgements

The Campaign to End Loneliness would like to express our gratitude to a large number of people and organisations who helped us to develop and pilot our impact measurement tool, and write this guidance. In particular, we'd like to thank Guy Robertson of Positive Ageing Associates, for overseeing the development the Campaign to End Loneliness Measurement Tool and members of our Research Hub who provided advice along the way and contributed to this report:

Professor Christina Victor, Brunel University

Chris Ring, Nottingham Trent University

Dr Tracy Collins, Salford University

Dr Bernadette Bartlam, Keele University

Julie Wrigley and Kay Silversides, Qa Research

Thank you to our tool steering group, who guided the Campaign team and Guy over the course of a year:

Sue Arthur, Independent Age

Jason Bergen, Calouste Gulbenkian Foundation

Karl Demian, Royal Voluntary Service

Jonathan Eastwood, Big Lottery Fund

Lilias Gillies, Wandsworth Older People's Forum

Sarah Handley, Big Lottery Fund

Andrea Hare, Public Health England

Lucy Harmer, Independent Age

Heather Heathfield, OPM

Phil Rossall, Age UK

Nicola Venus-Balgobin, Sense

And, finally, thank you to the following organisations that sent staff to development workshops and webinars, piloted the tool and gave comments on this guidance:

The Abbeyfield Society

Age UK Bromley and Greenwich

Age UK Cheshire

Age UK Wiltshire

Alzheimer's Society

Anchor Trust

Archway Foundation

Beth Johnson Foundation

Brighton & Hove Neighbourhood Care Scheme

Careline

Care Network Cambridgeshire

Carers Centre Bristol

Community Network

Cotswold District Council

Cotswolds Volunteers North

Coventry University

Cruse Bristol

CSV (now Volunteering Matters)

Dorset Partnership for Older People Programme

Family Mosaic

Friends of the Elderly

Growing Support

Halton Borough Council

Holbeck Elderly Aid

Holborn Community Association

Jigsaw Support Scheme

John Ellerman Foundation

Knowsley Council

London South Bank University

LinkAge Bristol

Link Line

Macular Society

Mentoring and Befriending Foundation

Mindings

NBFA Assisting the Elderly

New Dynamics of Ageing Older Peoples' Reference Group

NHS Warwickshire

Nottingham City Council

Oxfordshire County Council

RNIB

Rootless Garden

Rural Coffee Caravan Information Project

Salford City Council

Salford Royal NHS Foundation Trust

The Silver Line

Stafford and Surrounds Clinical Commissioning Group

Southville Centre Bristol

The Sovini Group

Staffordshire County Council

Stitchlinks CIC

Time to Talk Befriending

Together We Are Better

Tower Hamlets Borough Council

Tower Hamlets Friends and Neighbours

Toynbee Hall

Volunteer Edinburgh

West Sussex County Council

This guidance was written by Anna Goodman, Learning and Research Manager at the Campaign to End Loneliness, with contributions from Julie Wrigley and Kay Silversides (Qa Research) and Nicola Venus-Balgobin (Sense).

Appendix A: Campaign to End Loneliness Measurement Tool

We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:

- There are no right or wrong answers
- We would like you to be completely honest
- In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)

Questions

1. I am content with my friendships and relationships

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4	3	2	1	0

2. I have enough people I feel comfortable asking for help at any time

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
0	1	2	3	4

3. My relationships are as satisfying as I would want them to be

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4	3	2	1	0

Appendix B: The De Jong Gierveld 6-Item Loneliness Scale

We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:

- There are no right or wrong answers
- We would like you to be completely honest
- In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)

Questions

1. I experience a general sense of emptiness

Yes	More or Less	No
1	1	0

2. There are plenty of people I can rely on when I have problems

Yes	More or Less	No
0	1	1

3. There are many people I can trust completely

Yes	More or Less	No
0	1	1

4. I miss having people around me

Yes	More or Less	No
1	1	0

5. There are enough people I feel close to

Yes	More or Less	No
0	1	1

6. I often feel rejected

Yes	More or Less	No
1	1	0

Appendix C: The UCLA 3-Item Loneliness Scale

We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:

- There are no right or wrong answers
- We would like you to be completely honest
- In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)

Questions

1. **How often do you feel that you lack companionship?**

Hardly ever	Some of the time	Often
1	2	3

2. **How often do you feel left out?**

Hardly ever	Some of the time	Often
1	2	3

3. **How often do you feel isolated from others?**

Hardly ever	Some of the time	Often
1	2	3

Appendix D: Demographic Data

The following text can be used to introduce the need for demographic data:

We are asking these questions in order to better understand who is taking part in our social group/ project. This information will remain confidential and will not be shared with anyone else.

Gender

What is your gender?

1. Male
2. Female
3. Other _____

Age

What was your age last birthday? OR

What is your age?

1. Under 50 years old
2. 50-59 years old
3. 60-69 years old
4. 70-79 years old
5. 80-89 years old
6. Over 90 years old
7. Rather not say

Marital Status

Are you:

1. Single, that is, never married and never registered in a same-sex civil partnership
2. Married
3. Separated, but still legally married
4. Divorced
5. Widowed
6. In a registered same-sex civil partnership
7. Separated, but still legally in a same-sex civil partnership
8. Formerly in a same-sex civil partnership which is now legally dissolved
9. Surviving partner from a same-sex civil partnership
10. Rather not say

Ethnic group

Which of the following options best describes your ethnic group or background?

White

1. English/Welsh/Scottish/Northern Irish/British
2. Irish
3. Gypsy or Irish Traveller
4. Any other White background, please describe

Mixed/Multiple ethnic groups

5. White and Black Caribbean
6. White and Black African
7. White and Asian
8. Any other Mixed/Multiple ethnic background, please describe

Asian/Asian British

9. Indian
10. Pakistani
11. Bangladeshi
12. Chinese
13. Any other Asian background, please describe

Black/African/Caribbean/Black British

14. African
15. Caribbean
16. Any other Black/African/Caribbean background, please describe
17. Arab
18. Any other ethnic group, please describe
19. Rather not say

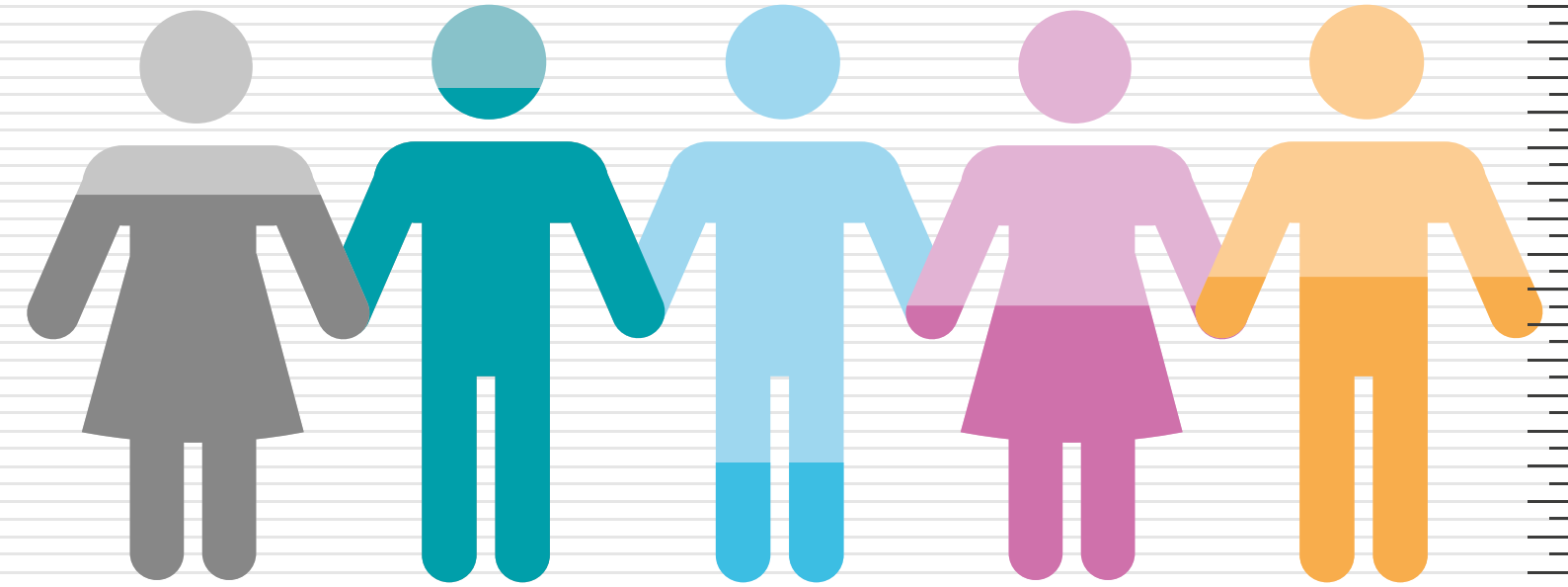
If you would like additional standardised questions on demographic data, for example on disability and impairment, we recommend the Office for National Statistics webpage on harmonised concepts and questions.[36]

Sexual orientation

What is your sexual orientation?

1. Lesbian
2. Gay
3. Bisexual
4. Heterosexual
5. Other _____

36 Primary set of harmonised concepts and questions. Available at: http://www.ons.gov.uk/ons/guide-method/harmonisation/primary-set-of-harmonised-concepts-and-questions/index.html [Accessed 30 April 2015]



About the Campaign

The Campaign to End Loneliness inspires thousands of people and organisations to do more to tackle loneliness in older age. We are a network of national, regional and local organisations and people working through community action, good practice, research and policy to create the right conditions to reduce loneliness in later life. We were launched in 2011, are led by five partner organisations, Age UK Oxfordshire, Independent Age, Manchester City Council, Royal Voluntary Service and Sense, and work alongside more than 2,000 supporters, all tackling loneliness in older age. Our work is funded by the Calouste Gulbenkian Foundation, the Tudor Trust, the Esmée Fairbairn Foundation and the John Ellerman Foundation.

Campaign to End Loneliness
3 Rufus Street
London
N1 6PE

For general queries, email us at
info@campaigntoendloneliness.org.uk
or call us on 020 7012 1409.

@EndLonelinessUK

www.campaigntoendloneliness.org.uk

Campaign to EndLoneliness
CONNECTIONS IN OLDER AGE

Esmée Fairbairn FOUNDATION

Design by i_do_creative www.i-do-creative.com

No one should have no one

Working to end loneliness amongst older people

About Age UK

Age UK is the country's largest charity dedicated to helping everyone make the most of later life. Age UK provides a wide range of services and its information and advice reached nearly 6 million people last year. The Age UK network comprises more than 150 local Age UKs covering most of England. Our family also includes Age Cymru, Age NI and Age Scotland.

December 2016
Report author: Jill Mortimer

Contents

No one should have no one

Most of us have felt very lonely and alone at some point in our lives.[1] It's a profoundly personal and painful experience and people can feel completely hopeless. Luckily for many, life moves on and these feelings pass.

But for some of us loneliness can become chronic, making us miserable and often causing us to lose self-confidence. It can become increasingly difficult to build new and meaningful relationships that could restore our sense of self and self-worth. The fact that loneliness carries a stigma can make it hard to admit to it and seek help. And often people don't know where to go for support.

Chronic loneliness can **increase the risk of serious health conditions**, such as diabetes, heart conditions and strokes, depression and dementia.

Chronic loneliness is affecting a growing number of older people, in line with the increase in the older population. Age UK estimates that over a million older people are lonely.[2] There are particular issues that are more common amongst older people – such as bereavement, ill health and complex long term health conditions, making it harder to stay connected.

Being miserable is bad enough, but there is evidence that chronic loneliness increases the risk of serious health conditions, such as diabetes, heart conditions and strokes, depression and dementia,[3] as well as making it much harder for an individual to help themselves and manage their conditions through exercise and good diet.

Growing numbers of lonely people mean increased demand on health services, in part because people are more likely to feel unwell but also because some are desperate for company and the GP and practice nurse may feel like the only people they can turn to. A survey of 1,000 GP practices found that nearly 90 per cent felt that some patients were coming because they were lonely, and 14 per cent estimated they were seeing six or more patients a day for this reason.[4]

In addition funding cuts mean that services like meals on wheels and day centres have been massively eroded. Other vital local services such as libraries, community centres, lunch clubs and public toilets are closing, reducing their hours and either introducing or raising charges. Pubs and shops are closing. Banks are withdrawing local branches.

Bus services are being reduced and some routes are being removed altogether. This makes it much harder for many older people to get out and about. Increasing delivery of services through email and the internet is more convenient for many people, but makes getting information and services difficult or impossible for those not online, which is the position for many older people.

But there is hope. The extraordinary response to the 'No one should have no one' campaign that Age UK ran in 2015 showed that the public is very concerned about loneliness amongst older people. Research showed that 80 per cent of those seeing the TV ad said it made them realise that loneliness is a real problem and 76 per cent said it made them want to help older people who are alone.[5] There were 33,000 visits to Age UK's befriending web pages and 12,000 people approached Age UK to find out more about volunteering opportunities.

Age UK is working hard with many other organisations to encourage us all to come together to help reduce loneliness in later life. We've developed an approach which can make better use of resources in the community to help older people who are feeling lonely and hopeless find the meaningful companionship they so desperately need.

It's not easy, especially at a time when community services are increasingly hard pressed. There is no quick fix or silver bullet. Many older people have lost heart and just assume this is how life is. The approach we're advocating requires many front line volunteers and workers to enhance their knowledge and skills to be really effective. But it is possible. The early results of Age UK's 'Testing Promising Approaches to Reducing Loneliness' programme indicate real improvements.

All of our experience in supporting older people shows the importance of recognising that everyone is unique. A person who is lonely can benefit hugely from talking to someone who gets to know them and helps them to do the things that give them pleasure and purpose – without prior assumptions about what they want and need. Many of the people that Age UK helps go on to become volunteers themselves. Older people play a very important and growing role in building communities where everyone, old and young, feel valued.

A survey of 1,000 GP practices found that **nearly 90%** felt that some patients were coming to the practice because they were lonely.

'It means I know someone is looking out for me if I need help or just advice or a chat, I know I can turn to Age UK and I know that I'm not just another person on a list – I really feel like they care about who I am and they're interested in me as a person. I can't get out and about as much as I'd like and although I have friends in the street where I live, Age UK gives me a different set of friends and things to do. I really couldn't live without them.' **Christine**

What is Age UK doing to address loneliness?

Age UK has a long history of providing services which address loneliness: for example our national **Call in Time** programme, our involvement in and support for the **Campaign to End Loneliness** and the many and diverse services provided by local Age UKs.

Call in Time

is a national service originally launched with the support of Zurich Community Trust in 2005. It works by recruiting and training volunteers to make one call a week to an older person who has been matched with a volunteer based on shared interests. The volunteers are supported by a team who make sure that the older person doesn't miss a call because of sickness or holidays. They also provide link ups with other services, such as help with benefits through Age UK Advice. The regular calls also help to pick up potential safeguarding issues that may otherwise be missed.

The Campaign to End Loneliness

was launched in 2011. It is led by five partner organisations, including Age UK Oxfordshire, and works alongside more than 2,000 supporters – many of whom are local Age UKs – all tackling loneliness in older age. Their work is funded by the Calouste Gulbenkian Foundation, the Tudor Trust and the Esmee Fairbairn Foundation.

Local Age UKs

have been providing services for many years that support older people and their families and carers. These include social activities that bring people together such as coffee mornings, lunch clubs, cookery classes, 'Men in Sheds'[6] groups and help with information technology. Many provide befriending services where people who are on their own get telephone calls and visits from volunteers.

Alison is still grieving for her late husband but having someone to chat to on the phone and in person once a week and getting out and meeting new people has helped tremendously with her emotional wellbeing and sense of self-confidence.

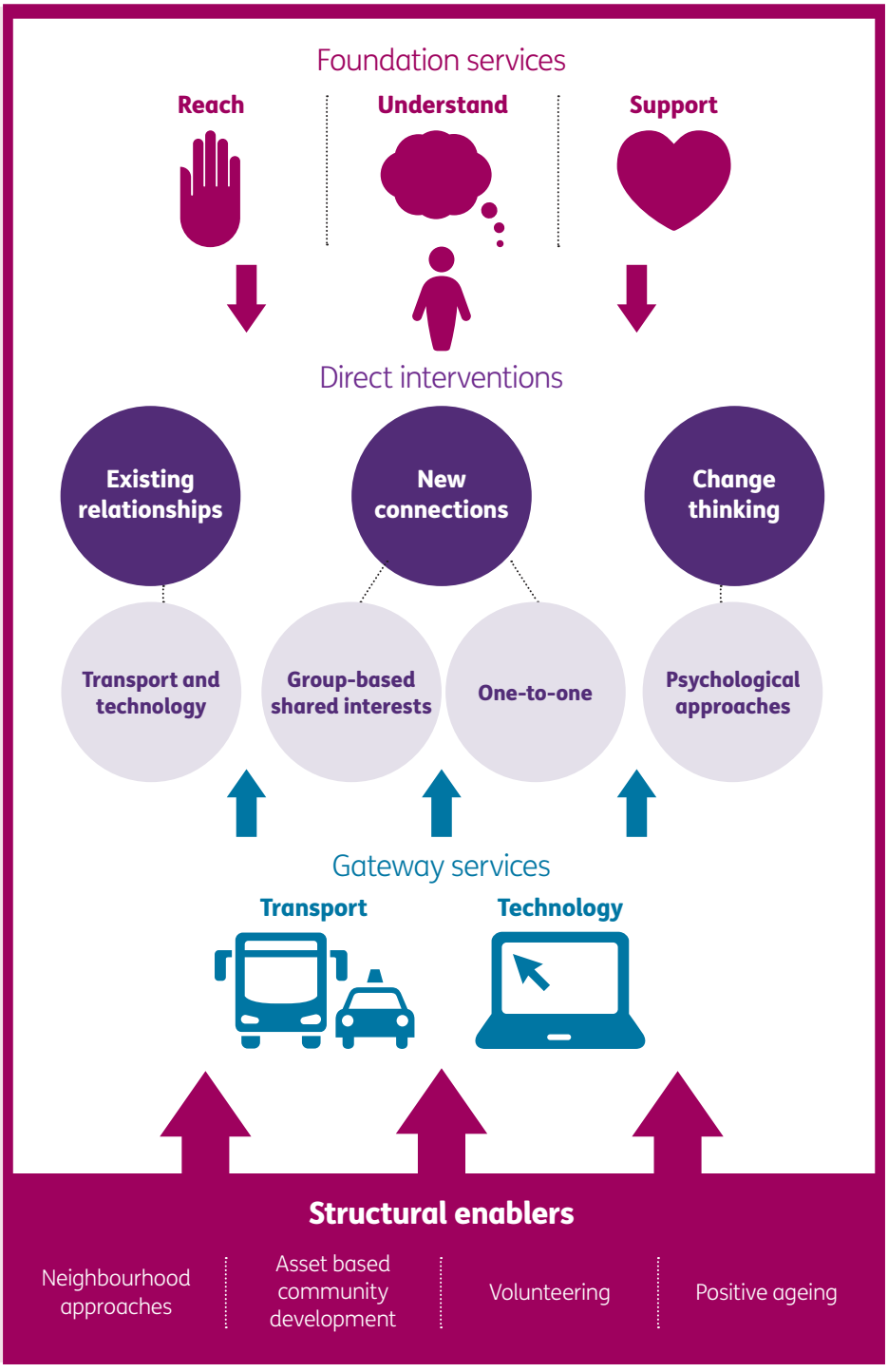
'I had nobody. I was completely lost. Day and night, week after week, month after month. The loneliness gets under your skin. "Call in Time" has changed my life from a colourless day by day of "getting through it" to getting back into "LIFE" state.'
Barbara

What works?

In 2015 Age UK and the Campaign to End Loneliness produced **'Promising Approaches to reducing loneliness and isolation in later life'**.[7] In this report, we asked the question 'What works?' and identified a large number of different sorts of services where there was some evidence that they had reduced loneliness. We presented a framework to help conceptualise what different types of approaches to loneliness were aiming to achieve. The Local Government Association endorsed this framework in its **'Combatting loneliness: a guide for local authorities'** launched in January 2016.

A new framework for loneliness

- **Foundation services**
  Services to reach and understand the specific needs of those experiencing loneliness.
- **Direct interventions**
  A menu of services that directly improve the number or quality of relationships older people have.
- **Gateway services**
  Improving transport and technology provision to help retain connections and independence in later life.
- **Structural enablers**
  Create the right structures and conditions in a local community to reduce the numbers of older people experiencing, or at risk of, loneliness.



The experts who contributed to the report felt that 'foundation services' were a particularly important element in successful interventions to help people become less lonely. These are services which focus on identifying older people who feel lonely and helping them address the specific issues that would help them improve their connections with others.

In 2015 Age UK launched **'Testing Promising Approaches to Reducing Loneliness'**, a Test and Learn programme with eight local Age UKs[8] to build the 'foundation services' approach into their services and evaluate the impact.[9]

'Eyes and ears on the ground'

The local Age UKs developed their outreach to find lonely older people through:

- Training their front line staff to recognise the characteristics of loneliness – their reception and information and advice workers as well as community development workers such as village agents and urban angels.[10]
- Working with professionals in the voluntary and statutory services who were already in contact with older people at high risk of loneliness. These include fire and rescue officers and police community support officers who carry out home visits; GPs and practice nurses; district nurses and occupational therapists; social workers and home from hospital services. Where one of these professionals felt an older person might be lonely they either told them about Age UK services, or asked them if they could forward their details onto the local Age UK.
- Working with people with strong community connections such as hairdressers and shopkeepers and people in faith groups who could hand out contact details for the local Age UK.

'Asking for help was hard, but I knew I couldn't manage much longer. It was one step at a time, much like getting over the falls, but I've definitely got my confidence back with the help I received from Age UK and am still able to talk to a befriender when I need to.'

Use loneliness 'heat mapping'

The 'reach' within particular areas was complemented using Age UK's loneliness heat mapping tool which identifies the relative risk of older residents being lonely in different neighbourhoods.[11] Areas appearing to be high risk but with limited services were then targeted to develop networks and services. The loneliness mapping tool was developed with the Office for National Statistics, using risk factors derived from the English Longitudinal Survey on Ageing, specifically age (75 and over), marital status (widowed or divorced), living alone, and being in poor health.[10]

Understand

To get to know people and be able to help them find solutions to their loneliness staff and volunteers were trained to carry out a 'guided conversation'. This is a type of loosely structured interview, designed to feel like a conversation whilst also finding out about the older person's current life circumstances, their interests and ambitions and what kind of activities and/or social connections might make them feel less lonely. The process of doing this also meant that many older people felt they were being listened to and their feelings taken seriously for the first time for many years.

Support

Sometimes the guided conversation resulted in matching the older person with a volunteer and a period of contact through telephone calls and visits, to help the individual overcome loss of confidence and start to be able to identify what would help them feel less lonely. These might be introductions to existing social groups such as luncheon clubs, cookery classes, 'Men in Sheds' groups, Walking Football,[11] book clubs, University of the Third Age meetings, to name just a few.[12] They might also help the older person to get there, through accompanying them and/or organising transport.

It could also involve helping them set up their own social networks by introducing them to people with similar interests – such as playing Scrabble, bridge, dog walking, choirs, local history groups – or enhancing IT skills so that they could use Skype to stay in contact with relatives and friends.

Sometimes it was more straightforward: for example accompanying someone to get out and about after recovering from a fall so they could develop the confidence to do it on their own, or helping them get benefits they were entitled to, such as Attendance Allowance. These relatively simple things could have an immediate impact: people got new hope and felt energised to work out their own solutions.

Age UK arranged for Joseph to visit the local lunch club and he's made some new friends in the area. Plus, he's started gardening again, with a little kick start from Age UK's gardeners who helped clear the undergrowth – this has also led to trips to the local garden centre with Derek (his volunteer visitor). Joseph doesn't really like admitting that he was lonely – he's a proud man who fought in WW2 and is highly decorated. He says now that he was too embarrassed to admit he needed help and friends and is extremely grateful to Age UK who 'refused to give up on him'.

Arthur's son was worried that his health was deteriorating because of the many hours he was spending alone in his flat in sheltered accommodation. He was unwilling to participate in group activities because of difficulties hearing. He had had a busy social life, but most of his friends had died, or were unable to visit. Age UK introduced him to Paul, who had had to retire early after an accident and was feeling increasingly isolated and depressed. They play dominoes and cribbage. They dissect the latest football match and reminisce about their time in the building trade – swapping funny stories of mishaps and adventures. Paul has provided Arthur with good company and a 'link' back to the job he loved. Arthur has helped restore Paul's sense of purpose and self-worth.

Evaluation and results

The final piece of the approach was building in evaluation to identify whether interventions from the programme were being effective in reducing loneliness. The local Age UKs used the following questions to measure the extent of the older person's loneliness:[13]

How often do you feel you lack companionship?

How often do you feel isolated from others?

How often do you feel left out?

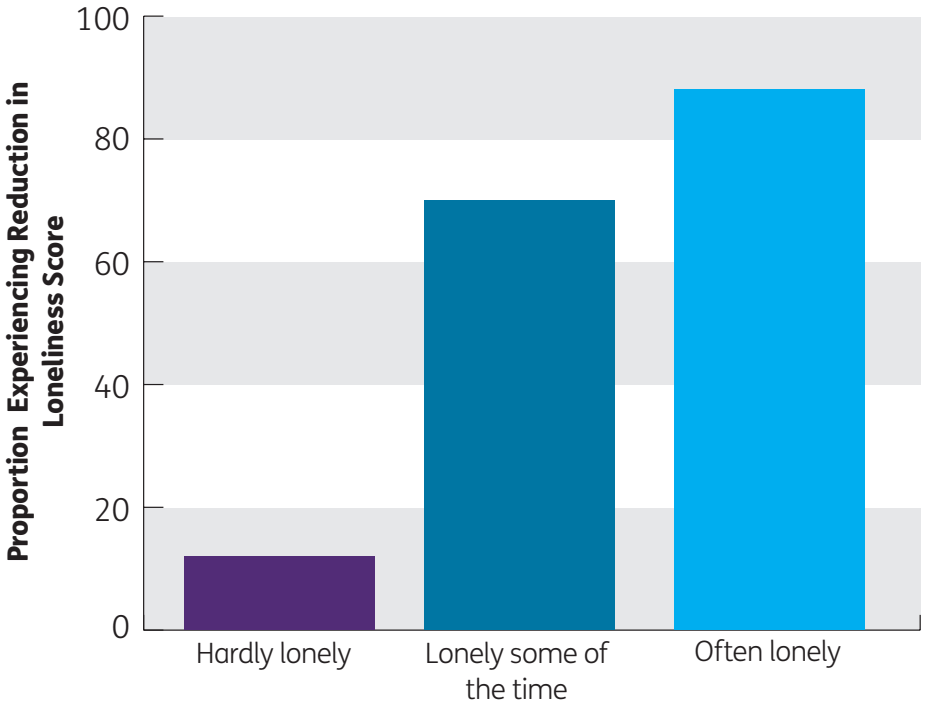
During the trial period over 1,000 older people were supported by their local Age UKs as part of the programme, of whom half had their loneliness levels measured again within six to 12 weeks of their initial guided conversation.

Amongst those people who were lonely often or some of the time at the beginning of the programme, **88 per cent and 70 per cent respectively had a reduction in their loneliness scores**.

This shows that the support and interventions older people received from the local Age UKs had a positive impact on their feelings of loneliness. In addition, qualitative information reveals that **for some the outcomes went far beyond simply feeling less lonely and included feelings of increased independence, wellbeing and connectedness with people**.

The programme continues into 2017.

Proportion experiencing reductions in loneliness in relation to their initial loneliness scores



Early in 2015 Gareth was diagnosed with cancer; his volunteers were determined to make sure his final days would be full of friendship and support. They all began to email each other and devised a rota to make sure that he had a visitor every day of the week. Between them they shopped, took Gareth to medical appointments and St John's Hospice, did odd jobs, helped him look after his cats, and most importantly gave him the company he so wanted. Gareth told Age UK on several occasions that although he knew the cancer would kill him eventually he believed that he would have died of loneliness before now, if it had not been for his involvement with Age UK.

What have we learnt?

Loneliness is intensely and uniquely personal

What works for one person isn't necessarily the answer for another. The trick is to establish a relationship with the individual, explore with them what would help and then support them do it. This is why a guided conversation is so important. For some, to help to build their self-confidence and sense of self-worth is an integral part of the approach. For others it's more to do with addressing physical or financial barriers.

Build awareness of loneliness into local services, develop these services and join them up

Within local Age UK services, community development workers such as village agents and urban angels developed their services to identify and explore loneliness amongst older people and provide tailored help. A wide range of staff and volunteers, including those on the reception desk or those providing information and advice about other matters, were equipped with the skills and knowledge to identify people who might be lonely. They got their permission to refer them on to services which could help.

'I've been given the recipe for making new friends'.

David, who joined a 'Cooking for one class'

‘Better together’. Enhance the reach of the service through working with other professionals in the statutory and voluntary sector as well as local people with extensive contacts with older people

In most areas it will be best to develop existing services rather than introduce a whole new range. Often Age UKs will be ideally placed to provide the ‘hub’ for services addressing loneliness amongst older people, through their existing contacts, access to trained volunteers and knowledge of other local services that can help, including what to do if there is an urgent requirement for health and care services.

National and local campaigns can increase awareness and encourage people to get in contact with relatives and neighbours who they think might be lonely, whilst letting them know there is somewhere where they can find support and help if they find an older person’s needs are too much for them to cope with on their own.

Use the Age UK loneliness heat mapping tool to identify the neighbourhoods where older people are at highest risk of loneliness

Used alongside local knowledge, the loneliness heat maps enabled the local Age UKs to explore whether existing services were reaching areas of potentially highest need and target areas of high risk with few existing services. They have also provided a very useful tool to engage commissioners, statutory and community service providers in discussions about loneliness in later life and where to prioritise resources.[14]

Most people will need training to be able to carry out guided conversations to start to find out what the individual wants and needs

For example we found that many Age UK workers were initially nervous about asking the loneliness questions precisely as worded and worried about people getting upset. Through training, support and feedback we found that it was best to ask these questions in the middle of the assessment rather than at the beginning or the end, and reassure those interviewing that the distress pre-exists the interview. Expressing the distress can be the beginning of finding a solution, and there are gentle techniques they can learn that can help them to respond to these powerful emotions compassionately and constructively.

Phone calls play a very important role as part of a range of services. Chronic loneliness will often need more intensive, face to face interventions

Feedback from people who are regularly contacted through the Call in Time telephone service shows that the calls are much appreciated. For some a phone call is what they prefer. Recent research[15] indicates that people who are very lonely need more than a regular phone call to reduce their feelings of loneliness, but even in these cases providing phone calls whilst a more intensive face to face service is being organised is a very useful bridging service, especially where demand exceeds supply and there is a need to wait for more in-depth support.

Supporting networks, activities and volunteers to tackle loneliness isn’t necessarily high cost, but it’s not cost-free

Reductions in voluntary and community sector funding[16] are making it more difficult to foster joint working and different approaches on the front line, and cutbacks in community infrastructure can exacerbate loneliness. Funders of community services need to take account of the impact of reductions in services or increases in charges on people at risk of loneliness.

Light-touch measurements of change over time are needed

The questions we used to measure loneliness have the advantage that, whilst requiring skills and confidence to ask them with the precise wording to ensure comparability, the actual asking doesn’t take that much time and can be done as part of the conversation to get to know the older person. The questions are tried and tested and academically validated and allow comparison with national datasets. They provide a scale to identify a range of experiences of loneliness and measure change. The data they produce is easily collated and compared with earlier findings to assess progress to date.

What can you do to prevent and tackle loneliness?

As a Member of Parliament you can:

- Find out more about loneliness among older people in your constituency and use your influence to raise awareness and bring people together to offer help.
- Become an Age Champion and be open to working with Age UK nationally and locally to help end loneliness among older people.
- Encourage your political party to engage with Age UK and other voluntary agencies to develop positive policy solutions.
- Take steps to put loneliness in later life on the Government's agenda and hold them to account for progress.
- Make the case for investment in local community resources to support sustainable, long term action to help lonely older people, wherever they may be.
- Support the work of the Jo Cox Commission on Loneliness – launching in early 2017.

As a local councillor you can:

- Build awareness of loneliness and potential solutions into all your council's strategic functions, especially public health, social care, housing and community development.
- Encourage use of the Age UK loneliness heat maps to assess need in your area – not forgetting that there may still be very lonely older people in 'low risk' areas.
- Include loneliness in your council's evaluation of its decisions through its scrutiny arrangements.
- Support local multi-agency partnerships to address loneliness, such as Health and Wellbeing Boards, Joint Strategic Needs Assessments, the Better Care Fund and Sustainability and Transformation Partnerships.
- Positively engage with Older People's Forums, your local Age UK and any other voluntary or community sector agencies working on loneliness in your area.
- Promote neighbourliness and community action in your ward and be prepared to lead by example.

'It's not so much about being alone. It's about being lonely, sometimes even when people are visiting. I was quite down after everything (husband's death, then stroke followed by a fall) and confined to the house. I'm feeling happier and less nervous now. Jean (the volunteer visitor) is my new friend who helps me do the things I want to do.' **Charlotte**

As a healthcare professional you can:

- Encourage your colleagues to take loneliness seriously as a health issue.
- Create development opportunities for staff in GP surgeries and community health services to recognise loneliness and know where to refer people for help.
- Support initiatives to address loneliness amongst older people, including 'social prescribing' and joint approaches with the voluntary and community sector such as 'care navigator schemes'.

As a business you can:

- Encourage and enable your employees to volunteer to help lonely older people, through Age UK and other organisations.
- Join in with other businesses, for example through your local Chamber of Commerce, on cross sector initiatives to combat loneliness among older people.
- Be open to sharing your resources, where relevant and appropriate, with community organisations to help address the problem – e.g. supermarket cafés could join up with their local voluntary organisation to run a coffee morning for older people.
- Be 'eyes on the ground' to spot possible loneliness amongst older people amongst your customers and know where they could get help.

As an individual you can:

- Make the effort to keep in contact with older relatives and friends.
- Be friendly to older people living nearby.
- Consider volunteering to help lonely and isolated older people, through Age UK or another local group.
- Recognise that loneliness could at some point affect us too, so we should value our friends and do what we can to sustain our own social networks, however busy and crowded our lives may appear to be.

'Getting older people to engage and acknowledge their loneliness was challenging at times, but taking an individual approach to each client really pays off.'

Age UK Volunteering and Community Activities Manager

'Adoption of the loneliness heat maps and a more evidenced approach has enabled conversations with our local authority's Community Engagement Team about the extent of risk across their geographical area and the need for more targeted provision.'

Age UK Senior Development Manager

References

1 **Loneliness** is when a person feels 'a lack of meaningful companionship'

2 TNS survey for Age UK, April 2014

3 Age UK Evidence Review on Loneliness June 2015: www.ageuk.org.uk/loneliness-evidence

4 Campaign to End Loneliness's survey of GPs, 2013. www.campaigntoendloneliness.org/blog/lonely-visits-to-the-gp/

5 TNS Omnibus Survey for Age UK, January 2016

6 **'Men in Sheds'** was a project piloted by Age UK in 2010 which supported older men who wanted to get together and share and learn new skills – all in the welcoming space of a 'Shed'. Many local Age UKs now provide similar services

7 Age UK and the Campaign to End Loneliness, 2015. *Promising Approaches to reducing loneliness and isolation in later life*: www.ageuk.org.uk/reducing-loneliness

8 The local Age UKs who participated in the programme were Age UK Barrow & District, Age UK Blackpool & District, Age UK North Craven and Age UK North Yorkshire, Age UK Oxfordshire, Age UK South Lakeland, Age UK South Tyneside and Age UK Wirral

9 Age UK, 2016. *Testing Promising Approaches to Reducing Loneliness*: www.ageuk.org.uk/loneliness-approaches

10 **Village Agents and Urban Angels** are staff and volunteers who work in communities to help identify older people who are lonely or isolated and help connect them to services and activities that can help them

11 The Age UK Loneliness Mapping Tool can be found at: www.ageuk.org.uk/loneliness-maps

12 **Walking Football** is a standard game of football where the players walk instead of run. It's designed to help men and women get fit or maintain an active lifestyle, no matter what their age and fitness. Walking Netball is based on the same principles

13 These questions are the UCLA 3 item loneliness scale and are used in the English Longitudinal Study of Ageing. For further information on why we used these rather than other questions designed to diagnose loneliness see page 10 of Age UK 2016 op cit

14 The Age UK Loneliness Mapping Tool, op cit

15 Moore, S. and Preston, C. 2015. *The Silver Line Tackling Loneliness in Older People: Evaluation report*

16 National Council of Voluntary Organisations 2014. Has the voluntary sector received disproportionate spending cuts?

This report aims to raise awareness about the importance of addressing chronic loneliness amongst older people.

It includes early findings from 'Testing Promising Approaches to Reducing Loneliness', an Age UK programme designed to test 'What works?'.

Age UK wants to encourage the many and diverse individuals, organisations and decision makers in national government, local authorities, the NHS, voluntary and community sector and business, as well as the general public, to join together and mobilise their resources and energies to identify and address loneliness and make sure that everyone has someone.

To donate or volunteer for the Call in Time telephone service go to **www.ageuk.org.uk/no-one**

For further information about Age UKs work on loneliness contact **policy@ageuk.org.uk**

Tavis House
1–6 Tavistock Square
London WC1H 9NA
0800 169 80 80
www.ageuk.org.uk

Love later life

The interviewees are referred to in the report by their first names which, in some cases, have been changed at their request.
(Please note all the photographs in this report are models – not the people we interviewed).

All data presented correct at time of publication.

Health Improvement Board - Exercise on Referral – Oxfordshire
By Oxfordshire Sport & Physical Activity

1. Purpose of Report

To make the Health Improvement Board aware of the various Exercise and Referral programmes running in Oxfordshire.

2. Information requested from the Health Improvement Board

Please see the detail below based on the brief as provided by the HIB. Further areas as requested will be presented upon in the meeting.

- An overview of all the local referral schemes in Oxfordshire
- Whether a local scheme is targeted at any particular group of people?
- How many GPs are engaged and how many referrals were made / activated?

3. Overview of Exercise and Referral programmes

District	Provider	Cost to participant	GPs engaged	Participants engaged	Continued membership	Particular focus groups : Additional conditions available	How is the scheme funded
Oxford City	Rosehill Community Centre (Oxford City Council)	Initial price £5.60 £1.30 per session.	No data	27	12	Supervised gym sessions	It has cost Rose Hill Community Centre £684.00 (16/17).
		Provider Comments	No outside funding has been given; Oxford City Council has supported the discounted EOR referral rate for the 12 week period.				
	Fusion x 3 sites	Initial price £5.60 £1.20 per session	No Data	203	Many of the people on the scheme go onto bonus card scheme after	Supervised gym sessions Swimming	There is no funding available for the scheme Fusion take on all the cost to continue to deliver the scheme at a highly discounted rate.

	Provider Comments	Main issue with the scheme is qualified instructors, with the cost of the course funding support is needed to get more instructors trained to deliver the scheme. We have demand for the programme but struggle to take more as we don't have the qualified staff available. The Oxford City scheme run by Fusion is the cheapest in the county for people to take part in. We would like to develop the scheme however would need funding support to help us develop and expand the programme.					
South & Vale	Healthwise operated by GLL x 5 sites	Pay and play (£3 year 1, £4 year 2 and £4.50 year 3), direct debit (£20 year 1, £25 year 2, £30 year 3) per month	No Data	515	54%	Supervised gym sessions. Swimming. Level 4 Cardiac Rehabilitation and trained in Motivational Interviewing.	The scheme funded through the leisure management contracts. Amount undisclosed.
		Providers comments	Due to having a co-ordinator in place to take direct communications from GP's and clients, direct promotion of the scheme to GP surgeries, creating a referral form that is one A4 side of paper, and training more staff at the different leisure centre sites to take more referrals. There are no plans in place to change any of existing conditions (either adding or removing conditions) and processes associated with the scheme as numbers are increasing well. Any adding of conditions would create a cost for the leisure providers that the district council do not have funding to provide eg for training staff in extra conditions, and may potentially require systems we are unable to provide eg separate rooms for individuals to exercise in. GP Referral is an integral element of the programme of use for the new leisure contract which is due to commence 1st August for a 10 year period.					
	South Oxford Leisure x 2 sites	£2.50 a session or £48 upfront for the 12 weeks.	5	35	22	Supervised gym sessions. Swimming	As a charity this is one of the schemes they run for community objectives.

		Provider Comments	We are currently investigating projects that help adults with mental health problems and diabetes prevention to benefit from physical activity. We also run a Disability Active gym and swim session that is supported by 'Exercise & Disability' qualified staff.				
West	Healthwise operated by GLL x 5 sites	Pay and play (£3 year 1, £4 year 2 and £4.50 year 3), direct debit (£20 year 1, £25 year 2, £30 year 3) per month	11	495	61%	Supervised gym sessions Level 4 certified in Cardiac Rehabilitation and trained in Motivational Interviewing. Cardiac & Pulmonary Rehabilitation classes, Heart Failure support class, Movement & Mobility class, Nordic Walking sessions and Table Tennis	The referral programme operates as an integral component of the Leisure Facilities within Oxfordshire and is a contractual commitment from GLL as Healthwise. Amount undisclosed
		Provider Comments	GP Referral is an integral element of the programme of use for the new leisure contract which is due to commence 1st August for a 10 year period. Level 4 certified in Cardiac Rehabilitation and trained in Motivational Interviewing. Whether a local scheme is targeted at any particular group of people. West Oxon does have a wider focus on engaging people with disabilities. However in the EOR scheme there has been no specific focus other than health conditions that are appropriate to referral, which may include people with disabilities but no more any anyone else				
Cherwell	Parkwood Community Leisure Legacy Leisure x 2 sites	£3.85 Pay As You Go	No data	222	110	Supervised gym sessions	Legacy Leisure is contractually obliged to deliver the scheme on behalf of Cherwell District Council.

		Provider Comments	Since taking on the scheme the most common issue is clients not being aware of how the scheme works. Prior to attending clients are not given any information about the scheme when they are referred (costs, number of sessions). Many patients are not told they have to pay for the scheme.

Prescription of exercise (referrals not typically Leisure centre referral)

Countywide	Go Active, Get Healthy	No cost	133	21790 new participants have taken part in the countywide physical activity opportunities designed for the inactive 1112 participants have registered directly into the Referral and Motivational Support Pathway	Self-sustained activities after funding end	Motivational Interviewing, district community activities, Exercise on Referral forward	Sport England
		Provider Comments	Note Funding has ended and this programme is currently not running. An initiative delivered by Oxfordshire Sport & Physical Activity and partners. For inactive individuals. A mixture of informal referrals and not limited to referral pathway through a medical professional. Community, self and online referrals were also optional.				
	Go Active Get Healthy with diabetes	No Cost	22 (to date) Note all 77 practises contacts		Self-sustained activities after funding end	Motivational Interviewing, district community activities, Exercise on Referral forward	Oxfordshire CCG

		Provider Comments	A new initiative delivered by Oxfordshire Sport & Physical Activity and partners. For individuals with diabetes. A mixture of informal referrals and not limited to referral pathway through a medical professional. Community, self and online referrals were also optional.				
	Active Body Healthy Mind	No Cost	No data	766	Self-sustained activities after funding end	Advice, support and community exercises	Sport England
		Provider Comments	An initiative delivered by Oxfordshire Sport & Physical Activity and partners. A mixture of informal referrals and not limited to referral pathway through a medical professional. Community, self and online referrals were also optional.				

4. Discussion Points

- There are 5 distinct leisure clients/commissioner (the district councils) and 3 providers/deliverers (leisure providers) of Exercise on Referral. Each is delivering their national programme. Each individual arrangement is specific to the district that is operated in.
- Where there are countywide issues (for example GP Referral forms that are owned by the CGG) there is a not a countywide co-ordinating mechanism at this moment in time. Oxfordshire Sport & Physical Activity can provide this role as the county wide partnership for sport and physical activity. There could also be a role for the Oxfordshire Strategic Physical Activity Group.
- With 95,000 people inactive across Oxfordshire (and the associated health dis-benefits with this) Exercise on Referral plays a part in reducing this but with the present attendance figures other initiatives will be required to allow choice of activity.
- Social prescribing may be a mechanism to increase the number of referrals but again it would need to link in with the wide variety of other referral routes to provide scale and choice for participants.
- Oxfordshire Sport & Physical Activity are currently building on the work of the Oxfordshire Sport & Physical Activity Needs Analysis to provide additional information on inactivity 'hot spots' This will enable more targeted work across all referral schemes for all inactive people.

5. Recommendation

Oxfordshire Sport & Physical Activity with Health Improvement Board endorsement to bring together organisations involved in Exercise and Referral to share best practise and look to ways forward on county wide issues.

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Health Improvement Partnership Board, September 2017

1. Briefing on Fuel Poverty, Health and a suggested strategic direction

1.1 The Health Improvement Board requested a workshop to encourage greater collaboration and joint working between organisations tackling fuel poverty and to identify areas for further targeted work. This would help set the strategic direction for Oxfordshire fuel poverty work. Recommendations from the workshop have been incorporated into this report.

1.2 The Health Improvement Board is asked to approve the work laid out in this report. It is requested that yearly reports are received on this topic.

2. Background

2.1 Low household income, poor energy efficiency of home (higher energy bills) and high energy prices (which also mean energy bills are higher) all have an impact on fuel poverty. If someone has to spend a lot of time in their home, this makes it more likely that they may struggle with energy bills and heating their home to a healthy temperature. Oxfordshire residents living in off gas areas are likely to pay more to heat their homes as alternatives are more expensive.

2.2 The government's *Low Income High Cost* (LIHC) indicator models *w*here residents have fuel costs above average (i.e. energy inefficient home) and were they to spend that amount, they would be left with a residual income below the official poverty line.

2.3 According to the 2015 LIHC indicator, England has an average of 11.0% of households in fuel poverty, the South East 9.4% and Oxfordshire's average is 9.6%. The rate varies across the county: Cherwell is 9.3%, and South Oxfordshire is 8.5%, Vale of White Horse is 8.4%, West Oxfordshire 8.7% and Oxford 12.8%. The rate often varies considerably in smaller areas within the districts too. All of the modelled rates have increased in 2015 from the previous year.

2.4 In their Fuel Poverty Strategy[1], the government showed the importance of energy efficient homes in addressing fuel poverty with a target to "**Ensure that as many fuel poor homes as is reasonably practicable achieve a minimum energy efficiency standard of Band C in their Energy Performance Certificate, by 2030."** Energy Performance Certificates rate properties that are being rented out or sold on their energy efficiency. Energy Company Obligation (ECO) funding, an obligation put on energy companies by the government to finance the energy efficiency of properties, is therefore now targeted at residents considered to be in fuel poverty.

[1] https://www.gov.uk/government/publications/cutting-the-cost-of-keeping-warm

3. Links with health

3.1 The National Institute for Health and Care Excellence (NICE) guidance on cold homes[2] includes people with the following as particularly vulnerable to cold homes. This includes cardiovascular conditions, respiratory conditions (COPD, childhood asthma), mental health conditions, disabilities, older people (65+), households with children under 5, pregnant women and people on a low income.

3.2 NICE guidelines recommend that in addition to setting a strategy, **Health and Wellbeing Boards should ensure or commission a local single point of contact for vulnerable people living in cold homes** which should be used by those in contact with vulnerable groups and be linked in with local referral services.

4. What good practice can we look to?

4.1 The workshop included a presentation on SHINE (Seasonal Health Intervention Network)[3], an Islington based, one-stop referral system for affordable warmth and seasonal health interventions. A single referral to SHINE leads to an assessment for around thirty potential interventions which include health and social care related ones. Included are energy advice, support and grants, benefits checks, energy doctor home visit, falls assessments, telecare applications, befriending services, fire safety checks and a handyman service. A quick video of the services can be found at https://www.ashden.org/winners/shine

5. Current work in Oxfordshire

5.1 The Affordable Warmth Network (AWN) partnership comprises the County, City and District councils, who all contribute to the network's annual running costs of £39,740 including VAT as well as non-paying partners including Age UK, Citizens Advice and the Oxford Diocese.

5.2 The charity National Energy Foundation (NEF), the provider from whom services are commissioned) provide administration support for the AWN partnership, compile reports to the Health Improvement Board (HIB) on the Fuel Poverty indicator, provide the free telephone and email single point of contact advice service and associated back-office functions, undertake bid writing, pulling in other partners and funds. They are now referring Oxfordshire clients to the LEAP project which incorporates home visits, small energy repairs and income maximisation advice. To maintain this single point of contact and service carried out by NEF, an annual commitment of £39,740 is required from Oxfordshire local authorities. This will continue to be needed, but recommended changes in this report will noticeably improve the value for money from this service.

5.3 Across Oxfordshire and Buckinghamshire, the Better Housing Better Health scheme offered grants for energy efficiency measures, home energy visits and assistance with energy, benefits and financial support. NEF, on behalf of

[2] https://www.nice.org.uk/guidance/ng6
[3] https://www.islington.gov.uk/environment/energy-services/shine

the AWN, applied for this funding as part of their role to lever in external funding for Oxfordshire. This resulted in 216 energy efficiency measures being installed, 71% of recipients reporting an improvement in health and wellbeing, estimated savings of £107,990 to the NHS, £53,840 of fuel debt being cleared and 131 people switching energy tariff or supplier (amongst other benefits). For more information check the video at https://youtu.be/gTpitJYiso8.

6. Principles for moving forward

6.1 The workshop highlighted a need to minimise duplication and therefore increase strong partnership working across Oxfordshire local authorities, health and social care professionals and advice providers. This will support the further roll out of fuel poverty related work across Oxfordshire. In the shorter term (i.e. immediate future), residents with health issues should be prioritised. In the longer term, every energy inefficient home in Oxfordshire should be addressed as they represent potential cold damp homes and therefore future health problems.

6.2 The current AWN advice service offers a consistent single point of contact for both residents and professionals to refer into – as recommended by the NICE guidelines. It now also refers directly to the LEAP project. This service offers a good starting point for a more holistic Oxfordshire service, and now offers an improved website. It needs to continue to offer value for money.

6.3 However, to move towards the provision of an integrated, multi-referral service (such as the SHINE service), the following changes are suggested **for the Board's approval:**

a. A new service incorporating the helpline and all onward referrals called 'Better Housing Better Health '(BHBH) will be established and rebranded. This will be promoted as a single point of contact service referring out to all relevant services and funding streams available at the time, including those currently under the banner of 'BHBH'. This will minimise confusion and duplication, and maximise engagement.
b. The service will offer direct referrals only rather than signposting thereby consistently linking in with all other services, reducing the number of people dropping out and producing more measurable outputs.
c. The AWN will aspire to increase the number of health and social care services that BHBH refers each year. In the first year, the target will be to incorporate the falls service, fire service, befriending service and Oxfordshire advice services.
d. In order to enable more referrals from health, social care and other frontline staff, the AWN partnership will clarify and clearly lay out the 'offer' from the service. This will be publicised to appropriate frontline professionals, partly via training packages (online and face to face) and can be aligned with the recent update of the AWN website [4].
e. Health and social care practitioners will be take up offers of education and training to increase awareness of fuel poverty related resources provided via the single point of contact and how to refer in. They will therefore refer all appropriate clients in to take advantage of the service.

[4] http://affordablewarmthnetwork.org.uk/

f. All services engaged with the new Better Housing Better Health service (including the single point of contact) will utilise existing Live Well and Family Integration Services databases to register their own services and seek other appropriate referrals where necessary. This further encourages integration within health and social care.

Debbie Haynes, Oxford City Council. dhaynes@oxford.gov.uk
Kate Eveleigh, Oxfordshire County Council
katharine.eveleigh@oxfordshire.gov.uk

Proposal for health conference

Title: How the natural environment can help meet the city's health priorities: A conference for Oxford's healthcare professionals and green space providers.

Aim: There is now clear evidence that local green spaces provide huge opportunities for improving residents' physical and mental health and wellbeing. Nationally, providers of outdoor spaces are seeking to collaborate with healthcare and public health organisations to maximise these benefits and deliver safe, cost-effective outcomes to meet health priorities and tackle inequalities. This conference provides an opportunity for this to happen locally.

EG South West Conference: https://www.youtube.com/watch?v=kTo-jI0r3ko

When: Spring 2018 **Venue:** Rose Hill Community Centre, Ashurst Way, Oxford

Cost to delegates:

What will it cover?

- It will focus on how green spaces and nature can help contribute to meeting Oxford's health priorities by:
    - Providing an opportunity to present ideas and practical examples of green spaces and nature delivering benefits to physical and mental health
    - Providing examples of best practice
    - Allowing Oxford's health professionals to network with those providing outdoor space and running nature-based projects on their doorstep
- It will identify any pros and cons from the point of view of health professionals and where and how green space providers can help, by:
    - Looking at the capacity to deliver and the willingness to refer
    - Identify any obstacles to communities utilising their local green space or developing healthier lifestyles

Who is it aimed at?

Decision makers working in the health system and green space such as:

- GPs
- Health Commissioners
- Members of Heath and Wellbeing Boards
- Social care providers
- Health service decision makers
- Green space providers (local authorities and trusts etc) and landowners
- Organisations running nature-based projects

Inspirational / Key note speaker suggestions

Dr. Dan Bloomfield is an expert on nature-based solutions to local health priorities. With support from NERC he runs a project (www.adoseofnature.net) at the University of Exeter to increase the number of 'green prescriptions' provided by GPs to patients with long-term conditions. https://youtu.be/su7nUVCBsbs

Cost to deliver: £500/800 Venue hire, refreshments including lunch, printed and on-line versions of materials, speakers.

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Health Improvement Partnership Board
Forward Plan

Date	Item
8 Feb 2018 2-4pm Oxford Town Hall	• Welfare reform – impact of Universal Credit • Oxford University Hospitals Trust Public Health Strategy • Oxford Health Public Health Strategy • Trailblazer project • Smoking cessation report card • Health Inequalities performance indicators
April / May (tbc)	• Housing Related Support Joint Management Group annual report
Standing items:	
• Minutes of the last meeting and any matters arising • Report from HIB Healthwatch Ambassadors • Performance Report (including any report cards) • Forward Plan	
Proposals/periodically:	
To be kept under regular review: • Re-commissioning of housing related support • Welfare reform • Oral Health Needs Assessment • Healthy Weight Action Plan • Oxfordshire Sport and Physical Activity • Health Protection Forum • Air Quality Management • Domestic Abuse services	

18 September 2017

Katie Read, Policy Officer
Katie.Read@oxfordshire.gov.uk
07584 909 530

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