Oldham Public Health
Annual Report 2012-13
Jobs, Homes and Friends
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Jobs, homes and friends

Introduction
Public Health is moving to Oldham Council. This opens up great potential for action on health and wellbeing to reach new areas.

Placing responsibility for improving the population’s health into the realm of the town hall recognises where the potential to act on the basic causes of health and health inequalities lies. It is right that locally elected councillors will have direct access to the Director of Public Health and that councillors are supported to lead local action to improve health.

Already in 2012 Oldham Council has agreed a Health and Wellbeing Strategy that is aimed at tackling the causes of ill health across everyone’s lifespan. The Oldham Public Health Charter, also agreed by Oldham Council, sets out the approach the council will take to improving health. The council is committed to ensuring that all its decisions which influence economic opportunity, early childhood development, schools, housing, workplace and environment contribute positively to the health and wellbeing of Oldham residents.

This is a strong start to the council’s assumption of responsibility for public health and bodes well for the future.

The purpose of the Director of Public Health’s annual report on the health and wellbeing of the people of Oldham is to give an assessment of the health of the population, where it is improving or not (better for some, worse for others) and to name the main priorities to achieve good health for everyone in Oldham. The annual report is the independent view of Oldham’s Director of Public Health.

However the report does not stand alone. Much of the information about health and wellbeing used in this report has been presented in the Joint Strategic Needs Assessment and has been drawn together into priorities for the borough’s health and wellbeing strategy.

The Public Health Annual Report then is a summary of the development of health and wellbeing in Oldham and an opportunity to give direction to what we should be doing to improve the future health and wellbeing in Oldham. It is hoped that the report provides information to encourage councillors, individuals and groups to ask questions about health and wellbeing in Oldham and not to settle for anything less than health for all.

Content of the Report
This year’s report is divided into four broad sections. The opening section looks at the population of Oldham and how it is changing and what this will mean for health and wellbeing in Oldham. It then goes on to review the statistics about illness in Oldham and compares illness in Oldham with other parts of Greater Manchester and the country.

The second section picks up information about what causes people in Oldham to die or become ill earlier than people in other parts of the country. These challenges to health are identified in three ways. The actual illnesses themselves, the risk factors that mean someone’s chances of staying healthy or becoming ill are increased and the broad underlying or social determinants such as having a job or not, having a secure, affordable and warm home and having social networks that will provide friendship and support. All three provide the context for priorities to improve health and wellbeing in Oldham.

Section three sets out what I think are the main priorities to improve health and wellbeing and to reduce inequalities in health in Oldham. Finally section four is given over to the Oldham Public Health Charter. This sets out the Council’s intention to champion health and wellbeing in Oldham. Links are made to the Council’s commitment to creating a Cooperative Oldham.

I am happy to receive comments or questions or suggestions to take this work forward.

Alan Higgins, Director of Public Health, Oldham

Acknowledgements
Thanks to the following people who provided much of the information that has gone into this year’s report.

Stacy Duggins  Senior Public Health Analyst, NHS Oldham
Julie Holt  Public Health Specialist, NHS, Oldham
Susan Kirkham  Corporate Research and Intelligence Manager, Oldham Council
Oldham’s Current Population

The estimated population for Oldham based on the 2011 Census is 224,900 people. The population is made up of 223,200 people living in households and 1,700 people living in communal establishments. A communal establishment is an establishment that provides managed residential accommodation, such as student or sheltered accommodation.

Oldham’s latest population structure by age band compared to the population structure of England can be seen in figure 1. Females make up over half (51%) of Oldham’s population and this is comparable to Greater Manchester, North West and national figures.

Oldham has a higher proportion of younger people compared to England but a lower proportion of older people for both males and females. In Oldham under 16s make up 22.4% of the population compared with 18.9% nationally. People aged 75 and over make up 6.5% of Oldham’s population compared with 7.8% of England’s population.

Source: Census 2011, ONS

Ethnicity in Oldham’s Population

The size of Oldham’s minority ethnic population has increased from 13.9% in 2001 to 22.5% in 2011, a significantly greater change than nationally.

The largest minority ethnic group in Oldham is Pakistani (10.1%) followed by Bangladeshis (7.3%), both groups making up a higher proportion of Oldham’s population than nationally (2.1% and 0.8% respectively). By contrast Indian (0.7%), Black (1.2%) and mixed heritage (1.8%) groups are relatively under-represented in Oldham compared to national figures.
Section One

Oldham's changing population

<table>
<thead>
<tr>
<th></th>
<th>Oldham (n)</th>
<th>Oldham (%)</th>
<th>GM (%)</th>
<th>North West (%)</th>
<th>England (%)</th>
</tr>
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<tr>
<td>White</td>
<td>174,326</td>
<td>77.5</td>
<td>83.8</td>
<td>90.2</td>
<td>85.5</td>
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<tr>
<td>Pakistani</td>
<td>22,686</td>
<td>10.1</td>
<td>4.8</td>
<td>2.7</td>
<td>2.1</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>16,310</td>
<td>7.3</td>
<td>1.3</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Indian</td>
<td>1,555</td>
<td>0.7</td>
<td>2.0</td>
<td>1.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Black (African/Caribbean)</td>
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<td>1.2</td>
<td>2.8</td>
<td>1.3</td>
<td>3.4</td>
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<tr>
<td>Mixed</td>
<td>4,057</td>
<td>1.8</td>
<td>2.3</td>
<td>1.6</td>
<td>2.2</td>
</tr>
<tr>
<td>Other ethnic groups</td>
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<td>1.4</td>
<td>3.1</td>
<td>2.0</td>
<td>3.2</td>
</tr>
<tr>
<td>All ethnic minorities</td>
<td>50,571</td>
<td>22.5</td>
<td>16.3</td>
<td>9.8</td>
<td>14.3</td>
</tr>
</tbody>
</table>

Figure 2: Ethnic Group Populations
Source: ONS Census 2011 KS201

A higher proportion of Oldham’s population (88.2%) were born in the UK than England as a whole (86.2%). The proportion of Oldham’s population (9.8%) born outside the European Union is similar to the England-wide proportion (9.4%), and higher than the proportions for the North West (5.5%) and Greater Manchester (8.6%).

Population density (people per hectare of land) in four wards in Oldham is more than 12 times the national average. Density is highest in Werneth (67.5), Coldhurst (58.1), Waterhead (52.4) and St. Mary’s (51.2).
Oldham’s changing population

Change in Population Since 2001

Oldham’s population has risen by 3.5% since 2001. This is lower than the rate of growth across the North West (4.8%) and considerably lower than the growth in the national population (7.9%).

In most of Oldham’s 20 wards, there has been an increase in estimated population numbers between the 2001 and 2011 censuses. The largest increases have been in Alexandra (19.3%), St. Mary’s (12.3%) and Coldhurst (10.6%) and in all cases the increase in males has been greater than that for females. In six wards population numbers have decreased. The largest decreases have been in Crompton (-4.2%), St. James’ (-3.2%) and Failsworth West (-2.8%).

How is Oldham’s population projected to change?

- Oldham’s population is projected to reach 237,000 people by 2021, a substantial 5.3% increase over the 2011 Census population estimate of 224,900. It is projected that:
  - Oldham’s population aged 0-4 years will increase considerably (by around 400 children a year) before peaking at 18,400 in 2016. By 2021, there will be around 17,700 children aged 0-4 in Oldham, a 7.3% increase over the 2011 Census estimate.
  - Oldham’s population aged 5-15 will reach 37,400 by 2021, a 10.3% increase of the 2011 Census population estimate for this age band.
  - by 2021, Oldham’s population aged 16-44 years will decrease by 500 people, from 86,500 to 86,000.
  - the population aged 45-64 years will increase by around 1,300 people by 2021, a 2.4% increase over the 2011 Census population estimate.
  - the population aged 65 years and over will increase steadily over the next ten years, reaching 39,500 in 2021, a 19.0% increase over the 2011 Census population estimate. Projected growth in this population is in line with previous projections.
  - the older populations are projected to steadily increase over the next ten years, with the 75 years and over population reaching approximately 18,500 by 2021, which is a 26% increase from the 2011 Census population estimate. The 85 and over population is projected to increase by 27%, increasing to approximately 5,300 by 2021.

Changes to Population Ethnicity

The ethnic composition of Oldham’s population is forecast to change over the next ten years.

- The proportion of Oldham’s population from white backgrounds is projected to decrease from 80.6% in 2012 to 75.4% by 2022.
- The proportion of Oldham’s Pakistani and Bangladeshi heritage populations is forecast to increase, reaching 10.2% and 9.2% respectively by 2022.
- Most of the change in ethnic composition that is forecast is due to the less youthful age structure of Oldham’s white population, combined with the very youthful age structures of Oldham’s Bangladeshi and Pakistani populations.

Figure 3: Forecast changes to the ethnic composition of Oldham’s population 2012-2022

Health, Wellbeing and Illness in Oldham

Life Expectancy and Disability-free Life Expectancy

Life expectancy estimates the average number of years that someone will live from birth. It is a reflection of the prevailing conditions that have an impact on health for the whole population at that time. Figure 4 tells us that males in Oldham will live for 75.7 years compared to 77 years for males in the North West and 78.6 years for England. Females will live for 80.5 years in Oldham compared to 81.1 years for females in the North West and 82.6 years for England.

Figure 4: Life Expectancy Trends

Increases in life expectancy can be seen in Oldham, regionally and nationally. The gap in life expectancy for females between Oldham (80.5), the North West (81.1) and England (82.6) is gradually narrowing. However Oldham still has the 19th worst life expectancy for females out of the 324 local authorities ranked in England.

For males in Oldham life expectancy has been increasing but not at the same rate as in the North West and England, meaning that the gap in life expectancy between Oldham (75.7) and the regional (77) and national average (78.6) has increased. Oldham also has the 16th worst life expectancy for males of the 324 local authorities in England.

Ward level life expectancy for 2007 to 2011 (figure 5) also demonstrates inequalities in Oldham as there is an 11.9 year difference between males living in Coldhurst, the worst-off ward in Oldham, and those in Saddleworth North, the second best-off ward in Oldham. For females there is a gap of 10.8 years between females in Alexandra and Crompton.

Source: NCHOD
What this means for health in Oldham

Oldham’s population is continuing to grow, although at a slower rate than the country as a whole. Most of the growth in population will be in children and young people. However the proportion of the population aged over 65 will also increase with significant growth in the over 75 and over 85 populations, to become a more significant proportion of the population. The ethnic makeup of Oldham will also continue to change with an increasing proportion of the population from people of Pakistani and Bangladeshi heritage.

Life expectancy in Oldham also continues to grow which reflects improvements in the factors that determine health in a population. However a better sense of the health of Oldham’s population is gained from comparing life expectancy in Oldham with life expectancy elsewhere. This shows that the health of Oldham’s population is worse than in the majority of the country and that it is not improving quickly enough to close the gap in health between Oldham and the rest of the country. Also that there is a big difference in your expectation of living a longer life depending on what part of Oldham you live in and the conditions associated with that area.

The next section looks at the implications of these population changes, especially the fact that people in Oldham tend to live shorter lives and become ill earlier than people living in other parts of the country.

Section One

Oldham’s changing population

Figure 5: Ward Level Life Expectancy in Oldham 2007-11

Male life expectancy at birth by ward in Oldham 2007-11

Female life expectancy at birth by ward in Oldham 2007-11

Source: Primary Care Mortality Database

‘Inequality in life expectancy at birth’ is an indicator that tells us the difference in life expectancy between the worst and best-off areas in a local authority. In Oldham males who are from the best-off areas will live 11.1 years longer than those in the worst-off areas and females who are best-off will live 10.3 years longer than the worst-off.

Disability-free life expectancy (DFLE) is the average number of years a person could expect to live without an illness or health problem that limits their daily activities. The ‘inequality in DFLE at birth’ indicator tells us the range in DFLE across a region from the worst-off to the best-off areas. In Oldham, for males from the best-off areas DFLE is 14.6 years higher than for males from the worst-off areas. This difference is higher than the regional (14.1 years) and national (10.9 years) differences. For females it is 12.8 years higher for those from the best-off areas, which is also higher than the regional (12.2 years) and national (9.2 years) values for this indicator.
Section Two
In this section I will look at the main diseases that cause people in Oldham to have shorter lives. I will then look at the risk factors that mean there is a greater chance of having a major disease. Finally I will look at what it is that strongly underscores the health of a population on a year-by-year basis and is the major influence on whether the whole population is having a reduced lifespan or living to old age, living with ill health or thriving to full potential.

In Oldham the main diseases contributing to premature mortality (deaths in people aged under 75) in 2011 for both males and females are cancer (40% and 46%) and cardiovascular disease (26% and 22% respectively). This is similar to the picture in England (2010) where cancer is the main cause of premature mortality for males and females (15% and 12%) and the second biggest cause is cardiovascular disease (12% and 5%).

For males in Oldham the rate of premature deaths from cancer has been increasing since 2005-07, so the gap between Oldham and England’s death rates has increased. At 2008-10 the death rate for cancers in males aged under 75 in Oldham was 151 per 100,000 compared to 137 for the North West and 122 for England.

The opposite has been the case for female under 75 cancer deaths, with mortality rates dropping since 2005-07 and the gap with England narrowing. The rate for Oldham females at 2008-10 was 122 per 100,000, which was higher than the North West (110 per 100,000) and England rate (99 per 100,000).

Coronary heart disease and stroke are the two main contributors to cardiovascular deaths for both males and females in Oldham. Deaths from coronary heart disease make up 68% of male deaths from cardiovascular disease and 51% of female deaths whereas stroke contributes 16% for males and 28% for females.

The rates of male and female premature cardiovascular disease mortality have been decreasing over the last 10 years and the gap with England has narrowed. The death rate for males aged under 75 in Oldham in 2008-10 was 129 per 100,000, which is higher than the North West (115) and England rate (95). The rate for females in Oldham was 56 per 100,000, which is also higher than the North West (52) and England rate (41).

Respiratory disease is the third biggest contributor to premature deaths in Oldham. Whilst death rates for England and the North West have stayed fairly constant for males and females since 2005-07, Oldham has seen an increase in rates. The death rate for males aged under 75 in Oldham in 2008-10 was 29 per 100,000, which is higher than the North West (17) and England rate (15). The death rate for females in Oldham was 18 per 100,000, which is also higher than the North West (15) and England (10).

So the main diseases related to a shortened lifespan in Oldham are cancers, heart disease and stroke and respiratory illness. Digestive diseases, particularly those associated with alcohol consumption, have also been rising.
Mental Illness

The number of adults in Oldham with symptoms of depression, anxiety and phobias is estimated to be around 33,000. People with such problems represent a large proportion of demand on primary health care services although perhaps only a quarter of people with problems actually present to health services. Admission rates to hospital for mental health problems are highest in Alexandra, Coldhurst and St Mary's wards.

The provision of mental health services in Oldham constitutes a significant proportion of overall spend on health services, and many mental health conditions result in long-term disablement. However several of these conditions can be prevented.

Risk Factors

It has been known for some time that some actions that people take or habits that are formed will be harmful to their health. The link between smoking and tobacco was formed from research in the 1950s and 1960s. Since then it has also been clear that smoking is a significant cause of heart disease, stroke and a range of respiratory diseases.

Having a diet that is high in overall energy content, a large proportion of that energy from fat, high sugar content and high salt content is related to higher risk of the cancers and heart disease and stroke that are killing people in Oldham earlier than elsewhere.

Alcohol misuse can lead to a range of public health problems, impacting directly on health through conditions such as alcohol poisoning and chronic liver disease and indirectly through accidents, violence and other negative social and behavioural effects. As alcohol contributes to social and health inequalities it is good that Oldham’s increasing and higher risk drinking has reduced to 20.7% since the previous year (24.4%) and is now lower than the North West (22.4%) and England (22.3%) average.

Being active is a great way of reducing your risk of becoming ill and it can contribute to a better sense of wellbeing. Of course the opposite is also true and being inactive has been linked to a wide range of the illnesses that shorten life and increase the burden on carers and on the health and social care services.

Figure 7 highlights risk factors and shows that, in Oldham, risk factors for health are more common than elsewhere: smoking, healthy eating and obesity prevalence are all significantly worse than the England average. The percentage of people in Oldham taking part in physical activity is also lower than the North West (11.7%) and England (11.2%) average. Owing to the impact that risk factors can have on preventable ill health and premature mortality, changing the everyday behaviour of people in Oldham would help to reduce the differences in mortality and life expectancy that exist between Oldham and England, as mentioned above.
The local Violence Indicator Profile shows that Oldham had significantly worse performance than the England average for violence against the person offences (15.4 per 1000 compared to 13.6 nationally), hospital admissions for violence (143.3 per 100,000 compared to 67.7), hospital admissions for unintentional and deliberate injuries in children (183.7 per 10,000 compared to 122.1) and A&E first attendances for assault (576.2 per 100,000 compared to 360.1).

The rate of sexual offences (1.01 per 1000 compared to 0.96 nationally) and suicide and injury undetermined for males (13.24 per 100,000 compared to 12.22), females (2.61 compared to 3.72) and all persons (7.83 per 100,000 compared to 7.92) are not significantly different to the national average.

In Summary...

The main causes of people dying early in Oldham are cancers (lung cancer, colorectal and breast) and cardiovascular disease (coronary heart disease and stroke). Mental illness is a significant health problem. The risk factors for ill health (smoking, poor diet, physical inactivity and alcohol consumption) are higher in Oldham than elsewhere.

Poorer people are more affected by illness and risk factors than better off people.
Social Determinants of Health

The Commission on Social Determinants of Health concluded that social inequalities in health, such as the difference in life expectancy between the best and worst off parts of Oldham and between Oldham and other parts of the country, arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. The findings were reported in the 2010 report Fair Society’s Healthy Lives.

These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit (Fair Society Healthy Lives).

The government has introduced £18 billion of welfare savings as part of its austerity programme and has suggested there may be £10 billion more to come by 2016. The impact of this welfare reform in Oldham has been summarised to mean:

- £18.438m lost per year to Oldham’s local economy, the main impact being on more vulnerable residents.
- £9.98m lost per year from previous changes to benefits.
- £28.418 lost in total per year to Oldham’s local economy.
- Those with mental health issues are more likely to be seriously affected.
- Children and young people in low income households will be adversely affected.
- Increases in levels of homelessness and destitution.
## Section Two

**Challenges to health in Oldham**

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for Oldham are shown below. On the chart, the value for Oldham is shown as a circle, against the range of results for England, shown as a bar.

![Chart showing key indicators of health outcomes and social determinants](image.png)

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<thead>
<tr>
<th>Indicator</th>
<th>Local Authority value</th>
<th>Regional value</th>
<th>England value</th>
<th>England worst</th>
<th>Range</th>
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<td></td>
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<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Male life expectancy at birth (years)</td>
<td>75.7</td>
<td>77.0</td>
<td>78.6</td>
<td>73.6</td>
<td></td>
<td>85.1</td>
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<tr>
<td>2 Inequality in male life expectancy at birth (years)</td>
<td>11.1</td>
<td>11.1</td>
<td>8.9</td>
<td>16.9</td>
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<td>3.1</td>
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<tr>
<td>3 Inequality in male disability-free life expectancy at birth (years)</td>
<td>14.6</td>
<td>14.1</td>
<td>10.9</td>
<td>20.0</td>
<td></td>
<td>1.8</td>
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<tr>
<td>Females</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4 Female life expectancy at birth (years)</td>
<td>80.5</td>
<td>81.1</td>
<td>82.6</td>
<td>79.1</td>
<td></td>
<td>89.8</td>
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<tr>
<td>5 Inequality in female life expectancy at birth (years)</td>
<td>10.3</td>
<td>8.1</td>
<td>5.9</td>
<td>11.6</td>
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<td>1.2</td>
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<tr>
<td>6 Inequality in female disability-free life expectancy at birth (years)</td>
<td>12.8</td>
<td>12.2</td>
<td>9.2</td>
<td>17.1</td>
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<td>1.3</td>
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<td><strong>Social determinants</strong></td>
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<tr>
<td>7 Children achieving a good level of development at age 5 (%)</td>
<td>51.7</td>
<td>57.6</td>
<td>58.8</td>
<td>49.5</td>
<td></td>
<td>71.4</td>
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<tr>
<td>8 Young people not in employment, education or training (NEET) (%)</td>
<td>8.0</td>
<td>7.5</td>
<td>6.7</td>
<td>12.3</td>
<td></td>
<td>2.6</td>
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<tr>
<td>9 People in households in receipt of means-tested benefits (%)</td>
<td>21.4</td>
<td>17.3</td>
<td>14.6</td>
<td>32.8</td>
<td></td>
<td>4.7</td>
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<tr>
<td>10 Inequality in percentage receiving means-tested benefits (% points)</td>
<td>49.8</td>
<td>40.5</td>
<td>29.0</td>
<td>55.1</td>
<td></td>
<td>4.6</td>
</tr>
</tbody>
</table>
Section Two

Challenges to health in Oldham

Source: London Health Observatory and UCL Institute of Health Equity

Indicator notes

The ‘Children achieving a good level of development at age 5’ indicator shows that in Oldham 51.7% of children were assessed by a teacher as having achieved a ‘good level of development’ in the year they turned five. This is lower than in the North West (57.6%) and significantly lower than in England (58.8%).

Eight per cent of 16 to 19 year olds in Oldham are not in employment, education or training, which is a higher percentage than in the North West (7.5%) and significantly higher than in England (6.7%).

In Oldham 21.4% of people live in households in receipt of means-tested benefits. This is a higher proportion of people than across the North West (17.3%) and England (14.6%). The ‘inequality in percentage receiving means-tested benefits’ indicator shows that 49.8% more people in the worst-off areas of Oldham are receiving benefits than in the best-off areas. This inequality is higher than in the North West (40.5%) and significantly higher than in England (29%).

In looking at what can be done to improve health and wellbeing, much thought has been given to changing people’s behaviour in relation to the risk factors that are the immediate causes of ill health. This is important and will continue. However, it is broadly recognised that the main factors that shape a population’s health will be social aspects such as readiness for school, educational success, employment opportunities, physical environment and social networks. Inequality itself is also recognised as a factor in health and wellbeing; the more unequal a society is the more health and wellbeing problems it will have.

The next section looks more closely at three of the social factors that affect health; jobs, homes and friends.

Jobs

The importance of work to health and wellbeing

In this continuing period of economic challenge retaining work and reducing impact of sickness on productivity are essential priorities. In health terms the priority is supporting people to stay in work and supporting employers to make work a positive attribute to good health. Health and Wellbeing programmes produce economic benefits across all sectors and all sizes of business: good health is good business.

Work meets important psychological needs in societies where employment is the norm. Work is central to individual identity, social roles and social status. Employment and socio-economic status are the main drivers of inequalities in physical and mental health and mortality. On the other hand various physical and psychosocial aspects of work can also be hazards and pose a risk to health.

Good work, characterised by job security, control and autonomy is associated with better physical and mental health than worklessness.

There is strong evidence that unemployment is generally harmful to health leading to higher mortality, poorer general health, long-standing illness, poorer mental health, higher medical consultation and hospital admission rates.

However there is also strong evidence that re-employment leads to improved self-esteem, improved general and mental health and reduced psychological distress and minor psychiatric morbidity. The magnitude of this impact is more or less comparable to the adverse effects of job loss.

Claimants who move off sickness benefits and (re)enter work experience improvements in income, socio-economic status, mental and general health, higher medical consultation and hospital admission rates.

In looking at what can be done to improve health and wellbeing, much thought has been given to changing people’s behaviour in relation to the risk factors that are the immediate causes of ill health. This is important and will continue. However, it is broadly recognised that the main factors that shape a population’s health will be social aspects such as readiness for school, educational success, employment opportunities, physical environment and social networks. Inequality itself is also recognised as a factor in health and wellbeing; the more unequal a society is the more health and wellbeing problems it will have.

The next section looks more closely at three of the social factors that affect health; jobs, homes and friends.
Work related health conditions

The annual economic costs of sickness absence and worklessness associated with working age ill-health are enormous. The main causes of sickness absences in the UK are musculoskeletal problems, cardio-respiratory illnesses and mental health conditions, which together account for around two thirds of all sickness absences. Alcohol misuse among employees is costly as is physical inactivity across a wide range of health problems.

In an average GP practice 1,200 in every 10,000 registered adults will have a common mental health problem. Two-fifths of work absences are caused by anxiety and depression.

Research in the UK has found that:

- musculoskeletal disorders contribute 55% of work related illness
- amongst manual workers acute back pain is the second most highly ranked cause of short term absence (54%, after the common cold) with other musculoskeletal disorders identified by 49% respondents
- musculoskeletal disorders are the second most commonly identified cause of long term absence for manual workers (44%) followed by chronic back pain (42%). Amongst non manual workers musculoskeletal disorders are the third most identified cause (31%).
- 580,000 people in England have rheumatoid arthritis (RA) with 26,000 new cases every year. Within 3 years of diagnosis half of the people with RA are registered work disabled.
- Ankylosing spondilitis (AS) affects 200,000 in the UK. Unemployment rates are three times higher in people with AS than in the general population.

Unemployment in Oldham

Oldham’s unemployment rate (5.9%) is at its highest since 1996, with rates being markedly higher among 16-24 year olds (8.2%), Bangladeshi-heritage residents (11.2%), and mixed heritage residents (10.3%), Black/Black British residents (8.7%) and Pakistani heritage residents (8.2%). Unemployment levels are particularly high in Coldhurst, St. Mary’s and Alexandra.

The rate of long term unemployment in Oldham in 2011 (7.8 per 1000) was significantly worse than in England (5.7) and was higher than in the North West (6.4). Worklessness is associated with poorer physical and mental health, higher self-reported ill health and limiting long term conditions and a higher prevalence of poor lifestyle behaviours like smoking and alcohol use.

Local survey research demonstrates a strong association between low household income and self-reported mental distress. Among those with a household income below £8,160, 43% show evidence of mental distress; more than twice the proportion (20%) among those with incomes over £36,301. Local survey research has also found that those unable to afford basic expenditures such as household contents insurance, and those concerned about being able to meet basic financial obligations in future report much higher levels of mental distress than their counterparts not experiencing the same levels of financial stress.

In Summary

Being in a job is better for health and having employment that is secure, offers the individual a level of control and a fair wage is better still. Absence from work through ill health can arise from conditions in work and/or be a reflection of the individual’s health behaviour outside work and of the features of the environment in which communities live. Unemployment is bad for health and in Oldham unemployment is currently higher in young people and in black and minority ethnic groups.
## Section Two

### Challenges to health in Oldham

#### Homes

The quality of housing affects health. The basic purpose of housing is to provide shelter, security, privacy and comfort. The characteristics of the environment where one lives can have both positive and negative effects.

Good quality housing provides natural light, adequate ventilation to ensure good air quality and reduce mould growth, includes the use of non-toxic materials, insulation to provide warmth and reduce noise, and is of a suitable design and construction to minimise injuries and falls, and other health and safety risks for the inhabitants (National Housing Federation, 2010).

Negative effects may be associated with nearby land uses, traffic, previous activities on a site, building materials used, as well as the quality of housing. Poor housing quality and homelessness are associated with a wide range of impacts on health and wellbeing. Issues such as dampness or cold temperatures, inadequate basic facilities, poor lighting, heating and ventilation, uneven or loose flooring, can make it difficult for the occupants to maintain good health and well-being.

#### Housing in Oldham

Oldham has approximately 90,000 households:

- 64.9% (58,259) are owner occupied
- 12.3% (10,944) are private rented
- 22.8% (20,396) are socially rented by housing associations of registered providers

The majority housing types in Oldham are:

- Terraced - 41.2% (38,326)
- Semi-detached properties - 33.8% (31,442)
- Flats and maisonettes - 12.6% (11,721)
- Detached - 12.3% (11,442)

Although the standard of private housing in Oldham is higher than the national average, rates of disrepair in private homes in Oldham (17.2%) are significantly higher than the national average (7.3%). The highest levels of disrepair (including issues such as poor roofs, windows and electrics) are in St Mary’s (53.3%) and Werneth wards (37.7%). There are an estimated 25,399 (37.2%) ‘vulnerable’ households in private housing in the Borough. (Private Sector Stock Condition Survey 2010)

Black and minority ethnic groups, particularly those of Asian heritage, are more likely to live in rented accommodation, pre-1919 terraced housing, larger family groups, overcrowded accommodation and houses in poor physical repair, characteristics which have implications for health.

Key hazards which may disproportionately affect Pakistani and Bangladeshi communities include overcrowding, damp and mould and excess cold.

#### Overcrowding

The proportion of overcrowded households in Oldham (7.5% or 6,772) is lower than the national (8.7%) and Greater Manchester (8.2%) levels. Oldham ranks 95th highest out of 348 local authorities in England and Wales in relation to overcrowding.

The 2010 Private Sector Stock Condition Survey found that by tenure, overcrowding is highest in private rented stock affecting 6.5% of such households. Owner occupation, in contrast, has the lowest levels of overcrowding affecting 4.1% of households.

West Oldham (12.3%) and East Oldham (8.6%) had the highest rates of overcrowding, almost three times and twice the borough average respectively. Failsworth and Hollinwood (2.6%), Chadderton (2%), Royton, Shaw and Crompton (1.9%) and Saddleworth and Lees (0.8%) had the lowest rates of overcrowding, mostly less than half the borough average.
In Oldham, the number of homelessness acceptances (households accepted by local authorities as owed the main homelessness duty) peaked in 2003/4. During this year 961 households were accepted as homeless and owed the main homelessness duty. This has reduced to 62 during the year 2012/13, a reduction of 93%. This reduction has been mirrored across neighbouring local authorities and is evident of the increased focus on prevention.

During 2012/13, 1601 households had their homelessness prevented. These figures highlight that there are still a significant number of households within the borough who are at risk of homelessness.

The main causes of homelessness within Oldham broadly reflect national trends and have remained consistent over a number of years. These include:

- Loss of lodgings
- Termination of Assured Short-hold Tenancy
- Domestic Violence
- Mortgage or rent arrears
- Required to leave accommodation provided by Home Office as NASS support

There is recognition that some groups are at increased risk of becoming homeless, including people with substance misuse difficulties, mental health issues, a history of offending and young people. There is a commitment to work across partnership agencies to support people at risk of homelessness to develop co-ordinated responses to their housing and support needs.

Fuel Poverty

Fuel poverty is defined as a household having to spend 10% or more of its disposable income on fuel use, including heating the home to an adequate standard of warmth, usually considered to be 21°C in a living room and 18°C in other rooms. Fuel poverty is influenced by poor housing, level of household occupancy, household incomes and fuel prices. It is estimated that 19.8% of the Oldham population is at risk of fuel poverty.

Vulnerable groups are the very young, older people, and those with long term illnesses or disability. Fuel poverty has particular relevance to health.

Diseases that may be made worse by living in a cold and/or damp home include Respiratory Diseases (Asthma. Chronic Obstructive Pulmonary Disease (COPD), Respiratory infections), Cardio Vascular Disease (Angina, Hypertension (high blood pressure), Heart disease, Cerebral vascular Accident (stroke)) and Musculoskeletal Diseases (Arthritis (any type), Back pain (long-term or severe), Damaged joints).

In 2010 Oldham had an overall rate of 19.8% of households classified as being in fuel poverty. In five areas this rose to over 35% of households. Over the last winter period (2010/11) there were 100 extra deaths than would have been expected.

Mostly the excess winter deaths are in people aged over 65 but children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems with implications for school attendance.

In 2012 the Oldham Council, Oldham Housing Investment Partnership and Oldham Clinical Commissioning Group agreed on an innovative approach to jointly commission work to take households out of fuel poverty in Oldham. This agreement will be put in place during 2013-14 and evaluated to see if it is working.

In Summary

The majority of homes in Oldham are in private ownership including privately rented accommodation. Rates of disrepair in private homes in Oldham (17.2%) are significantly higher than the national average (7.3%) and are highest in East and West Oldham. Overcrowding is an issue for a minority of homes but is higher in privately rented accommodation. Homelessness levels in Oldham have fallen significantly. Pakistani and Bangladeshi heritage communities are at greater risk of problems of ill health associated with poor housing. Fuel poverty and associated illness is a risk for close to one fifth of the Oldham population.

Friends

According to a recent review the effect of loneliness on mortality is comparable with or may even exceed the impact of factors such as physical inactivity and obesity, and is similar to the effect of cigarette smoking and alcohol consumption. Lonely individuals are at higher risk of hypertension and are more prone to depression, cognitive decline and dementia. Loneliness is associated with poor sleep, feelings of fatigue and low energy. Loneliness is a significant predictor of the onset of disability in older men who live alone.

Older people emphasize the importance to their quality of life of ‘companionship’ and of having ‘social or voluntary activities’. Yet nationally between 6-13 per cent feel lonely often or always. The percentage at risk of loneliness is likely to be much larger; half of all older people (about 5 million) say that the television is their main form of company.

As shown earlier the numbers of people over 75 and 85 in Oldham is projected to grow. Family dispersal and the number of single person households are likely to increase. These trends suggest that the problem of loneliness and isolation are likely to grow unless addressed.
Loneliness and isolation are not the same thing. Loneliness is a subjective negative feeling associated with loss (e.g., bereavement of a partner or a child relocating) whilst social isolation is the absence of meaningful relationships and contact with normal social networks caused by loss of mobility or deteriorating health. Whilst social isolation may be either voluntary or involuntary, loneliness is not something anyone would choose voluntary.

Loneliness is influenced by personal circumstances and events but is also subject to social, cultural and psychological factors. The causes of loneliness include not just physical isolation and lack of companionship, but also, lack of (or perception of a lack of) a useful role in society, low morale and lack of access to private transport.

A number of population groups are vulnerable to social isolation and loneliness including young care leavers, refugees, those with mental health problems, those who are widowed, or who have no children, and those on low incomes. Both loneliness and isolation increase with age and in those with health problems.

The English Longitudinal Study of Aging (ELSA) data, released every two years, can be used as a national dataset to benchmark local measurements against. Information released from five waves of the study in October 2012 showed that 1 in 20 adults over 50 are “detached” from social networks and that women were more likely to be detached from leisure activities than men, but less likely to be detached from social networks.

Older adults who are “single, separated or divorced, or widowed were more likely to be detached from three or more domains” than older adults living as part of a couple. Older adults with the lowest income, poor health and low education were more likely to be socially isolated. The report noted that limited access to private or public transport caused older adults to be more likely to not take part in “civic participation”, leisure activities and cultural engagements.

Analysis of the ELSA data also found that measurements of psychological wellbeing in 2004-5 could predict “onset of disability, slower walking speed, impaired self-rated health and the incidence of coronary heart disease in 2010-11”. Finally that those identified as having a greater enjoyment of life in 2002-3 were more likely to be alive nine years later, with the risk of dying being three times larger for people reporting lowest enjoyment of life (this was independent of other factors including age, wealth, health and education).

Loneliness and Social Isolation in Oldham

The 2010 You and Your Community Survey (a survey of Oldham residents aged 16+) found that around two-thirds of respondents (69%) were ‘satisfied with their life as a whole nowadays’ and 12% were dissatisfied. This varies between wards, with 55% in St. James’ and 87% in Saddleworth North. Dissatisfaction with life is highest among 16-44 year olds with disabilities (28%) and unemployed people (31%).

Residents were also asked about the number of good friends they had that lived nearby. Most (84%) had at least one good friend living nearby, fewer than in 2008 (87%). Around one in six (16%) had no good friends living nearby, proportionally more than in 2008 (13%). This ranged from 27% in Alexandra to 8% in Royton South.

Those who are less likely to have friends in their neighbourhood were:

- Residents aged 85+ (27% have no good friends living nearby compared with 16% overall)
- Residents with a disability (20%)
- Social tenants (19%)
- Those who live alone (21%)
- Residents from a white background (17% compared with 10% from a BME background)
- Residents living in Failsworth West (25%), Royton North (23%) and Alexandra (27%).
- Those with friends living nearby are more likely to feel a sense of belonging to their neighbourhood than those without (75% of those with five or more friends, compared with 47% among those without friends nearby).

In Summary

Loneliness and social isolation is bad for health and can predict future health problems. Older people are more prone to loneliness and social isolation and in particular people with low income, poor health and lower educational achievements. In Oldham the majority of people feel that they have at least one good friend nearby. However the proportion of people who feel they do not have good friends nearby is a significant minority and this varies across Oldham linked to levels of deprivation age, disability, social housing and ethnicity – resident from a white background reporting a higher level of isolation.
Section Three
What we need to do

In the previous sections I have shown how the population of Oldham is growing and continuing to change. I have also set out information about the health of the Oldham population, risk factors to health and the importance of the on-going social determinants of health that give us today’s pattern of wellbeing and illness in Oldham.

In this section I will set out what I think we should focus on to improve health and reduce inequalities in health in Oldham. This will not be an exhaustive list and will need more detail before activity is commissioned. I will make recommendations for the Health and Wellbeing Board in Oldham. The final section will be the Public Health Charter for Oldham as a positive statement of how the council will work with partners and people in Oldham to improve health and wellbeing.

Active and Engaged Communities

It has been a mainstay of international public health since the Ottawa Convention of 1986 that the promotion of health is most likely achieved through concrete and effective community action. At the heart of this is the empowerment of communities and the development of ownership and control for individuals and communities of their own destinies and endeavours.

In this approach a health asset is any factor that enhances the ability of individuals and communities to sustain health and wellbeing. Taking an assets approach leads to activities that are mainly about doing things with people rather than to them or for them. It is the goal of this approach that people do things to enhance their lives in partnership with other people in their communities. Systems of health and care provision come into play only when they are needed.

We need to move away from an overwhelming focus on deficits in health. By that I mean describing what is missing or a problem in a community in order to then describe a need for a service, usually healthcare, social care or behaviour change. This approach has value in informing the commissioning of services. However it does tend to follow a path towards the provision of services that respond to a problem and that provide services to people or for them.

Oldham’s District Partnerships are increasingly becoming the focus for the development of a cooperative approach to improving life for people in the borough. Recent developments have seen the creation of posts in each partnership to promote community development and youth work. In East Oldham there has been interest in piloting Asset Based Community Development for some time and several projects have been underway.

Such an approach has direct relevance to already existing priorities in the Oldham Health and Wellbeing Strategy. Giving every child the best start in life is a strategic theme that has relevance in Oldham and across the country. In addition to work through children’s centres and nurseries to better prepare children in Oldham for school, an asset approach to supporting communities will help to build the social context to change chances for children in Oldham.

An asset based community development approach will help to reconstruct communities by connecting people and further activating assets. The intention is to create an environment in which people, and children particularly, see the world as a structured place in which they can be confident of dealing with the challenges and to move on. Developing such an environment and outlook will enable children to recover from adverse life events that would otherwise affect their physical and mental health.

The present economic environment and the policies being followed to tackle it mean that there is less money for the provision of public services. Revision of the welfare system will have an impact on the communities in Oldham where health and wellbeing is currently at its worst. These developments make it more imperative to support communities to resist the challenges to their health and well-being.

Responding to this reduction in the provision of public services with the Cooperative Oldham programme in which people and communities are encouraged to do more for themselves sets up the opportunity to invest in support to communities through asset based community development on a large scale.

Harry Burns, Chief Medical Officer in Scotland, has set out three stages for development of community activity including collaborative planning, community organisation and action and transformational change. Parts of this approach are underway across Oldham but to varying degrees of investment and success. It is right that the focus on improving health should turn to activity that supports communities to take control of their lives.

The Health and Wellbeing Board in Oldham is recommended to:

- lead engagement with communities
- explore the sharing of power with communities, and
- request the investment of resources over years by Oldham Council and Oldham CCG in community development at a scale that is sufficient to have an impact on health
Regulating Risks

As well as the systems of care mentioned earlier that emerge around problems and needs, there are other systems that similarly identify commercial opportunities in communities and emerge to meet that perceived need. Such systems can undermine the health of a community by promoting need that leads to over consumption of alcohol, high calorie or high salt food or of tobacco.

It is important to support communities to sustain health and wellbeing by regulating the efforts of some systems to create a need and exploit it for commercial gain while also having a negative impact on health. Regulation such as the ban on smoking in public spaces has been successful in promoting health in unforeseen ways. The government is currently consulting on the right level to set a minimum price for the sale of alcohol as a means of ensuring that the alcohol retail system will have less impact on community wellbeing. Such action will be necessary to support communities to act on their own health and relevant in other systems such as food production and retail, town planning and transport.

The Health and Wellbeing Board is recommended to:

- Continue to support the introduction of a minimum unit price of alcohol set at 50p/unit
- Support the development of proposals to regulate the sugar content of soft drinks
- Consider the availability and further regulation of the availability of take away foods in Oldham

Jobs

The aims of a work and health strategy include keeping people healthy at work and providing accessible support to enable them to return to work after illness or injury.

Most of the financial benefits of health and wellbeing programmes take the form of cost savings rather than increased income or revenue flows. Programmes typically include ergonomic support and improvements, physiotherapy, physical wellbeing, flu immunisation.

One of the core components of work that protects good health and promotes health is enabling individuals to exert some control over their working environment through participating in decision making.

Early intervention when an employee becomes ill is proving very successful in preventing further health problems developing and getting people back to work quickly. There is research support for an early intervention service to help sick certified people to return to work.

The Fit For Work programme is being piloted across the country. The service takes referrals from GPs, employers and self-referrals for patients who have been signed off work for more than four weeks. The service works with the patient, their employer and GP, and addresses the barriers of returning to work including muscular and joint pain, mental health problems, and worries about family, money or work itself. The results from the pilot studies show three quarters of those referred returning to work, on average, within six weeks.

The Health and Wellbeing Board is recommended to:

- Request Oldham Council and CCG to invest in an early intervention service following the model of the Fit For Work programme
- Request Oldham Partnership to explore the means of supporting employers to develop employee participation in decision making in workplaces

Homes

Working between Oldham’s Clinical Commissioning Group, Oldham Council and First Choice Home housing association led to the development of the Joint Investment Agreement, with work targeted toward those most at risk of being in fuel poverty. The joint investment agreement aims to lift a thousand individuals out of fuel poverty, which will improve their quality of life and reduce their risk of poor physical and mental health.

In Oldham the housing associations are enthusiastic in wanting to engage in activity to improve the health of their tenants and of the population in Oldham. First Choice Homes Oldham has taken steps to raise health and wellbeing high on its agenda.

The Health and Wellbeing Board is recommended to:

- Support the implementation of the joint investment agreement on fuel poverty and its evaluation and further action following evaluation.
- To seek further investment in joint working with housing associations to deliver health and wellbeing programmes for tenants of social housing in Oldham.
Friends

Interventions to address social isolation and loneliness include:

- One-to-one interventions – befriending, mentoring and gate-keeping
- Group services
- Wider community engagement

Befriending - ‘an intervention that introduces the client to one or more individuals, whose main aim is to provide the client with additional social support through the development of an affirming, emotion-focused relationship over time’. The term covers many, varied initiatives, using involving volunteers or paid workers visiting an individual in their own home on a regular, time-limited basis but may include telephone or group befriending.

A systematic review of befriending schemes reported modest but significant reduction in depressive symptoms in the short and long term compared with usual care or no treatment.

Mentoring is ‘a relationship between a volunteer and an individual based on meeting agreed objectives set at the onset and where a social relationship if achieved is incidental’. Mentors work with the client on a short-term basis and one goal is to provide clients with the necessary skills and abilities to continue any achieved changes after the end of the mentoring period.

Gatekeeping – volunteers act as an interface between vulnerable or ‘hard-to-reach’ people and community and public services, providing them with emotional, practical and social support and helping them access appropriate interventions.

Group services – include day-centre services (such as lunch clubs) and social groups schemes which aim to help people to widen their social circles (including self help groups), the structure and ways of working depend on the groups’ needs.

Common characteristics of effective interventions in older people are those developed within the context of a theoretical basis, and those offering social activity and/or support within a group format. Interventions in which older people are active participants also appear to be effective.

Wider community engagement – includes programmes that support individuals to increase participation in existing activities (e.g. sport, use of libraries and museums) as well as use outreach and volunteer schemes. These include time banks.

Improving access to public and private transport for people aged over 50 to alleviate social isolation is recommended.

The Health and Wellbeing Board is recommended to

- target those groups affected e.g. lower social economic groups, the widowed, the physically isolated, people who have recently stopped driving, those with sensory impairment, less healthy older people and the very old with schemes to address social isolation and
- request prioritisation of investment from Oldham Council and CCG in schemes to reduce social isolation in Oldham.
The Oldham Public Health Charter was produced in response to the transfer of responsibility for improving health to Oldham Council. It was adopted by the Council as a way of demonstrating the Council’s commitment to doing everything it can to promote health and wellbeing in Oldham. The Charter develops themes of fairness, empowerment and working together linked to maximising value for money to make a bold statement of ambition and approach.

The approach includes ensuring that all decisions on, for example, economic opportunity, early childhood development, schools, housing, workplaces and the environment contribute positively to the health and wellbeing of Oldham people. The Charter is presented here in full.

The Oldham Public Health Charter

Our Ambition

Oldham is committed to creating the conditions for residents to take greater control over their own lives and enjoy the freedoms that lead to healthy and independent lives.

Our Approach

To help make this ambition a reality we have developed a values based approach to Public Health that draws from the Cooperative Charter for Oldham to focus on working collaboratively with residents, communities and partners to address the factors that impact on health and wellbeing in Oldham.

Fairness

People in different social circumstances experience different levels of health. In Oldham we will focus on reducing these differences as a matter of fairness and social justice.

Health in All Policies

A broad range of issues have a significant impact on health. This means that building a healthier Oldham will hinge largely on what is done to change policies that influence wider factors, such as economic opportunity, early childhood development, schools, housing, workplaces and the living environment. The current economic challenge to Oldham means that social value must be created from investments to have a positive impact on health and wellbeing. Everyone has a role to play in promoting health and we expect everyone to play their part, including individuals and communities as well as the public, private and voluntary sectors.

Empower Individuals and Communities

We will work in co-operation with residents to empower individuals and communities to be active in improving the health of people in our borough. This means that we will work with people to co-produce priorities and build on community assets to improve health. This will be achieved by devolving responsibility and activity to neighbourhood levels of working. Information about the state of health and wellbeing in Oldham and the ways that health can be improved will be made available to the public.

Evidence and Effectiveness

We will focus on action which is supported by strong evidence to deliver improvements to the health of people in Oldham. This will help us to ensure that public money is spent on actions which will achieve good quality health and social care, empowered individuals and communities, and a reduction in health inequalities.

Working Together

We will work together with the healthcare, voluntary and community sectors to support each other in achieving common goals in health and wellbeing, focusing on the potential of primary care services to support community wellbeing and work with partners to deliver more services through a neighbourhood model. We will work collaboratively to support the commissioning of effective and efficient health and social care services.

Protection

We will protect the Oldham population from threats to health by ensuring that preparedness for emergencies, immunisation, screening and early detection and infection control programmes are in place.

Our Resources

We will seek to maximise the value that we can achieve with our resources.

We will make effective use of the Public Health budget to deliver better health and wellbeing across Oldham. We will also promote better use of the council’s resources as a whole as well as those of our partners in order to achieve better health and wellbeing in Oldham.

We will capitalise on our specialist Public Health expertise to ensure that we build and maintain a detailed understanding of what has to be done to create an environment that supports positive health across Oldham, and the most effective way of achieving this.

We will work collaboratively with councils and partners across Greater Manchester to share Public Health capacity to greater effect, achieve greater impact in public health actions, and advocate for changes to national policies in order to achieve local improvements in health and wellbeing.
Sources for Key Sections

Demography and Health and Wellbeing in Oldham

Joint Strategic Needs Assessment for Oldham 2012

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